Evaluation of the UNFPA support to the HIV response (2016-2019)

Namibia

COUNTRY CASE STUDY

UNFPA Evaluation Office

2020

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FOREWORD

A founding Cosponsor of UNAIDS, UNFPA is a key partner in the global HIV response. It is a co-convenor (together with other United Nations Funds and Programmes) on HIV prevention among adolescents, youth and key populations, as well as on the decentralisation and integration of SRHR and HIV services. UNFPA also plays a technical role in prevention and condom programming within the Global Prevention Coalition and, as a chair of the UNAIDS Committee of Cosponsoring Organizations, is at the centre of the mechanism for coordinating the global response to HIV and AIDS.

Compared with a decade ago, HIV infections have declined globally, AIDS-related deaths have seen a dramatic reduction and considerable progress has been made towards the 90-90-90 targets. However, the global HIV care continuum is marred by considerable variations with several regions experiencing sharp increases in new infections. It also presents gaps that are greater for men, young people and key populations, while women continue to be disproportionately affected by the epidemic. Across the world, almost 10 million people await treatment and 1.7 million people acquire HIV every year, half of whom are among key populations and their partners.

The purpose of this evaluation is to assess the performance of UNFPA in integrating its approach to supporting the HIV response within the broader context of SRHR, population dynamics, gender equality and human rights. As part of this assessment, the evaluation paid particular attention to the contribution of UNFPA to: the prevention of sexual transmission; the linking of HIV with other aspects of SRHR and SGBV; and the promotion of gender equality and human rights in the context of HIV.

The evaluation of the UNFPA support to the HIV response covers the period from 2016 (when the current UNAIDS strategy was rolled out) to 2019 and is structured around a series of regional and country case studies. It also rests on key informant interviews, a comprehensive review of documents and data sets at global, regional and country levels, as well as an online survey of key informants in 59 countries. The case studies were selected to provide an illustrative example of UNFPA work to support the HIV response in very diverse contexts.

The overall evaluation highlights how UNFPA has been able to leverage the UNAIDS Division of Labour to guide its support to the HIV response at global, regional and country levels and has made an important contribution to meeting the needs of the most vulnerable. However, it also indicates that the absence (at corporate level) of a transformative result conveying a strong priority for realizing the rights of, in particular, the key populations, as well as a lack of an explicit strategy for UNFPA support to the HIV response have inhibited UNFPA from fully deploying its capacities to champion the rights of KPs. UNFPA has, however, demonstrated that linking and integrating SRHR, HIV and SGBV services is an effective approach to meeting the needs of the AGYW, other vulnerable groups and KPs. In fact, the evaluation points to the need to develop and strengthen guidance to regional and country offices on piloting and scaling integration at national level.

The overall evaluation also recommends that UNFPA builds on the results it has achieved and develops a strategy for its support to the HIV response. This strategy should detail the role of the Fund at global, regional and national levels and, aligning its responsibilities as a UNAIDS Cosponsor with UNFPA core mandate areas, should seek synergies between the HIV programming and other internal strategies and programmes in support of the transformative results. UNFPA should also continue to assert the critical importance of comprehensive condom programming and extend support to both supply chain strengthening and demand creation, especially among young people.

The present report provides the reader with a summary of the overall evaluation, followed by a presentation of the Namibia case study. Anchored in the Sub-saharan epidemic and cultural setting, where HIV prevalence keep going up for women and where girls represent four out of five new infections among adolescents, the Namibia case study results in a rich and detailed account of a UNFPA response tailored for the people in greatest need. It should be read in conjunction with the overall evaluation report and I encourage the reader to compare it with the other case studies (Indonesia and Georgia).

This evaluation would not have been possible without the invaluable inputs and support from a wide range of stakeholders, both within and outside UNFPA. I am deeply appreciative of the considerable time and contributions of colleagues working on the HIV response in UNFPA headquarters, regional offices and country offices who generously shared their knowledge. This evaluation also benefited from the critical insights of all technicians reunited in the Evaluation Reference Group, who co-authored a set of recommendations based on the independent conclusions of the report. Last but not least, I am extremely grateful to the colleagues in Regional Office in Johannesburg, as well as in the Country Office in Windhoek for the crucial role they played in facilitating the extensive data collection by the evaluation team for the present case study.

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ABBREVIATIONS AND ACRONYMS

AfriYAN	African Youth and Adolescent Network
AGYW	Adolescent Girls and Young Women
AIDS	Acquired immunodeficiency syndrome
ANC	Ante-Natal Care
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral Pharmaceuticals
CDC	Centre for Disease Control, United States Government
CO	Country Office
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organization
DPHC	Directorate for Primary Heath Care, Ministry of Health and Social Services
DSP	Directorate for Special Programmes
EAC	East African Community
EECA	Eastern Europe and Central Asia
EECARO	Eastern Europe and Central Asia Regional Office of UNFPA
EHG	Euro Health Group
EMTCT	Elimination of mother-to-child transmission
ERG	Evaluation Reference Group
ESA	East and Southern Africa
ESARO	East and Southern Africa Regional Office of UNFPA
FSW	Female Sex Worker
GBV	Gender-based violence
GTZ	German Technical Cooperation
HIV	Human immunodeficiency virus
HRBA	Human Rights-Based Approach
HTC	HIV Testing and Counselling
IBBS	Integrated Biological and Behavioural Surveillance Study
IOM	International Organization for Migration
IPPF	International Planned Parenthood Federation
JUNTA	Joint UN Team on AIDS
KP	Key Population
LGBTI	Lesbian, Bisexual, Gay, Transgender and Inter-sex
MDG	Millennium Development Goal
MEAC	Ministry of Education, Arts and Culture
MGECW	Ministry of Gender Equality and Child Welfare
MoHSS	Ministry of Health and Social Services
MSM	Men Who Have Sex with Men
MSYNS	Ministry of Sport, Youth and National Service
NAEC	National Aids Executive Committee
NAMPHIA	Namibia Population Based HIV Impact Assessment
NANASO	Namibia Network of AIDS Service Organizations
NAPPA	Namibia Planned Parenthood Association
NDHS	Namibia Demographic and Health Survey
NHA	National Health Accounts
NHISS	National HIV Sentinel Survey
NIMART	Nurse Initiated Management of ART
NSA	National Statistics Agency

NSF	National Strategic Framework
NYC	National Youth Council
OFL	Office of the First Lady
ORN	Out-Right Namibia
PEP	Post-Exposure Prophylaxis
PEPFAR	Presidents Emergency Fund for AIDS Relief (US)
PF	Parliamentary Forum
PLHIV	People Living With HIV
PMTCT	Prevention of Mother to Child Transmission
PNC	Post Natal Care
PrEP	Pre-Exposure Prophylactic
RIAP	Regional Intervention Action Plan
RO	Regional Office
SADC	Southern Africa Development Community
SFH	Society for Family Health Namibia
SGBV	Sexual Gender-Based Violence
SPD	Special Programmes Directorate
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
SYP	Safeguard Youth Programme
The Global Fund	The Global Fund for AIDS, Tuberculosis and Malaria
TWG	Technical Working Group
UBRAF	Unified Budget, Results and Accountability Framework (UNAIDS)
UHC	Universal Health Coverage
UMIC	Upper-Middle Income Country
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV and AIDS
UNCT	United Nations Country Team
UNESCO	United Nations Education Social and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNPAF	United Nations Partnership Framework
USAID	United States Agency for International Development
USD	United States Dollar
USG	United States Government
VMMC	Voluntary Male Medical Circumcision
WFP	World Food Program
WHO	World Health Organisation

GLOSSARY OF TERMS

Term	Definition	Source
Combination HIV prevention	A combination HIV prevention approach provides defined packages of services, including behavioural, biomedical and structural components, tailored to high priority population groups within their specific local contexts. A focus on supporting prevention choices helps to overcome fragmentation of prevention programmes into distinct streams for each prevention tool or intervention, often championed by different agencies and implemented separately. This does imply, however, that local stakeholders – including local governments, local civil society organizations and local communities – are at the centre of their own responses.	UNAIDS (2018) *HIV Prevention 2020 Road Map*
Key populations	UNAIDS considers gay men and other men who have sex with men, sex workers and their clients, transgender people, people who inject drugs and prisoners and other incarcerated people as the main key population groups. These populations often suffer from punitive laws or stigmatizing policies, and they are among the most likely to be exposed to HIV. Their engagement is critical to a successful HIV response everywhere - they are key to the epidemic and key to the response. The term “key populations at higher risk” also may be used more broadly, referring to additional populations that are most at risk of acquiring or transmitting HIV, regardless of the legal and policy environment.	UNAIDS (2015) *Terminology Guidelines*
Risk	Risk is defined as the risk of exposure to HIV or the likelihood that a person may acquire HIV. Behaviours, not membership of a group, place individuals in situations in which they may be exposed to HIV and certain behaviours create, increase or perpetuate risk. Avoid using the expressions “groups at risk” or “risk groups” - people with behaviours that may place them at higher risk of HIV exposure do not necessarily identify with any particular group.	UNAIDS (2015) *Terminology Guidelines*
Sexual and reproductive health package	This term refers to programmes, supplies and multi-integrated services to ensure that people are able to have not only a responsible, satisfying and safer sex life, but also the capability to reproduce and the freedom to decide if, when and how often to do so. It is particularly important that this decision be free of any inequality based on socioeconomic status, education level, age, ethnicity, religion or resources available in their environment. A sexual and reproductive health package aims to guarantee that men and women are informed of, and have access to, the following resources: safe, effective, affordable and voluntary acceptable methods of birth control; appropriate health-care services for sexual and reproductive care, treatment and support; and comprehensive sexuality education.	UNAIDS (2015) *Terminology Guidelines*
Sexual gender-based violence	This is now the terminology that is increasingly being used in all contexts, as this is one of the most common forms of violence encountered, including in intimate partner relationships as well as against those who have different sexual orientations.	
Vulnerability	Vulnerability refers to unequal opportunities, social exclusion, unemployment or precarious employment (and other social, cultural, political, legal and economic factors) that make a person more susceptible to HIV infection and developing AIDS. The factors underlying vulnerability may reduce the ability of individuals and communities to avoid HIV risk, and they may be outside of their control. These factors may include: lack of the knowledge and skills	UNAIDS (2015) *Terminology Guidelines*

	required to protect oneself and others; limited accessibility, quality and coverage of services; and restrictive societal factors, such as human-rights violations, punitive laws or harmful social and cultural norms (including practices, beliefs and laws that stigmatize and disempower certain populations). These factors, alone or in combination, may create or exacerbate individual and collective vulnerability to HIV.	
Vulnerable populations	Vulnerable populations are groups of people who are particularly vulnerable to HIV infection in certain situations or contexts, such as adolescents (particularly adolescent girls in sub-Saharan Africa), orphans, street children, people with disabilities and migrant and mobile workers. These populations are not affected by HIV uniformly across all countries and epidemics. These guidelines do not specifically address vulnerable populations, but much of the guidance can apply to them.	WHO (2014) *HIV Prevention, Diagnosis, Treatment and Care for Key Populations – Consolidated Guidelines*
Young people, youth and adolescents	Child: a person under 18 years of age, as defined by the United Nations. Adolescent: a person aged 10 to 19 years, as defined by the United Nations. Young person: a person between 10 and 24 years old, as defined by the United Nations. Youth: a person between 15 and 24 years old, as defined by the United Nations. The United Nations uses this age range for statistical purposes, but respects national and regional definitions of youth.	UNESCO (2018) *International technical guidance on sexuality education: An evidence-informed approach*
	Children: According to Article 1 of the Convention on the Rights of the Child, "a child means every human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier". Adolescents: Individuals between the ages of 10 and 19 years old are generally considered adolescents. Adolescents are not a homogenous group; physical and emotional maturation comes with age, but its progress varies among individuals of the same age. Also, different social and cultural factors can affect their health, their ability to make important personal decisions and their ability to access services. Youth: This term refers to individuals between the ages of 15 and 24. Young people: This term refers to those between the ages of 10 and 24.	WHO (2014) *HIV Prevention, Diagnosis, Treatment and Care for Key Populations – Consolidated Guidelines*
Linkages and integration	Linkages refer to bi-directional synergies in policy, systems and services between SRHR and HIV. It refers to a broader human rights-based approach, of which service integration is a subset. Integration refers to the service delivery level (whether at a facility or in the community) and can be understood as joining operational programmes to ensure effective outcomes through many modalities (multi-tasked providers, referral, one-stop shop services under one roof, etc.).	Interagency Working Group on SRHR and HIV Linkages (2017) *SRHR and HIV Linkages: Navigating the work in progress 2017*

EXECUTIVE SUMMARY OF THE OVERALL EVALUATION OF THE UNFPA SUPPORT TO HIV RESPONSE (2016-2019)

Purpose and scope of the evaluation

UNFPA is a key partner in the global response to the human immunodeficiency virus (HIV). It works at global, regional and national levels and advocates for sexual and reproductive health and rights (SRHR), scaling up integrated SRHR services, intensifying HIV prevention, supplying male and female condoms and lubricants, and tackling gender inequalities. UNFPA is a founding cosponsor of UNAIDS and, in the UNAIDS Division of Labour, is a co-convenor (with UNDP) on HIV prevention among key populations (KPs). UNFPA is also a co-convenor on HIV prevention among adolescents and youth (with UNICEF and UNESCO), and the integration of SRHR and HIV services (with WHO).

The purpose of this evaluation is to assess the performance of UNFPA in integrating its support to the HIV response within the broader context of SRHR, population dynamics, gender equality and human rights. The evaluation covers the period 2016-2019 and all types of interventions and responses to HIV supported by UNFPA at global, regional and national levels.

Methodology

The evaluation aims to identify the contribution made by UNFPA and adopts a theory-based approach with analysis of the intended results of UNFPA support. It also analyses the contextual factors related to the nature of the HIV epidemic and the response. The evaluation team developed a theory of change for all aspects of UNFPA support and, ultimately, detailed evaluation questions, which set out the areas of research. Associated with each question, key causal assumptions were tested via indicators using primary and secondary data gathered, analysed and presented by the evaluation team.

Data collection was structured around two regional and five country case studies supported by a wide range of methods: key informant interviews, a review of all relevant documents and data sets at global, regional and country level, and an on-line survey of key informants in 59 countries.

Main findings

The UNAIDS Division of Labour has served as an organizing framework to guide UNFPA efforts to promote HIV prevention and to link and integrate sexual reproductive health and rights/HIV/sexual gender-based violence (SRHR/HIV/SGBV) programming and services. Some UNFPA regional offices and country offices studied have been able to match their respective capacities, comparative advantages and mandates to their assigned role in HIV support, often with minimal resources. Country offices in Eastern Europe and Central Asia (EECA) and East and Southern Africa (ESA) have benefited from technical assistance, coordinated advocacy and programmatic support from regional offices: a level of support which may not be available in other UNFPA regions. For UNFPA overall, there is a tension between the role UNFPA has assumed under the UNAIDS Joint Programme, and the perceived diminished priority of HIV within the UNFPA strategic plan 2018-2021 (with reduced human and financial resources allocated to HIV dedicated programming). This has limited the ability of UNFPA to fulfil its expected leadership roles.

UNFPA has directed considerable effort towards promoting the rights of the most vulnerable, including adolescent girls and young women (AGYW), other young people at risk and KPs. This includes identifying crucial issues for policy and advocacy, and supporting efforts to improve the legal and policy environment for young people and key populations. However, these efforts are hindered

by the fact that the transformative results in the UNFPA strategic plan 2018-2021 do not refer specifically to the rights of young people and key populations in relation to HIV prevention, testing and treatment (although the ESA Regional Office has adopted a fourth transformative result: The elimination of sexual transmission of HIV and sexually transmitted infections). Another constraint to effective rights promotion has been the limitations UNFPA has experienced in basing its groundwork for rights policy and advocacy on an understanding of the challenges faced by the most vulnerable at the point of service delivery.

UNFPA has demonstrated a commitment to promoting linkages and supporting the integration of SRHR/HIV/SGBV services to improve access for marginalized, at-risk persons and key populations. UNFPA has also contributed to achieving quality, client-centred services at country level, especially in ESA, with strong support from the regional office, effective regional partners, and access to multi-year/multi-country funding for support to linkages and integration. However, efforts to scale integration of SRHR/HIV/SGBV services to national level face significant institutional and operational challenges. UNFPA has gained important experience at the regional and national level in ESA, but this does not yet sufficiently inform advocacy at global level. There is also a gap in UNFPA support to supply chain management for condoms and, in general, support to comprehensive condom programming (CCP) in the countries studied.

UNFPA has been active in forging partnerships and working with networks on critical aspects of the HIV response. At regional and country level, UNFPA has demonstrated an ability to foster strong relationships with organizations and networks led by adolescents, youth and key populations to support their capacity to engage meaningfully in national dialogue and action. At global level, a lack of common understanding within the organization on the priority assigned to the HIV response impairs UNFPA capacity to execute its mandate for leadership on HIV prevention. For instance, UNFPA has not yet maximized its comparative advantage and taken a lead role in revitalizing condom programming and SRHR/HIV/SGBV integration in response to the ECHO trial that highlighted the need to integrate HIV prevention, including condom programming, into family planning services.

UNFPA is an active and respected participant in mechanisms for coordinating support to the HIV response at global, regional and national levels. At global level, UNFPA staff participate actively in mechanisms and processes for budgeting and accountability of the UNAIDS Joint Programme and play a central role in the UNAIDS Committee of Cosponsoring Organizations (CCO) and the Global HIV Prevention Coalition. At both regional and country levels, UNFPA has supported efforts to improve sustainability and encourage national investment alongside its United Nations partners and other sources of financial support. However, many countries remain highly dependent on external sources of finance for HIV prevention.

Conclusions

1. UNFPA has been able to utilize the UNAIDS Division of Labour to guide its support to the HIV response in a manner consistent with its comparative advantages. However, strategic plan 2018-2021 does not explicitly recognize the central role UNFPA should play in preventing sexual transmission of HIV and realizing the rights and meeting the needs of key populations. As a result, there is an imbalance between the outward-facing ambition of UNFPA to fill a leadership role in the global HIV response and the inward-facing attention and priority paid to this responsibility. This imbalance, combined with the lack of an agreed UNFPA HIV strategy supported by a theory of change, and the necessary financial and human resources, has limited the ability of UNFPA to use advocacy to shape the global agenda and ensure prioritization of comprehensive HIV prevention. In countries where external resources are limited and the allocation of UNFPA core resources is constrained by the UNFPA business plan, these factors have contributed to an insufficient level of

attention to HIV prevention in family planning and a lack of prioritization for comprehensive condom programming.

2. UNFPA has made important contributions to realizing the rights and meeting the needs of the most vulnerable, including adolescent girls and young women and key populations. However, a number of factors inhibit the capacity of UNFPA to play its expected role in championing their rights and the ability of country offices to engage on sensitive issues in order to reform the broader legal and policy framework. The absence (at corporate level) of a transformative result conveying a strong priority for realizing the rights of, in particular, key populations, and the lack of an explicit strategy for UNFPA support to the HIV response, diminish the focus required for more effective action on rights. This is further limited by a UNFPA business model that does not foresee service delivery as a mode of engagement in many countries, hence constraining the capacity of country offices to address the ability of the most vulnerable and key populations to access quality services in HIV prevention, testing and treatment free from discrimination. These are often countries (as in EECA) where the pace of HIV infection is rising and is concentrated among key populations. Yet, support to rights promotion and meeting the needs of the most vulnerable is of limited effectiveness when not rooted in efforts to improve access to rights-based services.

3. UNFPA support has demonstrated that linking and integrating SRHR/HIV/SGBV programmes and services is an effective approach to meeting the needs of adolescent girls and young women, other vulnerable groups and key populations. UNFPA has also responded effectively to the proven link between sexual and gender-based violence and HIV infections among adolescent girls and young women by extending the integration agenda to include SGBV. UNFPA has made an important contribution to achieving quality, integrated services in SRHR/HIV/SGBV, especially in countries taking part in the 2gether 4 SRHR programme in ESA. This can be attributed to access to consistent financial support for this large multi-country project focused on linkages and integration, combined with a strong regional partnership with the Southern Africa Development Community (SADC), and sustained advocacy and technical support by UNFPA staff. However, the understanding, level and nature of support to integration varies widely across UNFPA regions and countries. Furthermore, the relative absence of UNFPA support to comprehensive condom programming in many countries can undermine some of the results obtained through linkages and integration of SRHR/HIV/SGBV.

4. UNFPA has effectively forged partnerships and worked with networks at regional and country level to promote meaningful participation of adolescent girls and young women, key populations and other vulnerable groups in the policy process. UNFPA has also contributed to the effectiveness of networks and civil society organizations (CSOs) led by adolescents, youth and key populations. However, empowering these partners requires adequate and sustained investment over time in order to build their capacity to engage in advocacy and policy-making to improve the HIV response, broader SRHR policies and the overall legal framework. Yet, UNFPA support to networks is currently constrained by a lack of guidance on how to extend participation beyond the stages of programme design and implementation into accountability by partner governments for effectively realizing the rights of young people, key populations and other vulnerable groups.

5. UNFPA participates actively in platforms and mechanisms for coordinating actions in support of the HIV response at global, regional and national levels. These platforms have successfully avoided duplication of efforts and conflicting messages from the United Nations country teams in host countries. UNFPA participation in coordinating mechanisms does, however, require a significant investment of time and resources. In addition, coordination among partners with a view to increasing and sustaining investments in HIV prevention, testing and treatment has been limited. This is despite the fact that the need is particularly acute in countries transitioning to upper-middle income country (UMIC) status, where resource-allocation models for large-scale programmes can result in abrupt

reductions in multilateral support. Reliance on external funding for key aspects of the HIV response by many countries presents a continuing risk to the sustainability of progress made.

Recommendations

1. Clarifying the role and strategic orientations of UNFPA on HIV

While the UNAIDS 2018 Division of Labour helps to guide UNFPA interventions, it cannot replace a clear statement from UNFPA senior management regarding the roles and responsibilities of the organization in the HIV response. UNFPA, as a matter of organizational priority, should develop and adopt a strategy for its support to the HIV response. This strategy should include the appropriate level of human and financial resources, setting priorities, and accommodating the flexible application of the business model. It should be supported by a theory of change detailing the role of UNFPA at global, regional and national levels, aligning UNFPA responsibilities as a UNAIDS cosponsor with UNFPA core mandate areas, and seeking synergies between UNFPA HIV programming and other internal strategies and programmes, in support of the transformative results of the strategic plan 2018-2021.

2. Meeting the needs of those left behind and promoting their rights

UNFPA needs to take steps to close the gap between rhetoric and action regarding human rights-based approaches in SRHR. To this end, it should develop tools for operationalizing the UNFPA commitment to rights in different technical areas, including in contributing to the HIV response. This should include explicit programming tools placing the promotion of rights - including the rights of adolescent girls and young women, key populations and other vulnerable groups - as a core strategic pillar of UNFPA work in support of the HIV response. It should also include efforts to promote rights literacy among UNFPA staff, service providers and communities. Finally, it should encompass the strengthening of accountability mechanisms or other components related to the identification (and follow-up) of potential violations of rights, especially in relation to access to quality SRHR services.

3. Linking and integrating SRHR/HIV/SGBV

Linking and integrating SRHR/HIV/SGBV services is key to an effective and sustainable national response to HIV. There is a need for UNFPA to build on lessons learned from the ECHO trial results, as well as from the experiences in EECA, ESA and other regions, to develop and strengthen guidance to regional and country offices on piloting and scaling linkages and integration at national level. This guidance should take stock of the diversity of contexts in which UNFPA operates, and should be communicated across all regional and country offices. The intent is to ensure that UNFPA maintains strong leadership on linkages and integration, and that country offices can be effective in supporting related programmatic action at country level, with regional offices providing the advocacy and technical support as needed.

4. Asserting leadership in comprehensive condom programming

UNFPA should continue to assert the critical importance of comprehensive condom programming and promoting its role in championing triple protection (prevention of HIV, other sexually transmitted infections (STIs) and unintended pregnancies). This should include providing support to condom programming (male and female condoms and lubricants) that is comprehensive and covers both supply and demand. Important elements of a comprehensive approach should include, in particular, further integration of condom programming into UNFPA support to family planning programmes. It should extend to strengthening supply chains (including in countries that do not currently benefit from the UNFPA Supplies Programme) and bolstering demand creation, especially among young people. A comprehensive approach to condom programming should also foresee the

reinforcement of public-private-people partnerships for increasing access to, and uptake of, condoms and lubricants.

5. Forging partnerships and supporting networks

UNFPA should increase support to the development of the community of regional and national networks by leveraging and allocating resources to strengthen the capacity of CSOs (particularly those catering for or led by KPs, adolescent girls and young people) to engage effectively in policy dialogue, and to access funding from national and international sources. UNFPA should also promote linkages between global, regional and national networks for advocacy and engagement of KPs, AGYW and other young people. Finally, UNFPA should explore collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria to support grant applications and the implementation of HIV prevention programmes, especially for programmes focused on AGYW and KPs.

6. Coordination and sustainability

UNFPA should take action to address risks to the sustainability of the HIV response as part of its role as a UNAIDS Cosponsor participating in the Joint Programme at global, regional and country levels. UNFPA should also advocate and collaborate with other development partners to promote sustainable HIV programming, including transition from external funding and integration of HIV into national and sector development programmes. It should advocate for increased emphasis on prevention within HIV responses under national stewardship and support national strategies and plans for incorporation of the essential package of SRHR interventions, including on HIV/STIs, into universal health coverage mechanisms. UNFPA should also consider technical assistance to national authorities developing proposals for external funding for the HIV response and ensure that the support to capacity development of health-care providers for family planning and other SRHR services does incorporate rights-based HIV prevention, testing and links to treatment.

Read the **evaluation report** of the UNFPA support to the HIV response (2016-2019) here


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1. INTRODUCTION OF THE CASE STUDY

1.1 Evaluation of UNFPA Support to the HIV Response (2016-2019)

The purpose of the evaluation is to assess the performance of United Nations Population Fund (UNFPA) in integrating its approach to HIV within the broader context of sexual and reproductive health and rights (SRHR), population dynamics, gender equality and human rights. As part of this assessment, the evaluation will pay particular attention to the contribution of UNFPA to:

- The prevention of the sexual transmission of the human immunodeficiency virus (HIV)
- The linking of HIV with other aspects of SRHR
- The promotion of gender equality and human rights in the context of HIV.

The **objective of this evaluation** is two-fold:

1. To **assess** how the framework set out in UNFPA Strategic Plans, 2014-2017 and 2018-2021 and in the United Nations Joint Programme on HIV and AIDS (UNAIDS) Unified Budget Results and Accountability Framework (UBRAF) 2016-2021, and further specified in thematic strategies and programmes (for example, UNFPA strategies for Adolescents and Youth and for Family Planning as well as for the UNFPA Supplies Programme) has guided the programming and implementation of UNFPA interventions in relation to HIV.[1]

2. To **facilitate learning** and to derive good practices from UNFPA experience in supporting efforts to address HIV across a range of key programmatic interventions in the three above-mentioned overlapping and mutually reinforcing thematic areas and in differing regional and national contexts.

1.1.1 Evaluation questions

The evaluation examines six major evaluation questions.

[1] In the case of Namibia, the country case study also takes into account the UNFPA *Regional Interventions Action Plan (RIAP) for East and Southern Africa 2014-2017 and its successor plan for 2018-201*9, both of which emphasize revitalizing HIV prevention.

Table 1: Evaluation questions by area of investigation

Evaluation criteria, areas of investigation and evaluation questions
Area of Investigation 1: UNFPA support to linking SRHR, HIV and SGBV, including integrated SRHR, HIV and SGBV service delivery
Evaluation Question: To what extent has UNFPA contributed to establishing and strengthening bi-directional linkages (policies, systems, communities and services) between SRHR, HIV and SGBV and to integrating SRHR, HIV and SGBV service delivery? (Relevance, Effectiveness, Sustainability)
Area of Investigation 2: UNFPA support to the HIV response corresponds to the needs of the at-risk and the most vulnerable, the marginalized and key populations (KPs)
Evaluation Question: To what extent has UNFPA support to HIV strategies and programmes contributed to meeting the needs of the at-risk, most vulnerable and marginalized people, especially (but not exclusively) adolescents and youth, key populations, women and persons with disabilities? (Relevance, Effectiveness, Gender Equality)
Area of Investigation 3: UNFPA support to the promotion of human rights and gender equality in the context of HIV
Evaluation Question: To what extent has UNFPA support contributed to engage and empower communities (including, but not only, adolescents and youth, key populations and women) to understand and claim their rights while also effectively advocating for policies and laws affecting human rights, gender equality and access to SRHR, HIV and SGBV services? (Relevance, Effectiveness, Gender Equality)
Area of Investigation 4: UNFPA efforts to act as a broker to forge partnerships and facilitate meaningful participation of a broad spectrum of partners in the HIV response
Evaluation Question: To what extent has UNFPA been effective at global, regional and country levels in forging and/or supporting networks, coalitions and partnerships to ensure meaningful participation of governments, civil society (especially adolescents and youth and key populations) and the private sector in dialogue and action on HIV prevention – including programme design, planning and implementation? (Effectiveness, Gender Equality, Sustainability)
Area of Investigation 5: UNFPA efforts to optimize its comparative advantage within UNAIDS Division of Labour
Evaluation Question: To what extent has UNFPA been able to ensure its comparative advantages at global, regional and national levels are recognized within its roles and responsibilities under the UNAIDS Division of Labour? (Effectiveness, Coordination, Efficiency, Sustainability)
Area of investigation 6: UNFPA efforts to support coordination of actions and resources to strengthen national leadership
Evaluation Question: To what extent has UNFPA effectively supported and participated in platforms for coordinating and sustaining resources and programmes aimed at preventing HIV, especially at national level? (Efficiency, Coordination, Sustainability)

1.1.2 Region and country case studies

A key feature of the evaluation is the completion of a series of field and desk-based regional and country case studies. Namibia was chosen as one of the field-based country case studies along with Georgia and Indonesia.

Table 2: Case studies

Desk regional case studies	Field country case studies	Desk country case studies
Eastern and Southern Africa (ESA)	Namibia	Zambia
Eastern Europe and Central Asia (EECA)	Georgia	Turkey
	Indonesia	

The evaluation team also conducted visits to UNFPA regional offices for East and Southern Africa (ESARO) and Eastern Europe and Central Asia (EECARO) in support of the regional desk studies.

1.2 Objectives of the field country case studies

The field-based country case studies aim to provide insights into the evaluation questions and a comprehensive nuanced picture of programme actions and their results. They allow the evaluation to explore the evaluation questions in greater depth than would be possible in desk studies. The country case studies are not individual programme evaluations at country level. Their objectives are to:

- Provide input for answering the evaluation questions and causal assumptions
- Triangulate date collected from other sources and respondents with qualitative and quantitative information collected in country
- Identify lessons learned.

1.3 Approach and methodology

Each field country case study uses a theory-based evaluation approach based on the theory of change and causal assumptions developed for UNFPA activities related to the HIV response. The reconstruction of the theory of change is described in detail in Annex A. The causal assumptions form the basis of the Evaluation Matrix (Annex B) and enable the evaluation to determine the contribution of UNFPA to the HIV-related outcomes in the theory of change.

The data collection methods used in each field country case study are:

- Identification and review of core documents at country level, including country programme documents and annual workplans, programme review and evaluation documents, monitoring and progress reports, national plans and programmes, minutes of coordination meetings and documents produced by other bilateral and multilateral agencies supporting the HIV response
- Review of financial data regarding programme investments
- Key informant interviews with a wide range of stakeholders at national level (Annex C)
- Visits to programme and service delivery sites, including interviews with service providers, social workers and counsellors

- Interviews and group discussions with individuals accessing sexual and reproductive health (SRHR)[2] and/or HIV services supported by UNFPA
- A debriefing workshop with participation by UNFPA country and regional office staff as well as representatives of government agencies and civil society organizations. This allowed the evaluation team to present preliminary findings and receive feedback on any gaps in the data used or factual errors or misrepresentation.

The evaluation also uses other methods, including an online survey of key stakeholders, interviews undertaken at global and regional level and a comprehensive global document and data review to ensure coverage of all elements of the UNFPA response to HIV.

The resulting evaluation data was analysed and interpreted jointly by the three evaluation team members. Each element of evidence was recorded in the evaluation matrix (Annex B) in relation to relevant evaluation questions and causal assumptions. This allowed the evaluation team to triangulate evidence from different sources and to develop the findings presented in Chapter 3.

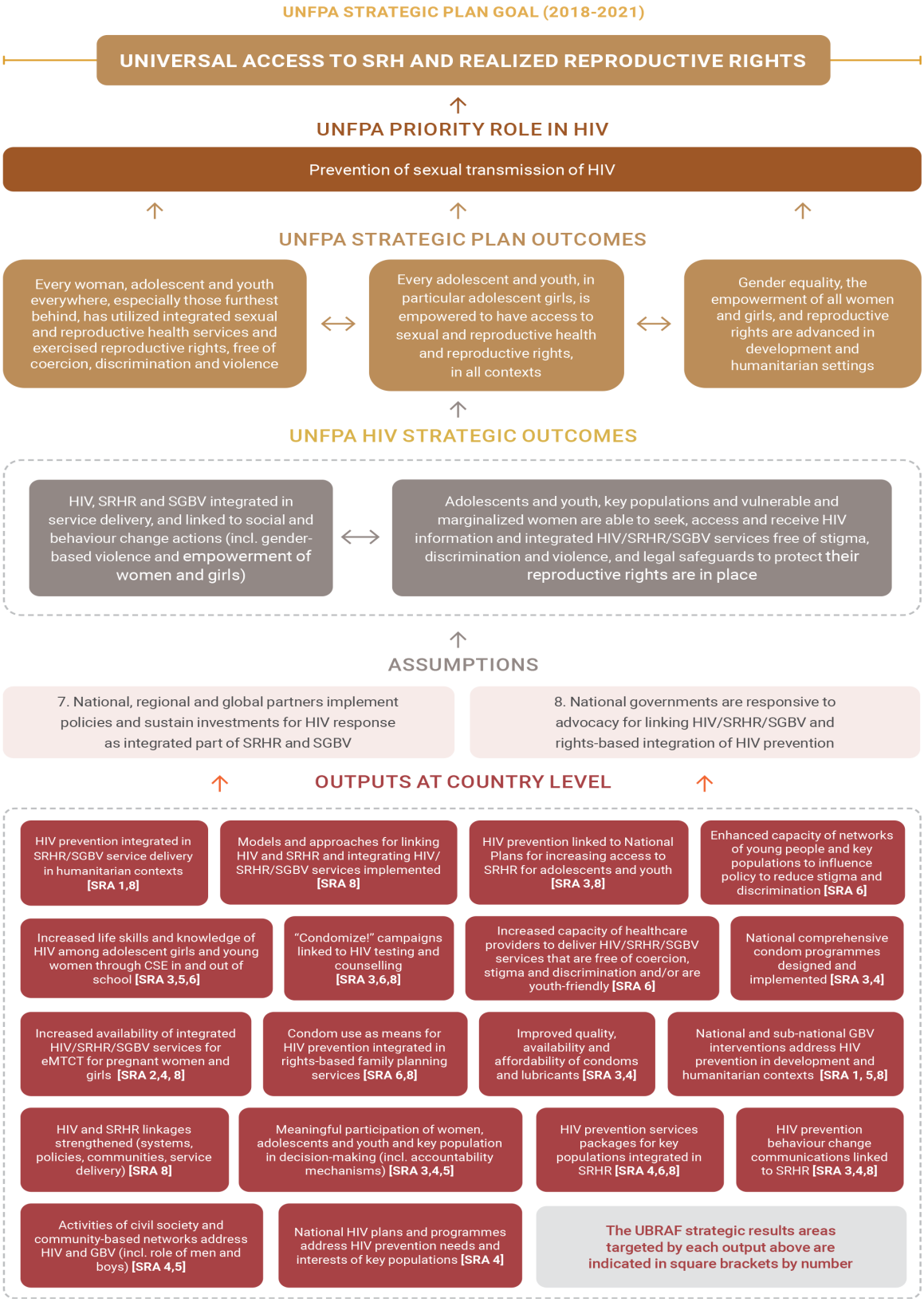
1.4 Overall theory of change

This section presents the **overall** theory of change for UNFPA support to the HIV response as developed during the inception phase, updated during data collection, and refined during the analysis and reporting stages of the evaluation. The theory of change presented here attempts to captures **all** of the different ways in which UNFPA currently supports the response to HIV, in **vastly differing contexts** and at **different levels** (global, regional and national). **In this sense, nowhere has the evaluation team seen this theory of change implemented in its entirety.**

In fact, the theory of change encompasses a wide range of activities and a multi-layered chain of results, which are difficult to effectively implement and sustain given the current staffing and financial resources available to UNFPA for the HIV response.

[2] ***Nota Bene***: During the evaluation period, documents describing national programmes and UNFPA support to the HIV response in Namibia have evolved in their use of terminology. In 2016, many documents refer to reproductive health (RH) or sexual and reproductive health (SRH). By 2018, most documents refer to sexual and reproductive health and rights (SRHR). There was a similar shift from references to gender-based violence (GBV) to sexual gender-based violence (SGBV). The shift from GBV to "SGBV" stems, in part, from the increasing work of UNFPA in humanitarian settings and on the women, peace and security agenda. "SGBV" was, inter alia, taken up by the Special Rapporteur on violence against women, its causes and consequences in a 2009 report, positioning sexual violence and rape as an explicitly (gendered) tool of conflict and war. "SGBV" is now the terminology that is increasingly being used in all contexts as this is one of the most common forms of violence encountered, including in intimate partner relationships as well as against those who have different sexual orientations. For consistency, the present report uses "SRHR" and "SGBV" throughout, unless quoting from a document.

Figure 1: Overall theory of change



ASSUMPTIONS

1. National leadership supported by HIV partners (especially UNFPA)
2. UNFPA support addresses national HIV priorities
3. Effective coordination of external support by JUNTA
4. UNFPA support builds on comparative advantage in each region and country
5. UNFPA support is matched by technical and financial capacity
6. Focused UNFPA support applicable to the nature of the epidemic

UNFPA ACTIVITIES AND INVESTMENTS

Young people and key populations

- Support and advocate for comprehensive sexuality education (CSE) in and out of school
- Capacity development of healthcare providers to deliver HIV prevention/ SRHR/SGBV services free of coercion, stigma and discrimination
- Support networks of adolescents and youth, at-risk, vulnerable and key populations to strengthen their capacity, leadership and participation in law- and policy-making and HIV programming

Condoms and primary prevention

- Support and advocate for comprehensive condom programmes (including total market approach)
- Support improved procurement and supply chain management of condoms and lubricants
- Knowledge development for effective prevention among at-risk and key populations (i.e. quality assurance of male and female condoms and lubricants)

Linking/integrating HIV/SRHR/SGBV

- Support to strengthen HIV/SRHR linkages at policy, system and service delivery level
- Advocate for and support use of tools/guidance for implementing integrated HIV/SRHR/ SGBV services
- Support learning and knowledge sharing, especially South-South cooperation on linking HIV/SRHR/ SGBV services

Strategic partnerships

- Advocacy and to revise policies and laws to facilitate access to HIV/SRHR/ SGBV services protect against harmful practices, discrimination and stigma
- Support civil society and community-based networks to contribute to development and implementation of HIV policies and programmes
- Support intergovernmental HIV networks to contribute to development and implementation of HIV policies and programmes
- Support networks and civil society organization engaged in addressing the regional and national legal framework

Coordination and strengthening/sustaining political commitment and funding
(Note: This is transversal and reinforces/acts as multiplier for the activity clusters above)

- Support and participate in global, regional and national HIV/SRHR/SGBV coordination mechanisms (incl. chair UNAIDS Coordination Committee)
- Co-convene global, regional and national HIV prevention coalitions
- Participate in and support Joint UN Team on AIDS (JUNTA)
- Resource mobilization/ promoting sustainability of funding of national HIV responses

PROBLEM

Almost four decades into the epidemic, and despite substantial progress, the number of people newly HIV-infected remains high. The nature of the epidemic has also been evolving with more than half of all new HIV infections (in 2018) occurring among key populations — sex workers, people who use drugs, gay men and other men who have sex with men, transgender people and prisoners — and their partners, while, in some regions, girls and young women continue to face disproportionate HIV risks. Structural factors contributing to HIV vulnerability include gender inequalities and violence, limited livelihood options, stigma and discrimination, gaps in knowledge of HIV status and lack of access to adequate health facilities.

External factors: Political developments – increasing discrimination – international HIV and SRHR financing trends – conservative attitudes towards key populations

Guiding principles: Human rights and gender equality – meaningful participation of affected populations – focus on groups left behind, most at-risk and most vulnerable – actions tailored to context – evidence-informed approach

1.5 Carrying out the HIV field-based case study in Namibia

1.5.1 Data collection activities

The Namibia country case study mission was carried out by a team composed of one international consultant, one national consultant and the evaluation manager (UNFPA Evaluation Office) from 20 – 31 May 2019. Two team members also conducted interviews at ESARO on 16 and 17 May to provide an overview of the regional context for UNFPA support to HIV in Namibia. The case study mission was preceded by a review of documents provided by the Namibia UNFPA country office (CO). These were supplemented by documents gathered from key informants during the field mission. For a list of documents referred to in the case study, see Annex F.

The evaluation team carried out extensive interviews with key stakeholders for UNFPA activities and support to the HIV response in Namibia, notably:

- The UNFPA Namibia staff including the representative and programme and technical specialists in HIV and family planning, adolescent SRHR, finance and monitoring and evaluation
- Senior policy makers and managers at the Republic of Namibia Ministries of Education, Arts and Culture (MEAC), Gender Equality and Child Welfare (MGECW), Health and Social Services (MoHSS), the Ministry of Youth, Sport and National Services (MYSNS) and the National Statistics Agency (NSA)
- Within the MoHSS the evaluation team met with the directorates most directly involved in the HIV response and the integration of services for HIV, sexual reproductive health (SRH) and gender-based violence (GBV): The Special Programmes Directorate (SPD), the Directorate for Primary Health Care (DPHC) and the Global Fund for AIDS, Tuberculosis and malaria (the Global Fund) Management Unit.
- The staff of the OFL
- A wide range of CSOs either providing services in HIV or representing adolescents, youth and or key populations (KPs)
- Staff of members of the Joint United Nations Team on AIDS (JUNTA) in Namibia including the International Organization for Migration (IOM) UNAIDS, the United Nations Education, Science and Cultural Organization (UNESCO), the World Health Organization (WHO), the World Food Programme (WFP), and the Office of the Resident Coordinator for Namibia
- Staff of the most active development partners engaged in supporting the HIV response in Namibia, the President's Programme for Emergency Relief (PEPFAR) and the Centre for Disease Control (CDC) both programmes of the United States Government
- The evaluation team also carried out group discussions with service providers and a small number of their clients.

Additionally, the evaluation team conducted visits to clinics and health centres implementing the national programme of integrating HIV/SRH/GBV services. Three sites were located in Windhoek: Okuryangava Clinic operated by the Namibia Planned Parenthood Association (NAPPA), Khomasdal Health Centre, and Maxulili Clinic (Okahandja Park). Two site visits were carried out in the Oshikoto region, which is characterized by a relatively high rate of HIV infection (estimated at 17.3 per cent in 2017)[3] and a large population of adolescents and youth: Okankolo Health Centre, Onandjokwe

[3] Ministry of Health and Social Services, *Namibia Population-Based HIV Impact Assessment (NAMPHIA): Summary Sheet: Preliminary Findings, p.2.*

Health District and Onandjokwe Intermediate Referral Hospital and the Onandjokwe Primary Health Care Clinic. During the site visits in Windhoek and the Oshikoto region, the evaluation team conducted a group discussion with members of the regional health management team. For a list of persons interviewed, see Annex C.

The visited sites were chosen to:

- Provide the evaluation access to hospitals, health centres and clinics that had been involved for some time in efforts to pilot-test and roll out the national programme to integrate HIV/SRHR/SGBV services
- Ensure that sites were visited in both urban and rural settings and in at least one region with relatively high rates of HIV infection.

The figure below provides an overview of administrative regions in Namibia and highlights the location of site visits by the evaluation team.

Figure 2: Administrative regions of Namibia

1 Kunene	5 Oshikoto	9 Erongo	13 Hardap
2 Omusati	6 Kavango West	10 Otjozondjupa	14 ǁKaras
3 Oshana	7 Kavango East	11 Omaheke	
4 Ohangwena	8 Zambezi	12 Khomas	

1.5.2 Limitations

The main focus of data collection for the Namibia case study has been key informants working in government or civil society engaged in the HIV response in Namibia. The evaluation team had limited contact with individual users of the services supported by UNFPA although it did have significant contact with staff of CSOs representing their interests. In addition, the sample of site visits was small and not representative of service provision in HIV/SRHR/GBV throughout the country. The sites visited were chosen to provide illustrations of the progress made in integrating these services and the challenges encountered in the process. Finally, up-to date and timely information on the HIV and

acquired immune-deficiency syndrome (AIDS) is limited in Namibia. Overall, the evaluation team is confident that the data collected strongly supports the validity of the findings reported in Chapter 3. The evidence for all findings is presented in the evaluation matrix in Annex B.

2. NATIONAL HIV CONTEXT AND PROGRAMME RESPONSE

2.1 2.1 Overview of the HIV epidemic in Namibia

2.1.1 HIV and AIDS data and trends

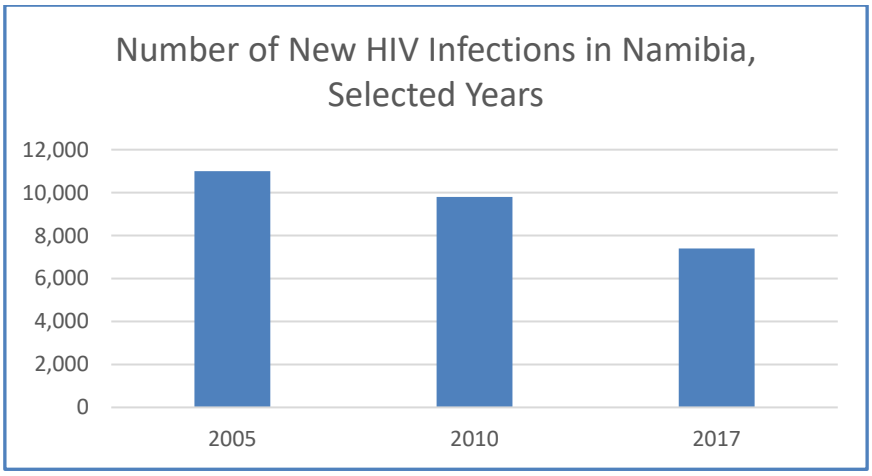
Namibia is situated on the South Western Coast of Africa and has a population estimated at 2.4 million in 2018. It is one of the most sparsely populated countries in the world (2.8 persons per square kilometre). In 2009, Namibia became an Upper-Middle Income Country (UMIC) with an estimated gross national income per capita of USD 5,630 by 2017.[4] Graduation into UMIC status has posed real challenges for Namibia as some key development partners (including UNFPA) use planning models limiting the level of resources and types of activities, which can be supported in countries with this status. This is especially troubling in Namibia because it has the second highest level of income inequality in the world, second only to South Africa.[5] As a result, Namibia has a very high level of poverty, especially in districts and regions outside the capital.

There is a limited body of timely and reliable data on the HIV and AIDS situation in Namibia since the last Namibia Demographic and Health Survey (NDHS) was carried out in 2013 and the last integrated biological and behavioural surveillance study (IBBS) was conducted in 2014. In the interim, data on HIV prevalence has been provided through the National HIV Sentinel Surveys (NHSS) conducted in 2014 and 2016. New IBBS surveys were undertaken in 2019 and the resulting report is only expected in 2020.[6] The most recent data on HIV and AIDS has been provided by the 2017 Namibia Population-Based HIV Impact Assessment (NAMPHIA).

As noted in the *National Strategic Framework*, "*Namibia has a high HIV prevalence and incidence rates and a generalized and mature HIV epidemic*".[7] However, Namibia has made progress in addressing the HIV epidemic since 2014. In 2014, the NDHS found a national prevalence rate among those 15-49 years of 14 per cent. By 2017, the HIV prevalence rate among the same group had declined to an estimated 11.5 per cent.[8] Namibia has also seen a decline in the number of new infections each year since 2010.

[4] Ministry of Health and Social Services, *National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22,* p.6.
[5] Data accessible at: https://data.worldbank.org/indicator/SI.POV.GINI?locations=NA
[6] *National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22,* p.18.
[7] *National Strategic Framework,* p.6.
[8] Ministry of Health and Social Services, *Namibia Population-Based HIV Impact Assessment: Preliminary Findings,* (2018), p.1.

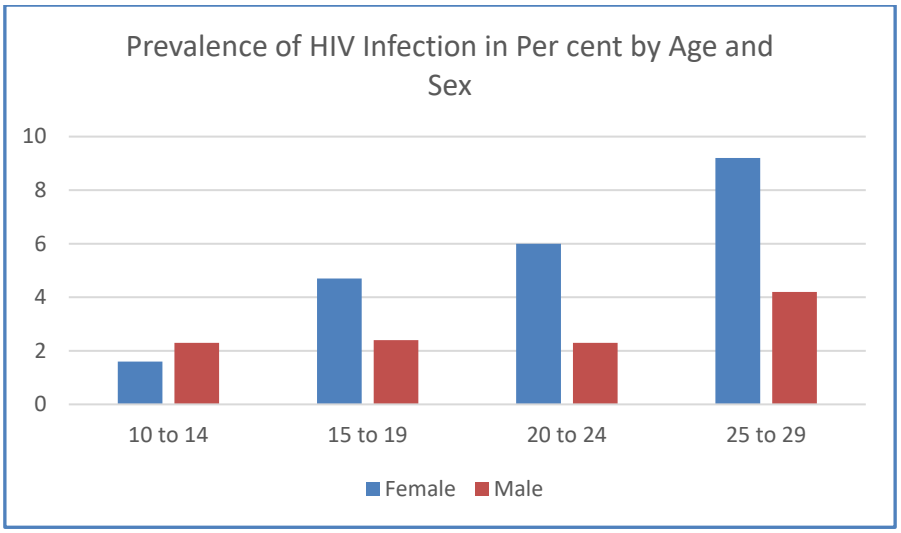
Figure 3: Number of new infections in selected years in Namibia



Source: UNAIDS, Country Data: Namibia

When the most recent data is disaggregated by age and sex, the highest estimated prevalence rate is among females aged 45-49 years (30.0 per cent). In every age category during reproductive years (15-49 years), prevalence rates are higher among females than for males. Estimated prevalence rates for adolescents and youth are lower than for older adults, but still at worrying levels. Many of the key informants expressed deep concern over what they perceive as rising rates of infection among younger people, especially adolescent girls and young women (AGYW). However, the report of the National HIV Sentinel Survey (NHISS) for 2016 indicates that prevalence rates for young people 15 to 24 years of age held remarkable steady in the four-year period from 2012 to 2016. They varied within a narrow band from a high of 8.9 per cent in 2012 to 8.5 per cent in 2016.[9]

Figure 4: Estimated prevalence of HIV infection among young people in 2017



Source: *NAMPHIA, 2017, Preliminary Findings,* p.2

There is also a strong regional pattern of intensity in the HIV epidemic in Namibia. In 2017, estimated HIV prevalence was lowest in the more central regions of Khomas (where the capital Windhoek is located) and Kunene. Prevalence was highest in the five northernmost regions of Oshana, Omusati,

[9] Ministry of Health and Social Services, *Surveillance Report of the 2016 National HIV Sentinel Survey*, (2016), p.27.

Oshikoto, Ohangwena and Zambezi. All five of the highest prevalence regions are located on or very near the border with Angola.

Table 3: Estimated HIV prevalence rates by region, 2017

Regions in order of HIV prevalence in 2017			
Region	**HIV Prevalence in %**	**Region**	**HIV Prevalence in %**
Kunene	7.6	Kavango West	12.1
Khomas	8.3	Kavango East	14.5
Omaheke	8.4	Oshana	15.8
Otjozondjupa	8.5	Omusati	16.9
Hardap	9.3	Oshikoto	17.3
Karas	9.7	Ohangwena	17.9
Erongo	10.6	Zambezi	22.3

Source: *NAMPHIA 2017: Preliminary Findings, p.2.*

Namibia has also made considerable progress toward achieving the 90-90-90 goals for 2020 as agreed jointly among UNAIDS and the Fast Track countries. However, men are less likely to know their status than women and, when they do, are less likely to remain on treatment and to achieve viral suppression.

Table 4: Progress toward achieving the 90-90-90 goals in Namibia, 2017

Group	Know their status (%)	On anti-retroviral treatment (ART) (%)	Virally suppressed (%)
Female	89.5	97.1	92.2
Male	79.6	94.9	89.5
Total	86.0	96.4	91.3

Source: *NAMPHIA 2017: Preliminary Findings, p.4.*

Solid data on the HIV situation of KPs is particularly scarce. The most recent available data is from the 2014 IBBS Study, which identified an estimated population of 6,500 men having sex with men (MSM). The *National Strategic Framework* (NSF) stresses that: "HIV prevalence among MSM varies from 10.2 per cent in Keetmanshoop, 7.1 per cent in Oshakati, 10.1 per cent in Swakopmund/Walvis Bay and 20.9 per cent in Windhoek. Each of these estimates are above the conventional 5 per cent threshold used to define a "key population" at elevated risk of HIV."[10]

The NSF points out that female sex workers (FSW) are among those experiencing the highest rates of HIV infection in Namibia. "Female sex workers are 3.5 times more likely to be living with HIV than other women in the general population. HIV prevalence among FSW was estimated to be 52 per cent in Katimal Mulilo, 31 per cent in Oshikango, 37.3 per cent in Swapkomund/Walvis Bay and 39.3 per cent in Windhoek. These rates are above the national HIV prevalence rates when compared to women of reproductive age in the general population."[11]

[10] *National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22,* p.19.
[11] *National Strategic Framework,* p.19.

2.1.2 Key challenges and issues

The most prominent challenges facing the response to HIV in Namibia include:

- The sustainability of funding for HIV treatment and prevention services in light of the high level of dependence on external sources for funding non-pharmaceutical recurrent costs, especially in light of Namibia's transition to UMIC status and the attendant reductions in donor financing
- High levels of rotation and turnover of front-line staff in health centres and clinics which necessitates extensive and continuous training, especially in light of the national effort to roll out integration of HIV and SRHR services
- Shortages of functioning equipment and adequate space in clinics, health centres and hospitals to allow full implementation of the national model of integration
- Continuing difficulties with the values and attitude of some health services staff which further discourages access to prevention and treatment services for adolescents and youth and key populations, especially the lesbian, bisexual, gay, and transgender, and inter-sex (LGBTI) community
- The need for greater communication, coordination and collaboration within MoHSS between the Directorate for Special Programmes (DSP) responsible for disease-specific programming, including HIV, and the Directorate for Primary Health Care (DPHC) responsible for family planning and other aspects of SRHR
- A relative lack of emphasis on prevention as reflected in national budgets and project and programme expenditures: In the 2015/16 fiscal year, HIV and AIDS funding for care and treatment accounted for 54 per cent of national expenditures on HIV while expenditures on prevention took up 19 per cent of the total. In the following fiscal year, the share of expenditures taken up by care and treatment rose to 59 per cent, while prevention declined slightly to 17 per cent of the total.[12]

2.1.3 Policy and programmatic response

Namibia has mounted a sustained programme of response to HIV with very significant domestic and external financing both before and during the evaluation period. In 2014, for example, total expenditures on HIV and AIDS prevention and treatment in Namibia amounted to USD 201.1 million with USD 111.0 million financed by the Government of the Republic of Namibia (referred to as 'the Government'), USD 71.4 million provided by PEPFAR, and USD 10.5 million funded by the Global Fund.[13]

The current, essential guiding document for the response to HIV is the *National Strategic Framework for the HIV and AIDS Response in Namibia 2917/18 to 2021/22,* published by the MoHSS in 2017 (referred to as "the NSF" by stakeholders).

The NSF sets out specific "impact results" to be achieved by 2022:

Priority 1: New HIV infections reduced by 75 per cent
Priority 2: HIV-related deaths reduced by 75 per cent
Priority 3: Elimination of mother-to-child transmission (EMTCT) to less than two per cent

[12] Ministry of Health and Social Services, *Namibia's Health and HIV Financing Landscape, 2015/16 and 2016/17: Evidence from the 2015/16 and 2016/17 Resource Tracking Exercises,* (August, 2018) p.27.
[13] UNAIDS, *Namibia, Country Data, 2017.* P.1

Priority 4: 100 per cent of newly identified people living with HIV (PLHIV) enrolled and retained on ART
Priority 5: Tuberculosis and HIV mortality reduced to 21 per 100,000 population
Priority 6: Domestic contribution towards the national HIV and AIDS response increased to 80 per cent.[14]

The NSF also identifies a set of ten different, high priority and high-impact programme areas aimed at achieving these results:[15]

Table 5: National strategic framework for the HIV response: Priority areas of programming

High impact programming areas identified in the National Strategic Framework	
AGYW	Pre-Exposure Prophylaxis (PrEP)
Voluntary Male Medical Circumcision (VMMC)	Prevention of mother-to-child transmission (PMTCT)
Prevention programmes for KPs: MSM and FSW	Treatment, Care and Support: Provision of ART
Condom promotion and distribution	HIV Testing Services (HIV testing and counselling, HTC)
Male involvement	Treatment of opportunistic infections

The conceptual framework of the NSF highlights the role of combination prevention with its dual population and service focus encompassing seven of the ten programming areas identified in Table 5: AGYW, KPs, male involvement, condoms, VMMC, PrEP and PMTCT. It also sets out different approaches to programme implementation aiming to "fast track" ending of AIDS by 2030.[16] These are particularly important to the role UNFPA has undertaken in supporting the HIV response in Namibia. Programme approaches with special relevance for UNFPA in Namibia are highlighted in bold in the following table.

Table 6: National strategic framework: Implementation approaches

Programme implementation approaches	
Use of a Combination Prevention approach	Integrating and implementing critical social and programmatic enablers, including **reduction of sexual gender-based violence (SGBV), removal of stigma and discrimination and social protection**
Fast-Track intensified programming for high impact populations, regions and sites	**HIV Integration in the health care system under MoHSS leadership**
Life-Cycle approaches to provide services to identified populations throughout their lives	HIV Mainstreaming within the development sector workplace (internal) and in development projects (external)

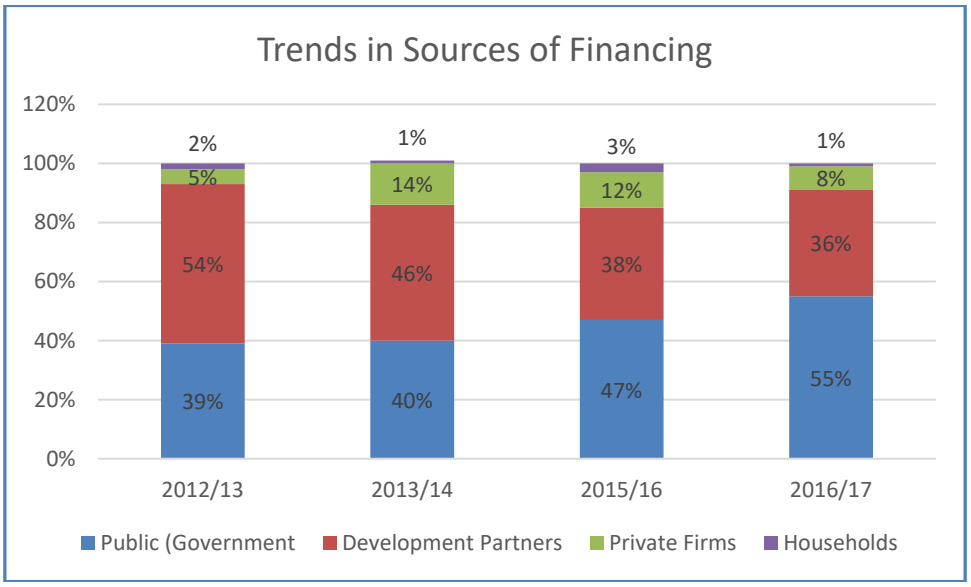
2.1.4 Financing the HIV response in Namibia

The most up-to-date information source regarding spending on HIV and AIDS in Namibia was published in 2018 by the MoHSS. *Namibia's Health and HIV Financing Landscape: Evidence from the 2015/16 and 2016/17 Resource Tracking Exercise* identifies both the overall level of funding and the sources used to finance spending on HIV. Recurrent, non-capital expenditures on HIV and AIDS grew from a reported USD 145 million in 2015/16 to USD 175.3 million in 2016/17.[17] The resource tracking study identifies the shifts in how HIV expenditures were financed over five different fiscal years. It

[14] *National Strategic Framework,* p.1
[15] *National Strategic Framework*, p.1
[16] *National Strategic Framework,* p.11.
[17] Ministry of Health and Social Services, *Namibia's Health and HIV Financing Landscape, 2015/16 and 2016/17: Evidence from the 2015/16 and 2016/17 Resource Tracking Exercises,* (August, 2018) p.5.

illustrates how the Government increased its percentage share of recurrent costs from 39 per cent in 2012/13 to 55 per cent in 2016/17, while the share of development partner financing fell from 54 per cent to 36 per cent in the same period.

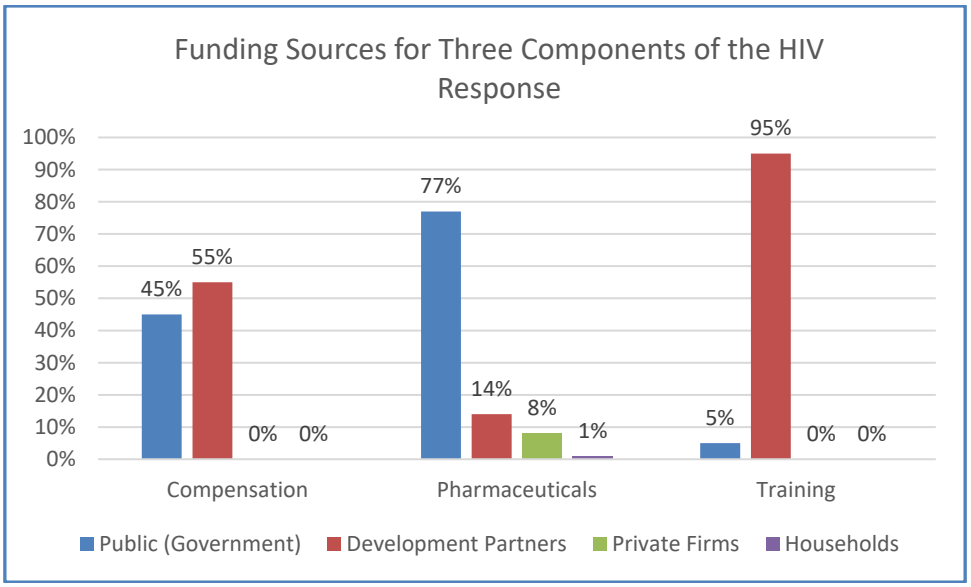
Figure 5: Changes in sources of funding 2012/13 to 2016/17



Source: MoHSS Namibia's Health and Financing Landscape, 2018

Despite this generally positive trend, there are continuing concerns about the sustainability of sources of financing for the HIV response in Namibia. While the Government has been largely responsible for financing the purchase of pharmaceuticals (including anti-retroviral drugs), it has relied largely on donor funding for major recurrent costs including training and compensation of employees.

Figure 6: Share of funding for key components of the HIV response: 2016/17



Source: MoHSS Namibia's Health and Financing Landscape, 2018

The *Resource Tracking Study* noted the risks to sustainability, especially for functional components of the HIV response and stressed that

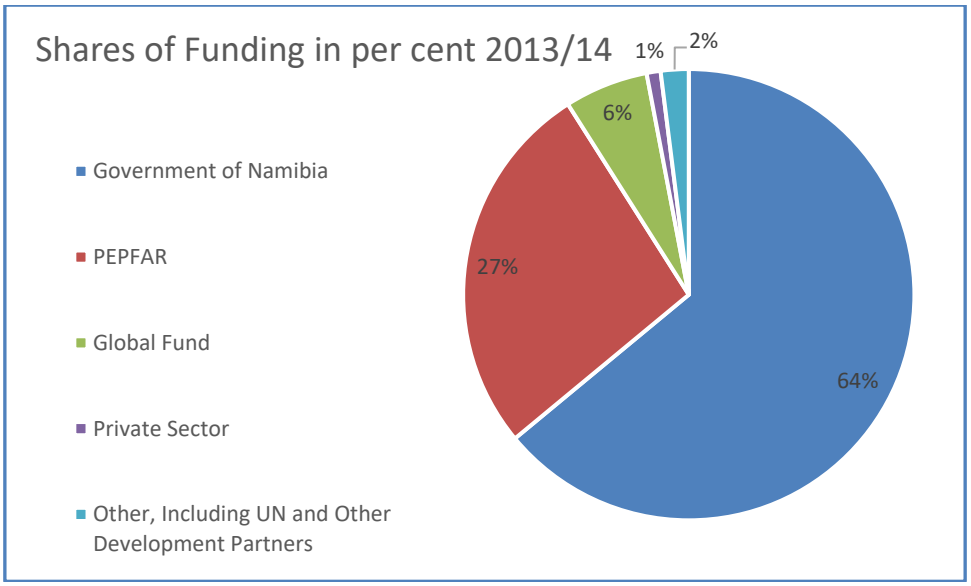
> "The HIV/AIDS program is exposed to significant risk in terms of donor reliance, with the donor contributions to the response amounting to 38 per cent in 2015/16 and 36 per cent in 2016/17. The government has shown a strong commitment to financing ARVs and intends to continue this commitment by aiming to fund the drugs exclusively from domestic resources by 2019. However, the response remains particularly vulnerable due to the reliance on donor funding for certain program areas such as prevention, health systems strengthening and program coordination, incentives for human resources (i.e., training), and research. It is also exposed to risk as a result of donors contributing significantly to certain factors of provision, such as employee compensation, pharmaceuticals, and training, as well as exclusively providing funding towards interventions for key populations. The reliance on donor funding means the country risks the collapse of these components when donors withdraw their funding support."[18]

Finally, it is important to recognize the modest scale of the financial contribution to the HIV response made by United Nations country team (UNCT) members in Namibia. The NSF notes that overall, (recurrent and capital) expenditure on HIV and AIDS totalled USD 213.3 million in 2013/14. After the government (64 per cent), the largest contributors are PEPFAR at 27 per cent and the Global Fund at 6 per cent. All other development partners, including the UNCT members and bilateral agencies such as the German Technical Cooperation Agency (GTZ) provided a combined 2 per cent of financing.[19] It should be noted, however, that the figures quoted from the NSF encompass both capital and recurrent expenditures. The National Health Accounts (NHA) for fiscal year 2013/14 indicate a different overall distribution of funding for HIV activities in Namibia with external donors accounting for 47 per cent of HIV expenditures and with the national government share at 38 per cent. The NHA report does not break out donor funding by source.[20]

Nonetheless, the predominance of PEPFAR and the Global Fund as external donors to the HIV response in Namibia represents a real risk to sustainability, especially in light of Namibia's accession to UMIC status. The NSF makes this point very clear: "Both Global Fund and PEPFAR resources envelopes in Namibia are expected to significantly reduce during the period of the NSF."[21]

[18] Ministry of Health and Social Services, *Namibia's Health and HIV Financing Landscape, 2015/16 and 2016/17: Evidence from the 2015/16 and 2016/17 Resource Tracking Exercises,* (August, 2018) p.27.
[19] *National Strategic Framework 2017/18 to 2021/22, p.69.*
[20] Ministry of Health and Social Services, *Namibia 2014/15 Health Accounts Report,* (September, 2017), p.15.
[21] *National Strategic Framework 2017/18 to 2021/22, p.69.*

Figure 7: Government and donor contribution to overall HIV expenditures in Namibia 2013/14



Source: MoHSS, National Strategic Framework for HIV and AIDS response 2017/18 to 2021/22

2.2 UNFPA HIV-related activities in Namibia

2.2.1 Strategic orientation and programmatic approach

UNFPA staff in Namibia described the definition of a strategic approach to supporting the HIV response as the result of a sustained dialogue with different ministries of the Government of Namibia including the MEAC, MGECW, MoHSS and MYSNS. This process (which occurred during the UNFPA/Namibia country programme 2015 to 2018), was guided by a number of considerations:

- UNFPA is not a major source of external financing for the HIV response
- The Government is the major investor in the HIV response (see Figure 6)
- UNFPA should not occupy any space in the national response that is already occupied by the Government and its ministries and should work within the strategies and mechanisms already in place.

As one UNFPA CO staff member noted: "All planning started with the priorities of the National Strategic Framework (NSF) on HIV and the broader National Development Plan. Discussions with government led to agreement that integration of SRHR and HIV would be UNFPA's main strategy for supporting the HIV response in Namibia." This view was supported by key informants interviewed within the MoHSS and among other development partners.

In addition, UNFPA Namibia needed to ensure that its work in support of the HIV response was in accordance with the agreed division of labour among UNAIDS co-sponsors at both global and national level and conformed to the *United Nations Partnership Framework (UNPAF) for 2014 to 2018* and its successor *United Nations Partnership Framework (UNPAF) for 2019-2023*. The UNFPA strategy for supporting the HIV response was also regularly discussed within the United Nations family through the meetings and deliberations of the JUNTA and the UNCT.

While UNFPA Namibia has used core resources and UBRAF funds to finance HIV-related action since 2016, another driver of UNFPA support to the HIV response in Namibia has been the enduring presence of two large-scale regional programmes with their own sources of funding.

The first of these is **a regional programme in support of integrating HIV SRHR and SGB services,** which has been implemented in two phases. During the first phase (2011 to 2017), the *SRHR Linkages Project* with funding from the European Union, Norway and Sweden was implemented jointly by UNFPA and UNAIDS. It operated in ten countries in East and Southern Africa (ESA) (Botswana, Kenya, Lesotho, Malawi, Namibia, Swaziland, Uganda, Zambia, and Zimbabwe). In February 2018, a second phase regional project in support of integration was launched. The Joint United Nations Regional Programme on SRHR/HIV and SGBV Integration (now called *2Gether 4 SRHR*) is a USD 45 million regional programme, funded by Sweden, to be jointly implemented by UNAIDS, UNFPA, UNICEF and WHO in five countries: Lesotho, Malawi, Uganda, Zambia and Zimbabwe. Under the joint programme, UNFPA continues to provide support to the integration process in Botswana, Eswatini, Kenya, Namibia and South Africa.

The second large regional project providing programmatic funding to UNFPA Namibia is the **Safeguard Young People Programme (SYP)** funded by Swiss Development Cooperation. SYP is a "comprehensive programme that aims to empower adolescents and young people aged 10 to 24 to protect themselves from sexually Transmitted Infections (STIs) including HIV, unintended pregnancies, unsafe abortions, early marriages, gender-based violence and harmful cultural practices while promoting gender equitable norms and protective behaviours."[22] The programme is administered regionally by UNFPA and operates in eight Southern African Countries: Botswana, Eswatini, Lesotho, Malawi, South Africa, Namibia, Zambia and Zimbabwe.

Based on all of the factors noted above, UNFPA support to the HIV response in Namibia both before and during the period under evaluation (2016 through 2019) has been characterized by:

- A strong focus with considerable technical and financial support to: i) the development and pilot testing of a model and package of integrated SRHR and HIV service delivery during the first linkages programme and ii) the national roll out of the Namibia model for integrating SRHR/HIV and SGBV services during the *2gether 4 SRHR programme*
- Significant investment in staff time, advocacy and financial support to programming for adolescents and youth, including comprehensive sexuality education (CSE)
- Continuing support to networks and CSOs providing services to or representing the HIV/SRHR/GBV needs of adolescent and youth and key populations, especially the LGBTI community
- Continuing support to national efforts to first quantify and second address the extent of SGBV both in its own right and as an important driver of HIV infections among AGYW.

2.2.2 HIV-related budgets and expenditures

In keeping with the strategy and programmatic approach outlined above, UNFPA Namibia expenditures in support of the HIV response have been mainly drawn from three sources: (i) the regional project on integrating SRHR and HIV (both phases of); (ii) the Safeguard Young People Programme and, (iii) UNAIDS funding provided to UNFPA Namibia under the UBRAF.

UNFPA Namibia project and programme expenditures related to the HIV response totalled USD 1,089,738 million for the period 2016 to 2018.[23]

[22] UNFPA, *Safeguard Young People Programme 2018 Annual Report,* (2019), p.5,
[23] All data on UNFPA Namibia HIV-related budgets and expenditures is drawn from *UNFPA Namibia Country Office Programme Expenditure Reports: 2016, 2017 and 2018.*

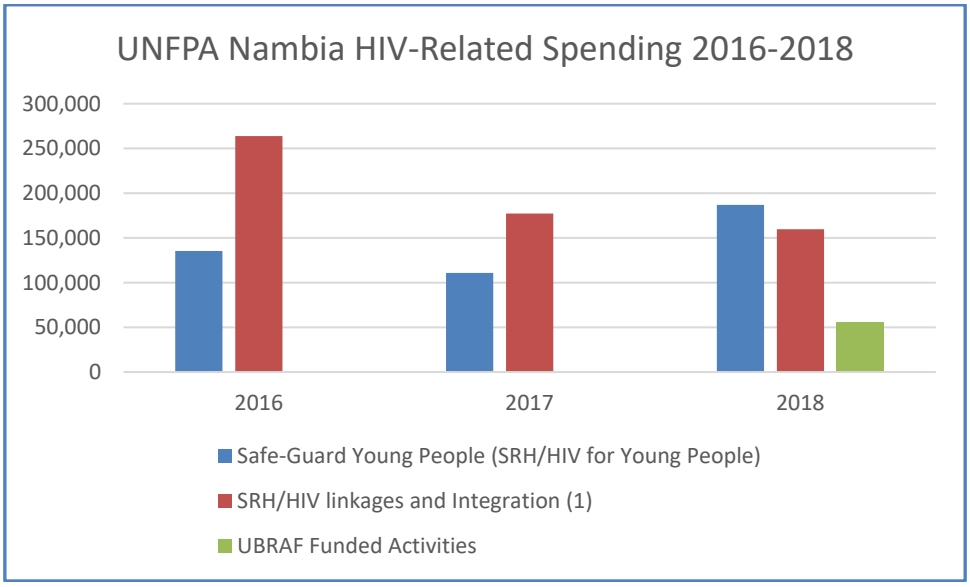
Table 7: UNFPA Namibia HIV-related project/programme expenditures 2016-2018, USD

Project	Non-UNFPA implementing partners	2016	2017	2018	2019 budget	Total exp 2016-2018
Safe-Guard Young People (SRH/HIV for Young People)	Ministry of Health and Social Services (MoHSS) Ministry of Sport, youth and National Service (MSYNS) Namibia Planned Parenthood Association (NAPPA) Ministry of Education, Arts and Culture (MEAC) Office of the First Lady (OFL)	135,384	110,855	186,844	130,000	**433,083**
SRH/HIV linkages and Integration (1)	Ministry of Health and Social Services (MoHSS) Namibia Planned Parenthood Association (NAPPA) Ministry of Gender Equality and Child Welfare (MGECW)	263,916	177,188	159,609		**600,713**
SRH/HIV Integration (2) 2Gether 4 SRHR	Ministry of Health and Social Services (MoHSS) Namibia Planned Parenthood Association (NAPPA)				279,102	
UBRAF Funded Activities	Ministry of Health and Social Services (MoHSS) Namibia Planned Parenthood Association (NAPPA) Society for Family Health (SFH)			55,942	101,466	**55,942**
New HIV-related programming introduced in 2019						
Namibia Gender Equality Project (SGBV Focus)	Ministry of Gender Equality and Child Welfare (MGECW) Gender Links Namibia				172,848	
Adolescent and Youth – Knowledge and Skills (YP1)	Office of the First lady (OFL) Ministry of Sport, youth and National Service (MSYNS)				301,346	
Adolescent and Youth – Access to Services (YP2)	Namibia Planned Parenthood Association (NAPPA)				157,789	

Project	Non-UNFPA implementing partners	2016	2017	2018	2019 budget	Total exp 2016-2018
Disability Data Strengthening	National Statistics Agency of Namibia (NSA) Ministry of Sport, youth and National Service (MSYNS)				92,923	
Sub-Totals		399,300	288,043	402,395	1,262,130	**1,089,738**

It should be noted that while the table above identifies significant UNAIDS programme funding under the UBRAF for the period 2018 and 2019, UBRAF began providing funds to UNFPA Namibia in 2010/11 and 2012/13. However, the level of funding for UNFPA Namibia increased significantly under the revised funding allocation formula adopted for the UBRAF and first applied in 2018.

Figure 8: UNFPA Namibia HIV-related spending by project/programme

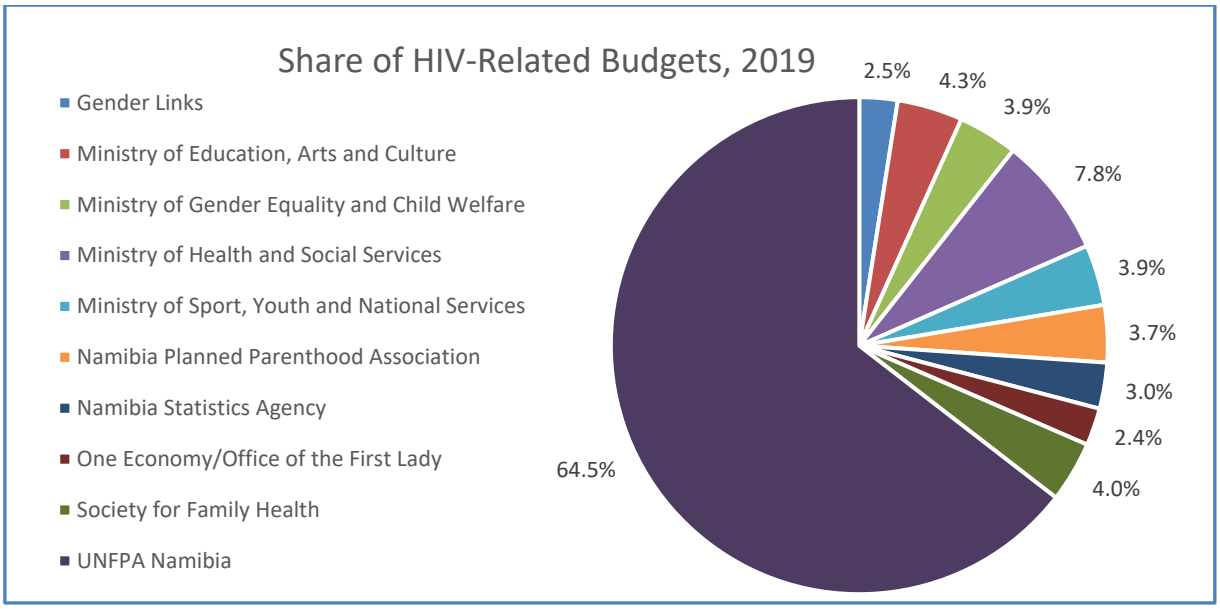


Source: UNFPA Namibia Project Monitoring Reports, 2016, 2017, 2018. Data provided by the UNFPA Country Office in Windhoek

For a detailed breakdown of the activities funded by UNFPA and allocations to each implementing partner, see Annex D.

HIV-related expenditures by UNFPA Namibia are either spent directly on goods and services in support of the agencies implementing HIV services and programmes or disbursed to those implementing partners who then spend the funds on their own costs. The figure below illustrates the share of HIV-related programme and project budgets allocated for expenditure by UNFPA and its implementing partner agencies in 2019.

Figure 9: Share of UNFPA HIV-related project/programme budget by implementing agency: 2019



Source: UNFPA Namibia Project Monitoring Reports 2019

It is important to note that some important partners of UNFPA in Namibia have received funding through the implementing agencies listed in the figure above. For example, Out-Right Namibia, an organization representing the LGBTI community has received funding through the Society for Family Health (SFH) and has benefited from clinical service provided by the Namibia Planned Parenthood Association. It is also important to point out that the large portion of the budget allocated to UNFPA in 2019 reflects the fact that the start of a new Namibia/UNFPA Country Programme requires that all implementing partners undergo a micro-assessment and funds cannot be transferred to those partners prior to finalization of the assessments.

2.2.3 Key implementing partners

Table 8 provides an overview of the key partners engaged with and by UNFPA Namibia in the past four years:

Table 8: Key HIV response partners in Namibia: Non-United Nations

Partner organization	Main roles and functions in HIV response	Main areas of UNFPA engagement and support
Ministry of Education, Arts and Culture (MEAC)	Responsible for in-school CSE and HIV and reducing HIV transmission among young people in schools	Advocacy for CSE at regional and national level and ongoing technical support to CSE
Ministry of Gender Equality and Child Welfare (MGECW)	Lead agency for gender equality and addressing SGBV in Namibia	Advocacy at national level and technical support on SGBV including a manual on links between SGBV and poor access to HIV prevention and treatment
Ministry of Health and Social Services (MoHSS)	Responsible for all HIV prevention and treatment activities delivered through public health services	Longstanding advocacy, technical and financial support to the integration of SRHR/HIV/SGBV services
Ministry of Sport, Youth and national Service (MYSNS)	Responsible for providing CSE and HIV prevention services to out-of-school adolescents and youth	Technical assistance on the *CSE Framework for Out-of-School Young People in Namibia* and technical and financial support to "Condomize" campaigns

Partner organization	Main roles and functions in HIV response	Main areas of UNFPA engagement and support
African Youth and Adolescents Network (AfriYAN) Namibia	Advocacy and communications work on HIV prevention and treatment for young people	Direct funding for AfriYAN activities including "Condomize" campaigns among university students
Namibia Planned Parenthood Association (NAPPA)	Providing youth and family friendly SRHR services including family planning, ART and PrEP	Funding NAPPA clinic in Windhoek as the pilot youth-friendly services facility under integration. Ongoing support to NAPPA operations in Zambezi, Kavango and Ohangwena regions
National Youth Council	Umbrella body for organizations working with adolescents and youth in Namibia	Funding and technical support
One Economy Foundation/Office of the First Lady (OFL)	Legal and programmatic work on SRHR issues and human rights for adolescents, youth and key populations (KPs), including SGBV	Financial and technical support including service packages for KPs, research products and good practices in combatting SGBV
Out-Right Namibia	Representing and providing services to the LGBTI community in Namibia	Funding through SFH and advocacy and support for their participation in HIV policy fora
Namibia Network of AIDS Service Organizations (NANASO)	Umbrella organization for CSOs engaged in HIV and AIDS services	Linking NANASO with the Southern African Development Community (SADC) Parliamentary Forum and Advocacy for CSO role in services to KPs
Society for Family Health Namibia (SFH)	Providing direct services in HIV prevention and treatment and funding sub-recipients engaged in services to KPs	Financial support (2019) to SFH for training health sector workers on competent SRH services for KPs

2.3 The regional dimension and its influence on UNFPA support in Namibia

2.3.1 Support from ESARO to the Namibia country office

Interviews held in Johannesburg at the UNFPA ESARO with UNFPA staff and partner organizations, as well as interviews with key informants in Namibia, describe a very close relationship between ESARO and UNFPA in Namibia. They point out important avenues of support used by ESARO to strengthen the UNFPA contribution to the HIV response in Namibia. These include:

- Providing technical leadership on HIV, including but not limited to SRHR/HIV/SGBV integration and HIV and SRHR services for adolescents and youth
- Mobilizing resources for and managing regional projects/programmes which are critical to the HIV response in Namibia
- Providing access through the HIV team in ESARO to other technical resources around issues such as gender equality and SGBV
- Maintaining strong partnerships and networks at the regional level including with intergovernmental bodies such as SADC and its Parliamentary Forum as well as the East African Community (EAC)
- Maintaining partnerships with regional networks of CSOs (for example AfriYAN)
- Operating the UMIC Support Unit at ESARO which reduces the administrative and operational burden on each CO in a UMIC country and allows for reallocation of resources to programming activities

- Most importantly, advocating and coordinating UNFPA inputs into important regional commitments, strategies and standards in SRHR, HIV and services for adolescents and youth. While ESARO usually takes the lead on UNFPA involvement in these regional initiatives, it often engages one or more COs in the process.

The interaction between ESARO and the Namibia CO has:

- Helped to shape the UNFPA strategy for supporting the HIV response in Namibia
- Provided important programme funding and coordination
- Assisted with the development and maintenance of technical standards
- Allowed the development and use of advocacy tools established at the regional level through cooperation with the SADC and the EAC.

2.3.2 The Southern Africa Development Community and the East Africa Community

The HIV response in Namibia benefits from strategies, commitments and guidelines developed and adopted at the regional level under the auspices of the SADC and the EAC. Examples of these include:

- *Ministerial commitments on **comprehensive sexuality education** and sexual and reproductive health services for adolescents and young people in Eastern and Southern Africa,* (2014)[24]
- *Minimum Standards for the **Integration of HIV and Sexual & Reproductive Health** in the SADC Region.* (2015)[25]
- *Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and **Rights Among Key Populations**.* (2018)[26]
- *Regional **Strategy for Sexual and Reproductive Health and Rights** (SRHR) 2019–2030.*[27]

As noted during interviews with the UNFPA team at ESARO: "*The SADC HIV Strategy and SADC KPs Strategies are visions to be translated into national action by 2030. They thus become advocacy tools for use at national level because no Ministry of Health or Ministry of Education wants to be left behind.*"

Interviews with key informants from different ministries of the Government and with staff of development partners and CSOs confirmed that almost all key stakeholders were knowledgeable of the regional commitments, standards and strategies for broader actions in SRHR and specific measures to respond to HIV. They also confirmed that most stakeholders, including the UNFPA Regional and CO actively use these regional commitments as advocacy tools.

[24] SADC, *Ministerial Commitment on Comprehensive Sexuality Education and sexual and reproductive health services for adolescents and young people in Eastern and Southern Africa,* (Dec. 2014), p.1-8.
[25] SADC, *Minimum Standards for the Integration of HIV and Sexual & Reproductive Health in the SADC Region, (2015).*
[26] SADC, *Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights Among Key Populations,* (2018).
[27] https://esaro.unfpa.org/en/news/groundbreaking-regional-strategy-sexual-and-reproductive-health-gets-ministerial-approval

3. CASE STUDY FINDINGS

3.1 Integrating HIV/SRH/SGBV services: the central strategy

UNFPA has been an early and consistent advocate for and supporter of HIV/SRH/SGBV services in Namibia based on two important regional projects/programmes on linkage and integration. The UNFPA Namibia CO has also provided technical support and advocacy for integration with continuous support from the ESARO. The development, pilot testing and national roll out of the Namibia model of integration is grounded in explicit regional and national priorities, strategies, policies and guidelines; it is not a donor-driven exercise. Considerable progress has been made to scale-up integration at a national level. However, the sites with an integrated model of SRHR/HIV/SGBV services face important operational challenges, most importantly the need for continuous training and specialized mentoring of staff, the lack of essential equipment (and the budgets for its purchase and/or maintenance) and the requirement for adequate space in the integrated facilities. Despite these limitations, selected sites have implemented (with some adjustments) the Namibia model of integration to noticeable improvements: a higher level of skills and expertise among staff (and hence improved morale) and improved, client-centred services. The Namibia model of integration has the potential to reduce stigma and increase the quality of SRHR/HIV/SGB prevention and treatment services over time. However, the effectiveness and sustainability of the model requires closer communication and cooperation between the two main directorates of the MoHSS responsible for HIV and SRHR services: the DSP and the DPHC.

For details of the evidence supporting findings in section 3.1, see the evaluation matrix (Annex B): Assumptions 1.1, 1.2, 1.3, 1.4, 1.5, 1.6 and 1.7.

3.1.1 UNFPA support to integration

UNFPA Namibia has been a key supporter of the process of integrating HIV and SRHR services since 2011, first under the J*oint UNFPA/UNAIDS Project on SRH* and *HIV Linkages* (2011-2017) and from 2018, under the *2gether 4 SRHR* regional programme. The focus of the *2gether 4 SRHR* programme has been broadened to include the integration of SGBV services so that the current programme now addresses the integration of SRHR, HIV and SGBV.

In 2011, UNFPA, UNAIDS, the WHO and the International Planned Parenthood Federation (IPPF) collaborated to support the MoHSS to undertake a rapid assessment of SRHR and HIV Linkages. According to interviews at MoHSS, UNFPA began full support of the process of piloting integration of SRHR and HIV services in 2015 in selected model clinics.

By the beginning of the evaluation period in 2016, UNFPA had supported the MoHSS in developing models for integrating SRHR and HIV services and pilot testing the models in seven sites (including a designated adolescent-friendly health services clinic operated by NAPPA in Windhoek. UNFPA had also supported a client satisfaction survey for all seven pilot facilities "demonstrating that service providers were satisfied with the integration services they offered to their clients and would recommend integration at other facilities as well as demonstrating that clients perceive that services, facilities are less stigmatizing and health care providers are friendlier."[28]

[28] UNFPA and UNAIDS, *Evaluation of the United Nations Population Fund and the Joint United Nations Programme on HIV/AIDS Project on Sexual and Reproductive Health and Rights and HIV Linkages: Country Report, Namibia.* (June 2016), p.8.

From that point onward, UNFPA Namibia has assisted the MoHSS with documenting the results of the pilots; further refining guidelines and tools for integration, providing technical assistance to health service staff in adopting the guidelines and integrating services. UNFPA has also helped to finance necessary equipment purchases, training of service providers and community engagement to explain and promote integrated services; UNFPA further supported the monitoring and evaluation of the pilots and the interchange of experiences at the national and regional level. A detailed profile of the activities financed by UNFPA in support of the integration process for each year of the evaluation period is provided in Annex D. In total, UNFPA Namibia disbursed USD 600,713 in support of integrating SRHR, HIV and SGBV services in the three-year period 2016 to 2018.

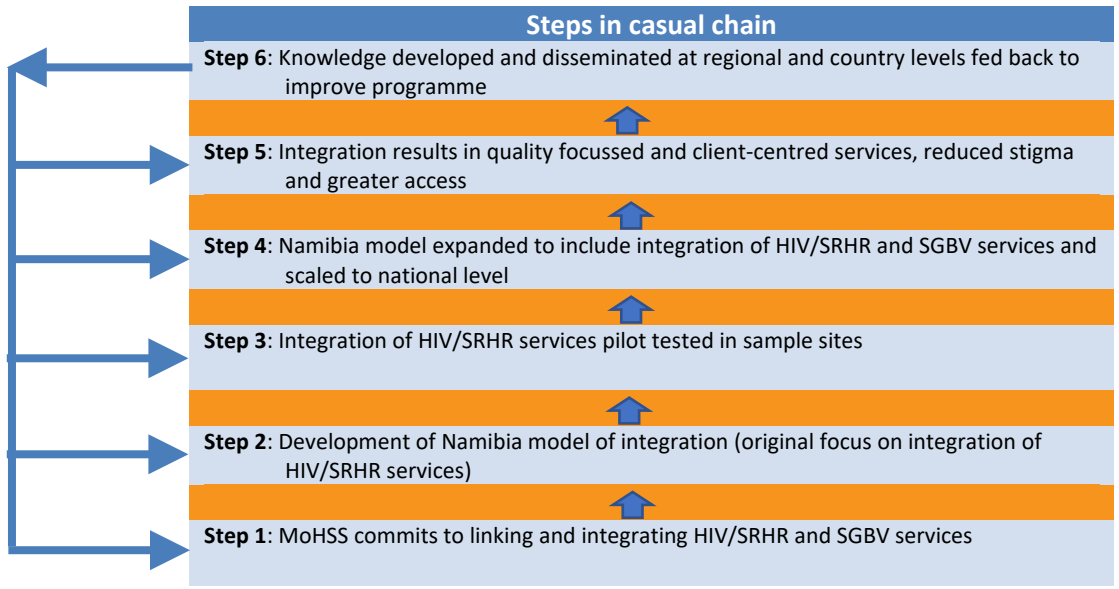
Interviews with key informants (including staff of the UNFPA CO, the MoHSS, and implementing partner CSOs) highlighted some aspects of UNFPA support to the integration process:

- "UNFPA support began with the pilot-phase with advocacy, technical assistance and support to research and document the Namibia model of integration. Since late 2017, UNFPA has been supporting the scale-up to national level based on the decision of MoHSS."
- "UNFPA provided technical and financial support to the Needs assessment on SRHR and HIV services linkages and integration conducted by MoHSS in 2011 and for the piloting of the integration which commenced in 2015 when a few health facilities/regions were selected. In the first phase UNFPA support focused on pilot regions and the model seemed to work well and was appreciated by the regions."
- In 2018, with UNFPA and Global Fund support, the implementation moved to the next phase of scaling up to other regions. Most of the funding for this was from donors. By 2019, integration of SRH and HIV services has rolled out to 98 out of 344 health facilities. Both the Global Fund and UNFPA are working with the DPHC to support regions and facilities with a high burden of HIV, mostly in the northern regions."
- "UNFPA was the first development partner in Namibia to really advocate for integration as a response to HIV and have been a champion of integration ever since. However, UNFPA acknowledges that it needs to be well planned – shortages of essential staff pose real difficulties."

During the inception phase of the evaluation of UNFPA support to the HIV response, the evaluation team developed a detailed theory of change covering all UNFPA activities and results in supporting HIV.[29] It is possible to extract from that model a simplified causal chain for the process of integrating HIV, SRHR, and SGBV services in Namibia. The figure below illustrates the links in the chain and the corresponding evaluation assumptions.

[29] UNFPA Evaluation Office, *Evaluation of UNFPA Support to the HIV Response: Inception Report.* April, 2019. P.17'

Figure 10: Simplified causal chain for integration of HIV, SRHR and SGBV services in Namibia



Evaluation assumptions	1.1 UNFPA support and advocacy for integration	1.2 UNFPA supported integration models implemented	1.7 Integration results in quality/client-centred services	1.6 Effective knowledge development and south-south consultation on integration

3.1.2 National commitment: the Namibia model of integration

There is a strong body of documentary evidence that the Government, and in particular, the MoHSS, has made and maintained a strong commitment to the strategy of integrating SRHR and HIV services. In 2016, the MoHSS, with support from UNFPA, UNAIDS and WHO published *National Guidelines on Health Services Integration: Sexual and Reproductive Health and Rights, HIV and Other Services.* The guideline document points out that the integration of HIV into other health services is called for in United Nations declarations, regional agreements and the NSF: "The 2011 United Nations General Assembly Political Declaration on HIV and AIDS, target number 10 calls for the elimination of parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts, as well as to strengthen social protection systems. Further, one of the strategies for operationalization of the SRH Framework of the Maputo Plan of Action is integrating STI/HIV and AIDS and SRHR programmes and services."[30]

This statement of commitment was further reinforced in 2017 with the adoption of the *NSF for HIV and AIDS Response in Namibia 2017/18 to 2021/21* which highlighted the need to integrate HIV and other services: "Service providers, and in particular the Ministry of Health and Social Services will provide the leadership necessary for the integration of HIV services within the mainstream health care service, including non-communicable diseases. Integration will not only improve service delivery but, also increase uptake and utilization."[31]

[30] Republic of Namibia, Ministry of Health and Social Services, *National Guidelines on Health Services Integration: Sexual and Reproductive Health and Rights, HIV and Other Services,* July, 2016, p.11 and p.13
[31] Republic of Namibia, Ministry of Health and Social Services, *National Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22.* 2017, p.12.

In 2018, following the completion of pilot studies in Namibia at the close of the first *Linkages Programme* (UNFPA and UNAIDS Project on SRHR and HIV Linkages in Southern Africa)[32] , the MoHSS produced a series of informative brochures to assist regional health authorities and facilities in the national roll out of the "Namibian Primary Healthcare Integration Model". The model has seven key features:

1. All services in SRHR and HIV offered every day
2. A nurse always works in the same screening room, which is numbered
3. On arrival, a receptionist assigns a client to a room and nurse
4. The client receives all services in one screening room
5. On clients' next visit, the receptionist assigns them to the same nurse and the same room
6. If needed, a client is referred for HIV counselling to take place in another room in the facility
7. If required, client will be referred to a doctor or a hospital for specialist care.[33]

MoHSS staff at ministry headquarters and in health centres and clinics refer to the Namibia Model of Integration as **one room, one patient, one nurse**.

In September 2018, following some reported difficulties in integration at health facilities, which, in turn, seemingly negatively impacted the retention of clients on ART, the Office of the Permanent Secretary of the MoHSS issued a circular addressed to all regional directors of health, chief medical officers, regional pharmacists, principal medical officers and health care workers. The purpose of the circular was "to reaffirm the Ministry's commitment to integration of services and provide further details and clarification on integration of health services for immediate implementation."[34] Circular No. 63 included a number of directives emphasizing the importance of integration while also noting that care should be taken in the process to ensure that appropriate resources and safeguards are in place.

Key informant interviews indicate continuing support for the overall national commitment to integrating HIV/SRHR/SGBV services but also confirm strong differences of opinion within MoHSS and among external stakeholder regarding the pace of the national roll out of the Namibia model of integration as well as how services should be organized within integrated facilities. This divergence of views is discussed in more detail below.

A Key Tool for Implementing Integration

The principal tool used during the pilot and roll out of integration of HIV and SRHR services in Namibia has been the summary document for the *National Guidelines on Health Services Integration: Sexual and Reproductive Health and Rights, HIV and Other Services*. The document recalls the international and national high-level decisions behind the integration strategy in Namibia, explains the concept of integration and its definition as well as the expected benefits. It also describes different models of integrated care before defining the Namibian model.

Most importantly, the guideline document details the process of integration. The process involves three major steps: Assessment, preparation and implementation. The guidelines provide detailed

[32] It was only in 2017 with the development of programme plans for the 2gether 4 SRHR regional programme on integration that SGBV services were added to UNFPA support to integration in the ESA region.

[33] Republic of Namibia, Ministry of Health and Social Services (MoHSS): *The Namibian Primary Healthcare Integration Model: Rationale for Scale-Up for Policy Makers.*2018 *The Namibian Primary Healthcare Integration Model: an evidence brief for community leaders.* 2018. *The Namibian Primary Healthcare Integration Model: Transition Process Overview.* 2018.

[34] Office of the Permanent Secretary, Ministry of Health and Social Services, *Circular No. 63 of 2018,* p. 1-2.

instructions for each step including key questions to be answered. For example, under Step 1. Assessment, the guidelines provide tools and checklists for assessing different dimensions of integration. This includes the following *what, who, when and where* questions:

- **What questions examine the content of integration**
  - What are the services provided in the clinic/health centre?
  - What is the workload in the facility?
  - What are the main reasons for visits to the facility?
- **Who questions address the personnel dimension of integration**
  - What type of providers work in the facility?
  - What language do they speak?
  - What are their training needs?
- **When questions focus on the time dimension of integration**
  - What are the working hours in the facility?
  - When are the different services provided?
  - Are services provided based on staff rotation, if so, how frequent are the rotations for different services?
- **Where questions deal with the space and patient movement in the facility**
  - How many rooms do you have?
  - How are different rooms used?
  - How are services organized? What does patient flow within the facility look like?
  - What is the time required to provide each service?
  - What is the waiting time for different services?
  - What takes up most of the time of the patient (waiting area, transition from one service provider to the other, consultation etc.? [35]

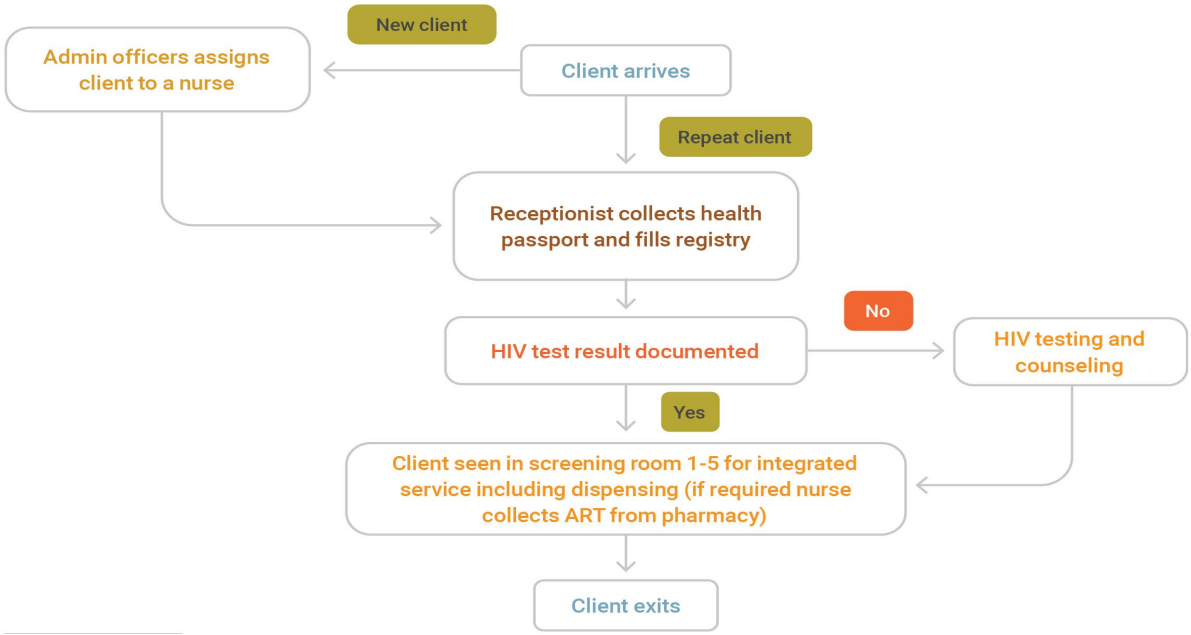
When the Namibia model of integrating HIV/SRHR/SGBV services is fully implemented, the result for patients should be access to all relevant services on any given day. There is no longer a need to seek specific services such as antenatal care (ANC) on specified clinic days. The model foresees a single waiting line for all clients to access services to be provided in screening rooms which are not specialized (instead, they are identified by a number or a colour) to avoid the stigma associated with, for example, ART services.

Client Flow in an Integrated Facility under the Namibia Model

During the site visit to the Onandjokwe Primary Health Care Clinic, in the Oshikoto Region, staff described the flow of patients under the integrated model according to the flow chart in Figure 11.

[35] Republic of Namibia, Ministry of Health and Social Services, *National Guidelines on Health Services Integration: Sexual and Reproductive Health and Rights, HIV and Other Services,* July, 2016, p.20-24.

Figure 11: Client flow in an integrated facility



It is important to note that some key informants indicated that HTC should be done in the same room under the "One nurse, One client, One room" model. However, the *National Guidelines on Health Services Integration* specifically allow for HTC services and consultation with a medical doctor to be provided in the same facility on the same day but not in the same room. The services to be provided in the screening room with a single nurse include ANC, post-natal care (PNC), family planning, immunization, screening for adult and child illnesses, dressings, tuberculosis care, pap smears, PMTCT and ARTs.[36]

3.1.3 Progress in integrating services

As of March 2018, the national consultation meeting on the SRHR/HIV/SGBV integration reported that the number of integrated health facilities in Namibia had grown from seven pilot sites to 78 health facilities in almost every region of the country. Further, 2 of the country's 14 regions (Oshikoto and Otjozondjupa) had scaled up to almost every primary healthcare facility. At the same meeting, the MoHSS provided details on progress in scaling integration across all 14 regions:

- Of 14 regions in Namibia, 7 had achieved their 2017/18 targets
- The 7 remaining regions were still planning to make progress toward achieving their targets
- Four regions were scaling up in facilities using Global Fund support: Kunene (4), Omusati (4), Ohangwena (12) and Oshana (6) amounting to 26 integrated facilities
- Two regions surpassed targets: Oshikoto: target 7, achieved 22; Otjozonjupa: target 8, achieved 17.[37]

[36] Ministry of Health and Social Services: *National Guidelines on Health Services Integration: Sexual and Reproductive Health and Rights, HIV and Other Services.* (2016) p.48

[37] Ministry of Health and Social Services, *Strengthening integrated sexual and reproductive health and rights (SRHR), HIV and Sexual and Gender-Based Violence (SGBV) services in East and Southern Africa (ESA – Namibia.* Presentation to the Namibia Country Validation Meeting, (March, 2018) p.7

In interviews, the MoHSS staff indicated that by 2019, integration had been rolled out to 98 of 344 health facilities. They also noted that both the Global Fund and UNFPA were continuing to support integration with a focus on regions and facilities with a high burden of HIV, especially in the northern regions of Namibia.

In order to assess the extent of integration, the evaluation team conducted site visits to three facilities in Windhoek and two in the Oshikoto region and interviewed members of the regional health management teams in both locations. The detailed results of interviews and site observations in these five different facilities are presented in Annex E. The table below provides an overview of the models of integration implemented in each site visited.

Table 9: Models of integration observed at sites in Windhoek and in Oshikoto Region

Facility	Characteristics of the integration model applied
Namibia Planned Parenthood Association (NAPPA) Okuryangava Clinic - Windhoek	While working with limitations of space and staff availability the clinic **provides partially integrated services**: • Clients are registered with preference in scheduling for first-time clients coming for ART or HIV testing and treatment • At the time of registration clients are assigned to a room for meeting a nurse/health worker • HIV, family planning and ANC clients are seen in the same room • All women who come for family planning services are proposed to be tested for HIV • Preliminary HIV testing is done by health assistants in a separate location in the same facility
Khomasdal Health Centre – Windhoek	Although the integration model was originally designed to provide comprehensive services in one room with one provider (and to help reduce stigma) the centre applies a **modified model of integration**: • Most patients are seen in one room by each nurse and those that need to be seen by a doctor are then referred • Pregnant women come early to the clinic and are given priority for ANC in a slight deviation from pure integration: they are given priority in assigning visits to screening rooms but the services in each room are still mostly integrated • The clinic has created a specialized space for testing and counselling for HIV. Another modification has been to create a space within the pharmacy where ART is provided to ART clients so they need not queue for access to medicines
Maxulili Clinic, Okahandja Park - North Windhoek	The clinic began the integration process in February 2019. It initially adopted the "one room" model but **now uses separate rooms for taking vital signs and for dressing wounds**. With regard to vital signs, there is not enough equipment for all the consulting rooms. For dressing wounds, although they have equipment, not all the staff are adequately trained. The integrated services are family planning, counselling, STI screening and immunization, however, • ANC is being provided separately due to problems of equipment and because staff (especially midwives) are not adequately trained in other services • HIV treatment is not integrated into the other services, but within HIV they do screening and counselling (for STIs) as well as family planning, and ANC • Similarly, all clients who come seeking family planning receive counselling in HIV prevention and PrEP • SGBV services have been integrated but if there is a potential prosecution the clinic refers the client to Katutura Hospital where there is a SGBV protection unit
Onandjokwe Primary Health Care Centre - Oshikoto Region	The health centre does its best to provide **fully integrated services** (see patient flow diagram in Figure 11):

Facility	Characteristics of the integration model applied
	• When a client enters, the receptionist collects their health passport and registers them on the patient tally. An administrative assistant then carries the file throughout the facility • HIV testing is undertaken in a separate room prior to assigning the client to a screening room. Under Provider Initiated Testing and Counselling all clients are tested • The client is assigned to one screening room (numbered 1 to 10) by the administrative officer if it is a new client; if already a client, they go to the screening room they attended on their first visit • Nurses in the screening room can prescribe and dispense ART to patients but only those on first line treatment • For clients whose initial test is positive, confirmatory testing is done in a separate location in the centre
Okankolo Health Centre, Onandjokwe Health District, Oshikoto Region	Staff of the centre have made **adjustments to the model for better workflow** and to respond to challenges. These include: • As the health centre is open 24 hours each day, they assign three nurses to each room, each one for an eight-hour shift • The pharmacy assistants assist nurses when needed in the screening rooms • The pharmacy assistants place the required anti-retroviral pharmaceuticals (ARVs) in the screening based on the estimate for the day. This is first line treatment ART • Administrative assistants carry the files as needed • All new clients are tested under Provider Initiated Testing and Counselling and are counselled (regardless of their status) • HTC is the only service that is not integrated into the other services because it takes much longer to counsel new clients who are positive

In at least four of the five sites visited (the exception being Maxulili Clinic, Okahandja Park, North Windhoek) staff have made relatively minor adjustments in order to implement at least the core set of integrated services envisioned in the Namibia model for integrating SRHR, HIV and SGBV services. All the sites visited allowed for HTC in a separate room in the facility; this is consistent with the national guidelines and should not be seen as a deviation from the integrated model.

In all five sites, pap smears and screening for cervical cancer were not being integrated into other services because of the specialized equipment and training required. In addition, in three of the four sites visited, HIV prevention services for adolescent girls and young women were provided in a separate location (a room or temporary building) by a nurse and peer educators provided under the PEPFAR-funded Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe Young Women (DREAMS) Programme.

3.1.4 Institutional and operational challenges to integration

Institutional resistance

In 2018, it became apparent that the national rollout of the Namibia model of integrated SRHR/HIV/SGBV services was encountering a number of significant operational and institutional challenges. In particular, staff of the DSP of the MoHSS and their key development partners, PEFPAR and the CDC raised the issue of how the integration process in some facilities was, reportedly, negatively affecting results in maintaining patients on ART and in achieving viral suppression. In interviews with the evaluation team, staff of these organizations indicated that:

- Roll out of integration at a national level had not been well coordinated between the DPHC and the DSP within the MoHSS and had resulted in disruptions in services and in errors in treatment of some ART patients

- Errors in treatment occurred because nurses untrained in HIV were dispensing ARV medicines and, for example, providing first line medications to clients who required second line treatment
- Integration was being applied in facilities which were not prepared, had too large a volume of ART patients and did not have sufficient well-trained staff
- The benefits of integration (as identified in the pilot-test) were not being realized either because the pilot test methodology was flawed or due to the fact that inadequate equipment, space and training meant that integrated facilities were still requiring ART patients to hand carry their own files (which are colour coded and clearly indicate their HIV positive status) and to access HIV designated corners in some pharmacies
- Finally, integration has reportedly influenced negatively the logging, entry and analysis of crucial data on HIV case management, retention of clients on ART and levels of viral suppression in many of the integrated facilities.

Finally, the national rollout of integrated SRHR/HIV and SGBV services is seen by some as a UNFPA-driven phenomenon. The same respondents indicated that integration was supported by the DPHC in an effort to "capture" some of the very large flow of funds from PEPFAR/CDC that are currently programmed through specialized, disease specific programmes managed by the DSP.

At the same time, it is important to note that other key informants at both regional and country level question these assertions. They point out:

- Integration is not a UNFPA or even a United Nations driven initiative, but has been supported by commitments, strategies and guidelines made at the level of SADC regionally and, repeatedly, by the MoHSS itself
- While integration might conceivably slow progress toward specific ART retention targets, the supporting data have not yet been shared with other key stakeholders
- Furthermore, maintaining separate facilities and staff for HIV services is not sustainable for the MoHSS.

In addition, during site visits, the evaluation team was told that any disruptions in services and resulting decline in measurable results during the transition to integrated services was usually temporary. As a staff member at one clinic pointed out: "There were problems in viral suppression for ART clients when they first started the integrated system. From a starting point of 94 per cent, the level of viral suppression declined to 83 per cent at first but then rose back to 94/95 per cent as the system stabilized. There were many new aspects to the integrated system both for the service providers and the community [to get used to]. Health centre staff needed to work with community members to make them comfortable with the new system. The period of disruption lasted from July to September 2018 but [the level of services] has since fully recovered."[38]

One response to the disruptions in service experienced during rollout of integration was the special *Directive 62, 2018* of the Office of the Permanent Secretary of MoHSS, which, while it reiterated an overall commitment to integration, also set out some important conditions that needed to be met during the national scale-up:

- Integration should follow a phased approach, of primary health care facilities as prescribed in the guidelines

[38]Site Visit to the Onandjokwe Intermediate Referral Hospital and the Onandjokwe Primary Health Care Clinic, Oshikoto Region.

- All regions should ensure that the required personnel are in place, equipped with the necessary skills and orientation on all programs to take on board the comprehensive approach
- Regional and district level health teams should support all their primary level health care facilities to transition to integrated service delivery whilst providing the necessary guidelines for the provision of standardized, quality health services in line with the 90-90-90 targets for HIV reduction, the FP 2020 targets, and child and adolescent health targets
- Changes at health facilities should occur only when appropriate skills are in place, orientation and training have been provided, and necessary equipment is installed
- Even in an integrated system, specialized services that meet a certain population's needs should be provided.[39]

Another result of the challenges encountered during the national scale-up of integration has been an agreement that UNFPA Namibia, with technical and contracting support from the ESARO would support the MoHSS in contracting an external firm to undertake a rapid assessment of the integration scale-up process. At the time of the evaluation mission, contracting of a suitable supplier was under way.

Operational challenges to integration

Some key stakeholders questioned whether the national scale-up of integration has actually impeded progress maintaining clients on ART. However, there is a general recognition that regions and facilities undertaking to implement the Namibia model of integration continue to face serious operational and infrastructure challenges. These challenges were identified in interviews with stakeholders in different offices in Windhoek, listed in programme review documents, and confirmed during the evaluation team's discussions with service providers at the sites visited. There is ample evidence of their frequent and serious nature. A fairly comprehensive list of these challenges was developed during the National Consultation Meeting on SRHR/HIV and GBV Integration hosted by the MoHSS in 2018:

- **Human Resource Constraints**: Specifically
  - Staff vacancies at regional, district and health facility level
  - Large and continuous training needs – including coordinated external training and provision of in-service training, mentoring and support: especially for Nurse-Initiated Management of Antiretroviral Treatment (NIMART)
  - Initial negative attitudes and resistance to change from staff members
  - Language barriers, especially in rural areas
  - Donor funded staff in ART clinics required to spend 80 per cent of time on HIV services
- **Infrastructure and Space**
  - Need to expand existing structures due to lack of screening rooms
  - Need for more benches/chairs and more space in waiting areas
  - Dilapidated infrastructure in some clinics
- **Equipment**
  - Shortage of basic equipment (blood pressure monitors, glucometers, etc.) to equip all screening rooms leading to sharing between rooms and requiring nurses to move to find equipment
  - Lack of funds to procure needed equipment
- **Other challenges**
  - Ongoing challenges posed by data logging and entry using separate, disease-specific registers

[39] Office of the Permanent Secretary, Ministry of Health and Social Services, *Circular No. 63 of 2018,* p. 1-2

- Lack of an integrated data collection and analysis system for integrated service
- The need for continuous sensitization of clients and community members to ensure understanding/acceptance of the new systems
- The high volume of clients in some clinics.[40]

A general challenge noted in some health facility visits and interviews was the perceived need for health centre staff (and by extension clients) for access to specialized expertise in some areas. For example, while not all staff can be highly trained in NIMART, or in critical ANC, there is a need for more readily available mentoring and supportive supervision of staff who may not have been fully trained in all aspects of integrated care.

3.1.5 Quality, client-centred services – the view so far

The preceding sections have established that integrating SRHR/HIV and SGBV services has been consistently supported by UNFPA, has remained a priority for government and is being scaled to the national level (albeit with real challenges and occasional modifications to the model). The question is whether this process is benefitting practitioners and clients, reducing stigma and improving access to quality HIV prevention and treatment services. Given constraints in time and resources, the evaluation team did not conduct client satisfaction surveys or exit interviews during the mission to Namibia. The team did, however, conduct individual interviews and group discussions with key stakeholders at the MoHSS, among development partners and with implementing agencies, including service providers and some beneficiaries at the health centres and clinics visited. The resulting evaluation evidence is not conclusive but it points to at least some positive results for both service providers and their clients:

The most recent, quantitative information on client satisfaction at integrated health facilities in Namibia dates back to 2016 when surveys were carried out in the seven pilot-test facilities as reported by the end-of-phase evaluation of the joint UNFPA and UNAIDS SRHR and HIV linkages project.

The 2016 evaluation pointed out: "Clients who completed the client exit interviews had varying perceptions of the quality of the services they received. Just under two thirds (65.1 per cent) rated services as either good (15.4 per cent) or very good (48.7 per cent). These ratings are corroborated by the findings from focus Group Discussions, where female clients reported that services were delivered at a high level of quality."[41] Of equal importance, "Female clients in the Focus Group Discussions reported that receiving integrated services saved them time and transport costs, and reduced discrimination against HIV testing and PLHIV. Female clients also noted that they preferred the facility because of proximity, affordability and reduced wait times in comparison to other facilities."[42]

At the National Consultation Meeting on the Joint SRHR/HIV/GBV Integration Programme in March 2018, the *Family Health Programme* of the DPHC presented findings on the results of the seven pilot health facilities supported in the first phase of integration. The reported results were as follows:

- Client waiting times reduced by 35.1 per cent (4 hours 51 minutes to 3 hours and 9 minutes)

[40] Republic of Namibia, Ministry of Health and Social Services, *National Consultation Meeting on the Joint SRHR/HIV/GBV Integration and Validation Meeting for SRHR/HIV/GBV Tools: Meeting Report.* March 2018, p. 13.
[41] UNFPA and UNAIDS, *Evaluation of the United Nations Population Fund and the Joint United Nations Programme on HIV/AIDS Project on Sexual and Reproductive Health and Rights and HIV Linkages: Country Report, Namibia.* (June 2016), p.20.
[42]UNFPA and UNAIDS *Evaluation: Country Report, Namibia,* (June, 2016), p.22.

- Time waiting in consultation room to receive ANC services reduced by 31.2 per cent to 36 minutes
- Productivity improved from 0.9 to 1.94 clients per nurse, per hour. An overall 53.6 per cent increase
- The number of ANC clients per month increased by 4.5 per cent
- The number of first-time family planning visits increased by 14.7 per cent. As most first-time family planning visits are by adolescent girls and young women this implies increased access by this group
- The number of routine ARV refills increased from an average of 654 per month to 761 per month
- Improved client/nurse communications and self-reported reduced stigma
- Improved accessibility of services with all services provided Monday to Friday
- A focus on the person/client and not "the disease"
- Improved nurse workload distribution and satisfaction.[43]

The evaluation team also raised the issue of the quality and client focus of integrated facilities in Namibia during key informant interviews with staff of the Government and with the staff of civil society organizations, either providing SRHR/HIV and GBV services or representing adolescents, youth and KPs. The table below provides a selection of responses, which are illustrative of views in different key stakeholder organizations.

Table 10: Key stakeholder views on quality, client-centred services in integrated facilities

Organization	Views on quality, client-centred services in SRHR/HIV/SGBV
UNFPA	"The one room, one nurse, one client is an interesting model and it can be effective. It allows full utilization of, for example, HIV/ART nurses and broadens the work experience of other nurses."
Ministry of Sport, Youth and National Service (MYSNS)	"Integration is the main and best strategy for addressing SGBV whether in health services or in and out of school settings. The Ministry's focus on SGBV is maintained by ensuring that it is well covered in their Comprehensive Sexuality activities but it is important that health service providers are integrating SGBV recognition and response into their service protocols."
Ministry of Health and Social Services (MoHSS)	"In particular, the assessment of the pilot showed that integration encouraged young people to access HIV prevention and treatment services and to get tested and know their status. The one nurse, one room, one client model also helped to build rapport between service providers and their clients."
Namibia Planned Parenthood Association (NAPPA)	"Integration needs to include more SGBV but it does allow them to spend more time with the client and thereby to build rapport and trust. This is especially important for young people and for KPs."
Out-Right Namibia	"The [LGBTI] community needs good access to confidential testing and that is best done through integration. However, the key factor in accessing testing and treatment for the community is the knowledge that a given health centre has a nurse or other service provider who treats them with sensitivity and respect. Not all health facilities/partners have well trained staff who are friendly – unlike NAPPA where they are friendly. In the first instance there might be a self-test done with the client (in an integrated facility). This would be followed by a confirmation test in another place. It is important that the person involved not be seen to move to the confirmation test because then it

[43] Ministry of Health and Social Services, *National Consultation Meeting on the Joint SRHR/HIV/GBV Integration: Meeting Report,* (March 2018), p,7-8.

Organization	Views on quality, client-centred services in SRHR/HIV/SGBV
	is assumed that they are HIV positive. It is better if the nurse takes the test sample to the separate site for confirmation."
PEPFAR/CDC	"Khomosdal clinic in Windhoek one of seven full-service clinics with real HIV specialization: ART services, cervical cancer screening, CD4 count testing, NIMART – a certain cadre of the nurses in the clinic do all the ART/HIV. Under the integrated model, as it is currently implemented, there are nurses without NIMART training doing that poorly. At times people who should be on second-line treatment are placed on first-line treatment."

The results of these and other interviews in Windhoek were tested by the evaluation team by comparing them with the responses of service providers and with the team's own observation of operations at the five integrated health facilities where site visits were conducted. The table below presents the highlights from interviews and observations at each site. It is interesting that the health service providers interviewed gave examples of two different types of positive results: those experienced by the service providers themselves and those that directly affected the quality of care for clients.

Table 11: Staff views and observations on benefits of integration for staff and clients

Facility	Views and observations on quality, client-centred care
Namibia Planned Parenthood Association (NAPPA) Okuryangava Clinic, Windhoek	• The fact that PrEP and ART are given in the same room **helps reduce stigma** since clients may be visiting the screening room for either purpose • After two years using this modified integrated approach the nurse in charge finds she has **a stronger and closer relationship with clients** • Delivering integrated services on a daily basis helps **staff keep skill levels high** • Originally trained as an HIV specialist the nurse in charge is now **able to stay up to date** on ANC, family planning and KPs
Khomasdal Health Centre – Windhoek	• Provided that the elements of **training, equipment and space are addressed**, integration can have a very good effect • The principle is sound: **provide the client with services they need in the same place, available every day from the same providers**. However, this is **dependent on resolving the challenges already identified**: space, equipment, need for continuous training, improved pre-service training, improved mentoring and supportive supervision in key specialty areas such as NIMAT
Maxulili Clinic, Okahandja Park, North Windhoek	• The eventual goal is to integrate all services (ANC/HIV/Vital Signs, etc.) • Staff are able to **develop a stronger relationship with clients** because they interact with them on a regular basis
Onandjokwe Primary Health Care Centre, Oshikoto Region	• Under the new system **the workflow has improved** • As noted by the District Nurse Manager, "when we first started with integration it was a big problem for nurses going to external clinics but after a lot of training, nurses sent to the external clinics are able to do much more than ART. Similarly, all nurses are now trained in ART. This **improves the effectiveness and the quality of client services at the clinics and outreach posts**. In the past it was difficult to assign ART specialist nurses as back up to outreach sites as they lacked skills in other areas." • It is very important to provide ongoing mentoring and refresher training. Under a USAID-funded Technical Assistance Programme, one nurse mentor is funded for each district in the region. The nurses in all 11 sites (six high volume and five low volume for ART) are supported with mentoring under the programme • Nurses **do develop better relationships with the clients** based on repeated contacts using the integrated model

Facility	Views and observations on quality, client-centred care
Okankolo Health Centre, Onandjokwe Health District, Oshikoto Region	• The health centre has seen **an improved uptake of HTC** and has been able to provide greater emphasis and support to the need for dual protection (for family planning and for protection from HIV) • Before integration, services were provided on specific days, which made it difficult for the clients to know for sure they would receive services after travelling long distances. Now **all services are provided from Monday to Friday** • In the past, few nurses were involved in ART and their knowledge was not shared with other nurses. Now **all the nurses are involved and, although it is challenging, they find it more rewarding as well** • Also, HIV patients now receive services from the same provider in the same room and are not moving from room to room carrying their own, conspicuous HIV file (with a blue border) and **integration helps to reduce stigma** • Clients **report that they are more satisfied** – they know their nurse and are able to build relationships. They are also more vocal about their systems and their needs after **building up their trust in the nurse they see regularly** • The Community ART Referral Groups have helped to **reduce stigma in the communities** which means that clients who are HIV positive are less likely to be subject to stigma when visiting the health centre

From the perspective of health care providers, integrated facilities were able to provide higher quality and more client-centred care mainly because they were able to develop and foster a stronger provider-client relationship over time. They also felt that their level of skill in different aspect of SRHR and HIV service delivery improved through the experience of delivering all services on a daily basis. Staff in the visited sites also noted an important caveat to these positive observations on the improved client experience and enhanced skills of service providers in integrated facilities: the need for continuous training and specialized support from skilled mentors on an ongoing basis if they were to fully realize the benefits of integration for both clients and service providers. They also highlighted the need to address other, non-training issues relating to equipment, space and infrastructure.

In summary, the documentary evidence, views of senior staff in government and CSOs, and observations from the site visits indicate strongly that the Namibia model of integrated delivery of SRHR/HIV/SGBV services as supported strongly by UNFPA remains a sound strategy for improving efficiency and strengthening the national response to HIV. Those sites which have been able to operate in a reasonably integrated way (with some adaptations to overcome operational challenges) seem to provide a greater level of satisfaction for both staff and clients and report some success in reducing stigma and improving access for clients living with HIV, including adolescents and youth and KPs. It will be important going forward, however, to identify strategies to ensure that i) integrated sites have access to adequately trained staff skilled in the full range of services offered (notably managing clients living with HIV to maintain ART and viral suppression levels), including provision of specialized mentoring as required, and ii) that required equipment and adequate space are available.

3.1.6 Knowledge generation and south-south cooperation on integration

One of the most prominent features of both phases of the regional programme to support integration (the *Joint UNAIDS/UNFPA Linkages Project: 2011 to 2017* and the *2gether 4 SRHR programme)* has been a commitment to south-south cooperation and shared lessons learning, both on a regional basis and within each of the participating countries, including Namibia. Significant examples of both formal and informal information exchanges of information across the region and in Namibia include:

- In 2016, Namibia hosted the 6th Steering Committee meeting of the UNFPA and UNAIDS Regional Project on Linking HIV/SRHR/TB/ and SGBV which served as a platform for countries to report on progress, share best practices and work on their results-based frameworks.

- The Minister of Health for Namibia was invited to be part of the Satellite Session and to share Namibia's experience around the integration 10 of SRHR/HIV at the International Conference on HIV/AIDS and STIs that took place in Abidjan, Cote D'Ivoire from 4 - 7 December 2017.

- During the pilot-testing phase of the Regional Project, the MoHSS developed a journal article documenting the experience of integrating the Epako clinic and its use of integrated SRHR/HIV services, which was shared with other countries in the region.

- During interviews and site visits the evaluation team was provided with many examples of information sharing on approaches and challenges in integrating SRHR/HIV/SGBV experiences across regions and among different sites within a region. For example, the Okankolo Heath Centre in Onandjokwe Health District has served as a model for how integration can be implemented for different health centres and clinics both in and outside of Oshikoto region.

- In 2018, "the National Consultation Meeting on the Joint SRHR/HIV/GBV Integration and Validation Meeting for SRHR/HIV/GBV Tools brought together all 14 Regional Health Teams along with national level staff of United Nations partners to review experiences, understand the bottlenecks, and develop clear scale-up plans for ensuring a majority of primary health care facilities and ART centres will be providing integrated services by 2020."[44]

One area where information sharing within Namibia is likely to be less effective now than during the first phase of the linkages/integration project is in sharing information within the MoHSS and between members of the JUNTA and the large-scale US government support programmes in HIV administered by PEPFAR and the CDC. As reported in the final programme report on the *Linkages Project*:

> "During the first phase of the regional programme on integration, activities in Namibia were coordinated by a National Steering Committee on SRHR/HIV Integration chaired by the Director of Primary Health Care (PHC), MoHSS and including representation by the MoHSS Directorates of Primary Health Care and Special Programmes as well as UNAIDS, UNFPA and PEPFAR/CDC."[45]

Unfortunately, this committee has not been functional since 2017 so that information sharing and communications between the SPD and DPHC within the MoHSS has not been as effective during the national rollout of integration as it was during the pilot phase.

3.1.7 Supply chains and condom programmes

While the NSF makes specific reference to the need to improve coordination and distribution of condoms as an element in the prevention strategy, this has not been a focus of UNFPA programming in Namibia, perhaps because the Global Fund has provided direct support to the Central Medical Stores regarding strengthening supply chains for contraceptives. A review of HIV-related budgets and

[44] Ministry of Health and Social Services, *National Consultation Meeting on the Joint SRHR/HIV/GBV Integration: Meeting Report,* (March 2018), p,4.
[45] UNFPA and UNAIDS. *The Joint United Nations Population Fund (UNFPA) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) Project on Sexual and Reproductive Health Linkages in Ten Countries in East and Southern Africa: Final Programme Report.* 2018, p.11

disbursements (see Annex D) also did not indicate that UNFPA projects and programmes were used to address Supply Chain Management issues during the evaluation period.

At the same time, it is important to note that UNFPA and MoHSS do collaborate annually to quantify condom needs and UNFPA is the sole source of female condoms for Namibia. There are important issues in the supply chain for condoms and other contraceptives in Namibia as reported by almost all the stakeholders interviewed. Staff at all five health centres visited by the evaluation team raised the issue that integration of family planning services into SRHR/HIV is currently made more difficult by shortages and stock-outs of family planning commodities, most importantly stock-outs of injectable contraceptives but also including condoms. Only oral contraceptives seemed to be in good supply in all five sites.

3.2 Efforts to meet the needs of marginalized people and promote rights

UNFPA has worked effectively in partnership with key ministries of the Government and with important CSOs to improve access to HIV prevention and treatment services for adolescents and youth and for KPs, especially members of the LGBTI community. Through support to the NSF on HIV and AIDS (2017/18 to 2021/22), UNFPA has helped to build a strong base for programming and advocacy relating to both improved access and to recognition of the rights of adolescents and youth and KPs. Two of the most important areas of UNFPA contribution to securing access to services and realizing the rights of adolescents and youth have been its support to CSE and efforts to combat SGBV. While the NSF explicitly recognizes the need for effective, rights-based programmes to meet the needs of MSM, it has relied almost exclusively on CSOs to identify, reach out to and provide services to the LGBTI community in Namibia. This limits the reach of professional, competent HIV prevention and treatment services for members of the community. It also presents a major risk to sustainability as these CSOs are almost exclusively funded by external development partners and this source of funding is declining in light of Namibia's achievement of UMIC status.

For details of the evidence supporting findings in section 3.2, see Annex B: Assumptions 2.1, 2.2, 2.3, and assumptions 3.1, 3.2, 3.3 and 3.4

UNFPA Namibia has been active in supporting efforts to provide effective HIV prevention and SRHR services to adolescents and youth, AGYW and to KPs, especially the LGBTI community in Namibia before and during the evaluation period. As detailed in Chapter 2, the main programmatic vehicle for this effort has been Namibia's share of the regional *SYP programme*, which accounted for USD 443,083 of expenditures in the three years 2016 to 2018 and has a budget of USD 130,000 in 2019. UNFPA also supported, access to condom programming for adolescents and youth and access to SRHR services for KPs using UNAIDS joint programme funding under the UBRAF in 2018 (USD 55,942) with a budget of USD 101,466 in 2019.
In supporting efforts to meet the needs of adolescents and youth, UNFPA Namibia partnered with the MEAC, the MSYNS and the MGECW. It also partnered with Namibian CSOs either delivering services to adolescents and youth or representing their interests, notably the AfriYAN, the National Youth Council (NYC) and NAPPA.

KPs among adolescents and youth (for example young people who are members of the LGBTI community or younger sex workers) are also a focus of the support UNFPA provides to efforts to meet the needs of adolescents and youth in Namibia. UNFPA provided technical support and financing to assist the development of manuals and guidelines for both in-school and out-of-school CSE. The CSE curriculum supported by UNFPA in Namibia makes explicit reference to the needs and

rights of LGBTI young people.[46] Beyond adolescents and youth, UNFPA also provides direct support to efforts to improve access to services and secure the rights of KPs, more specifically the LGBTI community. The main partners engaged by UNFPA in this field are the MEAC, the MoHSS (through support to the Technical Working Group (TGW) on KPs chaired by MoHSS, NAPPA, the OFL, Out-Right Namibia and the SFH.

3.2.1 Policy and advocacy: recognizing the HIV/SRHR needs of marginalized people in Namibia

UNFPA Namibia, in cooperation with its national partners, has been advocating for and providing technical support to efforts to recognize the needs of adolescents and youth, and KPs for access to HIV and SRHR services that meet their needs since well before 2016. As a result, among the ten priority programme areas set out in the NSF for the HIV and AIDS Response (2017/2018 to 2021/22), two are concerned with meeting the needs of adolescents and youth and MSM:

- "Adolescent Girls and Young Women (AGYW**):** The strategic focus of the NSF is to ensure that AGYW who are not infected with HIV remain negative and those diagnosed with HIV are linked to care and treatment. Efforts will be made to identify AGYW living with HIV, and do not know their HIV status through differentiated HIV testing services. Special attention and focus will be on AGYW KPs. Programming for AGYW will take a life-cycle and human rights approaches, and will be age and gender specific."
- "Prevention Programmes for KPs: The primary focus of the NSF is Men Having Sex with Men (MSM) and Female Sex Workers (FSW). Activities will encourage these at-risk groups to know their status and provide onward linkages to the treatment cascade."[47]

Staff of several CSOs noted that this was the first instance of an official document of the Government making reference to the legitimate needs of MSM. The NSF also established a programme objective and defines the primary target population for its work with AGYW and KPs.

For AGYW:

- "Programme Objective: To reach 90 per cent of AGYW and their sexual partners in high-burden geographic locations with high impact HIV combination prevention and sexual and reproductive health (SRH) interventions to reduce new HIV infections by 2022.
- Target Population**:** The primary target population is adolescent girls aged 10-24 years. Secondary target populations include: Sexual partners, Parents, School Counsellors, community gatekeepers, legal practitioners, law enforcement and health care workers." [48]

For MSM:

- Programme Objective**:** To target MSM with high impact HIV testing, prevention, treatment and care interventions necessary to achieve the fast-track targets i.e. 90-90-90 among the MSM by reaching them with combination prevention services by 2022.
- Target Population**:** Primary target population: Men having sex with Men (MSM). Secondary target population: Law enforcement, health care workers, law makers."[49]

[46] Government of the Republic of Namibia, Ministry of Education, Arts and Culture. *Comprehensive Sexuality Framework for Out of School Young People in Namibia: Unit Six: Relationships (2016).*
[47] Republic of Namibia, Ministry of Health and Social Services, Directorate of Special Programmes, *National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22,* p.2
[48] NSF, p.14
[49] NSF, p.18.

While the NSF analyses and recognized the very dangerous levels of HIV infection among FSW (see Section 2.1), interviews with key stakeholders indicate that there has been little or no programmatic or policy effort to address their needs for HIV prevention and treatment services. Attention to preventing HIV infections among FSWs must be seen as an important gap in meeting the needs of KPs.

Similarly, when asked about services designed to meet the specific needs of KPs, stakeholders (inside and outside of government services) noted that the official constitutional policy is one of non-discrimination: that is to say that all Namibian citizens have a right to access to services but that does not mean that services can be tailored to meet the needs of specific groups such as MSM. As noted by one serviced provider "there is a general agreement that all patients should be treated equally and that there should be no discrimination but there is no acceptance that adolescents and youth and KPs may require a special effort to overcome barriers; yet you cannot adequately address the epidemic without meeting their [specific] needs."

However, staff at different ministries indicated that they are able to interpret the non-discrimination element of Namibian law ways that helps them address the needs of KPs. One example was highlighted during interviews with the HIV and AIDS Management Unit of the MEAC which indicated that "policies do not call for any "special" designation or treatment of LGBTI learners but the Ministry is able to address their needs by relying on a set of agreed principles:

- All forms of discrimination are banned, including discrimination based on sexual orientation
- The Ministry of Education, Arts and Culture has a mandate to eliminate drop-outs, including by LGBTI leaners
- Dignity of the person and freedom from discrimination is protected by the constitution of Namibia
- All learners have a right to dignity
- Pregnant AGYW have a right to education and cannot be excluded from the classroom."

In practice, the result of national policy seems to be an informal division of labour in which government ministries such as MoHSS, rely on civil society to identify, engage with, represent and delivery services to KPs.

3.2.2 HIV services for adolescents and youth and key populations: initiatives and gaps

Meeting the needs of adolescents and youth

The evaluation team met with the most active partners of UNFPA engaged in identifying and meeting the SRHR/HIV/SGBV needs of adolescents and youth, including the need for effective prevention services, access to condoms and empowering information and knowledge. The table below summarizes some of the diverse ways that partners report working with UNFPA support to meet the needs of adolescents and youth. UNFPA support of CSE and efforts to address GBV are dealt with separately in Sections 3.2.5 and 3.2.6.

Table 12: UNFPA/Partner cooperation on meeting the SRHR/HIV needs of adolescents and youth

UNFPA Partner	Cooperation with UNFPA on meeting needs of adolescent and youth (Non-CSE)
Ministry of Sports, Youth and National Service (MSYNS)	• With UNFPA support, MSYNS engages youth through the use of the "Condomize" materials and methodology.[50] Peer education delivered programmes also highlight the need to use condoms for HIV prevention and for family planning • Through the use of drama and games programmes, young people are engaged in Behaviour Change Communication activities. In addition, peer educators are invited by Life-Skills Education Teachers to give presentations in schools while the MSYNS also engages with university students by providing "condomize" activities in university settings • UNFPA also provides technical and material support to the MSYNS in its partnership with NAPPA to run youth-friendly clinics in seven regions in the country.
Directorate for Special Programmes (DSP) Ministry of Health and Social Services (MoHSS)	"PEPFAR/CDC is supporting the DREAMS initiative to address rising rates of infection among AGYW. While (as per the reports to the Global Prevention Coalition meeting in Nairobi in May 2019) infection rates are declining globally, the absolute number of infected AGYW is still rising. It is a real struggle to effectively re-engage around the problem of prevention. There is need to get back to investing in and emphasizing the problems of prevention and how to encourage behavioural change."
Directorate for Primary Health Care (DPHC) Ministry of Health and Social Services (MoHSS)	"There is a real national emphasis on youth- friendly health services to be provided in all facilities – which is one rationale for integration. It is better for youth to be able to access all the SRHR/HIV/SGBV services in a single room. However, there is still a challenge to overcome negative attitudes among service providers when young people try to access SRHR services. Every adolescent in every facility must be able to access SRH services according to national policy."
Global Fund Programme Management Unit (MoHSS)	"UNFPA has been pretty closely/actively engaged in support to meeting the needs of adolescent girls and young women but there is a perceived tension between the US-AIDS funded DREAMS program and the UNFPA focus on CSE. The DREAMS programme does not have a CSE component."
One Economy Foundation/Office of the First Lady (OFL)	"The Be Free/Break Free Initiative was begun in 2016 after the First Lady became a Special Envoy for AIDS (UNAIDS). Under this initiative, the OFL reached out to youth-led organizations and reached over 10,000 young people, including young men, parents and professionals. The office convened panels of different stakeholders to examine HIV prevention among young people, especially AGYW. These included: • Youth led organizations • Social Workers • Police • Traditional Leaders • School Teachers • Parents In these forums they deal with risky behaviour (oral and anal sex), non-use of condoms, abortion and also LGBTI rights."
National Youth Council (NYC)	"AfriYAN has run 4-5 campaigns on HIV prevention for young people in the last year (2018/2019). They also reached out to higher education institutions during campaigns – at the universities in Windhoek (Supported by UNFPA in working with

[50] "Condomize" is a UNFPA developed and supported approach to mobilizing the most vulnerable including adolescents, youth, key populations and persons with disabilities to promote HIV protection and condom use through campaigns featuring peer education and innovative participatory activities. See https://www.unfpa.org/news/condomize-protects-vulnerable-populations-hiv

UNFPA Partner	Cooperation with UNFPA on meeting needs of adolescent and youth (Non-CSE)
African Youth and Adolescent Network (AfriYAN)	university campaigns). AfriYAN is currently in discussion with UNFPA regarding efforts to return to university campuses with the "Condomize" type campaigns. This is part of a wider effort to scale-up the campaign to all 12 campuses of the University of Namibia. First in the 2 campuses in Windhoek and then with the other ten campuses across the country."
PEPFAR/CDC	"PEPFAR/CDC are agnostic as to how you should deliver adolescent-friendly health services – it is not so much the process that matters (youth-friendly corners or specific days for youth for example).What matters is reaching adolescents girls and young women with what works for them and that they have had good results with the DREAMS programme approach. Peer driven programming seems to help preserve confidentiality and help youth gain the experience they need."

Meeting the needs of key populations

In Namibia, UNFPA has focused its efforts to improve SRHR/HIV services to meet the needs of KPs mainly by engaging with government and supporting CSOs working on issues of most relevance to the LGBTI community. In 2019, UNFPA began supporting efforts to reach and meet the needs of disabled people in Namibia but, at this point, these are focused on strengthening national capacity for gathering and analysing data on persons with disabilities.

The table below provides details on cooperation between UNFPA and its partners in meeting the specific SRHR/HIV needs of KPs as emphasized in meetings with staff of the identified organizations.

Table 13: UNFPA/Partner cooperation on meeting needs of key populations

UNFPA Namibia partner	Cooperation with UNFPA on meeting needs of KPs
Ministry of Education, Arts and Culture (MEAC)	"The job of the teacher is to create a safe environment in the classroom for all the students including LGBT students and those with a disability so they can participate fully in discussion and learning around CSE."
Out-Right Namibia	"The major concern for the LGBTI community is not just getting access to services for HIV and AIDS (including ART). The only focus of the PEPFAR/CDC/MoHSS (DSP) programme is getting and maintaining people on treatment. They do not address the critical problems of LGBTI people regarding employment, shelter, emotional stability, nutrition – unless these are addressed, it is very hard for them to access services and stay on treatment. There is a focus on getting LGBTI community members on Pre-Exposure Prophylactics (PrEP) but then they might not take their medication because of lack of food or no place to stay. It is very hard for people to stay compliant when most have no place to stay, have no steady employment and, for many, are involved in sex work. Many programmes are focused on providing information on HIV and on treatment of HIV but very few address the larger socio-cultural issues or the practical challenges."
Namibia Planned Parenthood Association (NAPPA)	"NAPPA has very good relations with Out-Right Namibia and, with UNFPA support, opened a clinic in Windhoek at the Out-Right Namibia drop-in centre but it no longer functions. NAPPA currently operates a Saturday clinic in Windhoek for LGBTI people."
One Economy Foundation/Office of the First Lady (OFL)	"The OFL is a strong public advocate for the requirement that public services and society as a whole need to be responsive to the needs of different communities including: ○ LGBTI persons ○ Commercial sex workers ○ Young people with disabilities ○ Tribal people ○ Young People in Nomadic Communities."

UNFPA Namibia partner	Cooperation with UNFPA on meeting needs of KPs
	On Friday 24 May 2019, the First Lady hosted a public discussion with representation from KPs (attended by a member of the evaluation team).
Society for Family Health Namibia (SFH)	"An example of what they do under this agreement is conducting (in late May 2019) a two-day training event for health workers on providing competent SRHR services to members of KPs (in partnership with the Office of the First Lady)."
UNAIDS	"UNAIDS would like to see UNFPA take on a strong role on advocacy for KPs. This is squarely within their mandate as a UNAIDS co-sponsor. In particular, there is a gap regarding advocacy and services for commercial sex workers where not much seems to be happening. UNFPA could address this more forcefully."
Technical Working Group on KPs	• "NAPPA used to operate an integrated drop-in centre at Out-Right Namibia. The country was looking at innovative ways to provide services and UNFPA was the only development partner willing to participate in supporting a facility for LGBTI people. This was the first time that a UN agency was willing to work with an organization representing KPs in Namibia. UNFPA is really an essential support for Out-Right Namibia." • There is a SADC Strategy for Responding to HIV among KPs and it can be used for advocacy. UNFPA uses it to support evidence gathering and reporting but [the Strategy] lacks practical mechanisms for implementation."
PEPFAR/CDC	"There is a real question around the best way to reach KPs. Do you integrate services into the population with dedicated clinics etc.? Or do you integrate community members into regular services through careful case management? You can cascade care into a single service point but you have a lot of work to do to make it work for KPs."

The experiences and views of UNFPA partners on meeting the needs of KPs in Namibia reinforce the idea that reaching LGBTI people with effective, professional services that meet their needs is still primarily the task of CSOs such as SFH, Out-Right and NAPPA. Further, UNFPA has been an effective advocate for meeting the SRHR/HIV needs of the LGBTI community and a leader in engaging with the community among the UNCT and the wider development community. It also seems clear that, while the NSF identified KPs as a target for services (in line with the SADC Regional Strategy for KPs), there is no real programmatic response to their needs on the part of MoHSS and other ministries as they continue to rely on CSOs as intermediaries.

In light of the different ways that UNFPA and its partners have cooperated to meet the needs of both adolescents and youth and KPs regarding SRHR and HIV, the evaluation team interviewed health care service providers and observed delivery of services at the five sites visited during the evaluation mission to Namibia. The table below summarizes the results of the site visits regarding services to adolescents and youth and to KPs as reported to the evaluation team by different service providers in each site.

Table 14: Serving adolescents and key populations in visited sites

Health facility	Adolescents and youth	KPs
Planned Parenthood Association (NAPPA) Okuryangava Clinic, Windhoek	"The clinic treats youth with respect and staff are known in the community for doing so. There used to be a strong stigma for youth using clinics but CSE in schools has helped to reduce the stigma young people feel so that they are more willing to use the clinic."	"In the past three years, the reaction of the general population to members of the LGBTI community has improved. LGBTI clients have serious trust issues and many have mental health issues and, crucially in other clinics, health services/staff are not well skilled in addressing the mental health needs of the community."

Health facility	Adolescents and youth	KPs
Khomasdal Health Centre – Windhoek	"Adolescents and youth often want to see the same service provider each time because they form a bond with a sympathetic nurse/health care provider."	"The main key population group they serve are MSM who come for testing and if positive want as rapid a service as possible to receive their ARTs and then leave. The clinic staff received special training on how to provide services to members of KPs. The one-day training was provided by a consultant contracted by the Society for Family Health. As with adolescents, key population members want to be served by the same nurse each time. The nurses get a reputation for being sympathetic and understanding."
Maxulili Clinic, Okahandja Park, North Windhoek	The clinic has a DREAMS programme team on-site providing services to adolescents and youth but this is a separate organization from the clinic. The DREAMS programme team provides AGYW with family planning, HIV testing and counselling and interventions relating to SGBV."	
Onandjokwe Primary Health Care Centre, Oshikoto Region	"In the past year, the health centre has begun separating out adolescents and youth because of the DREAMS project which is now operating at the facility and which uses its own pre-fabricated facilities. When the DREAMS nurses are present, their young clients do appreciate the services. When DREAMS nurses are away young clients are happy to access the clinic's regular nurses, including for SGBV services."	"In a rural area like this one, people do not self-identify as members of KPs so they are less visible. It is important that the Society for Family Health (SFH) has done work on values and culture to help care providers provide professional services to KPs."
Okankolo Health Centre, Onandjokwe Health District, Oshikoto Region	"Adolescents and youth (9-24 years of age) access the DREAMS programme. The DREAMS programme works specifically with Adolescent Girls and Young Women (AGYW) but there is only one DREAMS nurse in the facility."	"MSM, and LGBTI community members are not readily visible in the rural area and do not self-identify as such. They still may benefit from having access to a single provider over time, if that provider is sensitive to their needs and is respectful. There is a role for values training in this area."

It is interesting that the five sites visited generally reinforced the observation that, for both groups, adolescents and youth and members of the LGBTI community, access to a knowledgeable, competent and respectful service provider is a key factor in encouraging clients to access HIV prevention and treatment services. It is also important that work on values and cultures by SFH (with support from UNFPA) has been an important influence in a number of health centres. The evaluation team was able to interview some of the nurses, peer educators and clients (adolescent girls and young women) at DREAMS programme facilities within the sites visited (always a separate set of rooms or a separate building on the site of the facility). In every case, these young women emphasized that their AGYW clients accessing ART services had contracted HIV through SGBV, often from family members.

3.2.3 Civil society organizations as instruments to reach key populations

The practice of relying on CSOs (including the DREAMS programme operated by I-TECH an NGO based in the University of Washington with PEPFAR support) to reach adolescents and youth and, especially, KPs with HIV services presents a significant sustainability risk for Namibia. Most of these organizations are funded exclusively or largely by international development partners, who in turn are reducing funding to Namibia as an UMIC. As one key stakeholder noted: "the problem of CSO capacity is crucial to the question of how to empower and engage communities, including youth and adolescents and KPs. UNFPA and other external supporters have been working with CSOs up to now but with Namibia's transition to UMIC status, and if donors draw down their investment in CSOs, who will speak for KPs specifically?"

3.2.4 Identifying the rights dimension of the HIV response

The NSF identifies challenges and risks to meeting the SRHR/HIV needs of adolescents and youth, and KPs, which are linked directly to issues of rights, including rights to legal protection, reduction of stigma and discrimination and freedom from coercion.

The rights-related barriers to effective HIV prevention and care for AGYW are explicitly described in the NSF: "Pervasive harmful social and cultural practices continue to put young women at risk such as early marriages in some cultures. Thirty four per cent of women reported having experienced physical or sexual violence. The socio-economic climate where there is wide spread poverty and high unemployment rates among youth (27.29 per cent) continue to increase young women's vulnerability. Available data show limited uptake of sexual reproductive health and rights and HIV programmes by AGYW. 29 per cent of females aged 15-19 have never tested for HIV." [51]

The NSF also lists a specific set of challenges for providing effective HIV prevention to AGYW along with appropriate responses. Many of the challenges and responses are related to promoting gender equality and/or securing sexual and reproductive rights for AGYW. Both lists are extensive but some of the challenges and suggested responses correspond to the projects and programmes supported by UNFPA Namibia.[52]

Table 15: Rights related challenges for AGYW and NSF responses

Challenges	Responses
• Early sexual debut • School drop-outs due to pregnancy • Low rates of comprehensive knowledge about sexuality • Physical/sexual violence • Gender inequality • Negative social and cultural norms; Early child marriage practices • Gender norms that define masculinity and virility affect health behaviours and attitudes negatively	• Conduct community and social mobilization campaigns • Strengthen life skills and CSE • Strengthen school retention and re-entry programmes for learner mothers • Intensify GBV interventions and strategies • Strengthen engagement with parents and community gatekeepers through intergenerational dialogues to address harmful cultural practices • Accelerate capacity building of health workers, teachers, social workers, police workers and parents

The NSF also addresses the challenges to effective HIV prevention and treatment for MSM in Namibia in language that recognizes that many challenges derive from a denial of their basic rights.

[51] MoHSS, *National Strategic Framework, p.45.*
[52] MoHSS, *National Strategic Framework, p.46-47.*

> "Providing services to MSM remains a challenge, as societal attitude, norms and values do not affirm people of non-heterosexual identities or behaviours. In addition, the 1920 common law criminalises anal sex between two males. The patriarchal structure of Namibian society has also contributed to the strict definition of male and female identities and roles and expected behaviours that drive men with alternative sexual behaviours and identities underground and hard to reach with health services."[53]

Most of the challenges and strategies relating to reaching and providing effective HIV prevention and treatment services to MSM in the NSF are biomedical in orientation[54]. However, some deal with the policy and legal rights environment, stigma and human rights violations.

Table 16: Rights related challenges for MSM and NSF responses

Challenges	Responses
• Inadequate policy and legal environment to support programming and service delivery for MSM • Prevalence of stigma, discrimination and social exclusion • Human rights violation and social justice issues	• Strengthen policy level interventions (a policy on KPs) and advocate for legal review and reform • Develop information, educational and communication materials for MSM • Undertake capacity building and sensitization of health care workers on MSM • Establish safe spaces (i.e. shelters) for victims of abuse • Capacity building of MSM community on human rights advocacy • Document human rights violations for evidence based mitigating interventions • Promote and advocate for review and reform of structural barriers to health seeking behaviour, legal and social justice, and social protection

Interviews with the key stakeholders in government and CSOs confirmed that there is a common view of the rights issues. Adolescents and youth, as well as members of the LGBTI community, encounter specific barriers that prevent them from fully accessing and taking advantage of services for the prevention and treatment of HIV, including knowledge, condom use for prevention, PrEP and post-exposure prophylaxis (PEP) as well as effective ARTs. The main human rights-related challenges are:

- Continuing stigma and discrimination among health care workers against adolescents and youth seeking SRHR and HIV services as well as against the LGBTI community
- Continuing high level of teenage pregnancy and of SGBV which are reinforced by harmful social norms around early marriage
- An enduring legal framework that discriminates against adolescents and youth, and the LGBTI community (enduring criminal laws such as the Immoral Practices Act).
- Pushback against efforts to improve the knowledge and to empower adolescents and youth through CSE as well as pushback against improving rights and services for the LGBTI community.

UNFPA Support to addressing rights challenges

UNFPA Namibia has worked with key partners in applying some of the solutions and addressing a range of the rights-related challenges facing adolescents and youth as well as the LGBTI community

[53] MoHSS, *National Strategic Framework*, p.47
[54] MoHSS, *National Strategic Framework,* p.20.

as identified in the NSF. Examples cited in interviews with the implementing organizations (and cross-referenced in interviews with other partners) include:

- Supporting the MEAC with curriculum development and life skills teacher education on CSE
- Supporting the MYSNS on many different aspects of CSE (see below) and in working with peer educators on youth empowerment
- Supporting AfriYAN Namibia and the MSYNS in "Condomize" campaigns aimed at adolescents and youth, particularly university students
- Supporting the MGECW in its programming on GBV
- Supporting the ongoing operation of the Technical Working Group (TWG) on KPs under the coordination structure of the NSF and supporting participation by organizations representing the LGBTI community in the TWG
- Supporting the SFH in providing training to MoHSS staff on norms and values in dealing with LGBTI clients
- Providing support, through SFH, directly to CSOs campaigning for the rights of the LGBTI community (Out-Right Namibia)
- Supporting the OFL of Namibia in advocacy for the legal and social rights of adolescents and youth.

The SYP Programme has served as the main programming vehicle used by UNFPA Namibia to address the rights situation of adolescents and youth in relation to HIV prevention and treatment, especially through it support to CSE but also more directly at a policy and legal level. According to the SYP Programme 2018 annual report:

> "In Namibia, under the SYP umbrella, UNFPA participated in drafting the sections on adolescent girls, young women, condoms and KPs in the National Strategic Framework in HIV. SYP also supported the National Study on Child Marriage conducted by the Ministry of Gender Equality and Child Welfare."[55]

3.2.5 Comprehensive sexuality education as a rights initiative

UNFPA has been a long-term supporter of CSE in Namibia. While UNFPA Namibia currently works most directly in support of out-of-school CSE through the work of the MSYNS it has a historical relationship with the HIV and AIDS Management Unit of the MEAC where it has worked on curriculum development for CSE and continues to support efforts to institutionalize training of life skills education teachers who provide in-school CSE.

According to key stakeholder interviews, UNFPA Namibia began its support to CSE in 2014 by providing financial and technical support to a review of the life skills course syllabus in use at that time in Namibian schools. Along with UNESCO, UNFPA co-funded the development of a teacher training manual as well as on-line modules for teacher trainers and for student teachers.

One particularly important UNFPA contribution to out-of-school CSE in Namibia involves both the Regional and Country Offices. UNFPA ESARO supported the development of the framework for out-of-school CSE in the SADC region. This was subsequently adopted, with UNFPA Namibia support, to become the *Comprehensive Sexuality Education Framework for Out of School Young People in Namibia.* The Framework contains three major sections covering eleven units with supporting material and workbooks for teacher trainers, for instructors and for learners. Under the overall heading of My Future/My Choice, the sections and units of the framework include:

[55] UNFPA, *Safeguard Youth Programme: Annual Report, 2017*, (September 2018), p.7.

- Section One: Who Am I?
  - Unit 1: Values and Rights
  - Unit 2: Adolescent Development
  - Unit 3: Sexuality
  - Unit 4: Gender Roles and Equality
- Section Two: Where am I Going?
  - Unit 5: Planning for the Future
  - Unit 6: Relationships
  - Unit 7: Communications
- Section Three: How am I Going to Get There?
  - Unit 8: Pregnancy
  - Unit 9: Sexually Transmitted Infections and HIV
  - Unit 10: Prevention and Risk Reduction
  - Unit 11: Sexual and Gender-Based Violence[56]

An examination of the material indicates that issues relating to adolescent and youth, LGBTI and their rights as well as to gender equality and the role of both genders in eliminating SGBV are addressed clearly and directly in the content.

UNFPA and UNESCO work together in support of CSE in Namibia, with UNESCO generally responsible for in-school CSE, while UNFPA has the main responsibility in the UNCT for supporting CSE for out-of-school adolescents and youth. Interviews with UNFPA, UNESCO, the HIV and AIDS Management at MEAC and with staff at the MSYNS identified a consistent set of challenges facing CSE in Namibia irrespective of whether being delivered in or out of school:

- Resistance from community members
- Varying levels of coordination at regional level in Namibia due to sometime weak regional Health and Education Task Forces
- The fact that life skills courses, including CSE are not an examinable subject in Namibia's school system while teachers and schools are assessed against targets for results in examination. This can mean that time allocated to CSE is instead devoted to examinable subjects such as mathematics
- Lack of adequate attention to teaching CSE instruction during pre-service training of teachers.

Despite these challenges, key informants felt that CSE for both in- and out-of-school adolescents and youth was an important element in addressing the rights of adolescents and youth, including LGBTI young people, as well as to effective HIV prevention and treatment. They also credited both UNFPA and UNESCO with collaborating well to provide effective support to CSE.

3.2.6 Sexual gender-based violence: responding to the link to HIV

UNFPA has been engaged directly with a range of different partners in support of an effective response to SGBV, especially as a negative factor for access to HIV prevention and treatment for AGYW.

As already noted, the site visits conducted by the evaluation team provided evidence that SGBV is an important factor in the spread of HIV infection among AGYW. The table below illustrates some of the

[56] Government of the Republic of Namibia, Ministry of Youth, Sport and National Services *CSE Framework for Out of School Young People in Namibia.* 2016

most important examples of UNFPA Namibia support to efforts to strengthen the national response to SGBV. These are consistent with the strategies and programmes outlined in the NSF.

Table 17: UNFPA engagement with partners to address SGBV

UNFPA partner	UNFPA support to action on SGBV
Ministry of Education, Arts and Culture (MEAC) Ministry of Youth, Sports and National Service (MYSNS)	• Support to the development of curriculum and training modules for in and out of school CSE that specifically addresses the role of male and female adolescents and youth in combatting SGBV
Ministry of Gender Equality and Child Welfare (MGECW)	• Support to the national survey on GBV prevalence[57] • Support to the development of the Prioritized National Plan of Action on GBV[58] • Continuing support to the National Technical Working Group on SGBV
One Economy Foundation/OFL	• Ongoing financial and technical support on best practices in GBV • Support to case management for the legal response to cases of GBV that are egregious or could set a precedent • Support to advocacy for changes in legislation effecting GBV

The *Gender Violence Baseline Study* of 2017 identified the national prevalence of three types of GBV: Intimate partner violence by a current or former partner, rape and harmful social practices. With regard to HIV the study notes:[59]

> "Evidence suggests there is a close link between GBV and HIV infection. This is due to several factors. Violence or fear of violence increases the vulnerability of women and children to abuse. Women may not have sexual bargaining power to say no to unprotected sex and abrasions caused during sexual intercourse may increase one's risk to HIV infection. Studies have revealed that GBV and HIV are mutually reinforcing epidemics with, GBV being both a risk factor for HIV infection and a consequence of being infected with HIV."

The OFL of Namibia has been one of the most visible UNFPA partners in the national response to SGBV. Some of the more important ways that the OFL contributes to combatting SGBV include:

- The "*Break Free/Stay Free from Violence*" campaigns (since 2017)
- Research with perpetrators of SGBV to document how violence begins and escalates
- A focus on SGBV prevention that emphasizes increased awareness of early stages
- Advocacy for early awareness and intervention strategies
- Building partnerships in the SGBV response, including a 2019 MoU with the Namibia Correctional Services to work with perpetrators of violence to understand drivers of violence and to interact with young men in the community to combat GBV
- Providing direct legal support to prosecution of SGBV cases where there is a clear imbalance of power between the survivor and the alleged perpetrator
- Advocating for change and influencing legislation, including:

[57] Ministry of Gender Equality and Child Welfare: *National Gender Based Violence Baseline Study: Consolidating GBV Prevention and Fast-Tracking Namibia's Response.* (2017)
[58] Ministry of Gender Equality and Child Welfare, Republic of Namibia. *Prioritized National Plan of Action on Gender-Based Violence (2019-2023).* (2018), p.7
[59] In this section the authors use GBV when referring to documents published by the MGECW such as the baseline study and national plan of action because these documents do not use the term SGBV.

- The Gender Violence Act
- The Cyber Crimes Act
- Divorce Laws
- The Human Trafficking Act

Interviews with key stakeholders, including UNCT members and CSOs in Namibia, confirmed the general perception that the OFL, and the First Lady herself have been effective and powerful advocates for rights-focused change in Namibia. This includes efforts to advance the legal rights of young people and of the LGBTI community. It also includes efforts to effectively respond to the challenge of SGBV as a factor limiting access to HIV prevention and treatment services for AGYW.

3.3 Forging partnerships and supporting networks

At a regional level, the ESARO of UNFPA has been effective at forging partnerships and working with networks to develop regional strategies, frameworks, guidelines and training modules on critical aspects of the HIV response. In turn, these have helped support advocacy and technical assistance by the Namibia CO. In addition, the Namibia CO has engaged with and supported networks and CSOs to help create space for their meaningful participation in the national dialogue on an effective HIV response. UNFPA has found an important strategic ally in this process in the form of the OFL of Namibia. However, there is an ongoing question as to whether the CSOs supported by UNFPA (and other development partners) can sustain their capacity to take part in effective networks and partnerships in light of their dependence on diminishing sources of external finance.

For details of the evidence supporting findings in section 3.3, see Annex B: Assumption 2.4, 3.2 and 4.3.

As noted in Chapter 2, UNFPA Namibia has been able to draw on the work of regional networks in SADC and the EAC supported by UNFPA ESARO in the development of strategies, guidelines, and model laws on different aspects of the HIV response. This includes working with the SADC Parliamentary Forum and its Secretariat based in Windhoek. At the national and local level, UNFPA Namibia has also engaged with different networks and forged partnerships, often directly focused on ensuring that CSOs representing adolescents and youth and KPs are effectively represented in the national dialogue on HIV. The table below provides examples of organizations and networks supported by UNFPA and how they have engaged in the national dialogue in HIV.

Table 18: UNFPA engagement with networks

Organization/Network	Engagement in national dialogue on HIV response
Technical Working Group on KPs - Chaired by the MoHSS with participation of diverse groups representing the LGBTI Community	Provides a forum for LGBTI representing organizations to engage with MoHSS on issues of SRHR and LGBTI rights in HIV prevention and treatment
Parliamentary Standing Committee on SRHR	UNFPA supports and engages the committee to advocate for CSE
Namibia Network of AIDS Service Organizations (NANASO)	NANASO acts and the umbrella organization for CSOs providing HIV and AIDS services in Namibia. Within coordinating structure for the National AIDS Executive Committee (NAEC), NANASO represents the voice of CSOs
Southern Africa Development Community (SADC) Parliamentary Forum Secretariat	UNFPA helped to link NANASO to the Parliamentary Forum and advocate for CSO engagement in regional strategy setting on HIV

Organization/Network	Engagement in national dialogue on HIV response
National Youth Council/ African Youth and Adolescent Network (AfriYAN)	AfriYAN works with youth-led organizations at regional and local level in Namibia to engage in peer education and in behaviour change communications, as well as conducting "Condomize" campaigns. The National Youth Council represents youth-led organizations in consultations on HIV with MoHSS
Society for Family Health Namibia (SFH)	SFH serves as the secretariat for the TWG on KPs and also provides funding from development partners, including UNFPA and the Global Fund to CSOs representing and serving the LGBTI community, including Out-Right Namibia
Office of the First lady (OFL)	The OFL works directly with organizations led by adolescents and youth and by representatives of KPs. In 2016 and 2017, the Office convened panels of stakeholders to examine HIV prevention among young people, including youth led organizations, social workers, police officers, school teachers, traditional leaders and parents

Interviews with key stakeholders from government, development partners and civils society indicate that the CSOs and networks supported by UNFPA are able to engage meaningfully in the national dialogue on HIV. During a group discussion with members of the TWG on KPs, one participant noted:

> "The concept of SRHR (including sexual rights) gives the members of the TWG an opening to have a rights discussion with MoHSS. Generally speaking, the health policy space is a good one for having dialogue around rights, compared with other sectors at least. It is important to give credit to the Government of Namibia because the NSF for HIV is the only statutory document which states clearly that LGBTI people and other KPs have a right to non-discriminatory services."

Staff of NANASO and AfriYAN indicated that, with UNFPA support, they have been able to play a meaningful role in discussions on HIV policy: "UNFPA works hard to make sure that organizations representing adolescents and youth are "in the tent" regarding the national dialogue on HIV and AIDS". In fact, there was a general consensus among CSO staff interviewed that the national government recognizes the role that CSOs should play in ensuring services are appropriate to the needs of adolescents and youth and KPs.

The staff and UNAIDS also noted that ongoing dialogue with Parliamentarians on the part of UNFPA and other members of the UNCT had helped to create a better atmosphere among political leaders. As a result, these same leaders are now more willing to discuss HIV issues and to agree on a roadmap for future actions.

On the other hand, CSO key informants felt that the UNFPA CO was more likely to provide financial support to specific activities and less willing to fund efforts to strengthen the capacity of organizations and networks. They attributed this emphasis to a willingness to align the support provided to CSOs with the need for UNFPA to focus its efforts on specific results areas in HIV, rather than an attempt to develop the long-term capacities of the CSOs themselves. However, this approach does not quite take stock of the crisis in terms of financial viability and sustainability that currently affects the CSO community and heightens staff concerns about the ongoing capacity of these organizations.

3.4 The comparative advantage of UNFPA in Namibia

UNFPA in Namibia has undertaken specific, strategic roles in supporting the national response to HIV that are consistent with the global division of labour among UNAIDS co-sponsors and which reflect organizational comparative advantages. In addition, the support provided by UNFPA is strategic within the agreed priorities of the *NSF*. UNFPA has been able to match its mandate, history of engagement and technical capacity in Namibia to agreed leadership roles in support of SRHR/HIV/SGBV linkages in health service delivery; CSE, responding to SGBV and engaging with the LGBTI community in Namibia. In carrying out these roles, the CO in Namibia draws on the technical capacity of its own staff and also relies on ongoing support from the UNFPA ESARO (as well as other UNFPA COs in the region on an ***ad hoc*** manner).

For details of the evidence supporting findings in section 3.4, see Annex B: Assumptions 5.1, 5.2 and 5.3.

There is a strong consensus among key stakeholders interviewed that UNFPA has been able to identify a strategic role in the national response to HIV in Namibia that reflects its comparative advantage and is consistent with the agreed division of labour among the co-sponsors of the joint UNAIDS programme. The staff of UNAIDS in Namibia confirmed that the approach of the JUNTA in Namibia has been to "domesticate" the most recent agreement on the global division of labour among UNAIDS co-sponsors. As described in Chapter 2 (with greater detail in Annex D), UNFPA has consistently played it strongest role in Namibia through advocacy, technical assistance and financial support to the integration of SRHR/HIV/SGBV services in health services and through programming focused on the needs and rights of adolescents and youth and KPs.

Interviews with key stakeholders emphasized the strong fit between the roles taken on by UNFPA and its related comparative advantages in:

a) A history of close engagement with the MoHSS in support of linkages and integration in health services around SRHR/HIV/SGBV
b) A long history of support to CSE for out-of-school adolescents and youth
c) A recognized mandate within the UNCT to engage in support of the HIV prevention and treatment needs of adolescents and youth, especially AGYW
d) A reputation as the external development partner most fully engaged with organizations representing and serving the LGBTI community and has a long history of direct support and advocacy on their behalf
e) Access to technical resources and partnerships at the regional level within SADC and the EAC due to the ongoing work of UNFPA ESARO.

UNFPA Namibia has also been careful to ensure that it engages in advocacy and technical and financial support in areas which are important to the NSF on HIV. The CO has also developed consultative processes for annual work planning so that each partner ministry of the Government is assured that UNFPA is supporting interventions of strategic importance. This interactive and consultative process was highlighted by all four key government partner organizations (MoHSS, MEAC, MSYNS and MGECW).

In addition, key informants noted that UNFPA Namibia has been able to provide high quality technical support to projects and programmes for HIV prevention and treatment. At times, this technical support is based on work done at UNFPA ESARO, while other times it is provided directly by the Namibia CO. It also involves UNFPA Namibia drawing on expertise from other COs in an ad hoc manner; this was the case when UNFPA Namibia accessed a specialist in "Condomize" programming from the Lesotho office of UNFPA rather than headquarters in New York as it turned out to be

substantially more cost-effective. Interviews with key stakeholders from the Government, development partners and CSOs emphasized UNFPA technical capacity in health sector integration, and behaviour change communication for condom programming ("Condomize"), SGBV and CSE.

3.5 Coordination and sustainability

Namibia has a multi-faceted and overlapping system of platforms and mechanisms for coordinating action in support of the national response to HIV. While some parts of the coordination architecture work well, others are less active and lack direction. The NAEC appears to be insufficiently resources to provide leadership on the need for increased attention to prevention. Meanwhile, overlaps among task forces, committees, and technical working groups hamper the necessary coordination and guidance on HIV-related actions in the areas of education, health services and gender equality. On the other hand, the platforms for coordinating the work of the JUNTA and the UNCT work well, and are linked directly to the coordinating structure of the NSF. There is some concern that members of the UNCT should be more active and vocal in defending the national programme to scale-up integration of SRHR/HIV/SGBV services rather than leaving this role more or less exclusively to UNFPA. In addition, UNFPA, the members of the UNCT and PEPFAR/CDC have worked to assist the national Government to develop a sustainability strategy and to access different sources of finance, both internally and among developing partners. However, recent reductions in development partner financing of CSOs, have damaged the sustainable capacity of civil society. This is especially concerning as the national government clearly relies on CSOs to identify, represent and provide HIV prevention and treatment services to KPs, especially the LGBTI community.

For details of the evidence supporting findings in section 3.5, see Annex B: Assumptions 6.1, 6.2 and 6.3.

3.5.1 Coordination platforms and their effectiveness

UNFPA participates in a range of teams, task forces, coordinating committees and TWGs. For the sake of analysis, these can be grouped under four different, yet inter-linked coordinating platforms:

a) The components of the **NAEC** responsible for coordinating the operational aspects of the NSF; it includes both Technical Assistance Committees and TWGs. Importantly, the NSF draws an explicit link between coordinating mechanisms of the NAEC and the JUNTA. "The participation of the United Nations agencies is coordinated by UNAIDS through the United Nations Joint Team on HIV/AIDS."[60]

b) The **Health and Education Task Forces** operate at national level, in all 14 regions in Namibia and in each electoral constituency to coordinate the work of ministries, local authorities and development partners around health aspects of education. The national Health and Education Task Force has multi-sector participation including UNICEF/UNESCO/UNFPA, the University of Namibia (for teacher training) and MEAC, MGECW, MoHSS and MSYNS.

c) The coordinating mechanisms for the implementation of the **National Gender Policy** include implementation clusters for health, HIV and AIDS and for SGBV and human rights.

d) HIV coordinating mechanisms for the **UNCT** in Namibia. In the main, these consist of the JUNTA and the UNCT. The JUNTA meets monthly one week before the monthly meetings of

[60] Republic of Namibia, Ministry of Health and Social Services, *National Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22.* 2017, p.59.

the UNCT and is chaired by UNAIDS while the UNCT is chaired by Office of the United Nations Resident Coordinator. The work of the JUNTA and the UNCT regarding HIV is reflected in the Joint Programme of Support for AIDS in Namibia.

e) **The United Nations Partnership Framework (UNPAF)** has its own coordinating mechanism with, at its apex, the UNFPA Joint Steering Committee co-chaired by the Ministry of Economic Planning and the United Nations Resident Coordinator. At the operational level, it is supported by the meetings of the UNCT chaired by the Resident Coordinator. On matters of HIV and AIDS, the JUNTA provides input to the UNCT. In this way, the JUNTA is directly connected to the UNPAF coordinating mechanism, as illustrated in the governance structure and implementation mechanisms for the UNFPAF. The UNPAF also has specific clusters of participating UNCT members organized around different programming areas.[61]

There are differing opinions on the relative effectiveness and level of activity of these four major mechanisms for coordinating the HIV response in Namibia and the role of the national government, civil society, development partner and the United Nations in that response.

The NAEC and supporting technical working groups
The general consensus among key stakeholders is that the NAEC is not as dynamic as it could be to act as an effective coordinating mechanism for the national response to HIV in Namibia. In particular, some stakeholders felt that the NAEC was not active enough in advocating for and promoting investments in prevention considering the ongoing preeminent focus on testing and treatment, including PreP and ARTs. Stakeholders also noted that the different TWGs supporting the NAEC had very different levels of effectiveness. For example, the TWG on AGYW was seen as less effective in contrast with the TWG on KPs, which is regarded as active and effective. Overall, the NAEC is viewed as lacking the resources required for its leadership role resulting (in the words of one key informant) in the absence of a "strong, driving advocacy on the need to prioritize investments in HIV prevention."

Health education task forces
Key informants, in Windhoek and in Oshikoto region, indicate that the national level Health Education Task force has been reasonably active and effective but also noted that the Task Forces has not been working well in many of the 14 regions in the country. At regional level, they also noted that the mandates of the Health Education Task forces overlapped with the Regional AIDS Coordinating Committees, which operate under the NAEC structure.

The national gender policy and its clusters
There is limited evidence of the overall effectiveness of the mechanisms for coordinating the national gender policy. However, staff of the MGECW noted that UNFPA was active in the cluster for coordinating action on SGBV and human rights and the cluster for health, HIV and AIDS.

The JUNTA and UNCT
Since 2007, the JUNTA in Namibia has expanded to include any member of the UNCT with a role in providing support to the national HIV response. It meets regularly and, according to key stakeholders, functions quite well. One of its roles is to allocate the bi-annual allocation to Namibia under the UNAIDS UBRAF. However, stakeholders raised two negative observations on the operation of the JUNTA:

- There is some question within the JUNTA and among key informants in the MoHSS about the clarity of United Nations messaging around the SRHR needs of adolescents and youth. In

[61] Government of the Republic of Namibia, United Nations Namibia, *United Nations Partnership Framework (UNPAF) 2019-2023.* (2019), p.15

particular, the fact that UNFPA focuses strongly on SRHR and HIV prevention and treatment for adolescents and youth sometimes contrasts with WHO advocacy and support to a more general national strategy on adolescent health. While these two priorities are not necessarily in conflict, they do overlap, resulting, at times, in discordant messages to the national government (noted by development partners and government staff).

- From a UNFPA perspective, the response of JUNTA members to the ongoing pushback against national integration of SRHR/HIV/SGBV services has been disappointing. Some JUNTA members indicate that, the JUNTA as a group not been as vocal and active as they could be in supporting integration in meetings and public forums. This is particularly important because some development partners hold the view that UNFPA (rather than the government and the SADC) is the driving force behind MoHSS efforts to scale integration to the national level.

Overall, the views and experience of key stakeholders suggest that there is an over-abundance of mechanisms and platforms for coordinating different aspects of the HIV response in Namibia. While some of the sub-components such as specific TWGs are active and effective, there is room for more dynamic leadership at the apex level in NAEC and an opportunity to simplify some of the supporting structures. Finally, the process of integrating SRHR/HIV/SGBV services at a national scale has been hampered by problems in communications and coordination within the MoHSS and between PEFPAR/CDC and UNFPA. This may stem from the fact that the steering committee on integration, which operated during the pilot phase under the joint chair of DPHC and DSP of MoHSS has not been operational during the current phase of integration.

3.5.2 Allocation of resources and sustainable national financing

As noted in Chapter 2, the Government has steadily increased its share of the overall funding envelope for the national HIV response (64 per cent in 2017), and has been particularly active in buying pharmaceuticals including ARVs (77 per cent). Yet, it remains highly dependent on external funding for staff compensation (55 per cent in 2017) and for training (95 per cent).[62] There has also been a decline in funding (dating from 2018 and the most recent Global Fund grant to Namibia of USD 30 million, of which USD 7 million will be managed by NANASO)[63] of Namibian CSOs engaged in advocacy (dating from 2017 and the most recent Global Fund grant) and service provision for HIV prevention and treatment. UNFPA, members of the JUNTA and development partners active in the HIV response in Namibia are working in different ways to both encourage less dependency and to assist in securing new sources of funding. These efforts include:

- UNFPA, UNAIDS and PEPFAR/CDC support to MoHSS for organizing and taking part in a SADC meeting on sustainable resources for HIV programming in the region
- Supporting the work of the NAEC Technical Working Group on Resource Mobilization
- UNFPA has provided support to NAPPA in its efforts to secure funding on the next Global Fund round of financing
- The UNCT members are supporting the Government in preparation of an investment case for funding to meet the 2030 targets and to access continued funding from PEPFAR/CDC and the Global Fund.

The Global Fund Programme Management Team in the MoHSS reports that the DSP had recently developed a sustainability framework for the HIV Response. The resulting programme on sustainability is being operated by the Washington Group for Development, which was to circulate a

[62] Ministry of Health and Social Services, *Namibia's Health and HIV Financing Landscape, 2015/16 and 2016/17: Evidence from the 2015/16 and 2016/17 Resource Tracking Exercises,* (August, 2018)
[63] Interview with MoHSS

draft document on sustainability in late May 2019. The document was expected to identify needed efficiency gains and put the HIV response in the context of wider issues of sustaining health care investment, including:

- Universal Health Coverage
- Minimum Package of Services
- A Nutrition Strategic Framework
- Social Contracting Strategies (supported by UNAIDS)
- Links to Human Resources for Health.

While Namibia works to improve the sustainability of both the national public investment in the HIV response and the contributions made by external partners, it is important not to lose sight of the challenges faced by civil society. CSOs have been the organizations hardest hit by reduced development partner funding as a result of Namibia's new-found UMIC status. This is alarming given the implicit national policy of relying on CSOs to identify, represent and provide HIV services to KPs and, in turn, the historical dependence of Namibian CSOs on development partner funding.

4. CONCLUSIONS

This chapter presents the conclusions of the field-based country case study of Namibia. The conclusions presented here are based on the findings provided in Chapter 3. They are drawn from the answers to the six evaluation questions and address all areas of investigation of the evaluation.

4.1 Integration as the central strategy for support to the HIV response

1.	Since 2011, UNFPA has taken a lead role in supporting the process of first linking and then integrating SRHR/HIV and, since 2018, SGBV services in Namibia. Working closely in support of the MoHSS, UNFPA has assisted in preliminary assessment of linkages, developing and pilot testing the Namibia model of integration and subsequently rolling the model out to the national level. Through this process, UNFPA has worked to ensure that integration is a country-led process consistent with the SADC commitments, national strategies and priorities. While the UNFPA CO has been the direct partner working with the MoHSS, it has been strongly supported in this role by the team at UNFPA ESARO responsible for management and coordination of the Joint Regional Project on Linkages and the *2Gether 4 SRHR* programme.

2.	Since 2017, with continued and significant support from UNFPA, MoHSS has made important progress in scaling the Namibia model of integration to many health centres and clinics across all 14 regions. However, progress has been uneven due to significant organizational and operational challenges. The Namibia model places considerable demand on the skills and experience of health professionals in the newly integrated sites, which are already affected by frequent staff rotations. Continuing progress in the integration process could be hampered by the need to invest in pre-service and in-service training and to provide staff mentoring in different components of SRHR and HIV prevention and care.

3.	There is evidence that health centres that have implemented the Namibia model of integration have been able to improve client care, reduce wait times and reduce stigma for people living with HIV and for adolescents and KPs. The primary reason for this is the

	enhanced trust and a stronger relationship between clients and service providers. Health professionals working in the integrated sites also report improved job satisfaction and the ability to maintain a broader range of skills. Service providers also report frustration in dealing with issues such as lack of training, the need for more mentoring and problems with equipment and infrastructure. Some service providers, MoHSS staff and development partners contest these claimed benefits. In this context, the upcoming rapid assessment of the integration scale-up process is critically important

4.	The processing of taking the Namibia model of integrating SRHR/HIV/SGBV to scale at a national level has generated significant resistance. This resistance is, at least, partly grounded in miscommunication or lack of communication between the DSP of the MoHSS, responsible for disease-specific programmes including HIV treatment (including PEP, ART maintenance and viral suppression) and the DPHC (responsible for delivering other elements of SRH, including family planning).

4.2 Meeting the needs of marginalized people and promoting rights

5.	UNFPA has worked effectively with the MoHSS, MEAC, MSYNS and MGECW to ensure that national strategies and priorities reflect the need to provide effective HIV prevention and treatment services to adolescents and youth and to KPs, especially the LGBTI community. The NSF directly addresses the needs of AGYW as well as MSM and FSWs. It also addresses the problem of SGBV. There are, however, gaps in the national response to meeting these needs. There is very little evidence that either the MoHSS or CSOs are providing effective services to FSWs despite high rates of HIV infection among this KP. Efforts to address the HIV and SRHR needs of people with disabilities (including adolescents and youth) are limited or in very early stages of development. Importantly, interventions aimed at meeting the needs of the LGBTI community do not address broader socio-economic issues, which impact their access to prevention and treatment services, including retention on ART.

6.	While the MoHSS recognizes the importance of reaching out to KPs with SRH and HIV services, which meet their specific needs, this task has been, at least implicitly, assigned to CSOs. Yet, with Namibia's achievement of UMIC status, development partners are reducing their allocation of funds to CSOs, which remain highly dependent on external financing. In this context, UNFPA support to CSOs engaged with the LGBTI community in Namibia is both highly relevant, appreciated and essential. However, relying on CSOs for delivery of services to KPs limits the reach of professional, competent services to these marginalized groups.

7.	UNFPA has been very effective in supporting efforts to strengthen and institutionalize CSE in out-of-school settings. Further, the framework for CSE in Namibia (developed from the SADC framework) with UNFPA support deals explicitly with the role of young people in eliminating stigma for LGBTI adolescents and youth and addressing the causes of SGBV.

8.	UNFPA has worked with the MEAC, the MGECW and the OFL to address the legal framework and the provision of effective services to SGBV survivors. Health facilities operated by the MoHSS are addressing SGBV and its link to HIV mainly through the DREAMS programme, which is externally funded and operates in separate space attached to the health centres. In general, evidence suggests that current level of attention and investment

	do not allow to effectively address SGBV in the context of HIV prevention and treatment for AGYW.

4.3 Forging partnerships and supporting networks

9.	UNFPA has been strategic in developing partnerships and supporting networks engaged in promoting the rights of adolescents and youth and advocating for the rights of KPs. In particular, the OFL has been an effective partner in this work. However, UNFPA and its partners have found it difficult to effectively advocate for progress from a rights model, which emphasizes non-discrimination to one, which directly recognizes the right of LGBTI, people to competent, professional SRHR/HIV/SGBV services which meet their needs. UNFPA has, however, provided effective support to training health professionals in norms and values to ensure sympathetic and competent services.

10.	The UNFPA ESARO has been effective in forging and maintaining regional partnerships to develop region-wide strategies, frameworks, guidelines, and model laws, which have been endorsed by SADC and the EAC. The Namibia CO has also supported networks and CSOs, which have been active in the national dialogue in the HIV response. CSOs representing adolescents and youth and KPs note that UNFPA has played a central role in ensuring their meaningful participation in dialogue with government ministries through consistent, long-term advocacy efforts.

4.4 Comparative advantage

11.	In Namibia, UNFPA has been able to assume a strategic role in supporting the national HIV response while remaining fully in compliance with the agreed division of labour among UNAIDS co-sponsors and within the JUNTA. This role builds on comparative advantages both historical and technical in the areas of: SRHR/HIV/SGBV integration; CSE; behaviour change communications through “Condomize” campaigns; a recognized leadership role in supporting the LGBTI community; and access to managerial, technical and financial support from the Regional Office. Annual expenditures by UNFPA in Namibia in support of the HIV response are very modest compared with major funders PEPFAR/CDC and the Global Fund. Nonetheless, UNFPA has been able to position itself in support of important country-led strategic priorities and exert influence on the national response, which outweighs its modest financial contribution.

4.5 Coordination and Sustainability

12.	Mechanisms and platforms for coordinating action in response to HIV in Namibia are complex, multi-faceted and overlapping. While UNFPA continues to participate and make a positive contribution to many committees and working groups, there is a general recognition among stakeholders that overlap among different coordinating bodies can and should be reduced. Furthermore, the capacity of NAEC to play an active role in directing the national response is currently hampered by a lack of resources.

13.	While the Government has made a consistent effort to increase its share of total investment in the HIV response, it remains highly dependent on development partners for funding key recurrent expenditures, particularly for staff compensation (including incentive payments) and for training. This is a severe risk to the sustainability of results achieved with the support of UNFPA and other partners.

ANNEXES

A. **Logical reconstruction of the overall theory of change**
B. **Evaluation matrix**
C. **Persons interviewed**
D. **Detailed tables of HIV-related expenditures, 2016-2019**
E. **Summary of results of site visits**
F. **Main elements of bibliography**

ANNEX A: LOGICAL RECONSTRUCTION OF THE OVERALL THEORY OF CHANGE

An explicit theory of change describing how UNFPA supports the HIV response is necessary to allow the evaluation to apply contribution analysis to map causality (including the contributions of other actors) and infer the contribution UNFPA interventions have made (or are currently making) to the observed results and outcomes they are trying to influence. It provides evidence about the contribution made and information on whether the UNFPA HIV support is likely to achieve the intended results as well as what lessons can be learned.

The theory of change is also an essential instrument to establish the evaluation matrix (Annex B). The evaluation matrix contains the core elements of the evaluation: what is evaluated (evaluation criteria, evaluation questions and related issues to be examined – "assumptions to be assessed"), as well as the sources of information, indicators and most appropriate and feasible data collection methods for each of the questions identified. The evaluation matrix is a key feature of the structuring phase of the evaluation as it serves as an instrument to organize data collection and analysis.

1. Defining a theory of change

A theory of change is the representation of how a programme or set of activities contribute to desired changes, as well as the causal links and related assumptions that inform it. It demonstrates how and why a desired long-term goal is achieved through a sequence of interrelated results.

The process of developing a theory of change begins with the depiction of the causal links explaining how the activities of the intervention are expected to lead to desired results. The depiction of these causal links – or **pathways** from activities to results - forms the **intervention logic** of the UNFPA support to the HIV response at global, regional and national levels.

A theory of change allows the evaluators to identify the **causal assumptions** behind the links from activities to results – what has to happen for the causal assumptions to be realised. It is, in fact, the combination of a well-constructed intervention logic and the identification of key causal assumptions (clearly spelt out in the evaluation matrix) which characterises a useful theory of change.

2. Evaluative purpose of the theory of change

By visualizing how UNFPA support to the HIV response operates at country, regional and global levels, the development of a theory of change serves the following purposes:

- Identifying causal linkages from UNFPA activities and investments through different results levels to the outcomes and of the *UNFPA Strategic Plan (2018-2021)* – without losing sight of the 2014-2017 Strategic Plan
- Linking UNFPA activities and investments, output level results contributing to the SRAs of the UNAIDS UBRAF 2016-2021
- Making explicit the causal assumptions linking UNFPA support to identifiable results at the output, outcome and goal levels
- Formulating the evaluation questions to be investigated against which findings and conclusions will be reported

- Setting the evaluation design, as depicted in the evaluation matrix, including sources of information and data collection tools, to test the validity of causal assumptions associated with each evaluation question.

3. Nested theories of change

The term "**nested theories of change**" refers to the fact that two distinct types of theory of change can be developed to provide the necessary level of detail for an evaluation (or for programme design). The first type is an **overall theory of change** for UNFPA support to the HIV response (figure 1); it is the foundation for all of the work that follows.

The second theory of change type, **pathways theories of change**, should not be seen in any way as separate from the first. Rather, each pathway illustrates a sub-set of the actions and results documented in the overall theory of change. Pathway theories of change achieve this end by illuminating the causal links connecting different groups and typologies of UNFPA activities and investments to output and outcome level results. An important feature of the role played by UNFPA in the HIV response is the need to tailor the response to the nature of the epidemic and the social and political context in each region and country**. As a result, the contribution made by UNFPA in Namibia will differ markedly from the contribution in Georgia or Indonesia**. As a matter of fact, UNFPA may support different types of activities, engage with different partners, and focus on different target groups in either country – always within the programming bounds established in the overall theory of change (figure 1).

4. Process for developing the theory of change

The process of developing/reconstructing the theory of change for UNFPA support to the HIV response began with the evaluation team reviewing in detail the ToR and supporting documents. This was followed by an interactive process of consultation and development through the following stages:

1. Individual and group interviews carried out during the evaluation kick-off workshop (first meeting of the evaluation reference group) in December 2018, including presentations by UNFPA headquarters, regional and national staff engaged in support to the HIV response
2. Review of documents
3. Follow-up interviews carried out with UNFPA and UNICEF headquarter staff in January 2019
4. Development of a preliminary overall theory of change by the evaluation team presented at the theory of change workshop
5. A one-day workshop held at UNFPA headquarters on Friday 22 February to review, revise and replace the preliminary theory of change with participation of UNFPA headquarters and regional staff engaged in HIV activities and programming, facilitated by the evaluation team and the Evaluation Office
6. Circulation to the ERG of a note containing draft overall and pathway theories of change
7. Revision of the draft overall theory of change by the evaluation team (figure 1).

The workshop resulted in a re-orientation of the theory of change to better link it explicitly to the *UNFPA Strategic Plan (2018-2021)*, while still identifying how UNFPA support contributes to the SRA of the UNAIDS UBRAF. The workshop also established that prevention of the sexual transmission of HIV as the primary focus and key role of UNFPA in supporting the HIV response. This is achieved through to related and interlinked outcomes:

- Achieving greater linkage between HIV and SRHR policies, systems, communities and integrated services
- The empowerment of adolescents and youth and women to secure their right to information and to services in HIV and SRHR freed from stigma, discrimination, coercion, violence and harmful practices.

While the main focus of UNFPA support is on adolescents and youth (youth and adolescents) and women, UNFPA work in support of the HIV response recognizes as a cross-cutting guiding principle to respond to the needs of populations left behind, the most-at-risk of infection (key populations), and the most vulnerable.

5. How to read the theory of change

The diagram presented in figure 1 depicts the **overall** theory of change for UNFPA support to the HIV response resulting from the consultation process (stages 1 through 6) mentioned above. The structure moves up the chain of effects from UNFPA activities and investments at the bottom of the figure to the overall goal of the UNFPA Strategic Plan on top.

It is important to note that, as a result of the theory of change workshop, **the primary role and function** of UNFPA support to the HIV response was determined to be **the prevention of sexual transmission of HIV** (identified in the second row from the top in figure 1). Similarly, it is worth noting that each of the outputs identified at country level (in the green boxes, in the middle of the figure) are explicitly linked to different UBRAF strategic results areas *by number* (see pink box). While the theory of change is structured around UNFPA strategic outcomes and goal, it retains the necessary link to UBRAF strategic results areas.

Other important features of the theory of change include:

- The overall goal of prevention is achieved through two important strategic outcomes which translate country level outputs into outcomes: **(a) Strengthened linkages between SRHR and HIV** at policy, system, community and service levels along with integrated delivery of HIV and SRHR services; **(b)** Adolescents and youth and key populations, including people living with HIV, exercise their **rights to access HIV-related information and services** free from coercion, stigma, discrimination, violence and harmful practices.

- However, in order for the activities and investments supported by UNFPA to contribute to the output and outcome level results depicted in the theory of change, the **key critical assumptions**, shaded in blue in figure 1, **will need to be realized**. These assumptions, described in detail for each evaluation area of investigation and related evaluation question (see evaluation matrix in Annex B) are an important focus of the evaluation.

ANNEX B: EVALUATION MATRIX

Area of Investigation One: Extent and scope of UNFPA support to the integration of HIV with other sexual and reproductive health and rights strategies and programmes	
Evaluation Question 1: ***To what extent has UNFPA contributed to establishing and strengthening bi-directional linkages (policies, systems, communities and services) between HIV, SRHR and SGBV and to integrating HIV, SRHR and SGBV services?***	
Evaluation Criteria	*Relevance, Effectiveness, Efficiency*
Rationale	Strengthening linkages and bi-directional synergies between HIV, SRHR and SGBV is an important strategy behind many of UNFPA efforts to support the response to HIV. At the level of service users, an important result of strengthened linkages should be more integrated delivery of HIV, SRHR and SGBV services as well as integration of HIV, SRHR and SGBV behaviour change communications efforts.
Assumption 1.1: At global, regional, and national level UNFPA has **effectively supported and advocated initiatives for strengthening bi-directional linkages** between HIV, SRHR and SGBV policies, systems, communities and services.	
Indicators: • National HIV Strategy and SRHR Strategies, Roadmaps and Action Plans incorporate linkages between HIV, SRHR and SGBV • Health sector strategies and action plans incorporate linkages between HIV, SRHR and SGBV • National SRHR action plans and programmes, including family planning incorporate links to HIV prevention • Operational guidelines, service protocols and manuals for health services staff incorporate linkages between HIV, SRHR and SGBV services. • Opinions of global and regional stakeholders on UNFPA role in supporting integration (and its overall level of influence) • Extent to which HIV, SRHR and SGBV strategies and policies address gender equality and HIV-related stigma and discrimination (gender and human rights components)	
Observations	**Sources of Evidence**
UNFPA Namibia Expenditures on Linking and Integrating HIV/SRHR/SGBV • Most UNFPA **Namibia expenditures dedicated to strengthening linkages and integrating SRH/HIV/SGBV services** are made under the **Joint Regional Project on SRHR and HIV/AIDS Linkages in East and Southern Africa (phase 1) and the 2Gether 4SRHR Project (phase 2)**.[64] • UNFPA programme expenditures under the regional programme on linking and integrating SRHR/HIV and SGBV over the three-year period **totalled 600,713 USD** (2016 = 263,916 USD, 2017 = 177,188 USD, 2018 = 159,609 USD). For	• UNFPA Namibia CO Programme Expenditure Reports (2016/17/18)

[64] The addition of sexual-gender-based violence (SGBV) to be integrated into HIV and SRHR services occurred during the development of programme proposals for the 2Gether 4SRHR regional linkages (SRHR/HIV/SGBV) in 2017.

Assumption 1.1: At global, regional, and national level UNFPA has **effectively supported and advocated initiatives for strengthening bi-directional linkages** between HIV, SRHR and SGBV policies, systems, communities and services.	
2019, the UNFPA Namibia budget for supporting integration of HIV/SRH/SGBV through the regional 2Gether 4SRHR project is set at 279,102 USD • In that three-year time frame, the expenditures noted above were **allocated to different implementing bodies**: The Ministry of Health and Social Welfare, the Ministry of Gender Equality and Child Welfare, the Namibia Planned Parenthood Association, the One Economy Foundation (the project implementation division of the Office of the First Lady of Namibia) and UNFPA Namibia. • For details of UNFPA Namibia expenditures in support of integrating SRH/HIV/SGBV See Annex D.	
National Commitment to Integration of HIV/SRHR/SGBV • The *National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/21* makes **multiple references to the need to integrate HIV and SRHR services**. Examples include: o "***HIV Integration in the Health Care System:*** *Integration of HIV in other health services will be strengthened and will enable timely diagnosis and treatment of HIV, TB and other non-communicable diseases." p.4* o *"Service providers, and in particular **the MoHSS will provide the leadership necessary for the integration of HIV services within the mainstream health care service**, including non-communicable diseases. Integration will not only improve service delivery but, also increase uptake and utilization."* p.12.	• Republic of Namibia, MoHSS, *National Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22.* 2017, p.4 and p.12.
• In July 2016, the MoHSS, with support from UNFPA, UNAIDS and WHO (p.5) published *National Guidelines on Health Services Integration: Sexual and Reproductive Health and Rights, HIV and Other Services.* The guideline document points out **that the integration of HIV into other health services is called for in United Nations declarations, regional agreements and the NSF:** o *The 2011 United Nations General Assembly Political Declaration on HIV and AIDS, target number 10 calls for the 'elimination of parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts, as well as to strengthen social protection systems.* P. 11. o *One of the strategies for operationalization of the SRH Framework of the Maputo Plan of Action is integrating STI/HIV and AIDS and SRHR programmes and services.* P.11. o *The Revised NSF of 2010/11*-2016/17 focuses on integration of SRHR services with HIV services to optimize efficiencies and improve coverage. P.13.	• Republic of Namibia, MoHSS, *National Guidelines on Health Services Integration: Sexual and Reproductive Health and Rights, HIV and Other Services,* July, 2016, p.11 and p.13
• In 2018, following the completion of pilot studies in Namibia at the close of the first regional program on linking HIV and SRHR (United Nations Population Fund and UNAIDS Project on Sexual and Reproductive Health and Rights and HIV Linkages in Southern Africa), **the MoHSS produced a series of informative brochures to assist regional health authorities and facilities in the national roll-out of the "Namibian Primary Healthcare Integration Model"**. The model had seven key features: o 1. **All services** in SRHR and HIV **offered every day**	• Republic of Namibia, MoHSS: o *The Namibian Primary Healthcare Integration Model: Rationale for Scale-Up for Policy Makers.*2018, p.4

Assumption 1.1: At global, regional, and national level UNFPA has **effectively supported and advocated initiatives for strengthening bi-directional linkages** between HIV, SRHR and SGBV policies, systems, communities and services.	
○ 2. **A nurse always works in the same screening room**, which is numbered. ○ 3. On arrival a receptionist assigns a client to a room and nurse by numbering their Health Passport ○ 4. The **client receives all services in one screening room** ○ 5. On clients next visit the receptionist assigns them to the same nurse and the same room ○ 6. If needed, a client will be referred for HIV counselling in another room in the facility. ○ 7. If required, client will be referred to a doctor or a hospital for specialist care. • The material produced in 2018 in support of the national roll-out included products directed at policy makers, community leaders and health service workers: ○ *The Namibian Primary Health Care Integration Model:* ***Rationale for Scale-up for Policy Makers****.* ○ *The Namibian Primary Health Care Integration Model:* ***An evidence brief for community leaders****.* ○ *The Namibian Primary Health Care Integration Model:* ***Transition Process Overview****.* • The document for policy makers identified ten benefits to be derived from the integrated service model (p.4.): ○ 1. **Improved efficiency** through better use of the limited number of nurses available. ○ 2. **Clients no longer denied health services** because they are not scheduled on a given day ○ 3**. Saving money and time for clients** who reduce the number of repeat visits to facilities ○ 4. **Increased nurse job satisfaction** ○ 5. **Reduced stigma and discrimination** which in turn can increase adherence, reduce loss to follow up and increase use of clinics closer to the client's home ○ 6. **Improved quality of care** as trust is built between the client and the care giver ○ 7. Improved **quality of health information** ○ 8. Smooth **client flow** ○ 9. Increased **client satisfaction** ○ 10. Increased **service uptake**.	○ *The Namibian Primary Healthcare Integration Model: an evidence brief for community leaders. 2018.* ○ *The Namibian Primary Healthcare Integration Model: Transition Process Overview. 2018.*
• In September 2018, following some reported difficulties in integration at health facilities which, in turn, were seen as impacting on results regarding retention of clients on ART the Office of the Permanent Secretary of the MoHSS issued a circular addressed to all Regional Directors of Health, Chief Medical Officers, Regional Pharmacists, Principal Medical Officers and Health Care Workers. The purpose of the circular was "*to* ***reaffirm the Ministry's commitment to integration of services*** *and provide further details and clarification on integration of health services for immediate implementation*."p.1 • The Circular (*Circular No. 63 of 2018)* included a number of directives aimed at balancing the need to **press on forcefully with integration** (in accordance with national guidelines) while ensuring that any losses of gains made to that point in time were minimized. The directives reiterated the **importance of integration while also noting that care should be taken in the process to ensure that appropriate resources and safeguards are in place**. Highlights include: ○ *3.1: The most important priority is that Namibians receive the services they need.*	• Office of the Permanent Secretary, MoHSS, *Circular No. 63 of 2018,* p. 1-2.

Assumption 1.1: At global, regional, and national level UNFPA has **effectively supported and advocated initiatives for strengthening bi-directional linkages** between HIV, SRHR and SGBV policies, systems, communities and services.	
○ *3.2: Integration should follow a phased approach, of primary health care facilities as prescribed in the guidelines.* ○ *3.3: All regions should ensure that the required personnel are in place, equipped with the necessary skills and orientation on all programs to take on board the comprehensive approach.* ○ *3.4: Regional and District level health teams should support all their primary level health care facilities to transition to integrated service delivery whilst providing the necessary guidelines for the provision of standardized, quality health services in line with the 90-90-90 targets for HIV reduction, the FP 2020 targets, child and adolescent health targets, and global targets.* ○ *3.5: Changes at health facilities should take place when appropriate skills are in place, orientation and training have been provided, and necessary equipment are in place.* ○ *Even in an integrated system, **specialized services that meet a certain population's needs should be provided*** [Emphasis added].	
Integration of HIV and SRHR (and as of 2017 and the development of the 2gether 4 SRHR programme - SGBV) as a Core Strategy of UNFPA Namibia • "*Even before 2016, UNFPA staff met with the different Ministries of the Government of the Republic of Namibia to discuss the role the UNFPA CO and **the strategic direction the UNFPA programme** in Namibia should take. They had to consider a number of factors:* ○ *UNFPA is not one of the largest donors supporting the HIV response.* ○ *Government itself is the major investor in the HIV response, now estimated at 64 percent of recurrent costs.* ○ *UNFPA should not take over any space occupied by the national government but, rather, should work within the strategies and mechanisms of the national government*." • *"All planning starts with the priorities of the National Strategic Framework (NSF) on HIV and the broader National Development Plan 5. Their discussions with government led to agreement that **integration would be UNFPA's main strategy for supporting the HIV response in Namibia**. This reflected the fact that ten years of vertical programming managed by the Directorate of Special Programmes of the MoHSS was producing results but had led to neglect of the role of Primary Health Care in the HIV response."* • *"In the latest UNFPA Country Programme, UNFPA and the government have made some important changes to programming:* ○ *Dropped pursuit of outcomes in maternal health* ○ *SRHR/HIV Integration is now addressed under the heading of Adolescent Sexual and Reproductive Health and Rights (ASRHR)* ○ *Family Planning is now also under ASRHR* ○ *They moved from five focus regions in the fifth country programme to just two.* ○ *In relation to SRHR/HIV integration and to gender, they now work at the national level only."*	• Interview with UNFPA CO Staff in Windhoek

Assumption 1.1: At global, regional, and national level UNFPA has **effectively supported and advocated initiatives for strengthening bi-directional linkages** between HIV, SRHR and SGBV policies, systems, communities and services.	
• *"**With encouragement from UNFPA, MoHSS staff began looking into integration models and packages of intervention used in other jurisdictions and supported by UNFPA through the regional programme**. Before introducing a given model, MoHSS needed to research and document the model. UNFPA support began during the pilot phase with advocacy, technical assistance and support to the pilot process, working closely with the government. Now, for the past year and half (since late 2017) UNFPA has been supporting scale-up based on the decision of MoHSS."*	• Interview with UNFPA CO Staff
Views on UNFPA Support to Pilot Testing and Scale Up of the Namibia Model of Integration • *"UNFPA provided technical and financial support to the Needs assessment on SRHR and HIV services Linkages and Integration conducted by MoHSS in 2011 and the piloting of the Integration commenced in 2015 with a few health facilities/regions were selected for the pilot. In the first phase, UNFPA support focused on pilot regions and the model seemed to work well and was appreciated by the regions. It seems that in the first phase the clinics and health centres combined most PHC services but still kept TB and HIV clinics separately."* [***Note this is not the case according to the sites visited by the team and according to reports/evaluations of phase one of the integration process***] • *However, in 2018 when MoHSS rolled the model out at a national level, there were a number of incidents. The Directorate of Special Programmes (DSP) had trouble getting information and after investing millions in training for voluntary medical male circumcision (VMMC) and HIV testing and counselling as well as management of ART they felt the roll out was not well managed.* • *Ministry of Health Regional Offices/Health facilities used to assign staff to different clinics (ANC/FP/HIV/Tuberculosis) based on training and skills but now staff were assigned to general clinics providing all services (the one room, one nurse, one patient model). In some regions, the **Regional Chief Medical Officers say the process is working fine and in others, the Chief Medical Officers are pushing back** – "never in my district", they said. It has also caused problems in data collection as some regions have few staff trained adequately in data collection and data entry.* • In DSP's view: *you should not apply the same model of integration to all the facilities. In some high-volume sites, HIV patients do not want to wait with general patients in long queues for service*.	• Interview with the DSP of the MoHSS
UNFPA Support during the Pilot Phase • *"The UNFPA/Sweden [*the regional linkages programme*] support started in Omaheke region with support to Epako clinic. Epako clinic was one of the pilot sites for the integration and **UNFPA support to the implementation during the pilot was described as excellent, with good feedback from the users**. In particular, the assessment of the pilot showed that integration encouraged young people to access HIV prevention and treatment services and to get tested and know their status. The one nurse, one room, one client model helped to build rapport between service providers and their clients."* **Scaling up** • *"With UNFPA and Global Fund support, the implementation moved to the next phase which was scaling up to other regions. Most of the funding for this was from donors. **By 2019, integration of SRH and HIV services has rolled out to 98 out of 344 health facilities.** Both the Global Fund and UNFPA are working with PHC to support regions and facilities with a high burden of HIV, mostly in the northern regions."*	• Interviews DPHC, MoHSS

Assumption 1.1: At global, regional, and national level UNFPA has **effectively supported and advocated initiatives for strengthening bi-directional linkages** between HIV, SRHR and SGBV policies, systems, communities and services.	
HIV and family planning • *As a result of ongoing implementation of integrated services and availability of new technologies as well as emerging issues, MoHSS has made moves to revise and update family planning guidelines* • *UNFPA supports MoHSS in many aspects of SRHR including the Family Planning Policy and Guidelines* • *Family planning is one of the first services that was integrated into HIV services. The need is to integrate all programmes. If a client comes for Family Planning services, they should have access to the whole range:* o *HIV testing* o *HIV treatment* o *STI screening* o *Cervical cancer screening*	
• *UNFPA supported the National Gender Based Violence Baseline Study, which illustrates the **linkages between Sexual Gender Based Violence (SGBV) and access to HIV prevention** and treatment services, including ART.*	• Interview at the Ministry of Gender Equality and Child Welfare.
• *UNFPA supported the work of the Namibia Planned Parenthood Association (NAPPA) to operate a clinic at the Out Right Namibia drop-in centre in Windhoek. More specifically: "**A key factor** in accessing testing and treatment for the community is the knowledge that a given health centre has a nurse or other service provider who treats them with sensitivity and respect. Not all health facilities/partners have **well trained staff who are friendly** – unlike SFH and NAPPA where they are friendly."*	• Interview with Out Right Namibia
• *"UNFPA was the first development partner in Namibia to really advocate for integration as a response to HIV and have been a champion of integration since – however, they acknowledge that it needs to be well planned – **shortages of essential staff pose real difficulties**."*	• Interview with SFH Namibia
• "*UNFPA supported piloting of integration in five countries in SADC with some conversations with PEPFAR but no real engagement. At the end of the pilot study, they decided to support rollout of the integration model. In PEPFAR's opinion UNFPA did not really have strong support from the MoHSS because they focused mainly on one Directorate (PHC) to the exclusion of others* *The rollout of integration was flawed because the sites were selected for integration without good criteria and they [*UNFPA/PHC*] went ahead without keeping them informed so that implementation happened without proper consultation and buy-in. The main issue is that there was **not adequate buy-in from people with clinical experience in how HIV services are delivered**.*"	• Interview with staff of PEPFAR and the CDC Windhoek Office
• UNESCO staff noted that UNFPA serves as the lead United Nations Country Team (UNCT) member on SRH/HIV integration, UNFPA plays a major role and provides technical leadership. Also, from the perspective of UNESCO, "*UNFPA works closely with both the Directorates for Special Programmes and for Primary Health Care (within the MoHSS). On the other hand, **PEPFAR/CDC is clearly pushing back** hard against integration*."	• Interview with Staff of UNESCO Namibia

Assumption 1.1: At global, regional, and national level UNFPA has **effectively supported and advocated initiatives for strengthening bi-directional linkages** between HIV, SRHR and SGBV policies, systems, communities and services.	
• *"**UNFPA has worked mainly with UNAIDS and WHO to support the integration of HIV/SRHR/SGBV in Namibia**. In the pilot testing phase, it was mainly UNAIDS and UNFPA but in the most recent phase WHO is also engaged even though all the funding for Namibia was allocated to UNFPA."*	• Group interview with members of the JUNTA - I
Assumption 1.2: UNFPA supported operational models/approaches for strengthening bi-directional linkages and integrating HIV, SRHR and SGBV have been implemented.	
Indicators: • Regional and national plans for linkage and integration adopted by health authorities • National health authorities confirm adoption of plans/programmes in support of linking and integration • National linkage plans and programmes address three components of IAWGL model: - Enabling environment - Stronger health systems - More integrated delivery of SRHR and HIV services • Linkage programmes supported by UNFPA at regional national level report on progress (including in integration)	
Observations	**Sources of Evidence**
Tools Used in Implementation The principal tool used during the pilot testing and roll-out of integration of HIV, SRHR and SGBV services in Namibia has been the summary document for the **National Guidelines on Health Services Integration: Sexual and Reproductive Health and Rights, HIV and Other Services**. The document described the international and national high-level decisions behind the integration strategy in Namibia, explains the concept of integration and its definition as well as expected benefits. It also describes different models of integrated care before **defining the Namibian model**. Most importantly, the guidelines document details the process of integration. P.20-37. Features of the process include: • *Three major steps: 1**. Assessment, Preparation, Implementation** (p.20).* • *Detailed instructions for each step. For example, under Step 1. Assessment, the guidelines provide tools and checklists for assessing different dimensions of integration including:* o *"What looks at the content of integration; Assess the following* ▪ *What services are provided in the clinic/health centre?* ▪ *What is the workload in the facility?* ▪ *What are the main reasons for visits to the facility? (p.21)* o *"Who assesses the personal dimension of integration; Assess the following:* ▪ *What type of providers work in the facility?* ▪ *What language do they speak?* ▪ *What are their training needs? (p.23)* o *"When looks at the time dimension of integration; Assess the following:* ▪ *What are the working hours in the facility?*	• Republic of Namibia, MoHSS, *National Guidelines on Health Services Integration: Sexual and Reproductive Health and Rights, HIV and Other Services,* July, 2016, p.11 and p.20-48

Assumption 1.2: UNFPA supported operational models/approaches for strengthening bi-directional linkages and integrating HIV, SRHR and SGBV have been implemented.	
▪ *When are different services provided?* ▪ *Are services provided based on staff rotation, if so, how frequent are the rotations for different services? (p.23).* ○ *"Where assesses the space and patient movement in the facility; Look at the space and patient movement in the facility:* ▪ *How many rooms do you have?* ▪ *How are different rooms used?* ▪ *How are services organized? What does patient flow within the facility look like?* ▪ *What is the time required to provide each service?* ▪ *What is the waiting time for different services?* ▪ *What takes up most of the time of the patient (waiting area, transition from one service provider to the other, consultation etc.?* (p.24) • The guidelines provide **tools, checklists and scenarios** for each of the different steps in the process (Assessment, Preparation, and Implementation) as well as a note on how facilities should develop a monitoring and evaluation framework (p.39). • Practical tools are provided in the annexes to the guidelines which include: ○ *Annex 1: Patient Allocation Form* (p.41-43) ○ *Annex 2: Monthly Summary Sheet: total number of patients seen by each nurse" (*p.44) ○ *Annex 3: Provider's language and training needs analysis matrix"* (p.44) ○ *Annex 4: Checklist of minimum equipment needed for consultation room"* (p.45) ○ *Annex 5: List of essential medicines to be available in consultation rooms"* (p.450 ○ *Annex 6: Basket HIV and SRHR Services and the Marker Indicators"* (p.46) ○ *Annex 7: Holistic, person focused service delivery approach"* (p.47).	
• As noted above, in 2018, in support of the process of rolling out integration of services on a national scale, the **MoHSS produced a series of short briefs** to be used in informing key stakeholders including policy makers, community leaders and health care service providers **on the nature of the Namibia model** of integration, the process to be followed and the benefits to be expected. The process overview detailed six steps in the process to be followed at regional level: ○ **Step 0: Regional Preparation** – Set up an integration task force and Receive support from national counterparts ○ **Step 1: Orient and Engage** – Engage health facility managers, conduct a study visit, meet with health facility staff ○ **Step 2: Assess** – Who, What, Where and When ○ **Step 3: Prepare** – Space, staff, equipment, medicine and registers, community, getting ready for day one.	• Republic of Namibia, MoHSS: ○ *The Namibian Primary Healthcare Integration Model: Rationale for Scale-Up for Policy Makers.*2018, p.4 ○ *The Namibian Primary Healthcare Integration Model: an evidence brief for community leaders.* 2018. ○ *The Namibian Primary Healthcare Integration Model: Transition Process Overview.* 2018.

Assumption 1.2: UNFPA supported operational models/approaches for strengthening bi-directional linkages and integrating HIV, SRHR and SGBV have been implemented.	
○ **Step 4: Implement** – Allocating clients, supervision and support, common Client complaints, strengthening referral systems, addressing common implementation challenges ○ **Step 5: Review and Report** – Data capture, proposed indicators, workload analysis, sharing best practices.	
Progress on integration during Phase One of the Regional Programme: Pilot testing • *"Over the course of the five years of implementation of Phase 1 of the Project **UNFPA provided funding of approximately 555,286 USD, channelled through the MoHSS** at the national level who then coordinated the implementation of the program through seven pilot sites*."	• UNFPA and UNAIDS, *Evaluation of the United Nations Population Fund and the Joint United Nations Programme on HIV/AIDS Project on Sexual and Reproductive Health and Rights and HIV Linkages: Country Report, Namibia.* (June 2016)
• The Namibia country report for the final evaluation of phase one of the regional programme on integration listed a range of **activities carried out during the first phase** including: ○ A **briefing for Parliamentarians** on linkages between SRH and HIV by UNFPA, UNAIDS and the Namibia Planned Parenthood Association (NAPPA) ○ **A baseline assessment at seven pilot sites** involving in-depth interview with health care providers ○ Hiring an international consultant to provide technical support to the seven pilot facilities ○ Addition of two pilot sites (Kanono Clinic in Capirivi region and Okankolo clinic in Oshikoto region) ○ **Development of service models** based on results at the pilot sites ○ **Training and engagement of young peer educators** around pilot sites and with sex workers ○ A **situation analysis** to assess strengths, challenges and gaps in provision of adolescent friendly health services at health facility and community levels ○ **Support to the NAPPA clinic to provide adolescent friendly health services.**	• UNFPA and UNAIDS, *Evaluation of the United Nations Population Fund and the Joint United Nations Programme on HIV/AIDS Project on Sexual and Reproductive Health and Rights and HIV Linkages: Country Report, Namibia.* (June 2016), p.5.
• "*The findings from the client exit interviews conducted as part of this evaluation suggest that **clients feel that integration is relevant to their needs** and contexts. Almost all clients (97.5 percent) received the service that they sought".* (p.15) • *"From the health care provider side, the Client Satisfaction Survey revealed that **all service providers were satisfied** with the integration services they offered to their clients and most (95 percent) would recommend integration at other facilities.* (p.15)	• UNFPA and UNAIDS, *Evaluation of the United Nations Population Fund and the Joint United Nations Programme on HIV/AIDS Project on Sexual and Reproductive Health and Rights and HIV Linkages: Country Report, Namibia.* (June 2016), p.15.
• "*In Namibia, integration of HIV and SRHR services focused on a patient-centred Integrated Service Delivery model, using a **"one stop shop"** where each health care provider provides comprehensives services on a daily basis, to the same patients over time and **coordinates referrals to other levels of the system**. Findings from the Client Satisfaction Survey conducted by MoHSS show that HIV services were typically integrated into existing SRHR services like family planning, maternal and newborn care services, and prevention and management of STIs. Facilities providing these*	• UNFPA and UNAIDS, *Evaluation of the United Nations Population Fund and the Joint United Nations Programme on HIV/AIDS Project on Sexual and Reproductive Health and Rights and*

Assumption 1.2: UNFPA supported operational models/approaches for strengthening bi-directional linkages and integrating HIV, SRHR and SGBV have been implemented.	
SRHR services typically offered HIV services by referring clients to a different service site within the facility, but offered these services on the same day. HIV services offered included such as HTC, provider-initiated testing and counselling (clients are routinely offered HIV testing and counselling), psychosocial support, HIV prevention information and services for general population, condom provision, and prevention for and by people living with HIV. Some facilities that offered other SRHR services, like management of gender-based violence and prevention of unsafe abortion/management of post-abortion care, also offered HIV services by referring clients to a different service site within the facility on the same day; some, however, referred to another facility."	*HIV Linkages: Country Report, Namibia.* (June 2016), p.17.
Progress during Phase Two: rolling out integration • As per the report of the National Consultation Meeting on the Joint SRHR/HIV/GBV Integration and Tools Validation Meeting for SRHR/HIV/GBV Integration Tools (March 2018):*"Since the launch of the Integration Guidelines in 2015, the **number of integrated health facilities in Namibia has grown from seven pilot sites to 78 health facilities** in almost every region of the country. Two regions – Oshikoto and d Otjozondjupa – have already nearly scaled up to every primary healthcare facility."* P.4	• Republic of Namibia, MoHSS, *National Consultation Meeting on the Joint SRHR/HIV/GBV Integration and Validation Meeting for SRHR/HIV/GBV Tools: Meeting Report.* March 2018, p. 4.
• *"During 2016, the country committed **to scale up to 52 health facilities, to date with high level commitment from the lead ministry of health, 62 facilities are implementing SRHR/HIV integration**. Subsequently, in recognition of the great work undertaken in Namibia on SRHR/HIV Integration the Minister of Health for Namibia was invited to be part of the Satellite Session and to share Namibia's experience around the integration 10 of SRHR/HIV at the International Conference on HIV/AIDS and STIs that took place in Abidjan, Cote D'Ivoire from 4 - 7 December 2017. In 2016, Namibia hosted the 6th Steering Committee meeting of the UNFPA and UNAIDS Regional Project on Linking HIV/SRHR/TB/ and SGBV a platform for countries to report on progress, share best practices and work on their results-based frameworks."* P.9-10.	• UNFPA/UNAIDS/UNICEF/WHO and the Government of the Republic of Namibia, MoHSS, *Strengthening integrated sexual and reproductive health and rights (SRHR), HIV and Sexual and Gender-Based Violence (SGBV) services in East and Southern Africa (ESA). A Joint United Nations Regional Proposal. Programme Document: Namibia* (2018), p.9-10.

• Current Situation in Relation to Integration (2018):
  ○ **Of 14 regions in Namibia, 7 achieved their 2017/18 targets**
  ○ 7 remaining regions still planning to make progress toward achieving targets
  ○ 4 regions were currently scaling up in facilities using Global Fund support: Kunene (4), Omusati (4), Ohangwena (12) and Oshana (6): Total facilities scaling up in these districts = 26
  ○ Two regions surpassed targets: Oshikoto: target seven, achieved 22, Otjozonjupa: Target 8, achieved 17.
• Areas of ongoing activity in 2018
  ○ Capacity building for services providers in particular services
  ○ Community mobilization for integration
  ○ South to south visits among regions in Namibia to learn from each other's experiences
  ○ Advocacy packages being developed with support from UNFPA regional office
  ○ Evidence published in international journal
	• MoHSS, *Strengthening integrated sexual and reproductive health and rights (SRHR), HIV and Sexual and Gender-Based Violence (SGBV) services in East and Southern Africa (ESA – Namibia.* Presentation to the Namibia Country Validation Meeting, February 2018. Slide Number seven

Assumption 1.2: UNFPA supported operational models/approaches for strengthening bi-directional linkages and integrating HIV, SRHR and SGBV have been implemented.	
○ Political commitment at the highest level.	
• "*During, Phase 1, the regional programme to support integration of SRHR and HIV was a-well coordinated programme supported by UNAIDS and UNFPA. In the second phase beginning in 2018 (now called 2Gether 4SRHR) Namibia became a 'transition" country. At first UNFPA/UNICEF/WHO were involved together and very excited at the local office level. However, the decision was made at the overall program level that in Namibia the* ***funding would be for UNFPA only*** *[Note: according to UNFPA ESARO there was no interest on the part of UNICEF and WHO in continuing to deliver programming in the transition countries]. This has caused some* ***lack of engagement by other member of the UNAIDS co-sponsors****. Also, there is a problem getting the Directorate for Primary Health Care (DPHC) to be engaged and to have good communications between the DPHC and the Directorate of Special Programmes*".	• Interview with UNFPA CO Staff in Windhoek
• *"With UNFPA and Global Fund support the implementation moved to the next phase which was scaling up to other regions. Most of the funding for this was from donors.* ***By 2019, integration of SRH and HIV services has rolled out to 98 out of 344 health facilities****. Both the Global Fund and UNFPA are working with PHC to support regions and facilities with a high burden of HIV, mostly in the northern regions."*	• Interview with Directorate of Primary Health Care, MoHSS
• *"You need a high level of specialization, especially at these larger facilities where your hive high numbers of ART patients and you are engaged in the complex management of a chronic disease. Yes, it may be useful and necessary in smaller facilities to integrate but it is not feasible in the larger, high volume sites. A common reason given for integration is to avoid stigma, but in some cases integrated sites make PLWHIV even more visible with special corners for HIV clients in, for example, the pharmacy. While the pilot study in seven districts pointed to some benefits from integration but they (PEPFAR/CDC) severely question the methodology used. In their view,* ***the positives noted in the studies are outweighed by negative impacts on HIV/ART services. In some sites they actually see the level of viral suppression going backwards****."*	• Interview with staff of PEPFAR/CDC in Windhoek

Assumption 1.3: As a result, HIV, SRHR and SGBV services and interventions have been integrated both in health service delivery settings and in behaviour change and communications efforts, especially in relation to contraceptive services and family planning, including for EMTCT.

Indicators:

- Extent to which operational guidelines, service protocols and manuals that promote delivery of integrated HIV, SRHR and SGBV services are reportedly used by health services staff
- Reported quality and clarity of operational models for integration
- Programme expenditures on integration
- Evaluation findings on integration initiatives
- Reported experience and views of national health authorities and other implementing partners
- Examples of successful/unsuccessful efforts to link HIV to SRHR services at operational level as confirmed by site visits/discussions with service providers
- Data on aspects of service integration identified in the IAWG indicator list:
  - HIV counselling and testing and family planning integrated
  - Knowledge of HIV status

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- Met need for contraception - Sex worker access to services - MSM access to services	
Observations	**Sources of Evidence**
• As per Assumption 1.2 above, the MoHSS has tested and developed a Namibia model of integration of HIV, SRHR and SGBV services at facility level and has further **refined existing regional programme guidelines and tools for pilot testing and rolling out integration** in Namibia.	• Republic of Namibia, MoHSS, *National Guidelines on Health Services Integration: Sexual and Reproductive Health and Rights, HIV and Other Services,* July, 2016
• "UNFPA and the MoHSS agreed that the major question was "*how can we **develop a model that will serve the PHC (including SRH) needs of the population without neglecting the need for HIV** prevention and treatment*"?	• Interview with Staff of UNFPA CO, Windhoek
• **Minimum Package of Services: Namibia Model of Integrated SRHR and HIV Services** o Same Room, Same Day Services: ▪ Ante Natal Care (ANC), Post Natal Care (PNC), Family Planning, Immunization, Screening for Children and Adults, Dressing, Tuberculosis, Pap smear, Prevention of Mother to Child Transmission of HIV (PMTCT), Anti-Retroviral Treatment. o Different Room, Same Day Service ▪ HIV Testing and Counselling (HTC) o Facilitated Referral to Specialised Referral Services.	• Republic of Namibia, MoHSS, *National Guidelines on Health Services Integration: Sexual and Reproductive Health and Rights, HIV and Other Services,* July, 2016, p.48
• As per the report of the National Consultation Meeting on the Joint SRHR/HIV/GBV Integration and Validation Meeting for SRHR/HIV/GBV Integration Tools (March 2018):*"Since the launch of the Integration Guidelines in 2015, the **number of integrated health facilities in Namibia has grown from seven pilot sites to 78 health facilities** in almost every region of the country. Two regions – Oshikoto and d Otjozondjupa – have already nearly scaled up to every primary healthcare facility."* P.4	• Republic of Namibia, MoHSS, *National Consultation Meeting on the Joint SRHR/HIV/GBV Integration and Validation Meeting for SRHR/HIV/GBV Tools: Meeting Report.* March 2018, p. 4.
Operational Extent and Nature of Integrated Services – Interviews and Site Visits	
• *"**The one room, one nurse, one client** is an interesting model and it can be effective. It allows full utilization of, for example, HIV/ART nurses and broadens the work experience of other nurses. The government has invested considerable financial resources in integration on a national scale but has not yet seen concrete, quantifiable results."*	• Interview with Staff of UNFPA CO, Windhoek
• *For Namibia, the choice is clear, they have to integrate – they simply **do not have the resources to provide separate, stand-alone services**. It is one-sided and self-serving when some donors say that integration is not working.*	• Interview with staff of MoHSS, DPHC
• *"**Family planning is one of the first services that was integrated into HIV services**. The need is to integrate all programmes. If a client comes for FP services, they should have access to the whole range:* o *HIV testing* o *HIV treatment*	• Interview with staff of MoHSS, DPHC

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○ *STI screening* ○ *Cervical cancer screening"*	
• *The* **[LGBTI]** ***community needs good access to confidential testing*** *and that is best done through integration – integration would give them more access to testing. A key factor in accessing testing and treatment for the community is the knowledge that a given health centre has a nurse or other service provider who treats them with sensitivity and respect.* • ***Not all health facilities/partners have well trained with staff who are friendly*** *– unlike SFH and NAPPA where they are friendly. In the first instance there might be a self-test done with the client (in an integrated facility). This would be followed by a confirmation test in another place. It is important that the person involved not be seen to move to the confirmation test because then it is assumed that they are HIV positive. It is better if the nurse takes the test sample to the separate site for confirmation* [Note: In all health facilities the Evaluation Team visited testing and counselling were done separate from other functions] • *MoHSS worked with NAPPA to provide a nurse to work in their drop-in centre and provide clinical services. The idea was to have a center where LGBTI people could come and get tested and treated for HIV but people did not come because of stigma. It would have been better to have a full-service clinic so that people could come and begin with an innocuous problem like a headache and only later would they get around to HIV. NAPPA had to withdraw its funding because of its own funding issues and because attendance was too low. It would be* ***better to have an integrated clinic so community members would not know you were coming for testing****. Out-Right's dream is to have truly integrated services meeting the needs of LGBTI community members."*	• Interview with staff and members of Out-Right Namibia
• *NAPPA runs integrated SRH and HIV services in their clinics. The first service they integrated into SRH was Family Planning, subsequently they added Ant-Retroviral Therapy (ART) and Pre-Exposure Prophylactics (PEP). Integration needs to include more services on Sexual Gender-Based Violence (SGBV) but the current level of integration does allow them to spend more time with the client.*	• Interview with Staff of NAPPA at agency headquarters in Windhoek
• The clinic applies a **modified model of integration** with the following characteristics: ○ Clients are registered on arrival with a preference given to first-time clients who are seeking ART (they are moved forward in the queue because first time ART clients require extensive counselling and data entry in the patient register) ○ At registration clients are assigned to a specific room for their screening and counselling with a nurse/health worker – The clinic seven staff members: 1 Registered Nurse, 1 Clinical Assistant, 2 Peer Counsellors, 1 Health Assistant and 1 Community Based Reproductive Health Assistant (CBHRA) ○ Clients for HIV services (including PEP), Family Planning, Anti-Natal Care, Sexually Transmitted Infections (STI) screening are all seen in the same room. ○ Preliminary HIV Testing and Counselling (HTC) is done by the health assistants in a separate room in the facility [Note: this is consistent with the Namibia model of integration Minimum Package of Services which	• Interviews and Site Visit to the NAPPA Okuryangava Clinic, Windhoek

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indicates that HTC can be done in a separate room as long as service is provided on the same day – National Guidelines p.48].	
• Although the integration model was originally designed to provide comprehensive services in one room with one provider (and to help reduce stigma) the **clinic applies a modified model of integration** with the following characteristics: o Most patients are seen in one room by each nurse and those that need to be seen by a doctor are then referred to the doctor o Pregnant women come early to the clinic and are given priority for ANC in a slight deviation from pure integration (they are given priority in assigning visits to screening rooms but the services in each room are still mostly integrated) o The clinic has created a specialized space for testing and counselling for HIV. They have a Community Health Counsellor who tests for HIV – the testing is done in a separate room [This is consistent with the Namibia model which allows for HCT in a separate room] o Another modification has been to create a space within the pharmacy where ART is provided to ART clients o While HIV patients are not necessarily integrated among the others (for pharmaceutical services for example and for HTC), they do get other services such as Family Planning so it is integrated into, for example, ART and ART clients are happy with the services they receive.	• Interviews and Site Visit Observations: Khomasdal Health Centre, Windhoek
• The clinic began the integration process in February 2019 by integrating all services but **now uses separate rooms for taking vital signs and for dressing wounds**. With regard to vital signs there is not enough equipment for all the consulting rooms. For dressing wounds, although they have equipment, the problem is that not all the staff are adequately trained. Other modifications noted during the interviews and site visit include: o What have been integrated are services such as Family Planning, Counselling, STI screening, and immunization o Anti Natal Care (ANC) is being provided separately due to problems of equipment and because staff, especially midwives are not adequately trained in other services o HIV treatment is not integrated into the other services, but within HIV they do screening and counselling (for STIs) as well as Family Planning, and ANC. o Similarly, all clients who come seeking family planning receive counselling in HIV prevention and PEP o SGBV services have been integrated but if there is a potential prosecution the clinic refers the client to Katutura Hospital where there is a SGBV protection unit.	• Interviews and site visit: Maxulili Clinic, Okahandja Park, North Windhoek
History of Integration • The 1st meeting on integration with the whole team (Onandjokwe PHC Clinic and the other clinics in the district) took place in 2017. Prior to that the hospital had separate PHC clinic and separate ART clinic. The two units were merged and the PHC clinic moved to the present centre to incorporate the ART clinic as a prelude to integration. Integration	• Interviews and site visit to the Onandjokwe Intermediate Referral Hospital and the Onandjokwe Primary Health Care Clinic, Oshikoto Region. Interviews included facilities staff and

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started with 6 facilities in the district and then expanded to the others. Prior to integration the Regional team met with nurses from all the health centres and clinics. **Work Flow Issues Prior to Integration** ○ The ART centre was congested and the workflow was more than the staff could handle with patients lined up at each office and work station. ○ There was a separate clinic within the centre for PMTCT and for family planning with integration into HIV/ART. ○ There were many ART clients and the work flow would only reduce after 5 pm, there was also extraordinary crowding at the pharmacy. ○ It was difficult to re-assign nurses from the ART rooms either to other units in the health facility as needed or to fill in for sick and absent nurses in the 8 clinics. The PHC clinic in the hospital assists the 8 clinics in the district so they need to have nurses trained in all services. Under the prior system the clinics complained that nurses assigned to help out were only trained in ART and could not help with other services. **Work Flow Under the Integrated (Current Model) at the PHC Clinic** ○ When a client enters, the receptionist collects their health passport and registers them on the patient tally. An admin assistant then carries the file throughout the facility. ○ HIV testing is done in a separate room prior to assigning the client to a screening room. Under Provider Initiated Testing and Counselling (PITC) all clients are tested. [This is consistent with the Namibia model of integration which allows for HTC in a separate room] ○ There are ten screening rooms and 3 for doctors when a referral is made from a screening room ○ The client is assigned to one of screening rooms (1 to 10) by the admin officer if it is a new client; if an existing client they go to the screening room they attended on their first visit. ○ Nurses in the screening room can prescribe and dispense ART to patients but only those on first line treatment. ○ For clients whose initial test is positive, confirmatory testing is done in a separate location in the centre.	members of the District Health Management Team
History/Background of the Integration Process at the Centre • An assessment done in June 2012 of ANC clients showed that they were spending a great deal of time travelling to and attending ANC services. The centre began piloting integration in October 2012 and has been integrated to the present time. An evaluation was conducted in 2015 which included exit interviews with patients and interviews with staff. As a result of the experience at the centre, health facilities in the region are referred to Okankolo as a model for how integration can be done and how it can work. **Adjustments to the Integrated Model** • Along the way they have made adjustments to the model for better workflow and to adjust to challenges. These include: ○ Because the health centre is open 24 hours each day, they assign three nurses to each room, each one for an eight-hour shift. Nurses are assigned to the night shift for three months each year.	• Interviews and site visit: Okankolo Health Centre, Onandjokwe Health District, Oshikoto Region

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○ Having the pharmacy assistants assist nurses when needed in the screening/counselling rooms. ○ The pharmacy assistant also places the needed ARVs in the screening/services room based on the estimate for the day. This is first line treatment ART and can be up to 20 for a single room. ○ Having administrative assistants carry the files as needed ○ All new clients are tested under Provider Initiated Testing and Counselling and are counselled whether positive or negative ○ Consistent with the Guidelines, HIV testing and counselling is the only thing that is not integrated into the other services because it takes much longer to counsel new clients who are positive. ○ Counselling is done in a separate room by a health assistant. ○ As in other centres they have established Community ART Refill Groups (CARG)	
Challenges Encountered During the Integration Process in Namibia and Reactions Among Stakeholders	
• The National Consultation Meeting on SRHR/HIV and GBV Integration hosted by the MoHSS and the United Nations Joint Programme members (UNFPA, UNAIDS, UNICEF, WHO) in March 2018 identified a range of challenges and bottlenecks. Those noted most frequently included: ○ **Human Resource Constraints**: Specifically ▪ Staff vacancies at regional, district and health facility level ▪ Large training needs – including coordinated external training and provision of in-service training, mentoring and support: especially for Nurse Initiated ART (NIMART) ▪ Initial negative attitudes and resistance to change from staff members ▪ Language barriers, especially in rural areas ▪ Donor funded staff in ART Clinics making integration more difficult when required to spend 80 percent of time on HIV services. ○ **Infrastructure and Space** ▪ Need to expand existing structures due to lack of screening rooms ▪ Need for more benches/chairs and more space in waiting areas ▪ Dilapidated infrastructure in some clinics ○ **Equipment** ▪ Shortage of basic equipment (Blood Pressure Monitors, glucometers, etc.) to equip all screening rooms leading to sharing between rooms and requiring nurses to move to find equipment ▪ Lack of funds to procure needed equipment ○ **Other challenges** ▪ Continuous sensitization of clients to ensure understanding/acceptance of the new systems ▪ Integration of some services, especially Tuberculosis, Immunization and ART, the latter because of training and follow-up requirements and tradition of stand-alone ART clinics ▪ The high volume of clients in some clinics.	• Republic of Namibia, MoHSS, *National Consultation Meeting on the Joint SRHR/HIV/GBV Integration and Validation Meeting for SRHR/HIV/GBV Tools: Meeting Report.* March 2018, p. 13.

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• *"**The process of integration has not been without push-back**. In particular, the US Government (USG) - represented by PEPFAR/CDC - has its own **interest in maintaining the vertical programme run through DSP**, where CDC has its offices. This also comes at a time when relations between UNFPA and the USG are difficult given the current political environment in Washington. The USG delegation which visited UNFPA to discuss integration and its challenges seemed to be under the impression that UNFPA is the driving force behind integration when, in reality, it is a regional/national priority***.**" • "*One factor in the disagreement between the Directorate for Primary Health Care (DPHC) and the Directorate of Special Programmes (DSP) is the fact that the **vertical HIV programmes rely on an appreciable, well-financed, infrastructure** within the DSP. This has led to some conflict in recent years as the Directorate for Primary Health Care has not been as well resourced."* • *"In response to some of the controversy raised by PEPFAR/CDS, the UNFPA CO, jointly with the East and Southern Africa Regional Office (ESARO) is assisting the MoHSS with the design and implementation of a rapid **assessment of the integration process** which [financed by UNFPA with contracting run by ESARO]. During the planning process the Terms of Reference have been shared with PEPFAR/CDS for comment but the requested changes have been overwhelming in complexity and would require surrendering control of the review process from MoHSS/UNFPA to PEPFAR/CDC".* [Note: According to ESARO contracting of the consulting team was to be completed in June 2019. The total budget for the review is 25,000 USD]. • *"The key challenges are first the complexity and scale of the national roll-out of the Namibia model of integration and the opposition and push-back by the USG*."	• Interview with UNFPA CO Staff
• **The DSP** had difficulty getting information on integration and after investing millions in training for HIV testing and counselling as well as the management of ART they **feel the roll out was not well managed**. • In some regions, the Regional Chief Medical Officers say the process is working fine and in others the CMOs are pushing back – "*never in my district"*, they said. • Integration has also caused problems in **data collection** as some regions have few staff trained adequately in data collection and data entry. • Senior staff of DSP have the view that: *"**you should not apply the same model of integration to all the facilities**. In some high-volume sites, HIV patients do not want to wait with general patients in long queues for service."* **Data Collection, Entry, Reporting and Analysis** • Integration has not addressed the problem of integrating **patient registries and data logging, entry and analysis**. • Namibia has recently upgraded its national health information system to DHIS2, but the number and type of **indicators for HIV under DHIS2 are limited.** • DSP, PHC Directorate and the National Statistical agency are collaborating on supporting a "Situation Room" which will allow them to link different, disease-specific systems into the DHIS2. *"We need to get everyone around the table and make sure that the transition does not mean that months of data are lost."*	• Interview with staff of the DSP, MoHSS

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Moving Forward with Integration and the Problem of Coordination • DSP indicated support for integration but want it done in **a more coordinated way**. "*We need to find common ground among the different stake-holders".* • Coordination of the integration process was to be handled by the Director of Primary Health Care (MoHSS) but the appointment of the new Director was pending at the time of the recent evaluation. *"As soon as the Director of PHC is appointed we (SPD and DPHC) can begin the process of reaching a consensus ".*	
• There is an urgent need to provide facilities with the necessary **equipment and training** to support the one-nurse, one room, one patient model. • In some facilities the number of patients is overwhelming and **waiting lines seem to take longer**. • **Not all health facilities can integrate at the same pace** and to the same extent depending on training, equipment, space available. • "*Some donors are clearly not happy about integration. In 2018 there was a lot of back and forth between UNFPA and the Global Fund on one side and PEPFAR/CDC on the other despite the national commitment to integration. The **Directorate of Special Programmes has, with support from PEPFAR and CDC been pushing back against integration** but without stating clearly that they are against it – at least not face-to-face in meetings.*"	• Interview with the DPHC, MoHSS
• *"**The integration process raises potential for reduced absorption and retention rates for ART/HIV treatment** patients and this has resulted in a lot of resistance from PEPFAR. In the past, this has mainly been because the Ministry itself wants to pursue integration and the CDC does not. **Integration could slow down progress against PEPFAR targets** under its Country Operational Plan (COP) which has very hard targets that have to be reported to Washington."* It would be best if stakeholders could identify areas of integration that would benefit **service quality in HIV/ARTs** as well as other aspects of SRH. **Monitoring and Data** • *"PEPFAR says they need 1000 to 1200 data clerks to support data entry for their target setting and monitoring (a dashboard system for each health facility). This is to feed into a PEPFAR/CDC system rather than to support a national goal. **PEPFAR/CDC has set up a strong M&E system for the HIV programme and integrating the different data system now poses a challenge to MoHSS**."* • *"**PEPFAR resources have helped Namibia reach the 90/90/90 target** but it would be foolish to pretend that external agencies and the Government of Namibia have the same overall goals – **the goal of the MoHSS is to ensure that every citizen receives a reasonable level of service**. They cannot say they will focus on just key hot spots or specific parts of the country that have high incidences unlike the PEPFAR approach."*	• Interview with the Global Fund Programme Management Unit, MoHSS
• *"Operationally integration is challenging because it requires every health provider to have the full set of skills and equipment. **Integration works and does provide benefits but it is very equipment intensive**."* • *"**Data entry is a major challenge** as it is difficult to maintain patient registers and different disease specific programmes require very different indicators – disease specific registers are a major problem."*	• Interview with NAPPA, Windhoek

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• Staff of PEPFAR and CDC in Windhoek identified a range of problems and issues regarding, especially, the **rolling out of integration on a national basis** following the completion of pilot tests in phase one of the integration programme. The following are not direct quotes but a list of the apparent **mis-steps and challenges** identified during the interview: o *UNFPA did not really have strong support from the MoHSS because they focused mainly on one Directorate (PHC) to the exclusion of others.* o *The roll-out of integration was flawed because the sites were selected for integration without good criteria and they (UNFPA/PHC) went ahead without keeping PEPFAR/CDC and SPD informed so that implementation happened without proper consultation and buy-in.* o *Internally, PEPFAR and CDC feel that the biggest threat to a positive response to the epidemic has been the way that integration has been rolled out. The main issue is that there was not adequate buy in from people with clinical experience in how HIV services are delivered.* o *PEPFAR/CDC feel that: "if you ask people at the integrated clinics their opinion of integration they feel compelled to tell you what you want to hear.* o *The pilot study in seven districts pointed to some benefits from integration but they (PEPFAR/CDC) severely question the methodology used. In their view, the positives noted in the studies are outweighed by negative impacts on HIV/ART services.* o *In some sites they actually see the level of viral suppression going backwards."*	• Interview with PEPFAR/CDC
• *"There have been issues raised by some partners about problems in some facilities apparently caused by integration and as a result, following the August 2018 meeting noted below, **the MoHSS decided to carry out a rapid assessment**. Specifically, PEPFAR/CDC reported that performance data was declining in some facilities, although they did not share the actual data."* • *"In response to these issues, the MoHSS called a **meeting in August of 2018** which included:* o *MoHSS – DSP* o *MoHSS – PHC* o *UN* o *USG."* • *"There is an agreed ToR for the rapid assessment which will be funded by UNFPA with the hiring process almost complete and the work to start soon."* • *"The concept of integration still has strong support within the MoHSS and still shows real benefits for both patient care and efficient use of staff resources. All participants in **the August 2018 meeting recognized the need for better communications**."* • *It is important to note that integration is not somehow the result of only a UNFPA agenda [as indicated by PEPFAR/CDC]. **Integration is the accepted regional strategy as approved by SADC Ministers of Health and has been adopted as a national strategy by Namibia**. The problem is largely one of communication, especially between DSP and PHC. It was much better during the pilot phase when they had a steering committee chaired by MoHSS and with*	• Interview with Staff of UNAIDS, Windhoek

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participation by DSP and PHC and by UNFPA and UNAIDS as well as the Global Fund and PEPFAR/CDC on behalf of the USG. Continuation of the steering committee during the roll-out phase would have been a much better strategy. ***The re-activation of the Steering Committee on Integration was a recommendation of the Health Development Partners****."* • A key issue has always been the need for continuous training.	
• *"**PEPFAR/USG is clearly pushing back hard against integration**".*	• Interview with Staff of UNCT member, Windhoek
Challenges and Lessons Learned in the Process of Integration Raised in Interviews and Observed During Site Visits in Windhoek and Oshikoto	
• *"At first, providing the services was very challenging and hectic,* ***it took a couple of years to master the integrated approach****, there is, however, a set of* ***ongoing challenges***:" o **HIV counselling** involves addressing deep social problems, it is not just a biomedical issue. o The staff need to spend a considerable amount of time with HIV positive clients on counselling which makes it more difficult to maintain shorter wait times for other clients. o The need to fill out separate **disease registries** and maintaining separate client care booklets for PREP and ART patients presents a major burden. Setting up the record keeping for a new HIV patient takes about 40 minutes and is a considerable investment of staff time. o There is currently a **shortage of injectable contraceptives** across the country and condoms are currently out of stock in the clinic which makes it difficult to maintain the full package of services. o **Infrastructure and space** is a problem, the clinic has two structures for service delivery, one of which is a modified caravan and space is very limited.	• Interviews and site visit to the NAPPA Okuryangava Clinic, Windhoek
• *"**Integration works well is some areas but in other areas of practice it is not working well** at this clinic:"* o **ANC services** are in high demand, and there are long waiting lines, especially for first time clients o Not all staff are trained in HIV testing but some are. If **all nurses were trained** and had **access to equipmen**t the model would be more effective o **Waiting for long periods** for a doctor results in some patients leave without receiving their medicine. o **Staff and equipment shortages** are the biggest challenges faced by the clinic. For the implementation to work well they need more staff and equipment in each room. o Data management is a major challenge. There are separate patient registers for ANC, PMTCT, ART, PREP.etc	• Interviews and site visit observations: Khomasdal Health Centre, Windhoek
• "*While this particular clinic has adequate space, the key problems are* ***shortages of equipment*** *and* ***gaps in the training of staff*** *to provide a range of services*:" • *The main factor keeping HIV/ART services separate is* ***the lack of training for nurses, especially in NIMART****.* • *Integrating family planning is made harder by the* ***current stock-outs of injectables and oral contraceptives****, they now have only one-month supply of oral contraceptives.* • *They do have enough staff but their main problem is* ***equipment: blood pressure monitors, autoclaves, ECG machines, sonar, weighing scales.***	• Interviews and site visit: Maxulili Clinic, Okahandja Park, North Windhoek

Assumption 1.3: As a result, HIV, SRHR and SGBV services and interventions have been integrated both in health service delivery settings and in behaviour change and communications efforts, especially in relation to contraceptive services and family planning, including for EMTCT.	
• ***Record keeping is a major problem**. Nurses have difficulty tallying the numbers in separate registers and as a result record keeping is not of good quality. Nurses concentrate on providing services, not on maintaining the registers.*	
• *"Some service providers are reluctant to deal with HIV and ART. Similarly, the medical teams in the clinics can be reluctant to take on new responsibilities. However, when they receive training and mentoring staff are able to overcome their fears. There are **weaknesses in pre-service education for nurses**, so with integration there is need to start with reforming the curriculum for training nurses."* • *"There were problems in **viral suppression for ART clients** when they first started the integrated system. From a starting point of 94 percent, the level of viral suppression declined to 83 percent at first but then rose back to 94/95 percent as the system stabilized. There were many new aspects to the integrated system both for the service providers and the community. Health centre staff needed to **work with community members to make them comfortable** with the new system. The period of disruption lasted from July to September 2018 but has since fully recovered."* • ***Data management** is a real challenge. Some patients were lost in the transition in terms of data. ART booklets were not being filled out.* • *There were reportedly **some declines in outcomes for focused ante-natal care and the treatment of high-risk pregnancies.** In keeping with this finding, there is a need to ensure that other, non-HIV specialties such as focused ANC are not negatively impacted by integration. Having a mentor for these other areas of practice is also a real need.*	• Interviews and site visit to the Onandjokwe Intermediate Referral Hospital and the Onandjokwe Primary Health Care Clinic, Oshikoto Region. Interviews included facilities staff and members of the District Health Management Team

• *"**Equipment is a problem**, even though the Health Centre received a special allocation of equipment during the pilot phase, they have not been able to replace or repair equipment as needed due to lack of funds."*
• *"**Staff rotation** within the service is a major problem making it necessary to provide in-service training on a more or less constant basis but funds are lacking. When integration first started at the centre, all staff received the necessary training but when new staff come, they also need training."*
• *"A major challenge is the issue of **record keeping**. The senior nurse in charge used to go through the registers at the middle of the month and correct obvious errors and verify the number with the administrative assistant."*
• *"The health centre also has a problem with **stock-outs, especially for family planning**. At the time the evaluation team visited the stock-outs were reported for:*
  ○ *Injectable contraceptives (roughly one month's supply)*
  ○ *Oral contraceptives*
  ○ *Some ARVs (combination ARVs specifically).*
In response to stock-outs they try to borrow from other facilities and pay them back when the situation is reversed. They use a WhatsApp group of facilities to coordinate on this."
• *"There is a continuous **need for effective supportive supervision** from the district and regional office which has not been provided recently but was there during the pilot phase."*
	• Interviews and site visit: Okankolo Health Centre, Onandjokwe Health District, Oshikoto Region

Assumption 1.4: UNFPA has supported effective efforts to strengthen the management of supply chains for male and female condoms and lubricants (including in humanitarian settings).	
Indicators: • Key informant experience and opinion regarding extent to which national capacity in supply chain management (SCM) for HIV-related SRHR commodities (e.g. male and female condoms and lubricants and STI medications) has been enhanced • Reported results on UNFPA support to SCM – including volumes of procurement over time • Experience and views of supply chain managers at national and district level	
Observations	**Sources of Evidence**
• The NSF for the HIV and AIDS Response makes specific reference to the need to improved **condom prevention and distribution**: o *"The objective is to strengthen condom programming, promotion and distribution of both male and female condoms, and promote consistent and correct use. During the implementation of the NSF, it is anticipated that advocacy will be intensified to increase the use of condoms with the last sexual partner at high risk sex from 74.7 percent (2013) to 90 percent by 2022."*	• Republic of Namibia, MoHSS, Directorate of Special Programmes, *National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22,* p.23
• CO staff did not indicate significant efforts to support the strengthening of supply chains for condoms and lubricants. A review of project workplans and monitoring data **did not identify budgets or expenditures relating to Supply Chain Management (SCM)**	• Interviews with UNFPA CO in Windhoek • UNFPA Namibia, Project Monitoring Data, 2016, 2017 and 2018.
• *"In Namibia the **national government is responsible for procuring 100 percent of all condoms**. There is a national factory for condom production and the factory is trying to achieve WHO/UNFPA pre-qualification but so far with no success." There are political issues around the condom factory and apparently some **issues with quality control**. The Ministry is trying to re-brand the locally produced condoms.* • ***UNFPA and MoHSS collaborate annually in condom planning** and UNFPA is the only source of female condoms in the country. There are two different planning processes for quantifying the national condom requirement: one for HIV prevention and one for Family Planning but they rely on a single, integrated supply chain.* • *Where they do sometimes run into supply chain problems is not in importing and shipping to the Central Medical Stores (CMS). Rather **the CMS needs to have a better distribution plan**.* • *Condoms procured by MoHSS are provided free at **health facilities and other outlets** including distribution through NGOs but other branded condoms are also available at shops at a cost to interested users."*	• Interview with DSP, MoHSS
• Under its 37 million USD grant to Namibia for 2018-2020, the **Global Fund is providing "*a small amount*" to support condom purchases** channelled through the Directorate of Special Programmes of MoHSS. It is also providing support to the Central Medical Stores to **help improve infrastructure and support Supply Chain Management (SCM).**	• Interview with the Global Fund Programme Management Unit, MoHSS

Assumption 1.4: UNFPA has supported effective efforts to strengthen the management of supply chains for male and female condoms and lubricants (including in humanitarian settings).	
• *"With regard to family planning commodities and integration, there is a problem as the national government is currently **out-of-stock of injectables** and there are **shortages of condoms** in some clinics. At the moment NAPPA clinics have only oral contraceptives."*	• Interview with NAPPA, Windhoek
• Staff at all five health centres visited by the evaluation team raised the issue that **integration of family planning services into SRHR/HIV is currently made more difficult by shortages and stock outs of family planning commodities**, most importantly stock-outs of injectable contraceptives but also including condoms. Only oral contraceptives seemed to be in good supply in all five sites.	• Interviews and site visits: NAPPA Khomasdal Health Centre, Windhoek; Maxulili Clinic, Okahandja Park, North Windhoek; Onandjokwe Intermediate Referral Hospital and the Onandjokwe Primary Health Care Clinic, Oshikoto; Okankolo Health Centre, Onandjokwe Health District, Oshikoto Region

Assumption 1.5: UNFPA has effectively supported efforts to operationalise comprehensive condom programming at global, national and sub-national levels, with emphasis on promotion of the triple protection (HIV, STI and unwanted pregnancies) while encouraging engagement by the private sector – and these have been linked to other initiatives and programmes in HIV such as HIV testing and counselling.	
Indicators: • National HIV, SRHR and SGBV strategies include reference to Comprehensive Condom Programming (CCP) and its goals/targets • National programmes and strategies address the enabling political and social environment for demand, access and utilization of male and female condoms • Results reports and evaluation findings on CCP programmes in case-study countries • Views of national health authorities • Views/experience of non-governmental service providers, including private sector firms • Views of service providers in government health facilities • Experience of selected clients	
Observations	**Sources of Evidence**
The NSF refers to **condom programming under the heading of Combination Prevention** as one of four key service elements: Condom Prevention and Distribution, Voluntary Male Medical Circumcision (VMMC), Pre-Exposure Prophylaxis (PrEP) and Prevention of Mother to Child Transmission (PMTCT). It does not make a specific reference to Comprehensive Condom Programming.	• Republic of Namibia, MoHSS, Directorate of Special Programmes, *National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22,* p.11.
The main UNFPA supported activity in relation to condoms has been financing campaigns on condom use by young people: **"Condomize".** In 2018, the CO budgeted 47,848 USD for financing condom use campaigns aimed at youth in Namibia with an eventual expenditure of 34,868 USD. The funds were allocated from the UNFPA Namibia UBRAF allocation for the year.	• UNFPA Namibia, *Project Monitoring Data, 2018*
UNFPA and Condom Programming • *"When USAID/PEPFAR focused so much on clinical care **it drew resources away from prevention, including condoms.***	• Interview with SFH, Windhoek

Assumption 1.5: UNFPA has effectively supported efforts to operationalise comprehensive condom programming at global, national and sub-national levels, with emphasis on promotion of the triple protection (HIV, STI and unwanted pregnancies) while encouraging engagement by the private sector – and these have been linked to other initiatives and programmes in HIV such as HIV testing and counselling.	
• *UNFPA was very active in advocating for lubricants to be included in condom programming, it also works with government on condom policies, programming, campaigns and behaviour change communication* • *UNFPA funded AfriYAN in a "Condomize" campaign but it needs to be more actively promoted."*	
Assumption 1.6: UNFPA has effectively supported knowledge development and dissemination at global, regional and national level as well as supporting lessons learning and south-south cooperation on strengthening bi-directional linkages and integrating HIV, SRHR and SGBV services.	
Indicators: • Quantity and type of knowledge products at global, regional levels • Quality of global knowledge products • Dissemination activities: volume and frequency; reach • Reported use of global knowledge products at regional/country level • Extent of collaboration with HIV research community	
Observations	**Sources of Evidence**
• *"At the national level, stakeholders were engaged through the conduct of an initial rapid assessment and through committee meetings. UNFPA and UNAIDS key informants reported that MoHSS convened a* ***technical committee with a policy and strategic focus*** *in order to vet and discuss processes and next steps, and other interventions such as evaluations which needed to be brought for discussion and approval before endorsement by MoHSS. This committee has been engaged in at least two technical consultation meetings per year conducted with all structures and stakeholders. Site visits to facilities were also conducted, and guidelines were drafted for implementation of linkages and integration of SRHR and HIV."*	• UNFPA and UNAIDS, *Evaluation of the United Nations Population Fund and the Joint United Nations Programme on HIV/AIDS Project on Sexual and Reproductive Health and Rights and HIV Linkages: Country Report, Namibia.* (June 2016), p.5.
• *"****Namibia will serve as a model country*** *[*During 2gether 4 SRHR*] for other countries to learn from and is being twinned with Uganda for South-South exchange."*	• UNFPA/UNAIDS/UNICEF/WHO S*trengthening integrated sexual and reproductive health and rights (SRHR), HIV and Sexual and Gender-Based Violence (SGBV) services in East and Southern Africa (ESA). A Joint United Nations Regional Proposal.* Annex E. p.2.
• *"Through internal knowledge sharing,* ***countries were able to share information, learn and adapt approaches, tools and resources****, to strengthen their country programmes. The sharing of knowledge and experiences were facilitated by the Regional Offices of UNFPA and UNAIDS who brought technical expertise and continually shared the latest evidence around integration."* • *"Namibia developed a journal article that* ***documents the experience*** *of the Epako Clinic in using integrated services."*	• UNFPA and UNAIDS. *The Joint United Nations Population Fund (UNFPA) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) Project on Sexual and Reproductive Health*

Assumption 1.6: UNFPA has effectively supported knowledge development and dissemination at global, regional and national level as well as supporting lessons learning and south-south cooperation on strengthening bi-directional linkages and integrating HIV, SRHR and SGBV services.	
	Linkages in Ten Countries in East and Southern Africa: Final Programme Report. 2018, p.28
• *"During the first phase of the regional programme on integration, activities in Namibia were coordinated by a "**National Steering Committee on SRHR/HIV Integration** chaired by the Director of Primary Health Care (PHC), MoHSS and including representation by the MoHSS Directorates of Primary Health Care and Special Programmes as well as UNAIDS, UNFPA, and PEPFAR/CDC."*	• UNFPA and UNAIDS. *The Joint United Nations Population Fund (UNFPA) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) Project on Sexual and Reproductive Health Linkages in Ten Countries in East and Southern Africa: Final Programme Report.* 2018, p.11
• *"The **National Consultation Meeting on the Joint SRHR/HIV/GBV Integration** and Validation Meeting for SRHR/HIV/GBV Tools brought together all 14 Regional Health Teams along with national level staff of UN partners to review experiences, understand the bottlenecks, and develop clear scale-up plans for ensuring a majority of primary health care facilities and ART centres will be providing integrated services by 2020."*	• Republic of Namibia, MoHSS, *National Consultation Meeting on the Joint SRHR/HIV/GBV Integration and Validation Meeting for SRHR/HIV/GBV Tools. 26th-28th March, 2018: Meeting Report,* p. 4.
• *"Health facilities in Oshikoto Region are referred to Okankolo Health Centre as a **model for how integration can be implemented** and how it can improve services."*	• Interviews and Site Visit. Okankolo Health Centre, Onandjokwe Health District, Oshikoto Region.
Assumption 1.7: Linkage and integration of HIV, SRHR and SGBV has contributed to improved quality-focused and client-centred services and has resulted in increased access by the most-at risk, marginalized and vulnerable, and notably key populations. Including in humanitarian settings.	
Indicators: • Observed improvements in client centred services as reported by key informants • Client centred service observed during site visits to service delivery points • Experience/views of organisations representing women, adolescents and youth and key populations • Improvements in access monitored in programme results reports • Increased use of services reported in health information statistics systems (DHIS2) • Client satisfaction survey results such as the UNFPA Supplies annual surveys • Where available, secondary data on aspects of service integration identified in the IAWG indicator list: - HIV counselling and testing and family planning integrated - Knowledge of HIV status - Met need for contraception - Sex worker access to services MSM access to services	

Assumption 1.7: Linkage and integration of HIV, SRHR and SGBV has contributed to improved quality-focused and client-centred services and has resulted in increased access by the most-at risk, marginalized and vulnerable, and notably key populations. Including in humanitarian settings.	
Observations	**Sources of Evidence**
• *"Key informants reported an increased proportion of clients being tested for HIV due to the provision of Provider Initiated Counselling and Testing (PICT) and that out-patient screening and follow-up has increased, and focused ante-natal care follow-up had increased by 45 percent."*	• UNFPA and UNAIDS, *Evaluation of the United Nations Population Fund and the Joint United Nations Programme on HIV/AIDS Project on Sexual and Reproductive Health and Rights and HIV Linkages: Country Report, Namibia.* (June 2016), p.17.
• *"Clients who completed the client exit interviews had varying perceptions of the quality of the services they received. Just under two thirds (65.1 percent) rated services as either good (15.4 percent) or very good (48.7 percent). These ratings are corroborated by the findings from Focus Group Discussions, where female clients reported that services were delivered at a high level of quality."*	• UNFPA and UNAIDS, *Evaluation of the United Nations Population Fund and the Joint United Nations Programme on HIV/AIDS Project on Sexual and Reproductive Health and Rights and HIV Linkages: Country Report, Namibia.* (June 2016), p.20.
• *"Female clients in the Focus Group Discussions reported that receiving integrated services saved them time and transport costs, and reduced discrimination against HIV testing and PLHIV. Female clients also noted that they preferred the facility because of proximity, affordability and reduced wait times in comparison to other facilities."*	• UNFPA and UNAIDS, *Evaluation of the United Nations Population Fund and the Joint United Nations Programme on HIV/AIDS Project on Sexual and Reproductive Health and Rights and HIV Linkages: Country Report, Namibia.* (June 2016), p.22.
• At the National Consultation Meeting on the Joint SRHR/HIV/GBV Integration Programme in March, 2018, the Family Health Programme, Directorate of Primary Health Care, MoHSS presented findings on the results of the seven pilot health facilities supported in the first phase of integration. The reported results were as follows: o Client waiting times reduced by 35.1 percent (4 hours 51 minutes to 3 hours and 9 minutes) o Time in waiting in consultation room to receive ANC services reduced by 31.2 percent to 36 minutes. o Productivity improved from 0.9 to 1.94 clients per nurse, per hour. 53.6 percent. o The number of ANC clients per month increased by 4.5 percent. o The number of **first-time Family Planning visits increased by 14.7 percent**. As most first-time family planning visits are by **adolescent girls and young women this implies increased access** by this group. o The number of routine ARV refills increased from an average of 654 per month to 761 per month. o Improved client/nurse communications and self-reported reduced stigma. o Improved accessibility of services with all services provided Monday to Friday o A focus on the person/client and not "the disease"	• Republic of Namibia, MoHSS, *National Consultation Meeting on the Joint SRHR/HIV/GBV Integration and Validation Meeting for SRHR/HIV/GBV Tools: Meeting Report.* March 2018, p. 8.

Assumption 1.7: Linkage and integration of HIV, SRHR and SGBV has contributed to improved quality-focused and client-centred services and has resulted in increased access by the most-at risk, marginalized and vulnerable, and notably key populations. Including in humanitarian settings.	
○ Improved nurse workload satisfaction.	
• Benefits for clients from the integrated SRHR/HIV model in Namibia: ○ 1. Improved efficiency through better use of the limited number of nurses available. ○ 2. Clients no longer denied health services because they are not scheduled on a given day ○ 3. Saving money and time for clients who reduce the number of repeat visits to facilities ○ 4. Increased nurse job satisfaction ○ 5. Reduced stigma and discrimination which in turn can increase adherence, reduce loss to follow up and increase use of clinics closer to the client's home ○ 6. Improved quality of care as trust is built between the client and the care giver ○ 7. Improved quality of health information ○ 8.Smooth client flow ○ 9. Increased client satisfaction ○ 10. Increased service uptake.	• Republic of Namibia, MoHSS: *The Namibian Primary Healthcare Integration Model: Rationale for Scale-Up for Policy Makers.*2018, p.4
• *"The one room, one nurse, one client is an interesting model and it can be effective. It allows full utilization of, for example, HIV/ART nurses and broadens the work experience of other nurses."*	• Interview with Staff of the UNFPA CO
• "*Integration is the main and best strategy for addressing Sexual Gender-Based Violence (SGBV) whether in health services or in and out of school settings. The Ministry's focus on SGBV is maintained by ensuring that it is well covered in their Comprehensive Sexuality activities but it is important that health service providers are integrating SGBV recognition and response into their service protocols*."	• Interview with MYSNS
• *"In particular, the assessment of the pilot showed that integration encouraged young people to access HIV prevention and treatment services and to get tested and know their status. The one nurse, one room, one client model also helped to build rapport between service providers and their clients."*	• Interview with DPHC, MoHSS
• *"UNFPA support to the development of a manual explaining the linkages between SGBV and access to HIV testing and treatment including ART should help health service providers recognized SGBV effected clients and provide them with more client-centred care."*	• Interview, MECW
• "*The community needs good access to confidential testing and that is best done through integration – integration would give them more access to testing. However, the key factor in accessing testing and treatment for the community is the knowledge that a given health centre has a nurse or other service provider who treats them with sensitivity and respect.* • *"Not all health facilities/partners have well trained with staff who are friendly – unlike SFH and NAPPA where they are friendly. In the first instance there might be a self-test done with the client (in an integrated facility). This would be followed by a confirmation test in another place. It is important that the person involved not be seen to move to the confirmation test because then it is assumed that they are HIV positive. It is better if the nurse takes the test sample to the separate site for confirmation [Note: In all health facilities the Evaluation Team visited testing and counselling were done separate from other functions]"*	• Interview with Out-Right Namibia

Assumption 1.7: Linkage and integration of HIV, SRHR and SGBV has contributed to improved quality-focused and client-centred services and has resulted in increased access by the most-at risk, marginalized and vulnerable, and notably key populations. Including in humanitarian settings.	
• *"MoHSS worked with NAPPA to provide a nurse to work in their drop-in centre and provide clinical services. The idea was to have a centre where LGBTI people could come and get tested and treated for HIV but people did not come because of stigma. It would have been better to have a full-service clinic so that people could come and begin with an innocuous problem like a headache and only later would they get around to HIV. NAPPA had to withdraw its funding because of its own funding issues and because attendance was too low. It would be better to have an integrated clinic so community members would not know you were coming for testing."*	
• *"Integration needs to include more SGBV but it does allow them to spend more time with the client and thereby to build rapport and trust. This is especially important for young people and for key populations."*	• Interview with NAPPA, Windhoek
• "*Khomosdal clinic in Windhoek for example is one of seven full-service clinics with real specialization: ART services, cervical cancer screening, CD4 count testing, Nurse Initiated Management of ART (NIMART) – a certain cadre of the nurses in the clinic do all the ART/HIV. Under the integrated model as now implemented there are nurses without NIMART training doing that poorly. At times people who should be on second-line treatment are placed on first-line treatment*."	• Interview with PEPFAR/CDC Windhoek
Observations and Interview Results Regarding Improved, Client-Centred Care and Integration: Site Visits to Health Centres in Windhoek and Oshikoto Region	
• The fact that **PREP and ART are given in the same room helps reduce stigma** as clients may be visiting the screening room for either purpose. • After two years using this modified integrated approach the nurse in charge finds she has a stronger and **closer relationship with clients**. • Delivering integrated services on a daily basis helps **staff keep their skills level high** • Originally trained as an HIV specialist the nurse in charge is now able to stay up to date on ANC, FP, Key Populations	• Interviews and Site Visit to the NAPPA Okuryangava Clinic, Windhoek
• If the elements of **training, equipment and space** are addressed, integration can have a very good effect • The principle is sound: provide the client with services they need in the same place, available every day from the same providers. However, this is dependent on resolving the challenges already identified: space, equipment, need for continuous training, improved **pre-service training, improved mentoring and supportive supervision** in key specialty areas such as Nurse Initiated Management of ART (NIMAT)	• Interviews and site visit: Khomasdal Health Centre, Windhoek
• The eventual goal is to integrate all services (ANC/HIV/Vital Signs, etc.). • Staff are able to develop a **stronger relationship with clients** because they interact with them on a regular basis.	• Interviews and site visit: Maxulili Clinic, Okahandja Park, North Windhoek
• Under the new system the **workflow has improved**. • As noted by the District Nurse Manager, *"when we first started with integration it was a big problem for nurses going to external clinics but after a lot of training, nurses sent to the external clinics are able to do much more than ART. Similarly, **all nurses are now trained in ART**. This improves the effectiveness and the quality of client services at the clinics and outreach posts. In the past it was difficult to assign ART specialist nurses as back up to outreach sites as they lacked skills in other areas."*	• Interviews and site visit to the Onandjokwe Intermediate Referral Hospital and the Onandjokwe Primary Health Care Clinic, Oshikoto Region. Interviews included facilities staff and members of the District Health Management Team

Assumption 1.7: Linkage and integration of HIV, SRHR and SGBV has contributed to improved quality-focused and client-centred services and has resulted in increased access by the most-at risk, marginalized and vulnerable, and notably key populations. Including in humanitarian settings.	
• It is very important to provide ongoing **mentoring and refresher training**. Under a USAID funded Technical Assistance Programme, 1 nurse mentor is funded for each district in the region. The nurses in all 11 sites (six high volume and five low volume for ART) are supported with mentoring under the programme. • Nurses do develop **better relationships with the clients** based on repeated contacts using the integrated model.	
• The health centre has seen an **improved uptake of HTC** and has been able to provide greater emphasis and support to the need for **dual protection** (for family planning and for protection from HIV). • Before integration services were provided on specific days which made it difficult for the clients to know for sure they would receive services after travelling long distances. Now **all services are provided from Monday to Friday**. • In the past, few nurses were involved in ART and the knowledge was not shared with other nurses. Now **all the nurses are involved** and, though it is challenging, they find it more rewarding as well. • Also, HIV patients now receive services from the same provider in the same room and are not moving from room to room carrying their own, conspicuous HIV file (with a blue border). • **Clients do report they are more satisfied** – they know their nurse and are able to build relationships. They are also more vocal about their systems and their needs after building up their trust in the nurse they see regularly. • The **Community ART Referral Groups (CARG) have helped to reduce stigma in the communities** which means that clients who are HIV positive are less likely to be subject to stigma when visiting the health centre.	• Interviews and site visit: Okankolo Health Centre, Onandjokwe Health District, Oshikoto Region

Area of Investigation Two: Extent UNFPA support to the HIV response corresponds to the needs of most vulnerable and at risk populations	
Evaluation Question 2: ***To what extent has UNFPA support to HIV strategies and programmes contributed to meeting the needs of at risk, most vulnerable and marginalized people especially (but not exclusively) adolescents and youth, key populations, women and persons with disabilities?***	
Evaluation Criteria	*Relevance, Effectiveness, Efficiency*
Rationale	UNFPA has joint leadership under the UNAIDS division of labour for the prevention of HIV infection among adolescents and youth and key populations. In addition, UNFPA Strategic Plan, 2018 - 2021) and the guiding principles for UNFPA action in HIV emphasize the principle of No-One Left Behind, and the requirement to focus on meeting the needs of those at risk of HIV infection and most vulnerable.

Assumption 2.1: UNFPA has been effective in promoting and supporting national HIV strategies and programmes which *prioritize the needs of adolescents and youth, key populations and women for access to integrated HIV, SRHR and SGBV services (*while recognizing the changing nature of the epidemic and its implications) and emphasize the use of quality condoms and lubricants for HIV prevention. This includes meeting the needs of those marginalized for social and economic reasons other than age, gender or membership in a key population.

Indicators:

- National HIV strategies, action plans and programmes incorporate policies and promote approaches prioritizing needs of adolescents and youth, women and key populations
- Operational guidelines for HIV, SRHR and SGBV programming include measures specifically targeted to meeting needs of adolescents and youth/women/key populations for HIV prevention
- National strategies and programme documents make specific reference to the evolving nature of the epidemic and its implications for changing needs of adolescents and youth/women/key populations
- Where available, reported changes in national strategies, action plans, programmes and service guidelines to reflect changes in the epidemic

Observations	Sources of Evidence
UNFPA Namibia Budgets and Expenditures Focused on Meeting the Needs of Adolescents and Youth and Key Populations • UNFPA Namibia has directly supported programming for meeting the SRHR and HIV needs of adolescents and youth mainly through two large sources of funding: the **Regional Safeguard Young People Programme** (SYP) and (commencing in 2018) funding from **the UNAIDS Joint Programme** Unified Budget, Results and Accountability Framework (UBRAF). • From 2016 to 2018, UNFPA Namibia expenditures under the **SYP programme totalled 433,083 USD** (2016=135,384 USD, 2017 = 110,855 USD, 2018 = 186,844 USD. SYP programme funds were spent by four organizations: The Ministry of Youth, Sports and National Service (MSYNS); The Ministry of Education, Arts and Culture (MEAC) the Namibia Planned Parenthood Association (NAPPA) and UNFPA Namibia. • **In 2018, UBRAF expenditures by UNFPA Namibia amounted to 55,942 USD** (from a budget of 92,953 USD). The UBRAF funding was disbursed through four implementing agencies: MoHSS, NAPPA, the Society for Family Health and UNFPA. **In 2019, the budget for UBRAF funds for UNFPA Namibia was 101,946 USD**. UBRAF expenditures in both years were allocated mainly **to enhancing access to condoms for young people** (including "Condomize" campaigns), and for meeting the needs of key populations. • The **2019 budget year saw a major increase** in UNFPA Namibia budgets allocated to meeting the SRH/HIV/SGBV needs of adolescent and young people and of key populations. The SYP budget for 2019 is 130,000 USD but this has been augmented by two large projects focused on Adolescents and Youth: o the YP1 project focuses on **knowledge and skills building** and has a budget of 301,346 USD. Implementing agencies include the Ministry of Youth, Sports and National Service and the One Economy Foundation which is the programming arm of the Office of the First Lady of Namibia.	• UNFPA Namibia CO Programme Expenditure Reports (2016/17/18)

Assumption 2.1: UNFPA has been effective in promoting and supporting national HIV strategies and programmes which *prioritize the needs of adolescents and youth, key populations and women for access to integrated HIV, SRHR and SGBV services (*while recognizing the changing nature of the epidemic and its implications) and emphasize the use of quality condoms and lubricants for HIV prevention. This includes meeting the needs of those marginalized for social and economic reasons other than age, gender or membership in a key population.	
○ the YP2 project focused on **Adolescent and Youth access to SRHR/HIV/SGBV services** and has a budget of 157,789 USD in 2019. The only non-UNFPA implementing agency is NAPPA but most of the budget is allocated to meeting staffing costs for UNFPA. • In addition, the 2019 UNFPA Namibia budget includes a **large allocation (172,848 US) to the Namibia Gender Equality project which includes many activities focusing on Gender-Based Violence**, (172,848 US). Non-UNFPA implementing agencies include the Ministry of Gender Equality and Child Welfare and Gender Links Namibia. • For details of UNFPA expenditures focused on meeting the needs of youth and adolescents and key populations, see Annex D.	
• **UNFPA Support to Adolescent Friendly Health Services in Phase 1 of the Linkages Programme** • Activities in Namibia included: ○ *"Support to the NAPPA clinic as the only pilot site designated to provide **adolescent friendly-health services** (supported by Sida funds)."*	• UNFPA and UNAIDS, *Evaluation of the United Nations Population Fund and the Joint United Nations Programme on HIV/AIDS Project on Sexual and Reproductive Health and Rights and HIV Linkages: Country Report, Namibia.* (June 2016), p.5.
National Commitment to Meeting HIV Needs of Young People and Key Populations • The NSF for the HIV and AIDS Response (2017/18 to 2021/22) sets out ten priority programme areas. Of these ten, two are concerned with the needs of adolescents and key populations. ○ **"*Adolescents and Young Women (AGYW)*:** *The strategic focus of the NSF is to ensure that AGYW who are not infected with HIV remain negative and those diagnosed with HIV are linked to care and treatment. Efforts will be made to identify AGYW living with HIV, and do not know their HIV status through differentiated HIV testing services. Special attention and focus will be on AGYW key populations. Programming for AGYW will take a life-cycle and human rights approaches, and will be age and gender specific. The implementation will also target geographical hot spots where unmet needs are high. For AGYW, the NSF suggests targeting regions with the most need. These include: Kavango East, Kavango West, Ohangwena, Omusati, Oshikoto, Otjozondjupa, and Erongo Regions."* ○ ***"Prevention Programmes for Key Populations:** The primary focus of NSF is Men Having Sex with Men (MSM) and Female Sex Workers (FSW). Activities will encourage these at risk groups to know their status and provide onward linkages to the treatment cascade."*	• Republic of Namibia, MoHSS, Directorate of Special Programmes, *National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22,* p.2
• For both Adolescent Girls and Young Women (AGYW) and key populations the NFS identifies objectives and key target populations.	• Republic of Namibia, MoHSS, DSP, *National Strategic Framework for HIV*

Assumption 2.1: UNFPA has been effective in promoting and supporting national HIV strategies and programmes which *prioritize the needs of adolescents and youth, key populations and women for access to integrated HIV, SRHR and SGBV services (*while recognizing the changing nature of the epidemic and its implications) and emphasize the use of quality condoms and lubricants for HIV prevention. This includes meeting the needs of those marginalized for social and economic reasons other than age, gender or membership in a key population.	

• **For AGYW**:
  ○ *"**Programme Objective**: To reach 90 percent of AGYW and their sexual partners in high-burden geographic locations with high impact HIV combination prevention and sexual and reproductive health (SRH) interventions to reduce new HIV infections by 2022.*
  ○ ***Target Population:** The primary target population is adolescent girls aged 10-24 yrs. Secondary target populations include: Sexual partners, Parents, School Counsellors, community gatekeepers, legal practitioners, law enforcement and health care workers." P.14*
• **For Key Populations (MSM):**
  ○ ***Programme Objective:** To target MSM with high impact HIV testing, prevention, treatment and care interventions necessary to achieve the fast-track targets i.e. 90-90-90 among the MSM by reaching them with combination prevention services by 2022.*
  ○ ***Target Population:** Primary target population: Men having sex with Men (MSM). Secondary target population: Law enforcement, health care workers, law makers.*
	and AIDS Response in Namibia 2017/18 to 2021/22, p. 14 and p.18

HIV Situation of MSM in Namibia • "*In 2014, Namibia conducted the Integrated Biological and Behavioural Surveillance Study (IBBS) among Men who have sex with other men (MSM). It is estimated that there are approximately 6500 MSM in Namibia. However, due to stigma and discrimination, this study may not show a representative figure. Unprotected anal sex puts MSM at a higher risk of HIV infection. Some MSM are also known to be married our in heterosexual relationships, in are in single-sex incarcerated environments or engage in transactional sex. ….. **HIV prevalence among MSM varies from 10.2 percent in Keetmanshoop, 7.1 percent in Oshakati, 10.1 percent in Swakopmund/Walvis Bay and 20.9 percent in Windhoek**. Each of these estimates are above the conventional five percent threshold used to define a "key population" at elevated risk of HIV….* *"**Disclosure of sexual orientation was associated with experiencing human rights abuses and discrimination** of minorities, leading to poor mental health outcomes, which lead to diminished HIV treatment outcomes (Zahn et al. 2013.)*	• Republic of Namibia, MoHSS, DSP, *National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22*, p.19
HIV Situation of Female Sex Workers in Namibia • *"According to the 2014 IBBS Study "Most female sex workers were found to be single women below 35 years and have never been married. In Katima Mullo, 46 percent of FSW were between 18 and 24 years. In recent years, there has been **an increase in the number of young girls engaging in sex work**. Most of the young girls engaging in sex work come from poor family backgrounds and dysfunctional homes, while others have been victims of sexual abuse. Anecdotal information also suggests that some men are selling sex. Data from the IBBS (2015) show that clients of*	• Republic of Namibia, MoHSS, DSP, *National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22,* p.19

Assumption 2.1: UNFPA has been effective in promoting and supporting national HIV strategies and programmes which *prioritize the needs of adolescents and youth, key populations and women for access to integrated HIV, SRHR and SGBV services (*while recognizing the changing nature of the epidemic and its implications) and emphasize the use of quality condoms and lubricants for HIV prevention. This includes meeting the needs of those marginalized for social and economic reasons other than age, gender or membership in a key population.	
sex workers, and their sexual partners including spouses are at higher risk of HIV infection. Female sex workers are 3.5 times more likely to be living with HIV than other women in the general population. ***HIV prevalence among FSW was estimated to be 52 percent in Katimal Mulilo, 31 percent in Oshikango, 37.3 percent in Swapkomund/Walvis Bay and 39.3 percent in Windhoek****. These rates are above the national HIV prevalence rates when compared to women of reproductive age."*	
UNFPA Support to Meeting Needs of Adolescents and Youth and Key Populations and Government Policy and Programme Response	
• UNFPA has supported the evaluation of **Life-Skills-Based HIV/AIDS and Sexuality Education** in Namibian Schools. • The Ministry of Youth has adopted the **"condomize"** model for campaigns and has accessed funding from the Global Fund. • For In-School CSE, UNFPA supported development of **on-line courses and a manual for Trainers**. • UNFPA also supported the adaptation of the SADC regional **manual for out-of-school CSE** [Confirmed by Ministry of Youth and Sport]. • UNICEF is the UNCT member working on issues relating to **adolescents living with HIV**. • UNFPA has focused on **skills-building and age-appropriate CSE** and has worked very closely with UNESCO on this issue. • SADC has developed an **Adolescent Girls and Young Women strategy** which focuses on HIV and was supported by UNICEF. • Under the Compact of Commitments, which accompanies the current country programme in Namibia, the programmes **UNFPA supports need to reach 60,000 adolescents and youth over five years**. **Key Populations** • They have supported the Society for Family Health (SFH) in training nurses on how to address the needs of key populations. • They have provided direct support to NAPPA and, through SFH, to organizations like Out-Right Namibia. • The CO worked with UNFPA East and Southern Africa Regional Office (ESARO) on the SADC strategy for Key Populations. **Persons with Disability** • They have been accessing separate funding through the headquarters of UNICEF, UNDP and UNFPA for a planned joint programme on disability. The division of labour would be: o UNDP – Governance and coordination o UNICEF – Early Childhood Development o UNFPA – SRHR for persons with disabilities.	• Interview with UNFPA CO, Windhoek

Assumption 2.1: UNFPA has been effective in promoting and supporting national HIV strategies and programmes which *prioritize the needs of adolescents and youth, key populations and women for access to integrated HIV, SRHR and SGBV services (*while recognizing the changing nature of the epidemic and its implications) and emphasize the use of quality condoms and lubricants for HIV prevention. This includes meeting the needs of those marginalized for social and economic reasons other than age, gender or membership in a key population.	
• UNFPA regionally was able to use the East and Southern Africa Ministerial Commitments (ESA) operationalized at a regional level and to use them as advocacy tools at country level.	
Ministry of Education, Arts and Culture – Key Populations • "*The job of the teacher is to create a **safe environment in the classroom** for all the students including LGBT students and those with a disability so they can participate fully in discussion and learning around CSE."* • "*Politicians in Namibia are **reluctant to have any "special" designation or treatment of LGBTI** learners but the HAM Unit and the Ministry are able to address their needs by relying on a set of **agreed principles**:* o *All forms of discrimination are banned, including discrimination based on sexual orientation* o *They have a mandate to eliminate drop-outs, including by LGBTI leaners* o *Dignity of the person and freedom from discrimination is protected by the constitution* o *All learners have a right to dignity* o *Pregnant AGYW have a right to education and cannot be excluded from the classroom."*	• Interview with the HIV and AIDS Management Unit, MEAC
Ministry of Youth, Sports and National Service (NSYNS) – Reaching Adolescents and Youth. • With UNFPA support MYSNS engage youth through use of the "**Condomize methodology**" • The programmes highlight the need to use condoms for HIV prevention and for FP • Through the use of drama and games programmes involve young people in **Behaviour Change Communication** activities. • Peer educators are invited by Life-Skills Education Teachers to give presentations in schools while the ministry also engages with university students by providing "condomize" activities in university settings. • UNFPA provided MYSNS with "Condomize" materials and methodology. • They also see an improvement in the number of adolescents and youth seeking services since the start of the "Condomize" campaigns.	• Interview with MSYNS
• UNFPA provides technical and material support to the MSYNS in its partnership with NAPPA to run **youth-friendly clinics in seven regions** in the country. • The nurses running the clinics were initial recruited by the MSYNS but due to logistical challenges were handed over to NAPPA. • The clinics provide **integrated SRH and HIV services**.	• Interview with MSYNS
• *"UNFPA supports MoHSS programming to address **disproportionate HIV infection rates in adolescent girls and young women** (AGYW)."* • ***"Funding from development partners is allocated to support programme implementation in different regions/districts of Namibia**. Funding from Global Fund targets certain districts while PEPFAR/CDC are assigned some districts and direct funding from government support the remaining health districts."*	• Interview with the DSP, MoHSS

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• *"**PEPFAR/CDC is supporting the DREAMS initiative** to address rising rates of infection among AGYW. While (as per the reports to the Global Prevention Coalition meeting in Nairobi in May 2019) infection rates are declining globally, the absolute number of infected AGYW is still rising. It is a real struggle to effectively re-engage around the problem of prevention. There is need to get back to investing in and emphasizing the problems of prevention and how to encourage behavioural change."* • *"Regarding key populations: the last IBBS was in 2014 and it did look at key populations. MoHSS have almost completed the field work for the new (2019) IBBS. It will look at prevalence and access to services for **FSW, MSM, Transgender key populations.** They expect data analysis to be completed in August and September 2019 but there is no date set for release of the data."*	
• "*There is a real **national emphasis on youth friendly health services** to be provided in all facilities – which is one rationale for integration. It is better for youth to be able to access all the SRHR/HIV/SGBV services in a single room. However, there is still a **challenge to overcome negative attitudes among service providers** when young people try to access SRHR services. Every adolescent in every facility must be able to access SRH services according to national policy."*	• Interview with the DPHC, MoHSS
• *"UNFPA has been pretty closely/actively engaged in support to key populations and to meeting the needs of Adolescent Girls and Young women but there is a perceived tension between the US-AIDS funded DREAMS program and the UNFPA focus on Comprehensive Sexuality Education CSE. **The DREAMS programme does not have a CSE component."***	• Interview with the Global Fund Programme Management Unit, MoHSS
• *"UNFPA support to the Ministry shifted in 2016. Before 2016, they had a component of the regional programme (Safeguarding Youth Programme - SYP) which included a **component for gender and SRH and female condoms** but that component was shifted over to the MoHSS after 2016 and the end of the SYP programme. In their view it is not given the same high priority in MoHSS as it was under the SYP."*	• Interview with the MGECW
• "There is a general agreement that all patients should be treated equally and that there should be no discrimination but **there is no acceptance that adolescents and youth and key populations may require a special effort to overcome barriers** but you cannot adequately address the epidemic without meeting their needs."	• Interview with NANASO
• "*The **Be Free/Break Free Initiative** was begun in 2016 after the First Lady became a Special Envoy for AIDS (UNAIDS). Under this initiative, the Office of the First Lady (OFL) reached out to youth-led organizations and reached over 10,000 young people, including young men, parents and professionals. The office convened panels of different stakeholders to examine HIV prevention among young people, especially AGYW. These included:* o *Youth led organizations* o *Social Workers* o *Police* o *Traditional Leaders*	• Interview with the One Economy Foundation, OFL

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○ *School Teachers* ○ *Parents."* • *"In these forums they deal with risky behaviour (oral and anal sex), non-use of condoms, abortion and also LGBTI rights*." *"The **OFL is a strong public advocate** for the requirement that public services and society as a whole need to be responsive to the needs of different communities including:* ○ *LGBTI persons* ○ *Commercial Sex Workers* ○ *Young people with disabilities* ○ *Tribal people* ○ *Young People in Nomadic Communities."* • On Friday May 24 2019 the First Lady hosted a public discussion with representation from Key Populations (see documentation provided).	
UNFPA Support to Meeting the Needs of Adolescents, Youth and Key Populations and the National Response: Civil Society Perspectives	
• *"UNFPA helps meet the needs of adolescents and youth by supporting **AfriYAN advocacy and CSE for out of school youth and adolescents**. HIV, SRHR and SGBV are seen as interlinked service for young people and adolescents. AfriYAN workshops are done in line with commitment by the Health and Education Ministers of East and Southern Africa (the ESAQ Commitments) and include Teenage Pregnancy, SGBV and HIV/AIDS* • *"UNFPA provides 60% of the funding for AfriYAN activities (Other partners include GIZ, the Global Fund and the Ministry of Education)"*	• Interview with the NYC and the AfriYAN
• ***AfriYAN has run 4-5 campaigns on HIV prevention for young people** in the last year (2018/2019). They also reached out to higher education institutions during campaigns – at the universities in Windhoek (Supported by UNFPA in working with university campaigns). AfriYAN are currently in discussion with UNFPA regarding efforts to return to university campuses with the "Condomize" type campaigns. This is part of a wider effort to scale-up the campaign to all 12 campuses of the University of Namibia. First in the 2 campuses in Windhoek and then with the other ten campuses across the country.* • *"The National Youth Council has been in discussions with UNFPA in 2019 on how to secure better access to SRH/HIV for blind and deaf young people. AfriYAN plans on having workshops with groups of **young people with disabilities**. In the National Youth Council they have an organization for youth with disabilities. However, there is a lot of urgent work which needs to be done to encourage young people with disabilities to become organized and seek better access to SRHR and to HIV prevention and treatment services.* • ***"The advocacy work of AfriYAN builds on the Ministerial Commitments for Eastern and Southern Africa** (SADC Ministers of Health, Education, Gender and Youth and Sports) around:*	• Interview with the NYC and the AfriYAN

Assumption 2.1: UNFPA has been effective in promoting and supporting national HIV strategies and programmes which *prioritize the needs of adolescents and youth, key populations and women for access to integrated HIV, SRHR and SGBV services (*while recognizing the changing nature of the epidemic and its implications) and emphasize the use of quality condoms and lubricants for HIV prevention. This includes meeting the needs of those marginalized for social and economic reasons other than age, gender or membership in a key population.	
○ *Teenage pregnancy* ○ *SGBV* ○ *HIV and AIDS."*	
• *"The major concern for their community (LGBTI persons) is not getting access to services for HIV/AIDS (including ART). The only focus of programmes like the **PEPFAR/CDC/MoHSS (DSP)** is getting and maintaining people on treatment. They **don't address the critical problems of LGBTI people regarding employment, shelter, emotional stability, nutrition** – unless these are addressed it is very hard for them to access services and stay on treatment.* • *"There is a focus on getting LGBTI community members on **Pre-Exposure Prophylactics (PrEP)** but then they might not take their medication because of lack of food or no place to stay. It is very hard for people to stay compliant when most have no place to stay, have no steady employment and, for many, are involved in sex work."* • *"Many programmes are focused on providing information on HIV and on treatment of HIV but very few address the **larger socio-cultural issues or the practical challenges**."*	• Interview with Out-Right Namibia
• *"NAPPA had support from PEPFAR for CSE under the Project Hope Programme but this had to be stopped because of the more stringent application of **the "gag rule"** by the current US administration. As a result, they have had to retrench the staff who were running the programme. PEPFAR/CDC is now supporting the DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) programme to provide SRH/HIV services to adolescent girls in government-run clinics."* • *"**NAPPA has very good relations with Out-Right Namibia** and opened a clinic in Windhoek at the Out-Right Namibia drop-in centre but it no longer functions. NAPPA currently operates a Saturday clinic in Windhoek for LGBTI people."*	• Interview at NAPPA Headquarters, Windhoek
• *"2019 is the first time that SFH entered into a direct agreement for support from UNFPA. An example of what they do under this agreement is conducting (in late May 2019) a two-day **training event for health workers on providing competent SRHR services to members of key populations** (in partnership with the Office of the First Lady). With the assistance of a consultant, SFH makes use of a standardized tool on training health workers in addressing SGBV, with the assistance of a Consultant. They also focus on the problem of intergenerational sex as well as on SGBV in the tertiary education sector and meeting the needs of young women."* • "*UNFPA assisted in the development of a **handbook for health providers** on identifying and providing **services to survivors of SGBV."***	• Interview with the SFH, Windhoek
• *"NAPPA used to operate an integrated drop-in centre at Out-Right Namibia. The country was looking at innovative ways to provide services and UNFPA was the only development partner willing to participate in supporting **a facility for LGBTI people.** This was the first time that a UN agency was willing to work with an organization representing key populations. **UNFPA is really an essential support for Out-Right Namibia**.*	• Group Discussion at a meeting of the Technical Working Group on Key Populations, Windhoek

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• *There is a **SADC Strategy for Responding to HIV among Key Populations** and it can be used for advocacy. UNFPA uses it to support evidence gathering and reporting but it (the Strategy) lacks practical mechanisms for implementation."*	
Adolescents and Youth • *"PEPFAR/CDC are agnostic as to how you should deliver Adolescent Friendly Health Services (AFHS) – it is not so much the process that matters (youth friendly corners or specific days for youth for example).What matters is **reaching adolescents girls and young women** with what works for them and they have had good results with the DREAMS programme approach. Peer driven programming seems to help preserve confidentiality and help youth gain the experience they need."* **Key Populations** • *There is a real **question around the best way to reach Key Populations**. Do you integrate services into the population with dedicated clinics etc. or do you integrate community members into regular services through careful case management? You can cascade care into a single service point but you have a lot of work to do to make it work for Key Populations.*	• Interview with the PEPFAR/CDC
• *"UNAIDS would like to see UNFPA take on a **strong role on advocacy for key populations**. This is squarely within their mandate as a UNAIDS co-sponsor. In particular, there is a gap regarding advocacy and services for commercial sex workers where not much seems to be happening. UNFPA could address this more forcefully*."	• Interview with UNAIDS Namibia
For Observations Regarding Youth Friendly Services and Services for Key Populations as Observed During Site Visits See Assumption 2.3	

Assumption 2.2: UNFPA has been able to advocate for and support the implementation of Comprehensive Sexuality Education (CSE) for in-school and out-of-school adolescents and youth (adolescents and youth) alongside behaviour change communications efforts aimed at adolescents and youth with the goal of preventing HIV infections.
Indicators: • Where available, survey results regarding changing knowledge of HIV causes and prevention among adolescents and youth (e.g. percentage of women and men aged 15-24 who correctly identify both ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission) • Experience and view of partners implementing interventions targeting adolescents and youth – including ministry of education staff responsible for formal and non-formal education • Guidelines and teacher training curricula for comprehensive sexuality education include HIV prevention components • Observation of adolescents and youth friendly service outlets for HIV prevention and SRHR • Experience and views of adolescents and youth attending service outlets

Assumption 2.2: UNFPA has been able to advocate for and support the implementation of Comprehensive Sexuality Education (CSE) for in-school and out-of-school adolescents and youth (adolescents and youth) alongside behaviour change communications efforts aimed at adolescents and youth with the goal of preventing HIV infections.	
Observations	**Sources of Evidence**
• The main vehicle for UNFPA Support to **Comprehensive Sexuality Education** has been the **Regional Safeguard Youth Programme** which has allowed UNFPA Namibia to provide significant technical and financial support to the Ministry of Youth Sports and National Service (MYSNS) and the Ministry of Education, Arts and Culture (MEAC) in support of CSE throughout the evaluation period. Annual UNFPA expenditures under SYP each year have been: o 2016: 135,384 USD o 2017: 110,855 USD o 2018: 186, 844 USD o 2019 (Budgeted): 130,000 USD	• UNFPA Namibia Project Monitoring Reports: 2016, 17, 18 and 19.
• The **CSE Framework for Out-of-School Young People** in Namibia was adopted, with UNFPA support from the applicable Regional Framework for East and Southern Africa. It contains three major sections covering eleven units with supporting material and workbooks for teacher trainers, for instructors and for learners. The sections and units include: o Section One: Who Am I? ▪ Unit 1: Values and Rights ▪ Unit 2: Adolescent Development ▪ Unit 3: Sexuality ▪ Unit 4: Gender Roles and Equality o Section Two: Where am I Going? ▪ Unit 5: Planning for the Future ▪ Unit 6: Relationships ▪ Unit 7: Communications o Section Three: How am I Going to Get There? ▪ Unit 8: Pregnancy ▪ Unit 9: Sexually Transmitted Infections and HIV ▪ Unit 10: Prevention and Risk Reduction ▪ Unit 11: Sexual and Gender-Based Violence • An examination of the material indicates that issues relating to adolescent and youth LGBTI and their rights as well as gender equality and both genders role in eliminating SGBV are dealt with clearly and directly in the content.	• Government of the Republic of Namibia, MEAC. *CSE Framework for Out of School Young People in Namibia.* 2016
UNFPA Support to CSE • *"UNFPA started its support in 2014/15 by providing financial and technical support to a **review of the Life Skills Syllabus**. It was a co-funder (along with UNESCO) of the development of teacher training manual for CSE as well*	• Interview with the HIV and AIDS Management Unit of the MEAC

Assumption 2.2: UNFPA has been able to advocate for and support the implementation of Comprehensive Sexuality Education (CSE) for in-school and out-of-school adolescents and youth (adolescents and youth) alongside behaviour change communications efforts aimed at adolescents and youth with the goal of preventing HIV infections.	
as on-line training modules (examples provided). Training was rolled out in 2015/16/17 and 18. UNFPA also supported effort of the Ministry of Education in community mobilization and engaging Parliamentarians to support the new CSE Curriculum." **Achievements** • "*The process of **institutionalizing CSE in teacher training is starting to take root** and many teachers are delivering the comprehensive CSE curriculum. Considerable work has been done at community level to engage community members, traditional leaders, police, Civil Society Organizations, students and teachers. The National School Health Task Force was established with similar structures established at regional and constituency levels."* **Challenges** • *"Resistance from community members (often organized at the urging of North American-based evangelical churches and groups)* • *Regional School Health Task Forces (supported by UNFPA) vary in terms of strength, participation, and level of activity* • *Considerable work needs to be done engaging with communities, UNFPA has helped them engage with organizations of rural pastors for instance.* • *The fact that Life Skills courses are not included in examinations for educational promotion so at times teachers take the time allocated to life skills (and CSE) to teach mathematics and other examinable subjects.* • *Systems strengthening at the regional level is urgently needed.* • *Data management and Education Management Information Systems need to be strengthened and to include indicators on CSE."*	
*"Another **key cause of risky behaviour is poverty**. Many young people engage in transactional sex because of poverty. An assessment in one northern region showed that teenage girls were supported by "sugar daddies" but that support went to the entire family of the girl. CSE cannot be effective in cases of acute poverty because the poorest Adolescent Girls and Young Women are not in school."*	• Interview with the DPHC, MoHSS
• *"There is an urgent need to end the **relative neglect of prevention** and to better ensure that young people have access to information and services (including CSE)."*	• Interview with the Namibia Network of AIDS Services Organizations
• *"It should be easy to reach AGYW because you have a clear government policy, good tools and manuals for CSE, the **My Future/My Choice curriculum** presents a real opportunity."*	• Interview with PEPFAR/CDC
Comprehensive Sexuality Education (CSE) • *"The closest area of **collaboration between UNESCO and UNFPA** is Comprehensive Sexuality Education (CSE). In general terms UNFPA is responsible for supporting out-of-school CSE while UNESCO supports in-school CSE. However, UNFPA has a big role (in partnership with UNESCO) in the promotion and support of in-school CSE. This role includes:*	• Interview with UNESCO Namibia

Assumption 2.2: UNFPA has been able to advocate for and support the implementation of Comprehensive Sexuality Education (CSE) for in-school and out-of-school adolescents and youth (adolescents and youth) alongside behaviour change communications efforts aimed at adolescents and youth with the goal of preventing HIV infections.

- *Curriculum development*
- *Teacher training and support to universities training teachers*
- *Review of the life-skills curriculum."*

- *"The CSE curriculum is integrated into the life skills programme of the Ministry of Education, Arts and Culture. UNFPA support to the Ministry of Youth, Sports and National Service, and to CSOs engaged in providing CSE to out-of-school adolescents and youth is a significant part of its activities."*
- *"The CSE curriculum is quite broad and includes **modules on HIV prevention and on the rights of LGBTI** community members."*

Challenges for Supporting CSE

- *CSE in Namibia faces some **important challenges**:*
  - *Life skills is not an examinable subject in school in Namibia so it is often assigned to a temporary teacher and sometimes the class-time which should be spent on life skills is dedicated to strengthening student performance in areas where they will be examined.*
  - *Schools in Namibia are assessed and rated based on student performance in examinations in subjects required for promotion (which life skills is not) with a negative effect on resources for life skills education (which includes CSE).*
  - *Not enough attention is paid to CSE in the pre-service training provided to teachers. UNESCO has helped MoE to develop a module for teacher training for CSE to be provided to student teachers in their final year of schooling.*

Assumption 2.3: National governments respond positively to UNFPA advocacy and technical support efforts by allocating resources, altering policies and implementing programmes intended to ensure access to effective HIV, SRHR and SGBV services that meet the needs of adolescents and youth, key populations, women – and other at risk and marginalized groups (also applies to evaluation question 3).

Indicators:

- Experience and view of partners implementing interventions targeting adolescents and youth/women/key populations
- Guidelines, service protocols and manuals for HIV prevention services integrated into SRHR address needs of adolescents and youth/women/key populations
- Level of national government funds allocated to comprehensive sexuality education for adolescents and youth.
- Examples of changes in policies and laws to include provisions for quality and human-rights-based HIV, SRHR and SGBV services that meet the needs of adolescents and youth, key populations and women
- Observation of adolescents and youth friendly service outlets for HIV prevention and SRHR
- Experience and views of adolescents and youth attending service outlets
- Observation of integrated HIV, SRHR and SGBV services targeted to adolescents and youth/women/key populations
- Experience and views of organisations representing (and led by) adolescents and youth/women/key populations).

Assumption 2.3: National governments respond positively to UNFPA advocacy and technical support efforts by allocating resources, altering policies and implementing programmes intended to ensure access to effective HIV, SRHR and SGBV services that meet the needs of adolescents and youth, key populations, women – and other at risk and marginalized groups (also applies to evaluation question 3).	
Observations	**Sources of Evidence**
• For general national government response to UNFPA advocacy and support to improved services for Adolescents and Youth and Key Populations see Observations for Assumption 2.1 pages 30-32	• See Sources of Evidence for Assumption 2.1 pages 30-32
Observations and Interview Results re: Services for Adolescents, Youth and Key Populations Services: Site Visits in Windhoek and in Oshikoto Region	
Adolescents and Youth • *"The clinic treats youth with respect and staff are known in the community for doing so. There used to be a strong stigma for youth using clinics but **CSE in schools has helped to reduce the stigma young people feel** so that they are more willing to use the clinic."* **Key Populations** • *"The clinic was known as a women's centre but MSM have been coming for HIV testing and when men come, they are usually given first preference. In 2018 there was a **Saturday programme for MSM and other key populations** but they had to close it for lack of funds."* • *"In the past three years the reaction of the general population to members of the LGBTI community has improved but these clients have **serious trust issues and many have mental health issues** and, crucially in other clinics, health services/staff are not well skilled in addressing the mental health needs of the community."*	• Interviews and site visit to the NAPPA Okuryangava Clinic, Windhoek
Adolescents and Youth • *"Adolescents and youth clients often want to see the same service provider each time because they **form a bond with a sympathetic nurse/health care provider**."* **Key Populations** • *"The main key population group they serve are MSM who come for testing and if positive want as rapid a service as possible to receive their ARTs and then leave. The **clinic staff received special training on how to provide services to members of key populations**. The one-day training was provided by a Consultant provided by the Society for Family Health. As with adolescents, key population members want to be served by the same nurse each time. The nurses get a reputation for **being sympathetic and understanding**."*	• Interviews and site visit: Khomasdal Health Centre, Windhoek
Adolescents and Youth • *"**The DREAMS programme has peer educators, social workers and health educators**. They attempt to promote health-seeking behaviours among adolescents and youth. The clinic has a DREAMS programme team on-site providing services to adolescents and youth but this is a separate organization from the clinic. The DREAMS programme team provides Adolescent Girls and Young Women (AGYW) with **family planning, HIV testing and counselling and interventions relating to SGBV.** DREAMS is operated by I-TECH an NGO based in the University of Washington which has operated in Namibia for a long time with PEPFAR support."*	• Interviews and site visit: Maxulili Clinic, Okahandja Park, North Windhoek

Assumption 2.3: National governments respond positively to UNFPA advocacy and technical support efforts by allocating resources, altering policies and implementing programmes intended to ensure access to effective HIV, SRHR and SGBV services that meet the needs of adolescents and youth, key populations, women – and other at risk and marginalized groups (also applies to evaluation question 3).	
• DREAMS staff indicated to the evaluation team that **HIV infection among Adolescent Girls and Young Women (AGYW) is very often a result of Sexual Gender-Based Violence**, which was confirmed by a scan of the register.	
Adolescents and Youth • "*In the past year, the health centre has begun **separating out adolescents and youth because of the DREAMS project** which is now operating at the facility and which uses its own pre-fabricated facilities. A problem with DREAMS is that nurses and peer counsellors are not always present as they go out for field work and then their clients have to see the nurses from the PHC Clinic (although DREAMS clients do seem comfortable with accessing regular clinic staff). However, when the DREAMS nurses are present their young clients do appreciate the services."* • The evaluation team examined some DREAMS log books and discussed them with peer counsellors – there are very frequent notations that **HIV and or pregnancy was a result of SGBV**. **Key Populations** • *"In a rural area like this one, people do not self-identify as members of key populations so they are less visible. It is important that the Society for Family Health (SFH) has done **work on values and culture to help care providers provide professional services to key populations.**"*	• Interviews and site visit to the Onandjokwe Intermediate Referral Hospital and the Onandjokwe Primary Health Care Clinic, Oshikoto Region. Interviews included facilities staff and members of the District Health Management Team
Adolescents and Youth • "*Adolescents and youth (9-24 years of age) access the **DREAMS programme** (as in other facilities visited). The DREAMS programme works specifically with Adolescent Girls and Young Women (AGYW) but there is only one DREAMS nurse in the facility."* • *"The health centre staff attend to the **GBV cases** when there is an issue of rape. The provide medicines and refer the patient to a doctor at Onandjokwe Hospital while also informing the social worker and the police GBV unit. The clinic staff are not trained to take evidence."* • *"The centre has a staff responsible for **school health services**. They go to schools to assess children to provide health education and HIV prevention messages. The clinic contact person on school health takes part in the Regional Health Education Task Force meetings on a quarterly basis."* **Key Populations** • *"As per other centres in the district, **MSM, and LGBTI community members are not readily visible in the rural area** and do not self-identify as such. They still may benefit from having access to a single provider over time, if that provider is sensitive to their needs and is respectful. There is a role for values training in this area."*	• Interviews and site visit: Okankolo Health Centre, Onandjokwe Health District, Oshikoto Region

Assumption 2.4: UNFPA has effectively supported coalitions and networks of adolescents and youth, key populations and women to engage meaningfully and advocate for national policies and programmes which prioritize access to effective integrated HIV, SRHR and SGBV services (also applies to evaluation question 3).	
Indicators: • Workplans illustrate direct support of networks • Narrative reports of network activities illustrate role of UNFPA support • Examples of network advocacy for integrated HIV, SRHR and SGBV services • Experience and views of UNFPA staff/network representatives/national authorities	
Observations	**Sources of Evidence**
• *UNFPA has been a strong supporter of the Society for Family Health and has also supported the **TWG on Key Populations** which involves representation from organizations representing the LGBTI community.* • *Support to **NAPPA and Out-Right**, including to the formerly operational NAPPA clinic co-located with the Out-Right Offices.*	• Interview with UNFPA CO
• *UNFPA also supports and engages with the **Parliamentary Standing Committee on SRHR** to advocate for CSE.*	• Interview with the HIV and AIDS Management Unit of the MEAC
• *"The **Namibia CSO sector is suffering badly and struggling to stay afloat as donors cut budgets**. Only those with connections to large INGOs are expected to survive. However, UNFPA provides support to Society for Family Health for its SRHR/HIV Prevention programmes and to a few other NGOs such as Out-Right Namibia (Key Populations) and African Youth and Adolescent Network".*	• Interview with the DSP, MoHSS

• *"The **problem of CSO capacity** is crucial to the question of how to empower and engage communities, including youth and adolescents and key populations. UNFPA and other external supporters have been working with CSOs up to now but with Namibia's transition to Upper-Middle Income Country (UMIC) status, and if donors draw down their investment in CSOs, who will speak for key populations especially?"*
• *"Government policy does not really allow the Global Fund to directly fund CSOs representing key populations (although they do consult with them), so the **sustainability of CSOs working with key populations is a major concern**. For example:*
  ○ *The Business Coalition on HIV has closed down*
  ○ *The future of NANASO is uncertain*
  ○ *Others are struggling for funding, including: The Society for Family Health (works with key populations), NAAPA, Positive Vibes, the Walvis Bay Corridor Group (working with Commercial Sex Workers, Out-Right Namibia."*
• *"It seems that **CSOs in Namibia lack their own organic connection to the population** which would allow them to be more critical of government and the donors and to push back on funding cuts or bad policies. In Kenya, for example, you have a much more active CSO community."*
	• Interview with the Global Fund Programme Management Unit of the MoHSS

• *"**NANASO is an umbrella organization for CSOs**, established in 1991 and within the NAEC (National AIDS Executive Committee, NANASO represents the voice of Civil Society Organizations."*	• Interview with Namibia Network of AIDS Service Organizations

Assumption 2.4: UNFPA has effectively supported coalitions and networks of adolescents and youth, key populations and women to engage meaningfully and advocate for national policies and programmes which prioritize access to effective integrated HIV, SRHR and SGBV services (also applies to evaluation question 3).	

• *"The **diminishing level of resources drastically limits Civil Society space** to be involved – NANASO had ten sub-recipients of Global Fund Grant in the previous phase and this has been reduced to four in the current phase. NANASO grant funding has been as follows:*
  ○ *Phase 1: 2012 to 2014 = 14.8 million USD*
  ○ *Phase 2: 2015-2017 = 19 million USD*
  ○ *Phase 3: 2018-2020 = 6 million USD."*
• *"The organizations receiving support through NANASO from the Global Fund are only those with a very precise **focus on adolescents and youth and key populations."***	

• *"There is a fundamental conflict between rising rates of infection among young people and among key populations and the declining capacity of civil society organizations when the **government does not want to directly provide services specific to the needs of those groups but to rely on CSOs**. It's a triangular situation:*
  ○ *One side is the rising rate of infection among young people*
  ○ *Another is the government's reliance on CSOs to reach under-served adolescents and youth and key populations – and to promote their engagement*
  ○ *And the third, and weakest leg is declining investment and reduced capacity of Civil Society Organizations."*
• *"UNFPA is trying to help by working through the **Office of the First Lady** to engage with the Government on HIV, Early Marriage and Female menstrual hygiene rights for AGYW to keep girls in school."*
• *"NANASO worked with UNFPA and with the SADC Parliamentary Forum on SRHR **advocacy for Parliamentarians to ensure access for adolescents and young people**. NANASO also works with UNFPA to support CSOs such as Out-Right Namibia and the Society for Family Health in dealing with key populations and providing access to SRHR."*
	• Interview with Namibia Network of AIDS Service Organizations

• "*The **Be Free/Break Free Initiative** began in 2016 after the First Lady became a Special Envoy for AIDS (UNAIDS). Under this initiative the OFL reached out to youth-led organizations and reached over 10,000 young people, including young men, parents and professionals. They convened panels of different stakeholders to examine **HIV prevention among young people, especially AGYW**. These included:*
  ○ *Youth led organizations*
  ○ *Social Workers*
  ○ *Police*
  ○ *Traditional Leaders*
  ○ *School Teachers*
  ○ *Parents."*
• "In these forums they deal with **risky behaviour** (oral and anal sex), non-use of condoms, **abortion** and also **LGBTI rights**."
	• Interview with the One Economy Foundation, OFL

• *"**UNFPA does work to make sure that organizations representing adolescents and youth are in the tent regarding the national dialogue on HIV/AIDS**. In addition, the MoHSS recognizes that youth organizations are essential in*	• Interview with the AfriYAN

Assumption 2.4: UNFPA has effectively supported coalitions and networks of adolescents and youth, key populations and women to engage meaningfully and advocate for national policies and programmes which prioritize access to effective integrated HIV, SRHR and SGBV services (also applies to evaluation question 3).	
reaching this segment of the population. In the national dialogue, the NYC is recognized as the voice of youth. This participation extends all the way down to regional youth organizations, including AfriYAN."	
• *"For the National Youth Council, **the first priority is to build the institutional capacity of organizations** like AfriYAN, **rather than just seeing them as a service provider**. Last year, the NYC sent UNFPA a proposal to the UNFPA Country Representative focused on building institutional capacity among youth oriented CSOs and the hope it becomes part of the national youth policy. Currently the funding is quite narrowly focused because **UNFPA can only fund a narrow spectrum of mainly service delivery activities**. It would be good to make the partnership more meaningful and flexible over the longer-term including support to build institutional capacity."*	• Interview with the AfriYAN
• *"UNFPA supported the development and creation of the **Technical Working Group (TWG) on key populations** and continues to support its operation. You cannot have a TWG without the MoHSS on board. The Ministry is fully on board with the TWG as a mechanism for identifying ways for the national HIV response to reach the LGBTI community. In addition, the platform allows the community members to give guidance to MoHSS on what works in efforts to reach them. Ten years ago, the forum was non-existent and groups such as trans-gender women and men were excluded from the national plan. The current National Strategic Framework (NSF) now makes specific reference to transgender community members."*	• Group discussion with the members of the Technical Working Group on Key Populations

Assumption 2.5: UNFPA has been effective in supporting the implementation of programming tools for provision of accessible and effective HIV, SRHR and SGBV services for adolescents and youth, key populations and women *(also supports evaluation question 3).* Further, service providers have the capacity to provide these services.	
Indicators: • Quantity and content of programming tools • Examples of dissemination/training efforts for health facility staff using the programming tools supported by UNFPA • Evidence that training in linking and integrating HIV into SRHR has been accompanied by measures addressing incentives, equipment, supplies and infrastructure as needed.	
Observations	**Sources of Evidence**
• *"UNFPA started its support in 2014/15 by providing financial and technical support to a review of the **Life Skills Syllabus.** UNFPA co-funded (along with UNESCO) of the development of teacher training manual for CSE as well as on-line training modules (examples provided)."*	• Interview with the HIV and AIDS Management Unit of the MEAC
• *"In particular, UNFPA has been effective in advocacy for key populations and in the development of tools such as the **practitioner's handbook on SGBV**. SFH makes use of a standardized tool on training health workers in addressing SGBV."*	• Interview with the SFH, Windhoek
• *"There is a **regional framework for CSE for Out-of-School Young People** which was developed with UNFPA support and adopted by SADC Ministers of Health, Education and Youth. It was further adopted to a **CSE Framework for Out of School Young People in Namibia".***	• Interview with the MSYNS
• ***"**UNFPA helped to develop a manual for addressing the **linkages between SGBV and access to HIV prevention and treatment** services."*	• Interview with the MGECW

Assumption 2.5: UNFPA has been effective in supporting the implementation of programming tools for provision of accessible and effective HIV, SRHR and SGBV services for adolescents and youth, key populations and women *(also supports evaluation question 3).* Further, service providers have the capacity to provide these services.	
• ***"UNFPA has provided critical financial and technical support*** *including their service packages for* ***key populations*** *as well as* ***training in SRHR****. They use UNFPA research products, for example, UNFPA developed media guidelines to help them develop messages* ***on SGBV****. UNFPA also has given them access to best/good practices in combatting SGBV."*	• Interview with the One Economy Foundation/OFL
• In developing its **Regional Strategy for HIV Prevention, Treatment and Care and SRHR Among Key Populations**, the SADC Secretariat specifically referenced the UNFPA publication: *Implementing Comprehensive HIV and STI Programmes with Men who have Sex with Men: Practical Guidance for Collaborative Interventions (2015).*	• Southern African Development Community (SADC), *Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights Among Key Populations*, (2018) p. 22.

Area of Investigation Three: Extent of UNFPA promotion of human rights in the context of HIV	
Evaluation Question 3: ***To what extent has UNFPA support contributed to engage and empower communities (including but not only, adolescents and youth, key populations and women) to understand and claim their rights while also effectively advocating for policies and laws affecting human rights, gender equality and access to HIV, SRHR and SGBV services?***	
Evaluation Criteria	*Relevance, Effectiveness, Efficiency*
Rationale	As well as access for marginalized people, a key dimension of UNFPA support to the HIV response is its intended focus on empowerment and rights protection, including gender equality.

Assumption 3.1: UNFPA staff and key partners have a shared understanding of the meaning and importance of human rights and gender equality in the context of HIV.	
Indicators: • UNFPA guidelines on human rights-based approaches (HRBA) to HIV, SRHR and SGBV services – in use at CO level • Extent to which implementing partners are aware and knowledgeable about the content of the Guidelines on HRBA and HIV, SRHR and SGBV • HIV, SRHR and SGBV service guidelines incorporate some or all components of HRBA • Experience and views of service providers and clients	
Observations	**Sources of Evidence**
Key Stakeholder Strategies and Policies Regarding Human Rights Dimensions of HIV	
• "Pervasive harmful social and cultural practices continue to put young women at risk such as **early marriages** in some cultures. Thirty four percent (34%) women reported having experienced **physical or sexual violence**. The socio -economic climate where there is wide spread poverty and high unemployment rates among youth (27.29%) continue to increase **young women's vulnerability**. Additionally, low VMMC coverage and low uptake of HTS and Treatment services by their	• Republic of Namibia, MoHSS, DSP, *National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22,* p.15

Assumption 3.1: UNFPA staff and key partners have a shared understanding of the meaning and importance of human rights and gender equality in the context of HIV.

sexual partners significantly elevates their risk. Available data show limited uptake of sexual reproductive health and rights and HIV programmes by AGYW. **29% of females aged 15-19 have never tested for HIV**. **Condom use also remains low** (56%) among women of the same age group compared to their male counterparts at 68%. **Family planning coverage also remains low** at 24%."

- The **NSF for the HIV and AIDS Response identifies a specific set of challenges** for providing effective HIV prevention to Adolescent Girls and Young Women (AGYW) along with appropriate responses. Many of the challenges and responses are related to promoting gender equality and/or securing sexual and reproductive rights for AGYW. See the table below:

AGYW Gaps and Challenges	**AGYW Strategies**
• Early sexual debut • Intergeneration and transactional sex • High Teenage pregnancy rates • School drop outs due to pregnancies • Low comprehensive knowledge rates	• Conduct community and social mobilization campaigns • Strengthen Life skills and Comprehensive Sexuality Education (CSE) • Strengthen School retention and re-entry programmes for learner mothers • Accelerate implementation and compliance of the Learners Pregnancy Policy
• Age of testing consent (16years) whilst sexual debut is earlier • Physical/Sexual violence (34%) • Gender inequality • Negative social and cultural norms: Early child marriages practiced in some cultures	• Expedite implementation of the lowered age of consent of 14years Child Care and Protection Act and • Intensify SGBV interventions and strategies • Strengthen economic empowerment (provide job opportunities and income generating activities for out of school youth)
• Limited engagement of parents and care givers • High unemployment rates and widespread poverty. • Limited economic empowerment opportunities for young women. • Inadequate reach of vulnerable girls with social protection services.	• Strengthen engagement with parents and community gatekeepers through intergenerational dialogues to address harmful cultural practices and negative social norms • Strengthen social protection services

- Republic of Namibia, MoHSS, DSP, *National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22,* p.15. 16

Assumption 3.1: UNFPA staff and key partners have a shared understanding of the meaning and importance of human rights and gender equality in the context of HIV.

• Low condom use • Low testing uptake • Not all adolescents (26%) living with HIV are on treatment. • PrEP not yet available • Limited post exposure prophylaxis (PEP) uptake • Low HPV immunisation coverage • Low coverage of adolescent friendly service (AFS • Low/limited SRH/HIV Integration coverage	• Scale up facility and community based SRHR and HIV integrated services • Accelerate capacity building of health workers, teachers, social workers, police workers and parents • Scale up teen clubs for ALHIV to improve adherence and retention in care . • Update guidelines, protocols, and policies in line with new evidence • Accelerate the implementation of PrEP • Conduct HPV immunisation campaigns and screen ALHIV for cervical cancer	
• **Sexual Partners:** • Poor health seeking behaviour (low ART, low VMMC Low HTS uptake) • Gender norms that define masculinity and virility affect health behaviours and attitudes negatively	• Provide mentorship and peer education • Intensify SBCC campaigns to address low health seeking behaviours and negative gender norms • Strengthen community system. • Create access for more targeted HIV services- HTS, Treatment and VMMC	
• *"**Providing services to MSM remains a challenge**, as societal attitude, norms and values do not affirm people of non-heterosexual identities or behaviours. In addition, the 1920 common law criminalises anal sex between two males. The patriarchal structure of Namibian society has also contributed to the strict definition of male and female identities and roles and expected behaviours that drive men with alternative sexual behaviours and identities underground and hard to reach with health services.*		• Republic of Namibia, MoHSS, DSP, *National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22,* p.19
• Most of the challenges and strategies relating to reaching and providing effective **HIV prevention and treatment services to Men Having Sex with Men (MSM) in the NSF (p.20) are biomedical** in orientation. However, some, as identified in the table below, deal with the **policy and legal rights environment, stigma and human rights violations**:		• Republic of Namibia, MoHSS, DSP, *National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22,* p.21

MSM Gaps and Challenges	**MSM Strategies**
• Inadequate policy and legal environment to support programming and service delivery for MSM	• Strengthen policy level interventions (a policy on key populations) and advocate for legal review and reform
• Prevalence of stigma, discrimination and social exclusion	• Development information, educational communication materials for MSM • Undertake capacity building and sensitization of health care workers on MSM

Assumption 3.1: UNFPA staff and key partners have a shared understanding of the meaning and importance of human rights and gender equality in the context of HIV.		
• Human rights violation and social justice issues	• Establish safe spaces (i.e. shelters) for victims of abuse • Capacity building of MSM community on human rights advocacy • Document human rights violations for evidence based mitigating interventions • Promote and advocate for review and reform of structural barriers to health seeking behaviour, legal and social justice, and social protection	
• In the 2014 to 2016 Period, the **Regional Safeguard Young People Programme** supported a study, which systematically reviewed **laws and policies in 23 countries** in the region. The study found: o *"Only six countries in the region have set the **minimum age of consent without exception** [exceptions are made to accommodate marriage of younger women to older men], with prevents other laws from over-riding this age.* o *There is a lack of legal and policy provision on **age of consent to medical treatment**, which creates major barriers to accessing health care.* o *Only half of countries across East and Southern Africa have provisions to manage **learner pregnancy** but the majority of those countries approach it from **a punitive perspective**."*		• UNFPA, *The Safeguard Young People Programme: Three Years On: Addressing the urgent needs of youth across Southern Afica. (2017), p7.*
• An outcome of the study and advocacy by the SYP programme was the development of a **regional model law on child marriage**: o *The SYP Programme supported the development of the Southern Africa Development Community (SADC) Model Law on Child Marriage. Led by the SADC Parliamentary Forum, the historic model law is already guiding member states on how to eradicate child marriage and protect those already in marriage.*		• UNFPA, *The Safeguard Young People Programme: Three Years On: Addressing the urgent needs of youth across Southern Afica. (2017), p7.*
• "In Namibia, under the SYP umbrella, UNFPA participated in drafting the sections on **adolescent girls, young women, condoms and key populations** in the NSF in HIV. SYP supported the National Study on **Child Marriage** conducted by the Ministry of Gender Equality and Child Welfare."		• UNFPA, *Safeguard Youth Programme: Annual Report, 2017*, (September 2018), p.7.
• UNFPA supported the production of a **National Gender Based Violence Baseline Study**, published by the Ministry of Gender and Child Welfare in 2017. The study identified the extent of three types of SGBV (Intimate Partner Violence by a current or former partner; rape and, harmful social practices. With regard to HIV the study notes: o "*Evidence suggests there is a **close link between SGBV and HIV infection**. This is due to several factors. Violence or fear of violence increases the vulnerability of women and children to abuse. Women may not have sexual bargaining power to say no to unprotected sex and abrasions caused during sexual intercourse may increase ones risk to HIV Infection.* o *"Namibia has a high prevalence, high incidence, generalized and mature HIV epidemic, with **most new HIV infections transmitted through unprotected heterosexual sex and mother-to-child transmission**. Studies have revealed that sGBV and HIV are mutually reinforcing epidemics with, S**GBV being both a risk factor for HIV infection** and a consequence of being infected with HIV."*		• Republic of Namibia, MGECW. *National Gender Based Violence Baseline Study: Consolidating GBV Efforts and Fast-Tracking Namibia's Response*.

Assumption 3.1: UNFPA staff and key partners have a shared understanding of the meaning and importance of human rights and gender equality in the context of HIV.	
• **Stakeholder Views on the Human Rights Dimension of HIV Prevention and Treatment: Including SGBV**	
• *"The objective of HIV prevention among adolescents and youth means they must effectively address **teenage pregnancy, SGBV and access to Family Planning** – including distribution of condoms."*	• Interview with the HIV and AIDS Management (HAM) Unit, MEAC
• *"Politicians in Namibia are **reluctant to have any "special" designation or treatment of LGBTI learners** but the HAM Unit and the Ministry are able to address their needs by relying on a **set of agreed principles**:* o *All forms of discrimination are banned, including discrimination based on sexual orientation* o *They have a mandate to eliminate drop-outs, including by LGBTI learners* o *Dignity of the person and freedom from discrimination is protected by the constitution* o *All learners have a right to dignity* o *Pregnant AGYW have a right to education and cannot be excluded from the classroom."*	• Interview with the HIV and AIDS Management (HAM) Unit, MEAC
• *"**GBV is a topical issue in Namibia and commands national attention** given the frequency of its occurrence in the country. In 2016, the Ministry's focus shifted more directly to working on GBV as the primary use of UNFPA resources, UNFPA paid for a technical advisor on GBV for a year and in 2016, they did a national survey of the situation of GBV in Namibia. This led to the development of a National Plan of Action on GBV. The UNFPA advisor (2018) helped them to develop National and Regional Clusters on GBV. There is a National Technical Working Group on GBV, which meets on a quarterly basis with support from UNFPA as well as a cluster on Gender and Health. The Ministry of Gender works directly with men's groups on GBV in all 14 regions of the country. They target men and boys and work on gender equality, the role of men and boys in HIV prevention, their role in preventing GBV and the need for them to engage in efforts to stop the spread of HIV."*	• Interview with the MGWCW
• "***In schools they get feedback through the use of "talking boxes"** as well as from the consultative forums. They find evidence of:* o *Incest,* o *Sexual violence* o *Teenage pregnancy* o *Suppression of identity by Gay and Lesbian Youth who do not know how they can come out."* • *"The **expertise of the Office of the First Lady regarding SGBV** build on the work of the Break Free from Violence campaign of 2017. This was done by doing research among perpetrators and survivors and documenting the fact that violence starts with verbal and emotional abuse and escalates to physical violence. As a result, they **focus SGBV prevention work on three focus areas**:* o *Increased awareness of the early stages of violence* o *Advocacy for early intervention and prevention strategies* o *Using the platform of the Office of the First Lady to amplify messages and build partnerships. For example, they are working with corporations on the value of developing workplace SGBV prevention programmes and have done violence prevention workshops at several mine sites."*	• Interview with the One Economy Foundation/OFL

Assumption 3.1: UNFPA staff and key partners have a shared understanding of the meaning and importance of human rights and gender equality in the context of HIV.	
• "*Most of the time **AfriYAN engages youth around "risky sexual behaviour**". In some regions this will coalesce around child marriage and teenage pregnancy*."	• Interview with NYC/AfriYAN
• "*The current disconnect is in **sensitizing health workers and nurses to make them more aware of how to provide competent, professional HIV services to the LGBTi community** and for this to be achieved there is a need for more engagement by MoHSS. It is important to understand that the community is not asking for special treatment – only access to services that meet their needs. For example, lesbian women and transwomen (who identify as men) when they go for a pap smear may be treated with disdain or outright refusal. It's a lack of respect and a real lack of professionalism that they object to. To be fair to government, **the problem of discrimination and stigma is often not a problem of policy – it's a problem of the attitude of some health worker who for religious, cultural or tradition reasons** have a poor attitude to providing services to the LGBTI community."*	• Interview with Out-Right Namibia
• *"**NAPPA also provide post-abortion care in their clinics as the rate of unsafe abortions in Namibia is very high** – many girls go to South Africa for the procedure. In 2006 the Minister of Health tried to bring up a bill to legalize abortion but was unsuccessful, and the existing law only allows abortion to done when the life of the mother is at risk."* • *"In rural areas one needs to understand that a very different dynamic is at work socially, especially with reference to **LGBTI community members (and sex workers)**. They may not be able to come out openly but you still need to be able to recognize them and provide the confidential services they need.*	• Interview with NAPPA, Windhoek
• *"The **Namibian constitution provides for equality and non-discrimination on the basis of sex, race or sexual orientation**. However, there are still some existing laws in the country that prohibit certain practices that impact on the life of members of the key population. **The Immoral Practices Act**, which dates back to the time of the German colonists and a similar law passed by South Africa (at that time in control of Namibia) in 1980 are still on the legal books in Namibia. This became the **legal basis for persecution of LGBTI people** in Namibia. Although **the law is not enforced, it still exists**."* • *"There are also **hateful and harmful statements made by ruling party members** and by the SWAPO youth leaders and other social media influencers from time to time and Namibia lacks a basic law on hate speech. Fundamentalist Christians, often with backing from North America, also have considerable influence and can lead in pushing back against LGBTI rights."*	• Group Discussion with Members of the Technical Working Group on Key Populations
• *"The concept of SRHR (including sexual rights) gives the members of the TWG an opening to have a rights discussion with MoHSS. Generally speaking**, the health policy space is a good one for having dialogue around rights**, compared with other sectors at least."* • *"It is important to give credit to the Government of Namibia because the **NSF for HIV is the only statutory document which states clearly that LGBTI people and other key populations have a right to non-discriminatory services**."*	• Group Discussion with Members of the Technical Working Group on Key Populations
• *"There has been some **push-back on UN (and government) efforts to address the needs of key populations**. It often arises from lack of familiarity with the legal framework for key populations. The late May 2019 event for key populations hosted by the Office of the First Lady who chairs the national HIV council will deal with the legal environment for key populations."*	• Interview with UNAIDS, Namibia

Assumption 3.2: Networks representing adolescents and youth, women and key **populations have the capacity to meaningfully participate in and influence national dialogue and prompt changes in national policies and programmes to reduce stigma and discrimination** for their members, including people living with HIV. Further, they are able to assert their right to hold service providers accountable.	
Indicators: • Examples of changes in national policies, laws, strategies and programmes which explicitly recognize and respond to the needs of adolescents and youth, key populations, and women (for example, anti-discrimination laws protecting people living with HIV in place, decriminalization of HIV transmission, universal access to SRHR and HIV services etc.) • Experience and views of network staff • Experience and views of national health authorities • Experience and views of policy makers in areas effecting stigma and discrimination including criminal justice, education and health among others	
Observations	**Sources of Evidence**
• See observations and sources of evidence noted for assumption 2.4 above	
• *"The involvement of young people, not only as beneficiaries but also as partners and leaders in the programme at all levels – has brought a fresh perspective to policy discussions.* ***UNFPA supported AfriYAN to establish platforms for youth to influence policy at local, national and international meetings and events****, including UN General Assemblies and conferences. By the end of 2016, AfriYAN had established chapters or youth advisory panels in Namibia, South Africa, Zambia and Zimbabwe*	• UNFPA, *The Safeguard Young People Programme: Three Years on: Addressing the urgent needs of youth across Southern Africa. (2017), p. 16.*
• *One key UNFPA role in supporting effective engagement by networks is support to the Office of the First Lady on her work with key populations and work around SGBV.* ***The MoHSS and the Office of the First Lady (and the First Lady herself) are very vocal and active in advocating for the rights of the LGBTI community and in bringing them into the dialogue*** *on national policy.*	• Interview with UNFPA CO
• *"****Dialogue with Parliamentarians*** *has helped to create a better atmosphere among political leaders who are now willing to talk about HIV issues and will move to agree on the road map for moving forward. The Ministry of Justice is involved in this dialogue (with UNDP and UNAIDS taking the lead from the UN side)."*	• Interview with UNAIDS, Namibia
• *"UNFPA Supports and engages effectively with the* ***Parliamentary Standing Committee on Education*** *and coordinates that* ***dialogue with the HIV and AIDS Management Unit****."*	• Interview with HIV and AIDS Management Unit of the MEAC
• *UNFPA has assisted the Ministry in the* ***development of a National Youth Policy*** *to be submitted to cabinet. This will be followed by work on the development of a National Youth Development Framework.*	• Interview with the MSYNS

• *In* ***the area of SGBV****, the Ministry works with a wide variety of actors, including:*
  ○ *Men Engage*
  ○ *Women Action for Development*
  ○ *The Legal Assistance Centre (LAC)*
  ○ *Life Line/Child Line*
  ○ *Regain Trust*
  ○ *The Office of the First Lady*
However, ***some men's organizations have collapsed due to lack of funding*** *to reach out to community members.*
	• Interview with the MGECW

Assumption 3.2: Networks representing adolescents and youth, women and key **populations have the capacity to meaningfully participate in and influence national dialogue and prompt changes in national policies and programmes to reduce stigma and discrimination** for their members, including people living with HIV. Further, they are able to assert their right to hold service providers accountable.	

• *"The **advocacy work of AfriYAN builds on the Ministerial Commitments for Eastern and Southern Africa** (SADC Ministers of Health, Education, Gender and Youth and Sports) around:*
  ○ ***Teenage pregnancy***
  ○ ***SGBV***
  ○ ***HIV and AIDS**."*
	• Interview with NYC/AfriYAN

• *"The **OFL is a strong public advocate** for the requirement that public services and society as a whole need to be responsive to the needs of different communities including:*
  ○ ***LGBTI persons***
  ○ ***Commercial Sex Workers***
  ○ ***Young people with disabilities***
  ○ ***Tribal people***
  ○ ***Young People in Nomadic Communities***
On Friday May 24 2019 the First Lady hosted a public discussion with representation from Key Populations (see documentation provided)."
	• Interview with the One Economy Foundation/OFL

• *They (the **Office of the First Lady) see their role as influencing policy** for how the laws are to be enforced and prosecuted rather than legislation itself. They do influence legislation but that is the final responsibility of the Ministry of Justice and Office of the Prosecutor General. That said they have been able to influence:*
  ○ *The Gender Violence Act*
  ○ *The Cyber Crimes Act*
  ○ *The Divorce Laws*
  ○ *The Child Care and Protection Act*
  ○ *The Human Trafficking Act*
• *The OFL signed a Memorandum of Understanding with the Namibia Correctional Services to **work with perpetrators of violence** to understand drivers and to have inmates interact with young men in the community to combat SGBV.*
	• Interview with the One Economy Foundation/OFL

• *"The **First Lady has been a fierce and effective advocate** for addressing the rights of Adolescent Girls and Young Women (AGYW) and the LGBTI community."*	• Interview with the SFH, Windhoek
• *"The current **National Strategic Framework (NSF) on HIV and AIDS now makes specific reference to transgender community members**. The Technical Working Group provides many recommendations to MoHSS on a possible rights package and they are working with Parliamentarians on these issues. In general terms, the Ministry and Parliamentarians are responsive to inputs to policy and the legal framework from the TWG."*	• Group Discussion with Members of the Technical Working Group on Key Populations

Assumption 3.3: UNFPA has contributed to developing the capacity of health workers to deliver HIV prevention services (including access to rights-based family planning) in a manner free from stigma and discrimination with services more accessible to adolescents and youth (sometimes called youth friendly SRHR), key populations, women and those with disabilities.	
Indicators: • Evidence that training in linking and integrating HIV into SRHR has been accompanied by measures addressing incentives, equipment, supplies and infrastructure as needed • Extent to which training for health staff integrates avoidance of stigma and discrimination, gender sensitivity, attitudes towards key populations, youth-friendly service delivery, and sexual and reproductive rights and choices • Experience and views of national health authorities • Experience and views of health workers • Experience and views of adolescents and youth, key populations and women on HIV, SRHR and SGBV services • Where survey data reports it, percentage of people living with HIV who report experiences of HIV-related discrimination in health care settings • Views of staff of organisations and networks representing HIV, SRHR and SGBV needs of adolescents and youth, key populations and women	
Observations	**Sources of Evidence**
• Both the Safeguard Young People (SYP) and the 2Gether 4SRHR regional programmes have budgeted and spent resources on **training service providers in both the health and education sector** to provide services more appropriate to **the needs of adolescents and youth and to key populations.** • For the **SYP programme** the amounts expended for training service providers each year were: 2016 = 7,556 USD, 2017 = 15,561 USD, 2018 =19,960, 2019 (Budgeted) = 4,500 USD. • For the **Linkages Programme (Phase 1) and 2Gether 4SRHR (Phase 2),** annual reported expenditures in training were: 2016 = 44,986 USD, 2017 =13,776 USD, 2018 = 16,496 USD and in 2019 (budgeted) = 23,925 USD Note: not all of the training expenditures for these programmes will have focused on providing rights-based services free from stigma and discrimination but at least some proportion of these training expenditures have been focused on appropriate **provision of professional Youth Friendly Services and services to key populations**.	• UNFPA Namibia Project Monitoring Reports: 2016, 17, 18 and 19.
• In 2017, in Namibia, the Safeguard Young People Programme Reported: o "240 Frontline duty bearers were **trained in GBV**"	• UNFPA, *Safeguard Youth Programme: Annual Report, 2017*, (September 2018), p.5.
• *"UNFPA has supported the Ministry of Education, Arts and Culture with efforts to **institutionalize CSE within teacher training** – including training all teachers (not just those charged with Life Skills Education. To do this it has supported integration of CSE curriculum into teacher training at:* o *University of Namibia (UNAM)* o *The International University of Management (IUM)* o *The Institute of Open Learning (IOL)."* • *UNFPA was very supportive of this process and worked with the National Institute for Educational Development (NIED)".*	• Interview with the HIV and AIDS Management Unit of MEAC
• *"There is still a **challenge to overcome negative attitudes among service providers** when young people try to access SRHR services. According to national policy, every adolescent in every facility must be able to access SRH services."*	• Interview with the DPHC, MoHSS

Assumption 3.3: UNFPA has contributed to developing the capacity of health workers to deliver HIV prevention services (including access to rights-based family planning) in a manner free from stigma and discrimination with services more accessible to adolescents and youth (sometimes called youth friendly SRHR), key populations, women and those with disabilities.	
• *"In 2019, with UNFPA support, the **Society for Family Health (SFH)** conducted a two day training event for health workers on how to provide **competent SRHR services with members of key populations** (in partnership with the Office of the First Lady of Namibia). SFH also makes use of a standardized tool on training health workers in the clinical treatment of SGBV."*	• Interview with the SFH, Windhoek
Assumption 3.4: UNFPA has contributed to effective efforts to protect young women and girls, including those at risk of early marriage, from gender-based violence especially in relation to HIV prevention; and to provide young women and girls with information leading to empowerment through knowledge and behaviour change for HIV prevention. Further, HIV prevention has been integrated into efforts to improve clinical and other services for survivors of SGBV.	
Indicators: • Percentage of women aged 15-49 years who experience physical or sexual violence from a male intimate partner (12 months) • Reported trends (where available) in early marriage (as context) • Where survey data reports it (as in recent DHS), proportion of women and men who say that wife beating is an acceptable way for husbands to discipline their wives • National strategies and programmes developed and implemented with goal of preventing/reducing SGBV – with specific reference to preventing HIV • National HIV strategies/roadmaps/ workplans incorporate efforts to protect women and girls from SGBV and from coercion with its impact on HIV • Presence of laws, policies and regulations that protect adolescents and youth, key populations, women and PLIHV against SGBV • Staff of facilities report that post-SGBV clinical care integrates HIV, SRHR and SGBV • Views of national health and HIV authorities • Views and experience of networks and organisations engaged in protecting women and girls from SGBV, including in relation to HIV prevention	
Observations	**Sources of Evidence**
The Extent and Causes of Sexual and Gender-Based Violence in Namibia and the National Response	
• "***Pervasive harmful social and cultural practices continue to put young women at risk*** *such as early marriages in some cultures. Thirty four percent (34%) women reported having experienced physical or sexual violence. The socio -economic climate where there is wide spread poverty and high unemployment rates among youth (27.29%) continue to increase young women's vulnerability. Additionally, low VMMC coverage and low uptake of HTS and Treatment services by their sexual partners significantly elevates their risk. Available data show limited uptake of sexual reproductive health and rights and HIV programmes by AGYW. 29% of females aged 15-19 have never tested for HIV. Condom use also remains low (56%) among women of the same age group compared to their male counterparts at 68%. Family planning coverage also remains low at 24%."*	• Republic of Namibia, MoHSS, DSP, *National Strategic Framework for HIV and AIDS Response in Namibia 2017/18* to 2021/22, p.15
• *"Fifty percent of women who are divorced separated or widowed and 37 percent of women who are currently married or living together with a partner **have experienced physical violence since age 15**.* • *"Namibian police statistics for 2012 indicated that approximately 1100 cases of rape and attempted rape were reported, representing **60 rape cases per 100,000 people**. However, the actual number of rapes and other incidences of SGBV is likely to be much higher."*	• Republic of Namibia, MGECW. *National Gender Based Violence Baseline Study: Consolidating GBV Efforts and Fast-Tracking Namibia's Response,* (2017) p. 13.

<table>
<tr><td colspan="2">Assumption 3.4: UNFPA has contributed to effective efforts to protect young women and girls, including those at risk of early marriage, from gender-based violence especially in relation to HIV prevention; and to provide young women and girls with information leading to empowerment through knowledge and behaviour change for HIV prevention. Further, HIV prevention has been integrated into efforts to improve clinical and other services for survivors of SGBV.</td></tr>
<tr><td>• “Generally, GBV is deeply entrenched in the harmful socio-cultural norms. Harmful traditional norms are those that undermine women’s decision-making power, contribute to women’s poor health outcomes, maternal mortality and HIV infection.”</td><td></td></tr>
<tr><td>• Key SGBV Related Indicators:
o Over 1000 persons are raped each year, 90 percent are women
o Women who have experience sexual violence: 33 percent
o Women reporting experiencing physical violence during pregnancy: six percent
o Adolescents justify beating as acceptable: Girls 28 percent; Boys 29.5 percent
o Teenage pregnancy: National 19 percent; Kunene, 38.9 percent
o Secondary school completion for girls: 42 percent
o GBV survivors never seeking support services: 15 percent
o Women who do not access health services due to being denied permission (6 percent)
o Girls married by age of 18: 11 percent.</td><td>• UNFPA, GBV: Gender Based Violence in Namibia Brief (2017), p.1</td></tr>
<tr><td>• The Prioritized National Plan of Action on Gender-Based Violence (2019-2023) prepared with support from UNFPA and UNICEF identifies four Action Areas:
o Survivors First: Getting the Response Basics Right
o Safety Nets and Community Care: Primary Prevention Upgrade
o Youth in the Lead: Transforming Gender Norms for Long Term Prevention
o Counting the Cost: Adequate Data, Adequate Funding</td><td>• MGECW. Prioritized National Plan of Action on Gender-Based Violence (2019-2023). (2018), p.7</td></tr>
<tr><td>• Under each of the four Action Areas, the National Plan of Action identifies priorities, legal enabling actions and communications content. UNFPA support to combatting SGBV is concentrated in action areas one (the response for survivors) and action area two (youth leadership in transforming gender norms). The table below identifies the priorities, legal enablers and communications content for these two action areas:
<table>
<tr><th>Element of the Action Plan</th><th>Action Area One: Survivors First: Getting the Response Right</th><th>Action Area Three: Youth in the Lead: Transforming Gender Norms for Long Term Prevention</th></tr>
<tr><td>• Priority One</td><td>• First responders: providing empathetic, inclusive care to SGBV survivors and their families at first contact</td><td>• Raising non-violent, gender-sensitive children and adolescents: changing norms one generation at a time</td></tr>
<tr><td>• Priority Two</td><td>• Sound structures: strengthening procedures and infrastructure for better services to survivors</td><td>• Harnessing the energy: giving young people space to accelerate change</td></tr>
</table></td><td>• MGECW. Prioritized National Plan of Action on Gender-Based Violence (2019-2023). (2018), p.9 and 15</td></tr>
</table>

Assumption 3.4: UNFPA has contributed to effective efforts to protect young women and girls, including those at risk of early marriage, from gender-based violence especially in relation to HIV prevention; and to provide young women and girls with information leading to empowerment through knowledge and behaviour change for HIV prevention. Further, HIV prevention has been integrated into efforts to improve clinical and other services for survivors of SGBV.

• Priority Three	• Trafficking in persons: amplifying recognition and response		
• Legal Enablers	• Improve the protection order system • Regulations for trafficking in persons act, 2018	• Completion of regulations for the Child Care and Protection Act • Finalise and implement legislation to improve on-line safety	
• Communications Content	• What is SGBV? Where do I go for which service? • What are the warning signs? Where do I go for help? • Understanding formal warnings and protection orders: How do I get one? How does it work?	• Challenge, question, transform: disrupting the status quo of harmful norms • Culture of care • Cultivating consent: What is consent? What would be crossing the line? How do I seek consent?	

UNFPA Namibia Financial Support to Initiatives to Address Sexual Gender Based Violence

- For UNFPA in Namibia, the **Safeguard Young People (SYP) Programme** with its focus on Comprehensive Sexuality Education and engaging adolescents and youth through social media (the Tune Me mobile App) **has been an important vehicle for addressing Sexual Gender Based Violence (SGBV).** In 2017, UNFPA, under the SYP programme supported the **Office of the First Lady in documenting and publishing on-line stories on SGBV**. Similarly, in 2019, the SYP programme was used to support the One Economy Foundation/Office of the First Lady in **its Break Free/Be Free campaigns on SGBV**. In 2019, the Namibia CO of UNFPA also provided funding to the Ministry of Gender Equality and Child Welfare to generate knowledge documents and engage in **policy dialogue and advocacy on SGBV**.
- It is also worth noting that the second phase of the regional programme on linking and integrating HIV, SRHR and SGBV services: **2Gether 4SRHR was expanded to encompass integration of HIV/SRHR and SGBV services** in the delivery of health care.

- UNFPA Namibia, Project Monitoring Reports: 2016/17/18 and 19.

Key Stakeholder Experiences and Actions Relating to UNFPA Support to Addressing Sexual Gender Based Violence (SGBV)

Addressing Gender-Based Violence

- *"In April 2019, the Directorate for Primary Health Care of MoHSS launched the **clinical guide-book for providing services in SGBV is ensure appropriate referrals** because the cadre of social workers is split among:*
  - *Ministry of Gender Equality and Child Welfare*
  - *Ministry of Safety and Security*
  - *GBV Safety Units of the Police*
  - *MoHSS*

- Interview with the DPHC, MoHSS

Assumption 3.4: UNFPA has contributed to effective efforts to protect young women and girls, including those at risk of early marriage, from gender-based violence especially in relation to HIV prevention; and to provide young women and girls with information leading to empowerment through knowledge and behaviour change for HIV prevention. Further, HIV prevention has been integrated into efforts to improve clinical and other services for survivors of SGBV.	
• *In some regions the **GBV Protection Unit (of the Police) is located in the regional or district hospital** so the system of referral can work well. Similarly, if the life skills teachers in the schools are well trained and can spot abuse, or if it is spotted by Ministry of Gender social workers, they can then refer it to the GBV Protection Units."*	
• *"**Training of the health services staff to assess cases of SGBV and to make the proper referrals is very badly needed**. In visiting the sites (health facilities) the evaluation team will probably not see evidence of SGBV being integrated into other SRHR and HIV services yet."* [Note, DREAMS programme sites providing SRH and HIV services to AGYW indicated that GBV was a key concern of their AGYW clients].	• Interview with the DPHC, MoHSS
• *"The MGECW has its own social workers who work with the SGBV protection units located in different parts of the country. For this purpose, the Ministry has developed a **manual for Police officers in how to deal with SGBV and human trafficking** and is planning to conduct training for the police officers in different regions. UNFPA is also assisting the Ministry to conduct an **ongoing study on Child Marriage in Namibia**."*	• Interview with the MGECW

• *"The Office of the First Lady (OFL) engages in **case management for the legal response to cases of SGBV that are either egregious or could set a precedent** regarding, for example, imbalances of power between the survivor and the accused. For example, they became involved of a case of a young woman who had been assaulted by a magistrate. During case management work they select cases based on their merits and look at the larger implications for gender-based violence. As another example, they supported a case relating to cyber-crime (revenge pornography). They also refer survivors to other service delivery partners including:*
  ○ *Life Line/Child Line*
  ○ *Regain Trust*
  ○ *The GBV Investigation Unit*
  ○ *Slut-Shame Walk."*
• *"They work with the different Ministries concerned on these cases, including the Ministry of Justice, the Ministry of Safety and Security and the Police. On May 9**, 2019, the OFL launched the Namibia #MeToo campaign**. They had three national consultation meetings, covering four clusters: legal, psycho-social, medical and advocacy and data. The OFL also undertakes **capacity building (with UNFPA support) of students, lawyers, doctors, court clerks etc**. and has been established as a thought leader in the field. The strategy in combatting SGBV is to be pragmatic and to provide technical, moral and financial support where it is most needed.*
	• Interview with the One Economy Foundation/OFL

• *"The national roll out of **integrating HIV, SRHR and SGV services needs to incorporate more actions on combatting Sexual and Gender-Based Violence,** but the current model does allow health services staff to spend more time with clients and perhaps identify cases of SGBV."*	• Interview with the NAPPA, Windhoek
• *"**The Break Free/Stay Free campaign on Sexual and Gender Based Violence** undertaken by the Office of the First Lady of Namibia with UNFPA support is **very effective**."*	• Interview with UNAIDS Namibia

Assumption 3.4: UNFPA has contributed to effective efforts to protect young women and girls, including those at risk of early marriage, from gender-based violence especially in relation to HIV prevention; and to provide young women and girls with information leading to empowerment through knowledge and behaviour change for HIV prevention. Further, HIV prevention has been integrated into efforts to improve clinical and other services for survivors of SGBV.	
• ***"SGBV services have been integrated*** *but* ***if there is a potential prosecution the clinic refers*** *the client to Katutura Hospital where there is a* ***GBV protection unit****."*	• Site visit to Maxuilili Clinic, Okahandja Park - Windhoek
• *"The* ***health centre staff attend to the SGBV cases when there is an issue of rape****. They provide medicines and refer the patient to a doctor at Onandjokwe Hospital while also informing the social worker and the police GBV unit.* ***The clinic staff are not trained to take evidence in cases of rape.*****"**	• Site visit to Okankolo Health Center: Onandjokwe Health District, Oshikoto Region

Area of Investigation Four: Extent of UNFPA efforts as a broker to facilitate the participation of a broad spectrum of actors and contribute to forging partnerships	
Evaluation Question 4: ***To what extent has UNFPA been effective at global, regional and country level in forging and/or supporting networks, coalitions and partnerships to ensure meaningful participation of governments, civil society (especially adolescents and youth and key populations) and the private sector in dialogue and action on HIV prevention – including participation in programme design, planning and implementation?***	
Evaluation Criteria	*Effectiveness, sustainability, coordination*
Rationale	In order for those at risk and vulnerable, notably adolescents and youth and key populations to have access to effective integrated HIV, SRHR and SGBV services and to secure their rights to information and services free from stigma, discrimination and violence, it is important they participate meaningfully in regional, national and local dialogues and influence decision making on HIV prevention. Networks, coalitions and partnerships are effective mechanisms for engaging these groups in critically important debates on HIV policies and services.
Assumption 4.1: UNFPA has effectively supported platforms for south-south cooperation and joint lessons learning on strengthening bi-directional linkages and integrating HIV, SRHR and SGBV (also applies to assumption 1.6).	
Indicators: • Type and number of platforms and mechanisms for south-south consultation and cooperation supported by UNFPA • Frequency of south-south meetings/workshops/interactions on linkages/integration • Reported utility of south-south cooperative efforts on linkages/ integration supported by UNFPA	
Observations	**Sources of Evidence**
• See observations and sources of evidence for Assumption 1.6 above.	
Assumption 4.2: The support provided by UNFPA to global, regional and national partnerships (including for example HIV prevention coalitions) has contributed to more and better joint policy development and programming on HIV prevention. UNFPA support has also contributed to re-positioning HIV prevention as an essential component of SRHR with broad participation.	
Indicators:	

Assumption 4.2: The support provided by UNFPA to global, regional and national partnerships (including for example HIV prevention coalitions) has contributed to more and better joint policy development and programming on HIV prevention. UNFPA support has also contributed to re-positioning HIV prevention as an essential component of SRHR with broad participation.	
• Inter-governmental statements of policies and strategies for HIV, SRHR and SGBV reflect need for integration and protection of rights of adolescents and youth/women/ key populations • HIV prevention re-positioned as high priority in global and regional intergovernmental HIV strategies and policies • Views of national health authorities and national HIV commissions • Views of members of global, national HIV prevention coalitions	
Observations	**Sources of Evidence**
Regional Policy Guidance Developed Through Networking (SADC)	
• *"The Southern African Development Community's **(SADC) ground breaking and far-reaching Regional Strategy for Sexual and Reproductive Health and Rights (SRHR) 2019–2030, and corresponding Score Card to measure progress**, was approved by the Ministers of Health and Ministers responsible for HIV & AIDS from the 16 SADC Member States. The Sexual and Reproductive Health and Rights (SRHR) Strategy for the SADC Region (2019–2030) **provides a framework for the Member States to fast-track a healthy sexual and reproductive life for the people in the region, and for all people to be able to exercise their rights**. The first ever multi-sectoral score card to be adopted by a regional entity was also given the ministerial green light. The **purpose of the scorecard is for the region to measure progress** on achieving implementation of the strategy and the sustainable development goals."*	• UNFPA ESARO News Release, Nov. 13, 2018. Accessible at: ○ https://esaro.unfpa.org/en/news/groundbreaking-regional-strategy-sexual-and-reproductive-health-gets-ministerial-approval
• *"The **SADC's efforts to develop and adopt the SRHR Strategy and Score Card have been supported by UNAIDS, the United Nations Population Fund (UNFPA), the United Nations International Children's Emergency Fund (UNICEF) and the World Health Organization (WHO)** in partnership with SheDecides, Southern African civil society organizations and youth-led organizations. The four UN agencies, through the 2gether 4 SRHR Programme, supported the following:* ○ *The convening of the Technical Committee that oversaw the development of the draft SRHR Strategy for the SADC;* ○ *The recruitment of a consultant who helped to develop the draft SRHR Strategy for the SADC Region (2019 – 2030) and Score Card.* ○ *The convening of the Technical Consultation consisting of representatives from the Ministries of Health, Education, Youth and Gender, and from civil society and youth-led organizations. The 2gether 4 SRHR Programme is supported by the Government of Sweden (SIDA), which has invested $45 million in support from the United Nations to governments in the region to scale up the provision of quality integrated sexual and reproductive health and rights, HIV and sexual and gender-based violence services. The focus of the programme will now be to support the SADC and its 16 Member States to domesticate the strategy, in line with national laws and frameworks, and to populate the score card."*	• UNFPA ESARO News Release, Nov. 13, 2018. Accessible at: • https://esaro.unfpa.org/en/news/groundbreaking-regional-strategy-sexual-and-reproductive-health-gets-ministerial-approval
• *This work would not have been possible without the financial and technical assistance of UNDP, UNFPA and UNAIDS through their Regional Offices for East and Southern Africa".*	• SADC, *Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and*

Assumption 4.2: The support provided by UNFPA to global, regional and national partnerships (including for example HIV prevention coalitions) has contributed to more and better joint policy development and programming on HIV prevention. UNFPA support has also contributed to re-positioning HIV prevention as an essential component of SRHR with broad participation.	
• *"This **strategy is expected to serve as a guide to Member States** in designing and implementing appropriate Sexual and Reproductive Health (SRH) and **HIV Prevention, treatment and care programmes for key populations** focusing on the major issues that need to be addressed **at policy, legal, institutional and facility levels**."*	*Rights Among Key Populations*, (2018) p. 2.
• *"The strategic framework is not a strategic plan but **a guiding framework for SADC member states**. It aims to provide **details on how key populations are and remain more vulnerable to HIV than the general population**. It further **identifies the key barriers** they face in accessing HIV and SRH services, and identifies steps member states can take to **address these obstacles** and thereby lower the vulnerability of key populations to HIV and increase their access to HIV and SRH services."*	• SADC) *Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights Among Key Populations*, (2018) p. 9
• *"The international community has identified a number of **programmatic interventions that have been deemed effective for increasing key populations' access to HIV and SRH services**. The programmatic interventions are as follows:* o *Addressing legal, policy, structural and socio-cultural barriers* o *Ensuring financial commitments* o *Empowering both the general community and key populations* o *Addressing stigma, discrimination and vulnerability to violence.* o *Ensuring the availability of access to comprehensive health services."*	• SADC, *Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights Among Key Populations*, (2018) p. 22.
Key Informant Views on the Process of Policy Development at Regional Level and Its Impact on Programming in Namibia	
• *"The **SADC HIV Strategy and SADC Key Populations Strategies** are visions to be translated into national action by 2030. They thus become **advocacy tools** for use at national level because no Ministry of Health or Ministry of Education wants to be left behind."* **Steps in the Regional Policy Process: The Example of Key Populations** • *"**SADC as a collective body seeks to have a harmonized agenda for health throughout the region**. From time to time a Ministry of Health in a SADC country will say that "we need a common approach to issue X". Issues are most likely to get onto and stay on the SADC agenda if championed by a member state.* • *The next step is to do a **situation analysis**. For example, in the case of Key Populations more than one country was saying we need a common response to the needs of key populations in SRH/HIV. For example, Lesotho reported that 70 percent of sex workers in Lesotho were HIV positive. The **SADC Secretariat then approaches Technical partners for help**. The Secretariat, currently chaired by Namibia, is key to this process. It looked for technical partners in the development of the key populations strategy and **chose UNFPA because of a) its influence with countries and b) its regional tool for providing effective HIV services to key populations**."*	• Interview with UNFPA ESARO

Assumption 4.2: The support provided by UNFPA to global, regional and national partnerships (including for example HIV prevention coalitions) has contributed to more and better joint policy development and programming on HIV prevention. UNFPA support has also contributed to re-positioning HIV prevention as an essential component of SRHR with broad participation.	

• *The SADC Secretariat then convened a **Technical Working Group (TWG)** to oversee the development of the draft document. Then technical people from 16 member states are convened to review the draft document. For the review of the **SRHR strategy they had people from all 16 countries** representing:*
  ○ *Ministries of Health*
  ○ *Ministries of Education*
  ○ *Ministries responsible for Youth*
  ○ *Ministries responsible for Gender*
  ○ *Regional **Civil Society Organizations** representing Youth and key Populations as well as CSOs engaged in service delivery.*
• *UNFPA then funded a pre-meeting of the document review group. After receiving comment from the 16 countries and the regional CSOs, the TWG cleaned up the document and submitted it to the Council of Senior Officials (Permanent Secretary/Deputy Minister level). Since ESARO has both SADC and East African Community (EAC) countries (Tanzania takes part on both), there are slightly different processes and products.*
• *The **UNFPA advocacy strategy for both the SRHR and Key Populations Strategy was to find champions with influence. In both cases eSwatini (Swaziland), Namibia and South Africa formed a more liberal troika to push the content of the strategies.** The beauty of the SADC process is that there is less political involvement and much greater involvement of technical people before the draft document goes to the PS/Deputy Minister level. The Key Populations Strategy has thus become a framework for a SADC harmonized response setting out minimum standards which are aspirational for the member states. This allows the UN and local NGOs to place the needs of key populations on their advocacy agenda with real legitimacy. It also gives technical staff in ministries a way to link efforts to meet the needs of key populations back to agreed SADC regional documents."*	

• *"**UNFPA has been an active partner with the SADC Parliamentary Forum**, especially on research and advocacy for improving the legal environment, including:*
  ○ *Discriminatory age of consent laws*
  ○ *Development of a model law on early marriage. "*
• *"UNFPA support helped the SADC Parliamentary Forum to link to the East African Legislative Forum (the Parliamentary network of the East Africa Community).*
	• Interview with the SADC Parliamentary Forum, Windhoek

• *"**UNFPA was able to use the East and Southern Africa Ministerial Commitments** (ESA 2013) operationalized at a regional level as advocacy tools."*	• Interview with UNFPA CO, Windhoek

Assumption 4.2: The support provided by UNFPA to global, regional and national partnerships (including for example HIV prevention coalitions) has contributed to more and better joint policy development and programming on HIV prevention. UNFPA support has also contributed to re-positioning HIV prevention as an essential component of SRHR with broad participation.	
• *"**UNFPA involvement and promotion of Comprehensive Sexuality Education (CSE) in Namibia stems from and links with regional efforts** going back as far as 2013. In December 2013, UNAIDS called a meeting in South Africa and invited SADC ministries of health and education. The UN team highlighted the fact of 1.2 million new infections among adolescents in the region each year. At this meeting, SADC ministers committed to implement Comprehensive Sexuality Education for all those 10-24 years of age (adolescents and youth) in all 21 countries throughout Eastern and Southern Africa. Education and Health Ministries are core to this commitment. **The decision was taken to implement CSE through life-skills education**."*	• Interview with the HIV and AIDS Management Unit of the MEAC
• *"There is a **regional framework for CSE for out-of-school young people** which was developed with UNFPA support and adopted by the SADC Ministers of health, education and youth. This was further adopted to a CSE Framework for Out of School Young People in Namibia (2016)."*	• Interview with the MSYNS
• *"The **advocacy work of AfriYAN Namibia builds on the Ministerial Commitments for East and Southern Africa** (SADC Ministers of health, education and youth) in relation to **teenage pregnancy, Sexual and Gender Based Violence and HIV and AIDS."***	• Interview with the AfriYAN

Assumption 4.3: The development of policies and programmes for HIV prevention is characterized by the participation of diverse actors as advocated by UNFPA– especially organisations representing and led by adolescents and youth, key populations and women. This may include private sector participation in a total market approach to distribution of condoms for HIV prevention.	
Indicators: • Extent and frequency of national consultations on HIV prevention policy • Extent and frequency of participation by organisations representing and led by adolescents and youth, women and key populations in national forums and platforms for HIV prevention • Reported involvement of private sector actors in consultations on national HIV prevention strategies and programmes • Experience and views of national health authorities • Experience and views of staff of organisations representing adolescents and youth/women/key populations • Experience and views of organisations representing social marketing agencies and private sector firms engaged in distribution and sale of family planning products including condoms and lubricants	
Observations	**Sources of Evidence**
• *"**UNFPA has been a strong supporter of the Society for Family Health** and has also supported **the TWG on Key Populations** which involves representation from organizations representing the LGBTI community."*	• Interview with UNFPA CO for Namibia
• *"**NANASO** worked with UNFPA and with the SADC Parliamentary Forum on SRHR advocacy for Parliamentarians to ensure access for adolescents and young people. NANASO also works with UNFPA to support Civil Society Organizations such as **Out-Right Namibia and the Society for Family Health (SFH)** dealing with key populations and provide access to SRHR."*	• Interview with Namibia Network of AIDS Service Organizations

Assumption 4.3: The development of policies and programmes for HIV prevention is characterized by the participation of diverse actors as advocated by UNFPA–especially organisations representing and led by adolescents and youth, key populations and women. This may include private sector participation in a total market approach to distribution of condoms for HIV prevention.	

• *In each region, **AfriYAN engages in advocacy and dialogue** with a range of key stakeholders around the issues of teenage pregnancy, SGBV and HIV and AIDS. Stakeholders include:*
  ○ *Youth and adolescents*
  ○ *Traditional leaders*
  ○ *Government officials*
  ○ *Parents*
  ○ *Teachers*
  ○ *Police*
The dialogue begins by engaging with each group one at a time and then in a common forum."
	• Interview with the AfriYAN

• *"UNFPA works hard **to make sure that organizations representing adolescents and youth are "in the tent"** regarding the national dialogue on HIV and AIDS.*	• Interview with the AfriYAN
• *"UNFPA works hard **to ensure that Out-Right Namibia has a seat at the table and is involved in policy discussions**. In particular the HIV focal person at UNFPA communicates with them to make sure they get to take part in forums. She also linked them to NAPPA so they could work together."*	• Interview with Out-Right Namibia
• *"UNFPA **support to the office of the First Lady has helped build alliances with CSOs** representing the LGBTI community and other key populations."*	• Interview with the SFH, Windhoek
• *"UNFPA supported the development and creation of the **Technical Working Group (TWY) on key populations** and continues to support its operation. Members include: the MoHSS, Out-Right Namibia, Trans-Namibian Trust, Namibia Diverse Women and the Society for Family Health. You cannot have a TWG without the MoHSS on board."*	• Group Discussion with Members of the Technical Working Group on Key Populations

Assumption 4.4: National governments have been responsive to UNFPA advocacy for and support of meaningful participation of non-governmental actors in dialogue on HIV prevention policies and programmes including in programme development, implementation and accountability.	
Indicators: As per assumption 4.3	
Observations	**Sources of Evidence**
• *"There is **a reasonably good space for CSOs within the policy process** for HIV but the biggest **challenge is securing adequate resources**."*	• Interview with NANASO
• *"The **MoHSS recognizes that youth organizations are essential** in reaching this segment of the population. In the national dialogue, the National Youth Council is recognized as the voice of youth. This participation extends all the way down to regional youth organizations, including AfriYAN."*	• Interview with the AfriYAN
• *"The **national government does recognize that Civil Society Organizations (CSOs) have a role in ensuring services are appropriate to the LGBTI community** but could do more in ensuring that CSOs are involved in training and*	• Interview with Out-Right Namibia

Assumption 4.4: National governments have been responsive to UNFPA advocacy for and support of meaningful participation of non-governmental actors in dialogue on HIV prevention policies and programmes including in programme development, implementation and accountability.	
*sensitizing health sector staff. ORN have found in recent sessions the new staff from MoHSS that they deal with is **receptive to their input**."*	
• *"The MoHSS is fully on board with **the TWG** as a mechanism for identifying ways for the national HIV response to reach the LGBTI community. The platform **allows the community members to give guidance to MoHSS on what works in efforts to reach them**. The Ministry of Justice is also an open door for dialogue."*	• Group Discussion with Members of the Technical Working Group on Key Populations

Area of Investigation Five: Extent UNFPA has optimized its comparative advantage within the UNAIDS division of labour and has contributed to the collective strength of the cosponsors	
Evaluation Question 5: ***To what extent has UNFPA been able to ensure its comparative advantages at global, regional and national levels are recognized within its roles and responsibilities under the UNAIDS division of labour?***	
Evaluation Criteria	*Coordination, Efficiency, Effectiveness*
Rationale	It is essential that UNFPA is able to accept and carry out functions at global, regional and national level which reflect its comparative advantages among the UNAIDS cosponsors

Assumption 5.1: At global, regional and country level, UNFPA has been able to match its comparative advantages in mandate, brand recognition, and technical capacity to the tasks it takes on under the UNAIDS UBRAF. At country level, specifically, the Joint United Nations Team on AIDS (JUNTA) organisational structure and programming process recognizes and encourages a division of labour that assigns to UNFPA the role and responsibilities that capitalize on its distinctive advantages.

Indicators:

- Variation in roles taken on by UNFPA (under the UNAIDS cosponsor division of labour at country level) matched with changes in context of the epidemic and UNFPA technical capacity and mandate
- Experience and views of UNFPA CO staff
- Experience and views of national health and HIV authorities
- Experience and views of members of the JUNTA at country level
- Experience and views of implementing partners

Observations	**Sources of Evidence**
• *"UNFPA co-chairs Pillar Number 2 of the new (2019) **United Nations Partnership Framework (UNPAF) on social protection** (jointly with UNICEF). The UNPAF is a mechanism for coordinating the work of the entire United Nations Country Team, not just the Joint United Nations Team on AIDS (JUNTA) The Pillars and their chairs include:* o *Health – WHO* o *Education and Skills – UNICEF* o *Protection against violence – UNFPA* o *Social protection – UNFPA/UNICEF."*	• Interview with UNFPA CO
• *"In the UN team, UNFPA has the main responsibility for supporting the work of the Ministry **in Comprehensive Sexuality Education (CSE) for out of school youth** (WHO has a role as well but UNFPA is in the lead)."*	• Interview with the MSYNS)

Assumption 5.1: At global, regional and country level, UNFPA has been able to match its comparative advantages in mandate, brand recognition, and technical capacity to the tasks it takes on under the UNAIDS UBRAF. At country level, specifically, the Joint United Nations Team on AIDS (JUNTA) organisational structure and programming process recognizes and encourages a division of labour that assigns to UNFPA the role and responsibilities that capitalize on its distinctive advantages.	

• *Regarding the division of labour, the UNAIDS family in Namibia has worked hard to keep the basic division of labour as specified for UNAIDS co-sponsors as a whole so that the national level division of labour mirrors the global one – a **proper domestication of the global division of labour**.*
• *The joint programme has **four key focus areas for Combination Prevention**:*
  ○ *Adolescents and youth (young people)*
  ○ *Condoms planning, procurement and distribution*
  ○ *Key Populations*
  ○ *Advocacy*
  ○ *Legal Assessment undertaken by UNFPA provided a path for advocacy including the recent (May 24, 2019) event co-hosted by SFH and the Office of the First Lady*
  ○ *Sustainability.*
• *This holds for the whole United Nations Family. The 2014 to 2018 UNPAF treated HIV as a cross-cutting issue – the **current UNPAF has a proper HIV programme with an essential role for UNFPA**. They work through the profile of UNCT and its members to assign tasks.*
	• Interview with UNAIDS Namibia

• *"**UNFPA and UNESCO collaborate closely around Comprehensive Sexuality Education** (CSE) development and implementation in Namibia. In general terms UNFPA is responsible for supporting out-of-school CSE while UNESCO supports in-school CSE. However, UNFPA has a big role (in partnership with UNESCO) in the promotion and support of in-school CSE. This role includes:*
  ○ *Curriculum development*
  ○ *Teacher training and support to universities training teachers*
  ○ *Review of the life-skills curriculum."*
	• Interview with the UNECSO CO

• *"Under the existing United Nations Partnership Framework (UNPAF): 2014 to 2018, **the UN team has a joint plan for addressing HIV**. This will be updated to a new HIV plan for the 2019 to 2021 UNPAF. In the current (just ended UNPAF) the UN's plan to support HIV **focused on**:*
  ○ ***Prevention***
  ○ ***Treatment (WHO does the guidelines)***
  ○ ***Key Populations***
  Adolescents and Youth
• ***UNFPA played to their main strengths: Family Planning, Condoms and Education**. While they have a joint plan (described in the UNPAF) each agency also has its own workplan. In the joint plan they agree on the outcome areas and which output area receives contributions from each member organization.*
• *The JUNTA have **re-set the priorities for 2019-2021**. They will be:*
  ○ *Resource mobilization and sustainability*
  ○ *Combination Prevention including PMTCT*
	• Interview with selected members of the JUNTA, Namibia: WHO, Office of the Resident Coordinator, UNICEF, UN Women, and the WFP

Assumption 5.1: At global, regional and country level, UNFPA has been able to match its comparative advantages in mandate, brand recognition, and technical capacity to the tasks it takes on under the UNAIDS UBRAF. At country level, specifically, the Joint United Nations Team on AIDS (JUNTA) organisational structure and programming process recognizes and encourages a division of labour that assigns to UNFPA the role and responsibilities that capitalize on its distinctive advantages.	
○ *Human rights and gender."*	

Assumption 5.2: UNFPA supported activities and investments are strategically important to the HIV response, at global, regional and national level.	
Indicators: • National HIV strategies/roadmaps/action/plans/ programmes reflect advocacy and policy engagement by UNFPA (and cosponsors) • UNFPA supported activities concentrated in functional areas designated as high priority in national HIV strategies and programmes • UNFPA supported activities in HIV prevention and rights protection positioned to influence national policies and programmes going forward • Experience and views of national health and HIV authorities • Experience and views of members of the JUNTA at country level and bilateral agencies supporting the HIV response	
Observations	**Sources of Evidence**
• The Programme Implementation Approach segment of the **NSF for HIV Response** in Namibia: 2017/18 to 2021/22 has among its six component approaches: ***"e) HIV integration in the health care system*** *Service providers and in particular MoHSS (MoHSS will provide the leadership necessary for the integration of HIV services within mainstream health care including non-communicable diseases.* ***Integration will not only improve service delivery efficiency, but also increase uptake and utilization****."*	• MoHSS, Republic of Namibia, *National Strategic Framework (NSF) for HIV Response in Namibia: 2017/18 to 2021/22,* (2017) p.12
• *"The UNFPA CO works closely with implementing partners for both planning the new country programme and for development of the annual workplan but it all starts with the priorities of the National Strategic Framework (NSF) on HIV and the broader National Development Plan 5.* ***Their discussions with government led to agreement that integration would be UNFPA's main strategy for supporting the HIV response in Namibia****. This reflected the fact that ten years of vertical programming managed by the Directorate of Special Programmes (DSP) of the MoHSS was producing results but had led to neglect of the role of Primary Health Care in the HIV response."*	• Interview with UNFPA CO
• *Each year the MSYNS looks at its own priorities and annual workplans and identifies areas where they need support. They then have an annual planning meeting with UNFPA where they agree on the support to be provided and develop the main elements of the annual workplan for UNFPA supported activities.* ***UNFPA is helping them in 2019 in the development of a National Youth Policy*** *to be submitted to cabinet. This will be followed by working on the development of a National Youth Development Framework for approval near the end of the year (2019).*	• Interview with the MYSNS
• "***UNFPA has been most active*** *in the critically important area of supporting those Namibian organizations that work closely* ***with key populations and on prevention of HIV for Adolescent Girls and Young Women*** *(AGYW)"*	• Interview with the Global Fund Programme Management Unit, MoHSS
• *"A strategically important area that UNFPA could become more involved in is* ***advocacy to help unlock government resources for Civil Society Organizations (CSO) and to ensure that government engages more directly with civil society*** *on policy issues around HIV."*	• Interview with Namibia Network of AIDS Service Organizations
• *In particular, UNFPA has been effective in* ***advocacy for key populations*** *and in the development of tools such as the practitioner's handbook on Sexual Gender Based Violence (SGBV).*	• Interview with the SFH, Windhoek

Assumption 5.2: UNFPA supported activities and investments are strategically important to the HIV response, at global, regional and national level.	
• *"The **Office of the First Lady sees UNFPA as the go-to organization** on issues related to SRHR, especially for youth and adolescents and for key populations".*	• Interview with the One Economy Foundation/OFL
• *"**UNFPA support to Civil Society Organizations** engaged in providing out-of-school Comprehensive Sexuality Education (CSE) is a very significant, strategic contribution on behalf of the United Nations Country Team (UNCT)*	• Interview with UNESCO CO
• *"There is a high and **escalating incidence of SGBV with a clear inter-section between rape and HIV infection**. So, while there is a general decline in the overall infection rate this is not true for adolescent girls and young women and SGBV is a major factor in that. This argues for a strong role for UNFPA in supporting the response to SGBV. UNFPA chairs the UN working group on Gender and SGBV."*	• Interview with selected members of the JUNTA, Namibia: WHO, Office of the Resident Coordinator, UNICEF, UN Women, and the WFP
Assumption 5.3: UNFPA maintains the technical capacity required to carry out effectively the tasks assigned to it at global, regional and national levels as part of the UNAIDS consortium.	
Indicators: • See Assumption 5.1	
Observations	**Sources of Evidence**
• *"The **ESARO Upper Middle-Income Country (UMIC) Hub has been very helpful in providing support**. They have provided technical support, helped with resource mobilization, and organized inter-country meetings on HIV. They also help the CO to link with other technical resources at ESARO on an as-needed basis. This has greatly improved so that ESARO now is able to provide technical assessment and feedback within two weeks."*	• Interview with UNFPA CO
• *"**UNFPA key contributions have been around advocacy at regional and national levels** (see question two) **and technical support to Comprehensive Sexuality Education**."*	• Interview with the HIV and AIDS Management Unit of the MEAC
• "*The Ministry has a long history of collaboration with UNFPA during which it received **excellent technical support**."*	• Interview with the MSYNS
• "*UNFPA supports the MoHSS Directorate of Primary Health Care with technical support in all **key areas of HIV services, especially for adolescent services**."*	• Interview with the DPHC, MoHSS
• "***Family Planning is a key component of SRHR** and one of the strategic areas where UNFPA provides technical support to the Directorate for Primary Health Care."*	• Interview with the DPHC, MoHSS
• "*UNFPA provided important technical support to the **development of the Adolescent Girls and Young Women and Key Populations components** of the current Global Fund Grant Programme in Namibia."*	• Interview with the Global Fund Programme Management Unit, MoHSS
• *"**UNFPA is an essential source of both financial and technical support**."*	• Interview with Out-Right Namibia
• *"**UNFPA have technical strengths** in the areas of health sector integration, education for out of school youth and key populations as well as responding to Sexual Gender Based Violence in the context of the HIV Response."*	• Interview with selected members of the JUNTA, Namibia: WHO, Office of the Resident Coordinator, UNICEF, UN Women, and the WFP

Area of Investigation Six: Extent of UNPFA efforts to support the coordination of actions and resources to strengthen national leadership in the HIV response	
Evaluation Question 6: ***To what extent has UNFPA effectively supported and participated in platforms for coordinating and sustaining resources and programmes aimed at preventing HIV?***	
Evaluation Criteria	*Coordination, Sustainability*
Rationale	UNFPA and its partners are engaged in a common effort to encourage national leadership to increase sustainable national investments in HIV prevention over time. This requires concerted and coordinated efforts advocacy and associated financial and technical support along with responsive national authorities capable of making and realizing associated commitments.

Assumption 6.1: Global, regional and national coordination platforms (including the JUNTA) have been effective in identifying how external partners may most effectively contribute to nationally led policies and programmes for HIV prevention and coordinating subsequent external support.

Indicators:

- See assumption 5.1 above

Observations	Sources of Evidence
Prominent Coordinating Mechanisms for the HIV and AIDS Response in Namibia	
• "The current **coordination framework** includes the structures: i. The **Cabinet:** Cabinet is the highest policy making body on HIV/AIDS in Namibia ii. The **Meeting of Senior Civil Servants**: This is a monthly meeting of the Permanent Secretaries. It has the responsibility of ensuring harmonization and alignment o f the national response with government policy frameworks…. iii. The **National AIDS Executive Committee (NAEC):** The composition is multi-sectoral with representation from all stakeholders drawn from public and private sectors, civil society and the development partners with a mandate to provide technical leadership, facilitate programme development and planning, oversee capacity development and technical assistance, partnership strengthening and management of strategic information….. iv. **Regional AIDS Coordinating Committees** (RACOCS): RACOCS are multisectoral committees whose membership is drawn from all stakeholders operating in a specific regional with the mandate to facilitate and coordinate the regional response…. **v.** **Constituency AIDS Coordinating Committees** (CACOCS): CACOCS are responsible for co-ordinating the community response and operate under the auspices of their constituency councils.	• Republic of Namibia, MoHSS, *National Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22.* 2017, p.58.
• As per a diagram of the National Response Coordination Framework **the National AIDS Executive Committee (NAEC)** is supported by a set of committees reporting directly to it. Among the most important of these is the set of **Technical Advisory Committees (TAC)** which themselves are supported by different **Technical Working Groups (TWG).** • "*The participation of the United Nations agencies is coordinated by UNAIDS through the United Nations Joint Team on HIV/AIDS."*	• Republic of Namibia, MoHSS, *National Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22.* 2017, p.58 and 59.

Assumption 6.1: Global, regional and national coordination platforms (including the JUNTA) have been effective in identifying how external partners may most effectively contribute to nationally led policies and programmes for HIV prevention and coordinating subsequent external support.	
• The **National Gender Policy (2010-2020) has its own dedicated coordinating structure** headed by the National Gender Permanent Task Force, supported by a Coordination Mechanism Secretariat. • Under the authority of the Permanent Task Force there are **National Gender Plan of Action Clusters**, including those for: i. Gender-Based Violence and Human Rights ii. Health, HIV and AIDS iii. Education and the Girl Child iv. Poverty, Rural and Economic Development v. Governance, Peace and Security vi. Media Research, Information and Communications.	• Republic of Namibia, MGECW, *Coordination Mechanism for the Implementation of the National Gender Policy (2010-2020),* November, 2015, p.
• *"The United Nations Joint Team on AIDS **(JUNTA) was established in 2007** and is composed of all UN staff working full-time or part time on HIV and AIDS. In Namibia the Joint Team is comprised of staff members from the following organizations: **FAO, ILO, IOM, UNAIDS, UNESCO, UNFPA, UNHCR, UNICEF, UNODC, UNRC, WFP and WHO** as appointed by the respective heads of agencies. The JUNTA works to:* o *Support the established **national AIDS Coordination Structures and mechanisms** in its efforts to plan, implement and monitor the multi-sectoral and expanded national response;* o *Constitute an **entry point for national stakeholders** to access HIV and AIDS technical assistance and support from the UN system; and* o ***Formulate, implement and monitor the UN Joint Programme of Support to the national HIV response** based on the National Strategic Framework (NSF)".*	• *The United Nations Joint Programme of Support for AIDS in Namibia: 2014-2018.* (July, 2015), p.36.
• *The United Nations Partnership Framework **(UNPAF), is "a vehicle for strategic partnership and resource planning to drive programmes** through which the United Nations Country Team (UNCT) would support Namibia in the implementation of its development goals under vision 2030. The UNPAF is organized around **four pillars: Institutional Environment, Education and Skills, Health and Poverty Reduction**."*	• *The United Nations Partnership Framework (UNPAF) 2014-2018: Namibia Annual United Nations Country Results Report, 2016*. (June, 2017), p 6.
• The **UNPAF has its own coordinating mechanisms** including at its apex the UNFPA Joint Steering Committee co-chaired by the Ministry of Economic Planning and the United Nations Resident Coordinator. At the operational level it is supported by the meetings of the United Nations Country Team (UNCT) chaired by the Resident Coordinator. On matters of HIV and AIDS, the Joint UN Team on HIV and AIDS (JUNTA) provides input to the UNCT. In this way the JUNTA is connected directly to the UNPAF coordinating mechanism as illustrated in the Governance Structure and Implementation Mechanisms for the UNFPAF. (p.15).	• Government of the Republic of Namibia, United Nations Namibia, *United Nations Partnership Framework (UNPAF) 2019-2023.* (2019), p.13
• *"HIV/AIDS Namibia has launched the new **2017/18-2021/22 Strategic Framework on HIV and AIDS** linked with NDP 5 and to the 2016 United Nations Political Declaration for Ending AIDS by 2030. Building on the previous Joint Program, the UN has developed a new Joint Programme on HIV/AIDS aligned with this UNPAF. Under this programme, the UN will continue to work with different sectors and with civil society, to address HIV/AIDS in the different Pillars of the UNPAF. The programme **will focus on three main areas: i) strengthen the combination***	• Government of the Republic of Namibia, United Nations Namibia, *United Nations Partnership Framework (UNPAF) 2019-2023.* (2019), p.15

Assumption 6.1: Global, regional and national coordination platforms (including the JUNTA) have been effective in identifying how external partners may most effectively contribute to nationally led policies and programmes for HIV prevention and coordinating subsequent external support.	
prevention focusing on adolescent girls, young people, male engagement and key populations; ii) support the development and implementation of the Road Map for the elimination of HIV transmission from mother to child by 2022, iii) support resource mobilization, implementation and sustainability of the framework for epidemic control in Namibia, and support integration of food and nutrition in HIV/AIDS activities."	
• The ***National School Health Task Force*** **is the main coordinating body for efforts in health and education** and it has multi-sector participation including: o *UNICEF/UNESCO/UNFPA* o *The University of Namibia (for teacher training)* o *Republic of Namibia Ministries of:* ▪ Health and Social Services ▪ Education, Arts and Culture ▪ Sports, Youth and National Services ▪ Gender Equality and Child Welfare	• Interview with the HIV and AIDS Management Unit of the MEAC
Views and Experience of Key Informants Regarding UNFPA Participation and Effectiveness of Coordinating Mechanisms	
• *"**Regional coordinating structures (within Namibia) have not been working well recently and need to be revived**. The Regional Health Education Task Forces are weak in many of the regions. There is also the Regional AIDS Coordinating Committees coordinated by the Office of the Governor in each Region and draws membership from all the Ministries in the region and the CSOs involved in HIV programmes. There seems to be many parallel structures nationally and regionally with overlapping agenda and competing for time/participation by the same stakeholders".*	• Interview with the HIV and AIDS Management Unit of the MEAC
• "*In the national structure for coordinating action in the HIV response, under the National AIDS Executive Committee **(NAEC) which is the overall coordinating body**, there are a number of **Technical Advisory Committees** which in turn have Technical Working Groups. For example, there is a **TAC on HIV, which has a Technical Working Group (TWG) on STIs and Condom programming**. TWG's report to TACs, which, in turn, report to the NAEC.* [Nota Bene: In conversations with other key informants, including for example, the Global Fund, the NAEC is not seen as especially dynamic.] • ***Other Technical Working Groups** and their relative level of activity are:* o *Adult Girls and Young Women – strong in the beginning but less active now* o *Key Populations – reasonably active, supported by the Society for Family Health with UNFPA assistance* o *Condoms* o *Treatment of HIV* o *PMTCT quite active.* • There used to be a Maternal and Child Health Committee with a sub-group on SRH/HIV integration but this is now dormant.	• Interview with UNFPA CO

Assumption 6.1: Global, regional and national coordination platforms (including the JUNTA) have been effective in identifying how external partners may most effectively contribute to nationally led policies and programmes for HIV prevention and coordinating subsequent external support.	
• *"During the first (pilot) phase of the Integration programme there was **a steering committee on integration with participation by Directorate of Special Programmes and the Directorate for Primary Health Care** within the MoHSS as well as by UNFPA and PEPFAR/CDC. However, this steering committee **was not continued during the second phase as the MoHSS proceeded to roll out integration** across the country."*	• Interview with UNFPA CO
• *"Coordination bodies need to be strengthened and made more visible and active. The **NAEC lacks both resources and information**. This lack of information occurs because different UN agencies and departments of MoHSS are busy writing proposals and chasing resources."*	• Interview with the DSP, the MoHSS

• *"There are **many coordinating bodies and platforms but they do not receive adequate funding and support and are often not taken seriously** by the NAEC."*
• *"There are TACS (Technical Advisory Committees) under the NAEC which work with varying degrees of effectiveness:*
  ○ *The TAC on Treatment Works Well*
  ○ *The TAC on Combination Prevention has Technical Working Groups on:*
  ▪ *Key Populations*
  ▪ *Adolescent Girls and Young Women (AGYW)*
  ▪ *PrEP*
  ○ *The TAC on Monitoring and Evaluation meets but does not produce very much – it is mainly a vehicle for donor conversations on data gathering.*
  ○ *The TAC on HIV Response Coordination and Management does not meet but does have a functioning TWG on Resource Mobilization which seems to function fairly well but has no one to report to.*
• *The problem is that we don't have a strong, driving advocacy from the NAEC on the need **to prioritize investment in HIV prevention**."*
	• Interview with the Global Fund Management Unit, MoHSS

In reference to the coordinating structure of the **National Gender Programme**: • "*UNFPA has been active in support of the TWG on GBV and Human Rights and in the cluster for Gender and Health. However, UNFPA could have a more prominent role in the coordination cluster on Gender and Health which is not working very well and has not implemented its terms of reference and plan of action (MoHSS is supposed to chair this group but it does not meet often)."* • *"Clusters/TWGs on GBV and Education work well but the one on HIV and SRHR does not. The Cluster on GBV is chaired by the Ministry of Gender. UNFPA has also supported the establishment and operation of regional clusters on GBV."*	• Interview with the MGECW
• *"UNFPA provides considerable technical support to the **Technical Working Group on condom programming** under the NAEC structure."*	• Interview with the SFH
• *"The **TWG on key populations** provides a platform where MoHSS and the organizations representing key populations can have a dialogue. It was set up as an integral part of the national mechanism for coordinating action on HIV (the National AIDS Executive Committee - NAEC). The Society for Family Health serves as the Secretariat.*	• Group Discussion with Members of the Technical Working Group on Key Populations.

Assumption 6.1: Global, regional and national coordination platforms (including the JUNTA) have been effective in identifying how external partners may most effectively contribute to nationally led policies and programmes for HIV prevention and coordinating subsequent external support.	
UNFPA supported the establishment of the TWG and continues to support its operation through the Society for Family Health."	
• *"There has not been good coordination and consultation across the Directorate for Primary Health Care/Directorate of Special Programmes divide over the roll-out of integration. This may be because **the Steering Committee on Integration** which they co-chaired during the pilot-test phase was not continued during the roll-out phase."* • *"There needs to be better coordination around issues relating to adolescents and youth as well. And while all the key actors are involved in **the Health and Education Task Forces** (National, Regional, Constituency) they are not so effective. There is also the monthly health development partners Working Group chaired by WHO and WHO is active in make sure those meetings happen. On combatting S there is no conflict on policies but there is a failure to take advantage of possible synergies."*	• Interview with PEPFAR/CDC
• *"From the UN side they meet as the **JUNTA** on the last Thursday of every month. This then means that they are prepared to present any HIV questions/issues to the subsequent meeting of the UNCT which meets on the first Thursday each month."*	• Interview with UNAIDS Namibia
• *"UNESCO and UNFPA take part in the **National School Health Task Force** which has a sub-committee to monitor performance against the East and Southern Africa (ESA) Ministerial Commitments on CSE and SRH for young people. They also take part in the Adolescent Girls and Young Women (AGYW) Technical Working Group (TWG) under the NAEC structure."* • *"**The SADC meeting of Ministries of Health, Education and Youth** has a standing item which requires regular review of the experience of countries in the region as they roll out CSE in order to comply with the ESA commitments. In these regular reviews the government of Namibia is seen as a high achiever (doing well). UNESCO also participates in a gender-themed TWG which is co-led by UNFPA and the Ministry of Gender."*	• Interview with UNESCO CO
• *"Within the coordinating structure of **UNCT/JUNTA they have a Technical Working Group on Health** which includes UNFPA, UNAIDS, UNICEF and WHO. An issue arising from all this (see definitions of adolescent and youth health in question two) is the problem of sending a consistent message on health for adolescents and youth. Sometimes their government partners want to know: What is the UN telling us on adolescent health? When the WHO discusses the need for SRHR for adolescent girls and young women they want to put it in a larger strategy for adolescent health generally, while UNFPA can just refer to the SADC strategy for adolescent SRHR."* • *They are currently in the process of de-linking the Resident Coordinator function from one of the UN agencies to the "**newly created Resident Coordinator Office** which will be independent. Until a new RC is named the UNICEF Representative is acting as the UN Resident Coordinator in Namibia."* • *"The **JUNTA has a secretariat** at UNAIDS and the Secretary (UNAIDS) keeps everyone informed. They make planning decisions within the JUNTA and these are communicated to the subsequent meeting of the UNCT by the head of UNAIDS."*	• Interview with members of the JUNTA (IOM, WHO, Office of the Resident Coordinator, UNICEF, UN Women, WFP)

Assumption 6.1: Global, regional and national coordination platforms (including the JUNTA) have been effective in identifying how external partners may most effectively contribute to nationally led policies and programmes for HIV prevention and coordinating subsequent external support.

Assumption 6.2: Platforms and structures for coordinating support to the HIV response do not duplicate the work of other structures for coordinating action in HIV, SRHR and SGBV.

Indicators:

- Frequency of meetings of platforms for coordinating the HIV response and related platforms for coordination of other SRHR interventions (including mother and child health and family planning
- Overlapping mandates (or not) of HIV, SRHR and SGBV related coordinating platforms
- Cross-membership in platforms for coordinating action in HIV and in SRHR
- Reported overlap or duplication of effort among coordinating platforms as reported by participants

Observations	Sources of Evidence
• *"For education and health, Regional coordinating structures (within Namibia) have not been working well recently and need to be revived. The Regional Health Education Task Forces are weak in many of the regions. There is also the Regional AIDS Coordinating Committees coordinated by the Office of the Governor in each Region and drawing membership from all the Ministries in the region and the CSOs involved in HIV programmes. There seems to be **many parallel structures nationally and regionally with overlapping agendas and competing for time/participation** by the same stakeholders."*	• Interview with the HIV and AIDS Management Unit of the MEAC

Assumption 6.3: External partners, including UNFPA, have worked in concert to promote institutionalization of sustainable national investments in the HIV response that are appropriate to the evolving and emerging challenges and needs posed by the epidemic in that country.

Indicators:

- Agreed strategies and approaches among UNAIDS cosponsors and multilateral and bilateral partners regarding promotion of national investment in HIV response
- Trends over time in national investment in the HIV response both in absolute terms and in relation to external support
- Changes in national budget procedures and criteria which institutionalize investments in HIV: i.e. commencing a specific, regular budget line for HIV budgets at national, regional, district level
- Integration of HIV budgeting and resource allocation into efforts to put national health systems on a sustainable footing including development of national health insurance schemes/programmes
- Efforts to encourage private insurers and/or private, for profit, firms to invest in national and local HIV response

Observations	Sources of Evidence
• *"The MoHSS is organizing a SADC meeting on **sustainable resource for HIV programmes** in the region. This is being done with support to the Government of the Republic of Namibia from UNFPA, UNAIDS, and PEPFAR/CDC."*	• Interview with UNFPA CO
• *"Each year the MYS looks at its own priorities and annual workplans and identifies areas where they need support. They then have an annual planning meeting with UNFPA where they agree on the support to be provided and develop the main elements of the annual workplan for UNFPA supported activities."*	• Interview with the MSYNS
• *"The Technical Working Group on resource mobilization meets regularly but lacks an organizational focus. The problem is that we don't have a strong, driving advocacy from the NAEC on the need **to prioritize investment in HIV prevention**."*	• Interview with the Global Fund Programme Management Unit, MoHSS

Assumption 6.3: External partners, including UNFPA, have worked in concert to promote institutionalization of sustainable national investments in the HIV response that are appropriate to the evolving and emerging challenges and needs posed by the epidemic in that country.	
• *"As noted, the decline in resources from the Global Fund Grant is putting pressure on the CSO sector but NANASO and the CSOs are looking at the possibility of social contracting with support from UNAIDS."*	• Interview with Namibia Network of AIDS Service Organizations
• *"For the National Youth Council (NYC), the first priority is **to build the institutional capacity** of organizations like AfriYAN, rather than **just seeing them as a service provider**. Last year, the NYC sent UNFPA a proposal to the UNFPA Country Representative focused on building institutional capacity among youth oriented CSOs and the hope it becomes part of the national youth policy. Currently the funding is quite narrowly focused because UNFPA can only fund a narrow spectrum of mainly service delivery activities. It would be good to make the partnership more meaningful and flexible over the longer-term including support to build institutional capacity."*	• Interview with the NYC
• *"It is very difficult to get funding now that **Namibia has achieved Upper Middle-Income Country Status** (UMIC). UNFPA and the government are very open about calling people like Out-Right Namibia in for consultations but sometimes they are too focused on funding very specific types of interventions and do not look at capacity development of the organizations they need to access key populations.* • *Out-Right Namibia are totally project funded, and have no core funding. They are looking at non-traditional sources of funding such as the private sector and crowd funding. UNFPA is still an essential source of support for them."*	• Interview with Out-Right Namibia
• *"**UNFPA has helped NAPPA** in preparing a proposal for the new Global Fund Round of funding. It also put NAPPA in touch with the Namibia Institute for Democracy to focus the proposal to deal with issues of Human Rights. The proposal was successful and two of the activities proposed by NAPPA were funded. However, there is a need both for NAPPA to become a leaner organization and for increased investments in human resources and in improving their capacity for implementing services at the site. Development Partners – Including UNFPA are reluctant to fund capacity development for the organizations they support although they are willing to fund services. Further support is needed for proposal writing on resource mobilization. Additional support is also needed to procure equipment and materials to strengthen the implementation of integrated services."*	• Interview with NAPPA
• *"Regarding sustainability, Namibia has done well to reach the 90/90/90 targets. The UNCT is working with the Namibian Government on making the **investment case for funding to meet the 2030 targets** set by the UN Political Declaration on HIV/AIDS. They are trying to bring the US Government and Global Fund on board as part of this effort to meet the 2030 targets re: sustainability. UNAIDS also supports this effort within the SADC framework. They co-signed a letter on this from the UN to the US Government and the Global Fund. The new data from the NAMPHIA (if the report is released soon) can help build the investment case for the next round of funding from both PEPFAR and the Global Fund. The development partners involved in HIV are now discussing how to support the transition phase to a controlled epidemic – UNAIDS is in dialogue with PEPFAR/USAID and the Global Fund on this transition."*	• Interview with UNAIDS Namibia
Assumption 6.4: National governments have both the interest and the capacity to respond effectively to coordinated efforts to institutionalize and render more sustainable the national HIV response.	
Indicators: • As in 6.3 plus: • Views of national budget authorities	

<table>
<tr><td colspan="2">Assumption 6.4: National governments have both the interest and the capacity to respond effectively to coordinated efforts to institutionalize and render more sustainable the national HIV response.</td></tr>
<tr><td colspan="2">• Views of Staff of UNAIDS cosponsors
• Views of United Nations CO staff
• Views of bilateral agencies supporting HIV prevention</td></tr>
<tr><td>Observations</td><td>Sources of Evidence</td></tr>
<tr><td>Situation Analysis
• “Government spending on HIV and AIDS has been within the context of relatively high government allocation to the health sector. Government health expenditure as a percentage of total government expenditure in 2014 was approximately 14%. Public health expenditure as a percentage of GDP was estimated at 5.4% in 2014. In comparison with other upper middle-income countries in Africa, government expenditure in health is relatively high. Despite high government allocations to the health sector, sustainability of HIV/AIDS financing remains a major challenge and HIV/AIDS services are still significantly dependent on external funding from donor funding.”
• “The last National AIDS Spending Assessment (NASA) was conducted in 2014. According to the report 65% of the funding for the HIV/AIDS response came from domestic sources including 1% from private sources. Thirty five percent (35%) of resources came from international sources. The Government of Namibia (GRN) has been the largest contributor (64%) of HIV/AIDS funding followed by PEPFAR (27%), Global Fund (6%), and private sector (1%). The remaining funding came from a variety of sources including German Development Cooperation (GIZ), UN agencies, and other international sources. The HIV spending in Namibia was US$ 201,060,024 (approximately N$ 2.07 billion37) in the period 2012/13 and US$ 213,346,629 (approximately N$ 2.2 billion) in the period 2013/14 respectively. The NASA report shows an increase in the funds spent by 6% percent from 2012/2013 to 2013/2014. Most of the expenditure on HIV/AIDS funding went to the provision of ARTs. “
• “Both Global Fund and PEPFAR resource envelopes in Namibia are expected to significantly reduce during the period of the NSF (2017/18 – 2021/22). The Global Fund allocation to Namibia for 2018-20 representing only 20% annually of the 2016/17 commitment.”</td><td>• Republic of Namibia, MoHSS. National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22. (2018), p.69.</td></tr>
<tr><td>• In 2018, the MoHSS published the results of a review of Health and HIV spending in 2015/16 and 2016/17. The review reported expenditures and the sources of funds are summarized in the table below:
<table>
<tr><td>2015/16</td><td>2016/17</td></tr>
<tr><td>Total Recurrent Spending in Namibian Dollars: 1,955, 279, 116</td><td>Total Recurrent Spending in Namibian Dollars: 2,366,494,096</td></tr>
<tr><td>Estimated in USD at an Average Historical Exchange Rate of 13.5 N$ = 145 Million USD</td><td>Estimated in USD at an Average Historical Exchange Rate of 13.5 N$ = 175.3 Million USD</td></tr>
<tr><td>Sources of funding</td><td>Sources of funding</td></tr>
<tr><td>Public (Government of Namibia): 47 percent</td><td>Public (Government of Namibia: 55 percent</td></tr>
<tr><td>Donors: 38 percent</td><td>Donors: 36 percent</td></tr>
</table></td><td>• Republic of Namibia, Namibia’s Health and HIV Financing Landscape: Evidence from the 2015/16 and 2016/17 Resource Tracking Exercises. (August, 2018). P.24</td></tr>
</table>

Assumption 6.4: National governments have both the interest and the capacity to respond effectively to coordinated efforts to institutionalize and render more sustainable the national HIV response.

Private Companies: 12 percent	Private Companies: 8 percent
Households: 3 percent	Households: 1 percent

- The HIV Financing Landscape Study identified the trends in sources of financing for HIV related programming for five different fiscal years.

Year	Public (Government)	Donors	Private Firms	Households
2012/13	39 %	54 %	5 %	2 %
2013/14	40 %	46 %	14 %	1 %
2015/16	47 %	38 %	12 %	3 %
2016/17	55 %	36 %	8 %	1 %

- Republic of Namibia, *Namibia's Health and HIV Financing Landscape: Evidence from the 2015/16 and 2016/17 Resource Tracking Exercises.* (August, 2018). P.29

- The same study breaks down total AIDS expenditures by activity category.

Spending Category	Percentage Share 2015/16	Percentage Share 2016/17
Care and Treatment	54	59
Prevention	18	18
Orphans and Vulnerable Children (OVC)	20	18
Systems Strengthening	4	4
Incentives for Human Resources	3	4
Not Classified	1	1

- Republic of Namibia, *Namibia's Health and HIV Financing Landscape: Evidence from the 2015/16 and 2016/17 Resource Tracking Exercises.* (August, 2018). P.27

- While the national government funded 55 percent of all spending on HIV/AIDS in fiscal year 2016/17, **the share of spending provided for by different funding sources varied considerably across different functional categories** of expenditure. Notably, while the national government funded most purchasing of pharmaceuticals, including ARVs in 2016/17, almost all training was financed by donors:

Functional Spending Category (2016/17)	Percent Funded by Government	Percent Funded by Donors	Percent Funded by Private Firms	Percent Funded by Households
Compensation	45			
Lab Services	1	0	89	10
Pharmaceuticals	77	14	8	1
Other Health Care Goods	83	17	0	0
Training	5	95	0	0
Other	22	71	4	3

- Republic of Namibia, Namibia's Health and HIV Financing Landscape: Evidence from the 2015/16 and 2016/17 Resource Tracking Exercises. (August, 2018). P.27

- *"The resource tracking results show that the **HIV/AIDS program is exposed to significant risk in terms of donor reliance**, with the donor contributions to the response amounting to 38 percent in 2015/16 and 36 percent in 2016/17. The government has shown a strong commitment to financing ARVs and intends to continue this*

- Republic of Namibia, Namibia's Health and HIV Financing Landscape: Evidence

Assumption 6.4: National governments have both the interest and the capacity to respond effectively to coordinated efforts to institutionalize and render more sustainable the national HIV response.	
commitment by aiming to fund the drugs exclusively from domestic resources by 2019. However, the response remains particularly vulnerable due to the reliance on donor funding for certain program areas such as prevention, health systems strengthening and program coordination, incentives for human resources (i.e., training), and research. It is also exposed to risk as a result of donors contributing significantly to certain factors of provision, such as employee compensation, pharmaceuticals, and training, as well as exclusively providing funding towards interventions for key populations. The reliance on donor funding means the country risks the collapse of these components when donors withdraw their funding support."	from the 2015/16 and 2016/17 Resource Tracking Exercises. (August, 2018). P.27
• *"The government **needs to consider the sustainability of the HIV/AIDS response, not only in terms of overall financing, but rather, of all the resources required for each component of the response** and the capacity of the systems to effectively manage the response without donor support. To successfully deal with this situation, Namibia should give priority to the development of a country owned sustainability strategy for HIV/AIDS."*	• Republic of Namibia, Namibia's Health and HIV Financing Landscape: Evidence from the 2015/16 and 2016/17 Resource Tracking Exercises. (August, 2018). P.32
• *"Finally, there is **need to strengthen reporting of HIV/AIDS expenditure disaggregated by key populations** like sex workers, men who have sex with men, injecting drug users, etc. and by age characteristics. Often, these data on beneficiary characteristics were not carefully tracked and were not possible to disaggregate. Future resource tracking exercises should pay careful attention to collecting spending disaggregated by beneficiary characteristic and age profiles."*	• Republic of Namibia, Namibia's Health and HIV Financing Landscape: Evidence from the 2015/16 and 2016/17 Resource Tracking Exercises. (August, 2018). P.32
• Under the NSF, there was a situation analysis of sustainability conducted in 2018 and the Directorate of Special Programmes developed a sustainability framework for the HIV Response. The resulting programme on sustainability is now operated by the Washington Group for Development which has a draft document on sustainability to be shared at a meeting on 21 May 2019. It is expected to **identify needed efficiency gains and put the HIV response in the context of wider issues of sustaining health care investment**, including: o Universal Health Coverage o Minimum Package of Services o A Nutrition Strategic Framework o Social Contracting Strategies (Supported by UNAIDS) o Links to Human Resources for Health	• Interview with the Global Fund Programme Management Unit, MoHSS

ANNEX C: PERSONS INTERVIEWED

Name	Organization	Position
Acharya, Dr. Narmada	UNAIDS Regional Support Team for East and Southern Africa	Regional Programme Adviser
Akwenye, Uajorokisa	One Economy Foundation, Office of the First Lady	Programme Officer
Alughodi, Hileni	Onandjokwe Regional Health Management Team	Chief Health Programme Officer
Amaambo, Taimi	Society for Family Health	Executive Director
Amakali, Ruusa	Ministry of Sport Youth and National Service	Senior Youth Officer, Youth Health and Well Being
Amkongo, Loide	UNFPA Namibia	Assistant Representative and Adolescent SRH Specialist
Bakaroudis, Maria	UNFPA East and Southern Africa Regional Office	Comprehensive Sexuality Education Specialist
Bhera, Fungai	Namibia Planned Parenthood Association Okuryangava Clinic, Windhoek	Senior Registered Nurse
Black, Mathew	MoHSS, Global Fund Programme Management Unit	Acting Director
Boemo, Sekogma	Southern Africa Development Community Parliamentary Forum	Programme Manager, Human and Social Development
Braithwell, Mary	World Health Organization Namibia	HIV Specialist, JUNTA Representative
Delate, Richard	UNFPA East and Southern Africa Regional Office	Programme Specialist SRH/HIV
Diallo, Julie	UNFPA East and Southern Africa Regional Office	Gender Programme Specialist
Dziuban, Eric	United States Centres for Disease Control and Prevention	Country Director for Namibia
Fransina Rijatua	Namibia Planned Parenthood Association	Clinical Services Manager
Gayle, Dennia	UNFPA Namibia	Country Representative
Geza, Shirley	Onandjokwe Regional Health Management Team	Nurse Mentor
Gulma, Alemseged	Onandjokwe Regional Health Management Team	Pharmacist
Haiduwa, Lysias	Ministry of Sport Youth and National Service	Chief, Youth Programmes
Hanghombe, Salotte	MoHSS, Global Fund Programme Management Unit	Senior Programme Officer
Harris, Thomas	National Statistics Agency	Director, Population and Social Statistics
Hauwanga, Penelao	UNFPA Namibia	Finance Associate
Tjaronda, Albert	MoHSS, Directorate of Special Programmes	Senior Health Programme Administrator
Heita, Aina	UNESCO Namibia	National Programme Officer for Health and Education
Hidinua, Grace	UNFPA Namibia	Specialist, HIV Prevention and Family Planning

Name	Organization	Position
Idhoghela, Linda	National Statistics Agency	Programme Manager
Ikuambi, Rejoice	African Youth and Adolescents Network	Programs Manager
Johannes, Karin	Out Right Namibia	Monitoring and Evaluation Officer
Kakukura, Elizabeth	Office of the United Nations Resident Coordinator for Namibia	JUTA Representative
Kahikuata, Dr. Inaani	Ministry of Sport Youth and National Service	Director, Youth Development
Kamati, Lydia	Namibia Planned Parenthood Association Okuryangava Clinic, Windhoek	Clinical Assistant
Koita, Liana	National Statistics Agency	Programme Manager
Kuzee, Helena	Office of the First Lady	Executive Assistant to the First Lady of Namibia
Lindiwe, Siyaya	UNFPA East and Southern Africa Regional Office	Communications Analyst
Linosi, Bravo	MoHSS, Directorate of Special Programmes	HIV Prevention Coordinator
Lumbu, John	Onandjokwe Regional Health Management Team	Nurse Manager
Makokuha, Jacqueline	UNAIDS Regional Support Team for East and Southern Africa	Senior Policy and Strategy Adviser
Mensah, Ricardo	Out Right Namibia	Director
Mohloai, Teboho	Africa Youth and Adolescent Network	Secretary General for East and Southern Africa
Moses, Foibe	MoHSS, Directorate of Primary Health Care	Senior Health Programme Officer, Family Planning
Mayo, Rita	Out Right Namibia	Programme Officer
Modisaotsile, Innocent	UNFPA East and Southern Africa Regional Office	SRHR/HIV Adviser
Moyo, Sindiso	African Youth and Adolescents Network	Vice Chair
Mubonenwa, Rosina	Ministry of Gender Equality and Child Welfare	Director, Gender Mainstreaming
Nanuwe, Elizabeth	Khomasdal Health Centre, Windhoek	Registered Nurse in Charge
Nepela, Alina	Onandjokwe Intermediate Referral Hospital and Primary Health Care Clinic	Primary Health Care Supervisor
Ndongui, Saima	Okankolo Health Centre, Oshikoto Region	Data Clerk
Nghidimondjila, Cecila	Okanlolo Health Centre, Oshikoto Region	Registered Nurse in Charge
Nghitila, Sircca	National Youth Council	Programs Manager
Nghifikwa, Julius	Ministry of Education Arts and Culture, HIV and AIDS Management Unit	Deputy Director
Nitschke, Anne Marie	MoHSS, Directorate of Special Programmes	Director
Njembo, Tjinae	Maxuilili Clinic, Okahandja Park, Windhoek	Registered Nurse in Charge
Nsanzya, Kizito	UNFPA East and Southern Africa Regional Office	Monitoring and Evaluation Specialist
Ongpin, Patricia	UNAIDS Namibia	Fast Track Adviser
Odek, Willis	UNFPA East and Southern Africa Regional Office	Strategic Information Specialist, MI Country Hub

Name	Organization	Position
Odomosu, Alusegun	South Africa AIDS (SAFAIDS)/African Men for Sexual Health and Rights	Programme Officer
Osseni, Alladji	UNAIDS Namibia	Strategic Information Advisor
Philipose, Anandita	UNFPA East and Southern Africa Regional Office	Gender Equality Adviser
Penoshinge, Shililifa	Ministry of Gender Equality and Child Welfare	Deputy Director, Research
Salomo, Matheus	Okankolo Health Centre, Oshikoto Region	Pharmacist Assistant
Shechama, Immanuel	Onandjokwe Regional Health Management Team	Senior Health Programme Officer
Shaanika, Paulus, N.	Regional Health Management Team, Khomas	Senior Health Programme Officer
Shangula, Elizabeth	Onandjokwe Intermediate Referral Hospital and Primary Health Care Clinic	Chief Health Programme Officer, Family Health
Shapopi, Johannes	Out Right Namibia	Programme Officer
Shawa, Remy	UNESCO, East and Southern Africa	Regional Officer, HIV and Health Education
Sheende, O.	Onandjokwe Regional Health Management Team	DHIS Officer
Shihepo, Ella	Namibia Planned Parenthood Association	Interim Director
Shivute, Laina	Maxuilili Clinic, Okahandja Park, Windhoek	Registered Nurse for ART
Siraji, Dr. Saad	Onandjokwe Regional Health Management Team	Senior Medical Officer
Situmbeko, Florence	International Organization for Migration, Namibia	JUTA Representative
Spear, Carey	President's Emergency Fund for AIDS Relief, Namibia	Coordinator
Tjiroze, Mao	President's Emergency Fund for AIDS Relief, Namibia	PEPFAR
Barihuta, Tharcisse	UNAIDS Namibia	County Director
Stephanus, Frieda	Namibia Planned Parenthood Association	Director
Sunkutu, Dr. Kanyanta	UNFPA East and Southern Africa Regional Office	RHCS/CCP Technical Specialist
Takawira, Lucetta	UNFPA East and Southern Africa Regional Office	Finance Associate
Tjiroze, Meunayo	One Economy Foundation, Office of the First Lady	Programme Officer
Tjaronda, Sandi	Namibia Network of AIDS Service Organizations	Executive Director
Theron, Veronica	Office of the First Lady of Namibia	Technical Director to the First Lady
Tjarona, Mr. A	MoHSS, Technical Working Group on Key Populations	Chair
Ukola, Tomas	MoHSS, Directorate of Special Programmes	Deputy Director
Venaani, Cloudina	MoHSS, Directorate of Primary Health Care	Coordinator of AGYW Programmes

ANNEX D: DETAILED TABLES OF HIV-RELATED EXPENDITURES, 2016-2019

- Table 1: UNFPA HIV Related Project Budgets and Expenditures 2016
- Table 2: HIV Related Project Budgets and Expenditures: UNFPA Namibia: 2017
- Table 3: HIV Related Project Budgets and Expenditures for UNFPA Namibia: 2018
- Table 4: HIV Related Project Budgets and Expenditures: UNFPA Namibia 2019

Table 1: UNFPA HIV Related Project Budgets and Expenditures 2016

2016 Projects	Description	Implementing Agency	Project Budget	Disbursement (Excluding OFA)	Project Budget Utilization Rate
Safeguard Young People (SYP)	Adapt CSE Guide out of school	NAPPA	1,742	1,688	96.9%
	Advocacy Media and Comm Events	UNFPA	32,527	29,720	91.4%
	Train 40 health workers on AFH	MoHSS	0	0	
	Bank Charges Costs	NAPPA	511	382	74.7%
	Coordination Mechanism	NAPPA	740	-87	-11.7%
	Conduct CSE Sessions	NAPPA	226	226	99.9%
	Review AFHS cirriculum	MoHSS	9,234	9,234	100.0%
	Conduct national dialogues	MSYNS	3,509	3,373	96.1%
	Gate Keepers Capacity Building	NAPPA	12,069	13,725	113.7%
	General Operating	UNFPA	26,964	24,995	92.7%
	Operationaliz youth Task Force	NAPPA	1,881	1,205	64.1%
	Document Best Practices	UNFPA	3,950	3,219	81.5%
	Project Monitoring	UNFPA	513	513	100.0%
	Provide AYFHS to young people	NAPPA	7,556	7,584	100.4%
	Host Radio talk shows on SRH	NAPPA	976	815	83.5%
	Conduct social Mobilization	MSYNS	6,277	6,343	101.1%
	Staffing PS HIV and Youth	UNFPA	12,363	12,363	100.0%
	Support cost to NAPPA	NAPPA	706		0.0%
	Support cost to NAPPA	NAPPA	4,308		0.0%
	Collate Youth Status Report	MSYNS		15,024	
	Develop Youth Status Report	MSYNS	20,287	5,063	25.0%
Total for SYP			**146,337**	**135,384**	92.5%
Integrating SRH/HIV (UQA64 NAM)	Organize Advocacy meeting	MoHSS	0		0.0%
	Finalize cancer guidelines	MoHSS	0		0.0%
	Strengthen capacity for Lecturers	MoHSS	6,373	6,689	105.0%
	Final Evaluation SRH/HIV	UNFPA	7,264	7,347	101.1%
	Gatekeepers Capacity Building	NAPPA	5,803	2,154	37.1%
	GBV PREVALENCE STUDY	MGECW	41,849	41,849	100.0%
	Management orientation workshop	MoHSS	25,764	26,490	102.8%
	Management orientation workshop	UNFPA	8,650	8,650	100.0%
	Conduct Maternal Peri/Neonatal	MoHSS	2,078	2,078	100.0%
	Review and update NEM List	MoHSS	0		

2016 Projects	Description	Implementing Agency	Project Budget	Disbursement (Excluding OFA)	Project Budget Utilization Rate
	SRH/HIV Guidelines	MoHSS	4,388	4,388	100.0%
	SRH/HIV Guidelines	PU0074	0		
	PROCURE EQUIPMENT	MoHSS	24,821	22,425	90.3%
	Project REPORTS	MoHSS	5,975	6,298	105.4%
	Regional Meetings	UNFPA	235	230	97.7%
	Service Delivery SRH/HIV	UNFPA		-2,097	
	Finalize and print SRH Guide	MoHSS	6,736	6,874	102.0%
	Staffing Admin Prog Associate	UNFPA	42,753	46,854	109.6%
	Support stigma index	MoHSS	1,738	1,689	97.2%
	Mobilise & sensitize communities	MoHSS	3,200	3,109	97.1%
	TA & Capacity Building	MoHSS	240	240	100.0%
	TA & Capacity Building	UNFPA	43,916	40,300	91.8%
	TA & Capacity Building	UNFPA	34,530	4,686	13.6%
	Update protocol & develop supp	MoHSS	1,290	1,251	97.0%
	Train 120 young people	MoHSS	3,355	3,236	96.5%
	Train 120 young people	NAPPA	17,585	17,817	101.3%
	Document best practices of SRH	MoHSS	10,477	10,477	100.0%
	Document best practices of SRH	UNFPA	883	883	100.0%
Total for HIV/SRHR Integration Project UQA64NAM		**299,902**	**263,916**	88.0%	
Total		**446,239**	**399,300**	89.5%	

Table 2: HIV Related Project Budgets and Expenditures: UNFPA Namibia: 2017

Projects 2017	Activity Description	Implementing Agency	Project Budget	Disbursement	Budget Utilization Rate
Safeguard Young People	PLOCY, ADCY, MEDIA & COMM	UNFPA	6,420	6,420	100.0%
	Bank Charges and Direct Costs	NAPPA	3,019		0.0%
	Enhance Capacity AFHS clinics	NAPPA	4,000	4,131	103.3%
	CSE capacity in schools	NAPPA	8,000	6,909	86.4%
	CSE capacity in schools	UNFPA		239	
	CSE Capacity and advocacy	MEAC	435	435	99.9%
	Conduct CSE Training Teachers	MEAC	15,561	15,561	100.0%
	Support capacity Youth Network	MSYNS	5,000	4,264	85.3%
	Support capacity Youth Network	NAPPA		2,625	
	Community Dialogue Gatekeepers	NAPPA	5,020	2,863	57.0%
	Adapt CSE Framework and Print	MSYNS	14,946	14,946	100.0%
	Enhance CSO capacity on CSE	NAPPA	2,000	1,339	66.9%
	Enhance institution capacity	MoHSS	0		0.0%
	TA to Health information syste	MoHSS	3,615	3,615	100.0%
	Knowledge Management	UNFPA	5,000	4,125	82.5%
	Launch disseminate Youth Status	MSYNS	500		0.0%

	Staffing PS- HIV & com.	UNFPA	39,051	38,458	98.5%
	Strengthen SYP coordination	NAPPA	3,000	484	16.1%
	Meetings Monitoring & Training	UNFPA	4,433	4,443	100.2%
Total for SYP (CHA28)			**120,000**	**110,855**	**92.4%**
SRH/HIV Integration 1 (EU60 NAM)	PLOCY, ADCY, MEDIA & COMM	UNFPA	30,067	30,506	101.5%
	Enabling environment -SRH/HIV	MoHSS	10,500	10,500	100.0%
	Document I-stories on GBV&SRHR	One Economy Foundation	9,000	9,077	100.9%
	Knowledge Management	UNFPA	9,005	10,193	113.2%
	Staffing Admin Prog Associate	UNFPA	37,433	38,469	102.8%
	TA to quality integrated servi	MoHSS	62,900	62,900	100.0%
	TA to quality integrated servi	UNFPA	1,767	1,767	100.0%
	TRAINING01	UNFPA	17,478	13,776	78.8%
Total for SRH/HIV Int. 1 (EU60)			**178,151**	**177,188**	**99.5%**
Grand Total			**298,151**	**285,604**	**95.8%**

Table 3: HIV Related Project Budgets and Expenditures for UNFPA Namibia: 2018

Projects 2018	Activity Description	Implementing Agency	Project Budget	Disbursement (Excluding OFA)	Project Budget Implementation Rate
			A	D	H=D/A
Safeguard Young People (CHA28)		UNFPA		0	
	Policy, Adv. Media and Com.	UNFPA		121	
	CSE Capacity and advocacy	MEAC	19,490	19,960	102.4%
	Advocacy and Policy dialogue	UNFPA	11,655	11,459	98.3%
	Knowledge management	UNFPA	14,060	16,192	115.2%
	Meetings, Monitor & support Costs	UNFPA	27,704	26,319	95.0%
	Support CSE Capacity & Tuneme	MSYNS	8,024	8,024	100.0%
	Support TA for AY coordination	UNFPA	66,464	65,247	98.2%
	Roll Out Tune Me	UNFPA	1,228		
	Roll out Tune Me	MSYNS	2,507	2,507	100.0%
	Youth policy environment	MSYNS	38,013	37,016	97.4%
Total for Project CHA28NAM			**189,145**	**186,844**	**98.8%**
SRH/HIV Integration		UNFPA		0	
	Empower Communities access SRH	MoHSS	16,672	11,324	67.9%
	National Consultative Meeting	MoHSS	13,847	13,691	98.9%
	Programme Equipment &operation	UNFPA	3,750	3,867	103.1%
	Provide Technical support FP	MoHSS	20,000	12,720	63.6%
	Prog manager & prog support	UNFPA	82,000	65,467	79.8%
	TA scale SRHR/HIV/GBV services	MoHSS	18,199	16,496	90.6%
	Policy/ advocacy &communicatio	UNFPA	12,462	1,089	8.7%
	Coordination	UNFPA	2,816		
	Knowlegde, documentation& shar	UNFPA	8,000	5,636	70.4%

Projects 2018	Activity Description	Implementing Agency	Project Budget	Disbursement (Excluding OFA)	Project Budget Implementation Rate
			A	D	H=D/A
	Tech support, monitoring& capa	UNFPA	40,070	29,318	73.2%
Total for Project NAM05UZJ			**217,816**	**159,609**	**73.3%**
UBRAFNAM	Develop the AGYW Action Plan	MoHSS	11,100		
	Access to condoms for Youth	NAPPA	11,601	11,601	100.0%
	Access to condoms for Youth	UNFPA		310	
	Support access condoms youth	MoHSS	3,900	3,877	99.4%
	Support access condoms youth	UNFPA	33,193	19,081	57.5%
	Key populations access to serv	UNFPA	10,756	4,701	43.7%
	Enhance access service key pop	NAPPA	15,399	10,727	69.7%
	Enhance access service key pop	UNFPA	3,644	3,057	83.9%
	Support Cost for NAPPA	NAPPA	3,000	2,588	86.3%
Total for Project UBRAFNAM			**92,593**	**55,942**	**60.4%**
SRH/HIV Integration	Train 120 young people	MoHSS		0	
	Meetings and Consultations	UNFPA	962	955	99.3%
Total for Project UQA64NAM			**962**	**955**	**99.3%**
Total for Department B4300			**500,515**	**403,350**	**80.6%**

Table 4: HIV Related Project Budgets and Expenditures: UNFPA Namibia 2019

Projects 2019	Activity Description	Implementing Agency	Project Budget	Disbursement to July 20, 2019	Project Budget Implementation Rate
Safeguard Young People (SYP)				0	0
	Be free interventions	One Economy Found.	16,156	5,526	34.2%
	Break Free interventions	One Economy Found.	9,189		
	Advocacy and Policy dialogue	UNFPA	21,600	21,956	101.6%
	Knowledge management	UNFPA		31	
	Meetings, Monitoring & support costs	UNFPA	5,415	1,654	30.5%
	SYP STAFFING	UNFPA	16,142		
	Regional coordination	MEAC	4,990	1,206	24.2%
	Support CSE Capacity & Tuneme	MSNYS	4,500	2,794	62.1%
	Advocacy and Policy dialogues	MEAC	10,282		
	HIV Education Policy	MEAC	10,820		
	Inter-agency health taskforce	MEAC	7,150	1,337	18.7%
	Comprehensive Sexuality educat	MEAC	20,497	15,535	75.8%
	Youth Policy environment	MSNYS	3,259		

Projects 2019	Activity Description	Implementing Agency	Project Budget	Disbursement to July 20, 2019	Project Budget Implementation Rate
Total for SYP			**130,000**	**50,039**	38.5%
Namibia Gender Equality Program 1	Empowerment & asset building	Gender Links	13,000		
	Capacity building on SOP& PoA	MGECW	19,000		
	Generate GBV knowledge product	MGECW	17,000		
	Advocacy, dialogue, policy	MGECW	13,000		
	Support cost	One Economy Found.	1,900		
	Support cost GL	Gender Links	4,236		
	Staffing cost Gender/GBV	UNFPA	104,742	61,716	58.9%
Total for Project Namibia GE1			**172,878**	**61,716**	**35.7%**
Programme Coordination and Assistance	Advocacy, media and communication	PU0074	26,626	11,147	41.9%
Total for Project Coordination			**26,626**	**11,147**	41.9%
Disability Data Strengthening	Disability statistics Capacity	NSA	13,486	2,429	18.0%
	Strengthen capacities for NSDS	NSA	2,699	2,024	75.0%
	Prepare for 2021 PH census	NSA	21,203	3,543	16.7%
	DfD Technical Support	UNFPA	30,000	2,308	7.7%
	SRH info&Service-YP disability	MYSNS	25,535		
Total for Disability Data			**92,923**	**10,304**	**11.1%**
2Gether 4 SRHR Namibia	Capacity building of HCW	MoHSS	23,985	18,712	78.0%
	Community HW capacity	MoHSS	7,500		
	HIV Combination Prevention	MoHSS	9,000		
	Assessment	UNFPA	22,000		
	ASRH/HIV Meetings/ conference	MoHSS	11,000	4,778	43.4%
	Post abortioncare support/equi	UNFPA	14,000		
	Update/develop guides,strategy	MoHSS	27,019		
	Contribution programme suppor	UNFPA	4,000	2,893	72.3%
	Support Cost SFH	SFH	4,548		
	Access to ASRH Services	SFH	26,809		
	SRH package for AYP	SFH	8,500		
	Programme manager & Support	UNFPA	86,642	40,248	46.5%
	Implement SRH/HIV integration	MoHSS	20,000		
	Assessment -uptake servi	Gender Links	5,000	606	12.1%
	Community advocacy and policy	Gender Links	9,100	1,544	17.0%
Total for 2Gether 4SRHR			**279,102**	**68,782**	**24.6%**
Adolescent and Youth, Knowledge and Skills YP1	Conduct Audit	UNFPA	35,900	9,650	26.9%
	2019 Common Service budget	UNFPA	28,544	19,036	66.7%
	Documentation of Befree	One Economy Found.	3,500		0.0%
	Office operation &admin cost	UNFPA	64,282	9,503	14.8%
	Partnership and coordination	UNFPA	50,700	25,004	49.3%
	Staffing cost communication	UNFPA	63,000	30,440	48.3%

Projects 2019	Activity Description	Implementing Agency	Project Budget	Disbursement to July 20, 2019	Project Budget Implementation Rate
	Staffing cost Driver/Clerk	UNFPA	19,500	10,425	53.5%
	Staffing Programme/Admin	UNFPA	19,500	4,178	21.4%
	Advocacy & Policy dialogues MP	MSNYS	2,000	3,170	158.5%
	Youth leadership & participation	MSNYS	8,520	3,899	45.8%
	Youth Policy environment	MSNYS	5,900	1,114	18.9%
Total for AY Knowledge/Skills YP2			**301,346**	**116,419**	**38.6%**
Adolescent and Youth, Access to Services	Bank charges	NSA	400		
	ASRH information and service package	NAPPA	7,000		
	Monitoring and oversight	UNFPA	36,789	2,492	6.8%
	Staffing cost DfD and M&E	UNFPA	63,000	16,659	26.4%
	Staffing HIV/FP Specialist	UNFPA	26,600	26,514	99.7%
	UNCT contribution	UNFPA	24,000		
Total for AY Access to Services			**157,789**	**45,665**	**28.9%**
Total for Adolescent and Youth (YP1 and 2)			**459,135**	**162,084**	**35.3%**
UBRAF UNFPA Namibia	Support condoms access for AYP	UNFPA	14,815		
	Asset building and SRH -AGWY	NAPPA	14,360	5,739	**40.0%**
	Access to condoms for Youth	UNFPA		1,618	
	Access to condoms for Youth	UNFPA		577	
	Support access condoms youth	UNFPA	28,651	5,265	**18.4%**
	Support access condoms youth	UNFPA		679	
	Key populations access to services	UNFPA	8,000	7,066	**88.3%**
	Key populations access to services	UNFPA		39	
	SBCC - enhance access to info	NAPPA	20,000	6,258	**31.3%**
	NAPPA Support cost	NAPPA	5,640		
	Key population info & services	SFH	10,000		
Total for UBRAF Namibia			**101,466**	**27,242**	**26.8%**
Grand Total			**1,262,130.21**	**627,000**	**36.4%**

ANNEX E: SUMMARY OF RESULTS OF SITE VISITS

NAPPA Okuryangava Clinic - Windhoek		
Persons Interviewed: Fungai Bhera, Snr R/N; Lydia Kamati, Clinical Assistant		
Context/Background and Services	**Linkage and Integration**	**Meeting Needs of KP and A+Y**

- Affiliated with IPPF international
- Provides SRHR services to adolescents and youth (10-24 years old) and sexual minorities (LGBTI, Sex Workers, MSM, under-privileged)
- Nearest govt. health centre is Okuryangava PHC Clinic serving the nearby settlement but it does not do deliveries
- The NAPPA Youth friendly clinic does:
  - Contraceptives (oral, injectables, condoms)
  - ANC but not PNC
  - STI screening and treatment
  - HIV testing and treatment
  - PREP
  - Cervical cancer screening
  - Community based CSE
- Co-located with a kindergarten and SWAPO council daycare
- ART client load is about 8-10 per week
- For PREP = up to 15 per week
- ANC = about 15/20 women daily
- HIV testing can be 50-60 per day
Staffing:
1 Registered Nurse
1 Clinical Assistant
2 Peer Counsellors
1 Health Assistant
	Models/Types and Limits of Integration
	- Clients are registered with preference for first-time clients arriving for ART or HIV testing and treatment
	- At the time of registration clients are assigned to a room for meeting a nurse/health worker
	- They see HIV, FP, ANC clients in the same room
	- When women come for FP they are counselled to undergo HIV test
	- Preliminary HIV testing is done by health assistants in a separate room
	Challenges
	- At first, providing the services was very challenging and hectic, it took a couple of years to master the approach
	- HIV counselling involves addressing deep social problems
	- The staff need to spend a considerable amount of time with HIV positive clients on counselling
	- The need to fill out separate disease registries and maintaining separate client care booklets for PREP and ART patients presents a major burden
	- Setting up the record keeping for a new HIV patient takes about 40 minutes and is a burden
	- There is currently a shortage of injectable contraceptives across the country and condoms are currently out of stock
	- The clinic has two structures for service delivery, one of which is a modified caravan and space is really limited
	Achievements/Positive Results
	- The fact that PREP and ART are given in the same room helps reduce stigma
	- After two years using this modified integrated approach the nurse in charge finds she has a stronger and closer relationship with clients
	- Delivering integrated services on a daily basis means you keep your skills level high
	- Originally trained as an HIV specialist the nurse in charge is now able to stay up to date on ANC, FP, Key Populations
		On Adolescents and Youth
		- The clinic treats youth with respect and staff are known in the community for doing so
		- There was a stigma for youth using clinics but CSE in schools has helped
		On MSM and LGBTI Community
		- The clinic was known as a women's centre but MSM have been coming for HIV testing
		- When men come, they are usually given first preference
		- In 2018 there was a Saturday programme for MSM and other key populations but they had to close it for lack of funds
		- In the past three years the reaction of the general population to KPs has improved
		- These clients have serious trust issues and many have mental health issues
		- The health services/staff are not well skilled in addressing the mental health needs of the KPs

NAPPA Okuryangava Clinic - Windhoek		
Persons Interviewed: Fungai Bhera, Snr R/N; Lydia Kamati, Clinical Assistant		
Context/Background and Services	**Linkage and Integration**	**Meeting Needs of KP and A+Y**
1 Community-Based Reproductive Health Assistant (CBRHA)		

Khomasdal Health Centre – Windhoek: Elizabeth Nanuwe, R/N in Charge, Paulus N. Shaanika, Senior Health Programme Officer, Khomas Region		
Context/Background and Services	**Linkage and Integration**	**Meeting Needs of KP and A+Y**
- The facility is located on the western suburb of Windhoek and serves a large catchment population - Nurse in charge has been here for 2 and ½ years - In all they have four staff doing HIV counselling and testing - Most nurses are not trained in initiating patients on ART (NIMART) - One specialty HIV service is NIMART, Nurse Initiated Management of ART - The facility provides all PHC services including health education for pregnant women, as well as FP, HIV and other SRH services - It also provides post-natal services such as growth monitoring - Normal counselling of a returning ART patient is about 20 minutes but completing the register for a new HIV positive patient takes about 40 minutes.	**Application of Integration/Modifications** - The integration model was designed to provide comprehensive services in one room with one provider and to reduce stigma - Pregnant women come early to the clinic and are given priority for ANC in a slight deviation from pure integration - They have also created a specialized space for testing and counselling for HIV. They have a Community Health Counsellor who tests for HIV – the testing is done in a separate room - Most patients are seen in one room by each nurse and those that need to be seen by a doctor are then referred to the doctor - One solution has been to create a space within the pharmacy where ART is provided to ART clients - While HIV patients are not necessarily integrated among the others, they do get other services such as FP so it is integrated into, for example, ART and ART clients are happy with the services they receive. **Challenges** - It's a good programme in some areas but in some areas of practice it is not working for them - ANC for instance has very long lines and high demand, especially for first time clients - Not all staff are trained in HIV testing but some are. If all nurses were trained and had access to equipment the model would be more effective - Waiting for long periods for a doctor means some patients leave without receiving their medicine. - Staff and equipment shortage is the biggest challenge they face. For the implementation to work well they need more staff and equipment in each room. - Data management is a major challenge. There are separate patient registers for ANC, PMTCT, ART, PREP.etc	**Adolescents and Youth** - Adolescents and youth clients often want to see the same service provider each time because they form a bond with a sympathetic nurse/health care provider. **Key Populations** - The main key population group they serve are MSM - They come for testing and if positive want as rapid a service as possible to receive their ARTs and then leave. - The clinic staff received special training on how to provide services to members of key populations. The one-day training was provided by a Consultant provided by the Society for Family Health - As with adolescents, key population members want to be served by the same nurse each time. The nurses get a reputation for being sympathetic and - understanding.

Khomasdal Health Centre – Windhoek: Elizabeth Nanuwe, R/N in Charge, Paulus N. Shaanika, Senior Health Programme Officer, Khomas Region		
Context/Background and Services	**Linkage and Integration**	**Meeting Needs of KP and A+Y**
	Benefits/Achievements - If the elements of training, equipment and space are addressed, integration can have a very good effect - The principle is sound: provide the client with services they need in the same place, available every day from the same providers	

Maxuilili Clinic, Okahandja Park - Windhoek		
Persons Interviewed: Tjinae Njembo, R/N in-charge; Laina Shivute, R/N for ART		
Context/Background and Services	- **Linkage and Integration**	- **Meeting Needs of KP and A+Y**
- New clinic established in 2015 in the big informal settlement in the northern part of Windhoek - Provides PHC services including FP, HIV testing and counselling, ANC, emergency delivery and PNC services as well as ART - Integration only active since February 2019 - A very new clinic with lots of space - The clinic has four nurses trained in ART and a small cadre of community health workers - Adolescents and youth attend the clinic mainly to access the USAID sponsored DREAMS Programme - The clinic does provide emergency delivery services but routine deliveries and clients requiring a c-section are referred to Katutura State Hospital.	**Application of Integration/Modifications** - The clinic started the integration process in February 2019 and began by integrating all services but they now have separate rooms for taking vital signs and for dressing wounds. With regard to vital signs there is not enough equipment for all the consulting rooms. For dressing wounds, although they have equipment, the problem is that not all the staff are adequately trained. - ANC is also provided separately due to problems of equipment and because staff, especially midwives are not adequately trained. - What have been integrated are services such as Family Planning, Counselling, STI screening, immunization - The HIV side is not yet integrated into the other services, but within HIV they do screening and counselling (for STIs) as well as Family Planning, ANC. - Similarly, all clients who come seeking family planning receive counselling in HIV prevention and PREP - GBV services have been integrated but if there is a potential prosecution the clinic refers the client to Katutura Hospital where there is a GBV protection unit. **Challenges** - As noted above, while the clinic has adequate space, the problem is shortage of equipment and gaps in the training of staff to provide a range of services - The main factor keeping HIV/ART services separate is the lack of training for nurses, especially in NIMART. - Integrating family planning is made harder by the current stock-outs of injectables and oral contraceptives, they now have only one-month supply of oral contraceptives.	**Adolescents and Youth** - The DREAMS programme has peer educators, social workers and health educators. They attempt to promote health-seeking behaviours among adolescents and youth. - The clinic has a DREAMS programme team on-site providing services to adolescents and youth but this is a separate organization from the clinic. - The DREAMS programme team provides Adolescent Girls and Young Women (AGYW) with family planning, HIV testing and counselling and interventions relating to SGBV. - DREAMS is operated by I-TECH an NGO based in the University of Washington which has operated in Namibia for a long time with PEPFAR support.

Maxuilili Clinic, Okahandja Park - Windhoek		
Persons Interviewed: Tjinae Njembo, R/N in-charge; Laina Shivute, R/N for ART		
Context/Background and Services	- **Linkage and Integration**	- **Meeting Needs of KP and A+Y**
	- They do have enough staff but their main problem is equipment: blood pressure monitors, autoclaves, ECG machines, sonar, weighing scales - Record keeping is a major problem. They have difficulty tallying the numbers in separate registers and as a result record keeping is not of good quality. Nurses concentrate on providing services, not on maintaining the registers **Benefits/Achievements** - The eventual goal is to integrate all services (ANC/HIV/Vital Signs, etc.). - Staff do develop a stronger relationship with clients.	- DREAMS staff indicate that HIV infection among AGYW is very often a result of SGBV which was confirmed by a scan of the register

Onandjokwe Intermediate Referral Hospital and Onandjokwe PHC Clinic: Oshikoto Region		
Persons Interviewed: Alina Nepela, PHC Supervisor; Elizabeth Shangula, Chief Health Programme Officer (FH), RMT; Selma Alughodi, Chief Health Programme Officer (SP), RMT; Dr Saad Siraji, Senior Medical Officer; Shirley Lwande, Nurse Mentor; John Lumbu, Nurse Manager; Alemseged Gulma, Pharmacist		
Context/Background and Services	- **Linkage and Integration**	- **Meeting Needs of KP and A+Y**
Onandjokwe district is one of the 3 health districts in Oshikoto region Onandjokwe District has: - 1 Referral Hospital and 11 fixed PHC units = 3 health centres and 8 clinics all now integrated - PHC outreach teams in 43 communities - The population served is 37,956 - Under 1 year = 1167 - Under 5 = 5272 - Under 15 = 15,062 (40 percent) - Women of Child Bearing Age = 9031	**Application of Integration** - The 1st meeting on integration with the whole team (Onandjokwe PHC Clinic and the other clinics in the district) took place in 2017. Prior to that the hospital had separate PHC clinic and separate ART clinic. The two units were merged and the PHC clinic moved to the present centre to incorporate the ART clinic as a prelude to integration. - Integration started with 6 facilities in the district and then expanded to the others. Prior to integration they met with nurses from all the health centres and clinics. **Work Flow Prior to Integration** - In the ART clinic that existed, a patient started the process by receiving a Patient Care Booklet (PCB) assigned to them at the central admin office. The admin officer pulled the file on that patient and they carried it with them as they moved through the different parts of the clinic. - Paediatric services were provided outside in a trailer adjoining the centre - ART was prescribed in pre-specified consulting rooms (14,19,20,21) by specialized ART nurses. - When required nurses could refer patients to the doctor (room 22) - Room 15 was used for data capture on HIV	**Adolescents and Youth** - In the past year they have started separating out adolescents and youth because of the DREAMS project which is now operating at the facility - DREAMS uses its own pre-fabricated facilities - A problem with DREAMS is that nurses and peer counsellors are not always present as they go out for field work and then their clients have to see the nurses from the PHC Clinic - However, when the DREAMS nurses are present their young

Onandjokwe Intermediate Referral Hospital and Onandjokwe PHC Clinic: Oshikoto Region		
Persons Interviewed: Alina Nepela, PHC Supervisor; Elizabeth Shangula, Chief Health Programme Officer (FH), RMT; Selma Alughodi, Chief Health Programme Officer (SP), RMT; Dr Saad Siraji, Senior Medical Officer; Shirley Lwande, Nurse Mentor; John Lumbu, Nurse Manager; Alemseged Gulma, Pharmacist		
- Expected annual births = 1544 Persons ever enrolled on ART = 6,122 - The hospital has 45 outreach posts - 35 Community ART Referral Groups (CARG) - The CARGs represent a mechanism to overcome challenges of access to ART. Each group of 5-15 clients from the same community can select a person to go and refill ART prescriptions for the group - Each member does need to come to the clinic periodically for assessment and get their viral load checked.	- From the doctor's office patients went to the pharmacy for medications or to where they had blood drawn for testing and then home. - From 2005 on all nurses working in the unit were trained in ART. **Problems of Workflow in the Old System** - The ART centre was congested and the workflow was more than the staff could handle with patients lined up at each office and work station. - There was a separate clinic within the centre for PMTCT and for family planning with integration into HIV/ART. - There were many ART clients and the work flow would only reduce after 5 pm, there was also extraordinary crowding at the pharmacy. - It was difficult to re-assign nurses from the ART rooms either to other units in the health facility as needed or to fill in for sick and absent nurses in the 8 clinics. The PHC clinic in the hospital assists the 8 clinics in the district so they need to have nurses trained in all services. Under the prior system the clinics complained that nurses assigned to help out were only trained in ART and could not help with other services. **Work Flow Under the Integrated System** - When a client enters, the receptionist collects their health passport and registers them on the patient tally. An admin assistant then carries the file. - HIV testing is done in a separate room prior to assigning the client to a screening room. Under Provider Initiated Testing and Counselling (PITC) all clients are tested. - There are ten screening rooms and 3 for doctors when a referral is made from a screening room - The client is assigned to one of screening rooms (1 to 10) by the admin officer if it is a new client; if an existing client they go to the screening room they attended on their first visit. - Nurses in the screening room can prescribe and dispense ART to patients but only those on first line treatment. - For clients whose initial test is positive, confirmatory testing is done in a separate location in the centre - (See graphic of work flow) **Results/Benefits of Integration** - Under the new system the workflow has improved.	clients do appreciate the services - Evaluation Team examined some DREAMS log books and discussed them with peer counsellors – very frequent notations that HIV and or pregnancy was a result of SGBV. **Key Populations** - In a rural area like this one, people do not self-identify as members of key populations so they are less visible. - Society for Family Health (SFH) has done work on values and culture to help care providers provide professional services to key populations.

Onandjokwe Intermediate Referral Hospital and Onandjokwe PHC Clinic: Oshikoto Region		
Persons Interviewed: Alina Nepela, PHC Supervisor; Elizabeth Shangula, Chief Health Programme Officer (FH), RMT; Selma Alughodi, Chief Health Programme Officer (SP), RMT; Dr Saad Siraji, Senior Medical Officer; Shirley Lwande, Nurse Mentor; John Lumbu, Nurse Manager; Alemseged Gulma, Pharmacist		
	- As noted by the District Nurse Manager, when they first started with integration it was a big problem for nurses going to external clinics but after a lot of training nurses sent to the external clinics are able to do much more than ART. Similarly, all nurses are now trained in ART. - It is very important to provide ongoing mentoring and refresher training. Under a USAID funded Technical Assistance Programme, 1 nurse mentor is funded for each district in the region. - The nurses in all 11 sites (six high volume and five low volume for ART) are supported with mentoring under the programme. - Nurses do develop better relationships with the clients based on repeated contacts using the integrated model. **Challenges** - Some service providers are reluctant to deal with HIV and ART, the medical teams in the clinics can be reluctant to take on new responsibilities. However, when they get training and mentoring they are able to overcome their fears. - There are weaknesses in pre-service education for nurses so with integration there is need to start with reforming the curriculum for training nurses. - There were problems in data management and in viral suppression for ART clients when they first started the integrated system. From a starting point of 94 percent, the level of viral suppression declined to 83 percent at first but then rose back to 94/95 percent as the system stabilized. There were many new aspects to the integrated system both for the service providers and the community. They needed to work with community members to make them comfortable with the new system. The period of disruption lasted from July to September 2018 but has since fully recovered. - **Data management** is a real challenge. Some patients were lost in the transition in terms of data. ART booklets were not being filled out. - There were reportedly some declines in outcomes for focused ante-natal care and the treatment of high-risk pregnancies. - There is a need to ensure that other, non-HIV specialties such as focused ANC are not negatively impacted by integration. - Having a mentor for these other areas is also a real need. - In-service training is not strong enough and even though they request improved in-service training they find there are not adequate funds. - Nurses dispensing first-line treatment need training from the pharmacist.	

Onandjokwe Intermediate Referral Hospital and Onandjokwe PHC Clinic: Oshikoto Region		
Persons Interviewed: Alina Nepela, PHC Supervisor; Elizabeth Shangula, Chief Health Programme Officer (FH), RMT; Selma Alughodi, Chief Health Programme Officer (SP), RMT; Dr Saad Siraji, Senior Medical Officer; Shirley Lwande, Nurse Mentor; John Lumbu, Nurse Manager; Alemseged Gulma, Pharmacist		
	- There are also shortages of staff since nurses pre-package medicines for both the clinics and the outreach teams. - Equipment is a major challenge. Staff end up sharing Blood Pressure monitoring machines. They received a special allotment of equipment during the pilot phase but none since then. The need to share equipment means that nurses leave the examining room and then medicines can be stolen. - There are still differences in competency among nurses and more training is required. - Integrated family planning services are still hampered by stock-outs including for injectables (especially Depo-Provera) and oral contraceptives. - Reductions in outside funding, including funding international NGOs like Intra-Health are putting more demands on the integrated facilities so there is a need to upgrade the number of mentors. **Possible Adjustments and Improvements** - Ensure that regional/district mentors become part of the staff establishment of the MoHSS rather than paid by external donors as is the case now. - More investment in in-service training - Develop a system of technical focal points of trained nurses who can act as mentors and can provide quality assurance in key areas. - Move to a single register instead of multiple, disease-specific registers.	

Okankolo Health Center: Onandjokwe Health District, Oshikoto Region		
Persons Interviewed: Cecilia Nghidimondjila, R/N in-charge; Saima Ndongui, Data Clerk; Matheus Salomo, Pharmacist Assistant		
Context/Background and Services	- **Linkage and Integration**	- **Meeting Needs of KP and A+Y**
Facility and Catchment Profile - A Rural Health Center - 54 Km from the nearest hospital (Onandjokwe) - 43 villages in the catchment area - 9 outreach posts - 6 kindergartens and 3 primary schools - Population under 1 year = 327 - Under 5 = 1584	**Application of Integration and Modifications** - An assessment done in June 2012 of ANC clients showed that they were spending a great deal of time travelling to and attending ANC services. - The centre began piloting integration in October 2012 and has been integrated to the present time. An evaluation was conducted in 2015 which included exit interviews with patients and interviews with staff. - Health facilities in the region are referred to Okankolo as a model for how integration can be done and how it can work. - Along the way they have made adjustments to the model for better workflow and to adjust to challenges. These include:	Adolescents and Youth - Adolescents and youth (9-24 years of age) access the DREAMS programme (as in other facilities visited) - The DREAMS programme works specifically with Adolescent Girls and Young Women (AGYW) but there is

Okankolo Health Center: Onandjokwe Health District, Oshikoto Region		
Persons Interviewed: Cecilia Nghidimondjila, R/N in-charge; Saima Ndongui, Data Clerk; Matheus Salomo, Pharmacist Assistant		
- WCBA = 3,142 - Expected Births in 1 year = 537 **Services** - Health education - PMTCT - HTC - ANC, PNC, Immunization - Integrated Management of Child Illness (IMCI) - Labour and Delivery - Adolescent SRH - The health centre operates 24 hours a day - In-patient care for forty-eight hours; patients requiring longer hospitalization are transferred to Onandjokwe hospital **Staff** - 7 Registered Nurses - 7 Enrolled Nurses - 1 Midwife - 1 Pharmacy Assistant - 1 Community Health Care Worker - 1 Driver Approximate Patient Load for One Month - Out Patient Department 891 - Family Planning = 90 - HIV Testing and Counselling (HTC) 500 (on average) - PMTCT = 5 - Overall monthly attendance = approx. 2000	- Because the health centre is open 24 hours each day, they assign three nurses to each room, each one for an eight-hour shift. Nurses are assigned to the night shift for three months each year. - Having the pharmacy assistants assist nurses when needed in the screening/counselling rooms. - The pharmacy assistant also places the needed ARVs in the screening/services room based on the estimate for the day. This is first line treatment ART and can be up to 20 for a single room. - Having admin assistants carry the files as needed - All new clients are tested under PITC and are counselled whether positive or negative - HIV testing and counselling is the only thing that is not integrated into the other services because it takes much longer to counsel new clients who are positive. - Counselling is done in a separate room by a health assistant. - As in other centres they have established Community ART Refill Groups (CARG) - The center staff learned that you need proper community mobilization and education to assist clients in adapting to the new system. - You also need continuous support from the national and regional levels alongside continuous in-service training. **Benefits and Achievements** - They have seen an improved uptake of HTC and have been able to provide greater emphasis and support to the need for dual protection (for family planning and for protection from HIV. - Before integration services were provided on specific days which made it difficult for the clients to know for sure they would receive services after travelling long distances. Now all services are provided from Monday to Friday. - In the past, few nurses were involved in ART and the knowledge was not shared with other nurses. Now all the nurses are involved and, though it is challenging, they find it more rewarding as well. - Also, HIV patients now receive services from the same provider in the same room and are not moving from room to room carrying their own, conspicuous HIV file (with a blue border).	only one DREAMS nurse in the facility. - The clinic staff attend to the GBV cases when there is an issue of rape. The provide medicines and refer the patient to a doctor at Onandjokwe Hospital while also informing the social worker and the police GBV unit. The clinic staff are not trained to take evidence. - The centre has a staff responsible for school health services. They go to schools to assess children to provide health education and HIV prevention messages. - The DREAMS programme is run by Project Hope which is one of the USAID-funded NGOs in Namibia. They work with both boys and girls on GBV - The centre has a connection with life skills teachers in the schools. - The clinic contact person on school health takes part in the Regional Health Education Task Force meetings on a quarterly basis. **Key Populations** - As per other centres in the district, MSM, and LGBTI

Okankolo Health Center: Onandjokwe Health District, Oshikoto Region		
Persons Interviewed: Cecilia Nghidimondjila, R/N in-charge; Saima Ndongui, Data Clerk; Matheus Salomo, Pharmacist Assistant		

	- Clients do report they are more satisfied – they know their nurse and are able to build relationships. They are also more vocal about their systems and their needs after building up their trust in the nurse they see regularly.
	- The CARG groups have helped to reduce stigma in the communities.
	Challenges
	- Equipment is a problem, even though they received a special allocation of equipment during the pilot they have not been able to replace or repair equipment as needed due to lack of funds.
	- Staff rotation within the service is a major problem making it necessary to provide in-service training on a more or less constant basis but funds are lacking. When integration first started at the centre, all staff got the necessary training but when new staff come, they also need training.
	- A major challenge is the issue of record keeping. The senior nurse in charge used to go through the registers at the middle of the month and correct obvious errors and verify the number with the administrative assistant.
	- They also have a problem with stock-outs, especially for family planning. At the time the evaluation team visited the stock-outs were reported for:
	  - Injectable contraceptives (roughly one month's supply)
	  - Oral contraceptives
	  - Some ARVs (combination ARVs specifically).
	- In response to stock-outs they try to borrow from other facilities and pay them back when the situation is reversed. They use a WhatsApp group of facilities to coordinate on this.
	- There is a continuous need for effective supportive supervision from the district and regional office which has not been provided recently but was there during the pilot phase
		community members are not readily visible in the rural area and do not self-identify as such.
		- They still may benefit from having access to a single provider over time, if that provider is sensitive to their needs and is respectful. There is a role for values training in this area.

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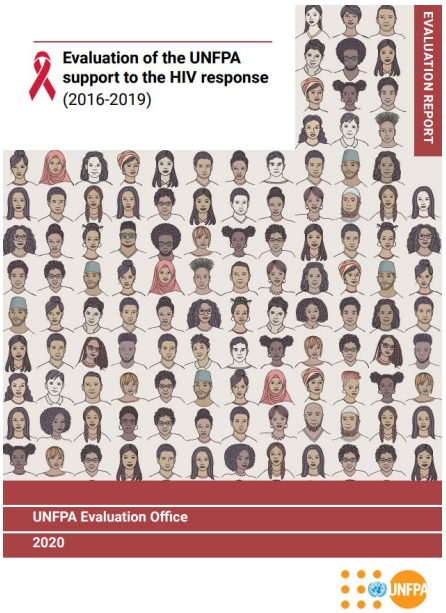

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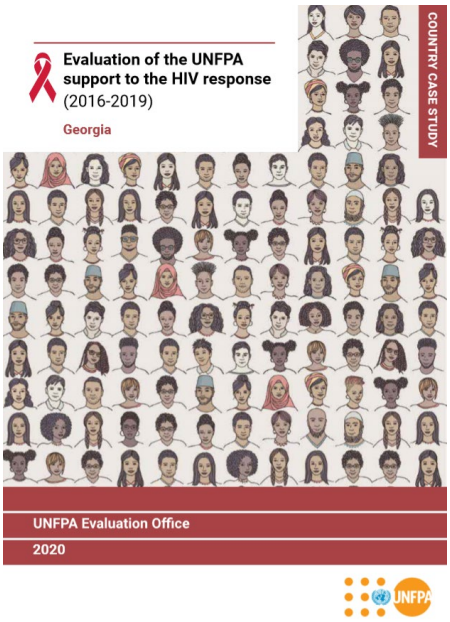
Evaluation brief of the UNFPA support to the HIV response (2016-2019)



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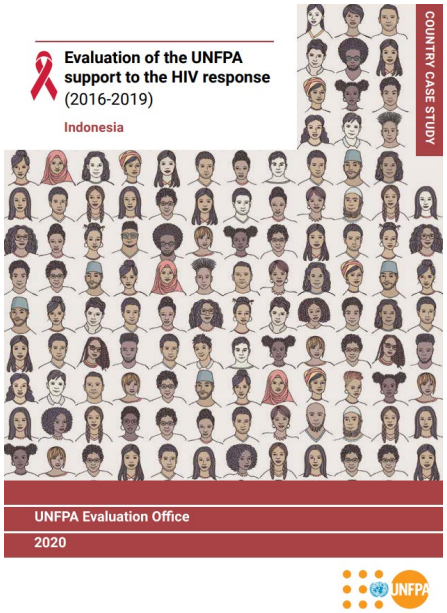

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