Children and HIV & AIDS in Namibia
CHILDREN AND HIV & AIDS
in Namibia

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For three decades, the world has been confronted by the HIV epidemic, and a major acceleration of the response has taken place since 2001. There are now some impressive achievements to report (4):

- The HIV infection rate in 33 countries has dropped in the past few years.
- More than 6 million people in low and middle income countries are on antiretroviral therapy.
- Global coverage of prevention of mother-to-child transmission of HIV services has reached over 50%.

However, these gains are fragile. For every person who starts antiretroviral treatment, there are two people who become newly infected. At the same time, every day 1000 children across the globe become infected with HIV.

In Namibia, there has also been progress and success. The HIV prevalence amongst pregnant women appears to have peaked around 2002 at 22% and has slowly declined since. There has been a significant decline in HIV prevalence among young women aged 15-24 years attending ANC (a proxy for new infections) from 17.9% in 2002 to 10.3% in 2010. PMTCT coverage was estimated at over 75% in 2010. Over 92,000 Namibians, of whom around 10% are children, are receiving life-saving antiretroviral therapy, which is over 90% of those in need. It is estimated that over 70,000 new HIV infections were averted between 2002 and 2010, and over 35,000 lives saved. The impact of this has been an estimated 50,000 Namibian children not becoming orphaned through losing one or both parents (5).
With Namibia’s high levels of poverty and inequality, food insecurity, and disparity, the HIV epidemic plays a large role in determining the survival rates of its children. The under-five mortality rate, infant mortality rate and neonatal mortality rates have all risen in the past decade, and maternal mortality has almost doubled (2). In 2009, out of 59,000 children born, 3000 did not reach their fifth birthday (6) (7); there were estimated to be 13 000 children between 0 and 14 years old living with HIV and 69,000 children orphaned by AIDS (8). It is estimated that 6 489 deaths between April 2010 to March 2011 were related to HIV (1).

There are many social consequences arising from the deaths of mothers and fathers, adult caregivers and family members and the burden of orphans and vulnerable children is extensive. Namibia’s resources are being strained as very significant amounts of funding are required for the prevention of HIV and care and support to those infected by HIV or affected by the impact of the epidemic (8). The total Namibia HIV response was estimated to be US$194 million between April 2008 and March 2009 with nearly 50% coming from domestic resources (9).

This paper gives an overview of the HIV epidemic and how it affects Namibia’s children. It was compiled through a review of literature detailing the many aspects of Namibia’s HIV epidemic, including latest available survey data, smaller studies and regional reports. It is essentially a collation of what is presently known about children and HIV and AIDS in Namibia.

As a child’s life progresses from the womb through various stages of childhood and adolescence, the risks and features of HIV infection and the appropriate care and support required change. This paper is thus organised with the child at the centre, around three broad age groups; birth and early years (0-5), primary school age (roughly 6-13), and adolescence (14-19).

| Mortality trends in Namibia 2000 - 2006 (2) |
|-----------------|-------|
| Infant mortality | 38 | 46 |
| Under five mortality | 62 | 69 |
| Neonatal mortality  | 27 | 29 |
| Maternal mortality    | 271 | 449 |
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**Acronyms:**

- AIDS: Acquired Immune Deficiency Syndrome
- ANC: Antenatal care
- ART: Anti-Retroviral Therapy
- ARV: Anti-retroviral
- CABA: Children Affected By AIDS
- CACOC: Constituency AIDS Coordinating Committee
- EID: Early Infant Diagnosis
- FY: Financial Year
- GBV: Gender Based Violence
- GFATM: Global Fund to fight AIDS, Tuberculosis and Malaria
- HIV: Human Immunodeficiency Virus
- HAKT: HIV-AIDS Knowledge Test
- MTCT: Mother-to-child transmission of HIV
- MTP III: Third Medium Term Plan on HIV/AIDS
- NABCOA: National Business Coalition
- NAC: National AIDS Committee
- NaCCaTuM: Namibia Coordination Committee on HIV/AIDS, TB and Malaria
- NAEC: National AIDS Executive Committee
- NANASO: Namibia Network of AIDS Service Organisations
- NDHS: Namibia Demographic and Health Survey
- NSF: National Strategic Framework
- OVC: Orphans and Vulnerable Children
- OYO: Ombetja Yehinga Organisation
- PCR: Polymerase Chain Reaction
- PEPFAR: U.S. President’s Emergency Plan for AIDS Relief
- PMTCT: Prevention of Mother-To-Child Transmission of HIV
- RAAP: Rapid Appraisals Analysis Process
- RACOC: Regional AIDS Coordinating Committee
- SACMEQ: Southern and Eastern Africa Consortium for Measuring Educational Quality
- TB: Tuberculosis
- UN: United Nations
- UNAIDS: Joint United Nations Programme on AIDS
- UNDP: United Nations Development Programme
- UNGASS: United Nations General Assembly Special Session on HIV/AIDS
- USAID: United States Agency for International Development
- WHO: World Health Organization

**Terms:**

- HIV prevalence: the proportion of individuals in a population who have HIV at a specific point in time (existing infections)
- HIV incidence: the proportion of people who have become infected with HIV during a specific period of time (new infections)
- Hyper-endemic: exhibiting high and continued incidence. A hyper-endemic HIV epidemic is defined by UNAIDS as a situation where 15% or more adults aged 15 years and older are living with HIV
- HIV viral load: a measure of the amount of active virus in an infected person’s body. The viral load is highest in the first 6-8 weeks after becoming infected with HIV and when a person develops AIDS
Part 1

Setting the Scene

Namibia: population, poverty and inequality

Strong economic growth since Independence (1990) has seen Namibia classified as an upper-middle income country. However, this has not translated into reduced rates of poverty, equitable distribution of resources nor contributed to employment creation. Namibia remains with the world’s highest income inequality¹ and poverty rates have essentially remained unchanged since the 1980s. In effect, the country’s social development has not kept pace with national level economic development.

Population and the impact of AIDS

It is estimated that in 2011, 42% of the total Namibian population of around 2.2 million are under the age of 18. Amongst these young Namibians, 26% are orphaned and vulnerable² (an estimated 250,000 children). 155,000 of these children are orphans (15% of the child population), with 69,000 estimated to have been orphaned through AIDS-related deaths (1).

The UN (11) indicates that deaths due to AIDS will reduce population growth and decrease the population size by increasing the number of deaths and reducing the number of births. The structure of the population may also alter as certain age groups are affected by AIDS differently. With fewer births and fewer children surviving childhood, there will ultimately be fewer adults of working age in the country.

Figure 1 shows the estimated population distribution in 2013 and 2030 in Namibia. The differences in the estimates reflect the AIDS and no-AIDS scenario. The figure indicates:

- A large reduction in under-10 population, due primarily to the impact of mother-to-child transmission of HIV.

### Table: Estimated Child population in Namibia in 2011

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Girls</th>
<th>Boys</th>
<th>Percentage of total population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children under 18 years old</td>
<td>921,184</td>
<td>461,231</td>
<td>42%</td>
</tr>
<tr>
<td>Children 14-18</td>
<td>244,654</td>
<td>123,186</td>
<td>11%</td>
</tr>
<tr>
<td>Children 7-13</td>
<td>328,504</td>
<td>164,130</td>
<td>15%</td>
</tr>
<tr>
<td>Children under 5 years old</td>
<td>291,757</td>
<td>145,979</td>
<td>= 13%</td>
</tr>
</tbody>
</table>

²An orphan is defined as a child below age 18 with one or both parents deceased; a vulnerable child is defined as a child below age 18 who has a chronically ill parent or who lives in a household in which an adult has been chronically ill or has died in the past 12 months (2)
The significant population reduction amongst 25-49 year olds, who are the most productive for economic development, income generation, and family care-giving.

Like other high HIV-prevalence countries in Sub Saharan Africa, Namibian women are more vulnerable to HIV and have higher infection rates than men. As such, the changes in population structure are more pronounced for women compared to men of the same age. The potential effects of a population imbalance by gender and in certain age groups may impact socio-economic development. The loss of people in the 25-49 year old age group to AIDS has far reaching implications for households, labour force, food production and the well-being of society (11).

**Poverty**

Namibia has had strong economic growth over a number of years. Namibia’s children are growing up in a relatively wealthy country with the resources for social and economic development. However, Namibia is also the most unequal society in the world. Many Namibians are poor and children bear the brunt of this poverty, which goes beyond just the lack of income and extends to access to public services. The implications of lack of access to quality public services are inextricably linked to the health and well-being of children of all ages.

Around 28% of households in Namibia can be classified as being poor, with 50% of these households severely poor (14% of all households). Households with children are 77% more likely to be poor compared to households without children, and there is significantly higher poverty amongst households with orphans and households headed by females (14).

<table>
<thead>
<tr>
<th>Poverty in Namibia</th>
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<tbody>
<tr>
<td>Gini coefficient (13)</td>
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<tr>
<td>Poor households (14)</td>
</tr>
<tr>
<td>Severely poor households (14)</td>
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<tr>
<td>Poor population (15)</td>
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<tr>
<td>Poor children (15)</td>
</tr>
<tr>
<td>Average number of children per household (2003/4) (16)</td>
</tr>
<tr>
<td>Non-poor</td>
</tr>
<tr>
<td>Poor</td>
</tr>
<tr>
<td>Severely poor</td>
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<tr>
<td>Unemployment rate (broad) (17)</td>
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<tr>
<td>Rural areas</td>
</tr>
<tr>
<td>Urban areas</td>
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<tr>
<td>20-24</td>
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<tr>
<td>Unemployed adolescent 15-19 (17)</td>
</tr>
<tr>
<td>Unemployed youth 20-24 (17)</td>
</tr>
<tr>
<td>Children aged 5-17 possessing 3 basic material needs (1 pair of shoes, 2 sets of clothes, 1 blanket) (2)</td>
</tr>
</tbody>
</table>

1Namibia’s GINI coefficient 2003/4 is 0.74 (13)
2Namibia reached upper middle income status in 2008 with a per capita gross national income of US$4,210
“Poor children are at risk of becoming poor adults and so poverty and deprivation are passed on to the next generation” (69)

Children are at a higher risk of poverty than the general population, with almost 44% of children, compared to 37% of the general population being poor (19). With poverty being closely linked to income, it is of great concern that half the working-age population is unemployed. There is especially high unemployment amongst the youth (68% among 20-24 year olds) and among females (58% compared to 44% of males). For those aged 15-19 dropping out of school, unemployment is near universal (84%) (20).

Too many Namibians have grown up caught in a vicious cycle of poverty. Growing up poor can have long-lasting development effects on a child, starting with the increased risk of being born with low birth weight and a greater potential of poor nutrition throughout childhood and into adult life. Poor nutritional status can increase the possibility of sickness or death, and reduce cognitive development. Lower performance at school may translate directly into limited job opportunities and therefore impact on earning potential. When AIDS-related illnesses and disability affects poor families, the result is further vulnerability due to loss of income for caregivers, and children may have an increase in caring responsibilities for who are sick. There are also additional expenditures for medical care to be factored in which drain the already limited household financial resources.

Whilst a direct correlation between child poverty and HIV prevalence in Namibia has not been established, some of the northern regions in the
country have both high HIV prevalence and the highest child poverty rates, making children in these regions especially vulnerable (see figure 2 for child poverty and HIV prevalence among pregnant women by region). In Kavango, Ohangwena and Oshikoto, child poverty rates are over 50% and HIV ANC prevalence rates around or over 20%. Caprivi and Oshana regions also show high levels of child poverty and high ANC HIV.

**Inequality**

With such high poverty levels in some regions of Namibia, it is clear that income in the country is not equally spread. One measure of inequality is the gini coefficient, which shows Namibia to be the most unequal country in the world. In a truly equal society, where every person in the population had the same income, the gini coefficient would measure 0. Where one person has all the income and everyone else has nothing, the measure would be 1. In Namibia, the gini coefficient is 0.74, indicating high inequality. This is despite Namibia’s gross national income (GNI) per capita increase from US$1,620 in 1990 to US$4,200 in 2008, and the gross domestic product more than tripling in the same period. Clearly, strong economic progress has been made, but the richest 1% of the country consumed more in value than the poorest 50% in 1990, and this has not significantly changed in the years since (22).

It is not only the distribution of income that is unequal in Namibia, but also access to public services (such as electricity, sanitation, piped water, schools, health facilities). There have been improvements in efforts to reach targets set in the National Development Plans, and in many cases providing access has been pro-poor (22). However, despite progress, there remains an urban-rural gap for all services. Sanitation, for example, is at unacceptably low levels throughout the country: only one-third of the population has access to safe sanitation, but in rural areas only 13% have access, compared to 61% in urban areas. In Ohangwena and Caprivi fewer than 10% of households have access to safe sanitation. Safe drinking water is more readily available (87% of households have access), but in Kavango and Omusati, under 70% of households have access to safe water (2). Lack of access to basic services is interrelated with poverty and may have the effect of increasing stress in the household and may affect the ability of caregivers to provide a nurturing family environment for children. Access to quality health care services is vital for households affected by HIV.

**HIV and AIDS in Namibia**

Namibia has a generalised HIV epidemic. This means that there is a high HIV prevalence among the whole population (and not just one section of society). The epidemic is now starting to stabilise, after a rapid increase from the time that the first case of HIV was reported in 1986 through until a peak in 2002. The main modes of transmission are heterosexual sex and mother-to-child transmission and there are a number of issues that drive the epidemic: multiple concurrent partnerships, intergenerational sex, pervasive alcohol abuse (leading to greater risk taking behaviour), low levels of HIV risk perception, transactional sex and high levels of population mobility (23). Certain sub groups of the population are more vulnerable to HIV infection than others, especially young women. In spite of increased knowledge on HIV and AIDS and most people knowing people living with HIV among their own family and friends, stigma and discrimination remains, which affects the efficacy of prevention and care efforts.
HIV Prevalence

HIV prevalence in Namibia is not yet measured through a population based survey. HIV-prevalence among pregnant women attending Ante Natal Clinics (ANC) is used to estimate the national HIV prevalence. Figure 3 shows the prevalence amongst pregnant women in Namibia from 2002 to 2010, indicating that the epidemic is stabilising: the HIV prevalence among pregnant women aged 15-49 for 2010 is 18.8%, a reduction from the high of 22% in 2002 (21).

However, this national figure for ANC HIV prevalence disguises the fact that HIV prevalence is unevenly spread throughout the country. While the national figure shows a decline since 2002 and an apparent stabilisation, some health districts are actually showing increases. The 2010 survey showed that 43% of sites surveyed showed a decrease in prevalence rates compared to 2008, but a number of sites increased substantially (Windhoek central, Aranos, Eenhana, Omaruru and Tsumeb). There also appears to be a difference between northern

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**Figure 3: HIV Prevalence in pregnant women (aged 15-49) from Sentinel Surveys 1992-2010 (21)**

**Figure 4: HIV Prevalence by Health District, 2004 and 2010 (21)**

**2004**

**2010**
and southern parts of the country, with the HIV prevalence in the southern part of the country declining between 2004 and 2010.

HIV prevalence has been consistently higher in the north of Namibia since 2004 (21). The northern regions where the HIV prevalence is highest are also the most densely populated regions outside of the capital city, Windhoek. The maps in figure 4 indicate a number of sites which had very low prevalence in 2004 (under 4%) but in 2010 showed a marked increase. Although the Katima Mulilo site still has the highest HIV prevalence in the country at 36%, it has been decreasing significantly from 43% in 2002. The lowest prevalence is found in Rehoboth, south of Windhoek (4%). With such geographical differences in HIV ANC prevalence, it is clear that the response and strategies need to be tailored to address the specific issues affecting different parts of the country.

Drivers of the epidemic
Research into behavioural and contextual factors driving the epidemic found that the specific factors driving the epidemic vary by location and group so much that Namibia has multiple epidemics occurring (23). While multiple concurrent partners, particularly with men having concurrent relationships and high partner turnover, are a significant factor in the spread of the epidemic throughout Namibia, certain regions in the country are more affected than others. Caprivi and Kavango, for instance, were the only regions where there was a striking rise in the proportion of men reporting two or more partners from 2000 to 2006. International borders (Caprivi) and ports (Walvis Bay) are homes to large groups of migrant men and widely available commercial sex which were found to be significant in the spread of HIV in these regions. Other drivers were found to be low levels of condom use, early sexual debut, low male circumcision, pervasive alcohol abuse combined with low levels of HIV risk perception and population mobility. More research is necessary into the variations to fully understand and make sound programmatic decisions, not only for regional interventions, but also for interventions targeting specific population groups, such as youth and in particular young women.

Looking at young women in Namibia, two subgroups of women were found to be particularly vulnerable to HIV infection: young, educated, employed urban women; and young married, cohabiting women, particularly poor and uneducated ones. By looking at the evidence of behaviours in men and women, young women appear to be at the highest risk of acquiring HIV and the risk appears to stem from their choice of partner rather than from their own behaviour. For instance the practice of having multiple and concurrent partnerships is much higher among men than women, and higher in educated and employed men. So, while prevention efforts need to concentrate on increasing knowledge and risk awareness among young women, prevention measures, possibly combined with stronger (enforcement of) legislation need to be introduced to address the high HIV-risk that young women are exposed to by men (23).

Pregnant women aged 15-19 years are the youngest age group to be tested at ANC sites. The 2010 Sentinel Survey indicates that HIV prevalence has been decreasing in this age group since 2002 (see figure 5). This is possibly due to awareness and a reduction in risk behaviours with a sharper drop from 2006 which was a time of rapid scale up of ART (24). This is significant as the prevalence amongst 15-19 year olds is often taken as a proxy for incidence (new infections) as most infections will have been recent.
The difficulty for Namibia, however, lies with how to interpret the changes in prevalence amongst this age group. It is not yet possible to determine how many women are actually being newly infected and how many women contracted the virus at birth. As antiretroviral therapy has been successfully rolled out and scaled up, there is a much greater chance of survival into adulthood for those who were infected through mother-to-child transmission of HIV (MTCT). The increase in numbers of people living with HIV taking ART not only affects survival into adulthood, but is also expected to result in fewer new infections. This happens because people who achieve an undetectable viral load (have less virus in the body) due to the ART are less infectious to sexual partners. A declining trend can be seen amongst 20-24 year olds, and 25-29 year olds which is encouraging (figure 5).

Substantial increases in HIV prevalence can be found in the 40-44 and 45-49 age groups (as shown in Figure 6). This shows how the epidemic is maturing in that those who were infected at a younger age are surviving often because of taking ART and move into the older age categories.

Prevalence data from sentinel surveillance provides vital insights into the extent of the epidemic, but is limited in some respects as it only tests pregnant women (non-pregnant women and men are obviously excluded). The fact that one in four pregnant women 40-49 years old are HIV positive represents a huge problem for the country, given the risks of passing the virus on through pregnancy, childbirth or breastfeeding.

**Stigma and Discrimination**

Stigma and discrimination surrounding HIV exists everywhere in the world and has contributed to the negative consequences associated with the epidemic. Stigma has been recognised as being fuelled by lack of understanding and misconceptions and can lead to discrimination (which is often described as the enactment of stigma) (25). Addressing stigma and discrimination is vital as both can prevent people getting tested for HIV, from seeking information on how to
reduce risk and can also be behind inadequate care and support for many people living with HIV. Namibia has been addressing stigma since the onset of the HIV epidemic and it was even the theme for the 2010 World AIDS Day. Numerous studies exist that document aspects of stigma among certain populations in Namibia such as HIV-positive support group members (26), orphans and vulnerable children (27), patients and carers in Namibia (28), and many other studies document issues with stigma surrounding treatment.

There is limited data available and evidence remains anecdotal that stigma and discrimination might be decreasing. Prevention efforts include increasing the knowledge surrounding HIV and risk. Around two-thirds of the population has comprehensive knowledge about HIV and AIDS\(^5\), with variations across regions, gender, educational levels and wealth quintiles (2). Given the increase in knowledge on HIV among the population it is possible that there has been an increase in accepting attitudes in recent years. This hypothesis is also supported by evidence that demonstrates an increase in support for education about condom use to prevent AIDS (2).}

\(^{5}\)Comprehensive knowledge means knowing that consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the risk of getting the AIDS virus, knowing that a healthy-looking person can have the AIDS virus, and rejecting the two or more common local misperceptions about AIDS transmission or prevention. (2)
by increases in HIV-testing rates during the last years. Also as the numbers of infected people in the country increase, levels of personal experience with HIV and HIV infected family and friends will also increase, giving rise to the opportunity for greater empathy and understanding (26).

**Estimated prevalence among adults and children**

One of the uses of the sentinel surveys is to be able to use the data in order to feed into a modelling package to be able to estimate the HIV prevalence amongst the whole population (including children). The estimated adult prevalence until 2015 is shown in figure 7, indicating an adult HIV estimated prevalence of 12% for March 2011. There are estimated to be about 14,000 children (0-14) who are infected with HIV by end 2010, 8,100 of whom are estimated to be in need of ART. About 69,000 children are estimated to have been orphaned (lost one or both parents) by AIDS (1).

Estimates of HIV incidence (the number of new HIV infections) are vital as over time, they can give an indication of how well prevention efforts are performing and also give an idea of where to target prevention interventions.

It is estimated that in 2011, around 4,400 Namibians will become newly infected: 46% will be males and 54% females. However, the distribution of the new infections (shown in figure 8) shows the real vulnerability of young girls. An estimated 73% of new infections in the 15-19 age group is expected to be amongst young girls and only 27% in boys. In the 20-24 age group, females will account for 62% of new infections.

The majority of HIV-positive Namibian children under the age of 14 will have been infected through mother-to-child transmission, and as such, boys and girls have similar rates of infection.
National Strategic Framework for HIV and AIDS 2010/11 - 2015/16

The National Strategic Framework for HIV and AIDS 2010/11 – 2015/16 encapsulates Namibia’s response to HIV and AIDS and follows on from the third Medium Term Plan (MTP III) which ended in March 2010. It was developed through a participatory and consultative process and is a framework that provides strategic policy, planning and implementation guidance and leadership for the national HIV and AIDS multi-sectoral response. It has identified and prioritised interventions and is linked to the goals and strategies of Vision 2030. The main priority of the NSF is “to maintain and improve the quality of life of Namibia’s people by preventing new infections from occurring and by providing comprehensive and quality treatment, care and support for those already infected by HIV and AIDS” (29). However, it also allows for decentralised planning and for each of the thirteen regions to have their own plans that are aligned to the National Operational Plan. This will allow for each region to target the main issues, drivers and impacts of the epidemic that are region-specific. The key goals of the NSF are to:

- Prevent new infections
- Ensure people living with HIV live longer
- Reduce the socio-economic impacts of HIV, especially among vulnerable households.

The NSF is structured around four integrally linked strategic intervention areas, each of which had defined outcome, outputs and key activities identified. The four areas are:

1. HIV Prevention
2. Treatment Care and Support
3. HIV Impact Mitigation
4. Response Management

By 2015/16, it is anticipated that the implementation of the NSF will contribute to the achievement of the following results:

<table>
<thead>
<tr>
<th>Description of impact level result</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National</strong></td>
</tr>
<tr>
<td>Namibian Human Development Index (HDI) is improved from 0.542 in 2008 to 0.55 by FY 2015/16</td>
</tr>
<tr>
<td>Annual number of new infections has reduced by 50% between FY2010/11 and FY 2015/16</td>
</tr>
<tr>
<td><strong>Prevention</strong></td>
</tr>
<tr>
<td>% of pregnant women attending ANC aged 15-24 who are HIV infected is reduced from 11% in 2008 to 5% by FY 2015/16</td>
</tr>
<tr>
<td>% of infected infants born to HIV positive mothers is reduced from 12% in 2007 to 4% by FY 2015/16</td>
</tr>
<tr>
<td><strong>Treatment, Care and Support</strong></td>
</tr>
<tr>
<td>Life expectancy has increased from 51.6 years in 2008 to 55 years in FY 2015/16</td>
</tr>
<tr>
<td>% of people reported dying from AIDS has decreased from 23% in 2008/9 to 18% in FY 2015/16</td>
</tr>
<tr>
<td><strong>Impact Mitigation</strong></td>
</tr>
<tr>
<td>% of poor households has decreased from 28% in 2008 to 20% in FY 2015/16</td>
</tr>
<tr>
<td>% of households with vulnerable individuals that are able to cope with the impact of HIV has increased to 50% by FY 2015/16</td>
</tr>
<tr>
<td><strong>Response Management</strong></td>
</tr>
<tr>
<td>Effective and efficient management of the response and service delivery for those infected and affected by HIV and AIDS</td>
</tr>
<tr>
<td>% of NSF service coverage targets (output level results) that have been met in the areas of HIV prevention, treatment care and support and impact mitigation has increased from 0% in 2009 to 0% by 2013 and to 75% by FY 2015/16</td>
</tr>
<tr>
<td>% of stakeholders that have expressed satisfaction with the level and type of services provided by MOHSS has increased from 60% in 2009 to 80% in FY 2015/16</td>
</tr>
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</table>
Children are prioritized across all the strategic intervention areas corresponding to the issues pertinent to the stages of their development. The strategic responses for PMTCT, EID, ART are key for birth and early years, whereas the response for prevention covers many issues for both primary and secondary school aged children. The planned activities for improving ART will be relevant for children of all ages who are living with HIV, as are the comprehensive responses required for OVCs. The NSF has recognised the particular vulnerability of women and young girls and aims to reduce the vulnerability to HIV infection and mitigate the impact of HIV and AIDS on girls (29).

NSF costing: The NSF has been costed for the whole five year period. The total resources necessary come to N$ 12,497,978,552 (N$ 12.5 billion; US$ 1.6 billion).

Many of the aspects of the NSF budget relate directly to the response need for children, others more indirectly (29).

**HIV and AIDS Funding**

**Spending:** In recent years, there has been a regular increase in Government spending on health as a percentage of total expenditure: spending rose from 11.7% in 2001/2 to 14.2% in 2008/9.

An analysis of spending on HIV and AIDS was undertaken for the first time in 2010 using the 2008/9 financial year data. The analysis revealed that almost a third of health funds were spent on HIV in 2008/9 (N$1.407 billion). However, it is not possible to determine exact spending on children as the analysis did not group all the spending on children in each area explicitly.

Figure 9 shows the proportion of HIV spending in 2008/9 on key intervention areas. It indicates that treatment and care account for almost half (44%) of the total spending on HIV. Obviously some of that will relate directly to paediatric treatment and care of children living with HIV, but it is not possible to determine that proportion. The only intervention that is dedicated to children is the
OVC programme and includes education, basic health care and other social services. This is an area that is currently exclusively funded by international donors and accounted for 18% of the total expenditure on HIV and AIDS (9). This represents an increase by 37% from the 2007/8 expenditure, which is encouraging and indicates a commitment to extend the support for OVC.

Overall the proportion of expenditure on prevention decreased from 32% in 2007/8 to 31% in 2008/9 (9) which is not fully in line with the approach prioritized in the NSF on prioritizing prevention. The expenditure on PMTCT increased from 4% of public health funds in 2007/8 to 11% in 2008/9, in line with the move to expand services and work towards virtual elimination of MTCT.

The analysis also highlighted the extent to which current spending on HIV/AIDS is reliant on donor funds. The Government contributes almost half of the funds for the national response, with the rest from external development partners. Between the period 2007/8 to 2008/9, donor funding for HIV/AIDS increased from N$ 686 million to N$ 719 million, the majority of which came either from the US President’s Emergency Plan for AIDS Relief (Pepfar) or the Global Fund to Fight AIDS, TB and Malaria.

This raises issues of long term sustainability, given the effect of the financial crisis on decreasing levels of development partner over-seas aid funding.
Children and HIV in Namibia

Namibia’s response to its children and HIV

Namibia’s response to the impact of the HIV epidemic on children has been progressive at many levels, particularly in relation to policy development.

Policies and laws

Namibia has established a strong foundation for an enabling environment that protects the rights of children through its Constitution and through being a signatory to key international conventions, including the Convention on the Rights of the Child (CRC), Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the African Charter on the Rights and Welfare of the Child).

The National Policy on HIV and AIDS, developed in 2007, commits to the involvement of children in relevant policies on HIV and AIDS and asserts the need to protect children from sexual abuse and exploitation. The Namibian HIV and AIDS Charter of Rights (2002) specifically prohibits all discrimination against children orphaned by AIDS. There are also a number of sector policies that specifically address children and HIV and AIDS including:

- National Policy on Orphans and Vulnerable Children (December 2004): reaffirms the rights of OVC in Namibia
- National Policy on HIV/AIDS for the Education Sector (2003): ensures the right to education for children affected by HIV and AIDS also when they cannot pay schools fees
- Education Sector Policy for Orphans and Vulnerable Children (August 2008): defines the tasks and responsibilities of those in the education sector to ensure OVC access, remain in and complete quality education

<table>
<thead>
<tr>
<th>Birth and early years</th>
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<tbody>
<tr>
<td>Number of facilities offering paediatric ART (8)</td>
<td>180</td>
</tr>
<tr>
<td>Estimated need for ART, children 0-14 (2009) (30)</td>
<td>9,200 [7,300 – 13,000]</td>
</tr>
<tr>
<td>Reported number of children 0-14 receiving ART (2009) (30)</td>
<td>8,188</td>
</tr>
<tr>
<td>HIV exposed infants tested for HIV at 6 weeks (2009/10) (31)</td>
<td>23%</td>
</tr>
<tr>
<td>Children under 5 underweight (2)</td>
<td>16.6%</td>
</tr>
<tr>
<td>Children under 5 stunted (2)</td>
<td>29%</td>
</tr>
<tr>
<td>Children under 5 wasted (2)</td>
<td>7.5%</td>
</tr>
<tr>
<td>Ratio of OVC to non-OVC underweight (2)</td>
<td>1.31</td>
</tr>
<tr>
<td>Children under 5 with births registered (2)</td>
<td>67.1%</td>
</tr>
<tr>
<td>With a certificate</td>
<td>60.4%</td>
</tr>
<tr>
<td>Without a certificate</td>
<td>6.7%</td>
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</tbody>
</table>
The Education Sector Policy for the Prevention and Management of Learner Pregnancy deals with HIV information, counselling and school attendance for pregnant learners.

National Policy and National Guidelines on Infant and Young Child Feeding (May 2011) include the latest knowledge and global guidance on infant feeding in the context of HIV.

HIV and the Life Cycle

The stages of a child’s life are marked by different developmental phases, challenges, and risks and vulnerability to HIV and its impact. This starts in the womb, with the health concerns of the mother and the unborn baby being paramount. At birth and throughout the early years the health and well-being of mother and child are still inextricably bound. Once a child has reached primary school age, there are more external influences on their lives that may start to play a role in their development. These increase with adolescence and the transition to adulthood. There are specific HIV risk factors across and within each stage of a child’s life.

Birth and early years

Mother-to-Child Transmission of HIV (MTCT)

Pregnant women who are HIV positive face the risk of transmitting HIV to their baby. This can happen during pregnancy, labour and delivery, or through breastfeeding.

Without any interventions the combined risk of transmission during pregnancy, delivery and breastfeeding is between 30% and 40% (see figure 10). Full and comprehensive Prevention of Mother-to-Child Transmission of HIV (PMTCT) interventions can reduce the risk of transmission to below 2% (29).

<table>
<thead>
<tr>
<th>Mother-to-child transmission data - Namibia</th>
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<tbody>
<tr>
<td>ANC coverage (2006/7) (2)</td>
</tr>
<tr>
<td>Births in a health facility (2006/7) (2)</td>
</tr>
<tr>
<td>Facilities offering ANC (2009) (8)</td>
</tr>
<tr>
<td>Facilities offering PMTCT (2009) (8)</td>
</tr>
<tr>
<td>HIV prevalence pregnant women 15-49 (2010) (31)</td>
</tr>
<tr>
<td>HIV prevalence pregnant women 15-19 (2010) (31)</td>
</tr>
<tr>
<td>HIV prevalence pregnant women 20-24 (2010) (31)</td>
</tr>
<tr>
<td>Estimated number of women in need of PMTCT (2010/2011) (1)</td>
</tr>
<tr>
<td>Percent of all pregnant women attending first ANC visit who received results of HIV test (2010) (32)</td>
</tr>
<tr>
<td>Percent of HIV-positive pregnant women receiving a complete course of ARV for PMTCT (2010) (32)</td>
</tr>
<tr>
<td>Percent of HIV exposed infants receiving DNA/PCR test within 8 weeks of birth (32)</td>
</tr>
</tbody>
</table>
The majority of HIV-positive Namibian children under the age of 14 will have been infected through mother-to-child transmission, and without access to essential services including antiretrovirals most will die in infancy or early childhood (34).

A critical factor for successful prevention of mother-to-child transmission is the mother and health worker’s knowledge of HIV status. With good antenatal care from a skilled provider, pregnant women can access vital testing and counselling services and when they are HIV-positive they can receive ARVs to reduce the risk of MTCT. With over 95% births in Namibia being attended by a skilled provider, the environment is optimal to reduce the risk of MTCT during labour and delivery. With good postnatal care, women with newborns have access to vital information and services to reduce the risk of MTCT through breastfeeding.

Namibia has made tremendous progress towards ensuring that all mothers receive good antenatal care and have skilled birth attendants. In 2006/7, almost all pregnant women (95%) received antenatal care from a skilled provider and 82% of all births took place in a health facility, although there are differences between regions and between mothers with different educational background (see figure 11). The inequitable access to services mentioned in part I, as well as the HIV epidemic have played a part in the virtual doubling of maternal mortality from 271 in 2000 to 449 in 2006/7.

Namibia introduced PMTCT initiatives in 2002. Initially, the programme was piloted in the state hospitals in Katutura and Oshakati and then expanded to other hospitals and health facilities throughout the country.

PMTCT involves a four-pronged approach to prevent HIV among infants and young children. This includes key interventions to be implemented as a component of overall maternal, newborn and child health services:

- Prong 1: Primary prevention of HIV among women of reproductive age within services
related to reproductive health such as antenatal care, postpartum/natal care and other health and HIV service delivery points, including working with community structures.

- Prong 2: Providing appropriate counselling and support to women living with HIV to enable them make an informed decision about their future reproductive life, with special attention to preventing unintended pregnancies.

- Prong 3: For pregnant women living with HIV, ensure HIV testing and access to the antiretroviral drugs that will help mothers’ own health and prevent infection being passed on to their babies during pregnancy, delivery and breastfeeding.

- Prong 4: Better integration of HIV care, treatment and support for women found to be positive, their babies and their families.

The focus of the PMTCT programme has been mainly on prong 3 and 4. By March 2010, 84% of all health facilities in Namibia offered PMTCT services, representing a huge expansion of PMTCT in just seven years. However, according to the 2009 Namibia Health Facility Census of those that report offering PMTCT services in 2009 actually only half provide the complete investigated package of HIV-testing, ARV prophylaxis, counselling for nutrition and infant feeding and family planning counselling services. Of these four interventions, ARVs are not given at all sites; only 54% of sites that provide PMTCT services provide also ARVs and in these cases HIV-positive mothers are referred to other health facilities for their ARVs. This increases the risk that these mothers do not benefit from a continuum of care and lose out on the best possible PMTCT interventions.

In Namibia in 2009-2010 it was estimated that between 4,027 and 10,952 women annually were in need of PMTCT (see figure 12). Since the modelling package uses programme data as well as survey data (from the Sentinel Surveys), it is not possible to provide exact figures, so confidence bounds are included to reflect the certainty around the figures. For the estimated number of women needing PMTCT in 2009/2010 therefore, the lower
bound figure (4 027) represents the estimated minimum number of women in need of PMTCT and 10,952 is the upper bound figure, or the expected maximum number for that time period (1). Ministry of Health data (MTP III final report) indicated that in the 12 months to March 2010, 8,426 women received a complete course of ARV prophylaxis to prevent MTCT. This figure is already higher than the median estimate of those in need, so the upper bound estimate (10,952) was used to calculate coverage. Therefore it was reported that 77% of all the pregnant women in need of PMTCT received a complete ARV course. New modelling exercises are being undertaken in 2011 and may provide more accurate estimates for programming and planning purposes.

The 77% coverage represents an increase in the number of women reached by the PMTCT programme with complete ARV prophylaxis, compared to April 2008–March 2009 where coverage was estimated to be 6 744 women (58% of those in need). Figure 13 shows the percent of HIV positive women receiving ARV prophylaxis. It shows that 77% of women received ARV prophylaxis (538 of the mothers received nevirapine less than two hours before delivery which does not count as ‘complete prophylaxis’ and therefore the figure reported is 77%).

By looking at the trends over time, it can be seen that the percentage of pregnant women with known HIV status who delivered in health facilities has almost trebled in the five years between 2004/5 to 2009/10. The presented data is only from state health facilities, and not from private health facilities (Figure 14).

New guidelines on infant feeding and HIV have taken away the uncertainty around breastfeeding options, recommending that HIV-positive mothers exclusively breastfeed for 6 months and continue breastfeeding until at least 12 months. ARVs are given during the breastfeeding period. However exclusive breastfeeding rates in Namibia are low and a significant effort is required to promote exclusive breastfeeding throughout the country.
Towards Virtual Elimination of MTCT
The impressive progress that has been made with PMTCT is seen in the increase in numbers of facilities that are now able to offer the programme, the increase in numbers of pregnant women being tested and counselled and knowing their status at delivery, and the achievement of reaching 77% of HIV-positive pregnant women accessing complete ARV for PMTCT. This indicates that there is high level commitment to eliminating the risk of HIV transmission by MTCT in Namibia.

Striving towards Virtual elimination of mother-to-child transmission of HIV is a major commitment which has been made by the Government of Namibia. The PMTCT objective under the NSF is to “ensure adequate and comprehensive provision of quality PMTCT services to all women of reproductive age” (29). This will include actions to strengthen the links between PMTCT and ART programmes, and integrate PMTCT in all appropriate clinical settings (including VCT, STI treatment clinics, family planning clinics, amongst others). Amongst the challenges to achieving virtual elimination are the need for greater involvement of men, ensuring promotion of exclusive breastfeeding for six months for all babies, strengthened capacities of health workers to provide adequate pre- and post-natal counseling and the development of efficient systems to follow-up all women and their children in need of PMTCT services.

Early Infant Diagnosis
One vital part of the PMTCT programme lies with testing of infants and the following up of mother-infant pairs. Whilst there has been an increase in HIV-positive pregnant women accessing ARVs for their own health and as a prophylaxis, there is a gap in the continuum of care, as not all HIV-exposed infants receive ARVs and get tested.

With the increased reach of the PMTCT programme, there are large numbers of HIV-exposed infants who need to be identified, tested and provided with follow-up care. During the 12 months to March 2010, the Ministry of Health & Social Services reported that 9,466 infants (85%) received ARVs, as shown in figure 13. This figure is higher than the number of pregnant women receiving ARVs for prophylaxis due to the inclusion of babies who were born outside of maternity facilities and brought in for post natal services, and because of some mothers were HIV-tested during delivery, and as such could not undertake a full course of ARV prophylaxis (31). Also reporting challenges might contribute to the discrepancy in the data observed.

Due to the high mortality rates amongst untreated HIV-positive babies, it is essential to identify and provide care and ARV treatment, along with cotrimoxazole for these infants. It is considered ideal for HIV-exposed infants to be tested for HIV within the first 8 weeks of life (35). An opportunity to test children exists between 4-6 weeks when they come for immunizations. Infants found to be HIV positive should receive ART immediately, to significantly reduce their risk of developing AIDS and dying at an early age (35).

In Namibia, prior to 2005 many infants were not being tested early, leading to late diagnosis. This was due to a number of factors, including geographic location and distances involved in accessing HIV clinics and mothers failing to make required return visits to the health facility, and mothers not wishing to disclose their own HIV-status to their partner. The follow-up
mechanisms to reach HIV-positive mothers and their children at community level were limited.

Namibia was one of the first sub Saharan African countries to launch their national Early Infant Diagnosis (EID) service in late 2005 and since its inception, the Ministry of Health and Social Services has expanded its coverage. Treatment guidelines were adapted to include eligibility and ART initiation of all HIV positive infants less than 12 months of age, and this occurred well in advance of the WHO 2008 global guidelines change (35).

In 2005 all 13 regions began participating in the EID programme and by 2009, 205 health facilities across the country had the service available. An EID review in 2009 found that coverage rates in Namibia were much higher than many other sub-Saharan countries, indicating “a strong and mature program” (35), although there is presently no way for systematic tracking of mother and baby pairs with a unique identification number, it is possible that there may be some double counting. The data may be incomplete as not all specimens have duplicate forms attached and the current forms are outdated (31). These issues are to be addressed as part of the NSF plans for strengthening PMTCT services.

ART for HIV-infected infants and children is not only life-saving, but make an important contribution to ensuring normal growth and development, as HIV can interfere with normal neurological and cognitive development. Nutritional assessments, counselling and support are recommended as an integral part of the HIV care plan (36). HIV infected children have increased energy requirements compared to uninfected children, and with Namibia’s endemic high rates of child malnutrition, extra care is necessary for those with HIV.

**Birth registration**

Every child has the right to a legal identity, as laid out in the Convention on the Rights of the Child, and stated in the Namibian Constitution. Without having a birth certificate, a child may have difficulty in enrolling in school or be registered for any Government assistance like child welfare grants. With many children being orphaned or becoming vulnerable through HIV, poverty, food insecurity, natural disasters and other circumstances, it is vital to ensure that when a baby is born, the birth is registered and a certificate is given.

In 2006/2007 the NDHS found that only around two-thirds of children had their births registered (67%) and of those, 7% did not have a certificate to prove identification. This represented a slight drop since 2000 when 71% of children were registered (see figure 15). Significant variations across regions and wealth quintiles were found. Some regions, such as Kavango and Kunene have up to a 10% drop in registrations between 2000 and 2006. The NDHS also found that mothers from the richest quintile were almost twice as likely to have registered the births of their babies than mothers from the poorest quintile.

The 2006 data indicated that mothers in Kavango region registered less than half of children’s births (46%) and in Ohangwena and Kunene only slightly more than half of births were registered (56%). Caprivi, the region with the highest HIV prevalence only had 62% of births registered in 2006.
In order to address the gaps in birth registration, the Government has developed a three-prong approach: mobile birth registration services to reach remote villages and settlements, use of regular Home Affairs facilities and opening birth registration facilities in hospitals. Between April 2009 and March 2010 the mobile registration campaign registered 18,000 children, and in 2010 21,000 additional children were registered. Over 23,750 children were registered in health facilities. All together in 2010, 65,405 children’s birth were registered, an increase from 41,532 in 2009 (figure 16).

In a review of birth registration in Khomas and Omaheke regions a number of factors were identified that hamper the registering of births:

- In some areas cultural factors mean that naming a child only happens months after birth
- Some mothers do not have proper documentation with them when they try to register a birth
- Lack of awareness about the need, requirements and benefits of birth registration among expectant mothers

Births registration is vital as registration papers are needed in order to access for instance child welfare grants. The increase in birth registrations since the introduction of mobile units and hospital based units is shown in figure 16, indicating the link between birth registration and access to child welfare grants. If birth registration can continue to increase, more children in need will be able to access vital support.

The NSF aims to have 80% of health facilities offering birth registration services by 2015 and increase the percentage of children who have their births registered and have a certificate to 85% by 2015.
Young children (primary school age, 6-13)

There are currently an estimated 328,500 children aged 7-13 in Namibia, and a greater number than this actually enrolled in primary school – 405,800. This age is important in relation to HIV, since it holds the period where children are learning and adopting many behaviours and attitudes. With an enrolment rate of 98% (100% female; 97% male) (38), primary school is an ideal setting for imparting vital information on HIV and AIDS, and supporting the development of life skills which will assist children to reduce their risk and develop healthy and safe behaviours.

Infection rates in young children
There is no HIV prevalence data specific to 6-13 year olds available in Namibia. In 2010/2011, it is estimated that approximately 14,000 children between 0-14 years are infected with HIV (1), the vast majority (estimated at more than 90%) will have been infected through MTCT (34).

Knowledge and Behaviour
Since the majority of children in this age group have not begun sexual activity, it is an important time to start developing sufficient knowledge and skills to protect themselves from HIV infection and reduce their vulnerability and risk. It has been found that when new behaviours are inculcated at an early age the likelihood of them being sustained through life are much higher. Hence, behaviour development among children as opposed to behaviour change among adults is proposed as a stronger approach to HIV prevention.

There is no nationally representative household survey that gives details of knowledge and behaviour among primary school age children. However younger school children are often part of regional surveys and smaller studies. A 2006 study on HIV and AIDS knowledge, attitudes, practices and behaviour was conducted in three northern regions (Kavango, Omaheke and Ohangwena) (40). It found that knowledge about HIV and AIDS amongst 10-14 year olds was very high, but knowledge of prevention was not quite so widespread. There was sexual activity in this age group and of concern was that of those who had had sex, 42% reported to have been forced and 23% reported to have had their first sexual
encounter with a partner more than 10 years older. Only a third of those who engaged in sexual activity consistently used a condom (40). Stigma was apparent in the 10-14 age group, with children expressing negative attitudes towards HIV-positive children. This may well be because of a lack of understanding of the disease, but it also underlines the need to reach children of this age with correct information, address anxiety and curb stigma.

The Southern and Eastern Africa Consortium for Monitoring Educational Quality (SACMEQ) developed a knowledge test on HIV and AIDS in response to the large numbers of children under the age of 15 who are infected and affected by HIV and AIDS. This test (known as HAKT) was administered to grade 6 pupils (around the age of 13) and teachers and addresses basic knowledge for protecting and promoting health. In Namibia, all the teachers in the sample had reached a minimal level of knowledge (meaning that respondents had mastered 50% of the officially designated curriculum that was assessed by HAKT), and 87% reached a desirable level (indicating 75% mastery of curriculum). Teachers seem well placed to impart knowledge about HIV and AIDS, as their levels of knowledge are good. However, the grade 6 pupils themselves had alarmingly low levels of knowledge. Around one-third of pupils (36%) reached a minimal level of knowledge, and only 6% had reached a desirable level. This contrast between teachers having high levels of knowledge but learners having very low levels of knowledge is of great concern, especially in the light of the fact that it was found that the pupils listed the classroom as the main source (93%) for information on HIV (41). Namibia’s scores were similar to the average scores across the other SACMEQ countries and indicate that the present approach to HIV learning in primary schools is not effective.

Prevention Interventions for young children

Life skills-based education: In recent years, more primary schools have been offering extra curricula life skills-based HIV prevention education, such as Window of Hope, a national extra-curricular school programme which reaches learners from ages 10-14 who are enrolled in grades 4-7. The programme started in 2004 and has proved important in sharing information and HIV risk reduction skills amongst the younger age group of school-going children. In 2007, just under two-thirds of primary schools (63%) taught life skills and this had increased to 75% by 2009 (31).

A number of challenges in delivering HIV prevention-focused life skills programmes in Namibian schools have been identified, including the limitations of having the life-skills programme as a non-examinable subject. This has the effect of the lack of accountability in delivering quality courses. Monitoring programmes and in particular reporting on the numbers of learners who are reached, in addition to measuring the outcomes are also identified challenges (31).

Orphans in schools

There is no significant difference in Namibian primary school attendance rates between orphans and vulnerable children (OVCS) and those who are not OVCS. In 2008, there were approximately 197,000 vulnerable children (126,000 orphans and 71,000 vulnerable) in schools. There are regional variations, with only 67% OVC attending school in Kunene, but all (100%) attend in Khomas and 99% in Oshana (2).
The Education Sector Policy for Orphans and Vulnerable Children was developed in order to specify the support mechanisms that are necessary to address the needs of orphans and vulnerable children in educational institutions. These include addressing economic, educational and psychological needs (42). The NSF provides strategies for addressing a range of needs for OVC, including ensuring attendance at early childhood development programmes and primary schools (29).

The presence of teacher counsellors at schools makes a positive difference” (43)

School counseling: The primary school system in Namibia has a system of teacher counsellors who, amongst other responsibilities, are meant to offer psycho-social counselling for children in need of support. An evaluation of school counselling in three regions in Namibia published in 2010 indicated that teacher counsellors at schools make a positive difference for learners, but little (if any) real counselling takes place. This is due to many reasons (including the lack of training and resources, both human and material), and there are serious shortcomings that prevent the current system from providing adequate support for children. Many teacher counsellors are compassionate and understanding and provide much needed support to learners who find themselves in dire circumstances, but a great many are insensitive and may do vulnerable children harm (43). The evaluation recommends that amongst the issues to be addressed is providing teachers with the skills to work with sensitive issues, including grief, loss and HIV and AIDS.

School feeding: Hunger appears to be a pervasive issue that children themselves have highlighted as one of the underlying stressors of their lives at school (43), (18). In line with the policy on Orphans and Vulnerable Children (42), Namibia has instituted school feeding programmes, which provide one meal a day for children in primary schools. In the second trimester of 2011 224,276 beneficiaries at 1,214 schools were receiving the school feeding (personal communication 2011). There is anecdotal information that the initiative may
encourage attendance, especially in some of the poorer regions. While there is no data available for the numbers of OVCs accessing school feeding, there is qualitative evidence that for some children it is their main meal of the day (18).

School Development Fund: There are other aspects of how poverty affects children at primary school age and can bring added stress to children affected by HIV. These include the lack of resources within a family to ensure school development fund fees are paid or that school uniforms are bought. Both of these issues play a large role in vulnerable children’s lives (43) (18). School fees have been cited in a number of studies to being a barrier for many children being able to access education, despite there being a policy that no child may be turned away school if they are unable to pay school development fund contributions (42). This is dealt with explicitly in the education sector policy for OVC. However, many children have indicated that they often suffer due to an inability to pay for school related expenses (18).

Child Welfare Grants: The Government of Namibia has dramatically scaled up the provision and coverage of child welfare grants in the past few years (figure 17). By February 2011, there were 123,748 beneficiaries of child welfare grants; an enormous increase from 8,823 in 2002 (see Figure 17). The provision of child welfare grants makes education possible for almost all of those children receiving (39) grants, and provides a way for some parents to feed the children in their care. However, the grants only target orphans, and not all poor and vulnerable children are orphans.

In a study investigating the effectiveness of Child Welfare Grants, 43% of the participating beneficiaries indicated that school related costs were the main spending item (39). As such, whilst child welfare grants are playing a vital role in giving support primarily to orphans, the funds are often being spent on costs from which they should be exempt.
Violence and abuse against children - increasing HIV risk and vulnerability:  Schools are meant to be safe and secure environments for all children. Violence and neglect appears to be a common thread to be found within both school and home environments: over one in four children (27%) under the age of 12 are forced into sexual intercourse (44). Many primary school children talk of violence experienced in their homes and the link between early childhood victimisation and later perpetration of violence against partners for both men and women can be made (18). The issue surrounding violence, gender-based violence and HIV and Aids has not been sufficiently explored in Namibia, but there are concerns of sexual grooming of young children that are particular practices that may exacerbate a young child’s vulnerability to HIV infection. In the Caprivi region, it has been noted that in some communities the initiation ritual for girls and young women commences with their first menstruation and may involve ‘sexual preparation’ (undertaken by male family members). This sexual ‘testing’ is sometimes done while the girls are drugged. These practices put young girls and women at great risk in the context of HIV (45)(46) along with the additional risk of pregnancy.

Adolescents aged 14-18

Adolescence marks a period of transition from childhood to adulthood. Generally, adolescents are defined as between 10-18, however, for the purpose of this paper, older adolescents are taken as young people of roughly secondary school age (14-18). There are nearly 250,000 children in this age group in Namibia, which is 11% of the total population.

Since this period is when most young Namibians commence sexual activity, adolescents have higher vulnerability to HIV infection.
HIV prevalence amongst 14-18 year olds
There is little confirmed data on the HIV prevalence rates amongst this age group. Since the HIV-prevalence estimates in Namibia are based on ANC data collected from pregnant girls and women, this is the most reliable proxy indicator available. The national HIV prevalence amongst 15-19 year old pregnant women was measured at 6.6% in 2010 (21), a significant decrease from 12% in 2000. While the 2010 figure of 6.6% is higher than the 2008 figure of 5.1% it is not yet clear if this is just a factor of data collection or that there actually has been increasing prevalence in this age group.

At the same time, any increased prevalence may not be due to an increase in new infections (incidence) because some children who were infected through MTCT in the past have survived into adolescence.

Through modeling, it is estimated that in 2010 across the country 4,714 people were newly infected (approximately 13 new infections every day) and that 16% of these new infections were amongst 15-19 years olds. 73% of those new infections were amongst girls, compared to 27% of boys of the same age (1). Behaviours that put young people, and especially young women at risk include early sexual debut, inconsistent condom use, multiple and concurrent partners, intergenerational and transactional sex.

Adolescent HIV risk and vulnerability factors
Teenage pregnancy: According to the NDHS, in 2006/07 one in seven women aged 15-19 have already started childbearing, 13% are already mothers and 3% are pregnant with their first child (2). Young women in rural areas are much more likely to be young mothers compared to those who are urban.

Young women with no education are ten times more likely to have begun childbearing by age 19 than those who have completed secondary school. This suggests that education may have

Comprehensive knowledge means knowing that consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the risk of getting the AIDS virus, knowing that a healthy-looking person can have the AIDS virus, and rejecting the two or more common local misperceptions about AIDS transmission or prevention.
protective effects. However pregnancy remains a problem for many young women, and it is the reason that many leave school (14% of early school leavers in 2009 left because of pregnancy (38)). The Ministry of Education learner pregnancy policy was updated in 2009, and instructs schools to provide supportive environments for the prevention of learners becoming parents. The policy also provides opportunities for post-delivery continuation of education with additional opportunities to safeguard the girls against any potential future abuse or exploitation and to break cycles of poverty.

**Knowledge and attitudes:** Knowledge of HIV and AIDS plays an important role in preventing HIV infection. Around two-thirds of young women and men aged 15-19 (62% and 59% respectively) have comprehensive knowledge of HIV. Among a broader age group of 15-24 year olds, there is no difference in knowledge levels of HIV and AIDS between rural and urban women, but rural men have a lower knowledge level than their urban counterparts (58% compared to 68%). Young people with more education (higher than secondary) are more likely to have comprehensive knowledge of HIV than those who have no education. People living in some of the regions with higher HIV prevalence rates have very low levels of knowledge. For example, only around one-third of young women in Kunene and young men in Ohangwena have comprehensive knowledge of HIV. The levels of knowledge in rural and urban areas and in the regions are shown in figure 18.

There are other studies that indicate a reasonably high level of knowledge, but these studies take just one element of knowledge, and cannot be compared to levels of comprehensive knowledge (40),(48),(49),(50).

**Stigma and discrimination:** Overall there has been an increase in the numbers of young people with accepting attitudes to PLWHIV between 2000 and 2006/7. Only just over one-third of men and women 15-19 had accepting attitudes for all four indicators (35% for men and 38% for women), but there was near universal acceptance for caring
for an infected family member (95% for men, 92% women). This is an increase from 2000 when 87% of young people were willing to care for infected family members. Young men 15-19 have a slightly lower level of acceptance than young women of the same age.

**Sexual Debut:** In 2006/7, 18% of Namibian boys and 7% of girls aged 15-19 had initiated sex by the age of 15. Young people in rural areas have first sexual intercourse earlier than those in urban areas and young people in Kavango and Caprivi regions are most likely to have had sex by age 15. Age at first sex increases with the level of educational, especially amongst women. One in four women with no education had sex before the age of 15, compared to less than 1% of women with more than secondary education. Between 2000 and 2006/7 NDHS data indicates that there was a decline in the number of young people aged 15-19 who had their first sex by 15 years of age. Amongst girls there was a decline from 10% to 7% and amongst boys there was a more dramatic decrease from 31% in 2000 to 19% in 2006/6. This decline is encouraging, but it is also possible that sensitive questions about sexual behaviour are under-reported in large household surveys. Data from smaller studies indicate much higher rate of early sexual debut: 27% of Namibian girls and 34% of boys have already had their first sexual encounter by the age of 15 and the trend suggests that each generation is having first sex earlier than previous ones (48).

**Multiple and Concurrent Partnerships (MCP):** Having multiple sexual partners concurrently is recognised as one of the key drivers of the HIV epidemic, since it raises the personal risk of acquiring HIV, and increases the odds of passing on the virus to other people within the sexual network.

Having concurrent partnerships (relationships that are closely spaced or overlapping in time) presents a high risk of HIV infection because a person with a newly acquired HIV infection is more likely to pass on the infection to additional sexual partners (because of the higher viral load in the first 6-8 weeks of infection) (23).

In Namibia there have been a number of community studies that try to assess the levels of multiple and concurrent relationships and turnover of partners. It was found that there were high levels of concurrency, predominantly amongst youth (15-24 year olds), with 1 in 10 respondents indicating they had concurrent partners. The nationally representative NDHS asked broadly for numbers of partners in the year previous to the study which includes concurrent relationships but cannot distinguish relationships that could be months apart in time. In this survey, 3% of sexually active 15-19 year old women and 17% of sexually active 15-19 year old men reported having more than one partner in the previous 12 months shown in figure 19). Much fewer women than men in Namibia are reporting multiple partnerships, but the highest levels are reported amongst women aged 15-24 residing in urban areas. Among men of the same age it was significant that being married or cohabiting did not significantly reduce multiple partnerships (23).

**Condom use:** Over three quarters of 15-19 year old women (86%) and men (88%) know a source for condoms, but despite improvements between 2000 and 2006/7, condom use in Namibia remains low and inconsistent (23).

Around two-thirds of women aged 15-19 (64%) and only around half of men (53%) used condoms at their first sexual encounter, which can be considered relatively low, especially
when over three-quarters knew where to obtain condoms in 2006/7. Urban youth report using condoms at first sex at a higher level than rural young people. The regional differences are also great: young women (37%) and young men (20%) in Kavango are least likely to report using condoms at first sex, whereas young people in regions such as Erongo, Khomas and Karas are more than twice as likely to report using condoms at first sex (74% of women in Erongo and men in Karas). Figure 19 shows that while three in four 15-19 women used condoms consistently with their last partner, the levels are much lower for men and also in higher risk sexual encounters for both men and women.

There is limited data available on condom use by HIV-positive adolescents and the only data available comes from the Voluntary Testing and Counselling (VCT) centres where adolescents are under-represented. However, there is data showing that 40% of HIV-positive men and women of all ages had not used a condom at all in the previous 3 months, despite being sexually active (23).

**Intergenerational sex:** Age-mixing in sexual relationships (intergenerational sex) has been said to be one of the key drivers of the HIV epidemic in Namibia. However the limited data presently available on this is far from conclusive. The NDHS indicates that 3% of women aged 15-17 and 6% of 18-19 year old women had had higher risk sex with a partner 10 or more years older (2), which does not indicate a significantly high level of age-mixing. A recent study among adolescent girls also found intergenerational sex to be an insignificant feature of the HIV infection risk among adolescent girls (51). However other community studies have found age-mixing to be much more prevalent, even in younger adolescents (40), with almost 30% of females reporting partners 10 or more years older (48).

**Transactional sex:** In Namibia, transactional sex (where sex is exchanged for food, money, gifts or other favours) appears to be increasing (23). The NDHS reports that 0.5% of men aged 15-19 have paid for sex, however transactional sex may involve the exchange of goods and services, and not just money. Regional studies have found respondents having a high acceptance of ‘sugar daddies and mommies’. In the recent study among adolescent girls, it was found that one-third of the sexually active girls had received money of gifts in exchange for sex. The motivations for these transactional relationships appeared to be mainly materialism rather than absolute poverty, as has been found in other studies (51).

**Multiple risk behaviours:** The levels of higher risk sexual behaviours are shown in figure 19. The NDHS defines higher-risk sex as sexual intercourse with a non-marital, non-cohabiting partner. While the levels of women reporting two or more partners can be seen as quite low, those 15-19 year olds reporting higher risk sex are very high (84%). 98% of men of the same age report higher risk intercourse – the highest proportion in all age groups. This represents high levels of risky sexual behaviour amongst sexually active adolescents and is of great concern, when contrasted with the relatively low levels of consistent condom
use.

**Gender:** There are some underlying factors relating to gender in Namibia’s societal structure that are significant in increasing the vulnerability of adolescent girls to HIV infection. It has been well documented that young women are more vulnerable to HIV infection in sub-Saharan Africa and Namibia (e.g., with 73% of the new infections in 2010 among 15-19 year olds being among females). What is not so well documented is the underlying social and structural inequalities and reasons why men and women perpetuate unequal power roles. With many diverse cultures in Namibia, there is no nationally representative data available. However, there are some regional studies that have highlighted that some culturally prescribed practices are harmful to women, and many that are particularly harmful to adolescent women. Practices such as initiation, dry sex, ritual cuttings are areas that are largely not discussed in terms of HIV risk to young women (45), and there is little data available for this age group when many initiations could take place.

Domestic violence and rape are recognised as problems in Namibia and the links between gender-based violence and HIV is becoming better understood. Global research indicates that HIV infection following forced sex is likely to be higher than in consensual sex, especially among younger persons. In Namibia, forced sex appears to be relatively widespread, with 18% to 50% (depending on the study) of young people reporting being forced into their first sexual intercourse (18). The indirect effects of gender-based violence are also important: victims of childhood sexual abuse have demonstrated higher HIV risk behaviours later in life (52).

**Adolescent HIV prevention interventions**

The NSF prioritises prevention as the key strategy to address the HIV epidemic in Namibia. It articulates the need for combined interventions “that will focus on biomedical and behavioural interventions at the same time as addressing underlying structural issues such as social norms” (29). This will be delivered by ensuring access to information, knowledge, skills and services within a conducive policy environment. The sector-specific and region-specific operational plans will allow for this specific targeting and addressing drivers that are pertinent in those areas.

Within this focus on prevention, comprehensive actions for adolescents and young people are prioritized.

**Information/knowledge interventions:** For the past decade in Namibia there have been a number of multimedia campaigns addressing different aspects of the HIV epidemic that directly affect adolescents (such as gender-based violence, multiple and concurrent partnerships). The most systematic approach is coordinated by the National Take Control Campaign which addresses issues ranging from safe sex, HIV and alcohol, relationships. The latest campaign covers multiple/concurrent partnerships (MCP).

Capitalising on the popularity of using cell phones among the youth, information and communication technology is being used to both raise awareness of multiple/concurrent partners and to provide an innovative platform for young people to talk about their concerns. Although not specifically targeting adolescents 14-18 year olds, a recent evaluation of the MCP campaign found the reach of the Campaign had been very high and that there had been
a positive trend towards reported behaviours around concurrent partner reduction also among young people reached by the campaign (53).

**Life Skills Interventions:** All public secondary schools have a Life Skills subject which is mandatory (but not examinable) and includes some HIV and AIDS information, but there is no stand-alone subject on HIV and AIDS.

My Future is My Choice (MFMC) is the only national official extra-curricular HIV prevention life skills programme in secondary schools which works alongside other programmes run by civil society partners. In 2009/2010, 86% of secondary schools taught MFMC, an increase from 70% in 2007 (31). However per school and per year only 66 learners can participate. That means that in 2008 only about 8% of learners benefited from MFMC and that over 50% of learners who leave secondary schools have not received the benefits from the life-skills curriculum. As with prevention programmes in primary school, they remain extra-curricular and not integrated into the school curriculum, which is one of the major weaknesses. A recent evaluation of MFMC found that the programme was perceived to be beneficial to participants, but there was a need to expand the reach to more learners (54).

Programmes reaching out of school youth and programmes conducted in out of school settings include Sports for Development (Galz and Goals and Kwata Cricket), church based programmes and performing arts programmes. However in the absence of proper mapping and coordination, the programmes remain at project level and are scattered country-wide.

**Voluntary HIV Counselling and Testing for adolescents:** According to NDHS, only 23% of women and 9% of men aged 15-19 had been tested for HIV and received results in past 12 months. Women in all subgroups were more likely than men to have taken a test and received the results. This indicates that promoting HIV testing amongst youth is vital, especially among young men. The regional variations indicate that only
16% women aged 15-24 in Caprivi, an area with high HIV ANC prevalence, had voluntarily been tested for HIV and received the results, and only 3% of men in Kavango. Amongst the youth throughout all the regions however, voluntary HIV testing remained well below 50%.

The National HIV Testing Day gives an opportunity to everyone to learn of their HIV status through increased and more easily accessible testing sites with the purpose of encouraging everyone to know their status. In 2010, 3,991 15-19 year olds were tested during the National Testing Day campaign and the proportion of HIV-positive results in this group was 2.6% (55).

Male circumcision: Low levels of male circumcision is thought to be a contributing factor in the HIV epidemic in Namibia and the Government now promotes male circumcision as an HIV-prevention measure. Traditionally, circumcision is practiced by only certain groups in Namibia, and therefore national rates appear low (17% of males aged 15-19 are circumcised) (2). The regions where circumcision is most common are those with relatively low HIV prevalence according to sentinel surveys (Omaheke and Otjozondjupa).

Adolescents living with HIV
There are a growing number of Namibian adolescents living with HIV. Some will have been infected at birth and survived, and others will be infected through sexual activity during their adolescence. While there are no exact figures available on the numbers of adolescents living with HIV, estimates have been modelled and indicate that in 2009 in Namibia there were 3,800 female (low estimate of 2,400, high estimate of 5,600) and 2,300 male (low estimate 1,300, high estimate 3,700) adolescents aged 10-19 HIV positive.

The period of adolescence is a challenge for all, and being HIV positive adds an additional burden. Adolescents living with HIV face specific issues in relation to:

- learning about their status
- reacting against taking medication daily
- coping with stigma and discrimination
- dealing with how to protect themselves and others from infection
- dealing with reproductive health and wanting to have children

There has been little focus on providing these young Namibians with specialised care and support. There are no dedicated services for adolescents living with HIV, and while there has been considerable emphasis on prevention of HIV infection, there is much less on the care of those already infected.

Orphans and Vulnerable Children
While many of the issues relating to children and HIV are specific to certain ages in a child’s development, orphaning and vulnerability cut across all ages. From the NDHS and Child Welfare Grant study, it is clear that not all children are vulnerable, not all orphans are orphaned by AIDS, not all orphans are vulnerable and not all vulnerable children are affected by AIDS (2) (39). HIV is a significant factor in orphaning and also in increasing vulnerability of children in Namibia, but not the only reason.

There are an estimated 3,800 [2,400-5,600] females
2,300 [1,300-3,700] males
aged 10-19 who are living with HIV in Namibia (2009)

“HIV-positive learners are not made aware of their rights and their specialized needs are not supported”

(67)
In 2006/7, 28% of Namibian children were deemed to be either orphaned and/or vulnerable (OVCs): 17% were orphaned. Namibia saw an increase of 1% in the number of double orphans (children having lost both parents) between 2000 and 2006/7 and the proportion of children under 15 who had lost one or both parents increased from 15% to 17% during the same period. The proportion of OVC increases with age: from 15% among children aged 2 years to 40% among children aged 15-17 years (2). In many countries, a number of issues affecting the vulnerability of children are assumed to be the domain of orphans, such as living with siblings or not living with biological parents. In Namibia, however, this does not necessarily apply: only one-quarter of all the children in Namibia live with both parents, and 24% do not live with either parent despite both parents being alive. This indicates that there are both orphans and non-orphans who do not live with parents and that vulnerabilities caused by not living with one or both parents are not necessarily the domain of orphans.

In some aspects orphans and children affected by AIDS in Namibia are worse off than other children, for instance:

- Fewer OVC have three basic material needs (shoes, two sets of clothes and a blanket) than non-OVC (41% OVC to 54% non-OVC) (see figure 20)
- OVC aged under 5 years are more likely to be underweight (27% OVC to 21% non OVC) (figure 21)
• There are more OVC girls (aged 15-17) who had sex before aged 15 (10%) than non-OVC (7%) (figure 22)

However, this data cannot be interpreted to indicate that all those who are not OVC are doing fine and are well-off. The figure for all children who have three basic material needs or who are underweight remains high also among the non-OVC population. When it comes to school attendance, it appears that there are more OVC attending school than non-OVC and in certain regions, such as Kunene, the difference is pronounced (67% of OVC attend school compared to 52% of non-OVC) (see figure 23).

Such information highlights that for Namibia, the definition of either being orphaned or vulnerable for purposes of targeting for interventions is not appropriate. Whilst having a family member in the household, or caregiver with HIV or AIDS is a contributing factor to poverty levels and adds to the vulnerability of children of all ages, it cannot be used to predict vulnerability. Using orphaning as a criteria for targeting, as the child welfare grant system currently does, means that many children who are in need of support are being excluded.

**Child Welfare Grants**

The history of the child welfare grant as a response to increasing numbers of children affected by HIV and AIDS has been well documented in Namibia, and the impressive increase in coverage (almost 10 fold in the past decade) of child welfare grants has already been highlighted (see figure 17 on page 29).

The 2010 assessment of the child welfare grants, conducted by the Ministry of Gender Equality and Child Welfare had a number of important findings, including (39):

- The grants currently do not significantly contribute to reducing child poverty, partly because of low amounts of the grants
- There are many vulnerable children in need of the grant but who are excluded due to their...
non-orphan status

- There is a very high administrative burden in administering the grants
- Many of the grant recipients use the grant to cover school-related costs, indicating that the policy of OVC exemptions to school fees was not being implemented.

Since the evaluation of the child welfare grant, the Ministry of Gender Equality and Child Welfare has succeeded in equalising the payment of the grant among all children in the household, so each child gets N$200 per month. This was a specific recommendation from the study to improve the impact on reduction of child poverty. Other recommendations for improving the effectiveness of the child welfare grant are being addressed in the provisions of the NSF for orphans and vulnerable children, namely to strengthen the coordination and management of the welfare grants and also to increase the coverage (29).

National Plan of Action for OVC (NPA)

Namibia made significant progress towards addressing the needs of OVC through the development and implementation of an NPA for OVC 2006-2010. This multisectoral guiding document for Namibia’s response to the increasing numbers and vulnerabilities of OVC of all ages was developed around 5 key areas for action:

- Rights and protection
- Education
- Care and support
- Health and nutrition
- Management and networking

The multi-sectoral OVC Permanent Task Force (PTF) advised, coordinated and monitored the implementation of the NPA. The PTF is the primary OVC coordination body and consists of members from government civil society and development stakeholders. Achievements and priorities from the NPA were integrated into the NSF.

Under the leadership of the Ministry of Gender Equality and Child Welfare, the Government is developing a new national plan / agenda for children which will focus on the broader set of vulnerable children and which will contribute to the new National Development Plan IV.

Alternative Care

Child care facilities represent an important response to children who are in need of a place of safety for alternative care when families and communities are unable to meet the challenge. Close to 1,100 children, many of whom have been affected by the HIV epidemic, are known to be in childcare facilities in Namibia (31). As a response to the concern of government and civil society actors over a growing number of unregistered childcare facilities, and the quality and standards of facilities, minimum standards for residential child care facilities have been developed and an alternative care policy has been drafted. In 2009 a qualitative foster care study was completed to identify and recommend locally feasible alternatives to provide a continuum of care for orphans. The results indicated that the majority of orphans are cared for within their extended families, and that kinship care is a more appropriate response for Namibia. These policy recommendations were integrated into the draft Child Care and Protection Bill.
Namibia’s changing focus – from HIV-specific to HIV sensitive social protection

Namibia’s response for children of all ages who have been made vulnerable by HIV has resulted in much progress, and has also undergone strategic shifts. After the Rapid Appraisal Analysis Process (RAAP) conducted in 2004, Namibia’s response focused on orphan-specific service delivery. As more understanding of the situation has emerged, the national response has started shifting towards a more comprehensive social protection approach, which is sensitive to the impact of HIV, but not specific to HIV and orphaining.


(27) Legal Assistance Centre [LAC]. *“ I just want to have a good life”: OVC and human rights in five regions in Namibia*. Windhoek: LAC, 2009.


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(62) Namibia Alliance for Improved Nutrition. Malnutrition in Namibia: the time to act is now! Windhoek, Namibia: s.n., [2010].