

Namibia's Prevention Planning Process

Successful Collaboration for a National Combination HIV Prevention Strategy



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Two members of the Total Control of the Epidemic community outreach program work to motivate an antiretroviral defaulter to resume treatment.

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In Walvis Bay, Namibia—one of the largest ports in Southern Africa—thousands of shipping containers line the shores between the sands of the Kalahari Desert and the Atlantic. Sailors and laborers flock to the harbor to find employment, and when the work day is done, they seek relaxation and entertainment on shore in their housing settlements, where bars offer a potent local brew and a place to meet women.

It is not difficult to find young women who are willing to exchange sex for the modest things a dockworker's money can buy: a pretty piece of jewelry, a pair of the must-have brand of jeans, a cell phone. But some of them—occasionally girls as young as 14 years of age—will discover that these transactions can also lead to HIV infection.

In this setting, the aptly named Multipurpose Center offers a broad mix of HIV prevention services combining mutually supportive behavioral, biological, and structural interventions, all targeted to the local epidemiology. The Center—one of only a few of its type in Namibia—houses an HIV testing clinic, trains HIV outreach workers and community mobilizers to educate the surrounding community about HIV, offers condoms, and encourages individuals to come in for HIV testing and counseling. Other Center services include providing meals for orphans and vulnerable children, support groups for people living with HIV (PLHIV), home-based care and counseling, and group cultural and drama activities focusing on HIV prevention. The Center also experiments with income-generation activities—a bike repair shop, gardening classes, a catering service, computer training, and a course in tailoring—to create economic opportunities for young women that Center staff hope will compete with the men at the port.

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The Center reflects how Walvis Bay's potent array of HIV drivers—alcohol, migrant work, intergenerational and transactional sex—requires a combination of tailored responses. The combination approach may avoid some of Namibia's prevention pitfalls, such as the unmet promise of more than a decade of building national awareness. Despite near universal knowledge of HIV, high levels of vulnerability and risk behavior persist.

Namibia's national prevention planning has started the process of coordinating prevention program design and implementation to ensure these multiple drivers are tackled at the regional and local levels.

Combination Prevention Programming

Namibia has formulated a comprehensive national combination prevention strategy through a long-term planning and advocacy process. Although a combination approach was not explicitly planned at the time of its launch, Namibia's 2010 national prevention program strategy is now firmly grounded within a combined prevention framework.

Namibia's prevention response illustrates several key aspects of combination HIV prevention programming in a high-prevalence generalized HIV epidemic, including:

- Using all available data to identify a wide range of key factors that influence the epidemic, including biological, behavioral, social, and structural factors
- Tailoring prevention design to regional and community-level contexts
- Addressing structural issues, including gender, alcohol abuse, and poverty

- Linking prevention program activities to clinical services.

Namibia's experience illustrates the level of coordination needed to institute combination prevention within a national program. The carefully planned sequence of events that led to a national prevention strategy also provided the impetus to establish a National Technical Advisory Committee for Prevention (TAC/P) with a full-time coordinator within the Namibia Ministry of Health and Social Services (MOHSS)/Directorate of Special Programs (DSP). The TAC/P and its related technical working groups provide ongoing guidance for focused, evidence-based interventions that address key factors influencing the epidemic. Some of the remaining challenges will be met over the coming months, as Namibia undertakes the next phase of its planning process, the development of a comprehensive operational plan. All in all, Namibia's prevention planning process provides a useful template for countries that want to implement a combination HIV prevention approach within high-prevalence generalized epidemics.

Combination HIV prevention includes a mix of strategies and risk-reduction approaches that use current epidemiological and programmatic evidence to target different audiences with simultaneous behavioral, biomedical, social normative, and structural interventions that respond to local realities.

The Origins of the Prevention Planning Process

In 2006, Namibia's HIV prevalence was estimated to be among the highest in the world: 20 percent among pregnant women aged 15 to 49 years attending antenatal care clinics. In response to this alarmingly high prevalence and to serious perceived gaps in Namibia's HIV prevention programs, a group of highly motivated technical advisors from the MOHSS, the Joint U.N. Programme on HIV/AIDS (UNAIDS), the U.N. Children's Fund (UNICEF), the U.S. Centers for Disease Control and Prevention (CDC), and the U.S. Agency for International Development (USAID) collaborated to develop a systematic prevention planning process aimed at reducing the spread of HIV in Namibia (MOHSS/DSP 2007).

Could Namibia's prevention programs reduce this high HIV prevalence? While the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) had budgeted U.S.\$19 million in fiscal year 2007 for prevention in Namibia, the MOHSS itself was primarily focused on treatment, care, and support. Prevention programming within the country was not centrally coordinated; no single government agency was responsible for prevention, and there was no point person for prevention within the MOHSS.

There also had been no effort to synthesize the fragmented evidence on the HIV epidemic in Namibia and on factors driving HIV transmission as the basis from which to develop a comprehensive national prevention strategy. After a decade of activities to raise awareness of HIV, client populations had begun to "tune out" prevention messages, and revitalized behavior change approaches were needed.

The Namibian government also faced a funding dilemma. With antiretroviral (ARV) coverage

approaching 80 percent of those in need, the momentum for treatment programs and for prevention of mother-to-child HIV transmission programming was strong. Yet how could Namibia continue to afford the costs of treatment? The country needed to find a way to slow the spread of HIV.

Technical Approach

Namibia currently faces a generalized HIV epidemic that is primarily transmitted sexually. There are now suggestions of a decline in HIV prevalence. In 2008 and 2009, a modeling exercise produced an estimate of national HIV prevalence of 13.3 percent in the general population aged 15 to 49 years. While data from antenatal clinic surveillance suggest prevalence among older women had increased, prevalence among younger women aged 15 to 19 had declined from 12 percent in 2000 to 5 percent in 2008 (MOHSS/DSP 2010). But HIV prevalence varies greatly across the country's 13 regions, from 6 percent to 30 percent, with very high prevalence in the more densely populated areas along Namibia's northern border. This variation presents a major challenge: to tailor prevention programs to fit this wide range of regional prevalence.

Namibia's HIV prevention program: The national strategic response to HIV is guided by two key planning documents: the *Medium Term Plan III for 2004-2009* and the newly completed *National Strategic Framework (NSF) for 2010/11-2015/16* (MOHSS/DSP 2010).¹ The National AIDS Executive Committee (NAEC) is tasked with providing overarching technical leadership, management oversight, and coordination for the national HIV program through multi-sectoral partners, while the MOHSS manages and coordinates the ongoing

¹The NSF was reviewed and approved by the National AIDS Committee, the highest governmental policymaking body on HIV. It was approved by the Cabinet and received final approval by the Parliament of Namibia on World AIDS Day 2010.

implementation of the national HIV response through the DSP. Namibia's regions coordinate their efforts through Regional AIDS Coordinating Committees and at the local township level.

Among other activities, the national program has engaged in large-scale efforts to distribute free condoms and to provide HIV counseling, testing, and referral services in most regions. Programs reach out to different populations, such as residents of nature conservancies, agricultural workers, high-risk transport workers, and the nation's educators, among others. PEPFAR has provided funding for a variety of prevention programs in Namibia, including support for a full-time prevention advisor posted within the MOHSS/DSP, technical support advisors for blood safety and medical injection safety programs, and a range of implementing

partners, including the Total Control of the Epidemic Program of Development Aid for People to People. This community-based effort educates hundreds of thousands of community members about HIV prevention and links them to appropriate prevention, care, and treatment services.

Namibia's internationally recognized success in rapidly expanding access to ARVs to more than 80 percent coverage plays a role in the nation's prevention efforts. Supported by the nationwide network of counseling, testing, and referral services, the government provides antiretroviral therapy (ART) at all hospitals and health centers and at some of the larger clinics (LeBeau and Yoder 2008). Based on the emerging recognition of the immunosuppressive effects of ART, there is growing recognition that "ARV treatment as prevention"

BUILDING CAPACITY FOR COMBINATION PREVENTION

Since 2008, the Communication for Change (C-Change) Program, which is funded by PEPFAR through USAID, has used a combination prevention approach to strengthen Namibian behavior change communications using a tailored program for building capacity for more than 20 local organizations.

Because levels of knowledge about HIV are generally quite high, organizations were encouraged to focus on addressing the main drivers of the epidemic (e.g., high rates of multiple and concurrent partnerships) while providing linkages to other biomedical and structural interventions.

Using a participatory process, C-Change assessed the behavior change communication efforts of all youth, workplace, and community prevention programs, focusing on organizations' core competencies in program design, implementation, and monitoring and evaluation. A program for building capacity was tailored to address the specific needs of each organization. This enables partners to "refocus their current HIV

prevention programs to include evidence-based programming, *combined prevention* including *combined behavior change* related to the drivers of the epidemic, and provision of or links to biomedical and structural interventions" (C-Change 2010, 1, emphasis added).

Source: C-Change 2008, 2010



The staff of a local community-based organization, Caprivi Hope for Life, received training in early 2010 in the use of C-Change's interpersonal communication materials on multiple and concurrent partnerships.

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can fit into a combination approach to prevention.² Namibia's presumed decline in HIV incidence may be associated with three main factors: 1) reduction in risk behaviors leading to fewer new infections; 2) pool saturation, where those most likely to be infected have already been infected; and 3) high ART coverage, which has reduced viral load and thus infectivity (MEASURE Evaluation and USAID/Namibia 2009).

Initiating the Prevention Planning Process

The concerted advocacy to scale-up prevention began in 2006 with an ad hoc Prevention Working Group made up of technical advisors working within the MOHSS/DSP and a range of development partner agencies, including UNICEF, UNAIDS, The Deutsche Gesellschaft für Internationale Zusammenarbeit, PEPFAR, CDC, and USAID. Members developed a close and collegial rapport. Through their participation in regular NAEC meetings, Prevention Working Group members held a forum to discuss emerging findings on the drivers of the HIV epidemic and build political will for a greater emphasis on prevention.

Strategic sequence of steps toward the National Prevention Strategy (NPS): In September 2007, the Prevention Working Group proposed a planning process for developing a national prevention strategy under the supervision of the MOHSS/DSP (MOHSS/DSP 2007). The process included five steps:

1. Situation assessments to identify the drivers of the epidemic and key contextual issues
2. A response analysis to understand Namibia's current investments in prevention programs

3. Identification of global best practices in prevention
4. A national consensus meeting to permit stakeholders to consider and discuss the findings of the earlier steps and to develop an appropriate prevention response
5. An NPS and budgeted action plan based on the outcomes of the prior four activities.

Ultimately, some of these five key steps were not implemented as planned, but for a first-time national prevention planning process, the initiative was a promising if imperfect effort. The proposal took regional participation seriously. The planned situation assessments included workshops with regional delegates to assess drivers of the epidemic at regional levels. The response analysis intended to map prevention activities at the regional level in collaboration with the Regional AIDS Coordinating Committees.

NAEC approved the proposal, and the U.S.\$450,000 cost was shared by UNAIDS, UNICEF, and USAID. PEPFAR supported the situation assessments and response analysis conducted by MEASURE Evaluation, as well as costs for drafting the NPS. Early in 2008, the MOHSS agreed to the development of a scope of work for a national prevention coordinator funded by PEPFAR to increase the capacity within the MOHSS/DSP to move this ambitious planning process forward.

Addressing major structural factors: As part of the prevention advocacy process, in 2008 PEPFAR/Namibia successfully competed for special USAID pilot initiative funding to address two major structural factors within Namibia's HIV epidemic: alcohol and gender. A full-time MOHSS staffer now leads an Alcohol Technical Working Group with PEPFAR-funded technical assistance and human resources support. Gender is a cross-cutting theme within Namibia's NSF for 2010 to 2014, and the 2010 National Testing Day theme was "Engage men for testing."

²Studies in diverse settings indicate that wider treatment is associated with fewer new HIV infections. See www.aidstar-one.com/focus_areas/prevention/pkb/biomedical_interventions/antiretroviral_therapy_hiv_prevention_strategy

The Five Steps of the Planning Process

Step 1—Conduct a situation analysis to identify and map the drivers of the epidemic: The situation analysis resulted from close collaboration between monitoring and evaluation (M&E) technical advisors within the MOHSS, DSP, UNAIDS, PEPFAR, and analysts at MEASURE Evaluation. This collaboration paid off by ensuring that the data, despite limitations, were used effectively and to the fullest extent feasible. Data from multiple sources were triangulated to identify the drivers most likely to contribute to the spread of HIV at the national and regional levels (de la Torre et al. 2008). The analysis identified the most common risk behaviors, characteristics associated with higher risk behavior and testing positive for HIV, and key regional differences in biomedical, social, and sexual drivers. A major constraint was the absence of biomarker data in the 2006 to 2007 Namibia National Demographic and Health Survey, which precluded establishing correlations between HIV and behavioral data (MOHSS and Macro International 2008). A parallel qualitative situation analysis was conducted, focusing on two likely drivers of the HIV pandemic: alcohol and concurrent partnerships (LeBeau and Yoder 2008).

The “drivers document,” drafted by MEASURE Evaluation (de la Torre et al. 2008), was transformative. It summarized the quantitative analysis and created regional profiles of key factors associated with the epidemic. The analysis literally put the drivers on the map, plotting key indicators for various drivers in all 13 regions by gender and succinctly summarizing the findings at the national and regional level. The document generated a commitment to evidence-based prevention strategies and underscored the need for regionally tailored programs instead of one uniform national approach. This tailoring is fundamental to combination prevention.

The key drivers to emerge from the analysis covered the full range implicit in a combination prevention approach:

- Biological: Lack of male circumcision
- Behavioral: Multiple and concurrent partnerships (MCP), inconsistent condom use, and excessive alcohol use
- Social: Norms governing the expected roles of men and women, the formation of sexual partnerships, and marriage, which together create an environment for intergenerational and transactional sex
- Structural: Migration, changing marital patterns, and poverty.

Step 2—Mapping Namibia’s prevention efforts: The prevention planning process was supposed to map Namibia’s ongoing prevention programs to be published as a companion document with the drivers document. Due to contractual problems, this second step was not completed. This gap has yet to be filled and illustrates the limitations of the planning process.

Step 3—Identification of global best practices in prevention pertinent to Namibia: This step was implemented, with support from UNAIDS, by having a global expert on HIV prevention, Professor Marie Laga, develop a survey of the evidence for different prevention priorities and what has worked in other regions (Laga 2008). A UNAIDS prevention taxonomy document, which summarized global priorities, was developed and used as a guide to help the development of prevention strategies, but was not published.

Step 4—Build a broad national consensus on prevention: Namibia’s First National Prevention Consultation was convened in November 2008 by the MOHSS (MOHSS and UNAIDS 2008). Thanks

to careful preparation by Prevention Working Group members, there were over 130 participants, ranging from the most senior ministry officials from MOHSS and the Ministry of Information and Communication Technology and several other ministries, as well as participants from the regional level including several regional governors and a majority of the 13 Regional AIDS Coordinators. Representatives of all of the major development partners and implementing nongovernmental organizations (NGOs) attended. The two-day consultation had three main objectives: to identify likely drivers of the epidemic, to reach consensus on HIV prevention priorities, and to identify HIV prevention strategies to be included in the next NSF. An additional goal was to strengthen inter-ministerial and multi-sectoral coordination. Using participatory approaches (see section on “How the National Consultation Prioritized the Key Drivers of the Epidemic”), the consultation meeting succeeded in both meeting these immediate objectives and providing the impetus for important institutional change.

Step 5—Complete the strategy document:

The first draft of this important document was completed in November 2009, but the final completion of the NPS was on hold until the NSF was approved (MOHSS/DSP and TAC/P 2009). The TAC/P plans to use the draft NPS as a basis to operationalize the final NSF with detailed core strategic matrices, budgeted workplans, and M&E plans corresponding to each of the drivers that the NSF has selected as a priority.

Roles and Responsibilities

From ad hoc Prevention Working Group to TAC/P, a milestone for national prevention:

Shortly after the national consultation, a national prevention coordinator began work. Over a period of months, the NAEC approved a formal Terms of Reference to officially establish the TAC/P, with the goal of providing “guidance and coordination on

HOW THE NATIONAL CONSULTATION PRIORITIZED THE KEY DRIVERS OF THE EPIDEMIC

Day One (November 5, 2008): The situation analysis results were presented with regional maps for each driver. Presentations were made on some of the major drivers: alcohol, MCP, most-at-risk populations, and male circumcision. From a list of 17 drivers, participants selected five: alcohol use, MCP, inconsistent condom use/unprotected sex, transactional sex, and lack of HIV testing and knowledge of status.

Participants also identified five cross-cutting issues as important considerations for each priority driver: cultural and social norms, gender roles, mobility patterns, specific target groups (e.g., prisoners and men who have sex with men), and stigma and discrimination.

Day Two (November 6, 2008): The following day included small group breakout sessions on each of the five drivers. Each group suggested intervention ideas using a three-step approach: identify target populations for their driver, determine suitable outcomes for the population, and recommend interventions for each of these outcomes at the environmental, community, and individual levels. Participants generated new intervention ideas for the five drivers, discussed and prioritized prevention strategies, and made recommendations for the new national prevention strategy. Overall recommendations included improving collaboration across government and civil sectors, and between national and regional levels; increasing access to services through outreach and mobile activities; and conducting additional research, especially among most-at-risk populations.

Source: MOHSS and UNAIDS 2008

Namibia's HIV prevention strategy development and implementation, ensuring an integrated, harmonized, and comprehensive approach" (MOHSS/DSP 2008, 1). A major milestone in national prevention promotion, the Terms of Reference explicitly authorizes the TAC/P to work on seven areas: sexual transmission (sexually transmitted infections, risk behaviors); medical transmission (injection and blood safety, biosafety); facility-based strategies; community- and workplace-based strategies; mass media strategies to change social norms; initiatives targeting most-at-risk populations, including prevention for PLHIV; and factors that exacerbate the epidemic (gender norms and alcohol).

The TAC/P's overall responsibilities cover the full range of activities required for a combination prevention program: giving technical guidance during the development of an NPS, as well as technical oversight during implementation; guiding the process for establishing the local evidence base for HIV prevention; developing prevention goals, strategies, and targets to be integrated within the NSF for 2010 to 2014; and establishing working groups on specific prevention topics.

The TAC/P facilitates an integrated approach:

A wide range of prevention stakeholders participate in the monthly TAC/P meetings and the TAC/P attendance list for 2010 included more than 70 representatives from 35 agencies. Agencies included key Namibian ministries, major national NGOs representing PLHIV and HIV service agencies, major multilateral agencies, key local prevention implementing agencies, bilateral international agencies, and international HIV agencies.

Prevention technical working groups:

The TAC/P provides a supportive environment that advises and facilitates the work of technical working groups. While some of these groups actually preceded the formal establishment of the TAC/P, most now work collaboratively under the aegis of the TAC/P. Group members attend the meetings of other groups, and groups submit documents to each other for comments. Coordination is achieved by cross-attendance and by circulating documents for comments.

The TAC/P's active role in the completion of the NSF:

The TAC/P plays a central role in national planning decisions for prevention and provides essential guidance for the NSF. The prevention section of the NSF incorporates all key aspects of the TAC/P's draft NPS and includes the TAC/P Terms of Reference mandates for prevention activities. The NSF is guided by the draft NPS' combination prevention conceptual framework (see Figure 1). While this figure is somewhat inexact in the use of terms, it provides a practical visual outline for the combination prevention approach, showing the simultaneous roles of behavioral, structural, and biological interventions.



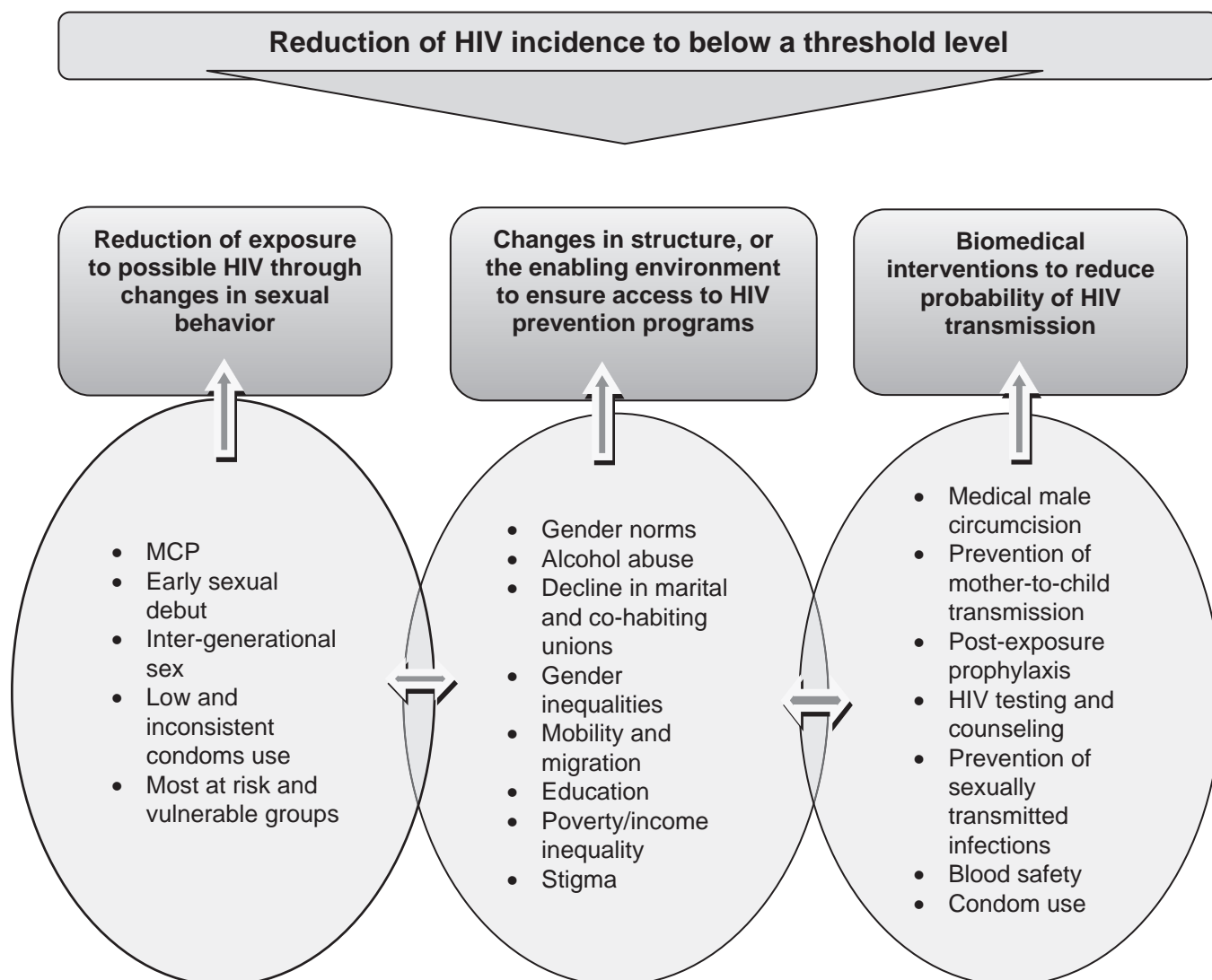
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Two members of a community-based support organization who implement HIV behavior change programs for remote rural residents of nature conservancies in northern Namibia.

Program Results

Program objectives achieved: The planning process has met most of the goals outlined in the

FIGURE 1. NAMIBIA'S COMBINATION PREVENTION STRATEGY FRAMEWORK



Source: MOHSS/DSP 2010

September 2007 proposal, including the overall objective of increasing national commitment to a refocused prevention strategy. The situation analysis provided useful findings on the important drivers of the epidemic and contextual factors. The participatory process of the national planning consultation was highly inclusive. While still a draft, the NPS was instrumental in guiding the development of the NSF and many of its ideas were ultimately incorporated into the framework.

The prevention planning process led to an MOHSS agreement to hire a national prevention coordinator for a formally recognized TAC/P with a comprehensive prevention mandate. The TAC/P serves a constructive role guiding the development of the NSF and provides a forum to share and coordinate prevention strategies at the national level.

Program objectives not yet achieved:

Because of contractual problems, the mapping of

ongoing prevention programs was not completed. This has impeded the proposed involvement of regions in mapping the response and developing regional prevention strategies. The final objectives and a budgeted national prevention action plan are still pending, but substantial progress is being made in this direction as Namibia undertakes the development of a Roadmap for the Implementation of HIV Prevention in spring and summer of 2011.

Getting traction—the following are examples of how national prevention planning translates into program practice:

- **The drivers document:** Although not universal, there appears to be widespread approval of the drivers document among Namibia's prevention stakeholders, most of whom are familiar with at least two or three drivers at both the national and regional levels. Some stakeholders feel more emphasis should be given to gender, gender norms, and stigma, while others, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, feel it should be structured around risk groups rather than drivers.
- **The National Prevention Consultation:** Stakeholders who participated in the event felt it was a major step toward consensus on the drivers and prevention strategies, as well as an opportunity to share ideas, get input from regional representatives, and build impetus for prevention programs. They felt it was an important transition, and was the first time that prevention strategies had been shared.
- **The TAC/P:** Virtually all prevention stakeholders are aware of and actively participate in the TAC/P, including representatives of organizations and agencies for PLHIV and the private sector. The few agency representatives who were not aware of the TAC/P expressed interest in participating. Many express an extremely positive view of the TAC/P as a mechanism for sharing ideas,

coordinating activities for more coherent strategic interventions, and avoiding duplication of effort. An active TAC/P member working within the MOHSS pointed out, "We learn more about the civil society outside of the [Ministry of Health]." A senior prevention expert remarked, "I used to think I knew what others are doing. Now I know more. Every month we get new ideas." Some stakeholders have concerns about how to move from sharing to implementation and how to coordinate and plan parallel efforts to address multiple drivers. Others recommend that the TAC/P should have a budget and that the coordinator position be on a higher administrative level so as to have more influence within the MOHSS.

- **The NPS:** There is near universal support among prevention stakeholders for the draft National Planning Strategy. Some are disappointed about how long it has taken to draft the NPS and expressed concern about the possible redundancy in having two national-level strategic documents, the NSF and the NPS.

What Worked Well

Collegiality: While it may appear self-evident, subjective, and too elusive to be replicable, it is nonetheless noteworthy that, due in part to strong rapport, senior prevention and M&E staff at the CDC, MOHSS, UNICEF, UNAIDS, and USAID developed close working relationships. Many coordinating bodies in countries throughout the world struggle to achieve a similar level of collegiality and cooperation.

An exceptional situation analysis: The situation analysis was a success due to the concerted effort by M&E technical advisors to ensure a thorough analysis of limited data. By insisting on mapping the drivers of the epidemic at the regional level, these advisors developed a document that captured the attention of the national HIV prevention community. It was also exceptional because of the

active role of country-level HIV program staff; it was not, as usually happens, dominated by staff outside of the country.

An effective national prevention consultation: The two-day meeting generated the impetus to implement the next steps. Without it, stakeholders might still be discussing what needs to be done in Namibia. It ensured that the results of the studies and the importance of prevention were on the agenda of senior MOHSS staff. Finally, it provided a consensus that encouraged prevention stakeholders to work together.

Providing guidance to the NSF through 2016: The TAC/P is an important national prevention resource and plays a central role in developing the prevention components for the NSF. By virtue of its diverse membership of HIV prevention agencies, it can provide coordinated technical leadership for all components of the NSF, including blood safety, prevention for PLHIV, male circumcision, and alcohol abuse.

Coordination of national social and behavioral change strategies for key epidemic drivers: The TAC/P and the MCP Technical Working Group have been instrumental in the development of national behavior change campaigns implemented by experienced lead agencies with coordinated, evidence-based approaches. The “Break the Chain” Campaign to address MCP has broken new ground by using standardized, multilevel, multichannel approaches with mass media and interpersonal communication materials. The TAC/P’s Alcohol Technical Working Group recently replicated this approach for alcohol and HIV.

Challenges

Coordinating a combination prevention portfolio: The process of simultaneously developing responses for multiple drivers, such as MCP, alcohol, and male circumcision, is a major challenge. A work planning process to phase in and set priorities for activities can help achieve a locally tailored balance.

Avoiding a donor-driven process: Initially, there was concern that the planning process would end up being donor-driven without being endorsed by key national stakeholders, especially the MOHSS. Gradual evidence-based advocacy achieved ownership among all stakeholders.

HOW DOES NAMIBIA’S PREVENTION PLANNING PROCESS DEMONSTRATE A COMBINATION PREVENTION APPROACH?

- By using evidence to target prevention activities addressing social, economic, and cultural drivers of transmission
- By including a combination of risk reduction approaches (biomedical, behavioral, and structural)
- By linking program participants to diagnostic and treatment services
- By engaging appropriate leaders and decision makers
- By strengthening capacity to manage prevention programs.

Building capacity and participation in prevention at the regional and local level:

The prevention planning process sought genuine regional participation, but the expected regional follow-up to map prevention programs for local commitment did not take place.

Getting prevention players coordinated and aligned:

Namibia has traditionally relied on the Ministry of Information and Communication Technology to roll-out national communication campaigns, yet the TAC/P is housed within the MOHSS. Bridging traditional boundaries between line ministries is a long-term challenge.

TAC/P gaps in membership: There are still some important gaps in the membership of the TAC/P, such as the Voluntary Counseling and Testing Technical Working Group and the PEPFAR-funded through USAID Safe Injection Program.

Future Programming

National prevention roadmap: In spring, 2011, through the involvement of the MOHSS, the TAC/P is spearheading the development of a Roadmap for the Implementation of HIV Prevention. This comprehensive implementation strategy will focus on the “who, how, where, and when” of achieving a balanced combination prevention approach. The Roadmap aims to provide the necessary foundation for systematic scale-up of services.

Future management challenges: The TAC/P must devise a coordination process that works for a large number of driver-specific prevention activities. The competing demands of scaling up multiple prevention initiatives to address such diverse drivers as stigma, MCP, alcohol abuse, and male circumcision will require concerted planning and

coordination to ensure the best sequence of activities for maximum synergy.

Mapping the response: There may still be a need to inventory and map existing prevention programs and services to identify gaps and opportunities at both the national and regional levels. It is clearly important to map the prevention programs that have been developed, especially for a combination prevention approach, where messages and partners need to be coordinated and targeted appropriately.

Follow-up at the regional level: The original plan was for the regions to somehow develop their own assessment of local drivers and develop their own tailored responses. Especially in high-prevalence regions, a prevention coordination structure at the regional level, with regional quarterly meetings, may help build local ownership and encourage “home-grown” strategies.

Prevention programs with PLHIV:

Representatives from several agencies advocated for more work to expand and enhance programs by and for PLHIV, including treatment literacy and development of personal prevention plans.

The value of a truly multi-sectoral approach:

Despite excellent progress, prevention programming remains closely allied with just the MOHSS and the Ministry of Information and Communication Technology. HIV prevention programs need a greater mandate within other line ministries, which are often not as responsive.

Recommendations

Collaborate across multilateral and bilateral boundaries:

The Namibian experience demonstrates how diverse agencies,

multiple government ministries, UNAIDS, UNICEF, USAID, and PEPFAR can share ideas and resources to develop a common agenda for prevention.

Build good working relationships: The extraordinary rapport that helped launch Namibia's prevention planning process is highly subjective and not easily replicated. Organizational development efforts to establish interagency collegiality may be necessary.

Engage appropriate leaders and decision makers at all levels: The prevention consultation made an unprecedented effort to include the full range of national and regional leadership. The ongoing TAC/P membership is extremely inclusive.

Strengthen management capacity for prevention programs: The roll-out of the C-Change prevention capacity assessment process, followed by training for building capacity and support for combination prevention project strategies, has reached a wide range of agencies working in prevention.

Invest in highly qualified senior leadership with high motivation and experience: The Namibia planning process was long-term, with a phased sequence of activities that required constant oversight and commitment. It had the benefit of a highly qualified, experienced, and committed cadre of M&E and prevention staff as well as local implementing partners. Duplicating Namibia's successful planning process will require comparable experience and commitment.

Replicate the Namibian planning process: Namibia's experience shows that basic strategic planning can make a difference

in building a combination prevention approach. A well-designed prevention plan can be rolled out to strengthen the national prevention infrastructure. To do this, the planning process takes a step back from what is usually done (developing plans for specific risk groups) and instead addresses social and economic drivers, using an evidence-based approach. The process should take place in a consultative, participatory environment to achieve group commitment among stakeholders for a combination prevention policy. Since the time Namibian prevention planning process was initiated, appreciation of and experience with the combination prevention approach have grown worldwide. As a result, it may be easier to make the case for replicating Namibia's planning approach in countries that lack an adequate national prevention infrastructure. ■

RESOURCES

Alcohol Consumption, Sexual Partners, and HIV Transmission in Namibia

www.measuredhs.com/pubs/pub_details.cfm?id=950&srchTp=home

C-Change Strengthening Capacity in SBCC Programming

<http://c-changeprogram.org/where-we-work/namibia>

HIV/AIDS in Namibia – Behavioural and Contextual Factors Driving the Epidemic

www.cpc.unc.edu/measure/publications/sr-09-53

National Strategic Framework for 2010/11-2015/16

www.aidstar-one.com/combination_prevention_namibia

Report of the First National Consultation on HIV Prevention in Namibia

www.hivresponse.gov.na/downloads/PreventionReport_v4%20FINAL.pdf

TAC/P Terms of Reference
www.aidstar-one.com/combination_prevention_namibia

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