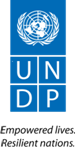
**UNDP HIV and AIDS Programme**

****

**Report on the Final Evaluation of the HIV Programme in UNDP**

**June 2013**





**TABLE OF CONTENTS 2**

List of Appendices 3

List of Tables 4

Acronyms and Abbreviations 5

**EXECUTIVE SUMMARY 7**

**Chapter 1: Background 12**

* 1. Introduction 12
  2. Project Description 13
  3. Purpose and Objectives of the Evaluation 16

**Chapter 2: Evaluation Methodology 17**

2.1 Introduction 17

2.2 Data Collection Methodologies 17

2.3 Data Management and Analysis 18

2.4 Limitations of the Evaluation 18

**Chapter 3: Evaluation Findings 19**

3.1 Developing Capacities for the Mainstreaming of 19

HIV and AIDS in the Public Sector

3. 2 Enhancing Capacities for Local Responses 21

* 1. Sustaining Leadership for an Expanded Response 25
  2. Addressing the Gender Dimensions of the Epidemic 31
  3. Achievement of Project Objectives 32
  4. National Ownership 33
  5. National HIV and AIDS Response 34
  6. Impact 36
  7. Level of Participation 37
  8. Sustainability 37
  9. Achievement of MDG 6 39
  10. Paris Declaration 40
  11. Lessons Learned 40

**4.0 Conclusion 41**

**5.0 Recommendations 43**

**REFERENCES 43**

**APPENDICES 44**

Appendix A: Terms of Reference 44

Appendix B: List of Participants 50

**LIST OF TABLES**

TABLE 1: List of Implementing Agencies and Collaborating Partners 18

TABLE 2: Income Generating Projects 29

**ACRONYMS AND ABBREVIATIONS**

|  |
| --- |
| **AIDS Acquired Immune Deficiency Syndrome** |
| **AMICAALL Alliance of Mayors and Municipal Leaders on HIV and AIDS in Africa** |
| **ART Antiretroviral Therapy** |
| **ARV Antiretroviral** |
| **BCC Behaviour Change Communication** |
| **BCI Behaviour Change Interventions** |
| **CACOC Constituency AIDS Coordinating Committee** |
| **CBOs Community-Based Organisations** |
| **CC Community Conversations** |
| **CCE-CC Community Capacity Enhancement-Community Conversations** |
| **CEO Chief Executive Officer** |
| **CF Community Facilitator** |
| **DRFN Desert Research Foundation of Namibia** |
| **FBOs Faith-Based Organisations** |
| **GBV Gender Based Violence** |
| **GRN Government of the Republic of Namibia** |
| **GTZ Deutsche Gesellschaft für Technische Zusammenarbeit** |
| **HIV Human Immunodeficiency Virus** |
| **HRO Human Resources Officer** |
| **LA Local Authority** |
| **LAC Legal Assistance Centre** |
| **LDP Leadership Development Programme** |
| **MAWF Ministry of Agriculture, Water, and Forestry** |
| **MC Male Circumcision** |
| **MCP Multiple and Concurrent Partnerships** |
| **MDGs Millennium Development Goals** |
| **MGECW Ministry of Gender Equality and Child Welfare** |
| **MOHSS Ministry of Health and Social Services** |
| **MoHSS Ministry of Health and Social Services** |
| **MRLGHRD Ministry of Regional and Local Government, Housing and Rural Development** |
| **MTP Medium Term Plan** |
| **NAC National AIDS Council** |
| **NANASO Namibia Network of AIDS Service Organisations** |
| **NDHS Namibia Demographic and Health Survey** |
| **NDP National Development Plan** |
| **NIPAM Namibia Institute of Public Administration and Management** |
| **NGO Non Governmental Organisation** |
| **NPC National Planning Commission** |
| **NSF National Strategic Framework** |
| **M & E Monitoring and Evaluation** |
| **OI Opportunistic Infection** |
| **OMA Offices, Ministries, Agencies (of Government)** |
| **OPM Office of the Prime Minister** |
| **OVC Orphans and Vulnerable Children** |
| **PD Paris Declaration** |
| **PLHWHA People Living with HIV and AIDS** |
| **PMTCT Prevention of Mother to Child Transmission** |
| **RACOC Regional AIDS Coordinating Committee** |
| **RC Regional Council** |
| **SADC Southern African Development Community** |
| **SME Small-to-Medium Enterprises** |
| **STI Sexual Transmitted Infection** |
| **TB Tuberculosis** |
| **ToR Terms of Reference** |
| **UNAIDS Joint United Nations Programme on HIV and AIDS** |
| **UNDAF UN Development Assistance Framework** |
| **UNDP United Nations Development Programme** |
| **UNFPA United Nations Population Fund** |
| **UNGASS United Nations General Assembly Special Session on HIV and AIDS** |
| **UNV United Nations Volunteer** |
| **VCT Voluntary Counselling and Testing** |
| **WPP Workplace Programme** |

**EXECUTIVE SUMMARY**

This report synthesises the results of the final evaluation of UNDP’s HIV AND AIDS Project from 2007-2013. The report does not aspire to have all the answers or to cover every intervention. However, it provides an opportunity to review essential elements of the project. It identifies important lessons learned during project implementation cycle in the hope of improved programming and replicating good practices.

**Project Description**

Given these outcomes, the objectives of the HIV and AIDS Project were therefore to:

1. Develop capacities for the mainstreaming of HIV and AIDS strategies in the Public Sector;
2. Enhance capacities for HIV and AIDS local responses;
3. Address the gender dimensions of the epidemic and;
4. Sustain leadership commitment for an expanded response

***HIV and AIDS Mainstreaming in the Public Sector****:*

This project supported the goals and strategic plans of the national development plans which called for mainstreaming of HIV and AIDS in policies, plans and budgets. UNDP therefore supported the OPM to lead, oversee and coordinate mainstreaming of HIV and AIDS in OMAs. Through technical support from UNDP local and regional offices, the OPM conducted an assessment study in 2008 on the impact of HIV and AIDS in the public sector. The study provided the data to visualise the problem, understand its characteristics, extend and magnitude, which enhanced evidence based planning in the public sector. Furthermore, through UNDP local and regional offices, the OPM benefited from various capacity-building, activities, including training on communication and training tools in mainstreaming of HIV and AIDS, transformation leadership and workplace conversations.

***Enhance capacities for local responses:***

To enhance capacities for local responses, UNDP had an agreement with MRLGHRD which is mandated in MTP III and NSF to coordinate local responses at regional and sub-regional levels. This level of the project aimed to develop human and institutional leadership capacities for enhanced local responses. The major activities under this objective included:

*Mainstreaming of HIV and AIDS in Local Authorities:* AMICAALL in conjunction with SIAPAC rolled out the HIV and AIDS Impact Assessment and Strategic Planning a toolkit specifically developed for local authorities. The toolkit helped local authorities to assess the impact of HIV and AIDS pandemic on regional and local government. The toolkit was rolled out in 10 local authorities with support from SIAPAC. This exercise provided AMICAALL with the needed capacity to better support local authority HIV and AIDS responses. AMICAALL conducted training for LAs on policy development. Additionally, LAs were assisted to appoint HIV and AIDS focal point persons and peer educators were trained. A HIV and AIDS Workplace Community Conversations Training Guide was developed which used the same methodological approach as CCE-CC in the wellness programmes.

*Community Capacity Enhancement- Community Conversations (CCE-CC):* To enhance capacities for local responses, UNDP provided technical support in the area of mobilizing communities for action around HIV and AIDS using the CCE- CC methodology. The methodology was launched in 2007 in the four piloted regions, namely Caprivi, Oshana, Kavango and Erongo. The approach was later extended to another five regions: Kavango, Omusati, Ohangwena, Karas and Omaheke (KOOKO) in 2009. By the end of 2009, 25 communities in 25 LAs were involved in community conversations. In partnership with UNV, the project integrated volunteerism into its programming and mobilized a diversity of volunteers. The United Nations Volunteers (UNV) programme provided both national and international volunteers to build capacities. The Community Facilitators (CFs) were volunteers from the communities where community conversations were taking place. The CCE-CC methodological approach stimulated community participation and action on HIV and AIDS.

*Gender Mainstreaming:*As stated in the NSF, gender inequality is a structural driver of the epidemic in the country. The project mainstreamed gender into CCE-CC, where communities analyzed gender inequalities in their contexts and tailor made solutions to address these inequalities. Through community conversations, communities challenged and openly discussed gender issues related to HIV and AIDS such as condom use, gender based violence (GBV), multiple concurrent partnerships (MCP), transactional sex, polygamy, wife inheritance, teenage pregnancies and poverty.

*Sustaining leadership for an expanded response:* Effective AIDS responses require strong leadership from inside and outside government, at national and local levels. Although strong leadership has been shown, it has not been adequately translated into practical terms. As such, the Project sought to promote sustained leadership capacities and commitment so as to activate urgent responses to the National Strategic Framework for HIV and AIDS (NSF), 2010-2015. This was achieved through the LDP which was driven by the UNDP in partnership with MRLGHRD and OPM. Capacities for local leaders were enhanced through the leadership development programme (LDP) which involved training of leaders in leadership transformation so that they can take a leading in addressing HIV and AIDS in their constituencies.

**Evaluation Objectives**

The purpose of the evaluation was to assess the contributions of the project to national HIV and AIDS responses and attainment of MDG6. The terms of reference called upon the evaluation to assess whether the project was aligned to national development priorities, the level of participation of beneficiaries, sustainability of project activities and its contribution to the achievement of the Paris Declaration.

**Evaluation Methodology**

Although the evaluation combined both qualitative and quantitative methodologies, it was predominantly qualitative. The rationale was to provide participants with the opportunity to articulate their insights via focused group discussions and get in-depth appreciation of their experiences. Desk review involved reviewing national documents such as the development plans, HIV and AIDS Strategic Plans, relevant policies, project documents, training manuals and tools, implementing agencies’ monthly reports and M&E reports among others. Quantitative data was gathered from reviewed documents. Interviews were held with representatives of key partners, collaborating partners, community beneficiaries and representatives of selected regional councils (RC) and local authorities (LA). A total of five regions (Caprivi, Ohangwena, Omaheke, Karas and Kunene) were sampled for the evaluation.

**Evaluation Findings**

Overall, the evaluation found that UNDP supported activities both upstream and downstream. These activities included mainstreaming HIV and AIDS into the public sector planning and budgeting processes, leadership development programmes for HIV and AIDS; Community Conversations to engage local communities in the response and stimulate HIV and AIDS-related initiatives at the community level while enhancing capacity development at both national and local levels.

*Mainstreaming of HIV and AIDS*

The Project contributed significantly to acceptance of the multi-sectoral approach required to mitigate the impacts of the epidemic and the need for mainstreaming HIV and AIDS in the public sector. To achieve this, the Project enhanced the capacity of OPM in facilitating mainstreaming of HIV and AIDS in the OMAs. The project was widely considered to have been instrumental in successfully helping to mainstream HIV and AIDS in the public sector. The success of the project was in its ability to transform leadership which consequently resulted in mainstreaming HIV and AIDS in their action and strategic plans. In addition, the impact assessment study provided evidence to convince leadership to take action to curtail further impact of HIV and AIDS. Through the project, OMAs established workplace programmes and are slowly integrating HIV and AIDS in their plans, programmes and budgets. It is imperative to note that although mainstreaming in OMAs is gaining momentum, levels of maturity vary across OMAs.

*Strengthening Leadership*

The Project helped strengthen HIV and AIDS-related leadership through the LDP which used transformational leadership approaches to develop leadership constructs among politicians, government officials and community leaders. The LDP triggered some important changes as it generated influential responses and results. The results included allocation of resources to HIV and AIDS activities. In addition, the Project managed to institutionalize the LDP in NIPAM, which can sustain the efforts in the long-term. The evaluation found inspiring examples of leadership “breakthroughs,” particularly in the Community Conversations and leadership development programmes. Substantial numbers of people who participated in leadership training attested to its value in invigorating their commitment to mainstreaming HIV and AIDS responses in their programmes and budgets. However, it is difficult to assess whether leadership “breakthrough initiatives developed” will have a broad impact given the high staff turnover in government, particularly local government. The concern is the loss of LDP “graduates” from ongoing involvement in HIV and AIDS activities and the need to reinforce gains through follow-up mechanisms and have the training continuously.

*Enhancing Local Capacities*

*CCE-CC Methodology*

The participatory process of CCE-CC enhanced knowledge on AIDS and helped to break the silence, reduced stigma and led to increased uptake of HIV and AIDS Services. Community capacities were enhanced in nine (9)regions where the methodology was rolled out, enabling communities to question century-old cultural practices, critically analyze their own vulnerabilities, craft their own solutions and demand better service delivery from their local authorities. Volunteerism strengthened trust from communities as the volunteers were members of their community. In addition, it created opportunities for participation. The integration of the volunteerism into the project empowered the volunteers as they develop communication and facilitation skills.

*Gender mainstreaming*

Through community mobilisation, the Project positively and markedly influenced gender dynamics. As aforementioned, through community conversations, communities questioned cultural practices which made both men and women vulnerable to HIV infection. It was reported by beneficiaries that practices such as wife inheritance and polygamy were debated, enabling communities to acknowledge how the practices fuel HIV and AIDS. In addition, communities discussed the skewed power relations which hindered condom use and facilitated transactional sex, particularly among women. However, it was difficult to establish whether the Project had changed gender-related issues concerning HIV and AIDS on a significant scale.

**Recommendations**

On the basis of the evidence gathered in the evaluation, the evaluation recommends the following:

1. The Project should not simply end; the planned exit strategy must be well communicated to the recipients and transfer of responsibility should be fully ensured.
2. In future processes, it is advisable to actively involve the mother ministry and transfer responsibility so that ownership and sustainability can be achieved.
3. Given the severe challenges in government, particularly local levels, UNDP should consider to continue providing technical assistance in some areas.
4. In the future, projects should piggy-back on government existing structures, which in turn leverage resources, ensure ownership and sustainability.

**CHAPTER ONE**

**-BACKGROUND-**

**1. Introduction**

Namibia has one of the highest prevalence of HIV and AIDS in the world. The country has a generalized HIV epidemic, with HIV prevalence rate among pregnant women of 18.2% for those aged 15 to 49 (MoHSS, 2012). With a population of approximately 2 million, 240 000 people are living with HIV with a large number of unrecorded cases (WHO, 2006). According to MoHSS (2010), twenty-three percent (23%) of the deaths in the country are AIDS- related. Due to the epidemic, life expectancy has reduced from 62 years in 1991 to 49 years in 2001 (NDP3, cited in MoHSS, 2010).

An AIDS epidemic of such magnitude affects not only individuals but also threatens all sectors in the country. The epidemic has negatively impacted on development indicators and remain a major development challenge to the country. Factors contributing to the spread of HIV are numerous and complex and relate to economic and social issues. Several behavioural and contextual factors have been noted as driving the epidemic in Namibia.

BEHAVIOURAL AND CONTEXTUAL DRIVERS OF THE EPIDEMIC IN NAMIBIA

* Poverty associated with significant income inequalities and widespread unemployment;
* Multiple sexual relationships;
* Inconsistent and incorrect condom use;
* Alcohol abuse;
* Intergenerational and transactional sex;
* Cultural practices, such as subordination of women, early sexual debuts; and
* High mobility and population dislocation. **MoHSS, 2008**

The epidemic is a major concern to the Republic of Namibia, as it is to many other Sub-Saharan countries. The pandemic has affected both the public and private sector in the country. Namibia has ratified several international conventions and protocols that are relevant to addressing HIV and AIDS. The country has ratified the Millennium Declaration and Millennium Development Goals (2000), Abuja Declaration and Framework Plan of Action of HIV/AIDS, TB, and ORD (2001), The UNGASS Declaration of Commitment on HIV/AIDS (2001), The Maseru Declaration on the fight against HIV/AIDS in Southern African Development Community (SADC) region, WHO Regional Committee for Africa, 53rd Session, Brazzaville.

By ratifying these international instruments, the Government of Namibia committed itself to take all necessary measures to address HIV and AIDS at the country level, including legislative reforms and allocation of resources.

The UN Development Assistance Framework (UNDAF) 2006-2010 is the strategic response by the UN to the development challenge of the Triple Threat. The UNDAF 2006-2010, aims to guide integrated programming among the UN Agencies working in Namibia to support government and civil society to reach Namibia’s economic and social development goals, outlined in Vision 2030, the MDGs, NDPIII and other international commitments signed by the Government of Republic of Namibia (GRN). UNDAF outcome 1 states that *HIV and AIDS response is strengthened.*

Given this outcome, the objectives of the HIV and AIDS Project were therefore to:

1. Develop capacities for the mainstreaming of HIV and AIDS strategies in the Public Sector;
2. Enhance capacities for local responses;
3. Address the gender dimensions of the epidemic and;
4. Sustain leadership for an expanded response

**PROJECT DESCRIPTION**

1. **HIV and AIDS Mainstreaming in the Public Sector**

The project supported the goals of the then strategic plan (MTP III) and the current strategic plan, which provides for mainstreaming of HIV and AIDS. UNAIDS proposed the following working definition of mainstreaming AIDS:

*“Mainstreaming AIDS is a process that enables development actors to address the causes and effects of AIDS in an effective and sustained manner, both through their usual work and within their workplace”. (UNAIDS, World Bank and UNDP, 2005)* Mainstreaming of HIV and AIDS has two dimensions which are interlinked: internal and external mainstreaming. *Internal mainstreaming* implies identifying and responding to factors – individual and organiza­tional that are likely to increase vulnerability to HIV infection for sector staff and immediate family members. It also involves developing workplace HIV and AIDS policies and programmes for employees. On the other hand, e*xternal mainstreaming* means identifying and responding to factors that are likely to increase vulnerability to HIV infection for communities or those consid­ered clients of the sector. It means taking action to contain the threats posed by the epidemic to the achievement of the goals of the sector, as well as ensuring that the sector’s practices do not exacerbate the epidemic.

Mainstreaming is entrenched in national development plans and strategic plans which all call for multi-sectoral approaches and mainstreaming of HIV and AIDS in plans and development processes. UNDP supported the OPM to lead, oversee and coordinate mainstreaming of HIV and AIDS in OMAs. Through this support, a study on the impact of HIV and AIDS in the Public sector was conducted to assess the vulnerability factors of different OMAs and develop targeted interventions. The study provided an insight on the importance of developing and funding HIV and AIDS programmes with the aim to preserve the human resource required for increased productivity and delivery on ministerial mandates. This support accorded 22 Permanent Secretaries from different OMAs to understand the implications of weak HIV and AIDS programming and budgeting in relation to absenteeism and low productivity. The support also ensured development of a Coordination Strategy which guided the development and of HIV and AIDS activities in the public sector as well as the establishment of the HIV division within the Office of the Prime Minister. The support also resulted in the development of a national policy on HIV and AIDS for the public sector currently implemented in all OMAs.

1. **Enhance Capacities For Local Responses:**

To enhance capacities for local responses, UNDP signed an MOU with the MRLGHRD which was informed by the national documents such as the MTP III (former HIV and AIDS national plan) and NSF (the current HIV and AIDS plan) for local responses. At this level the programme aimed to develop human and institutional leadership capacities at local levels to generate breakthrough initiatives within local responses aimed at reversing the pandemic. This was achieved through using the structures of local government such as the LAs, RCs, the RACOC and CACOC. Strengthening capacities for local responses was achieved through mainstreaming HIV and AIDS into local government structures and contributed to improved leadership capacities while enhancing community capacity through the CCE-CC methodological approach.

This programme modelled a partnership between civil society, Government and the UN to enhance synergies required for easy acceleration of planned activities. AMICAALL was assigned the role of mainstreaming HIV and AIDS in local authorities in close collaboration with the MRLGHRD. This enhanced good working relations among between regional councils and local authorities in the 9 pilot regions. Through this initiative, AMICAALL in conjunction with SIAPAC rolled out the HIV and AIDS Impact Assessment and Strategic Planning a toolkit specifically developed for local authorities. The tool kit helped local authorities to assess the impact of HIV and AIDS pandemic on regional and local government. The toolkit was rolled out in 10 local authorities with support from SIAPAC. This exercise provided AMICAALL with the needed capacity to better support local authority HIV and AIDS responses.

The Community Capacity Enhancement-through community conversations (CCE-CC) methodology was launched in 2007 in the four piloted regions, namely Caprivi, Oshana, Kavango and Erongo. The approach was later extended to another five regions: Kavango, Omusati, Ohangwena, Karas and Omaheke (KOOKO) in 2009. The CCE-CC methodological approach focused on stimulating community participation and action on HIV and AIDS. The approach resulted in 23 participating communities integrating community responses and interventions into Local Government planning, budgeting and implementation processes, thereby bringing the government closer to the people.

1. **Address the Gender Dimensions of the Epidemic**

The gender dimensions of HIV and AIDS have since been recognized. As stated in various studies, women in Namibia have traditionally suffered discrimination and exclusion from full participation in the political, socio-economic and cultural life of the nation. The project mainstreamed gender through community conversations. Through community conversations, communities analyzed gender inequalities in their contexts and tailor made solutions to address these inequalities. Communities analyzed gender inequalities and how gender norms influence the impact of HIV and AIDS. Gender issues discussed included condom use, transactional sex, gender based violence (GBV), polygamy, wife inheritance and teenage pregnancy.

1. **Sustaining Leadership for an Expanded Response**

Effective HIV and AIDS responses require strong leadership from inside and outside government, at national and local levels. The UNGASS Declaration of Commitment calls for a new and innovative type of leadership at all levels of government and civil society.

“Strong leadership at all levels of society is essential for an effective response to the epidemic. Leadership by Governments in combating HIV/AIDS is essential and their efforts should be complemented by the full and active participation of civil society, the business community and the private sector. Leadership involves personal commitment and concrete actions.” **United Nations General Assembly Special Session on HIV/AIDS**, **UNGASS**

Vision 2030 and NDP3 calls for a sustained commitment from political leaders to the national response while the National Policy on HIV and AIDS focuses on the need for leadership commitment at all levels to ensure effective multi-sectoral response. Although strong leadership has been shown, it has not been adequately translated into practical action that yields tangible results. Thus there is still need to mobilize political and community leaders in the national response to the epidemic. As such, the LDP driven by the UNDP in partnership with MRLGHRD and OPM with the intention to promote sustained leadership capacities translated into a fully fledged curriculum currently integrated in NIPAM for sustainability. This tool supported MRLGHRD to adhere to the commitment for engagement of leaders so as to activate urgent responses and action to the National Strategic Framework for HIV and AIDS (NSF), 2010-2015.

**1.2. Purpose and objectives of the evaluation**

The Evaluation sought to measure programmatic results and to improve the implementation process of the Project, generate knowledge, identify good practices and lessons learned that can be replicated. Overall objective was to measure whether the Project achieved its intended results as stated in the project document. The focus of the evaluation was to make an assessment of project results with a forward looking focus. The specific objectives of the evaluation as stated in the ToR were to:

1. Measure the extent to which the HIV programme has contributed to addressing the objectives as outlined in the project document.
2. Measure the degree of implementation in terms of efficiency, participation of national ownership, quality delivered on outputs and outcomes, as well as overall implementation as outlined in the project document.
3. Measure the extent to which the HIV programme has contributed to the overall HIV response both nationally and regionally. Specifically look at the results at outcome level in relation the targeted population, beneficiaries, participants whether individuals, communities, institutions, as stipulated in the project document were supported as inscribed in the project document.
4. Measure the HIV programme’s contribution to the objectives set out in MTP III and the NSF.
5. Identify and document substantive lessons learned and good practices documented during the implementation process.

**CHAPTER TWO**

**-EVALUATION METHODOLOGY-**

**2.1 Introduction**

Data collection methods used were primarily qualitative in nature.Quantitative data was gathered from the documents which were reviewed.The approach used ensured that the views and opinions of a sample of beneficiaries, stakeholders and role players were taken into consideration in an environment where active participation was encouraged and promoted. The following methodologies were used for the evaluation:

**2.2 Data Collection Methodologies**

**Desk review**: Background documents on the HIV epidemic and response in Namibia, project and relevant international documents were reviewed. Desk review included the following documents:

1. Strategic documents; Vision 2030, NDPs, Medium Term Plan III 2004-2009 (MTPIII), National Strategic Framework 2010/11 – 2015/16, National HIV and AIDS Policy, Paris Declaration for Action, MDG reports,
2. Programmatic Reports: Sectoral reports, project annual reports, status and visit reports, progress reports, toolkits and training manuals, reports on the implementation of the, relevant documents or reports on One UN, Delivering as One.
3. Population based survey reports: Namibia Demographic and Health Survey,
4. Sub-populations survey reports; HIV Sentinel Surveillance Reports, Behaviour Surveillance Survey,
5. Programme Reviews: Namibia Country UNGASS Reports,
6. Epidemic and response synthesis, programme data and other relevant data sources.

The evaluation gathered evidence for the analysis of contributions and outcomes at three levels:

1. *Key institutions and individuals at the policy level.* This involved interviews with key partners’ (OPM, MRLGHRD, AMICAALL, and UNDP).

2. *Implementing institutions and individuals at the intermediate level*. This included collaborating partners; local authorities, regional councils and civil society organisations (CSOs).

3. *Community-level assessments.* These interviews and discussions explored the perspectives of community leadership and beneficiaries in communities. These included CCE Coordinators, CCE facilitators, traditional leaders, community members and officials from regional councils and local authorities.

**Key informant Interviews:** Key informant interviews were conducted with selected stakeholders from government, bilateral, multilateral and CSOs who participated and are still participating in the project to have in-depth understanding of progress, challenges and the future direction of the project. A semi-structured interview guide was administered to implementing agencies and collaborating partners. The field work for the evaluation was limited to five regions: Karas, Kunene, Ohangwena, Omaheke and Caprivi. Key Informant Interviews (KIIs) were conducted with representatives of local authorities and regional councils and with representatives of the agencies in the table below:

**TABLE 1: List of Implementing Agencies and Collaborating Partners**

|  |  |  |
| --- | --- | --- |
| **Government ministries** | **UN Agencies** | **CSOs/Development partners** |
| **Office of the Prime Minister**  **National Planning Commission Secretariat**  **Ministry of Gender Equality & Child Welfare**  **Ministry of Regional and Local Government, Housing and Rural Development**  **Ministry of Health and Social Services**  **Regional Councils, Local Authorities** | UNDP  UNAIDS | AMICAALL  GTZ  Nara Training Centre  NANASO  Namibia Association of Local Authority Officers  NIPAM  USAID |

**Focus group discussions:** discussions were held with community members who benefited from CCE-CC, committee members of income generating projects.

**2.3 Data Management and Analysis**

The data was assembled and typed into a word processing program. This was done manually and analyzed using content and thematic approaches and it involved classifying responses into meaningful categories so as to bring out their essential pattern. This will closely followed the main themes of the evaluation as stated in the ToR.

**2.4 Limitations of the Evaluation**

The site visits were not necessarily representative of the overall project. Due to time constraints, it was not feasible for the evaluation team to visit all the activity sites and organizations. Some local government representatives could not be interviewed during regional evaluation field visits due to involvement in other duties. In addition, some of the required documentation from different partners was not available for review.

**CHAPTER THREE**

**-EVALUATION FINDINGS-**

The findings of the evaluation are organized around the questions posed in terms of reference (Appendix A), taking the opportunity to not only respond to each question, but also to expand on the issues concerned, as appropriate. Conclusions and recommendations complete the relevant issues of the evaluation.

**3.1 DEVELOPING CAPACITIES FOR THE MAINSTREAMING OF HIV AND AIDS IN THE PUBLIC SECTOR**

Vision 2030 strategies highlight the need for leadership at all levels, a multi-sectoral approach, the inclusion of HIV and AIDS in all development plans and a greater understanding of the impact of HIV and AIDS on all of the sectors. In addition, the national development plans (NDP1, 2, 3 and the recently launched NDP 4) all echo the urgency to for multi-sectoral approaches if achievements are to be realized. A mid-term review of the MTP III among others, emphasized the critical need for a systematic approach to mainstreaming of HIV and AIDS among others in all sectors and all organizations, with dedicated staff, and budgeted plans for incorporation into core functions of sectors by 2010 in order to facilitate a rapid scaling up of the response.

By Constitution, the Office of the Prime Minister (OPM) is mandated to provide leadership in terms of government accountability, policy formulation, implementation and monitoring and evaluation (M &E) and advocacy. There are thirty four (34) OMAs. Evaluation findings indicate that following the *Mainstreaming of HIV and AIDS Guide*, the OPM engaged in several activities with the technical assistance of UNDP to ensure that HIV and AIDS was mainstreamed in all OMAs. The activities involved sensitizing senior managers on mainstreaming of HIV and AIDS in their respective constituencies. This was achieved through organizing breakfast meetings with Permanent Secretaries, Directors and Deputy Directors of OMAs to share on mainstreaming. In addition, sectoral focal points in ministries were established to develop workplace wellness programmes which would look at internal and external mainstreaming.

Through sensitisation of OMAs leadership, there was appreciation of mainstreaming of HIV and AIDS in OMAs as leadership realised the impact of the epidemic on their departments. Equipped with this sensitisation, the OPM with the technical assistance of UNDP commissioned an impact assessment study in 2008 on OMAs to assess the impact of HIV and AIDS on their functions. The study revealed partly that there was high mobility of staff in OMAs due to discharging their duties in regional offices as decentralisation has not effectively taken up. It was clear in the interviews that although the impact assessment study had several benefits including providing evidence for programming, the major drawback was it was lengthy, to a point that by completion of the study some of the issues had changed.

Through technical support from UNDP local and regional offices, the OPM benefited from capacity building. The staff received training on communication and training tools in mainstreaming of HIV and AIDS, transformation leadership and workplace conversations. Equipped with the knowledge, skills and competencies, the OPM capacitated Human Resources Offices (HROs) in OMAs by training them on the tools they could use to track the epidemic in their OMAs and for reporting purposes. To ensure sustainability of leadership commitment, the Leadership Development Programme (LDP) has since been institutionalised in NIPAM.

Currently, the OPM is in the process of developing a Public Sector Wellness Policy which is meant to be mainstreamed in the Public Service Medical Scheme and staff rules. In addition, the Office is working on mainstreaming HIV and AIDS in Environmental Impact Assessment under the Ministry of Environment. This seeks to assess the mainstreaming of HIV and AIDS in capital projects. There is also collaboration with NIPAM to develop a curriculum on gender mainstreaming and HIV and AIDS. To achieve this, the Office is making use of training manuals developed in the past. With this venture, it was reported that it would be possible to compel government cadres to enrol for the courses. The Office also aims to integrate gender and HIV into the job descriptions of Human Resources Officers (HRO).

Overall, mainstreaming HIV and AIDS in the public sector saw a transformation in leadership which consequently resulted in mainstreaming HIV and AIDS in their action and strategic plans OMAs and slowly allocating budgets for HIV and AIDS activities. Although momentum has been building up, challenges were also highlighted. The major challenge reported was the scarcity of financial resources to OPM to carry out its mandate. With the end of funding from UNDP, the Office was likely to be crippled as the budget allocation from government was reported to be extremely meagre. It was made clear that without the funding from UNDP, mainstreaming of HIV and AIDS in the public sector would have been impossible. The second challenge highlighted was in the area of capacity building. UNDP was commended for developing the capacity of the Office, however, after the stoppage of UNDP, funding, the Office was struggling to develop its capacity due to financial constraints.

It was also highlighted in the interviews that the focal persons’ positions in OMAs were voluntary and not permanent posts. Given this scenario, HIV and AIDS activities most of the time are neglected as the focal persons give priority to their core functions. It was reported that the delay in appointing permanent focal persons in OMAs lied in the bureaucratic nature of government as these posts had since been proposed to be permanent posts.

With regards to leadership support, it was alluded that there were mixed responses from leadership of OMAs. After sensitisation of leaders through breakfast meetings, some senior managers fully came on board and had become champions, however, other leaders have taken mainstreaming half heartedly and this can be evidenced by the slow pace of mainstreaming in their departments. It was felt that leadership commitment could have been maintained through breakfast meetings and sector persons meetings which were discontinued. Without leadership commitment and support, ownership was reported to be fragmented as currently mainstreaming is not mandatory due to non-existence of procedures to compel OMAs to mainstream HIV and AIDS. The end result of this has been a minimal number of strategic and annual plans which have mainstreamed HIV and AIDS and small amounts of funds being allocated for HIV and AIDS activities.

To sustain the programme, it was echoed that government must allocate sufficient resources to the division, both financial and human resources. Furthermore, capacity building of division staff needed to be continuous to ensure that they are equipped with up-to-date knowledge, skills and competencies which are needed to discharge their duties. Capacity building would also ensure staff are exposed to international standards. A scaled-up response would be possible if the Office had procedures to compel OMAs to mainstream HIV and AIDS, without these, efforts will be scattered, ad hoc and haphazard. The M&E system was reported to be in need of strengthening as currently one could not tell what OMAs were doing. Reporting was said to be weak, with some OMAs not reporting at all. Previously M & E was ensured through quarterly sector focal persons meetings where each focal person reported on progress in their respective OMA, this was then verified by visits to the OMAs by the division.

**3.2 ENHANCING CAPACITIES FOR LOCAL RESPONSES**

In the expanded response to HIV and AIDS, community based structures represent a critical operational strategy, because it prioritizes delivery of interventions by local-level stakeholders. The MTP III recognised local responses as critical to the national response. According to the NSF; its implementation “*depends on both existing capacities as well as capacity that need to be developed during the five years”* (NSF, 2010:98)

Even though international agreements indicate that governmental entities are responsible for protecting and solving needs of citizenry, such entities are institutionally weak and face financial constraints to meet their obligations. Public entities, especially the ones at local levels have a series of institutional weaknesses for dealing with a myriad of development issues including HIV and AIDS. In seeking to enhance capacities for local responses, UNDP provided technical support to MRLGHRD in mainstreaming HIV and AIDS in local authorities and regional councils.

**ROLE OF LOCAL GOVERNMENT IN THE NATIONAL HIV AND AIDS RESPONSE**

“Namibia’s Constitution provides for a unitary state with decentralised/devolved administration of services through Regional Councils and local authorities. In the expanded response to the HIV and AIDS epidemic the regional level plays an increasingly important role in terms of coordination, supervision, monitoring & evaluation, strengthening partnerships and networking and facilitating the overall multi-sectoral response”.

**ANNUAL MONITORING AND EVALUATION REPORT FOR MTP III (1 April 2004 – 31 March 2006)**

As stated in the NSF, *“Capacity building of local leadership and sub-national structures as well as strong mechanisms to ensure accountability to the NSF is vital for sustained interventions”.*

The Ministry of Regional & Local Government, Housing and Rural Development (MoRLGHRD) is responsible for coordination of and support to the regional response as implemented by the 13 Regional Councils. To enhance capacities for local responses, UNDP provided technical support in the area of mobilizing communities for action around HIV and AIDS using the CCE- CC methodology. In addition, capacities for local leaders was enhanced through the leadership development programme (LDP) which involved training of leaders in leadership transformation so that they can take a leading in addressing HIV and AIDS in their constituencies.

**3.2.1 Mainstreaming of HIV and AIDS in Local Government**

**3.2.1.1 Workplace Wellness Programmes**

The MTP III and NSF provide a very clear framework, which commits line ministries and sectors to the implementation of comprehensive workplace programmes. In addition, a Labour Code on HIV and AIDS is in place under the Labour Act.

In partnership and with the technical assistance from the AIDS Law unit of the legal Assistance Centre, AMICAALL conducted training for LAs on policy development. LAC also assisted in reviewing existing policies developed by LAs and aligned them to the national legal and policy frameworks. Additionally, LAs were assisted to appoint HIV and AIDS focal point persons and peer educators were trained. It was pointed out in the interviews with focal persons of piloted LAs that due to work overload, peer educators are left with no or little time to implement their activities. In addition, the peer educators do not receive the required support from management which consequently hampers effective implementation of activities, especially information sessions which should be compulsory and conducted during office hours. The other constraint commonly cited was lack of capacity building-it was highlighted that the peer educators were not receiving the so much needed refresher courses due to lack of funds.

AMICAALL in collaboration with SIAPAC developed an impact assessment toolkit to enhance the capacity of their LAs to better understand the impacts of HIV and AIDS and to develop Strategic Plans as an appropriate response to the epidemic. The toolkit was administered in selected LAs (10) in four regions of Namibia, namely Caprivi, Erongo Kunene and Oshana (COKE regions).The toolkit aimed to capacitate LAs to respond systematically and effectively to the epidemic, thus ensuring that they fulfill their responsibilities as stipulated in the MTPIII. The impact assessment project entailed the LAs collecting the necessary information to inform their Impact Assessment Reports and the Steering Committee and Technical Working Group would meet to discuss progress in relation to strengths, weaknesses and challenges. Some of the LAs did exceptionally well in collecting the data. Support visits to LAs were done by SIAPAC.

A HIV and AIDS Workplace Community Conversations Training Guide was developed which used the same methodological approach as CCE-CC in the wellness programmes. Similar to CCE-CC, the workplace conversations were meant to stimulate discussion on issues related to HIV and AIDS.

While some progress has been made in wellness programmes, much work remains to be done in order to fulfil the national targets. According to AMICAALL’s latest report, 30 LAs have functional HIV and AIDS workplace programmes. The evaluation revealed that regional councils and local authorities have started putting in a specific budget for their HIV workplace programmes. The amount varies across regional councils (RC) and local authorities (LA). Overall, budget allocation remain low and this was attributed to firstly, to the low local government revenue base and secondly to attitudes of leadership towards HIV and AIDS.

The Workplace Programmes in the LAs still lag behind in terms of implementation of comprehensive HIV and AIDS workplace initiatives. Some of the piloted LAs had few activities being implemented aggressively but other activities were neglected and lacked visibility. In the entire LAs piloted condom distribution was vibrant, however activities such as information sharing sessions were being implemented inconsistently. In other words, extremely few LAs have established comprehensive prevention, treatment, care and support interventions for their workplaces.

**3.2.1.2 Management and coordination (M&E)**

To respond effectively to HIV and AIDS, there is need for an effective management and co-ordination. The effectiveness of HIV and AIDS programmes depend heavily on their level of institutionalisation. The process of institutionalisation of workplace HIV and AIDS programmes in LAs is mixed. All local authorities have earmarked budgetary resources to address HIV and AIDS in their constituencies. Some LAs have appointed Councillors as part of their political commitment to oversee HIV programmes. In addition, some LAs have established committees, and made HIV and AIDS a standing point in their Council agendas. It was clear from the evaluation that although LAs are slowly mainstreaming HIV and AIDS, more efforts are needed in setting up structures to manage and coordinate the response. Of the piloted LAs, only one had a fulltime and dedicated focal person. In the other LAs, the focal persons were volunteers who already had their own core duties hence HIV and AIDS activities were neglected and lacked the priority and visibility they deserved. Respondents noted the lack of human resources and absorptive capacity as the primary barriers to effective use of available financial resources. Human resources are inadequate at both an individual level and the government level.

The situation is aggravated by the meagre budget allocation to HIV and AIDS activities. Sufficient and cost-effective budget allocations are necessary for the successful implementation of HIV and AIDS. Although all local authorities have earmarked budgetary resources to address HIV and AIDS in their constituencies, majority of the budgets are minimal and cannot sustain the activities. One focal person commented that;

*“Our HIV and AIDS budget is very low, we were informed by AMICAALL that our budget is for a village council not a town council like us”.*

In such an environment, HIV and AIDS get short shrift in resource allocation. Due to inadequate funding, HIV and AIDS activities in many regions were found to suffer and are likely to die a natural death. The low budgetary allocation was commonly attributed to LAs low revenue base. This was echoed by one key informant;

*“It is difficult to allocate financial resources for HIV and AIDS when some LAs are struggling to pay their water and electricity bills”.*

It is imperative to note that a scaled-up response to HIV and AIDS implies that all sectors must contribute resources. In that light, LAs need to acknowledge the full implications of this shift through resource allocation and budgeting processes.

* 1. **SUSTAINING LEADERSHIP FOR AN EXPANDED RESPONSE**

Leadership is essential to ensure an effective and sustained response to HIV and AIDS at local levels.

*Political commitment is the decision of leaders to use their power, influence, and personal involvement to ensure that HIV and AIDS programmes receive the visibility, leadership, resources, and ongoing political support that is required to support effective action to limit the spread of HIV and mitigate the impacts of the epidemic (POLICY, Project, 2000).*

The NSF acknowledges that the *“lack of adequate and sustained leadership”* as a challenge to the national response and reiterates the need “*to strengthen the capacity and participation of all leaders in the design and implementation of the national multi-sectoral response at appropriate levels of the leadership”*.

As mentioned in earlier sections, UNDP capacitated local leaders through the transformational leadership programme. Through this programme, AMICAALL trained selected councillors, CEOs, mayors, directors and deputy directors in local authorities on the transformational leadership. The evaluation revealed that the programme instilled a deep sense of responsibility and commitment to strengthen the response to HIV and AIDS in the leaders’ different areas of jurisdiction. The leaders who participated in the programme appreciated it as it made them adopt leadership practices based on collaboration, democratisation and participation. Overall, the programme was instrumental in leveraging the commitment of leaders to the response to HIV and AIDS in their constituencies. However, it needs to be stated that although the evaluation found inspiring examples of leadership “breakthroughs,” through the leadership development programme. It was uncertain whether the Project had achieved sufficient scale and depth to respond fully to leadership needs given the scenario that some of the trained leaders were political leaders whose term of office had expired and the slow pace of mainstreaming in other LAs.

The evaluation found that the motivations of leaders and their attitudes towards the local response to the epidemic are varied. Reasons for non-commitment were reported to include that the leaders in non-health sector simply did not comprehend the scale of the epidemic and how it can affect their communities or what they can do about it. Another constraint to commitment was inadequate resources and capacity in the face of competing development priorities. It was clear in the interviews that most LAs are facing several overarching capacity challenges, which directly influence their capacities to deliver quality and affordable public services to all citizenry in their constituencies.

It is imperative to note that, although public pronouncements by political leaders constitute one manifestation of commitment, it certainly is not the only one. Public statements do not necessarily derive from an attachment to a cause. There is an urgent need for local leaders to show commitment by engaging in actions consistent with the positions they publicly advocate. Furthermore, leaders need to exhibit commitment by committing their institutions’ resources to deal more effectively with HIV and AIDS. The majority of the pilot municipalities do not have sufficient capacity in human and financial resources.

**3.3.1. COMMUNITY CONVERSATION ENHANCEMENT (CCE-CC)**

The CCE, using Community Conversations (CC), is a methodology for mobilizing communities for action around HIV and AIDS. It is based on a participatory approaches and recognition that communities have the capacity to change and sustain hope in the midst of the HIV and AIDS epidemic. It is an approach that has as its foundation, on the creation of safe, interactive spaces for facilitated conversations, reflections and applications based on relationships of trust and mutual respect. The NSF clearly highlights that; “*Communities are both beneficiaries and implementers of HIV and AIDS programmes. ……………community involvement has greatly contributed to ownership and constitutes a critical element for sustainability and service uptake”.*

**Community Conversation in Oshana region**

UNDP supported community mobilisation using the CCE-CC methodology. Since the inception of the project in 2007, AMICAALL has been mobilising communities using the CCE-CC approach on behalf of MRLGHRD. The CCE approach was initially piloted in four regions; COKE and later rolled out to five regions (KOOKO). By the end of 2009, 25 communities in 25 LAs were involved in community conversations. The United Nations Volunteers (UNV) programme provided both national and international Volunteers to build capacities. With the technical assistance of UNDP, the Programme Manager: CCE under AMICAALL trained 9 UNVs who were recruited as CCE Coordinators. The CCE Coordinators were trained as ToTs who trained CFs, volunteers in the selected areas were CCE-CC was to being conducted. The CCE Coordinator supported each facilitator to develop action plans and stimulate discussions on HIV and AIDS at community level.

Traditional leaders were trained by AMICAALL on the CCE-CC approach. Evaluation findings show that through the involvement of traditional leaders in CCE-CC, it enabled these “custodians of culture” to counteract new ideas and practices through interpretation of customary law or religious texts. Beneficiaries and CFs interviewed reported that through community conversations issues such as condom use, modes of transmission and prevention of HIV, MCP, Alcohol abuse, poverty, ARVs, VCT, stigma and discrimination, intergenerational and transactional sex, OVC were openly discussed. The conversations did not only dwell on HIV and AIDS but extended to basic service delivery. It was clear in the interviews that the conversations had widespread impact.

Through community conversations, uptake of HIV and AIDS services increased. It was reported that there was an increased number of people, particularly men who went for HIV testing and accessed ARVs and increased use of condoms. In Kunene region, it was reported;

*“Men went out in numbers for treatment”* (Community Facilitator, Outjo)

Similarly, in Caprivi region it was reported;

*“Men stopped sharing ARVs with their wives”.* (Community Facilitator, Bukalo)

In Ohangwena region,

*“I have received numerous requests to bring more condoms every time I come for field visits”.* (Key Informant, Eenanha)

The conversations created conducive environment to discuss cultural practices which were not openly discussed or debated. In Opuwo where wife inheritance is practiced, community conversations resulted in the couples going for VCT prior to wife inheritance and in some cases wives being inherited but with no sexual relations taking place. One beneficiary in Caprivi region echoed;

*“Through the conversations, we discussed openly sensitive cultural practices such as Murarika, where a man can have sex with a woman without her knowledge”.*

Dialogue on several issues led to communities crafting their own solutions to address the issues they identified and later implementing their plans of action. For example, in Onamatadiva community, Ohangwena region, a standing rule was passed that no shebeens would open during community conversations and during the evaluation it was revealed that the rule was still being enforced even though community conversations had ended but now applied to any community meetings held. In addition to the rule, the community resolved on the hours of operation for the shebeens.



**San Community in Onamatadiva Village, Ohangwena region**

The CCE- CC was recognized by all parties interviewed that it was a “powerful approach”, and highly empowering to the community. Community conversations created open and non-threatening environments were the drivers of the epidemic as identified in MTP III and NSF were openly discussed and solutions tailored. The approach was applauded for strengthening community capacities to participate actively in local and national development and to support social transformation. It is worth noting that the approach has aroused interest in other development partners who have expressed interest of adopting the approach in their areas of focus. In Caprivi region, it was reported that DRFN had requested the RC to conduct training for community members in Bwabwata National Park. The conversations did not only address HIV and AIDS issues but also capacitated communities to demand quality service delivery from local government. In Gobabis, through community conversations, the informal settlement of Kanaan benefited from water and sanitation which is ongoing. Likewise, informal settlements in Caprivi and Karas regions were reported to have benefited from electrification of the areas which resulted in a decrease in rape cases. Thus, CCE-CC ensured that local government programme design and planning was informed by communities, thereby bringing the government closer to the people.

One can go further to mention the unifying effect of CCE-CC as it collectively brought community members of different ethnic backgrounds to discussissues of common interests. Indigenous populations were also part of these community conversations, in Opuwo, community conversations were held in communities of OvaHimba whilst in Ohangwena, Kunene, Omaheke, the San communities were part of the community conversations.

The community conversations culminated in communities identifying income generating projects which would enable them to address some of the identified problems such as poverty, unemployment and adherence to ARVs. Evaluation field visits revealed that most of the IGAs were still in infancy stages. The table below shows the projects which were identified in the different regions.

**Table 2: Income Generating Projects**

|  |  |
| --- | --- |
| **Region** | **Type of project (s)** |
| Caprivi | * Hammer mill * Gardening |
| Kavango | * Boat |
| Omaheke | * Bakery * Gardening and goat breeding |
| Ohangwena | * Gardening * Poultry |
| Kunene | * Gardening * Cattle breeding and selling |
| Karas | * Poultry |

The income generating projects received initial capital from UNDP ranging from N$25 000 -45 000. It was clear from discussions with project committee members and beneficiaries that they were grateful to UNDP for the funds. However, majority of the beneficiaries highlighted that the funds were insufficient. In this regard, several LAs and RCs have filled in the gap by supporting the projects in various ways ranging from provision of land for the projects to operate from, logistics, staff support, supplying building material, water tanks, and seeds. Delays in operations were raised by beneficiaries and were attributed delays in service provision by some service providers and logistical arrangements by regional councils and LAs. Beneficiaries noted that they required capacity building related to the projects to be able to sustain them.

Although the CCE-CC approach was commended “as one of the best approaches”, the approach was reported to have structural shortcomings which threaten its sustainability.

The project created a parallel structure to that of government. Staff structures initiated by the project, in particular, CCE Coordinators and CFs were exclusive to those of the government. It was reported that to leverage resources and for sustainability, the structure should have piggy-back on the existing government structure. The CCE Coordinators and CFs were directly remunerated by UNDP. Regions with dynamic community facilitators may continue community conversations, while others may cease to perform them. After the end of UNDP funding mid-year 2012, the CCE Coordinators and CFs were “meant” to be assimilated by RCs and LAs respectively although this was reported to have been communicated to the RCs and LAs. It was evident during evaluation fieldwork that not all CCE Coordinators and CFs had been assimilated.

It was reported that the parallel structure in some RCs created tension. It was reported that the position of CCE Coordinator was pegged to be at par with the position of CLO in the government structure. In addition, the reporting structure was also reported to be flawed as the CCE Coordinators were made to report directly to the Director of Rural Planning when in essence they were to report to the CLO. The scale-up of the approach to other areas in the constituencies is under threat as it all depends on the assimilation of CFs of which given the scarcity of resources in LAs and RCs, this may not happen.

In relation to this, it was reported that the ideal setting would have been UNDP awarding the MRLGHRD to oversee all administrative functions. It was reported if that had happened in the initial institutional arrangements that would have ensured national ownership and consequently sustainability.

Another key challenge to the continuation and scale up efforts of CCE-CC relate to a lack of financial and technical resources. Interviewed community facilitators reported experiencing problems in transport to roll-out the approach to other areas in their constituencies. In some regions, the regional councils and constituency offices were supportive through provision of transport, stationery and payment of subsistence and travel allowances whenever community facilitators attended training workshops. Although the regional and constituency offices had been supportive, it was reported that they were also grappling with being under resourced.

Several key informants reported the challenge of non-feedback to communities after raising their concerns in community conversations. It was reported that in most cases issues raised by communities were not discussed in platforms such as Council and executive meetings so that solutions could be found and feedback given to communities. This was aggravated by the fact that most of the LAs leadership did not attend the community conversations to primarily hear issues of discontent. To some extent, this demoralised both communities and community facilitators. For the later, it made their job difficult as communities lost trust and confidence in them. One community facilitator commented;

*“You can discuss and discuss the issues but if there is no solution to the problems, communities feel why waste time just discussing”.*

Although all 13 regions have RACOCs, not all of them are active and this is the case with CACOs at constituency level which are not well established in all regions. It has to be noted that these are the structures which should be supporting communities and coordinating the response at grassroots, without them being operational it leaves the question of whether the identified issues in the community found their way into the national coordination and management structures.

**3.4 ADDRESSING THE GENDER DIMENSIONS OF THE EPIDEMIC**

Gender and HIV/AIDS are inextricably linked. Gender inequality is a key factor in the HIV and AIDS epidemic among women, and young girls, in particular, are disproportionately affected by the pandemic. The NSF notes the need to address structural drivers of the epidemic which include, *“gender inequalities and gender violence and other social norms”.*

The project mainstreamed gender downstream, that is by integrating it into community conversations where communities analyzed gender inequalities in their contexts and tailor made solutions to address these inequalities. Evaluation findings indicate that issues of gender based violence (GBV), wife inheritance, polygamy, multiple concurrent partnerships (MCP), condom use were openly discussed in community conversations. By bringing together men, women and different generations, the CCE-CC approach allowed different perspectives on gender to be heard and taken into account when decisions were made.

By initiating community dialogue on gender issues, communities were encouraged to explore a wide array of practices that affect girls and women. In several interviews and group discussions, it was reported that many of the gender issues discussed have a direct link to HIV infection. The discussions were reported to have empowered girls and women to recognise negative and harmful practices while strengthening positive cultural values and activities. One beneficiary noted;

*“As women, our eyes were opened, we became aware of what is GBV as some of us experienced it but didn’t know it’s GBV......... the same applies to men, some were perpetrators without knowing that what they were doing was GBV or against the law.* **(FGD participant, Eenanha)**

It was reported that some communities through community dialogue had found ways of replacing cultural practices which promoted gender inequality with “substitute” actions. In Opuwo where wife inheritance is practiced, it was reported that the community members were now going for VCT prior to wife inheritance and in some cases wife inheritance took place but with no sexual relations.

Although gender issues were integrated in community discussions, it was difficult to establish that the Project changed gender-related issues concerning HIV and AIDS on a significant scale.

**3.5 ACHIEVEMENT OF PROJECT OBJECTIVES**

The evaluation reviewed the project against set project objectives. The project appears to have achieved most of its objectives. **Firstly,** the project contributed to acceptance of the multi-sectoral nature of HIV and AIDS and the need for mainstreaming. Through the work with the Office, mainstreaming of HIV and AIDS in OMAs was achieved as evidenced by establishment of functional workplace programmes in all OMAs, even though the level of maturity differs across.

Secondly, the Project enhanced capacities for local responses through the leadership development programme (LDP) and community mobilization using the CCE-CC methodology. The institutionalization of the LDP is evidence to the achievement of this goal. Overall, the LDP was instrumental in leveraging the commitment of leaders to the response to HIV and AIDS in their constituencies. However, it needs to be stated that although the evaluation found inspiring examples of leadership “breakthroughs,” through the leadership development programme, it was uncertain whether the Project had achieved sufficient scale and depth to respond fully to leadership needs given the scenario that some of the trained leaders were political leaders whose term of office had expired and the slow pace of mainstreaming in other LAs.

The Project mainstreamed gender into community conversations, where communities analysed gender inequalities in their contexts and tailor made solutions to address these inequalities. However, sustainability and effectiveness could have been achieved if the Project had created synergy with MoGECW.

**3.6 NATIONAL OWNERSHIP**

From the very outset of any programme or project, it is important to build national ownership. In this Project, ownership by the government is reflected in the mainstreaming of HIV and AIDS in the public sector. Although commitment in implementing HIV mainstreaming in some sectors is still insufficient, most sectors have integrated HIV and AIDS into their plans and routine programmes.

Another best practice that epitomizes the Project is **the grass-roots participation which was** achieved through CCE-CC. Community dialogue created actions which were locally owned and hence more likely to be relevant and sustainable. The Project managed to stimulate community action and won the support of traditional leaders who in most cases are the “custodians of culture”. Buying the support of traditional leaders was a major accomplishment for the Project considering that these leaders often exert a more significant influence at the grass-roots level than government and other formal and “modern” institutions do. Often the laws and policies promulgated by parliament hold less sway in rural, traditional communities than centuries-old customary laws enforced and reinforced by community sanctions and taboos. Working closely with communities and traditional leaders can be the reason why communities have owned CCE-CC and the immense popularity it has at grassroots level. Integration of volunteerism was an important strategy which created opportunities for participation and contributed significantly to increased social integration in communities. It was evident in the interviews with the volunteers (CFs) that they became closely involved with their communities in which they worked and lived and engaged beyond the scope of their daily tasks. A common finding in the surveyed regions was that the volunteers were rolling out CCE-CC to areas beyond their constituencies.

The LDP to some extent created leadership commitment, which consequently generated action and produced results. Leaders took action of allocating resources to HIV and AIDS activities. The programme reinforced the technical, managerial and administrative capabilities of leaders. More broadly, the institutionalisation of LDP in NIPAM shows ownership of the programme.

One of the potential obstacles to ownership mentioned was the insufficient involvement of the MRLGHRD in planning and implementation from the beginning. Concerns were raised that the key ministry’s guidance, support, and involvement was not fully solicited. If it had been solicited, structural flaws of creation of a parallel structure would not have occurred. It was further echoed by key informants that administration of the project remained under UNDP instead of the mother ministry. It was felt that ownership could have been achieved if UNDP had relinquished administration of the Project and let the ministry oversee all administrative functions. Currently, ownership of project activities seems to be fragmented due to lack of a unified and aggressive stand point from the mother ministry. Efforts are likely to remain fragmented as it is only proactive LAs and RCs which will maintain project activities. One key informant in the regions remarked;

*“You cannot expect the lower structures to do so much when they do not get support from the higher structures”.*

**3.7 NATIONAL HIV AND AIDS RESPONSE**

The evaluation assessed the project’s overall design in terms of its relevance and adaptation to the local context. It considered the degree to which the project was relevant to the cultural, economic, and political context in the country, as well as the extent to which it is suited to the priorities of the national response.

The project fitted well into existing national development plans, strategic plans and programmes that address development issues and HIV and AIDS. The project was implemented amid an enabling policy environment wherein the MTP III mandated governmental and nongovernmental organizations to support a more systematic and effective response to HIV and AIDS. The national strategic plan calls for concerted efforts from the public and private sectors. The project supported the goals of the then strategic plan (MTP III) and the current strategic plan, NSF which provides for mainstreaming of HIV and AIDS, enhancing local responses, mainstreaming gender and improving leadership.

Mainstreaming HIV and AIDS in the public sector and local responses was aligned and informed by national development priorities. Mainstreaming of HIV and AIDS is entrenched in a number of national strategic documents;

* Vision 2030
* NDP III, IV
* MTP III
* NSF

The UNDP HIV Programme was therefore anchored in the broader socio-economic development frameworks which are aligned to international commitments the country has made.The programme was based on the country’s national Vision, according to which Namibia aspires to become an industrialized and developed nation by 2030 and national development plans which seek to revive and sustain economic growth; reduce inequality; create employment; eradicate poverty; promote gender equality and equity; reduce regional inequalities; ensure environmental sustainability; and combat HI and AIDS. As clearly shown below, the National development plans, strategic plans and national policy on HIV and AIDS call for multi-sectoral approaches and mainstreaming of HIV and AIDS in plans and development processes. The NDP III states; *mainstreaming HIV/AIDS in socio-economic development*, with activities to *strengthen capacity for* *mainstreaming HIV/AIDS in development processes and for tracking resource flows and the impact of AIDS* *on the economy*.

The National HIV and AIDS Policy endorses that;

*Government, at central, regional and local level, and partners, shall ensure the mainstreaming of HIV/AIDS into all policies, plans and programmes.*

The Third Medium Term Plan (MTP III) 2004-2009 requires implementing partners to *systematically include HIV/AIDS, STI and TB in all sectoral and programme analyses, strategies and plans in all organisations – Ministries, parastatals, private, NGO, FBO and SME sectors.*

The project supported the national strategic interventions of MTP III and NSF namely prevention, treatment, care and support, impact mitigation and response management. Through community conversations there was an increased uptake of prevention services; VCT, Male Circumcision (MC), condom use. In addition, uptake of HIV treatment increased, particularly in men, a group which has been noted not to access treatment on time. The income generating projects act as a safety net and a prevention tool. The projects are integral to ART, help to meet more effectively the nutritional needs of PLHWHA receiving treatment. The projects also act as a prevent tool by breaking the vicious cycle of poverty which may cause people to engage in transactional sex.

Community conversations also created open, non-threatening spaces to openly discuss the drivers of the epidemic in the country. Gender inequalities are identified in NSF has a structural driver of HIV and AIDS in the country. In addition, cultural practices, norms and values have also been cited as drivers of the epidemic. CCE-CC created platforms were such issues were discussed and challenged, creating new mind sets, in other words, transforming communities into addressing them.

**3.8 IMPACT**

The evaluation assessed the positive, direct and indirect impacts of the Project as reported by participants. In particular, the evaluation looked at the impact of the Project on the various stakeholders and considered whether the project had succeeded, through its strategy, to achieve its purpose.

The benefits of the CCE-CC approach were noticeable during the evaluator’s field visits to communities, particularly communities which benefited from the income generating projects. Their aptitude and initiative were remarkable. The beneficiaries were enthusiastic to share their experiences of community conversations. The beneficiaries that the evaluator met in the communities truly appreciated the opportunity to discuss their community problems and be able to benefit from income generating projects. When asked about the benefits of CCE-CC, beneficiaries mentioned the increased knowledge on HIV and AIDS, uptake of VCT, ARVs, condom use, decrease in alcohol abuse, gender based violence and MCP. The communities were empowered. The income generating projects were reported to be a bonus from CCE-CC which would go a long way in improving adherence to treatment for PLWHA, assisting vulnerable households and increasing household income.

Mainstreaming contributions seem to have substantial impact. The benefits of mainstreaming of HIV and AIDS in the public sector are noticeable in the number of OMAs with workplace programmes, and in the increased number of OMAs which have mainstreamed HIV and AIDS in their strategic and annual plans and budgets. Although more work is till to be done, visible achievements can be seen. The impact on local government was also evident. LAs and regional councils are slowly integrating HIV and AIDS into their plans and programmes. Overall, the project contributed immensely to acceptance of the multi-sectoral nature of the epidemic and the need for mainstreaming of HIV and AIDS issues in policies, plans and action in government responses beyond the health and HIV and AIDS sectors. However, despite the initiatives of UNDP, and successes in facilitating mainstreaming in policy statements, implementation of mainstreaming is still at an early stage.

The capacity building interventions provided by the project had a great impact on the various stakeholders. The training targeting leaders at national and local levels contributed to deepening commitment to HIV and AIDS. Furthermore, the project enhanced the capacities of leaders which enabled them to recognize their roles and responsibilities in the national response. This is turn saw visible commitments in some leaders and actions being taken through allocation of resources to the cause.

**3.9 LEVEL OF PARTICIPATION**

During evaluation field visits it was found that community participation in community conversations was impressive and the conversations had a diverse composition (old, young, women, men, traditional leaders, traditional healers, religious healers and all ethnic groups). As aforementioned, integration of volunteerism into programming created opportunities for participation and contributed significantly to solidarity and strengthening of trust. Overall there were many examples cited by survey participants giving positive input regarding their involvement. It was clear that community members had been fully involved in CCE-CC from step one to the final step. An exceptional example was the active involvement of communities in choosing income generating projects, writing a funding proposal for the chosen project and then implementing the project. Instituting a committee for the projects was also left to the community. In all the piloted regions, all income generating projects had established committees to oversee project management and coordination. It was reported that the committee members had been democratically elected. Committee members reported having assigned clear roles and responsibilities among themselves and regularly holding planning meetings. Interestingly, some committees were able to show records of meetings and personal information of committee members.

After training of CCE-CC methodological approach, community facilitators and other community members were continuing to roll-out CCE-CC in adjacent areas in their constituencies and beyond. This was the case in Caprivi and Karas regions.

In terms of the workplace programmes, OMAs, LAs and RCs are left to design their own programmes and implement them. OMAs, LAs and RCs lead on matters of their participation, their contribution and their needs of the programme. In the piloted regions, it was reported that the LAs developed their own workplace policies with the guidance of MOL and AMICAALL. Similarly, establishment of workplace committees was democratic.

**3.10 SUSTAINABILITY**

This section examines the strategies used to promote sustainability and the continuing development of opportunities to sustain project activities. In particular, it assesses whether any steps were taken to ensure the continuation of project activities after completion of the project, including sources of funding and partnerships with other organizations and/or the Government and identifies areas where this may be strengthened.

The sustainability of the project rests on the ability and willingness of the government and communities to continue project activities. Sustainability of the programme at the financial, institutional and community levels is critical to ensuring its effectiveness and long-term impact. The project aimed to achieve this by promoting national ownership and by encouraging increased use of national resources in the financing, planning, and implementation of the project.

The process of engaging communities is likely to sustain CCE-CC. The Project enlisted the support of traditional leaders which made traditional leaders allies in changing social attitudes and behaviour. Enlisting traditional leaders and other local authorities also has an important multiplier effect as they pass on information to their own members and constituents. During evaluation field visits, some communities were found to be rolling-out CCE-CC to adjacent areas in their constituencies. This was achieved with support from regional and constituency offices which provided transport. It is worth to note that the sustainability of such efforts is fragmented as it is only dynamic regional and constituency offices which have been able to render such support. In addition, constituency offices were reported to be under resourced which is likely to jeopardize these efforts. To sustain CCE-CC, several key informants reiterated that there is need to explore other synergies, for instance it was recommended that CCE-CC must be integrated into community activities of all ministries or ministries which are visible and enjoy a strong presence at grassroots level such as MoHSS, MoGECW, MAWF. In relation to this idea, it was alluded that the approach need to be marketed not only as an approach for community action on HIV and AIDS but for any other development issues so that more partners can buy into it.

Capacity-building at the national and local levels to some extent may build sustainability. The project managed to build capacity at national and local levels. Given the fact that there are severe human capacity problems in the public sector in terms of planning, implementing and monitoring and evaluating of programmes, the project added value on this dimension. The project provided training in the areas of transformational leadership, policy development, peer education, CCE-CC, impact assessment, HIV and AIDS modelling and projections just to mention a few.

The wellness programmes in public sector and local government are likely to be sustainable, since OMAs, LAs and RCs had begun committing resources to these programmes. With a Public Sector Wellness Programme Policy underway, this would institutionalize the programmes.

One of the major threats to sustainability which has been aforementioned is the aspect that instead of using existing government structures, the project created a parallel structure which is likely to endanger the long-tern sustenance of project activities. Staff structures initiated by the project, in particular, CCE Coordinators and CFs may be *partially* sustainable as they are exclusive to those of the government. Regions with dynamic community facilitators may continue community conversations, while others may cease to perform them. It was evident during evaluation fieldwork that in some communities CCE-CC had stopped as community facilitators were no longer receiving an allowance after UNDP funding came to an end in 2012. Although some RCs and LAs had assimilated CCE Coordinators and community facilitators respectively, some had not done so. Karas region had not taken the CCE Coordinator on board after the end of the project. In Kunene, the CCE Coordinator was taken up by the RC but in a different capacity. LAs which had not absorbed Community facilitators cited financial constraints as the major challenge; however, some LAs reported having made budgetary provisions in the upcoming financial year. It is uncertain whether this will take place as in most of the piloted regions, the financial year had not commenced.

Some of the key informants noted that the project had not sufficiently involved the MRLGHRD in planning and implementation from the beginning. It was reported that administration of the project remained under UNDP instead of the Ministry. It was felt that sustainability could have been achieved if the ministry had from the beginning been awarded the opportunity to oversee all other administrative functions with technical assistance of UNDP. Thus, sustenance of project activities may not be uniform at regional level as dynamic LAs and RCs will seek to continue project activities whilst others may not. Uniformity may not be achieved as the ministry which can pass a directive to lower levels seem to have partially owned the project.

As aforementioned, capacity building is crucial to the survival of project activities. Given the high staff turnover in government and particularly local government, capacity building has to be continuous, however this is likely to be a challenge, particularly for local government structures which are already over-burdened with a plethora of responsibilities and are understaffed, under resourced and under motivated. Some LAs are grappling with mismanagement, whilst others underwent major restructuring. If support is not forthcoming, then longer term outcomes could be jeopardized. A lack of refresher training may make trainees remain with out-dated information and no opportunities to refine their skills and competencies. This is true for focal persons, peer educators and community facilitators.

In addition, it was reported by many participants that there seemed to be “HIV and AIDS fatigue” among workers. Such attitudes could make the efforts wane overtime.

**3.11 ACHIEVEMENT OF MDG 6**

Heads of State from around the world adopted the Millennium Declaration in September 2000. Namibia has ratified the MDGs and is committed to the attainment of these goals. Of the eight MDGs, Goal 6 calls for halting and beginning to reverse the spread of HIV and AIDS, malaria and other major diseases by 2015. Through strengthening national and local capacities, the Project will enable the government to achieve this goal. Even though some areas remain work in progress, overall the Project through mainstreaming of HIV and AIDS in the public sector, local government will make the country remain on track in accomplishing the goal. In addition, stimulating community action on HIV and AIDS, enabled communities to realise their vulnerability and act on reducing it.

**3.12 PARIS DECLARATION**

The Paris Declaration (PD) on Aid Effectiveness, endorsed in March 2005, is now recognised as a landmark international agreement aimed at improving the quality of aid and its impact on development.

The PD has five pillars, namely **ownership**, **alignment**, **harmonization, management for development results** (MfDR) and **mutual accountability**. *Ownership* to some extent was achieved through active participation of project beneficiaries at national and local levels. Through active involvement, the Project ensured that recipients articulated their own development priorities and managed the process. The March 2005 Paris Declaration on Aid Effectiveness committed participants to address *“insufficient integration of global programmes and initiatives into partner countries’ broader development agendas*”, including critical areas such as HIV and AIDS. There is abundant evidence that the programme was *aligned* to country strategies and national priorities. The Project was aligned to the national development plans, the National Policy on HIV and AIDS, the MTP III and even the NSF 2010-2016. *Harmonization* focuses on having the delivery of aid well coordinated among donor countries to reduce transaction costs. *Managing for results* recommends placing focus on aid making a tangible impact on the ground. Abundant evidence was provided above on the impact of the Project, particularly the CCE-CC, mainstreaming and LDP. *Mutual accountability* calls for transparency in the accounting for the use of aid funds between donors and host countries. Although some form of mutual accountability was achieved, in some areas it failed. As aforementioned, the Project’s administrative functions remained under the control of UNDP instead of being relinquished to MRLGHRD.

**3.13 LESSONS LEARNED**

The evaluation also assessed the lessons learned during the implementation cycle. The importance of documenting the lessons learned is to ensure that the lessons learned are not lost and are used for replication and scaling up in future initiatives.

* Mainstreaming HIV and AIDS into existing plans and programmes enlarges capacities and reaches greater numbers inside and outside institutions. It is a resource leveraging mechanism as it is incorporated in annual plans and therefore budgeted for.
* Active participation of stakeholders greatly increases effectiveness of the activities. Use of participatory approaches fosters ownership of project activities and has lasting effect even after project life.
* Stakeholder involvement especially local structures have an important multiplier effect as stakeholders pass on information to their own members and constituents. This in turn generates meaningful ownership.
* The success of community-based initiatives lies in the extent to which a project is able to engage and involve the community.
* Consultative process ensures better understanding of a project or programme by key stakeholders, which results in better implementation. This may take time but it is good to go through this process.
* Capacity-building is an on-going process. Resources have to be expended on a regular basis to build capacity at all levels. High staff turnover in public agencies calls for periodical investment in capacity building.
* It takes time to change deeply ingrained attitudes and behaviours or longstanding socioeconomic factors, longer than a project has to give.
* Leadership commitment is necessary in all levels of policy development, dissemination and implementation.
* Coordinated action is required if efforts are to be effective.

**4.0 CONCLUSION**

This section summarizes major findings of the evaluation and sets out recommendations for action by UNDP.

Overall, the evaluation found that the Project has been instrumental in integration of HIV and AIDS in the public sector and has facilitated increased leadership commitment to HIV and AIDS. The Project contributed in a substantial way in building capacities of national and local structures. Project activities led to substantive changes in government and grass-roots levels within specific targeted areas and groups. The Project engaged in *upstream* work with OPM and NPC to strengthen macro-level responses. Evaluation findings indicate that engagement with higher levels of governance resulted in the greatest influence in shaping policy and strategy. *Mid-stream* interventions at *decentralized, sub-national* levels of government also yielded results as reflected by the documented successes at local government level. Support for decentralized, participatory planning, and capacity development of local government was commended by LAs and RCs. Community mobilization *downstream* cannot be underscored. Innovative interventions such as the LDP and CCE-CC contributed to important paradigm shifts. Overall, the Project set important precedents and had significant impact has on the UNDAF outcome 1. Although, sizeable contributions were made, there were a number of missed opportunities, as cited in earlier sections. One prominent area of missed opportunity was gender mainstreaming. Given the intimate link between gender and HIV/AIDS and that gender based violence is an area of concern to the country, strong collaboration with MOGECW would have been more effective. In addition, the aspect of parallel structures needs to be addressed in the future, if interventions are to be owned and sustained.

**5.0 RECOMMENDATIONS**

On the basis of the evidence gathered, in the evaluation, the evaluation recommends the following:

1. Strengthening civil society to act as interlocutor with the government would be complementary strategy that can ensure a certain degree of continuity in the institutional strengthening efforts.
2. The Project should not simply end; the planned exit strategy must be well communicated to the recipients and transfer of responsibility should be fully ensured.
3. In future processes, it is advisable to actively involve the mother ministry and transfer responsibility so that ownership and sustainability can be achieved.
4. Given the severe challenges in government, particularly local levels, UNDP should consider to continue providing technical assistance in some areas.
5. In the future, projects should piggy-back on government existing structures, which in turn leverage resources, ensure ownership and sustainability.
6. Extending the community based approaches need to other ministries, especially those with a strong grassroots presence. This implies that UNDP needs to provide technical support in this regard to these entities.

**REFERENCES**

1. AMICAALL Namibia Charter, undated. 2009 Annual Report: AMICAALL, Windhoek, Namibia
2. Government of the Republic of Namibia and the United Nations System in Namibia, 2004. United Nations Namibia Common Country Assessment, Windhoek, Namibia.
3. MoHSS, 2005. Draft Operational Plan for National Monitoring, Evaluation and Reporting on HIV/AIDS 2004-2009, Windhoek, Namibia.
4. MoHSS, 2005. Sector Report HIV/AIDS MTP3 year 2004-2005, Windhoek, Namibia.
5. MoHSS. 2007, Progress Report on the Third Medium Term Plan on HIV /AIDS, April 2006-March, MoHSS: Windhoek, Namibia.
6. MoHSS. 2008, HIV/AIDS in Namibia: Behavioral and Contextual Factors Driving the Epidemic, MoHSS: Windhoek, Namibia.
7. MoHSS. 2008, A Guide to HIV/AIDS Mainstreaming, MoHSS: Windhoek, Namibia.
8. MoHSS. 2012, Report on the 2012 National HIV sentinel survey, MoHSS: Windhoek,Namibia.
9. MRLGHRD, 2010. Support Visit Report Community Capacity Enhancement – Community Conversation (CCE – CC), MRLGHRD, Windhoek, Namibia
10. Namibia Network of AIDS Service Organisations [NANASO], 2005. Monitoring and Evaluation of the Civil Society contribution to tackling HIV/AIDS in Namibia: Current levels of activity among NGOs, CBOs and Faith-based Organisations in relation to tackling HIV/AIDS in Namibia, Windhoek, Namibia.
11. Office of the Prime Minister, undated. HIV/AIDS Public Sector Coordination Strategy 2010-2015: OPM, Windhoek, Namibia
12. Republic of Namibia. 2007. A Guide to Workplace Programmes, Republic of Namibia: Windhoek, Namibia.
13. Republic of Namibia, 2007. National Policy on HIV and AIDS, MoHSS: Windhoek, Namibia.
14. Republic of Namibia, Demographic and Health Survey 2006-2007. MoHSS, Windhoek,Namibia
15. Republic of Namibia, The National Strategic Plan on HIV/AIDS (MTPIII), 2004-2009, MoHSS: Windhoek, Namibia.
16. Republic of Namibia, 2010. National Strategic Framework for HIV and AIDS Response in Namibia 2010/11-2015/16, MoHSS: Windhoek, Namibia.
17. United Nations Namibia, 2005. United Nations Development Assistance Framework Namibia 2006-2010 (UNDAF), Windhoek, Namibia.
18. UNDP, UNAIDS and OPM, 2005. Namibia Public Service Report on HIV and AIDS Impact Assessment, UNDP, UNAIDS and OPM: Windhoek, Namibia

**APPENDICES**

**Appendix A: Draft Terms of Reference**

**Draft Terms of Reference**

Evaluation of the HIV programme from 2007 to 2012

Exercise to be undertaken from the 7th to the 28th January 2013

**1. General Context of HIV in Namibia**

Since the onset of the HIV epidemic in the mid-eighties more than 188 500.00 are living with HIV. The epidemic has negatively impacted on health and development indicators over the past 20 years and will remain a major development challenge for the next 10 to 20 years. The HIV prevalence stabilized at around 13% in the general population and impacts directly and indirectly on the well-being of the vast majority of the population. It continues to burden the health care system, the performance of the formal and informal economy, the capacity of public and private sectors to provide services, and the attainment of all MDGs.

***2. Prevalence and Incidence***

With an estimated adult HIV prevalence of 13.5 per cent in 2010/11 Namibia is ranked among the 10 countries with the highest prevalence levels in the world [[1]](#endnote-1). An estimated 188,500 people were living with HIV in 2010/11 (MoHSS/UNAIDS) among which some 17,500 children below the age of 15.[[2]](#endnote-2) HIV prevalence among pregnant women attending antenatal care rapidly increased from 4.2 per cent in 1992 to a peak of 22 per cent in 2002 before it declined to 18.8 per cent in 2010. There is broad regional variation in HIV prevalence rates among pregnant women, ranging from 4 per cent in Rehoboth to 36 per cent in Katima Mulilo. Prevalence rates are highest in the Northern regions.

**3. Proposed HIV programme**

From 2004 -2009, HIV/AIDS response in Namibia was guided by the National Strategic Plan on HIV/AIDS (MTP III, 2004-2009). This was the first practical attempt to address HIV/AIDS as a development challenge following from the National Development Plan (NDP) 2 which had the overall goal of reducing HIV transmission to below epidemic levels and minimizing the impacts of HIV/AIDS on infected individuals and affected families, communities, regions and sectors. A mid-term review of the MTP 3 among others, emphasized the critical need for a systematic approach to mainstreaming[[3]](#footnote-1) of HIV/AIDS among others in all sectors and all organizations, with dedicated staff, and budgeted plans for incorporation into core functions of sectors by 2010 in order to facilitate a rapid scaling up of the response[[4]](#footnote-2). Within the five years MTP III implementation, the most significant achievements of the national response were:

* The reduction of the national prevalence from 22% to 19.7%.
* The increase in treatment for People Living with HIV/AIDS from 13,000 in 2004 to 24, 018 as of June 2006

The current NDP 4 as well as Vision 2030, there is an acknowledgment that the current and future effects of HIV/AIDS on the populations’ health status, service delivery and poverty calls for a behaviour change, intensified prevention, treatment, care and roll out of workplace programmes within the public service. It also identifies the following strategies among others to address the epidemic:

* The need for greater understanding of the impact of HIV and AIDS on all the sectors;
* Investing adequate resources to address the epidemic;
* Ensuring that all development plans and sectors include and implement HIV/AIDS responses in their efforts;
* Promotion of policies to combat stigma and discrimination;
* Sound political leadership and involvement of all sectors
* An enhanced ability to monitor and evaluate the epidemics’ impact[[5]](#footnote-3).

**4. Main objectives of the HIV and AIDS programme**

**a) Developing capacities for the mainstreaming of HIV/AIDS strategies in the Public Sector**

Besides the recognition that HIV/AIDS is a development challenge, two key principles underpin the formulation and implementation of MTP III namely; multi-sectoral engagement and broad political commitment. Both MTP III and the current HIV and AIDS National Strategic Framework provides, broad framework committing all sectors including Offices, Ministries and Agencies (OMAs) to the integration and implementation of HIV and AIDS strategies as an integral part of their mandates.

* Facilitating a process of mainstreaming HIV/AIDS into the development planning process (NDP 3) and core business of all OMAs
* Providing follow up support for integrating HIV/AIDS activities into the annual plans and budgets of OMAs
* Addressing the limited human capacities within the government OMAs for programme management monitoring and reporting.
* Supporting specific ministries in mainstreaming HIV/AIDS

**b) Enhancing capacities for local responses:**

MTP III sub component 4.1 clearly identifies local responses as an in integral part of the national response[[6]](#footnote-4). Given the call for decentralized, community-based responses, the Regional Councils (RC) and Local Authorities (LA) are decentralized structures playing a critical role as the institutional hub for the management of local responses. This is reflected in the regional and LA commitments outlined in the MTP III[[7]](#footnote-5).

Additional challenges included the following:

* Strengthening the capacities of local authorities, Constituency Development Committees (CDCs, Constituency AIDS Committees (CACOCs) in planning and implementing local responses
* Strengthening the relationships between RCs, LAs, Communities, NGOs, CBOs,
* Providing timely technical and financial support for community responses
* Promoting a methodology of engaging and linking community needs with LA and RC planning and implementation processes.

**c) Addressing the gender dimensions of the epidemic**

* The need to accelerate the capacity development processes around the concept of gender within the context of HIV and AIDS
* To address the deep rooted gender issues such as unequal power relations, intergenerational sex, unequal access to basic social services, gender based violence among others and
* To ensure that gender is practically mainstreamed into HIV and AIDS programming from national level to community level.

**d) Sustaining leadership for an expanded response**

Over the years, the Namibian Government has shown strong leadership around HIV and AIDS prevention, treatment Care and support. However, Leaders (political, religious, business, youth and traditional) however still require more information and support in order to strengthen and focus their commitment to the multi sectoral response, awareness raising and information sharing[[8]](#footnote-6). As a signatory to the UNGASS declaration of commitments, the challenge is how to urgently translate these leadership commitments into action that:

* reflects increased visibility of leadership at all levels[[9]](#footnote-7),
* harnesses the energies of organizations for an expanded response
* ensures allocation of adequate domestic resources for action,
* Empowers individuals to take effective action against the epidemic

**5. Overall goal of the evaluation is to:**

a. Measure the extent to which the HIV programme has contributed to addressing the objectives as outlined in the project document.

b. Measure the degree of implementation in terms of efficiency, participation of national ownership, quality delivered on outputs and outcomes, as well as overall implementation as outlined in the project document.

c. Measure the extent to which the HIV programme has contributed to the overall HIV response both nationally and regionally. Specifically look at the results at outcome level in relation the targeted population, beneficiaries, participants whether individuals, communities, institutions, as stipulated in the project document were supported as inscribed in the project document.

d. Measure the HIV programme’s contribution to the objectives set out in MTP III and the NSF.

e. Identify and document substantive lessons learned and good practices documented during the implementation process.

**6. Level of analysis and evaluation criteria**

a. To what extent the HIV programme the best option to respond to HIV national challenges stated in both MTP III and the NSF?

b. To what extent the implementing partners participating in the HIV programme had an added value to solve the HIV and AIDS response challenges stated in the project document?

**7. Results level evaluation**

Assess the extent to which the HIV Programme contributed to:

a. The Millennium Development Goal 6 at the local and national levels

b. Increased knowledge and evidence required for policy dialogue and programming.

c. Implementation of the principles of the Paris Declaration and Accra Agenda for Action?

d. Making an impact on institutional reform to mainstream HIV and AIDS into plans and budgets.

e. Probability of the benefits of the intervention continuing in the long term (sustainability of interventions introduced).

**8. Methodological Approach**

This evaluation will use methodologies and techniques as determined by the specific needs for information, the questions set out in the TORs and the availability of resources and the priorities of stakeholders. The consultant is expected to analyse all relevant information sources, such as reports, project document, internal review reports, programme files, strategic country development programme, mid-term evaluations and any other documents that may provide evidence on which to form judgements. The consultant is also expected to use interviews, surveys or any other relevant quantitative and/or qualitative tool as a means to collect relevant data for the final evaluation. The evaluation team will make sure that the voices, opinions and information of targeted citizens/participants of the HIV programme are taken into account.

Key Government/partner Documents for review will include partner policy, strategy and programme documents that inform the project. These include the National Strategic Framework documents on HIV and AIDS, the National Development Plan, Vision 2030 and other policy and strategy documents relevant to the design and implementation of the project.

Key Informant Interviews will target relevant programme personnel based at UNDP, project personnel, and counterparts in from implementing agencies, government departments, civil society and other executing agencies

**9. Required Qualification for this Consultancy**

* A Masters Degree in a development related field, e.g. Health, Community Development, Social Work.
* A minimum of five (5) years experience working in the field of HIV and AIDS.
* A good understanding of the national policy and strategy context in relation to HIV and AIDS
* Good analytical and reporting skills and fluency in written and spoken English.
* Ability to assess complex situations in order to succinctly and clearly distil critical issues and draw realistic conclusions.

10. Submission from Consultant

It is **mandatory** for the consultant to provide information supporting suitability for this assignment which should include the following:

* The consultant shall submit an up-to-date résumé, with certified copies of academic certificates,
* At least two traceable references from previous clients as evidence of ability to undertake assignments.
* The consultant shall also submit a brief (not more than 5 pages) technical proposal including the following:
* Brief interpretation of the TOR,
* Summary of methodology to be used for the evaluation (approach).
* A quotation in the format provided below:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name of Consultant: …………………………………………………………………………………………………… | | | | | |
| **Price Schedule Breakdown Structure (in Namibian Dollars)**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Item** | **Unit Cost** | **Description of Unit** | **# of Units** | **Cost per Item** | | Daily Consulting Fee |  |  |  |  | | Other Costs (please specify) | unit |  |  |  | | Total Proposed Budget |  |  |  |  | | | | | | |
|  |  |  | |  |  |
| Submitted by (Name & Signature): | | | ………………………………………………………………… | | |
| Date: …………………………………………………. | | | | | |
|  | | | | | |

**10. Deliverables of this evaluation**

* **Inception Report**

This report should be submitted within 5 days of the submission of all programme documentation to the evaluation team. The report will be 5 to 10 pages in length and will propose the methods, sources and procedures to be used for data collection. It will also include a proposed timeline of activities and submission of deliverables. This report will be used as an initial point of agreement and understanding between the consultant and the evaluation reference team.

* **Draft Final Report**

The draft final report will be submitted within 5 days after the completion of the visits to OMAs and other implementing institutions in Windhoek.

The draft final report will contain the same sections as the final and will be 15 to 20 pages in length. This report will be shared among the evaluation reference team. It will also contain an executive summary of no more than 3 pages that includes a brief description of the HIV programme, its context and current situation, the purpose of the evaluation, the methodology employed and its main findings, conclusions and recommendations. The final report will be shared with evaluation reference team to seek their comments and suggestions.

**Final Evaluation Report** The final evaluation will besubmitted within 5 days after reception of the draft final report with comments.

The final report will be 15 to 20 pages in length containing an executive summary of no more than 5 pages that include a brief description of the HIV programme, its context and current situation, the purpose of the evaluation, the methodology employed and its major findings, conclusions and recommendations. The final report will be submitted to the evaluation reference team.

1. 2010/11 Estimates and Projections of the Impact of HIV/AIDS in Namibia, Ministry of Health and Social Services and UNAIDS, December 2011 [↑](#endnote-ref-1)
2. Republic of Namibia, Ministry of Health and Social Services. United Nations General Assembly Special Session (UNGASS) Country Report, April 2006-March 2007. Windhoek, Namibia.

   **Appendix B: List of Participants**

   |  |  |  |  |
   | --- | --- | --- | --- |
   | **Name** | | **Designation** | **Organisation** |
   | **Ms. Sarah Mwilima** | | Assistant Resident Representative/Head: Governance, HIV and Gender | UNDP |
   | **Mr. Henk Van Renterghem** | | Country Coordinator Namibia | UNAIDS |
   | **Mr. Jeremia Ntinda** | | Country Director | AMICAALL Namibia |
   | **Mr. Hannu Shivute** | | Chief Liaison Officer | MRLGHRD |
   | **Mr Marenga Kapanda** | |  | Office of the Prime Minister |
   | **Mr. Immanuel Mwilima** | | Former Programme Manager: CCE-CC | GTZ |
   | **Ms. Connie Podewitz** | | Chief Health Programme Administrator | MOHSS: Directorate of Special Programmes |
   | **Mr. Benson Matali** | |  | MOGECW: Directorate of Gender |
   | **Mr. Michael Conteh** | | Social Researcher | NIPAM |
   | **REGIONAL REPRESENTATIVES** | | | |
   | **CAPRIVI** | | | |
   | **Mr. Cletius Mubita** | | Acting Deputy Director: Planning | Caprivi Regional Council |
   | **Mr. Mbuche** | | Community Liaison Officer | Caprivi Regional Council |
   | **Mr. Richard Lyamine** | | CCE Coordinator | Caprivi Regional Council |
   | **Mr. Mukaya Johns** | | Wellness Officer | Katima Mulilo Town Council |
   | **Hammer mill committee members** | | - | Bukalo village, Caprivi region |
   |  | |  |  |
   | **KUNENE** | | | |
   | **Ms. Juanita** | | Public Relations Officer/HIV and AIDS Focal Person | Outjo Town Council |
   | **Mr. Franco !Gomseb** | | Honourable Deputy Mayor | Outjo Town Council |
   | **Mr. Jaco Labuschagne** | | Health Inspector | Outjo Town Council |
   | **Community garden members** | | - | Outjo Town Council |
   | **Mr. Wellem** | | Former CCE Coordinator | Kunene Regional Council |
   | **Mr Fossy Kavari** | | HIV and AIDS Focal Person | Opuwo Town Council |
   | **Mr. Charles Uaraji** | | Community Liaison Officer | Kunene Regional Council |
   |  | |  |  |
   | **OMAHEKE REGION** | | | |
   | **Ms. Frieda Shimakaleni** | | Manager: Human Resources & Corporate Services | Gobabis Municipality |
   | **Ms. Elizabeth Amutenya** | | Honourable Deputy Mayor | Gobabis Municipality |
   | **Ms. Magdalena Beukes** | | Honourable Councillor | Gobabis Municipality |
   | **Ms. Valerie Tjirimuje** | | Community Liaison Officer | Omaheke regional council |
   | **Community Facilitators** | | - | Gobabis Municipality |
   | **Kanaan Bakery Committee members** | | - | Gobabis Municipality |
   | **Ms. Wilhemina Witbooi** | | Community Facilitator | Leonardville Village Council |
   | **Mr. Fritz Namseb** | | Community Facilitator | Leonardville Village Council |
   | **Leornadville Project Beneficiaries** | | - | Leonardville Village Council, Omaheke region |
   | **KARAS REGION** | | | |
   | **Ms. Caroline. W. Arenerse** | | Honourable Mayor | Karasburg Town Council |
   | **Ms Stephnie Matroos** | | Human Resources Officer | Karasburg Town Council |
   | **Mr. Benediktus B. Isaaks** | | Community Facilitator | Karasburg Town Council |
   | **Mr. Celestinus Rooi** | | Community Facilitator | Karasburg Town Council |
   | **Ms. Menesia Keister** | | Former CCE Coordinator | Karas Region |
   | **Mr. Jegg Christiaan** | | Strategic Executive: Local Economic Development | Keetmanshoop Municipality |
   | **Ms. Milly Cloete** | | HIV and AIDS Focal Person | Keetmanshoop Municipality |
   | **Ms. Jeaneta Boois** | | Human Resources Officer | Keetmanshoop Municipality |
   |  | |  |  |
   | **OHANGWENA REGION** | | | |
   | **Mr. F. Hasenanye Shilongo** | Director: Planning & Development Services | | Ohangwena Regional Council |
   | **Ms. Natalia. N. Ndaitwa** | Deputy Director: Rural Services/Gender Focal Person | | Ohangwena Regional Council |
   | **Ms. M. Bernard** | Deputy Director: Human Resources | | Ohangwena Regional Council |
   | **Ms. Rauna Pohamba** | CCE Coordinator | | Ohangwena Regional Council |
   | **Mr. Walde Ndevashiya** | Chief Executive Officer | | Eenanha Town Council |
   | **Ms. Martha. K. Asser** | Head: Community Services & Public Health/HIV and AIDS Focal Person | | Eenanha Town Council |
   | **Mr. Leornard Nghihadlwa** | Headman | | Ohalamo, Eenanha Town Council |
   | **Mr. Martin Erasmus** | Community Facilitator | | Eenanha Town Council |
   | **Mr. Markus Amupanda** | Community Facilitator | | Eenanha Town Council |
   | **Eenanha Poultry Project Beneficiaries** | - | | Eenanha Town Council |
   | **Onamatadiva Gardening Project Beneficiaries** | - | | Onamatadiva Village, Ohangwena region |

   [↑](#endnote-ref-2)
3. Mainstreaming HIV/AIDS strategies means incorporating the implications of HIV/AIDS into normal, everyday considerations and actions of the organization. Mainstreaming has two aspects to consider – how HIV & AIDS is affecting the organization itself (workplace) and how HIV & AIDS is affecting the core functions of the organization. Mainstreaming thus have two components: internal mainstreaming (workplace programmes) and external mainstreaming (responding to MTP 3 commitments) [↑](#footnote-ref-1)
4. [↑](#footnote-ref-2)
5. See Vision 2030 page 57 [↑](#footnote-ref-3)
6. See MTP III pages 32, [↑](#footnote-ref-4)
7. See MTP III pages 135, 149-180 [↑](#footnote-ref-5)
8. See 2005 UNDAF page 5 [↑](#footnote-ref-6)
9. See follow up to the declaration of commitments on HIV/AIDS, Namibia Country report page 26 [↑](#footnote-ref-7)