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### United Nations Children's Fund

Executive Board

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Item 5 of the provisional agenda\*

### **Draft country programme document\*\***

#### **Namibia**

#### *Summary*

The Executive Director presents the draft country programme document for Namibia for discussion and comments. The Executive Board is requested to approve the aggregate indicative budget of \$3,335,000 from regular resources, subject to the availability of funds, and \$21,665,000 in other resources, subject to the availability of specific-purpose contributions, for the period 2006 to 2010.

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\* E/ICEF/2005/7.

\*\* In accordance with Executive Board decision 2002/4 (E/ICEF/2002/8), the present document will be revised and posted on the UNICEF website in October 2005, together with the summary results matrix. It will then be approved by the Executive Board at its first regular session of 2006.

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*Basic data*<sup>†</sup>  
(2003 unless otherwise stated)

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Child population (millions, under 18 years)	1.0
U5MR (per 1,000 live births)	65
Underweight (% , moderate and severe, 2000)	24
Maternal mortality ratio (per 100,000 live births, 2000)	270
Primary school enrolment and attendance (% net, male/female, 2000, 2001/2002)	77/78 76/81
Primary school children reaching grade 5 (% , 2000/2001)	94
Use of improved drinking water sources (% , 2000)	80
Adult HIV prevalence rate (% , end 2003)	21.3
Child work (% , children 5-14 years old)	n/a
GNI per capita (US\$)	870
One-year-olds immunized against DPT3 (%)	82
One-year-olds immunized against measles (%)	70

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<sup>†</sup> More comprehensive country data on children and women are available at [www.unicef.org](http://www.unicef.org).

## The situation of children and women

1. Since independence in 1990, Namibia has made significant progress in fulfilling the rights of children and women. A lower-middle-income country, with \$870 per capita gross national income, Namibia has strengthened social services and has introduced progressive social policies. However, the apartheid legacy includes a high level of income disparity (Gini coefficient of 0.70), with 38 per cent of households in relative poverty, and 9 per cent in extreme poverty. HIV/AIDS is now threatening the social sector gains.

2. The 2004 HIV sentinel survey reflects a national prevalence rate of 19.8 per cent among pregnant women, ranging from 8.6 per cent to 42.9 per cent among the thirteen regions. Although this rate is a drop from the 2002 level of 22.2 per cent, the epidemic is at its peak for morbidity and mortality among the population in the productive age range of 15 to 49. HIV/AIDS is a primary cause in the drop in life expectancy, from 61 to 49 years between 1991 and 2001. Of Namibia's 1.8 million people, 150,000 to 180,000 are estimated to be HIV positive. It is encouraging that HIV prevalence among youths 15-19 years old declined from 12 per cent in 1998 to 10 per cent in 2004. Challenges remain, however, especially given the fact that two thirds of young Namibians do not believe that they are at risk of contracting HIV. On average, the age of sexual debut is 17 for males and 18 for females, but it is less than 15 for a significant minority.

3. The infant mortality rate, currently 52 per 1,000 live births, is expected to rise to 72 per 1,000 by 2010 and to continue to vary widely among regions. The under-five mortality rate stands at 65 per 1,000 live births, with the top five causes of death being acute respiratory infections, diarrhoea, AIDS (causing almost 40 per cent of all under-five deaths), malnutrition and malaria. Malaria remains a major problem in nine northern regions, where prevalence rates are 59 deaths per 100,000 population. Mosquito net use is at a low of 7 per cent, and seasonal outbreaks contribute to a malaria mortality rate as high as 120 per 100,000 (2001).

Immunization coverage has been erratic, with rates dropping from 88 per cent (DPT3) and 78 per cent (measles) in 2001, to 84 and 72 per cent, respectively, in 2003.

4. The maternal mortality rate increased from 225 to 271 deaths per 100,000 live births between 1992 and 2000. The antenatal care coverage rate is 90.6 per cent of pregnant women, and 75.5 per cent of all deliveries are assisted by trained personnel. Pregnancy rates have dropped from 22 to 18 per cent among teenagers 15-19 years old, though 39 per cent of 19-year-old girls are either mothers or are pregnant. It is estimated that each year 15,400 HIV-positive mothers give birth to 6,180 HIV-positive infants.

5. The 2001 census noted 167,000 orphaned children, with one in seven children under 15 years having lost one or both parents. By 2021, the number of orphans is projected to be 250,000, a number that will represent a third of the population under 18. A majority of the orphans are cared for by elderly grandmothers.

6. Malnutrition is a persistent problem, with 24 per cent of under-fives moderately or severely malnourished. As a result of recurrent droughts and floods, over one third of the population regularly needs food assistance. The impact of HIV/AIDS has further weakened precarious livelihoods, and traditional household and community coping mechanisms are faltering.

7. The 2004 Common Country Assessment (CCA) highlighted HIV/AIDS, food insecurity and the diminishing capacity of service delivery systems — the three factors known as the “triple threat” in southern Africa’s humanitarian crisis. Based on the *Namibia 2004 Millennium Development Goals Report*, the CCA indicates that Namibia is “on track” for several Goals but is stagnating on others, the achievement of which is seriously hampered by HIV/AIDS. One such area of stagnation is health gains for children. By 2010, infant mortality is expected to be 60 per cent higher than it would have been in the absence of HIV/AIDS.

8. While the report on the Millennium Development Goals notes the progress achieved towards making basic education free and accessible to all (net enrolment exceeds 87 per cent and shows gender parity), HIV/AIDS is beginning to undermine teachers’ capacity to deliver quality education and could potentially reduce the attendance of girls, who typically care for the sick. Dropout rates are expected to increase among the growing numbers of children affected by AIDS. Some groups who remain economically and socially marginalized continue to have lower enrolment rates than the national average, especially among girls.

9. Domestic and sexual violence against women and young girls is a major concern. One study indicated that 44 per cent of men believe that husbands have a right to beat their wives. From 2000 to 2003, the number of reported rape cases rose from 698 to 894, with gross underreporting still suspected. Legislation to protect women and children from violence and abuse has been adopted but enforcement remains a challenge, given limited government capacity. Women suffer from negative cultural attitudes, economic dependency and discrimination, all of which restrict their ability to exercise equality in relationships and to negotiate safe sex. The wide prevalence of alcohol abuse, which contributes to violence, is only beginning to be acknowledged as a societal problem.

10. Due to Namibia’s status as a lower-middle-income country, official development assistance (ODA) declined by 46 per cent from 1991 to 2001.

Fortunately, funding for HIV/AIDS has increased, primarily from the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) and the United States President's Emergency Plan for AIDS Relief. However, this focused funding does not address broader systemic and capacity issues affecting Namibia's development gains.

## **Key results and lessons learned from previous cooperation, 2002-2005**

### **Key results achieved**

11. In the first six years of implementation, the "My Future is My Choice" programme reached 170,000 youths aged 15-19 with HIV prevention/life skills training, most likely contributing to the decline in HIV prevalence noted for that age group, as reported in the sentinel surveys. The challenges are to reach every adolescent in that age group and to sustain the training as an effective after-school activity. A new in-school life skills programme, "Window of Hope", was launched in 2004 to reach 10- to 14-year olds before they become sexually active.

12. The "Take Control" media campaign for adolescent HIV prevention became fully owned and managed by the Ministry of Information and Broadcasting in 2002. Further complementing the life skills programme, the adolescent-friendly health services (AFHS) programme covers 12 out of the 34 health districts, ensuring access to reproductive health, peer counselling and condoms for sexually active adolescents. In the same districts, the Integrated Management of Childhood Illness (IMCI) initiative provided skills training in case-management. A study of early childhood care and development (ECD) practices was used to develop a communication strategy to improve care giving for 0- to 3-year olds.

13. Support for prevention of mother-to-child transmission of HIV (PMTCT) contributed to the creation of a national policy and guidelines on Infant and Young Child Feeding in the context of HIV. Other support for social policy and legislation development was instrumental in the creation of the national policy for orphans and vulnerable children (OVC), ECD policy adjustments and the Domestic Violence and Child Justice bills. Support to girls' education in Kavango Region, which has the lowest retention rates for girls, resulted in a significant increase in school completion and a reduction of 10 per cent in teenage pregnancies within two years.

14. The 2004 OVC Rapid Assessment, Analysis and Action Plan (RAAAP) will help accelerate action for a holistic approach to OVC programming, from the policy level to community capacity development. The UNICEF-supported Church Alliance for Orphans has emerged as a major network reaching 167 communities.

15. A critical leveraging result was the technical assistance given by UNICEF to the Government to obtain significant funds from the Global Fund in 2003. These funds complement UNICEF support to HIV behaviour-change communication, life skills, PMTCT and OVC and will significantly strengthen and expand governmental and non-governmental programmes.

### **Lessons learned**

16. Fund-raising was negatively affected by the sharply decreased levels of ODA. While funding for HIV-prevention activities increased, non-HIV/AIDS interventions,

especially for maternal and child health, ECD, OVC and child protection issues, did not attract adequate donor funding. UNICEF set-aside funds were made available for accelerating OVC and sustaining ECD activities, but in other programme areas shortfalls reduced coverage. To further prioritize UNICEF support, programme areas with limited impact, such as ECD pre-school access and quality assurance and juvenile justice, have been reconsidered.

17. The negative synergy of the triple threat is affecting progress made in maternal and child survival and in basic education access and retention. Hence, there is a need to refocus the resources of UNICEF to help maintain and strengthen critical services for children and women, such as immunization and malaria control. These high-impact child survival interventions will need direct support to have greater impact on morbidity and mortality rather than being diluted through integration in other programmes. With the growing numbers of OVC, ensuring access and retention to basic education, especially for girls, is also at risk.

18. Achieving geographic convergence of UNICEF programmes remained a challenge, affected as it was by different Ministries' choice of regions. Lack of convergence, combined with the wide breadth of activities covered, tended to spread limited resources too thin. Furthermore, monitoring processes with clear accountabilities at national and sub-national levels needed improvement.

19. For HIV/AIDS impact mitigation, an urgent need for appropriate interventions to support community capacity development has emerged. United Nations agencies and development partners will need to work closely with the Government to develop practical interventions to reinforce community coping strategies for OVC care.

## The country programme, 2006-2010

### Summary budget table\*

<i>Programme</i>	<i>(In thousands of United States dollars)</i>		
	<i>Regular resources</i>	<i>Other resources</i>	<i>Total</i>
Maternal and child survival, care and development	925	5 415	6 340
Education for HIV prevention and mitigation	925	7 585	8 510
Special protection for vulnerable children	835	7 585	8 420
Cross-sectoral costs	650	1 080	1 730
<b>Total</b>	<b>3 335</b>	<b>21 665</b>	<b>25 000</b>

\* An additional requirement for an emergency response of \$180,000 per annum is anticipated through an existing appeal.

### Preparation process

20. The CCA/United Nations Development Assistance Framework (UNDAF) was prepared in 2004 in a participatory process involving resident and non-resident United Nations agencies, Government Ministries, non-governmental organizations (NGOs) and development partners. Under the aegis of the National Planning Commission and in partnership with United Nations agencies, UNICEF contributed

its staff strength, especially staff familiarity with the planning tools, to facilitate the process. The CCA used a human rights approach and causality analysis to provide evidence of HIV/AIDS, food insecurity and the diminishing capacity of critical institutions and services. Based on the CCA, the UNDAF has three priority outcomes. These address the triple threat through country programme outcomes designed as common areas for action by United Nations agencies.

21. The preparation process involved four intersectoral workshops that were guided by a Core Working Group and headed by a senior Government official, thereby ensuring that the UNDAF was fully in line with national priorities. The Government's clear demand for joint programming by the United Nations agencies was respected through a commitment to jointly plan and prepare the country programme documents (CPDs), action plans and annual work plans.

22. In line with the commitments of UNICEF in the UNDAF, the draft of the new CPD was shared with United Nations agencies and stakeholders. Joint consultations were held with the World Health Organization (WHO), the United Nations Population Fund (UNFPA) and counterpart Ministries. In late February, the draft CPDs for UNICEF and UNFPA were jointly reviewed with the Government and United Nations and development partners.

#### **Goals, key results and strategies**

23. The overall goal of the country programme is to contribute to the achievement of the Millennium Development Goals through support to HIV prevention, care, support and mitigate the impact of HIV/AIDS on critical services for children and women. This goal will be achieved by means of three focus areas, which will contribute to the reduction of child and maternal mortality rates, reduction of HIV prevalence among adolescents 13 to 19 years old and an increase in access to critical services in health, education and protection by the most vulnerable groups, especially children affected by HIV/AIDS. The programme will contribute to the achievement of the following key impacts and outcome results, to be achieved by 2010:

#### *24. Maternal and child survival:*

- (a) Increased routine Expanded Programme on Immunization (EPI) coverage to 80 per cent, and sustained polio eradication and neonatal tetanus elimination;
- (b) Reduced proportion of infants infected with HIV, by 50 per cent;
- (c) Increased coverage of long-lasting insecticide-treated bed nets, from 7 per cent (2000) to 40 per cent;
- (d) Increased skilled attendance at deliveries, from 60 per cent in 2000 to 85 per cent;
- (e) Increased access to reproductive health services by adolescents;
- (f) Early childhood care practices improved for children 0-3 years old among the most vulnerable households.

25. *HIV prevention and impact mitigation:*

(a) Increased access to correct information about HIV and the acquisition of skills needed for HIV prevention by adolescents, contributing to a reduction in national HIV prevalence to 7 per cent for the age group 13-19;

(b) Sustained primary school enrolment (93 per cent) and completion (85 per cent) rates, especially among girls, focusing on five regions with high HIV and OVC prevalence.

26. *Special protection:*

(a) Increased access to critical services and care practices for children orphaned or made vulnerable by HIV/AIDS in five high-prevalence regions;

(b) Reduced incidence of sexual abuse of children and women.

27. To achieve these key results, the programme will apply the following **strategies**: (a) pursue joint programming and ensure that it is undertaken with United Nations and other partners for maximizing impact; (b) ensure sub-national convergence of critical interventions (ECD for 0-3, OVC and basic education) in five regions with high HIV prevalence; (c) strengthen the capacity of key implementing partners, especially religious networks, for community outreach; (d) strengthen community coping mechanisms for OVC care through a holistic approach to HIV/AIDS impact mitigation; (e) ensure sustained national coverage for adolescent HIV-prevention life skills in all schools; (f) undertake evidence-based advocacy and social policy development for the rights of children and women; (g) ensure a focus on prevention of violence against children and women by addressing underlying causes, such as those related to gender and alcohol abuse; (h) undertake efforts to improve national capacity in monitoring, evaluation and strategic planning systems for children's and women's rights; (i) ensure that behaviour-change communication, social mobilization and gender-sensitive programming are integrated into all sub-components; and (j) pursue the active involvement of adolescents in programme planning, monitoring and implementation.

**Relationship to national priorities and the UNDAF**

28. The programme will directly contribute to all three of the UNDAF outcomes and six of the nine country programme outcomes. Hence, the total resource mobilization target of \$25 million will be for UNDAF commitments. The UNDAF addresses one of the most critical priorities of the country, meeting the challenge of HIV/AIDS, as defined in the National Development Plan Two (NDP2), 2001-2006, and the National Strategic Plan for HIV/AIDS: Third Medium-Term Plan (MTP3), 2004-2009. The programme will support activities defined in MTP3 in HIV prevention, care and support, and impact mitigation.

29. The National Poverty Reduction Strategy and NDP2 outline the importance of an integrated approach to food security and nutrition, health delivery systems, water and sanitation and family food practices as being central to poverty reduction. Education and health services have been given priority since independence and were reaffirmed in the NDP2. NDP2 is a building block of Vision 2030, a long-term plan for making Namibia a developed, high-income country by 2030. The Vision focuses

on developing human resources by investing in education and health, ensuring gender equality and equity, and combating HIV/AIDS.

30. The programme will support the implementation of the policies on Early Childhood Development (1996, being revised), HIV/AIDS for the Education Sector (2003), Orphans and Vulnerable Children (2004), the Infant and Young Child Feeding (2004) and the draft Policy on Education for Orphans and Vulnerable Children.

### **Relationship to international priorities**

31. The Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination against Women and the declarations of the United Nations Special Session on Children and the Special Session on HIV/AIDS provided the framework for the national policies and priorities and thereby the country programme. Since no recent country submissions were made to either Convention Committee, the programme reflects earlier recommendations made by the Committee on the Rights of the Child, including a recommendation to translate legislation and policies regarding children's and women's rights into action at sub-national levels. The UNICEF organizational priorities in the draft medium-term strategic plan 2006-2009 and the goals and strategies in *A World Fit for Children* are also central to the programme of cooperation. Child survival and development, children and AIDS, child protection and girls' education are all components of the programme, while child rights and policy advocacy are cross-sectoral elements.

32. The Government of Namibia-UNICEF country programme will contribute to the attainment of the Millennium Development Goals as follows:

(a) *Goal 1, poverty and hunger*: a focus on malnutrition among the most vulnerable groups (0- to 3-year olds, especially in vulnerable households);

(b) *Goal 2, universal primary education*: focus on access and retention for children made vulnerable by HIV and AIDS, with special attention given to girls;

(c) *Goal 3, gender equality for women*: focus on addressing gender and societal alcohol abuse as well as on gender dimensions in education, maternal/child health and adolescent HIV prevention;

(d) *Goals 4 and 5, child and maternal mortality*: focus on EPI, malaria control, nutrition surveillance/growth promotion, ECD care practices for children 0-3 and reproductive health;

(e) *Goal 6, HIV/AIDS, malaria and other diseases*: focus on adolescent HIV-prevention and life skills and malaria control, and make links to *Goal 4* support areas;

(f) *Goal 8, partnership for development*: focus on advocacy and promotion of rights for leveraging resources for children and women.

### **Programme components**

#### **Maternal and child survival and development**

33. This component will support Government efforts to reduce child and maternal mortality and combat HIV/AIDS and malaria, thereby contributing to Millennium

Development Goals 1, 4, 5 and 6, and three UNDAF country programme outcomes. The component will support the Primary Health Care Strategy of the Ministry of Health and Social Services and the ECD policy implementation of the Ministry of Gender Equality and Child Welfare. The areas of focus will be immunization “plus”, malaria control, promotion of early child care practices, nutrition, maternal health and AFHS.

34. The **child survival and development** sub-component will expand and strengthen routine immunization “plus” services, striving for full immunization coverage of 80 per cent of children under one. The focus will be on measles control, sustained maternal and neonatal tetanus elimination and polio eradication. Expanded coverage and use of insecticide-treated bed nets (ITNs) will be supported. Care practices, including addressing gender dimensions of care, will be promoted by linking service providers with families and communities and in implementing the ECD policy. Growth monitoring/promotion will be strengthened through community-based surveillance to detect children at risk, participatory nutrition education and training of health workers for management of severe malnutrition. Given the worsening impact of the chronic drought and floods in regions with high HIV prevalence, sub-national emergency response efforts will be supported.

35. The **maternal and adolescent reproductive health** sub-component will support the following: efforts to increase access to antenatal care “plus”, reducing the risk of malaria during pregnancy, tetanus immunization and the use of ITNs and AFHS. Emphasis will be placed on improving access to essential obstetric care, postnatal care, maternal mortality audits and behavioural change regarding gender-based attitudes linked with delays in seeking, reaching and receiving care. Efforts will be made to integrate AFHS, Infant and Young Child Feeding policy implementation and PMTCT into maternal and child health services.

#### **Education for HIV prevention and mitigation**

36. In support of Millennium Development Goals 2, 3 and 6 and contributing to two UNDAF country programme outcomes, UNICEF will promote the empowerment of young people through the provision of knowledge and skills for HIV prevention and by creating a supportive network and environment for young people affected by HIV/AIDS. The programme will contribute to the reduction of HIV prevalence in the age group 13-19, from 10 per cent (2004) to 7 per cent by 2010, and to increased access and retention in basic education, focusing particularly on orphaned children and girls. HIV prevention among young people will be implemented nationwide, while the education system reform will be implemented in convergence with other components in selected regions.

37. The **adolescent HIV prevention** sub-component will work with the Ministry of Education to support life skills education through “My Future is My Choice” for 15- to 18-year-olds, and “Window of Hope” for 10- to 14-year-olds, while partnerships with youth networks will reach out-of-school youth. Capacity-building initiatives, including technical support and training, will be provided to the HIV and AIDS Management Unit and 13 Regional AIDS Committees for Education responsible for HIV-related interventions in the education sector. Teacher capacities will be strengthened for improved life skills education in HIV/AIDS and sexual health.

38. The **access to basic education** sub-component will help to mitigate the impact of HIV/AIDS on schooling through the promotion of public debate leading to policy reform that ensures access to education for children affected by HIV/AIDS. Initial interventions will take place in two regions where systems will be established to reimburse schools that exempt OVCs from paying school development fund fees. Planning and mapping support will be provided to improve children's access to school feeding programmes and to address the anticipated decrease in teacher capacity. Regional and community capacity to support vulnerable children will be strengthened through the reinforcement of counselling support groups and the establishment of community- and school-based networks to ensure school access and retention of children, especially girls.

39. Communication activities, including interpersonal communication, the use of mass media for promoting demand for services, and social mobilization, will be integrated into both sub-components. Three areas of focus will be girls' increased vulnerability to HIV transmission, girls' increased burden of caring for others, and the lack of an enabling environment for adolescents. The component falls within the framework of the Government's MTP3 on HIV/AIDS and the Education and Training Sector Improvement Plan (ETSIP). The main donors are the Government of Sweden for "My Future Is My Choice", the Government of the Netherlands for "Window of Hope" and the National Committees for UNICEF of Belgium and Germany for "Take Control".

#### **Special protection for vulnerable children component**

40. In support of Millennium Development Goals 1, 3 and 6 and two UNDAF country programme outcomes, the component will strengthen the multisectoral efforts at the national, regional and community levels to address the most critical protection issues of orphaned and other vulnerable children and violence against women and children, including addressing gender and alcohol abuse as underlying factors. Results for each sub-component are defined below.

41. The sub-component on **special protection** will contribute to the goal of reducing the number of reported cases of violence against women and children. It will involve community-based interventions to prevent violence against women and children through awareness-raising and the extension of support from health services, police protection units for women and children, NGOs and faith-based networks. Gender issues and alcohol abuse will be addressed through these networks and through the Coalition for Responsible Drinking, consisting of private-sector, government and NGO partners. Research on emerging issues, such as child labour and children who live or work on the street, will inform the development of appropriate plans and interventions. Advocacy will be undertaken for legal reform for the protection of child and women's rights, including inheritance, and the implementation of existing protective legislation.

42. The sub-component on **capacity development for the care of vulnerable children** will support efforts to ensure access to critical social and economic services for 85 per cent of vulnerable households caring for OVC, especially those households that are headed by the elderly or children, in five regions with high HIV prevalence. The services will include health and nutrition, ECD and basic education. Ensuring such access will be effected through establishment of community support structures and the strengthening of community self-help groups, linking efforts with

economic activities to ensure food security. The sub-component will be carried out initially through a joint United Nations programme in the Caprivi Region and with other partners in four other regions. Technical assistance will be provided to support the implementation of the national action plan of the 2004 OVC RAAAP and advocacy for the OVC policy implementation. The main funding source will be the regionally negotiated multi-country funding for OVC of the United Kingdom's Department for International Development.

43. **Cross-sectoral costs** will cover activities that cut across the three components and also contribute to UNDAF outcomes: external communication and advocacy, programme planning, monitoring and evaluation and supply procurement. Integral parts of the three programme components and the cross-cutting external communication interventions will be advocacy and social mobilization for promoting the rights of children and women and leveraging resources for children in order to take to scale UNICEF interventions in partnership with major players.

### **Major partnerships**

44. The programme of cooperation will work with major development partners and United Nations agencies in pursuit of the common areas of the UNDAF country programme outcomes and outputs. Partnerships include those with WHO and UNFPA for Maternal and Child Survival and Development; UNFPA and the United Nations Educational, Scientific and Cultural Organization (UNESCO) for Education for HIV Prevention and Mitigation; and the Food and Agriculture Organization of the United Nations, the World Food Programme, UNESCO and UNFPA for the joint programme in Special Protection, developing community capacity development for families and communities affected by HIV/AIDS.

45. The Centers for Disease Control and Prevention in the United States will be a partner for the PMTCT initiatives and for the extension of support to general primary health care and outreach capacity development. The basic education interventions will be carried out in association with the Education Sector Partners Advisory Group within the ETSIP coordination framework being developed with World Bank support. The OVC programming will be done in partnership with the United States Agency for International Development/Family Health International towards supporting the national OVC action plan and RAAAP implementation. Other major partners include the Church Alliance for Orphans and the Coalition for Responsible Drinking, which consists of the private sector, NGOs and Government Ministries.

### **Monitoring, evaluation and programme management**

46. Based on the UNDAF monitoring and evaluation plan, the Government of Namibia-UNICEF Integrated Monitoring and Evaluation Plan (IMEP) will be developed jointly with partners and updated annually. The country programme action plan (CPAP) results and resources framework will serve as the basis for tracking contributions to the UNDAF outputs and outcomes as well as to the Millennium Development Goals and national targets.

47. The IMEP will be organized into three interlinked sub-sets, the first focusing on studies, surveys and evaluations of selected programme interventions for baseline and mid-term progress. Emphasis will be placed on information and data gaps, including those in special protection and behaviour change. Among the non-

UNICEF studies and surveys to be used for tracking programme results will be the Demographic and Health Survey (2006) and HIV sentinel surveys (2004, 2006 and 2010).

48. The second sub-set, implementation monitoring, will be undertaken jointly with implementing and other partners, including United Nations agencies. Activities include tracking indicators specified in the CPAP results framework through the identified “means of verification”; field implementation monitoring; periodic joint assessments; and monitoring of activity implementation and financial management. These will be reflected in the annual work plans and reviewed in the joint annual reviews with relevant United Nations agency partners.

49. The third sub-set involves tracking progress towards achievement of national goals and objectives linked to the country’s international commitments and the Millennium Development Goals. It includes monitoring process as well as impact indicators. *DevInfo* will be promoted as a common United Nations system as well a system for monitoring the Millennium Development Goals and National Development Plan goals. The national surveys in the first sub-set will complement data from management information systems of the counterpart Ministries.

50. Under the National Planning Commission, a working group comprising government managers from the lead Ministry for each component, collaborating partners, UNICEF and United Nations partner agencies will oversee the implementation of the programme and guide the IMEP as an integral part of the UNDAF monitoring and evaluation framework. Emphasis will be placed on joint planning and annual work plan development, monitoring and joint mid-year and annual reviews with common counterparts. A joint UNDAF mid-term review is envisaged for 2008 and a programme evaluation in 2010.

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