Investment Cases Towards Ending Unmet Need for Family Planning and Gender-Based Violence

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LIST OF ACRONYMS

AfHEA	African Health Economics and Policy Association
AU	African Union
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CPR	Contraceptive Prevalence Rate
ESARO	East and Southern Africa Regional Office
FP	Family Planning
GBV	Gender-Based Violence
GDP	Gross Domestic Product
ICPD	International Conference on Population and Development
IPV	Intimate Partner Violence
LiST	Lives Saved Tool
mCPR	Modern Contraceptive Prevalence Rate
MGECW	Ministry of Gender Equality and Child Welfare
MHSS	Ministry of Health and Social Services
NDHS	Namibia Demographic and Health Survey
NDP5	5th National Development Plan
NGOs	Non-Governmental Organizations
NHS	National Health Services
NRG	National Reference Group
SADC	Southern Africa Development Community
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender-Based Violence
SSA	Sub-Saharan African
TFR	Total Fertility Rate
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNPFA	United Nations Population Fund
VAWG	Violence against Women and Girls
WHO	World Health Organization

EXECUTIVE SUMMARY

Namibia has a population of about 2.5 million people, which is projected to reach 3.0 million in 2031 (NHS, 2019). The current annual population growth rate is about 1.9 per cent but is expected to decline to 1.7 per cent by 2030. The female population is approximately 1.29 million (52 per cent), while the male population is about 1.21 million (48 per cent). Overall life expectancy is 63.4 years; 66.2 years for females, and 60.4 for males. There has been a significant decline in the fertility rate from 4.5 children per woman in 1996 to 3.3 children per woman in 2019. However, the high level of teenage pregnancy is a serious concern. The national teenage pregnancy rate stands at 19 per cent, suggesting that one in five adolescent girls aged 15 to 19 years has begun childbearing. The country has a young population, with over 35 per cent under 15 years. Over 56 per cent of the population is under 25 years, and about two-thirds are below 35 years.

Sexual and reproductive health and rights remain essential for achieving sustainable development, with significant impacts on maternal, newborn, child and adolescent health (Starrs *et al.*, 2018). Family planning remains a top priority in the development agenda of countries not only as a matter of human rights but central to women's empowerment, poverty reduction and achieving sustainable development. In Namibia, the contraceptive prevalence rate (CPR) has increased rapidly, from 23 per cent in 1992 to 61 per cent in 2020. The national CPR target of 80 per cent is expected to be achieved by 2030. Modern contraceptive prevalence rate (mCPR) has increased rapidly from 21 per cent in 1992 to 58 per cent in 2020. The rate varies considerably by age, with teenage girls less likely to use contraception than women aged between 25 and 39 years (25 per cent and 59 per cent, respectively). There are also considerable differences in CPR and mCPR among different sub-groups. For example, rural women, those without formal education, and those from poor households have low contraceptive use.

Gender-based violence (GBV), or violence against women and girls (VAWG), is a global pandemic. About 35 per cent of women worldwide have experienced either physical and/or sexual intimate partner violence or

non-partner sexual violence. Over 7 per cent of women have been sexually assaulted by someone other than a partner, and as many as 38 per cent of murders of women have been committed by an intimate partner. Gender-based violence is devastating to the survivors and imposes significant social and economic costs on society. Evidence suggests that children exposed to violence are more likely to become perpetrators in the future. Sexual and gender-based violence (SGBV) remains a persistent challenge in Namibia, with an increasing incidence of intimate partner violence (IPV), sexual violence and femicide. The NDHS (2013) has estimated that 33 per cent of never-married women aged 15-49 have experienced physical, sexual and/or emotional violence from their partner. About 32 per cent of adolescent girls aged 15-19 and 35 per cent of young women aged 20-24 have experienced physical violence from a partner. During the period 2012 to 2016, the Namibian Police identified the five top forms of violence on reported cases as 22,174 assault with grievous bodily harm; 18,054 common assault; 2,839 rape; 1,138 attempted murder and 734 murder cases. With the significant prevalence in the country, failure to address issues related to GBV and VAWG could pose serious consequences and costs to society in the future.

The two investment cases developed for Namibia – (1) Ending unmet need for family planning and (2) Ending gender-based violence – are expected to inform strategic partnership efforts and mobilize additional domestic and external financing required to achieve the transformative results for the country. With the continuously evolving sustainable financing landscape, situating investments within the development, humanitarian and peace nexus in the country is critical, considering the increased occurrences of public health emergencies. This is particularly the case with the current public health crisis due to the COVID-19 pandemic and its disruptive impact on the supply chain for modern contraceptives and other health commodities around the world.

The Spectrum software was used to analyse the transformative results on unmet need for family planning. The FamPlan module in Spectrum was used to linearly extrapolate annual CPR, mCPR, fertility rate, unmet need for family planning and the cost of investing in family planning. The costs were disaggregated for each of the interventions and by type of cost. The Impact40 online toolkit was used to estimate the number of unintended pregnancies averted, maternal deaths averted, and unsafe abortions averted by scaled-up use of modern contraceptives. It was ensured that these models were coherent to allow for comparability of the results. Three scenarios were laid out: scenario 1, assuming CPR is maintained at approximately 61 per cent; scenario 2, assuming a CPR target of 75 per cent by 2030; and scenario 3, assuming a CPR target of 80 per cent.

A similar methodology was used to estimate the impact and costs associated with GBV intervention. However, it should be noted that the GBV interventions covered in Impact40 are limited and mainly focus on Intimate Partner Violence (IPV). Therefore, the estimated impact and costs of GBV interventions in Namibia only represent those relevant for IPV. As such, the estimates provided in this study are to be considered as the minimum impact and minimum costs for achieving the GBV targets. Also, it is important to note that data for some of the GBV intervention indicators were unavailable for the base year 2020. Moreover, data for some indicators are not nationally representative. To address these limitations, assumptions were made for some of the baseline estimates. Similarly, assumptions were made for some of the targets where gaps exist in the available data. Three scenarios were also drawn up: scenario 1, with a 2 per cent annual increase in interventions; scenario 2, with a 10 per cent additional annual increase in interventions over scenario 1 level; and scenario 3 with an additional 10 per cent annual increase in interventions over scenario 2 level.

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Ending unmet need for family planning

- Family planning services uptake in Namibia has increased rapidly over the years, with an estimated contraceptive prevalence rate (CPR) of approximately 61 per cent for married and/or women in union aged 15-49 years. The national target for CPR is 80 per cent by 2030. Modern contraceptive prevalence rate (mCPR) grew rapidly from 21 per cent in 1992 to 58 per cent in 2020. The estimates indicate that there is a need to increase investments in family planning programmes over time and implement selected interventions with greater impact.
- Achieving the total fertility rate target of 2.0 by 2030 hinges on the Government's ability to increase the CPR to at least 75 per cent by 2030. Unmet need for family planning will be halved from 15.2 per cent to 7.5 per cent if the CPR is increased to 75 per cent and to 5.1 per cent if the CPR is increased to 80 per cent by 2030.
- Investing in family planning in Namibia will reduce the number of unintended pregnancies, maternal deaths, and unsafe abortions in the coming years. In total, 619,870 unintended pregnancies will be averted between 2020 and 2030 if the current CPR of 60.6 per cent remains unchanged (with mCPR of 58 per cent). This will increase to 767,135 if the CPR is increased to 75 per cent (with mCPR of 72 per cent) and to 818,312 if the CPR is increased to 80 per cent (with mCPR of 77 per cent).
- Similarly, more maternal deaths would be averted by increasing the CPR. If the current CPR of 60.6 per cent remains unchanged (mCPR of 58 per cent), 1,256 maternal deaths will be averted, while about 1,556 deaths will be averted if the CPR is increased to 75 per cent (mCPR of 72 per cent), and 1,658 if the CPR is increased to 80 per cent (mCPR of 77 per cent).
- The number of unsafe abortions averted between 2020 and 2030 will increase to 129,429 if the current CPR of 60.6 per cent remains unchanged, to 160,179 if the CPR is increased to 75 per cent (mCPR of 72 per cent) and to 170,863 if the CPR is increased to 80 per cent (mCPR of 77 per cent).
- Maintaining the current CPR between 2020 and 2030 will require an additional cost of about US$3.2 million (an annual

average of US$319,903). However, scaling up the CPR to 80 per cent in 2030 will require an additional cost of US$7.3 million (an annual average of US$729,956).

Ending gender-based violence

- Without any intervention, the number of women experiencing IPV in a year would increase from 113,539 in 2020 to 127,697 in 2030, with a cumulative total of 1.3 million between 2020 and 2030 (an annual average of 120,903).
- Under the status quo scenario (maintaining the current coverage rate of interventions), a total of 52,111 IPV cases would be averted between 2020 and 2030.
- In scaling up the different GBV interventions, the number of IPV cases in Namibia is expected to decline even more, with 119,430 cases of IPV averted between 2020 and 2030 under scenario 3.
- Maintaining current levels of GBV interventions would cost US$98.5 million (an annual average of US$8.9 million). Economic empowerment intervention would account for 63 per cent of the estimated costs, followed by programme support accounting for 13 per cent. Achieving the intervention outcomes in scenario 3 would cost US$114.5 million (an annual average of US$10.4 million) with economic empowerment and programme support interventions still accounting for about 63 per cent and 13 per cent of the estimated resources, respectively.

The summary of the impact and cost of high-impact interventions required to achieve the transformative results is presented below:

Summary of costs and impacts of interventions, 2020-2030

UNMET NEED FOR FAMILY PLANNING	SCENARIO 1 (STATUS QUO, 61% CPR)	SCENARIO 2 (75% CPR)	SCENARIO 3 (80% CPR)
Total intervention costs (US$)	8,881,575	12,009,268	13,095,640
IMPACTS OF INTERVENTION			
Cumulative number of unintended pregnancies averted	619,870	767,135	818,312
Number of maternal deaths averted	1,256	1,556	1,658
Number of unsafe abortions averted	129,429	160,179	170,863
ENDING GENDER-BASED VIOLENCE	**SCENARIO 1 (STATUS QUO, 2% ANNUAL INCREASE)**	**SCENARIO 2 (10% ANNUAL INCREASE OVER SCENARIO 1)**	**SCENARIO 3 (10% ANNUAL INCREASE OVER SCENARIO 2)**
Total cost of interventions (US$)	98,434,198	106,444,343	114,454,490
Impact: Number of cases of gender-based violence averted	52,111	85,543	119,430

Conclusion and recommendations

The investment cases provide quantitative analyses to support decision-making in scaling up identified interventions to improve human development outcomes including sexual and reproductive health and rights, particularly for two transformative results: (i) ending unmet need for family planning and (ii) ending gender-based violence. The cases presented show the costs and impacts of achieving both transformative results.

The impacts or gains from investing in scaling up priority interventions include averting maternal deaths, unintended pregnancies, and unsafe abortion, which in turn contribute to improved health and well-being, gender equality and socioeconomic transformation.

Women and girls need family planning and GBV prevention support irrespective of their age, educational qualification, socioeconomic status and geographic location. This is particularly important as large-scale emergencies like the COVID-19 pandemic have weakened the support mechanisms of GBV prevention and response and delivery of essential services, including family planning, leaving many women and adolescents even more vulnerable.

This study underscores the evidence of GBV and unmet need for family planning in Namibia and recognizes actions taken in line with the country's development framework, the 5th National Development Plan (NDP5) 2017/18 - 2021/22. To achieve the goals in the Plan, the following recommendations are put forward:

Ending unmet needs for family planning

1) Promote the inclusion of all family planning services such as modern contraceptives method mix, counselling and follow-up in the essential benefits package of all health insurance schemes.

2) Strengthen advocacy to increase domestic resource mobilization (DRM) to finance family planning interventions and introduce innovative financing mechanisms to mobilize additional revenues.

3) Promote community involvement and address gender inequalities that can impact agency, bodily autonomy and rights-based family planning decisions.

4) Improve efficiency in the use of available family planning resources at all levels to increase the value of spending and foster multi-stakeholder partnerships to support innovative financing initiatives at all levels.

5) Ensure that development programmes targeting poor and vulnerable groups are mandated to contribute towards family planning within the context of Universal Health Coverage (UHC).

Ending gender-based violence

1) Strengthen the delivery of GBV interventions within municipal plans and budgets.

2) Mainstream GBV within development programmes to contribute towards addressing the high prevalence of GBV.

3) Strengthen the capacity of justice, law enforcement and human rights institutions to accelerate prevention and response to GBV while creating special mechanisms to ensure timely and speedy prosecution of perpetrators.

4) Take measures to strengthen equitable access to quality education and skills development as an important tool to reduce women's and girls' vulnerabilities and end GBV.

4) Integrate women's economic empowerment and gender equality in the employment and social protection systems.

5) Strengthen and reinforce GBV data availability for better targeting of interventions.

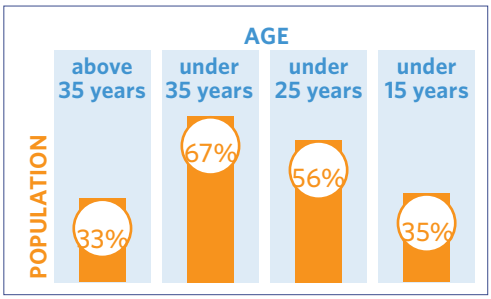
1. COUNTRY CONTEXT

1.1 Demography

Namibia is an upper-middle-income country bordered by South Africa, Botswana and Angola. The economy has grown substantially since Namibia's independence in 1990, with an average annual growth rate of 3.16 per cent between 1990 and 2021.[1] This economic growth has made higher living standards possible for many, but a larger segment of the population remains vulnerable. The country has enjoyed political stability and sound economic management since independence, yet poverty and inequality levels are among the highest in the world. The persistent income inequality (Gini coefficient of 0.646)[2] and high unemployment rate (33.4 per cent) suggest that the economic growth has not led to job creation as expected. Extreme socioeconomic inequalities inherited from the apartheid government persist despite continuous public expenditure on social programmes by post-apartheid administrations.

Namibia has a population of about 2.5 million people, which is projected to reach 3.0 million in 2031 (NHS, 2019). The current population growth rate is estimated at about 1.9 per cent but is expected to decline to 1.7 per cent by 2030. The female population is approximately 1.29 million (about 52 per cent), while the male population is about 1.21 million[3] (about 48 per cent). Overall life expectancy at birth is at 63.4 years, 66.2 years for females and 60.4 for males.[4] There has been a significant decline in fertility rate from 4.5 children per woman in 1996 to 3.32 in 2019. However, the high level of teenage pregnancy is a concern. The country has a young population, with over 35 per cent under the age of 15. Over 56 per cent is under the age of 25, and about two-thirds are below the age of 35. The national teenage pregnancy rate stands at 19 per cent, suggesting that about one in five adolescent girls aged 15 to 19 years has begun childbearing.[5]

Namibia has a YOUTHFUL POPULATION of 52% female and 48% male, with over 56% UNDER THE AGE OF 25. THE HIGH LEVEL OF TEENAGE PREGNANCY (19%), i.e., 1 out of 5 women aged 15-19 has begun childbearing, POSES A SERIOUS CONCERN.



[1] https://www.google.com/search?q=economic+growth+in+Namibia+1990+to+2021&sxsrf=ALeKk03EmsNG-Hj_IwX-JpEn_2yME2YfR_A%3A1629381153036

[2] Human Development Report 2020 The Next Frontier: Human Development and the Anthropocene, briefing note for countries on the 2020 Human Development Report. NAM.pdf (undp.org)

[3] https://www.statista.com/statistics/967893/total-population-of-namibia-by-gender/

[4] https://countryeconomy.com/demography/life-expectancy/namibia

[5] https://namibia.unfpa.org/en/news/teenage-mother-tells-her-story-5#:~:text=Namibia%20has%20a%20young%20population,similar%20situations%20as%20%2F%2FGar

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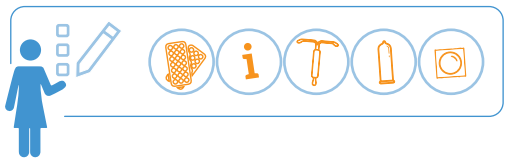
Namibia is among the least densely populated countries in the world. The population density is estimated at about three persons per square kilometre and is projected to increase to four persons per square kilometre in 2030 if the current rate of population growth persists.[6] Namibia has an urban growth rate of 4.96 per cent per annum compared to the 3.3 per cent average urbanization rate for Africa. Over 55 per cent of the population is in urban areas, which is projected to reach 60 per cent by 2030 (National Planning Commission, 2015). The urban population growth is primarily attributed to rural-urban migration and the natural population increase. Consequently, there has been an increase in informal settlements in urban areas.

The dependency ratio in Namibia is still high at 68 per cent, despite a decline from 77 per cent in 2011.[7] The high dependency ratio reduces the ability of families and Government to invest in human capital development and reduces household savings and investments, thereby hindering overall economic growth and development. Effective family planning has been shown to be important in reducing poverty, income inequality, gender inequality, and maternal and child mortality while improving women's productivity (Cleland *et al.*, 2006; Prata *et al.*, 2017). Promoting voluntary family planning lowers the number of unintended pregnancies, unsafe abortions, maternal deaths and child births. In Namibia, contraceptive prevalence rate in 2020 was approximately

[6] https://www.worldometers.info/world-population/namibia-population/#:~:text=Namibia%202020%20population%20is%20estimated,of%20the%20total%20world%20population.

[7] https://data.worldbank.org/indicator/SP.POP.DPND?locations=NA



FAMILY PLANNING PROGRAMMES ARE ESPECIALLY IMPORTANT AMONG TEENAGERS who are less likely to use contraceptive methods than adult women (25% vs 59%).

61 per cent for married or in-union women and 52 per cent for all women aged 15-49 years.[8] The rate of unmet need for family planning is 10 per cent for all women and 15 per cent for married and in-union women aged 15-49 years.

Gender-based violence (GBV) remains a persistent challenge in Namibia, with increasing incidence of intimate partner violence (IPV), sexual violence, and femicide against women and girls recorded annually. Between September 2019 and September 2020, Namibia recorded over 5,000 cases of GBV, 800 cases of rape and 74 femicides countrywide.[9] It is important to note that GBV is always underreported. A 2020 UNFPA GBV brief for Namibia[10] showed that over 15 per cent of GBV survivors do not seek support services. GBV poses significant costs to well-being, gender equality and inclusive sustainable development. A 2016 World Bank report indicated that "the annual cost of GBV against women to the global economy is estimated to be US$12 trillion".[11]

1.2 Unmet need for family planning

Globally, sexual and reproductive health and rights (SRHR) are essential for sustainable development, and significantly impact maternal, newborn, child and adolescent health (Starrs *et al.*, 2018). Contraceptive prevalence rate in Namibia has increased rapidly over the years, from 23 per cent in 1992 to approximately 61 per cent in 2020 (NDHS, 2013).[12] The national CPR target is expected to be 80 per cent by 2030. Modern contraceptive prevalence rate (mCPR) has also risen rapidly from 21 per cent in 1992 to 58 per cent in 2020 (Figure 1.1). These estimates were obtained from the Namibia Demographic and Health Survey (NDHS 1992/2013) data and from United Nations projections on family planning indicators.[13] The estimates indicate the need to further increase investment in family planning programmes over time and implement prioritized interventions with high returns on investment to meet the national targets for SRHR.

The 2013 NDHS data indicate that there were considerable differences in CPR by age, with teenage girls less likely to use contraception than women aged between 25 and 39 (25 per cent and 59 per cent, respectively). Namibia has one of the highest rates of teenage pregnancy in the Eastern and Southern Africa region at 19 per cent. The rate is more than three times higher among those in the lowest income quintile compared to those in the highest quintile (NDHS, 2013).

There were also considerable differences in CPR and mCPR among other population sub-groups. For example, rural women, those with no formal education and those from poor households had lower contraceptive use in Namibia.

[8] https://www.unfpa.org/data/world-population/NA

[9] https://namibia.fes.de/e/no-more-gender-based-violence-and-learner-pregnancies-in-namibia#:~:text=Between%20the%20period%20of%20September,rape%20and%2074%20femicides%20countrywide

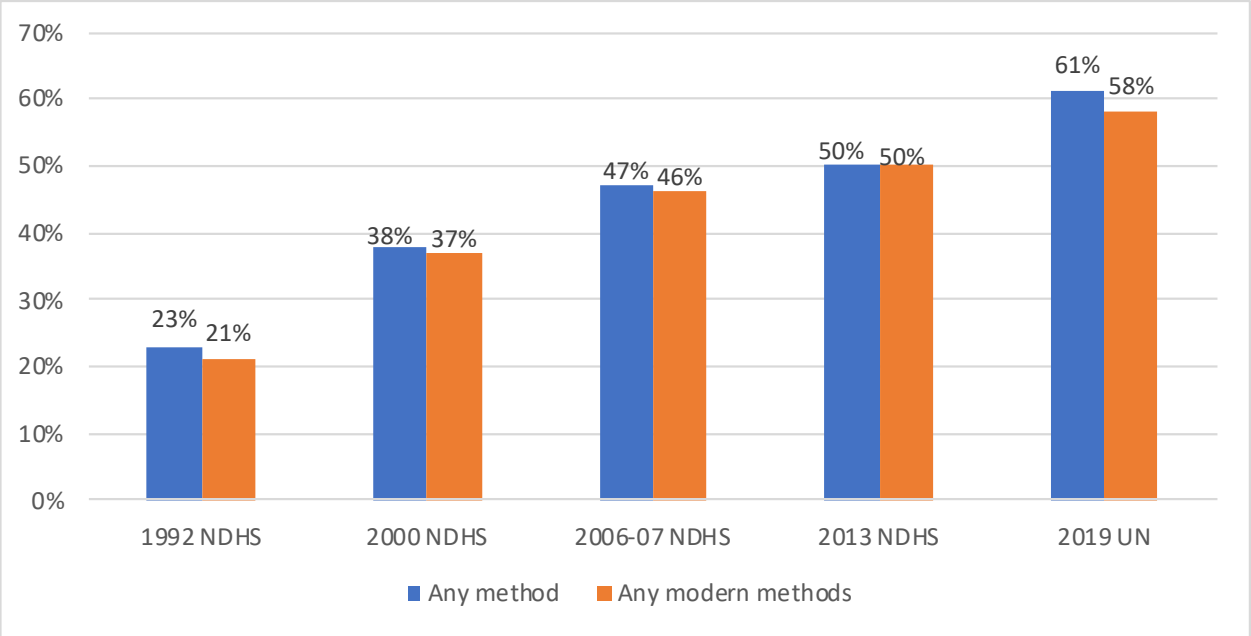
[10] https://namibia.unfpa.org/sites/default/files/pub-pdf/gbv-fact_sheet_november_2020.pdf

[11] World Bank (2018). Counting the Cost: The Price Society Pays for Violence Against Women.

[12] https://www.unfpa.org/data/world-population/NA

[13] CPR and unmet need projections come from United Nations, Department of Economic and Social Affairs, Population Division (2019). Estimates and Projections of Family Planning Indicators 2019. New York: United Nations.

Figure 1.1: Trends in contraceptive use among all women aged 15-49 years in Namibia



Sources: NDHS, 2013 and estimates and projections of Family Planning indicators 2020

The majority of modern contraceptive users (73 per cent) obtained contraceptives from a public health facility (NDHS, 2013). This indicates that the Government plays a crucial role in ensuring access to and use of modern contraceptives in Namibia. Family planning services are available in all public health facilities across the country. However, there are limitations on the method mix due to supply-related challenges.[14] While the Government's commitment to promoting family planning programmes is significant, actions need to be accelerated to ensure universal access to quality contraception, especially addressing inequality in access to contraception.

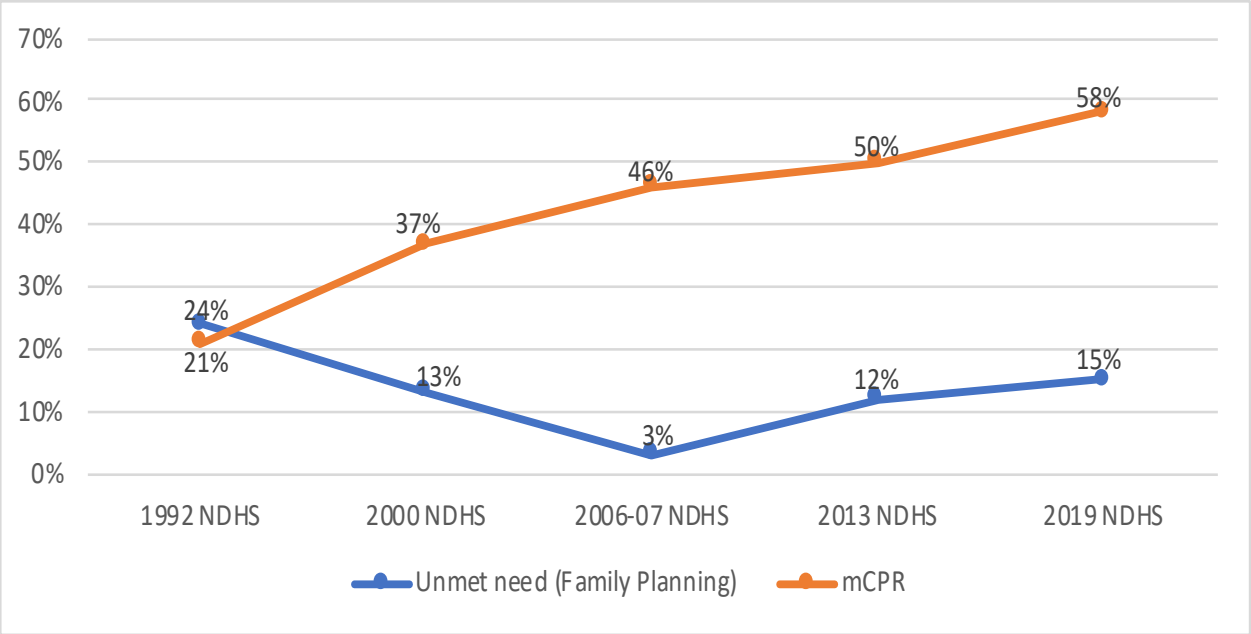
Promoting family planning and ensuring equitable access to preferred contraceptive methods for women and couples is essential in improving maternal health and child survival, reducing the number of unsafe abortions, preventing sexually transmitted infections, including HIV, empowering women, advancing gender equality and promoting inclusive social and economic development.

However, substantial gaps exist in the use of modern contraceptive methods among individuals and couples. The proportion of married or in-union women with unmet need for family planning (i.e., those who want to delay or stop childbearing, but are not using any contraceptive method) has fallen from 24 per cent in 1992 to about 15 per cent in 2020 (NDHS, 2013; UNFPA, 2019).[15] Figure 1.2 shows the trend in the use of modern contraceptive use and unmet need for family planning in Namibia.

Modern CPR has been consistently on the rise since 1992 and unmet need for family planning was declining up to 2006/2007. However, unmet need for family planning rose again from 3 per cent in 2006 to 12 per cent in 2013 and to 15 per cent in 2019, albeit still lower than 24 per cent in 1992. This trend suggests the need to sustain the level of increase in mCPR in population groups that need family planning interventions and also to determine factors that affect delivery of interventions.

[14] https://www.afro.who.int/sites/default/files/2019-12/CCS%20Namibia%20-%2007%20August%202019.pdf
[15] https://www.unfpa.org/data/world-population/NA

Figure 1.2: Trends in the use of modern contraceptives and unmet family planning need

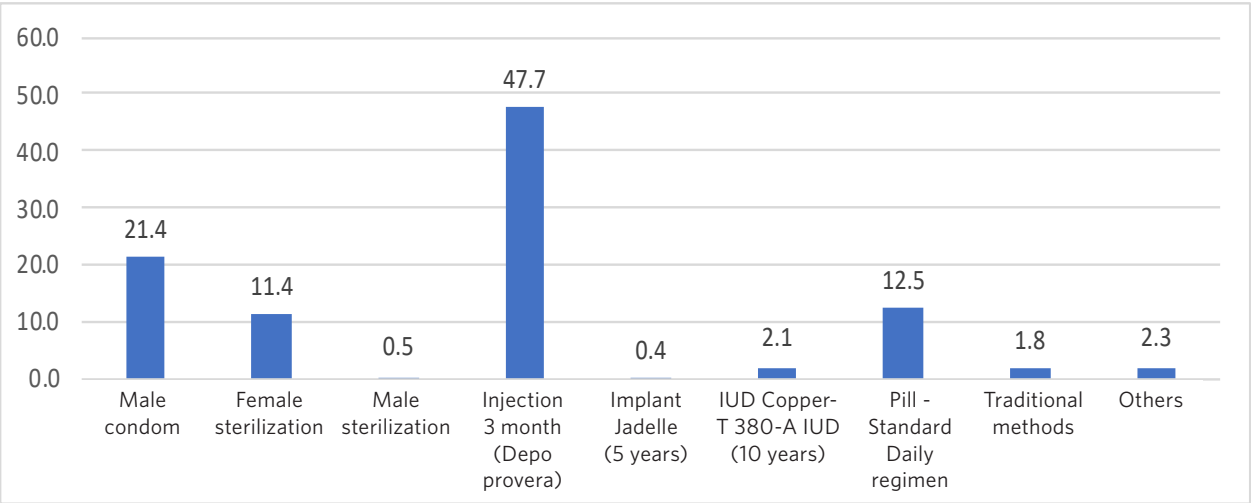


Sources: NDHS (1992, 2000, 2006/7 and 2013) and United Nations estimates and projections of family planning indicators 2019

1.2.1 Contraceptive method mix in Namibia

Figure 1.3 shows the contraceptive method mix among women aged 15-49 years in Namibia. The modern contraceptive method mix accounts for 96 per cent of all contraceptive method mix in Namibia. The most used modern method is injectables (48 per cent), followed by male condom (21 per cent), pills (13 per cent) and female sterilization (11 per cent). Only 1.8 per cent of women reported using traditional methods (withdrawal 0.5 per cent; periodic abstinence 0.4 per cent and 0.9 per cent for other traditional methods).

Figure 1.3: Contraceptive method mix in Namibia (%), 2019



Source: CPR and unmet need projections come from United Nations, Department of Economic and Social Affairs, Population Division (2019). Estimates and Projections of Family Planning Indicators 2019. New York: United Nations.

It is important to emphasize that stock-outs of family planning commodities have been of great concern prior to and during the COVID-19 pandemic. The COVID-19 lockdown restrictions disrupted many health services, and it was estimated that globally, in 2020, 47 million women in 114 low- and middle-income countries may not have been able to access modern contraceptives due to movement (lockdown) restrictions that persisted for up to six months, and could have resulted in over 7 million unintended pregnancies.[16] It was further estimated that if the lockdown continued, an additional two million women may be unable to use modern contraceptives for every three months in lockdown. In Namibia, it was estimated that without any effort to mitigate disruption of services, between 23,400 and 92,900 women would be unable to access modern contraception and that would result in 585 to 27,900 unintended pregnancies.[17] This is critical considering the need to strengthen systems and community resilience ahead of future global health emergencies and any shocks and disruptions that the country may experience.

1.3 Gender-based violence

Gender-based violence (GBV) or violence against women and girls (VAWG), is a global pandemic, with one in every three women being a victim of GBV in their lifetime. That is, 35 per cent of women worldwide have experienced or are likely to experience either physical and/or sexual intimate partner violence or non-partner sexual violence. Over 7 per cent of women have been assaulted sexually by someone other than a partner and as many as 38 per cent of murders of women are committed by an intimate partner.

Gender-based violence is devastating to the survivors of violence and their families and imposes significant social and economic costs. Moreover, evidence suggests that children exposed to violence are more likely to become perpetrators in the future. As such, failure to address issues related to GBV poses significant consequences and costs to future generations.

Apart from health implications, GBV has cost implications for the economy and for individuals. These include direct costs of health-care services, judicial services and social services, as well as expenditures related to GBV prevention and response. Indirect costs include the value of lost productivity from both paid and unpaid work, as well as the foregone value of lifetime earnings, public and private sector revenues, and taxes paid by women who lose their lives as a result of GBV. In some countries, the estimated cost associated with GBV is 3.7 per cent of Gross Domestic Product (GDP), which is more than double the amount most governments allocate to sectors like education.[18] According to the 2016 World Bank report, the annual cost of GBV against women to the global economy is estimated to be US$12 trillion.[19]

With the COVID-19 pandemic, cases of domestic violence have been rising significantly across the globe, particularly following lockdown measures instituted by governments to contain the spread of the virus. Before the pandemic (a year prior to April 2020), 243 million women and girls worldwide were reported to have experienced physical and/or sexual violence by an intimate partner.[20] It was estimated that an additional 15 million cases of GBV will be reported for every three months of lockdown during the pandemic.[21] The UN Women's[22] report shows that some countries around the

[16] UNFPA projections predict calamitous impact on women's health as COVID-19 pandemic continues https://www.unfpa.org/press/new-unfpa-projections-predict-calamitous-impact-womens-health-covid-19-pandemic-continues

[17] Maintaining Access to Contraceptives During COVID-19 Disruptions. Potential impacts and mitigation in Namibia. https://www.rhsupplies.org/activities-resources/tools/micro/

[18] https://assets.kpmg/content/dam/kpmg/za/pdf/2017/01/za-Too-costly-to-ignore.pdf

[19] World Bank (2018). Counting the Cost: The Price Society Pays for Violence Against Women.

[20] https://data.unwomen.org/sites/default/files/documents/COVID19/Infographic_VAW-COVID19.pdf

[21] UNFPA,27 April 2020, https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_impact_brief_for_UNFPA_24_April_2020_1.pdf (accessed on 27 January 2021).

[22] United Nations Entity for Gender Equality and the Empowerment of Women.

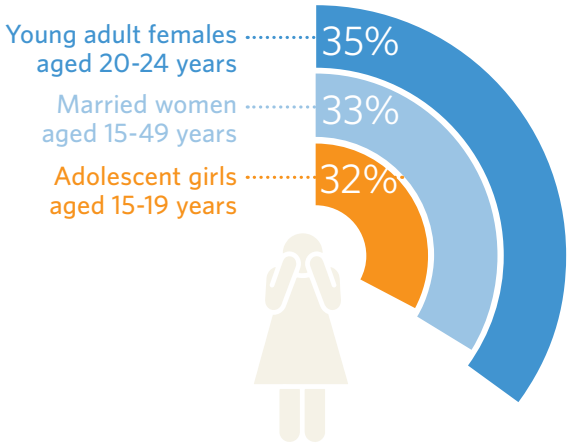
world, particularly those highly affected by COVID-19, have registered up to 30 per cent increase in reported domestic violence cases and around 33 per cent increase in GBV, with most victims being women and girls.[23] As countries implement measures to contain the spread of the virus across several waves of the COVID-19 pandemic, it is important to ensure inclusion of GBV prevention and response in national response and recovery plans.

1.3.1 Gender-based violence in Namibia

Sexual and gender-based violence (SGBV) remains a persistent challenge in Namibia, with the rising incidence of intimate partner violence (IPV), sexual violence, and femicide of women and girls. Between September 2019 and September 2020, the Namibian Police recorded over 5,000 cases of GBV, 800 cases of rape and 74 femicides countrywide.[24] The Namibia Demographic Health Survey (2013) indicates that 33 per cent of never-married women aged 15-49 have experienced physical, sexual, and/or emotional violence from their partner. About 32 per cent of adolescent girls aged 15-19 and 35 per cent of young adult females aged 20-24 have experienced physical violence from a partner. The Namibian Police identified five top forms of violence reported in the country in 2012-2016 based on cases reported: 22,174 were assault with grievous bodily harm; 18,054 were common assault; 2,839 were rape; 1,138 were attempted murder; and 734 were murder.[25] It should be noted that GBV cases are always underreported as many do not seek support services. In a UNFPA GBV brief for Namibia in 2020,[26] over 15 per cent of GBV survivors do not seek support services. The report also suggests that over 1,000 people are victims of rape each year, over 90 per cent of whom are women.

There is currently limited data in Namibia to quantify the cost of GBV to human development and economic performance of the country such as on the direct costs of prevention, treatment and support for survivors, and prosecution of perpetrators, as well as indirect and intangible costs such as days of work lost by the victim, the emotional cost in human pain and suffering by the victims, and negative impact on family members, especially children, to mention a few. The investment case took into consideration the hidden nature of GBV in society, and therefore, the difficulty of estimating the real prevalence of GBV, its costs, and resulting economic impact. The availability of data would help to raise awareness of the urgency of taking concrete action to prevent GBV and to provide survivors with comprehensive high-quality response services, including referral services of law enforcement, and recourse to justice.

WOMEN who have EXPERIENCED PHYSICAL, SEXUAL, and/or EMOTIONAL VIOLENCE FROM THEIR PARTNER include:



(**Source**: Namibia Demographic Health Survey, 2013)

[23] https://www.sadc.int/files/8115/8755/0975/Statement_by_SADC_Executive_Secretary_on_COVID-19_and_Gender-Based_Violence-ENGLISH.pdf

[24] https://namibia.fes.de/e/no-more-gender-based-violence-and-learner-pregnancies-in-namibia#:~:text=Between%20the%20period%20of%20September,rape%20and%2074%20femicides%20countrywide.

[25] https://namibia.unfpa.org/en/topics/gender-based-violence 3#:~:text=The%20Namibia%20Demographic%20Health%20Survey,emotional%20violence%20from%20their%20

[26] https://namibia.unfpa.org/sites/default/files/pub-pdf/gbv-fact_sheet_november_2020.pdf

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1.4 Making a case for investing in transformative results

Closing the gaps in equitable access to quality family planning, and GBV prevention and response in Namibia will be pursued to enable achievement of Targets 3.7 and 5.6 of the Sustainable Development Goals (SDGs). The investment cases are aimed at accelerating towards two transformative results:

- Ending unmet need for family planning
- Ending gender-based violence (GBV)

The development of the family planning and GBV investment cases present an opportunity to focus on the unfinished business of the International Conference on Population and Development (ICPD) Agenda in Namibia. They define the scale and scope of investments needed to prioritize high-impact and cost-effective interventions to accelerate progress towards achievement of these transformative results, which are also in line with national aspirations reflected in the country's development framework(s), especially the 5th National Development Plan (NDP5). The investment cases are expected to inform strategic partnership efforts with UNFPA and other partners and the mobilization of additional domestic and external financing to support the achievement of the transformative results. Given the continuously evolving sustainable financing landscape, situating country-level investments within the development, humanitarian and peace nexus is critical, considering the increased occurrences of public health emergencies such as the COVID-19 pandemic, climate change risks and vulnerabilities, among others.

1.4.1 Why invest in family planning in Namibia?

As highlighted in earlier sections, Starrs *et al.*, (2018) show that investing in family planning results in improvements in health and well-being, significantly improves prospects towards achieving gender equality, increases productivity, reduces poverty; and generates other multigenerational benefits for children and households. The benefits also include increases in young women's years of education and earnings, household savings and assets, and children's years of schooling, which consequently increase productivity gains for GDP growth and reduction in inequalities. Thus, the immediate health and economic benefits are well worth the cost of investments, and the payoffs are even greater when considering the broader, long-term benefits for women, families, and society.

Evidence from Kohler and Behrman (2014) suggests significant return on investments with every US$1 invested in family planning programmes aimed at eliminating unmet need for modern contraception, yielding US$120 in savings in public health care and economic opportunity costs in the long term. Starbird *et al.*, (2016) also found that additional investments in family planning services would save developing countries an aggregate of over US$11 billion each year in maternal and newborn health care costs. Among all the 169 SDG targets, universal access to contraception has been cited as having the second highest return on investment.[27] Unfortunately, investments and spending on family planning activities remain low in many African countries, including Namibia. Developing sustainable financing mechanisms, resource mobilization strategies, and efficient management of available resources are imperatives to achieving improved access to and use of modern contraceptives and for reducing unmet need for family planning.

1.4.2 Why invest in gender-based violence prevention and response?

Ending GBV supports the realization of basic human rights and enables full participation of women, men, girls, and youth in social, economic, civil, and political life in society. Investing in GBV prevention reduces associated unintended pregnancies, deaths, and diseases, such as STIs and HIV. It has also been shown that preventing child abuse, intimate partner violence (IPV), and sexual violence has a range of other health benefits, including a reduction in depression, smoking, alcohol and drug abuse, and the risk of involvement in violence as a victim or perpetrator. The World Health Organization (WHO) estimates that childhood sexual abuse accounts for 27 per cent of post-traumatic stress disorders, 10 per cent of panic disorders, 8 per cent of suicide attempts, and 6 per cent of cases of depression, suicide, and sexually transmitted infections (WHO, 2008). A study by the United Nations Office on Drugs and Crime and the World Bank suggests that investing in GBV prevention can accelerate overall economic development.[28] Preventing GBV can lead to increased revenues due to productivity gains contributed by a healthy and protected population and through savings from reduction in the direct and indirect costs of GBV.[29]

1.5 Developing the investment cases: methodology

The development of the investment cases for Namibia involved an extensive consultative and active engagement process, with input from a

[27] United Nations Office on Drugs and Crime and the World Bank. (2007). Crime, violence, and development: Trends, costs, and policy options in the Caribbean. Washington/Vienna: United Nations Office on Drugs and Crime and the Latin America and the Caribbean Region of the World Bank.

[28] United Nations Office on Drugs and Crime and the World Bank. (2007). Crime, violence, and development: Trends, costs, and policy options in the Caribbean. Washington/Vienna: United Nations Office on Drugs and Crime and the Latin America and the Caribbean Region of the World Bank.

[29] https://assets.kpmg/content/dam/kpmg/za/pdf/2017/01/za-Too-costly-to-ignore.pdf

core National Reference Group (NRG) and guidance from representatives of UNFPA in Namibia and its Eastern and Southern Africa Regional Office (ESARO). Desk reviews were conducted by the study team to extract data from relevant documents including on laws, policies and strategic plans, and research publications, as well as national and international commitments. The impact and cost estimates for each of the transformative results under varied scenarios are presented in the following chapters.

1.5.1 Limitations

While the investment cases should have used recent baseline data for coverage of interventions and prevalence of key indicators, some of the baseline and national targets by 2030 were not readily available. Data on projected funding drawn from expenditure data at the country level was also not readily available. The data limitations hindered estimation of the financing gap and should be an area for further elaboration and research. National survey data such as from the NDHS and other periodic sources of official statistics do not include data for most of the interventions. As indicated in the various sections, several assumptions were used to populate the data. In addition, the COVID-19 outbreak limited face-to-face meetings and possible field visits to collect relevant additional data. All meetings were conducted online to avoid the risks related to the spread of the virus.

There were also a number of challenges with the modelling tools used. One significant drawback of the FamPlan tool is that it does not generate comprehensive health system costs. The online Impact40 is the only tool that could be used for GBV for the study and was limited to estimating intimate partner violence (IPV). Since countries differ in the type of GBV intervention policies in place, the software needs to be flexible to accommodate country-specific interventions and baseline information.

Many countries like Namibia have been successful in the implementation of comprehensive GBV interventions, yet there are no readily available data to monitor and measure effectiveness of the interventions to guide scaling up efforts. Most of the available GBV data are dated between 2013 and 2017. With the baseline set at 2020, setting assumptions was a challenge. However, such limitations do not undermine the estimates presented in this study. This is because the assumptions around the baseline and targets for 2030 are for the minimum level of impact and cost for each investment case.

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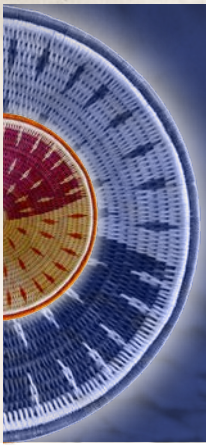


2. ENDING UNMET NEED FOR FAMILY PLANNING

2.1 Introduction

Between 2010 and 2014, unintended pregnancy accounted for 44 per cent of all pregnancies worldwide, with 62 unintended pregnancies occurring for every 1,000 women aged 15-44 years (Bearak *et al.*, 2018). The disparity between high-income countries (45 per 1,000 women), compared to low- and middle-income countries (65 per 1,000 women) is notable. A significant proportion of these pregnancies results in abortion and other adverse pregnancy outcomes (Bearak *et al.*, 2018).

On average, 73.3 million safe and unsafe abortions occur worldwide each year, with 39 abortions per 1,000 women of reproductive age between 15-49 years (Bearak *et al.*, 2020). In addition, approximately 3 out of every 10 (29 per cent) of all pregnancies, and about 6 out of every 10 (61 per cent) unintended pregnancies end in an abortion (Bearak *et al.*, 2020). Ganatra *et al.*, (2007) suggested that 1 out of every 3 abortions is carried out in an unsafe or dangerous condition and 3 out of every 4 abortions in Africa are unsafe. About seven million women are hospitalized each year in developing countries, because of unsafe abortion (Singh and Maddow-Zimet, 2012). A report by Vlassoff *et al.* (2008) showed that it costs the world US$553 million to treat unsafe abortion-related complications each year. Unsafe abortion accounts for 4.7 per cent to 13.2 per cent of maternal deaths each year (Say *et al.*, 2014).

In Namibia, it is difficult to determine the scale of unsafe abortions, the associated consequences on maternal health outcomes and costs to the health system on individuals, and to society because it is criminalized. However, available data suggest that unsafe abortions may have reached as many as 7,000 in 2017,[30] accounting for about 12 per cent to 16 per cent of maternal deaths (Tibinyane 2003; MHSS 2014), higher than the above-quoted average.

This chapter presents estimates of the impact and costs of selected proven interventions aimed at ending unmet need for family planning.

2.2 Methodology

This analysis compares the estimated investment and potential benefits at the national level in a baseline or "status quo" scenario, and two alternative scenarios for reducing unmet need for family planning in Namibia between 2020 and 2030 — one based on the SDG target, and the other based on national target. The Impact40 online toolkit was used to estimate the number of unintended pregnancies averted, maternal deaths averted, and unsafe abortions averted. However, this does not represent the complete impact of the family planning programme as the analysis did not estimate the direct social and economic benefits and the indirect costs saved from possible productivity loss as these were outside the scope of work.

[30] Unsafe abortions reach 7,000 mark - The Namibian.

The FamPlan tool in the Spectrum software (Avenir Health) was used to calculate users, annual CPR, mCPR, fertility rate, unmet need for family planning and the cost of investing in family planning. The Lives Saved Tool (LiST) was used to estimate the intervention costs. The investment costs cover drugs and supply, other recurrent costs, capital, and labour.

2.2.1 Baseline data and analysis

The estimates relied on country level baseline data from the FamPlan module in the Spectrum tool. Where national level data were available, these were compared with the pre-set baseline data in the tool, and where variances were found, the most recent data were used. These included national data on fertility rate, contraceptive prevalence and unmet need for family planning.

2.2.2 Assumptions under the different scenarios

To obtain the 2030 estimates for unmet need for family planning, fertility rate, and modern contraceptive prevalence rate, several assumptions were made across different scenarios. The first is the status quo scenario (business as usual) which maintained the current contraceptive prevalence rate. Two additional scenarios were based on: i) SDG targets 3.7 and 5.6 for all countries around the world; and ii) the national target set for 2030.

Scenario 1: Status quo

In the first scenario, the current contraceptive prevalence rate (CPR) of 60.6 per cent or approximately 61 per cent (with mCPR at 58.1 per cent) is maintained. The total fertility rate at baseline is 3.32 children per woman and unmet need is 15.2 per cent.[31] The assumption is that the current CPR will remain unchanged into the future without any changes in policy and programme interventions.

Scenario 2: Projection based on SDG target

In the second scenario, the CPR target for 2030 is set at 75 per cent. This is based on the SDG target urging all countries to achieve a CPR of 75 per cent by 2030. This requires acceleration of policy and programme interventions aimed at increasing the current rate of contraceptive prevalence rate from 60.6 per cent to 75 per cent (and mCPR of 58.1 per cent to 71.9 per cent) by 2030.

Scenario 3: Projection based on national target

In the third scenario, CPR is set at 80 per cent (with mCPR of 76.7 per cent) for 2030 based on the national target.[32] This requires further acceleration of policy and programme interventions to increase the current CPR.

2.3 Policy targets: contraceptive prevalence rates, fertility rate and unmet need for family planning

Based on the above scenarios, the share of the population using modern contraceptives was determined to increase significantly between 2020 and 2030 (Table 2.1). In particular, the mCPR increases from about 58 per cent in the first scenario to 72 per cent in the second scenario and to 77 per cent in the third scenario. The results also suggest an increasing prevalence rate of traditional contraceptives but far less than the increase in mCPR (Table 2.1 and Figure 2.2).

The results in Table 2.1 show that investing in family planning reduces total fertility rate and unmet need for family planning between 2020 and 2030. The objective of the Government of Namibia is to reduce total fertility rate to 2.0 children per woman by 2030.[33] The results in Table 2.1 suggest that with the current CPR, total fertility rate will be 3.32 in 2030. Total

[31] The CPR value of 60.6% in 2020, fertility rate of 3.32 and unmet need of 15.2% are obtained from United Nations, Department of Economic and Social Affairs, Population Division (2019). Estimates and Projections of Family Planning Indicators 2019. New York: United Nations.

[32] https://www.namfisa.com.na/wp-content/uploads/2017/10/Vision-2030.pdf

[33] https://www.namfisa.com.na/wp-content/uploads/2017/10/Vision-2030.pdf

fertility rate will reduce to 2.0 by 2030 if the CPR is increased to 75 per cent (scenario 2) and to 1.5 if the CPR is increased to 80 per cent (scenario 3). Hence, achieving the total fertility target of 2.0 by 2030 hinges on the Government's ability to increase the CPR to at least 75 per cent by 2030. Unmet need for family planning will decline from 15.2 per cent to 7.5 per cent if the CPR is increased to 75 per cent (scenario 2) and to 5.1 per cent if the CPR is increased to 80 per cent (scenario 3) by 2030. (See Table 2.1 and Figures 2.1-2.4).

Table 2.1: Policy targets: contraceptive prevalence rates, fertility rate and unmet need for family planning

	STATUS QUO		SCENARIO 2		SCENARIO 3	
Policy targets	**2020**	**2030**	**2025**	**2030**	**2025**	**2030**
Contraceptive prevalence rate (CPR)(%)	60.6	60.6	67.8	75.0	70.3	80.0
Modern contraceptive prevalence rate (mCPR)(%)	58.1	58.1	65.0	71.9	67.4	76.7
Fertility rate (children per woman)	3.32	3.32	2.63	1.9	2.39	1.5
Unmet need for family planning (%)	15.2	15.2	11.3	7.5	9.9	5.1

Note: Unmet need for family planning was set at 15.2% and CPR at 60.6% in 2020. These are data obtained from United Nations, Department of Economic and Social Affairs, Population Division (2019). Estimates and Projections of Family Planning Indicators 2019. New York: United Nations. Fertility rate set at 3.32 in 2020 are obtained from https://www.macrotrends.net/countries/NAM/namibia/fertility-rate

Figure 2.1: Trends in contraceptive prevalence rate under different scenarios, 2020-2030

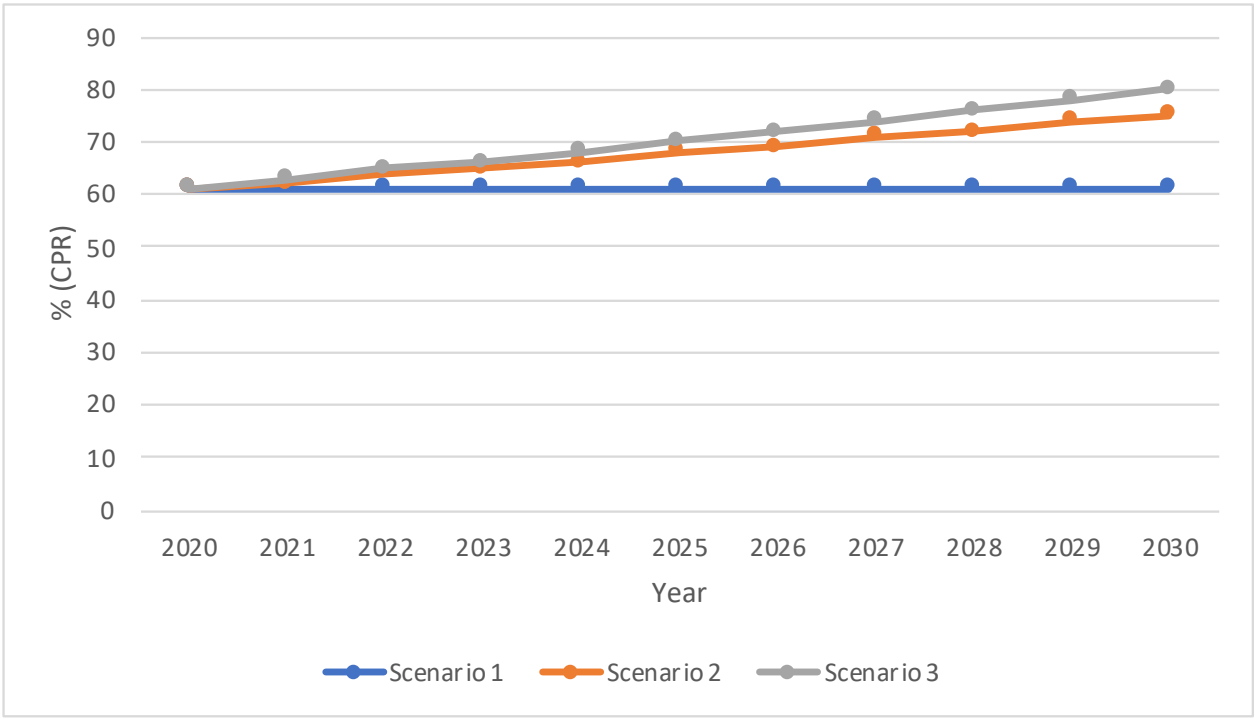


Figure 2.2: Trends in modern contraceptive prevalence rate under different scenarios, 2020-2030

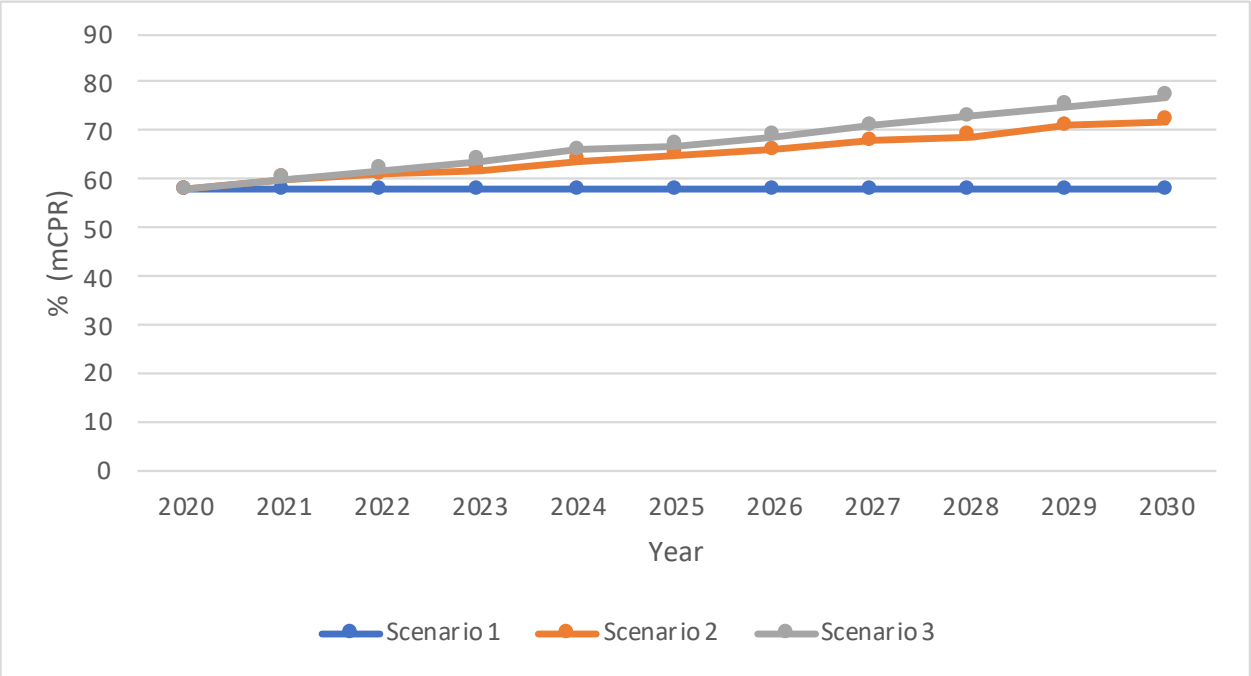


Figure 2.3: Trends in fertility rate under different scenarios, 2020-2030

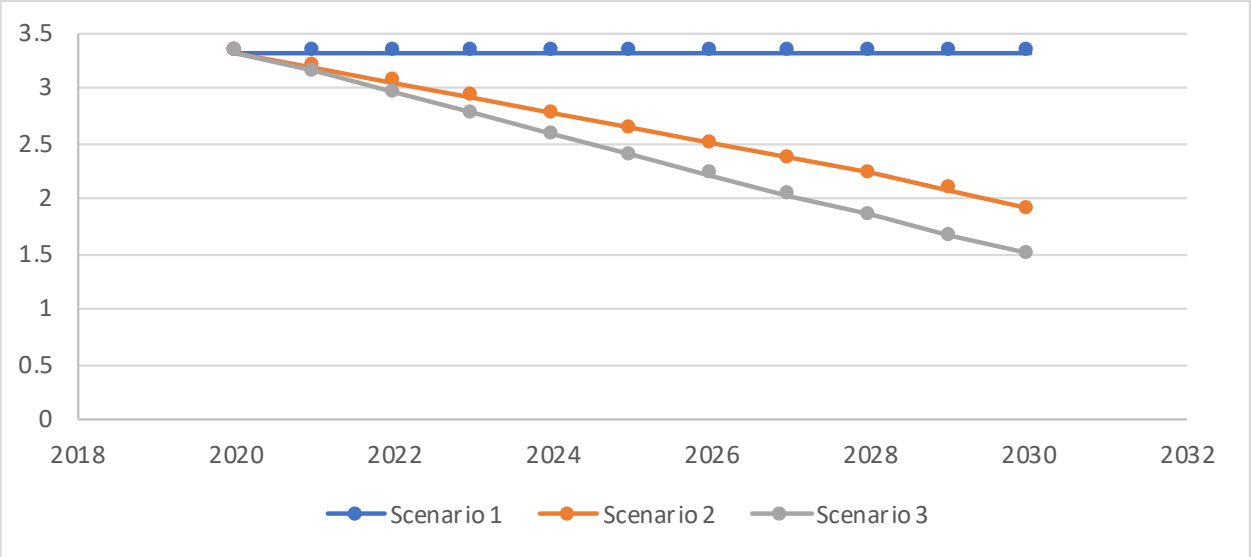
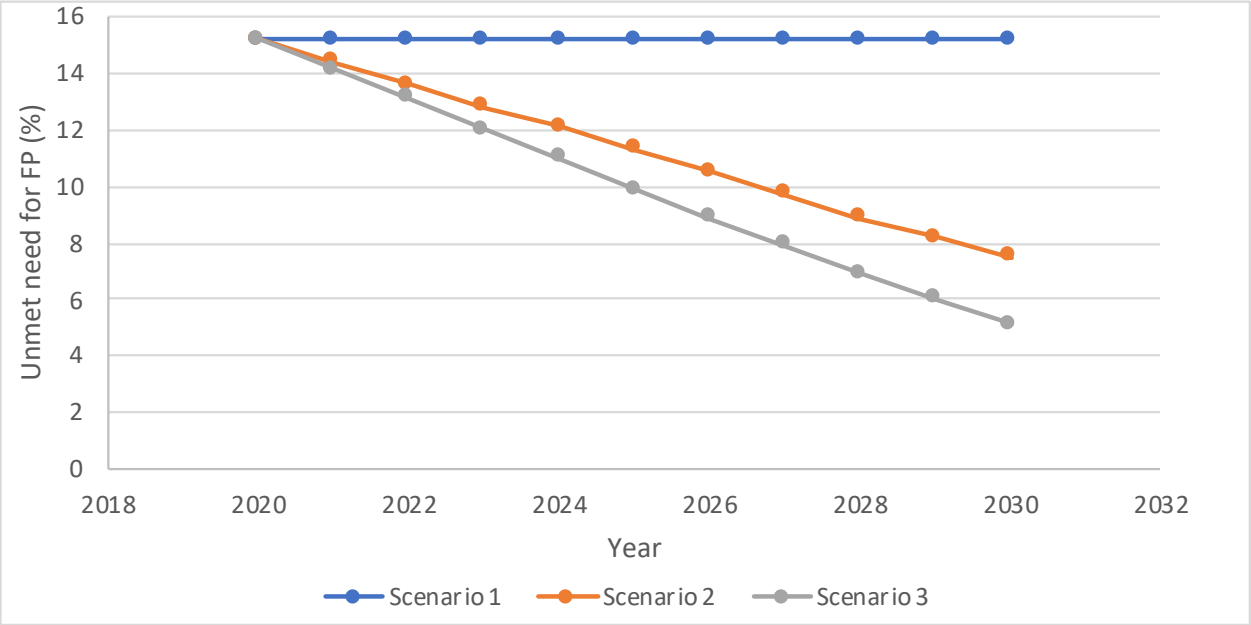


Figure 2.4: Trends in unmet need for family planning under different scenarios, 2020-2030



2.4 Impact and cost of ending unmet need for family planning

2.4.1 The impact of ending unmet need for family planning.

The proportion of modern contraception in Namibia will increase significantly between 2020 and 2030 across the scenarios. Modern contraceptive users will increase to 159,653 in the status quo scenario in 2030. The number of users will increase to 197,574 in 2030 or about 24 per cent more under scenario 2 with the SDG CPR target of 75 per cent (with 71.9 per cent mCPR). In scenario 3, with a target of 80 per cent CPR (with 76.7 per cent mCPR), there will be 210,764 users of modern contraceptives in 2030. This is 32 per cent more than the status quo scenario in 2030. (See Table A2, Appendix A).

Table 2.2: Cumulative number of users of all and modern contraceptive methods under different scenarios

	SCENARIO 1		SCENARIO 2		SCENARIO 3	
Year	**All users**	**Modern methods users**	**All users**	**Modern methods users**	**All users**	**Modern methods users**
2020	136,549	130,961	136,549	130,961	136,549	130,961
2025	858,806	825,620	910,941	874,445	929,044	891,427
2030	1,654,782	1,593,008	1,858,980	1,787,315	1,929,884	1,854,899

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2.4.2 Averting unintended pregnancies, maternal deaths and unsafe abortions

Namibia has one of the highest prevalences of unintended pregnancies in sub-Saharan Africa. One out of every two pregnancies in Namibia is unintended (54.5 per cent prevalence rate), compared to the sub-Saharan African average of 29 per cent (Ameyaw *et al.*, 2019). This is mainly due to the high rate of teenage pregnancy that stands at 19 per cent, i.e., about one out of every five women aged 15 to 19 years had begun childbearing (NDHS, 2013). Nearly half (45.1 per cent) of girls who became pregnant between the ages of 15 and 19 received little, or no education and 70 per cent of pregnancies in this age group were unintended.[34] These statistics are alarming as they contribute to unfavourable outcomes such as school drop-out, infection from sexually transmitted diseases, death from complications, and 'baby dumping' for many who cannot afford to terminate pregnancy.

Table 2.3 shows the gains from investing in family planning in Namibia in terms of reductions in the number of unintended pregnancies, maternal deaths, and unsafe abortions. In total, 619,870 unintended pregnancies will be averted between 2020 and 2030 if the current CPR of 60.6 per cent remains unchanged. This will increase to 767,135 if the CPR is raised to 75 per cent and to 818,312 if the CPR is increased to 80 per cent. In total, 1,256 maternal deaths will be averted under scenario 1, about 1,556 under scenario 2 and 1,658 under scenario 3. During the same period, the number of unsafe abortions averted will increase from 129,429 in scenario 1 to 160,179 in scenario 2 and to 170,863 in scenario 3. (See Figures 2.5 to 2.7).

54.5%
Namibia

The prevalence rate of UNINTENDED PREGNANCIES IN NAMIBIA IS ALMOST DOUBLE the average rate in the sub-Saharan Africa (SSA) region.

29%
SSA

[34] Namibia tackles early pregnancy - The Namibian.

Table 2.3: Total number of unintended pregnancies, maternal deaths and unsafe abortions averted, 2020-2030

	SCENARIO 1	SCENARIO 2	SCENARIO 3
Unintended pregnancies averted	619,870	767,135	818,312
Maternal deaths averted	1,256	1,556	1,658
Unsafe abortions averted	129,429	160,179	170,863

Figure 2.5: Trends in maternal deaths averted by investing in family planning, 2020-2030

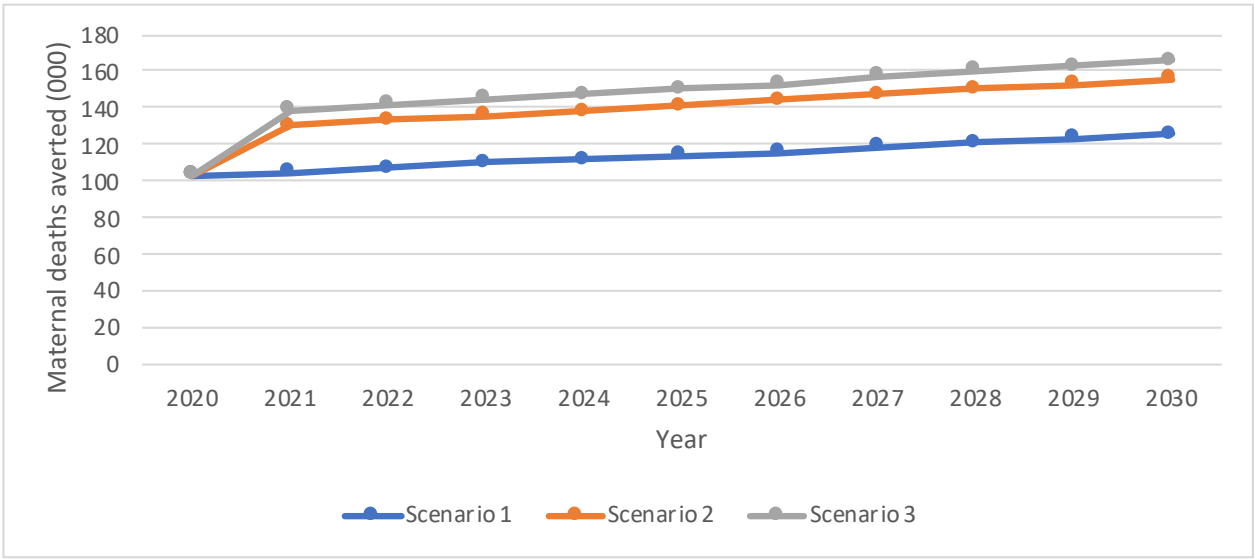
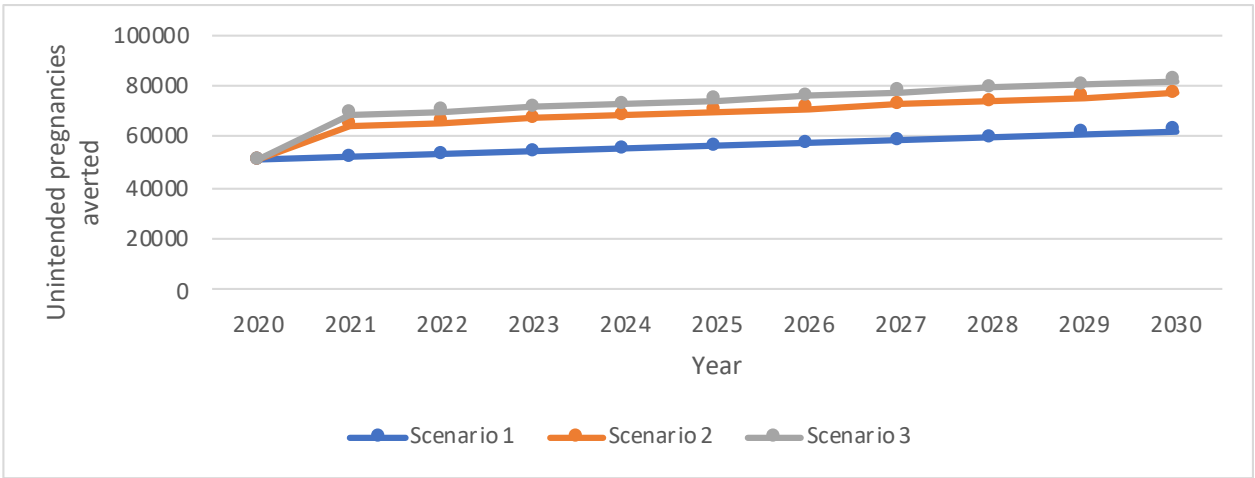
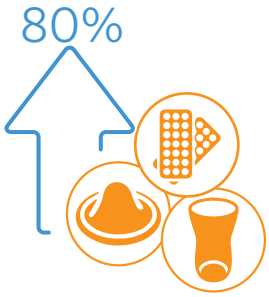


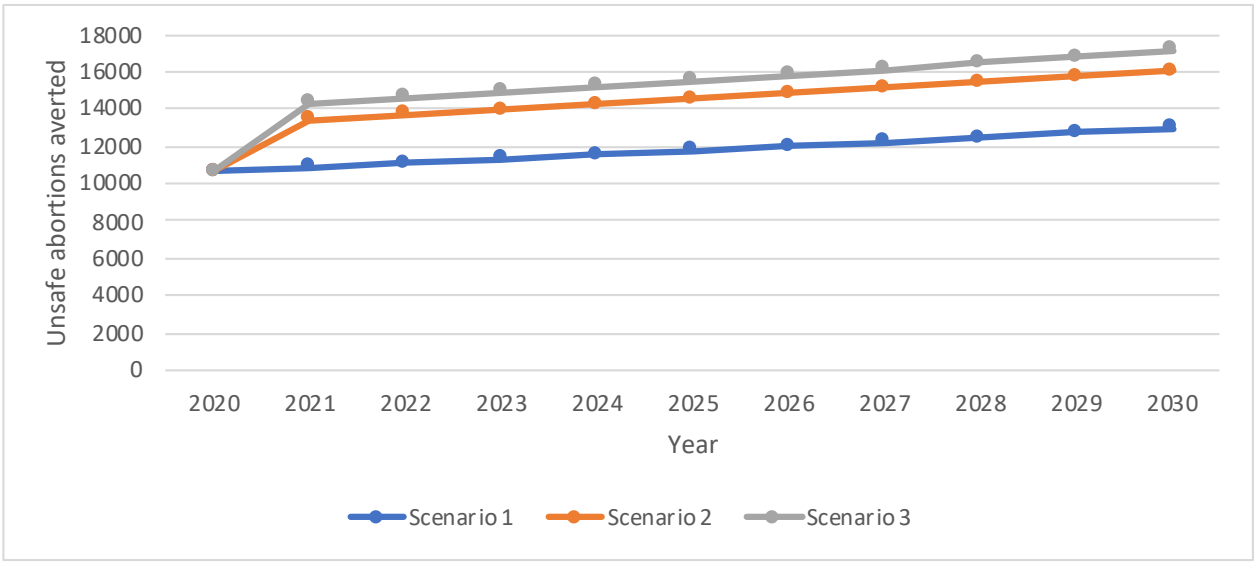
Figure 2.6: Trends in unintended pregnancies averted by investing in family planning, 2020-2030





IF THE CONTRACEPTIVE PREVALENCE RATE IS INCREASED TO 80%, the total number of UNSAFE ABORTIONS AVERTED between 2020 and 2030 WILL INCREASE BY 32% from 129,429 with the current contraceptive prevalence rate to 170,863. LIKEWISE, 32% MORE UNINTENDED PREGNANCIES WOULD BE AVERTED, from about 620,000 under the status quo to 818,312 with 80 (mCPR 76.7).

Figure 2.7: Trends in unsafe abortions averted by investing in family planning, 2020-2030



2.4.3 Description of costs

Table 2.4 and Figures 2.8 and 2.9 present estimates of incremental costs of modern contraception by category for the different scenarios. The breakdown of costs by category by year for modern contraceptive method mix is reported in Tables A5 to A9 in Appendix A. The costs are categorized into labour costs, capital costs, drugs and supply costs, and other recurrent costs. These costs are estimated based on the three CPR scenarios (60.6 per cent, 75 per cent and 80 per cent). The total investment required to achieve the set targets between 2020 and 2030 is US$8.88 million under the status quo scenario, US$12.0 million under scenario 2, and US$13.10 million under scenario 3.

The results show that labour costs will account for 67 per cent of the total costs, followed by capital cost (15 per cent), drugs and supply cost (14 per cent), and other recurrent costs (4 per cent). The results are consistent across the different scenarios, with labour costs accounting for the majority of the incremental costs (Table 2.4).

Table 2.4: Summary of total incremental costs of mCPR by category, under the different scenarios (US$)

	SCENARIO 1			SCENARIO 2		SCENARIO 3	
Cost category	**2020**	**2020-2025**	**2020-2030**	**2020-2025**	**2020-2030**	**2020-2025**	**2020-2030**
Drugs and supply costs	000	163,999	634,084	380,896	1,483,248	456,295	1,778,275
Other-recurrent costs	000	54,312	209,993	126,150	491,238	151,124	588,953
Capital costs	000	185,146	715,840	429,978	1,674,400	515,084	2,007,423
Labour Costs	512,996	3,493,477	7,321,658	3,752,213	8,360,382	3,841,991	8,720,989
Total intervention costs	512,996	3,896,934	8,881,575	4,689,237	12,009,268	4,964,494	13,095,640

INCREASING THE CONTRACEPTIVE PREVALENCE RATE TO 75% BY 2030 would require a total incremental COST OF US$12 MILLION while RAISING the CPR TO 80% would require a total incremental COST OF US$13.1 MILLION.

Figure 2.8: Trends in total incremental costs of mCPR under the different scenarios (US$)

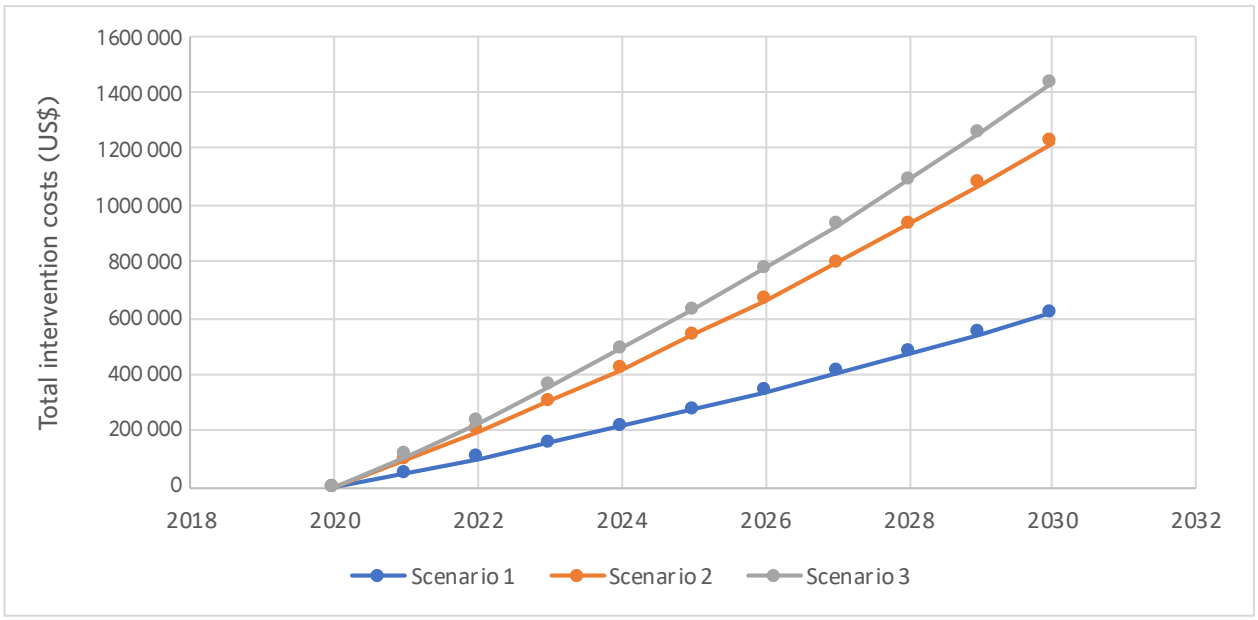
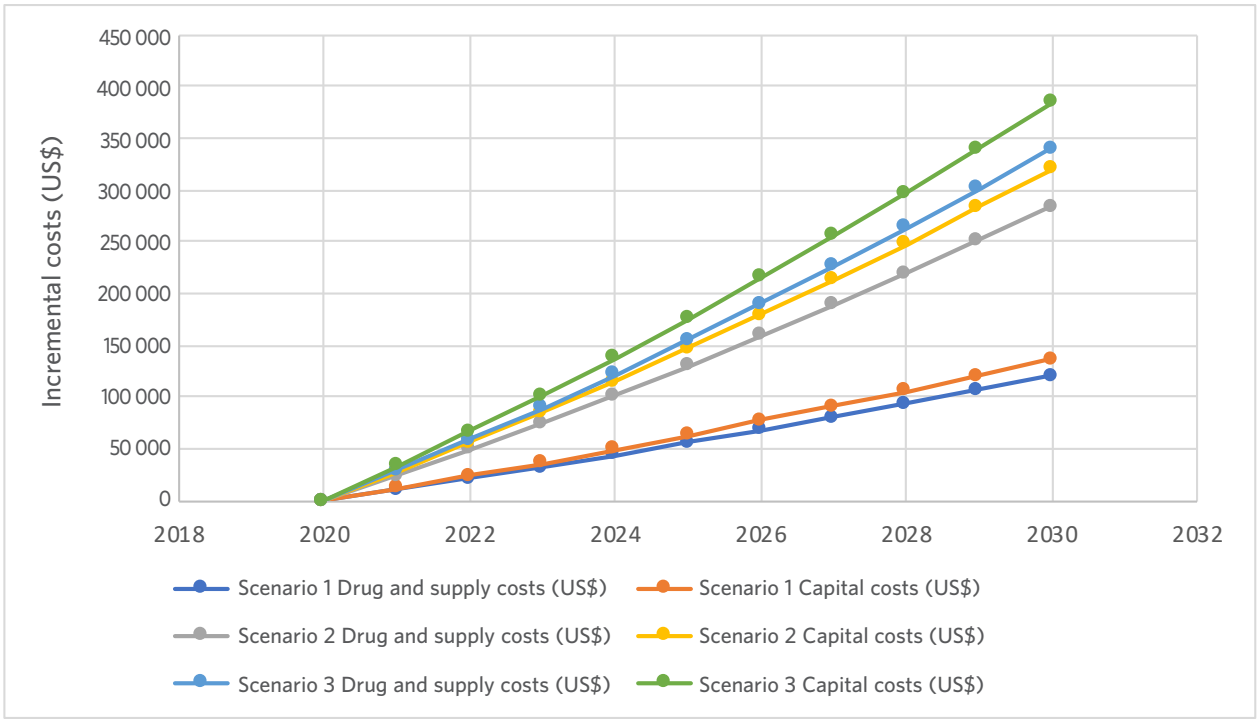


Figure 2.9: Trends in incremental costs of mCPR (US$) under the different scenarios, by cost category



3. ENDING GENDER-BASED VIOLENCE

3.1 Introduction

The objective of this chapter is to provide estimates of how much it would cost the Government of Namibia to implement high-impact interventions to prevent or end gender-based violence (GBV) on women and young girls, and determine the impact of these interventions. The analytical details are discussed in the following sub-sections.

3.2 Government effort towards ending gender-based violence

While the Government of Namibia has made substantial progress towards addressing some of the issues related to GBV, these efforts have met a number of challenges. Over the years, the Government has adopted and revised several policies and strategies relating to GBV and wider gender-related issues. Both national and international policy instruments have been adopted. At the international level, the country is a party to the following instruments:[35]

- The UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). This aims to end sex discrimination, including gender-based violence.
- The UN Convention on the Rights of the Child. Among others, the Convention obligates countries to protect children from all forms of violence, maltreatment, or exploitation, including sexual abuse.
- The UN Declaration on the Elimination of Violence against Women. This affirms that violence against women constitutes a violation of their rights and fundamental freedoms.
- The Beijing Declaration and Platform for Action. This calls on governments, among other things, to enact or reinforce legislation and other measures to address violence against women and girls in homes, the workplace, the community, and society.
- The UN Resolution on the Elimination of Domestic Violence against Women. This calls on states to strengthen and implement legislation that prohibits domestic violence and to focus on the treatment and the rehabilitation of victims, in addition to the prosecution of perpetrators.
- The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. This calls for measures to address violence against women taking place both in private and in public. It also addresses the punishment of perpetrators, the identification of causes of violence against women and the provision of services for survivors.
- The SADC Protocol on Gender and Development. This requires Member States to enact and enforce legislation prohibiting all forms of gender-based violence; ensure that perpetrators are brought to justice; and implement educational policies and programmes addressing gender-based violence.

[35] https://www.unafei.or.jp/publications/pdf/RS_No110/No110_10_No173_VE_Martin_1.pdf

A number of national laws and policies supportive of the fight against gender-based violence have been implemented in the country. The constitution of Namibia lays the foundation to address the causes of GBV and pave the way to address GBV with legislative backing.

- Article 8(1) of the Constitution of the Republic of Namibia states that "the dignity of all persons shall be inviolable", and Article 8(2)(b) states that "no person shall be subject to torture or to cruel, inhuman or degrading treatment or punishment." Article 10 stipulates that "all persons shall be equal before the law" and that "no persons may be discriminated against on the grounds of sex, race, colour, religion, creed or social or economic status".
- Article 23(3), "In the enactment of legislation and the application of any policies and practices contemplated by [the Constitution], it shall be permissible to have regard to the fact that women in Namibia have traditionally suffered special discrimination, and that they need to be encouraged and enabled to play a full, equal and effective role in the political, social, economic and cultural life of the nation".
- Article 95(a) puts forth that "the State shall actively promote and maintain the welfare of the people by adopting, inter alia, policies aimed at the following: enactment of legislation to ensure equality of opportunity for women, to enable them to participate fully in all spheres of the Namibian society".

These policy instruments have been translated into concrete actions through a number of measures that have been put into place by the Government of Namibia. These include the National Gender Policy, which primarily focuses on achieving gender equality and the empowerment of both males and females in the country (Ministry of Gender Equality and Child Welfare, 2010); Vision 2030 and the National Development Plan; the National Plan on Gender-based Violence, 2019-2023; Combating of Rape Act 8 of 2000; and the Combating of Domestic Violence Act 4 of 2003.

3.3 Methodology

To quantify the impact and estimate the costs associated with GBV interventions in Namibia, the Impact40 tool was used. However, it should be noted that GBV interventions in Impact40 are limited and mainly focus on intimate partner violence (IPV). This limits the analysis from looking into other forms of GBV and interventions that exist in the country. Thus, the impact and costs of GBV interventions provided in this study can be considered as the minimum for achieving the set targets. Some GBV interventions and indicators do not have baseline year data but are only available for years before the baseline year that is pre-set in the software. In addition, data for some indicators are not nationally representative. For this reason, assumptions were made around the baseline and targets, where possible.

3.3.1 Assumptions on the baseline and targeted intervention coverage rate

The 2015 GBV interventions coverage data presented in Table 3.1 were extracted from existing government reports. (See a detailed elaboration in Appendix B). Assumptions were made using the 2015 intervention coverage rates to generate the 2020 baseline data. The average GDP growth rate for Namibia between 2015 and 2020 was -0.35 per cent (6.1 per cent in 2015, 0.6 per cent in 2016, -1.0 per cent in 2017, 1.1 per cent in 2018, -1.6 per cent in 2019 and -7.3 per cent in 2020).[36,37] Based on this trend, it was assumed that there had been no additional investments in the GBV intervention coverage between 2015 and 2020. The projected impact and costs of investing in GBV between 2020 and 2030, based on these baseline assumptions, are thus to be considered as minimum investments.

[36] https://www.bon.com.na/CMSTemplates/Bon/Files/bon.com.na/5e/5e90a8f2-579c-4449-b73b-ab9de3ba6e9b.pdf
[37] https://www.bon.com.na/CMSTemplates/Bon/Files/bon.com.na/53/53850e4f-4ab9-427f-b023-f0642d0c5af6.pdf

The Namibian economic outlook[38] projects a positive economic growth rate of 2.7 per cent in 2021 and 3.3 per cent in 2022, for average growth of 3 per cent. Based on this, it was assumed that the Government could increase investments in GBV interventions between 2021 and 2030, resulting in an annual increment of 2 per cent GBV intervention coverage under scenario 1. For outreach to female sex workers, a coverage rate of 5 per cent in 2021 was assumed and an additional 5 per cent annually. Scenario 2 estimates were obtained by increasing the estimates of scenario 1 by 10 per cent and scenario 3 by further increasing the estimates of scenario 2 by 10 per cent. Using the coverage rate at baseline and the 2030 targets for the different scenarios, the coverage rates for the period between 2020 and 2030 were projected. (See Table 3.2).

Table 3.1: GBV intervention coverage rates (%) at baseline and target scenarios in 2030

	2015	2020	2030		
Intervention	**Data**	**Baseline**	**Scenario 1**	**Scenario 2**	**Scenario 3**
Community mobilization	62	62	74	84	94
Outreach to male youth	37	39	47	57	67
Economic empowerment	60	60	72	82	92
Outreach to female sex workers	00	00	50	60	70
Mass media	37	37	44	54	64
Counselling	50	50	60	70	80
Treatment	60	60	72	82	92

Table 3.2: GBC intervention coverage rates (%) between 2020 and 2030

	SCENARIO 1			SCENARIO 2		SCENARIO 3	
Intervention	**2020**	**2025**	**2030**	**2025**	**2030**	**2025**	**2030**
Community mobilization	62	68	74	73	84	78	94
Outreach to male youth	39	43	47	48	57	53	67
Economic empowerment	60	66	72	71	82	76	92
Outreach to female sex workers	0	25	50	30	60	35	70
Mass media	37	40.5	44	45.5	54	50.5	64
Counselling	50	55	60	60	70	65	80
Treatment	60	66	72	71	82	76	92

[38] https://www.bon.com.na/CMSTemplates/Bon/Files/bon.com.na/02/028351bb-556d-4917-ba74-45e97e0f1374.pdf

3.3.2 Per capita GBV intervention costs

To estimate GBV intervention costs for Namibia, we adopted the standardized GBV per capita unit costs in Impact40, as shown in Table 3.3 below.

The adopted standardized GBV per capita unit costs show that the lowest cost will be spent for mass media (US$0.27) while the highest cost will be for treatment (US$213.27), in order to realize the results in Table 3.4. An additional fixed amount of US$100,000 would be required annually to support or strengthen the activities of relevant NGOs. The unit costs in Table 3.3 could, in some cases, be lower than the proposed GBV per unit cost. For example, a report from the Ministry of Gender Equality and Child Welfare shows that a total of N$2,000,000 was budgeted to economically empower 85 women (or US$1,769 per person) based on an average exchange rate of N$13.3 per US$ in 2017, which is much higher than the per unit cost of US$48.12 in Table 3.3. Since the cost data are related in particular to IPV, the costs of ending gender-based violence reported in this study can be considered to reflect minimum costs.

3.3.3 The impact of investing to end GBV

Results shown in Table 3.4 suggest that in 2020, intimate partner violence (IPV) in Namibia was 17 per cent. When the intervention in scenario 1 is adopted, there is a modest improvement in reducing IPV between 2020 and 2030. The improvement is progressively higher in scenarios 2 and 3. With the proposed GBV interventions, the IPV level is reduced from 17 per cent in 2020 to 15.7 per cent for scenario 1, to 14.9 per cent for scenario 2, and 14.1 per cent for scenario 3 by 2030.

In 2020, the number of partners experiencing IPV was 113,539. Under scenario 1, the number will increase to 127,697 in 2030, but with increase in coverage of interventions, will be reduced to 121,208 under scenario 2 and to 114,594 under scenario 3. The results suggest that while the number of IPV cases will rise from 2020 in each scenario, the rate of decline will be higher, moving from scenario 1 to scenario 3. The GBV interventions are important in significantly reducing the number exposed to IPV (Figure 3.1). The number of cases of IPV averted is 10,045 in 2030 under scenario 1; 16,534 under scenario 2, and 23,148 under scenario 3. Cumulatively, 52,111 cases of IPV will be averted under scenario 1; 85,543 cases averted under scenario 2, and 119,430 cases under scenario 3. (See Table 3.4 and Figure 3.1).

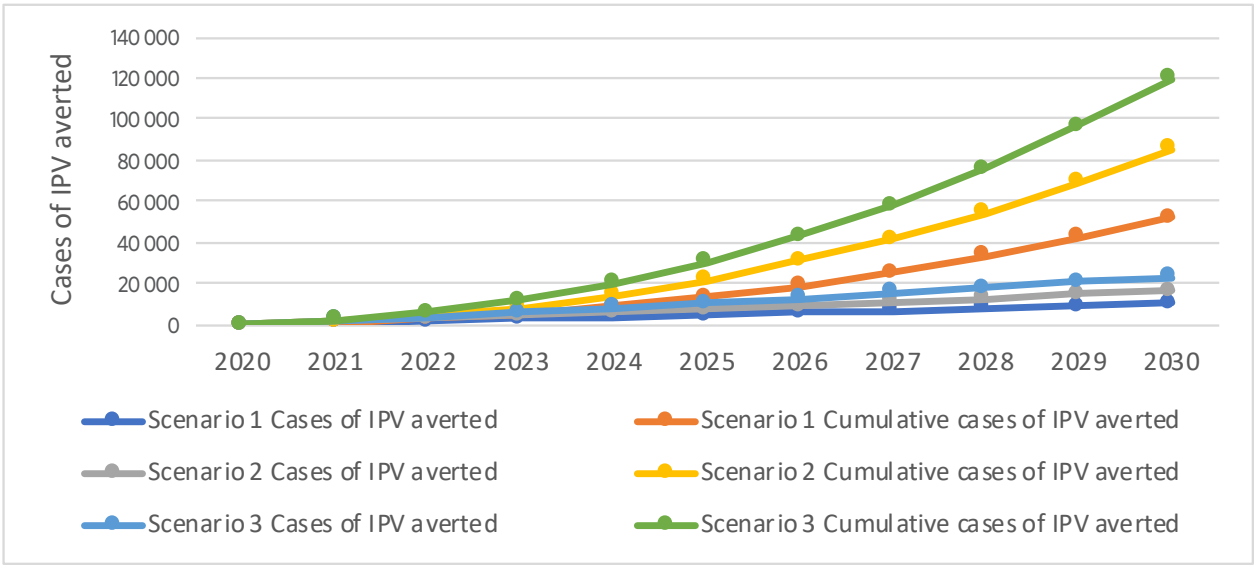
Table 3.3: Anti-GBV intervention unit costs

INTERVENTION	UNIT COST (US$)	
Community mobilization	3.77	Per person reached
Outreach to male youth	11.70	Per person reached
Economic empowerment	48.12	Per person reached
Outreach to female sex workers	13.64	Per person reached
Mass media	0.27	Per person reached
Counselling	7.57	Per person reached
Treatment	213.27	Per person reached
NGO strengthening	100,000	Per year
Programme support	15	Per cent of direct costs

Table 3.4: The impact of anti-GBV interventions on intimate partner violence (IPV)

IMPACT (RESULT)	SCENARIO 1			SCENARIO 2		SCENARIO 3	
	2020	2025	2030	2025	2030	2025	2030
Per cent experiencing IPV	17.0	16.3	15.7	15.9	14.9	15.6	14.1
Number experiencing IPV	113,539	121,094	127,697	118,191	121,208	115,261	114,594
Cumulative number experiencing IPV	113,539	704,275	1,329,938	695,834	1,296,505	687,335	1,262,619
Cases of IPV averted	000	4,547	10,045	7,450	16,534	10,379	23,148
Cumulative cases of IPV averted	000	13,266	52,111	21,707	85,543	30,206	119,430

Figure 3.1: Number of cases and cumulative cases of IPV averted under GBV interventions scenarios



3.3.4 The costs of investment in ending GBV in Namibia

Table 3.5 presents the estimated costs of interventions to address GBV in Namibia between 2020 and 2030. These interventions include community mobilization, outreach, economic empowerment, media campaigns, counselling, treatment, and support for advocacy groups/programmes. The estimates show a cost of over US$7.3 million in 2020, to a cumulative cost of over US$98 million for the period 2020-2030 under scenario 1; over US$106 million under scenario 2; and over US$114.5 million under scenario 3. (See Table 3.5 and Figure 3.2). The estimates show that over 63 per cent of the needed resources will be for economic empowerment accounts, followed by about 13 per cent for support programmes, 10 per cent for community mobilization, and 7 per cent for counselling (Table 3.6).

Table 3.5: Cumulative costs of investment in ending GBV in Namibia, 2020–2030 (US$)

INTERVENTION	SCENARIO 1			SCENARIO 2		SCENARIO 3	
	2020	2020-2025	2020-2030	2020-2025	2020-2030	2020-2025	2020-2030
Community mobilization	751,859	4,710,654	9,022,574	4,891,507	9,685,200	5,072,360	10,347,825
Outreach to male youth	239,361	1,608,471	3,272,214	1,709,286	3,667,150	1,810,101	4,062,086
Economic empowerment	4,575,035	30,675,895	62,281,720	31,926,765	67,177,013	33,177,636	72,072,306
Outreach to female sex workers	0	88,718	347,711	106,461	417,253	124,205	486,795
Mass media	129,265	852,710	1,723,280	908,890	1,943,664	965,070	2,164,047
Counselling	512,079	3,384,487	6,851,747	3,549,010	7,496,563	3,713,534	8,141,380
Treatment	75,120	495,428	995,708	515,471	1,073,455	535,514	1,151,203
NGO strengthening	100,000	600,000	1,100,000	600,000	1,100,000	600,000	1,100,000
Programme support	957,408	6,362,454	12,839,243	6,631,109	13,884,045	6,899,763	14,928,846
Total cumulative costs	7,340,128	48,778,817	98,434,197	50,838,500	106,444,343	52,898,182	114,454,490

Figure 3.2: Total costs of investment (US$) in GBV for the different scenarios

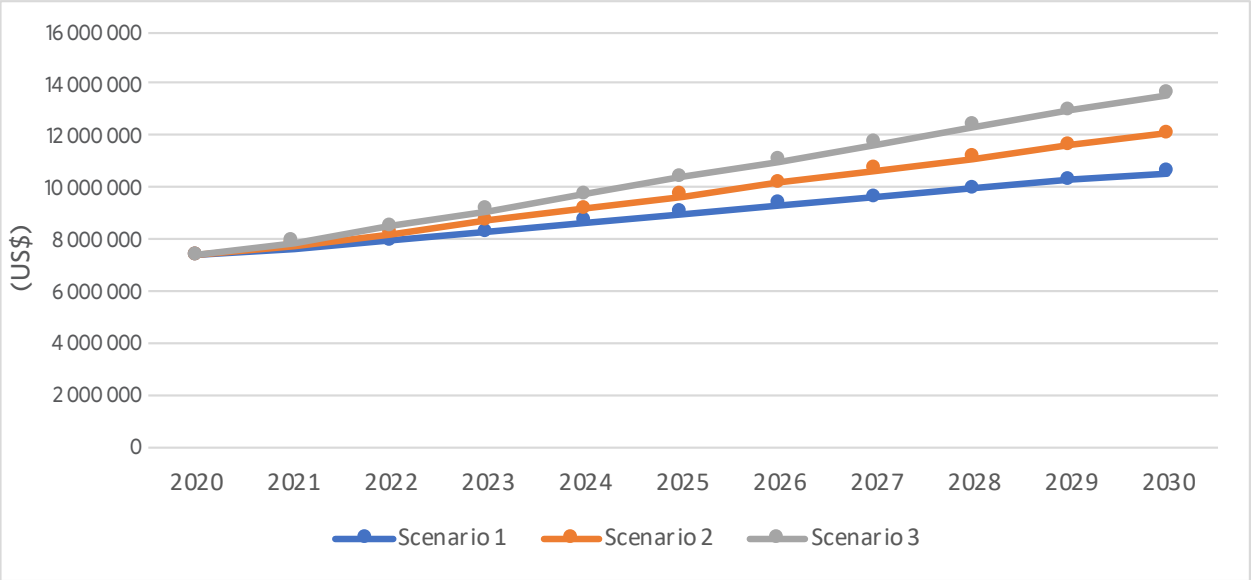


Table 3.6: Contribution of each intervention to total investment costs (%): Scenario 1

INTERVENTION	2020	2025	2030
Community mobilization	10.2	9.1	8.4
Outreach to male youth	3.3	3.3	3.4
Economic empowerment	62.3	63.4	63.7
Outreach to female sex workers	0.0	0.3	0.6
Mass media	1.8	1.7	1.8
Counselling	7.0	6.9	7.1
Treatment	1.0	1.0	1.0
NGO strengthening	1.4	1.1	0.9
Programme support	13.0	13.0	13.0
Total	**100.0**	**100.0**	**100.0**

4. SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

4.1 Summary of findings

4.1.1 Ending unmet need for family planning

- Family planning services uptake in Namibia has increased rapidly over the years, with an estimated contraceptive prevalence rate (CPR) of approximately 61 per cent for married and/or in-union women aged 15-49 in 2020. Modern contraceptive prevalence rate (mCPR) has likewise increased rapidly to 58 per cent in 2020. To achieve the national CPR target of 80 per cent by 2030, family planning services need to be further expanded. Increased investment in family planning programmes aim to scale up high impact and tailored interventions with higher returns on investment.
- Achieving the total fertility rate target of 2.0 by 2030 hinges on the Government's ability to increase the CPR to at least 75 per cent by 2030. Unmet need for family planning will decline from 15.2 per cent to 7.5 per cent if the CPR is increased to 75 per cent and to 5.1 per cent if the CPR is increased to 80 per cent by 2030.
- Investing in family planning in Namibia will reduce the number of unintended pregnancies, maternal deaths, and unsafe abortions. Overall, a cumulative total of 619,870 unintended pregnancies will be averted between 2020 and 2030 if the current CPR of 60.6 per cent remains unchanged (mCPR is 58 per cent). This will increase to 767,135 if the CPR is increased to 75 per cent (mCPR is 72 per cent) and to 818,312 if the CPR is increased to 80 per cent (mCPR is 77 per cent).
- Likewise, a total of 1,256 maternal deaths will be averted if the current CPR of 60.6 per cent remains unchanged (with 58 per cent mCPR), about 1,556 if the CPR is increased to 75 per cent (with 72 per cent mCPR), and 1,658 if the CPR is increased to 80 per cent (with 77 per cent mCPR).
- The total number of unsafe abortions averted between 2020 and 2030 will increase from 129,429 if the current CPR of 60.6 per cent remains unchanged, to 160,179 if the CPR is increased to 75 per cent and to 170,863 if the CPR is increased to 80 per cent.
- Maintaining the current CPR between 2020 and 2030 will cost about US$3.2 million (an annual average of US$319,903). Scaling up the CPR to 80 per cent in 2030 will cost US$7.3 million over the period 2020-2030 (an annual average of US$729,956).

4.1.2 Ending gender-based violence

- Without additional intervention, scenario 1, the number of women experiencing IPV would increase from 113,539 in 2020 to 127,697 in 2030, with a cumulative total of 1.3 million between 2020 and 2030 (or an annual average of 120,903). Maintaining the current level of interventions, a cumulative total of 52,111 IPV cases will be averted.

- Scaling up GBV interventions will result in fewer women experiencing IPV in Namibia. A cumulative total of 119,430 cases of IPV would be averted between 2020 and 2030 under scenario 3, more than double that of the current level of interventions.
- Maintaining current levels of GBV interventions, scenario 1, would cost US$98 million during the period 2020-2030 (an annual average of US$8.9 million). Economic empowerment interventions will account for 63 per cent of the estimated cost of interventions, followed by programme support accounting for 13 per cent. Achieving the intervention coverage in scenario 3 would cost US$114.5 million (an annual average of US$10.4 million), with economic empowerment and programme support interventions accounting for the same share of 63 per cent and 13 per cent, respectively.

4.2 Conclusion

The investment cases provide quantitative arguments to support decision-making on scaling up interventions towards achieving the transformative results of ending unmet need for family planning and gender-based violence in Namibia. These include estimates on the specific types of interventions and related costs and the nature and magnitude of impact or gains in scaling up investment in interventions under different scenarios. The impact of scaling up family planning interventions includes averted maternal deaths, unintended pregnancies, and unsafe abortions. In the case of GBV interventions, gains will translate into a reduction in IPV cases. These are, in turn, expected to accrue to long term health and non-health benefits to individuals, households and society as a whole.

Scaling up the CPR to reach 75 per cent by 2030 (from the current CPR rate of 60.6 per cent) would result in approximately 24 per cent higher reductions of unintended pregnancies, maternal deaths, and unsafe abortions; while scaling up the CPR to 80 per cent would result in 32 per cent higher reductions in unintended pregnancies, maternal deaths, and unsafe abortions. The cost of scaling up the CPR to 75 per cent would involve a total additional cost of 35 per cent over the cost of maintaining the CPR at 60.6 per cent, while scaling up the CPR to 80 per cent would involve a total additional cost of about 47 per cent more than the cost of maintaining a 60.6 per cent CPR.

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4.3 Recommendations

4.3.1 Ending unmet need for family planning

1) Promote the inclusion of all family planning services such as modern contraceptives method mix, counselling, and follow-up in the essential benefits package of all health insurance schemes.

2) Strengthen advocacy to increase domestic resource mobilization to finance family planning interventions and introduce innovative financing mechanisms to mobilize additional revenues.

3) Promote community involvement and address gender inequalities that can impact agency, bodily autonomy and rights-based family planning decisions.

4) Improve efficiency in the use of available family planning resources at all levels to increase the value of spending and foster multi-stakeholder partnerships to support innovative financing initiatives at all levels.

5) Ensure development programmes targeting the poor and vulnerable groups are mandated to contribute towards family planning within the context of Universal Health Coverage (UHC).

4.3.2 Ending gender-based violence

1) Strengthen delivery of GBV interventions within municipal plans and budgets.

2) Mainstream GBV within development programmes to contribute towards addressing the high prevalence of GBV.

3) Strengthen the capacity of justice, law enforcement and human rights institutions to accelerate prevention and response to GBV while creating special mechanisms to ensure timely and speedy prosecution of perpetrators.

4) Take measures to strengthen equitable access to quality education and skills development as an important tool to reduce women's and girls' vulnerabilities and end GBV.

5) Integrate women's economic empowerment and gender equality in the employment and social protection systems.

6) Strengthen and reinforce GBV data availability for better targeting of interventions.

In order to undertake periodic updates of the investment case estimates, it is important to improve availability of data for service coverage for priority interventions, establish clear targets in policy documents and track expenditures through Systems of Health Accounts or related financial reporting frameworks.

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APPENDIX A: FAMILY PLANNING INTERVENTIONS

Table A1: Policy targets: contraceptive prevalence rate, fertility rate and unmet need for family planning

	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
Status Quo (Scenario 1)											
CPR (%)	60.6	60.6	60.6	60.6	60.6	60.6	60.6	60.6	60.6	60.6	60.6
mCPR (%)	58.1	58.1	58.1	58.1	58.1	58.1	58.1	58.1	58.1	58.1	58.1
Fertility rate	3.32	3.32	3.32	3.32	3.32	3.32	3.32	3.32	3.32	3.32	3.32
Unmet need (%)	15.2	15.2	15.2	15.2	15.2	15.2	15.2	15.2	15.2	15.2	15.2
Scenario 2											
CPR (%)	60.6	62.0	63.5	64.9	66.4	67.8	69.2	70.7	72.1	73.6	75.0
mCPR (%)	58.1	59.5	60.9	62.3	63.6	65.0	66.4	67.8	69.2	70.6	71.9
Fertility rate	3.32	3.18	3.05	2.91	2.77	2.63	2.49	2.36	2.22	2.08	1.9
Unmet need (%)	15.2	14.4	13.6	12.8	12.1	11.3	10.5	9.7	8.9	8.2	7.5
Scenario 3											
CPR (%)	60.6	62.5	64.5	66.4	68.4	70.3	72.2	74.2	76.1	78.1	80.0
mCPR (%)	58.1	60.0	61.8	63.7	65.6	67.4	69.3	71.1	73.0	74.9	76.7
Fertility rate	3.32	3.14	2.95	2.77	2.58	2.39	2.21	2.02	1.84	1.65	1.5
Unmet need (%)	15.2	14.1	13.1	12.0	11.0	9.9	8.9	7.9	6.9	6.0	5.1

Note: Unmet need for family planning set at 15.2% and CPR at 60.6% in 2020 were obtained from United Nations, Department of Economic and Social Affairs, Population Division (2019). Estimates and Projections of Family Planning Indicators 2019. New York: United Nations. Fertility rate set at 3.32 in 2020 was obtained from https://www.macrotrends.net/countries/NAM/namibia/fertility-rate.

Table A2: Number of users of contraceptives and modern contraceptives

	SCENARIO 1		SCENARIO 2		SCENARIO 3	
Year	**Users**	**mUsers**	**Users**	**mUsers**	**Users**	**mUsers**
2020	136,549	130,961	136,549	130,961	136,549	130,961
2021	139,080	133,537	142,385	136,590	143,532	137,652
2022	141,687	136,173	148,421	142,427	150,759	144,602
2023	144,363	138,862	154,654	148,467	158,228	151,808
2024	147,127	141,620	161,111	154,737	165,967	159,299
2025	150,000	144,467	167,821	161,263	174,009	167,105
2026	152,958	147,384	174,766	168,033	182,339	175,215
2027	155,996	150,365	181,944	175,047	190,954	183,632
2028	159,142	153,437	189,394	182,344	199,899	192,399
2029	162,340	156,549	197,058	189,872	209,113	201,462
2030	165,540	159,653	204,877	197,574	218,535	210,764
Total	**1,654,782**	**1,593,008**	**1,858,980**	**1,787,315**	**1,929,884**	**1,854,899**

Note: Users represent number of users of all types of contraceptives, while mUsers refer to number of users of modern contraceptives. Scenario 1 estimates are based on the current CPR (60.6%); scenario 2 estimates are based on the SDG target of 75% CPR; and scenario 3 is based on the national target of 80% CPR.

Table A3: Health benefits of investing in family planning in Namibia, 2020 to 2030

	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	TOTAL
Scenario 1 (60.6% CPR)												
Unintended pregnancies averted	50,959	51,962	52,988	54,034	55,107	56,215	57,350	58,510	59,705	60,916	62,124	619,870
Maternal deaths averted	103	105	107	110	112	114	116	119	121	123	126	1,256
Unsafe abortions averted	10,640	10,850	11,064	11,282	11,506	11,738	11,975	12,217	12,466	12,719	12,972	129,429
Scenario 2 (75% CPR)												
Unintended pregnancies averted	50,959	64,309	65,578	66,872	68,200	69,570	70,974	72,409	73,888	75,386	76,880	767,135
Maternal deaths averted	103	130	133	136	138	141	144	147	150	153	156	1,556
Unsafe abortions averted	10,640	13,428	13,693	13,963	14,240	14,526	14,819	15,119	15,428	15,741	16,053	160,179
Scenario 3 (80% CPR)												
Unintended pregnancies averted	50,959	68,596	69,951	71,332	72,749	74,211	75,710	77,241	78,819	80,418	82,012	818,312
Maternal deaths averted	103	139	142	145	147	150	153	157	160	163	166	1,658
Unsafe abortions averted	10,640	14,323	14,606	14,894	15,190	15,495	15,808	16,128	16,457	16,791	17,124	170,863

Table A4: Summary of incremental costs for family planning, by cost category for different scenarios (US$)

	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	TOTAL
Status Quo (60.6% CPR)												
Drug and supply costs	0	10,494	21,321	32,427	43,907	55,850	68,136	80,744	93,815	107,075	120,315	634,084
Other recurrent costs	0	3,475	7,061	10,739	14,541	18,496	22,565	26,741	31,069	35,461	39,845	209,993
Capital costs	0	11,848	24,071	36,608	49,569	63,050	76,921	91,154	105,909	120,880	135,830	715,840
Labour costs	512,996	538,701	565,867	594,462	624,698	656,753	690,532	726,119	763,830	803,311	844,389	7,321,658
Total intervention costs	**512,996**	**564,518**	**618,320**	**674,236**	**732,715**	**794,149**	**858,154**	**924,758**	**994,623**	**1,066,727**	**1,140,379**	**8,881,575**
Scenario 2 (75% CPR)												
Drug and supply costs	0	24,270	49,348	75,240	102,072	129,966	158,823	188,640	219,607	251,428	283,854	1,483,248
Other recurrent costs	0	8,038	16,344	24,919	33,805	43,044	52,601	62,476	72,732	83,270	94,009	491,238
Capital costs	0	27,396	55,706	84,936	115,226	146,714	179,291	212,951	247,908	283,831	320,441	1,674,400
Labour costs	518,649	557,579	599,142	643,543	691,117	742,183	796,762	855,077	917,632	984,151	1,054,547	8,360,382
Total intervention costs	**518,649**	**617,283**	**720,540**	**828,638**	**942,220**	**1,061,907**	**1,187,477**	**1,319,144**	**1,457,879**	**1,602,680**	**1,752,851**	**12,009,268**
Scenario 3 (80% CPR)												
Drug and supply costs	0	29,071	59,097	90,123	122,285	155,719	190,330	226,122	263,303	301,568	340,657	1,778,275
Other recurrent costs	0	9,629	19,573	29,849	40,500	51,573	63,036	74,890	87,204	99,877	112,822	588,953
Capital costs	0	32,814	66,710	101,735	138,042	175,783	214,855	255,260	297,233	340,430	384,561	2,007,423
Labour Costs	520,551	564,134	610,696	660,585	714,179	771,846	833,647	899,854	971,035	1,046,943	1,127,519	8,720,989
Total intervention costs	**520,551**	**635,648**	**756,076**	**882,292**	**1,015,006**	**1,154,921**	**1,301,868**	**1,456,126**	**1,618,775**	**1,788,818**	**1,965,559**	**13,095,640**

Table A5: Total incremental costs for drugs and supply, by modern contraceptive mix (US$)

	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	TOTAL
Scenario 1 (60.6% CPR)											
Pill - Standard daily regimen	1,939	3,936	5,985	8,103	10,303	12,570	14,897	17,306	19,756	22,208	**117,003**
Condom - Male	4,247	8,623	13,114	17,752	22,574	27,540	32,637	37,917	43,285	48,655	**256,344**
Injectable - 3 month (Depo Provera)	4,127	8,379	12,743	17,251	21,936	26,762	31,716	36,846	42,062	47,281	**249,103**
IUD-Copper-T380-A IUD (10 years)	16	33	50	68	87	107	126	147	167	186	**987**
Implant - Jadelle (5 years)	18	38	58	78	100	122	145	169	192	214	**1,134**
Female sterilization	144	306	468	643	834	1,017	1,201	1,404	1,584	1,739	**9,340**
Male sterilization	3	6	9	12	16	19	22	26	30	32	**175**
Scenario 2 (75% CPR)											
Pill - Standard daily regimen	4,470	9,094	13,869	18,815	23,955	29,275	34,773	40,480	46,351	52,340	**273,422**
Condom - Male	9,794	19,924	30,385	41,222	52,484	64,140	76,186	88,689	101,552	114,673	**599,049**
Injectable - 3 month (Depo Provera)	9,517	19,361	29,527	40,058	51,001	62,328	74,034	86,184	98,684	111,434	**582,128**
IUD - Copper-T 380-A IUD (10 years)	39	79	120	163	208	254	301	351	401	450	**2,366**
Implant - Jadelle (5 years)	45	90	137	186	237	290	344	401	458	515	**2,703**
Female sterilization	397	784	1,179	1,598	2,043	2,491	2,948	3,438	3,910	4,361	**23,149**
Male sterilization	7	15	22	30	38	46	55	64	73	81	**431**
Scenario 3 (80% CPR)											
Pill - Standard daily regimen	5,349	10,885	16,606	22,534	28,695	35,075	41,675	48,527	55,585	62,802	**327,733**
Condom - Male	11,720	23,848	36,382	49,371	62,869	76,848	91,306	106,319	121,784	137,596	**718,043**
Injectable - 3 month (Depo Provera)	11,389	23,174	35,355	47,977	61,093	74,677	88,727	103,316	118,344	133,710	**697,762**
IUD - Copper-T 380-A IUD (10 years)	48	96	145	197	251	306	363	422	482	542	**2,852**
Implant - Jadelle (5 years)	55	109	166	224	286	349	414	482	551	620	**3,256**
Female sterilization	501	966	1,442	1,946	2,479	3,018	3,571	4,161	4,734	5,288	**28,106**
Male sterilization	9	18	27	36	46	56	67	78	88	99	**524**

Table A6: Total incremental costs for other recurrent costs, by modern contraceptive mix (US$)

	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	TOTAL
Scenario 1 (60.6% CPR)											
Pill - Standard daily regimen	328	666	1,013	1,372	1,744	2,128	2,522	2,930	3,344	3,759	**19,806**
Condom - Male	563	1,142	1,737	2,351	2,990	3,648	4,323	5,022	5,733	6,445	**33,954**
Injectable - 3 month (Depo Provera)	2,513	5,102	7,759	10,503	13,355	16,293	19,310	22,433	25,609	28,787	**151,664**
IUD - Copper-T 380-A IUD (10 years)	23	47	71	97	124	151	179	208	237	263	**1,400**
Implant - Jadelle (5 years)	4	9	14	19	24	30	35	41	47	52	**275**
Female sterilization	44	93	142	195	252	308	364	425	479	526	**2,828**
Male sterilization	1	2	3	5	6	7	9	10	11	12	**66**
Scenario 2 (75% CPR)											
Pill - Standard daily regimen	757	1,539	2,348	3,185	4,055	4,956	5,887	6,853	7,847	8,860	**46,287**
Condom - Male	1,297	2,639	4,025	5,460	6,952	8,496	10,091	11,748	13,451	15,189	**79,348**
Injectable - 3 month (Depo Provera)	5,794	11,788	17,977	24,389	31,051	37,948	45,074	52,472	60,082	67,845	**354,420**
IUD - Copper-T 380-A IUD (10 years)	56	112	170	231	294	359	426	497	567	637	**3,349**
Implant - Jadelle (5 years)	11	22	33	45	58	71	84	98	112	126	**660**
Female sterilization	120	237	357	484	618	754	892	1,041	1,184	1,320	**7,007**
Male sterilization	3	6	8	11	14	18	21	24	28	31	**164**
Scenario 3 (80% CPR)											
Pill - Standard daily regimen	906	1,843	2,811	3,815	4,858	5,938	7,055	8,215	9,410	10,632	**55,483**
Condom - Male	1,552	3,159	4,819	6,540	8,327	10,179	12,094	14,083	16,131	18,226	**95,110**
Injectable - 3 month (Depo Provera)	6,934	14,109	21,525	29,210	37,196	45,466	54,021	62,902	72,052	81,407	**424,822**
IUD - Copper-T 380-A IUD (10 years)	69	136	206	278	355	433	513	598	683	768	**4,039**
Implant - Jadelle (5 years)	13	27	40	55	70	85	101	118	134	151	**794**
Female sterilization	152	292	437	589	750	914	1,081	1,259	1,433	1,601	**8,508**
Male sterilization	4	7	10	14	18	21	25	30	34	38	**201**

Table A7: Total incremental capital costs, by modern contraceptive mix (US$)

	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	TOTAL
Scenario 1 (60.6% CPR)											
Pill - Standard daily regimen	1,121	2,276	3,461	4,685	5,958	7,268	8,614	10,007	11,424	12,841	**67,655**
Condom - Male	1,922	3,901	5,933	8,032	10,213	12,460	14,766	17,155	19,583	22,013	**115,978**
Injectable - 3 month (Depo Provera)	8,583	17,426	26,501	35,875	45,618	55,653	65,955	76,624	87,471	98,325	**518,031**
IUD - Copper-T 380-A IUD (10 years)	72	149	227	309	396	483	572	666	757	842	**4,473**
Implant - Jadelle (5 years)	14	30	45	61	78	95	113	132	150	167	**885**
Female sterilization	133	283	432	593	769	939	1,108	1,296	1,461	1,604	**8,618**
Male sterilization	3	7	10	14	18	22	26	30	34	38	**202**
Scenario 2 (75% CPR)											
Pill - Standard daily regimen	2,585	5,258	8,019	10,879	13,851	16,928	20,107	23,407	26,801	30,264	**158,099**
Condom - Male	4,431	9,014	13,747	18,650	23,745	29,019	34,469	40,126	45,945	51,881	**271,027**
Injectable - 3 month (Depo Provera)	19,792	40,263	61,404	83,304	106,061	129,616	153,959	179,228	205,221	231,737	**1,210,585**
IUD - Copper-T 380-A IUD (10 years)	179	359	545	739	942	1,150	1,364	1,589	1,814	2,038	**10,719**
Implant - Jadelle (5 years)	35	71	107	145	185	226	268	313	357	402	**2,109**
Female sterilization	366	724	1,088	1,474	1,885	2,298	2,720	3,172	3,608	4,024	**21,359**
Male sterilization	9	17	26	35	44	54	64	74	85	94	**502**
Scenario 3 (80% CPR)											
Pill - Standard daily regimen	3,093	6,294	9,602	13,030	16,592	20,281	24,097	28,059	32,141	36,314	**189,503**
Condom - Male	5,302	10,790	16,460	22,337	28,444	34,768	41,310	48,102	55,098	62,252	**324,863**
Injectable - 3 month (Depo Provera)	23,684	48,193	73,523	99,772	127,049	155,298	184,516	214,854	246,106	278,061	**1,451,056**
IUD - Copper-T 380-A IUD (10 years)	219	436	658	891	1,135	1,385	1,642	1,913	2,185	2,456	**12,920**
Implant - Jadelle (5 years)	43	85	129	175	223	272	323	376	430	484	**2,540**
Female sterilization	462	892	1,331	1,795	2,287	2,785	3,295	3,839	4,369	4,880	**25,935**
Male sterilization	11	21	31	42	54	65	77	90	102	114	**607**

Table A8: Total incremental labour costs, by modern contraceptive mix (US$)

	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	TOTAL
Scenario 1 (60.6% CPR)												
Pill - Standard daily regimen	58,953	61,907	65,023	68,304	71,770	75,440	79,313	83,395	87,714	92,251	96,986	**841,056**
Condom - Male	88,429	92,860	97,534	102,456	107,655	113,159	118,969	125,093	131,571	138,376	145,478	**1,261,580**
Injectable - 3 month (Depo Provera)	321,236	337,332	354,310	372,192	391,076	411,072	432,176	454,422	477,956	502,676	528,476	**4,582,924**
IUD - Copper-T 380-A IUD (10 years)	4,074	4,278	4,497	4,726	4,969	5,230	5,502	5,787	6,093	6,407	6,727	**58,290**
Implant - Jadelle (5 years)	884	929	976	1,026	1,078	1,134	1,193	1,255	1,321	1,389	1,459	**12,644**
Female sterilization	26,077	27,383	28,810	30,296	31,899	33,632	35,414	37,275	39,300	41,310	43,295	**374,691**
Male sterilization	1,222	1,284	1,350	1,420	1,495	1,577	1,660	1,747	1,842	1,936	2,029	**17,562**
Other contraceptives	12,120	12,727	13,367	14,042	14,755	15,509	16,305	17,144	18,032	18,965	19,938	**172,904**
Scenario 2 (75% CPR)												
Pill - Standard daily regimen	58,953	63,378	68,113	73,174	78,592	84,403	90,621	97,267	104,388	111,980	120,032	**950,901**
Condom - Male	88,429	95,067	102,169	109,760	117,888	126,604	135,931	145,900	156,583	167,969	180,047	**1,426,347**
Injectable - 3 month (Depo Provera)	321,236	345,348	371,148	398,724	428,248	459,913	493,793	530,009	568,815	610,179	654,054	**5,181,467**
IUD - Copper-T 380-A IUD (10 years)	4,388	4,717	5,064	5,434	5,832	6,262	6,718	7,203	7,728	8,278	8,853	**70,477**
Implant - Jadelle (5 years)	938	1,008	1,083	1,162	1,248	1,340	1,437	1,542	1,654	1,772	1,896	**15,080**
Female sterilization	31,126	33,463	35,880	38,444	41,221	44,237	47,411	50,779	54,451	58,222	62,079	**497,313**
Male sterilization	1,459	1,569	1,682	1,802	1,932	2,074	2,222	2,380	2,552	2,729	2,910	**23,311**
Other contraceptives	12,120	13,029	14,003	15,043	16,157	17,352	18,630	19,996	21,460	23,021	24,676	**195,487**
Scenario 3 (80% CPR)												
Pill - Standard daily regimen	58,953	63,889	69,186	74,864	80,960	87,515	94,547	102,083	110,178	118,830	128,034	**989,039**
Condom - Male	88,429	95,833	103,779	112,296	121,440	131,272	141,820	153,125	165,267	178,245	192,050	**1,483,556**
Injectable - 3 month (Depo Provera)	321,236	348,131	376,995	407,937	441,155	476,871	515,188	556,254	600,363	647,507	697,658	**5,389,295**
IUD - Copper-T 380-A IUD (10 years)	4,493	4,869	5,261	5,680	6,132	6,620	7,140	7,695	8,296	8,928	9,591	**74,705**
Implant - Jadelle (5 years)	956	1,036	1,120	1,210	1,306	1,411	1,522	1,641	1,769	1,905	2,048	**15,924**
Female sterilization	32,825	35,574	38,335	41,272	44,458	47,919	51,576	55,468	59,712	64,094	68,601	**539,834**
Male sterilization	1,539	1,668	1,797	1,935	2,084	2,246	2,418	2,600	2,799	3,004	3,216	**25,306**
Other contraceptives	12,120	13,134	14,223	15,391	16,644	17,991	19,437	20,986	22,651	24,429	26,321	**203,327**

Table A9: Total incremental intervention costs, by modern contraceptive mix (US$)

	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	TOTAL
Scenario 1 (60.6% CPR)											
Pill - Standard daily regimen	6,342	12,947	19,811	26,976	34,492	42,325	50,474	59,004	67,822	76,841	**397,034**
Condom - Male	11,162	22,771	34,811	47,361	60,507	74,186	88,390	103,235	118,548	134,162	**695,133**
Injectable - 3 month (Depo Provera)	31,319	63,981	97,959	133,469	170,746	209,648	250,167	292,622	336,583	381,633	**1,968,127**
IUD - Copper-T 380-A IUD (10 years)	315	651	999	1,369	1,763	2,169	2,590	3,040	3,493	3,945	**20,334**
Implant - Jadelle (5 years)	81	168	258	353	453	557	664	778	893	1,008	**5,213**
Female sterilization	1,627	3,416	5,260	7,253	9,410	11,602	13,872	16,349	18,758	21,088	**108,635**
Male sterilization	68	143	220	303	394	486	582	686	789	890	**4,561**
Scenario 2 (75% CPR)											
Pill - Standard daily regimen	12,237	25,051	38,456	52,518	67,311	82,826	99,080	116,175	134,025	152,543	**780,222**
Condom - Male	22,160	45,317	69,488	94,790	121,355	149,155	178,216	208,716	240,488	273,362	**1,403,047**
Injectable - 3 month (Depo Provera)	59,215	121,325	186,397	254,762	326,791	402,449	481,840	565,463	652,930	743,835	**3,795,007**
IUD - Copper-T 380-A IUD (10 years)	604	1,228	1,882	2,577	3,318	4,093	4,907	5,777	6,672	7,590	**38,648**
Implant - Jadelle (5 years)	161	328	502	686	882	1,086	1,300	1,527	1,760	2,000	**10,232**
Female sterilization	3,219	6,499	9,941	13,650	17,657	21,827	26,214	30,976	35,798	40,658	**206,439**
Male sterilization	128	260	399	549	711	881	1,061	1,256	1,455	1,658	**8,358**
Scenario 3 (80% CPR)											
Pill - Standard daily regimen	14,284	29,254	44,930	61,386	78,707	96,888	115,957	136,026	157,013	178,828	**913,273**
Condom - Male	25,978	53,146	81,529	111,259	142,483	175,186	209,406	245,341	282,828	321,695	**1,648,851**
Injectable - 3 month (Depo Provera)	68,901	141,236	217,105	296,878	380,973	469,394	562,283	660,200	762,773	869,599	**4,429,342**
IUD - Copper-T 380-A IUD (10 years)	712	1,436	2,196	3,005	3,867	4,770	5,720	6,735	7,785	8,864	**45,090**
Implant - Jadelle (5 years)	191	385	589	804	1,033	1,272	1,522	1,789	2,064	2,346	**11,995**
Female sterilization	3,863	7,660	11,657	15,962	20,611	25,468	30,590	36,146	41,805	47,544	**241,306**
Male sterilization	153	304	464	637	825	1,022	1,231	1,457	1,690	1,928	**9,711**

APPENDIX B: GENDER-BASED VIOLENCE (GBV) INTERVENTIONS

Community mobilization

The Ministry of Gender Equality and Child Welfare (MGECW) in 2019/2020 conducted community sensitization meetings on the gender-related laws and National Gender Policy in all 14 regions with the focus to educate people on their rights and responsibilities under these laws. They were also sensitized on available GBV services, promotion of positive cultural practices and beliefs, strengthening the overall coordination mechanism for the implementation of the National Gender Policy and enforcing the formulation and enactment of gender-related laws and policies. The Gender Link Namibia 2016–2020 suggests that in 2015 community outreach on GBV was 62 per cent.[39]

Outreach to male youth

According to the MGECW report, the number of community members reached through community mobilization in 2019/2020 was 25,845 (63 per cent female and 37 per cent male). Namibia's population in 2020 was estimated at 2,541,000, of which 1,232,000 (48 per cent) are male, and 1,309,000 (52 per cent) are female.[40] According to Namibia's 5th National Development Plan (NDP5), youth between the ages of 16 and 35 represent 37 per cent of the population.[41] It was estimated that the male youth population in 2020 was 455,840 and youth outreach was 2.4 per cent. Media coverage in the country was 37 per cent in 2015. It was assumed that male youth outreach should be 39 per cent at the minimum.

[39] https://genderlinks.org.za/wp-content/uploads/2019/04/GBV_Namibia_GLStrategy_2016-2020-1.pdf

[40] https://knoema.com/atlas/Namibia/topics/Demographics/Population/Male-to-female-ratio#:~:text=Namibia%20%2D%20Male%20to%20female%20ratio%20of%20the%20total%20population&text=In%202020%2C%20male%20to%20female,per%20100%20females%20in%202020

[41] Namibia's 5th National Development Plan: Working Together Towards Prosperity 2017/18-2021/22, Windhoek: Republic of Namibia, 2017 at 52.

Economic empowerment

Evidence suggests that gender inequalities increase the risk of gender-based violence, especially by men against women.[42] Thus, reducing the gender inequality gap would decrease the level of GBV. The African Development Bank in 2015 compiled the Gender Equality Index for 52 African countries. It considered three dimensions of gender equality: economic empowerment, human development, and laws and institutions as these are areas where government action is required.[43] Namibia was ranked as the third-best country overall in the gender parity index in 2015.

The African Union (AU) uses the Gender Scorecard based on the African Gender and Development Index. It scores countries on the basis of three clusters of indicators: economic empowerment (employment, business, access to land and access to credit), social empowerment (education and health), and political empowerment (women in parliament and in ministerial positions). The scores consider empowerment of women in comparison to men. A score of 0 represents the highest gender inequality, 10 represents gender parity; and higher than 10 indicates women outperformed men.[44] Namibia's scores for economic empowerment are 5 for business, 8 for access to land, 8 for access to credit and 8 for employment. Thus, its average score for economic empowerment was 6 out of 10 (60 per cent) in 2015. The study, therefore, assumed that the level of economic empowerment in Namibia was 60 per cent in 2015. A 3 per cent increase annually in its score was assumed to establish the baseline for 2020 and the 2030 target.

Outreach to female sex workers

There are no consistent estimates of the numbers of sex workers in Namibia.[45] However, Integrated Bio-behavioural Surveillance Studies among female sex workers in 2013-2014 estimated the population of female sex workers aged 15-49 years to range from 1,800 to 3,400 in Windhoek; 825 to 1,500 in Walvis Bay/Swakopmund;[46] 380 to 2,000 in Katima Mulilo; and 775 to 2,750 in Oshikango.[47] There seems to be a lack of

[42] https://www.who.int/violence_injury_prevention/violence/gender.pdf

[43] Africa Development Bank Group, Empowering African Women: An Agenda for Action, Africa Gender Equality Index 2015 at 2 (available at http://www.afdb.org/en/topics-and-sectors/topics/quality-assurance-results/gender-equality-index), and accompanying "Gender Equality Index Technical Note" (available at http://www.afdb.org/fileadmin/uploads/afdb/Documents/Generic-Documents/Gender_Equality_Index_Methodological_Note.pdf).

[44] Union Commission, African Gender Scorecard, 2015 at 3-4 (available at https://www.au.int/web/sites/default/files/documents/31260-doc-2015_auc_african_gender_scorecard_en.pdf).

[45] Matthew Greenall, Sex Work and HIV in Namibia: Review of the literature and current programmes, Windhoek: UNFPA and UNAIDS, 2011. None have been located since this overview was published.

[46] Summary Results of Phase One of the Integrated Bio-behavioural Surveillance Study (IBBSS) among Female Sex Workers (FSW): Windhoek and Walvis Bay/Swakopmund, Namibia, 2013-2014", Windhoek: Ministry of Health and Social Services at 4.

[47] Summary Results of Phase Two of the Integrated Bio-behavioural Surveillance Study (IBBSS) among Female Sex Workers (FSW): Katima Mulilo and Oshikango, Namibia, 2013-2014", Windhoek: Ministry of Health and Social Services at 4.

interventions in sensitizing female sex workers in Namibia, thus, the study assumed a zero per cent intervention at the baseline and that interventions would be introduced from 2021 with annual coverage of 5 per cent.

Mass media

The country boasts a broad cross-section of media with five national daily newspapers, four weekly tabloids, one financial weekly, several periodicals, two commercial television stations, one religious television channel and seven commercial radio stations.[48]

Analysis of GBV media coverage from April 2017 to April 2018 by the Namibia Media Monitoring Agency (NaMedia)[49] indicated that "abuse and domestic violence appeared at least 26 per cent of the time throughout print and broadcast media in Namibia". Furthermore, it showed that GBV received more media coverage compared to issues such as child marriages.[50] The analysis concluded that coverage of GBV cases in Namibia has increased, with Namibian newspapers covering 29 per cent of GBV news. The results, however, are uneven as two newspapers - The Namibian and Namibian Sun - recorded different categories of GBV.[51] In the 2015 gender barometer for Namibia, 27 per cent of media houses in Namibia had gender policies, while only 36 per cent had sexual harassment policies.[52] The study assumed 27 per cent as the baseline and an annual increase of 3 per cent for projection from 2020 to the 2030 target.

Counselling of GBV victims and perpetrators

In the same study conducted in Windhoek in 2015, about 80 per cent of those who approached the police station or went to a GBV investigation unit received counselling from a social worker. This suggests that at least 50 per cent of the sample received counselling services. However, 67 per cent of them complained of harsh questioning or unsympathetic treatment by social workers and were dissatisfied with the delays, lack of follow-up, failure to render meaningful assistance to keep the client safe, and the problem of the Unit's limited opening hours. Many women also complained about being sent back and forth between the police station and the local GBV Investigation Unit. Again, it is expected that victims in Windhoek are more likely to receive counselling services, and thus, 37 per cent could be higher than the national average. However, since 2015 is prior to the baseline year, it was assumed that other regions might have experienced some improvement between 2015 and 2020 and that 50 per cent would be the baseline rate for counselling for GBV victims in Namibia.

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[48] https://fesmedia-africa.fes.de/uploads/media/AMB_Namibia_2011_01.pdf

[49] Report provided by NaMedia.

[50] While child marriage is part of Namibia's national definition of GBV, this study excluded it from their definition.

[51] http://www.mediaombudsmannamibia.org/downloads/codeofethics_online.pdf

[52] https://genderlinks.org.za/wp-content/uploads/imported/articles/attachments/20978_baro_2015_namibia_ch_9_media.pdf

Treatment of GBV survivors

Gender-Based Violence Investigation Units (formerly known as Woman and Child Protection Units) and specialized police centres have been established in all regions throughout the country. Specialized police centres help in providing a coordinated multisectoral approach to detecting, investigating, and preventing gender-based violence. The protection units provide victim-friendly services and give the survivors of GBV access to the services of a specially-trained police officer who investigates and take statements, a medical doctor who examines the assaulted victims to collect forensic evidence and treat their injuries, and a social worker to provide counselling and support. According to the Namibia gender analysis in 2017, there were 15 units across the country.[53] A study on abused women in Windhoek in 2015 suggests that over 60 per cent of these women approached an ordinary police station or went to or were referred to a GBV Investigation Unit,[54] while 15 per cent of GBV survivors do not seek support. The services from the Unit were considered helpful as 92 per cent of the women assisted were satisfied, and 86 per cent noted that the staff were competent. In Windhoek, being the capital city, it is expected that many victims are more likely to receive treatment, and thus, 60 per cent could be above the national average. The study assumed that other regions might have experienced improvement in GBV treatment between 2015 and 2020 and, therefore, considered 60 per cent to be the treatment rate for Namibia at the baseline for 2020. A 3 per cent increase annually was also assumed to determine the 2030 projected target.

[53] https://eeas.europa.eu/sites/default/files/namibia_gender_analysis_2017.pdf
[54] https://cms.my.na/assets/documents/p1cl0r4st9obrao011b01lqo13rg4.pdf

Table B1: Anti-GBV coverage rates between 2020 and 2030, (%)

INTERVENTION	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
Scenario 1 (2% annual increase)											
Community mobilization	62	63.2	64.4	65.6	66.8	68	69.2	70.4	71.6	72.8	74
Outreach to male youth	39	39.8	40.6	41.4	42.2	43	43.8	44.6	45.4	46.2	47
Economic empowerment	60	61.2	62.4	63.6	64.8	66	67.2	68.4	69.6	70.8	72
Outreach to female sex workers	0	5	10	15	20	25	30	35	40	45	50
Mass media	37	37.7	38.4	39.1	39.8	40.5	41.2	41.9	42.6	43.3	44
Counselling	50	51	52	53	54	55	56	57	58	59	60
Treatment	60	61.2	62.4	63.6	64.8	66	67.2	68.4	69.6	70.8	72
Scenario 2 (+10% annual increase)											
Community mobilization	62	64.2	66.4	68.6	70.8	73	75.2	77.4	79.6	81.8	84
Outreach to male youth	39	40.8	42.6	44.4	46.2	48	49.8	51.6	53.4	55.2	57
Economic empowerment	60	62.2	64.4	66.6	68.8	71	73.2	75.4	77.6	79.8	82
Outreach to female sex workers	0	6	12	18	24	30	36	42	48	54	60
Mass media	37	38.7	40.4	42.1	43.8	45.5	47.2	48.9	50.6	52.3	54
Counselling	50	52	54	56	58	60	62	64	66	68	70
Treatment	60	62.2	64.4	66.6	68.8	71	73.2	75.4	77.6	79.8	82
Scenario 3 (additional 10% annual increase)											
Community mobilization	62	65.2	68.4	71.6	74.8	78	81.2	84.4	87.6	90.8	94
Outreach to male youth	39	41.8	44.6	47.4	50.2	53	55.8	58.6	61.4	64.2	67
Economic empowerment	60	63.2	66.4	69.6	72.8	76	79.2	82.4	85.6	88.8	92
Outreach to female sex workers	0	7	14	21	28	35	42	49	56	63	70
Mass media	37	39.7	42.4	45.1	47.8	50.5	53.2	55.9	58.6	61.3	64
Counselling	50	53	56	59	62	65	68	71	74	77	80
Treatment	60	63.2	66.4	69.6	72.8	76	79.2	82.4	85.6	88.8	92

Table B2: Anti-GBV intervention unit costs (US$)

INTERVENTION	UNIT COST (US$)	
Community mobilization	3.77	Per person reached
Outreach to male youth	11.70	Per person reached
Economic empowerment	48.12	Per person reached
Outreach to female sex workers	13.64	Per person reached
Mass media	0.27	Per person reached
Counselling	7.57	Per person reached
Treatment	213.27	Per person reached
NGO strengthening	100,000	Per year
Programme support	15	Per cent of direct costs

Table B3: The impact of anti-GBV interventions on intimate partner violence, 2020–2030

	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	TOTAL
Scenario 1												
Per cent experiencing IPV	17	16.8	16.7	16.6	16.5	16.3	16.2	16.1	16	15.8	15.7	
Number experiencing IPV	113,539	115,125	116,674	118,185	119,658	121,094	122,491	123,850	125,171	126,454	127,697	**1,329,938**
Cases of IPV averted	0	834	1,706	2,616	3,562	4,547	5,570	6,631	7,730	8,868	10,045	**52,111**
Scenario 2												
Per cent experiencing IPV	17	16.8	16.6	16.4	16.2	15.9	15.7	15.5	15.3	15.1	14.9	
Number experiencing IPV	113,539	114,598	115,593	116,523	117,390	118,191	118,927	119,597	120,201	120,738	121,208	**1,296,505**
Cases of IPV averted	0	1,362	2,787	4,277	5,831	7,450	9,134	10,884	12,701	14,584	16,534	**85,543**
Scenario 3												
Per cent experiencing IPV	17	16.7	16.4	16.1	15.8	15.6	15.3	15	14.7	14.4	14.1	
Number experiencing IPV	113,539	114,069	114,507	114,853	115,104	115,261	115,323	115,288	115,155	114,924	114,594	**1,262,617**
Cases of IPV averted	0	1,890	3,873	5,948	8,116	10,379	12,738	15,193	17,746	20,398	23,148	**119,430**

Table B4: Costs of investing in ending GBV in Namibia (US$), 2020-2030

	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	TOTAL
Scenario 1												
Community mobilization	751,859	765,387	778,628	791,766	804,925	818,090	833,113	848,136	862,943	877,174	890,555	9,022,576
Outreach to male youth	239,361	249,611	261,074	273,480	286,221	298,724	310,562	322,075	333,192	343,871	354,044	3,272,215
Economic empowerment	4,575,035	4,766,400	4,981,120	5,213,909	5,452,821	5,686,610	5,908,117	6,123,080	6,329,988	6,528,063	6,716,576	62,281,719
Outreach to female sex workers	0	5,624	11,456	17,508	23,795	30,334	37,126	44,192	51,534	59,142	66,999	347,710
Mass media	129,265	134,168	139,220	144,466	149,939	155,652	161,532	167,644	173,961	180,429	187,004	1,723,280
Counselling	512,079	531,932	552,380	573,594	595,715	618,787	642,589	667,324	692,872	718,991	745,484	6,851,747
Treatment	75,120	78,023	80,984	84,002	87,080	90,219	93,418	96,676	99,994	103,374	106,817	995,707
NGO strengthening	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	1,100,000
Programme support	957,408	994,672	1,035,729	1,079,809	1,125,074	1,169,762	1,212,969	1,255,369	1,296,673	1,336,656	1,375,122	12,839,243
Total	**7,340,128**	**7,625,817**	**7,940,592**	**8,278,533**	**8,625,570**	**8,968,178**	**9,299,427**	**9,624,496**	**9,941,156**	**10,247,700**	**10,542,601**	**98,434,198**
Scenario 2												
Community mobilization	751,859	777,498	802,809	827,974	853,124	878,243	905,348	932,468	959,361	985,616	1,010,900	9,685,200
Outreach to male youth	239,361	255,882	273,935	293,298	313,351	333,459	353,105	372,625	391,904	410,859	429,372	3,667,151
Economic empowerment	4,575,035	4,844,283	5,140,772	5,459,848	5,789,415	6,117,414	6,435,628	6,749,711	7,057,573	7,357,901	7,649,434	67,177,014
Outreach to female sex workers	0	6,749	13,748	21,009	28,554	36,401	44,551	53,030	61,841	70,970	80,399	417,252
Mass media	129,265	137,727	146,471	155,550	165,008	174,868	185,057	195,651	206,630	217,932	229,505	1,943,664
Counselling	512,079	542,362	573,625	606,062	639,842	675,041	711,438	749,276	788,441	828,667	869,732	7,496,565
Treatment	75,120	79,298	83,579	87,964	92,455	97,054	101,759	106,570	111,487	116,514	121,653	1,073,453
NGO strengthening	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	1,100,000
Programme support	957,408	1,011,570	1,070,241	1,132,756	1,197,262	1,261,872	1,325,533	1,388,900	1,451,586	1,513,269	1,573,649	13,884,046
Total	**7,340,128**	**7,755,368**	**8,205,180**	**8,684,461**	**9,179,011**	**9,674,352**	**10,162,418**	**10,648,231**	**11,128,822**	**11,601,729**	**12,064,643**	**106,444,343**
Scenario 3												
Community mobilization	751,859	789,608	826,989	864,183	901,323	938,397	977,583	1,016,800	1,055,779	1,094,057	1,131,245	10,347,823
Outreach to male youth	239,361	262,154	286,796	313,115	340,481	368,194	395,648	423,175	450,616	477,846	504,700	4,062,086
Economic empowerment	4,575,035	4,922,165	5,300,423	5,705,787	6,126,008	6,548,218	6,963,138	7,376,342	7,785,158	8,187,740	8,582,291	72,072,305
Outreach to female sex workers	0	7,874	16,039	24,511	33,313	42,468	51,976	61,869	72,148	82,799	93,799	486,796
Mass media	129,265	141,286	153,722	166,635	180,078	194,084	208,581	223,658	239,298	255,435	272,006	2,164,048
Counselling	512,079	552,792	594,871	638,530	683,969	731,294	780,287	831,228	884,009	938,344	993,979	8,141,382
Treatment	75,120	80,573	86,175	91,927	97,831	103,889	110,100	116,464	122,981	129,655	136,489	1,151,204
NGO strengthening	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	1,100,000
Programme support	957,408	1,028,468	1,104,752	1,185,703	1,269,450	1,353,982	1,438,097	1,522,430	1,606,498	1,689,881	1,772,176	14,928,845
Total	**7,340,128**	**7,884,919**	**8,469,767**	**9,090,390**	**9,732,453**	**10,380,526**	**11,025,410**	**11,671,965**	**12,316,488**	**12,955,758**	**13,586,686**	**114,454,490**

Table B5: Percentage contribution of each intervention to total intervention costs (Scenario 1)

	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
Community mobilization	10.2	10	9.8	9.6	9.3	9.1	9.0	8.8	8.7	8.6	8.4
Outreach to male youth	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.4	3.4	3.4
Economic empowerment	62.3	62.5	62.7	63	63.2	63.4	63.5	63.6	63.7	63.7	63.7
Outreach to female sex workers	0	0.1	0.1	0.2	0.3	0.3	0.4	0.5	0.5	0.6	0.6
Mass media	1.8	1.8	1.8	1.7	1.7	1.7	1.7	1.7	1.7	1.8	1.8
Counselling	7.0	7.0	7.0	6.9	6.9	6.9	6.9	6.9	7.0	7.0	7.1
Treatment	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
NGO strengthening	1.4	1.3	1.3	1.2	1.2	1.1	1.1	1.0	1.0	1.0	0.9
Programme support	13.0	13.0	13.0	13.0	13.0	13.0	13.0	13.0	13.0	13.0	13.0