



NAMIBIA

Health Facility Census 2009



Key Findings on HIV/AIDS, TB, and STIs

This report summarises the key findings on HIV/AIDS and STIs of the 2009 Namibia Health Facility Census (HFC) which was carried out by the Directorate of Special Programmes (HIV/AIDS/TB/MALARIA) in the Ministry of Health and Social Services (MoHSS). ICF Macro provided technical assistance. The 2009 Namibia HFC is part of the worldwide MEASURE DHS project which assists countries in the collection of data to monitor and evaluate population, health, and nutrition programmes. Financial support for the census was received from the United States Agency for International Development, the Global Fund to Fight AIDS, Tuberculosis and Malaria, Government of the Republic of Namibia, and the World Health Organisation.

Additional information about the 2009 Namibia HFC may be obtained from the Ministry of Health and Social Services (MoHSS), Private Bag 13198, Windhoek, Namibia; Telephone: (264-61) 203-2826; Fax: (264-61) 224-155; E-mail: doccentre@mhss.gov.na; Internet: www.healthnet.org.na

Additional information about the DHS project may be obtained from ICF Macro, 11785 Beltsville Drive, Calverton, MD 20705 USA; Telephone: 301-572-0200, Fax: 301-572-0999, E-mail: reports@measuredhs.com, Internet: <http://www.measuredhs.com>.

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Introduction

The HIV/AIDS component of the 2009 Namibia Health Facility Census (NHFC) provides a comprehensive picture of the availability and quality of HIV/AIDS services nationwide, as well as the strengths and weaknesses of facility-based services related to HIV/AIDS, such as counselling and testing (CT), preventing mother-to-child-transmission (PMTCT) of HIV, and care and support services (CSS). The NHFC was carried out by the Directorate of Special Programmes (HIV/AIDS/TB/MALARIA) in the Ministry of Health and Social Services (MoHSS).

The major objectives of the 2009 Namibia HFC are to:

- Describe how well prepared facilities are to provide quality reproductive and child health services as well as services for some infectious diseases (HIV/AIDS, STIs, malaria, and TB);
- Provide a comprehensive body of information on the performance of the full range of public and private health care facilities that provide reproductive health, child health, tuberculosis (TB), malaria, and HIV/AIDS services;
- Help identify strengths and weaknesses in the delivery of reproductive health, child health, TB, malaria, and HIV/AIDS services at health care facilities, producing information that can be used to better target service delivery improvement interventions and to improve ongoing supervisory systems;
- Describe the processes used in providing child, maternal, and reproductive health services and the extent to which accepted standards for quality service provision are followed;
- Provide information for periodically monitoring progress in improving the delivery of reproductive, child health, and HIV/AIDS services at Namibian health facilities;
- Provide baseline information on the capacity of health facilities to provide basic and advanced HIV/AIDS care and support services, and on the record-keeping systems in place for monitoring HIV/AIDS preventive, diagnostic, care, and support services.

The 2009 NHFC provides national- and regional-level representative information for hospitals, health centres, clinics, stand-alone voluntary counselling and testing (VCT) facilities and sick bays offering maternal and child health (MCH) and HIV/AIDS-related services. Data were collected from all functioning health facilities in Namibia. These facilities were under various management authorities, including government, private-for-profit, mission, NGOs, ministry of defence (MoD), and the Namibia police. In each facility visited, data were collected from all or a sample of health service providers available on the day of the visit, as well as from a sample of sick children, family planning clients, and antenatal care (ANC) clients. Trained interviewers collected the data between July and October 2009.

This report summarises the major findings on HIV/AIDS and STI services based on interviews and observations at 411 health care facilities. Graphs and figures presented in this report include table numbers in parentheses. These table numbers refer to the tables in the 2009 Namibia Health Facility Census Final Report. Table numbers that include an A in the title, e.g. Table A-5.5, refer to tables found in the appendix of the final report, rather than the chapters. To put the results of the 2009 Namibia HFC into context, this report also includes findings from the 2006 Namibia Demographic and Health Survey (NDHS) based on data from 13,719 Namibians. This information is provided in red boxes.

HIV/AIDS in Namibia

The first case of HIV/AIDS in Namibia was reported in 1986. Since then, the HIV prevalence rate in pregnant women continued to rise and peaked in the year 2002 (MoHSS Sentinel Surveillance, 2008). It is estimated that in 2008-09 a total of 174,000 people in Namibia were living with HIV, and there were 5,800 new infections during that year (MoHSS, 2008/09 HIV Estimates and Projections). To address the epidemic, the Ministry of Health and Social Services (MoHSS) established the National AIDS Coordination Programme in 2004. This programme is managed by the Directorate of Special Programmes (TB, Malaria, and HIV/AIDS). The Directorate is responsible for providing assistance to all sectors develop and implement sector-related HIV/AIDS activity plans in accordance with sectoral obligations as contained in the Third Medium-Term Plan on HIV/AIDS (MTP3) (MoHSS Medium-Term Plan on HIV/AIDS, 2004).

The 2006-07 NDHS recently assessed HIV/AIDS related knowledge, attitudes, and behaviours in Namibia. The majority of Namibian women (84%) and men (87%) know that HIV can be prevented by using condoms. Slightly more women (90%) and men (92%) know that HIV can be prevented by limiting sexual intercourse to one uninfected partner.

Three percent of women and 16% of men had two or more sexual partners in the 12 months before the survey. Among these respondents, 66% of women and 74% of men reported using a condom at last sex.

Half of women and one-third of men have ever been tested for HIV and received their results. This is an increase from the 2000 NDHS where 22% of women and 23% of men had ever been tested for HIV and received their results. Among women who gave birth in the two years before the survey, 73% received counseling about HIV during antenatal care (ANC) visits. The majority of women who were counselled voluntarily accepted an offer for the HIV test and received the test results (62%).



© 2004 HCP Namibia, Courtesy of Photoshare. Community members in Rehoboth, Namibia assess how HIV/AIDS affects them through a series of peer group discussions, followed by a community meeting where results are shared with the larger community as a way to help fight the HIV epidemic in Namibia.

Availability of HIV/AIDS Services in Namibia

The availability of HIV/AIDS services varies widely throughout Namibia. Almost all (98%) health facilities in Namibia have an HIV testing system. Nine in ten health care facilities in Namibia provide some care and support services (CSS) for HIV. Most (81%) health facilities offer post-exposure prophylaxis for health facility staff. Three quarters of facilities report that they provide PMTCT services.

Other HIV-related health services are less widely available. Youth friendly testing services are available at 21% of facilities. Additionally, only 18% of facilities offer antiretroviral therapy (ART), which means they prescribe ART and/or provide medical follow-up services.

Overall, HIV/AIDS services are more likely to be available in hospitals and health centres than in clinics or sick bays.

Overview of HIV-Related Health Care Services in Namibia: Percent of Facilities Offering Services

Region	HIV Testing System* (N=411)	Care and Support Services (CSS) (N=396)	Antiretroviral Therapy (ART) prescribe and/or provide follow-up (N=396)	Preventing Mother-to-Child Transmission (PMTCT)** (N=396)	Post-Exposure Prophylaxis (PEP) (N=411)	Youth Friendly Testing Services (YFS) (N=402)***
Caprivi	97	96	18	89	34	21
Erongo	95	89	39	64	84	14
Hardap	100	100	29	71	87	13
Karas	96	88	28	88	92	16
Kavango	100	77	12	82	93	22
Khomas	86	85	18	18	67	13
Kunene	100	89	14	64	83	7
Ohangwena	100	97	16	94	73	18
Omaheke	100	94	6	88	75	63
Omusati	100	86	8	84	98	18
Oshana	100	100	10	75	95	19
Oshikoto	100	100	18	95	64	45
Otjondjupa	100	90	21	62	90	23
Managing Authority						
MoHSS	100	92	17	85	84	24
Mission/NGO	100	89	21	89	83	21
Private	88	80	22	20	63	2
MoD/POLICE	79	77	8	8	79	0
Total	98	90	18	74	81	21

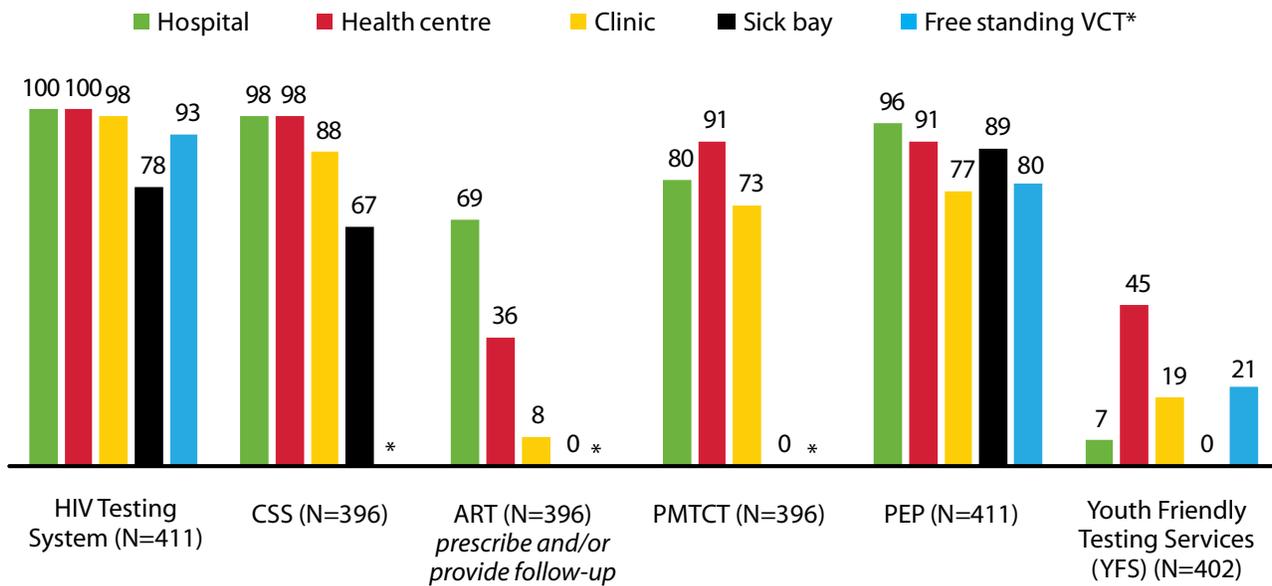
*HIV testing system means that the facility reports conducting the test in the facility or in an affiliated external laboratory, or has an agreement with a testing site that is expected to return results to the facility.

**At least one of the four elements of PMTCT: HIV testing system in the facility, antiretroviral (ARV) prophylaxis for the mother and infant, counselling on maternal nutrition and infant feeding for HIV positive mothers, or family planning counselling or services.

***Among facilities with an HIV testing system.

Availability of HIV/AIDS-Related Services among All Facilities

(Tables 8.1, 8.2, 8.4, 8.5, A-8.20, A-8.17.1)



*Free-standing VCTs are only included in data regarding HIV testing systems, PEP, and youth friendly testing services.

HIV Testing

A facility is considered to have an HIV testing system if it conducts the test in the facility or in an affiliated external laboratory, or has an agreement with a testing site where the test results are expected to be returned to the facility.

HIV testing services vary by region, type of facility, and managing authority. Almost all (98%) facilities in Namibia report having an HIV testing system. All hospitals and health centres have an HIV testing system, as do 98% of clinics and 93% of free-standing VCTs. Sick bays (78%) are less likely to have an HIV testing system. In all but four regions of Namibia, 100% of facilities have an HIV testing system. Facilities in Khomas are less likely (86%) to have an HIV testing system, while 95% of facilities in Erongo, 96% of facilities in Karas and 97% of facilities in Caprivi have an HIV testing system. All facilities managed by the Ministry of Health and Social Services (MoHSS) or by Mission/NGO have an HIV testing system, compared with only 88% of private facilities and 79% of Ministry of Defense/Police (MoD/Police) facilities.



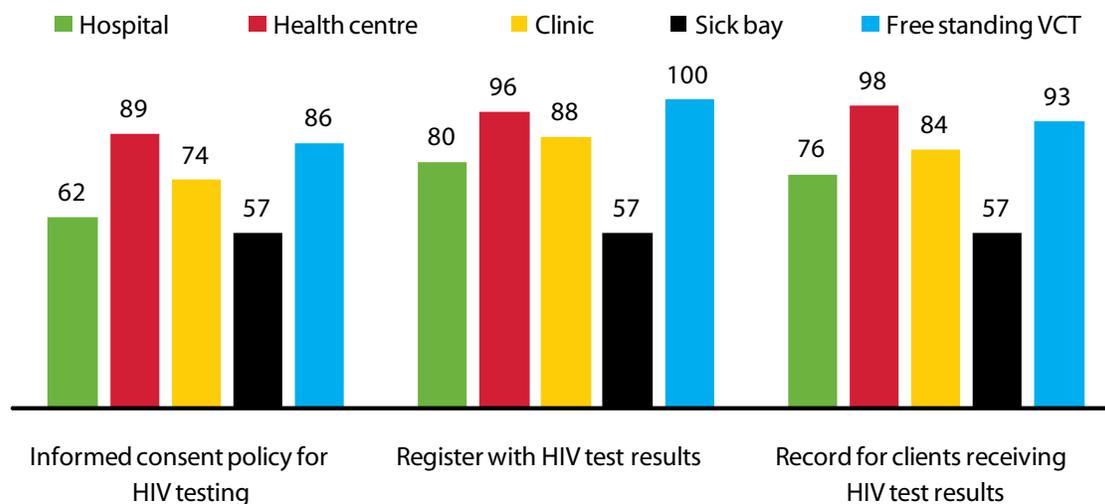
© 2004 Deborah McSmith, Courtesy of Photoshare. Community leaders participate in an HIV/AIDS testing and counselling training program at the Malarial Research Center near the Andara Hospital in Upper Namibia.

Among facilities reporting an HIV testing system, 81% had the HIV test available in the facility or in an affiliated lab. The remaining 19% of facilities have an agreement with a testing site where the test results are expected to be returned to the facility. Three-quarters of facilities reporting an HIV testing system had an informed consent policy available at the service site. Most (88%) facilities with an HIV testing system have a register with HIV test results; slightly fewer (84%) had a record for clients receiving test results.

HIV Testing Systems

(Table 8.1)

Among facilities with an HIV testing system, percent with the following items (N=402)



Care and Support Services

Care and support services (CSS) are any health services that support and improve the life of an HIV-infected person. They include the treatment of opportunistic infections (OIs) or symptoms related to HIV, palliative care, nutritional rehabilitation services, and care for paediatric HIV/AIDS patients. Since HIV-infected persons are at higher risk of developing opportunistic infections like tuberculosis as a result of their suppressed immune system, immediate treatment of OIs and other infections is essential. Care and support services are available at almost all hospitals and health centres in Namibia, compared to only 88% of clinics and 67% of sick bays. All advanced CSS services (the basic services, plus palliative care, ART, inpatient care, and post-exposure prophylaxis) are available in 7% of all health facilities, mainly at hospitals (43%).

Good record keeping systems are not universal in CSS facilities. About half (48%) of facilities offering basic CSS have a register with HIV/AIDS-related client diagnosis in any eligible service site. Record systems for individual appointments were observed in any relevant sites in only one-quarter of CSS facilities. This lack of good record keeping makes it difficult to monitor the disease burden of HIV and to properly plan allocation of funds, medicines and other supplies.

Tuberculosis in HIV Service Sites

Tuberculosis (TB) is a leading cause of death among people infected with HIV. The World Health Organization recommends directly observed treatment short-course (DOTS) to treat TB. DOTS ensures that patients take their drugs regularly and complete their treatment. This regime cures patients and helps prevent drug resistance.

Overall, 90% of facilities offering CSS provide some TB diagnostic or treatment services. Availability varies by region, ranging from a low of 61% in Khomas to a high of 100% in Caprivi. Two-thirds of facilities offering CSS report that they are part of the national DOTS programme and 52% say they follow the DOTS treatment. However, a substantial percentage of facilities do not have all of the elements needed for proper TB treatment. For example, only 72% of facilities offering CSS and following the DOTS strategy had all first-line TB medicines (any combination of isoniazid, rifampicin, ethambutol, and pyrazinamide and streptomycin). Only 65% of facilities offering CSS and following the DOTS strategy have observed client registers for DOTS. Almost all (98%) have treatment protocols available at the service site.

TB Treatment and/or Follow-up Using DOTS Percent among Facilities Offering CSS (N=355)

	Any TB diagnostic or treatment services	Report they are part of national DOTS programme	Follow DOTS Treatment*
Caprivi	100	19	30
Erongo	97	81	66
Hardap	90	81	57
Karas	91	73	77
Kavango	95	70	57
Khomas	61	39	39
Kunene	80	52	28
Ohangwena	94	90	68
Omaheke	93	93	87
Omusati	93	57	21
Oshana	95	80	35
Oshikoto	91	36	68
Otjozondjupa	85	81	73
Total	90	65	52

*Treatment strategy followed is either direct-observe two months with four months follow up, or direct-observe six months.

Sexually Transmitted Infections Services in HIV Service Sites

Sexually transmitted infections (STIs) are a known risk factor for contracting HIV. Thus, facilities where HIV/AIDS services are offered are prime locations for the counselling, diagnosis, treatment, and prevention of STIs and vice versa. In Namibia, 98% of facilities offering CSS for HIV/AIDS also treat STIs. Of the facilities offering CSS and STI treatment services, 91% have STI treatment protocols in any relevant site. Sick bays are least likely to have treatment protocols at any site.

At least one medicine for treating each major STI (syphilis, chlamydia, trichomoniasis, and gonorrhoea) was available in 87% of facilities offering CSS and STI treatment services. Medicines are more likely to be available in hospitals (98%) and health centres (93%) than in clinics (84%) or sick bays (83%).

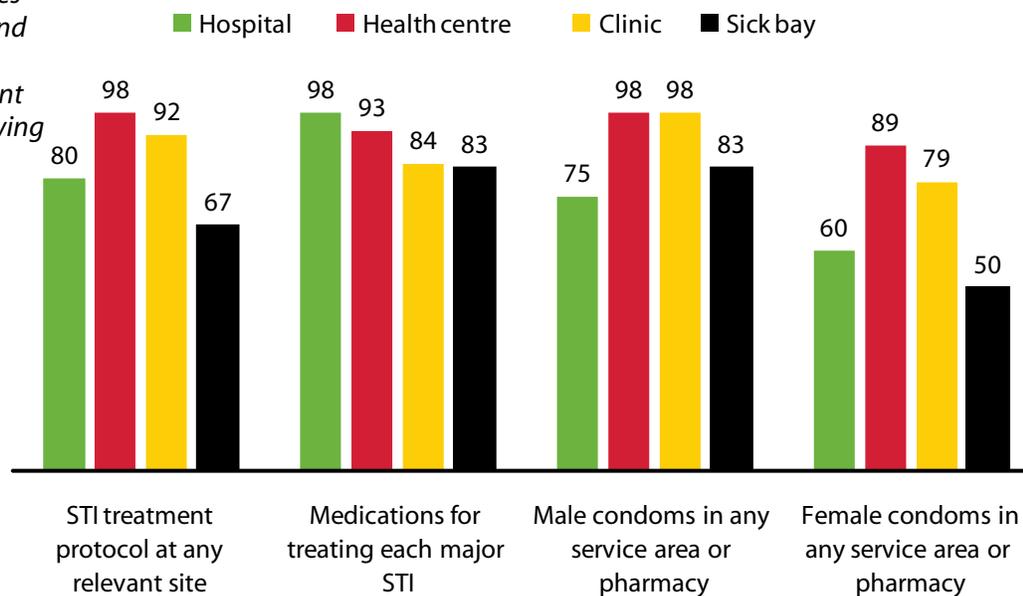
Male condoms are available in 95% of facilities and female condoms are available in 78% of facilities offering CSS and STI treatment services in Namibia. Male and female condoms are more likely to be available in health centres and clinics than in hospitals or sick bays. MoHSS and Mission/NGO facilities are much more likely than private or MoD/Police facilities to have condoms.

Of facilities offering CSS and STI services, 79% have all three elements for quality STI services: treatment protocols at any relevant unit; medicines for treating common STIs; and condoms in any service area or pharmacy.

Components of STI Services

(Table A-8.6)

Among facilities offering CSS and STI treatment services, percent with the following items (N=349)



Treatment of Opportunistic Infections

Appropriate treatment of opportunistic infections (OIs) improves the quality and extends the life span of people living with HIV and AIDS. In addition to TB, common OIs include topical fungal infections, chronic diarrhoea, and bacterial pneumonia.

Almost all facilities offering CSS for HIV/AIDS can provide treatment for bacterial infections (including pneumonia) as well as management of chronic diarrhoea and basic management of pain. Most facilities (93%) have intravenous fluid with infusion sets for rehydration and 96% have oral rehydration salts. However, only 30% can treat topical fungal infections, including all hospitals and 50% of sick bays.

The quality of OI treatment is not clear, however. Few facilities have providers trained to treat OIs. Overall, only one quarter of facilities that offer CSS have at least one provider who received training in the treatment of OIs during the three years preceding the survey. Even fewer facilities have a provider trained to provide nutritional rehabilitation (15%), palliative care (12%), or treat HIV/AIDS related neurological disorders (8%). Not surprisingly, lower level health facilities such as clinics and sick bays are the least likely to have a trained provider.

OI treatment guidelines are available in only 10% of facilities that offer CSS. Health centres are more likely than other facility types to have observed OI treatment guidelines.



© 2005 Alfredo L. Fort, Courtesy of Photoshare. A local physician stands with community volunteer counsellors at Katutura Hospital, Windhoek.

Availability of Co-trimoxazole Prophylaxis

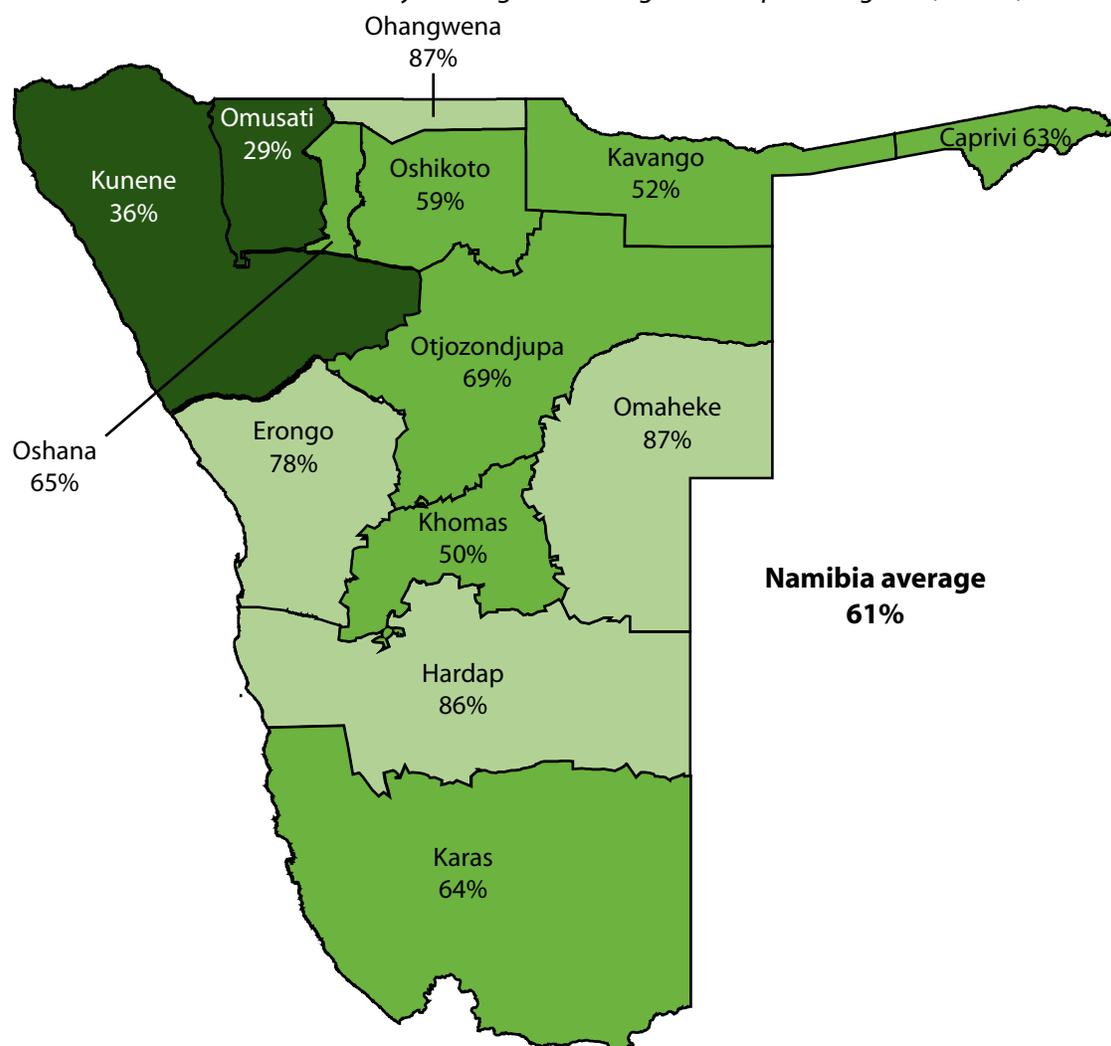
Co-trimoxazole prophylaxis for the prevention of HIV-related infections in people living with HIV/AIDS is an integral component of the HIV/AIDS CSS package in Namibia. About six in ten facilities providing CSS routinely offer preventive treatment such as co-trimoxazole prophylactic treatment (CPT) to HIV/AIDS patients. Another 17% of facilities provide CPT selectively. Health centres (83%) and hospitals (64%) are most likely to routinely offer CPT. MoHSS (64%) and Mission/NGO (60%) facilities are more likely than private (46%) and MoD/Police (40%) facilities to routinely offer CPT. CPT is most frequently offered routinely in Ohangwena and Omaheke (87% each) and least frequently offered routinely in Kunene (36%) and Omusati (29%) regions.

Of the CSS facilities that report they ever offer primary preventive treatment such as CPT, 89% had co-trimoxazole available. Almost all hospitals (97%) had co-trimoxazole available, in comparison to 86% of health centres and 88% of clinics. Just one-quarter (24%) of facilities had a provider of CPT trained in the three years before the survey, and only 5% of facilities offering CPT had a protocol available in any service sites.

Availability of CPT

(Table A-8.9)

Percent of facilities routinely offering CPT among facilities providing CSS (N=355)



Advanced Clinical Care and Support Services

Namibians have been dealing with HIV/AIDS for quite some time; however, advanced health services for HIV/AIDS are not widely available.

Laboratory testing capacity is defined as either having laboratory capacity on site or a documented system for sending blood elsewhere and receiving results for the test. Most (81%) CSS facilities have laboratory testing capacity for white cell counts and for haemoglobin or haematocrit (93%). Laboratory testing capacity is least common in sick bays.

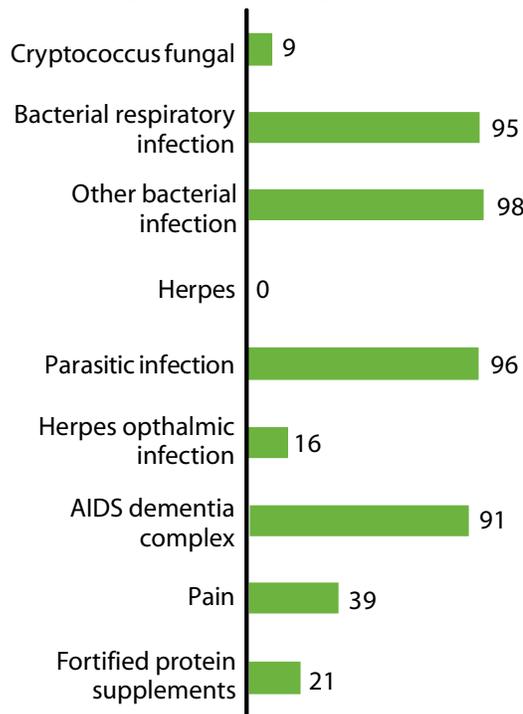
Medicines to treat bacterial infections and AIDS dementia complex are common; however only 9% of CSS facilities have at least two medicines to treat cryptococcus fungal infection, only 16% can treat herpes ophthalmic infection, and 39% have at least two medicines to treat or manage pain. Only 15% of facilities have one medicine to treat herpes; no facilities have two medicines to treat herpes. Less than a quarter of facilities can provide fortified protein supplements (21%) or treat Kaposi’s sarcoma (18%). Hospitals are more likely to provide these services than other facility types.

One quarter of CSS facilities offer home-based care, either in the facility or through outreach. Approximately two in ten CSS facilities have at least one trained provider for community home-based care for HIV/AIDS clients.

Percent of Facilities with at Least Two Types of Medicines to Treat Each Opportunistic Infection

(Table A-8.14)

Among facilities offering CSS (N=355)



Antiretroviral Therapy

Antiretroviral drugs can significantly prolong and improve the quality of life for people living with HIV and AIDS. According to national policy, prescription and provision of antiretroviral therapy (ART) should be done by trained health personnel, who should regularly monitor the condition of these clients to ensure that an effective ART regime is being implemented and that side effects are properly managed.

Quality ART services include the following:

- trained staff;
- protocols and guidelines for care and support services;
- consistent supply of antiretroviral (ARV) medicines;
- a system for client appointments and follow-up services;
- individual client records for continuity of care; and
- record-keeping systems to ensure ARV compliance.

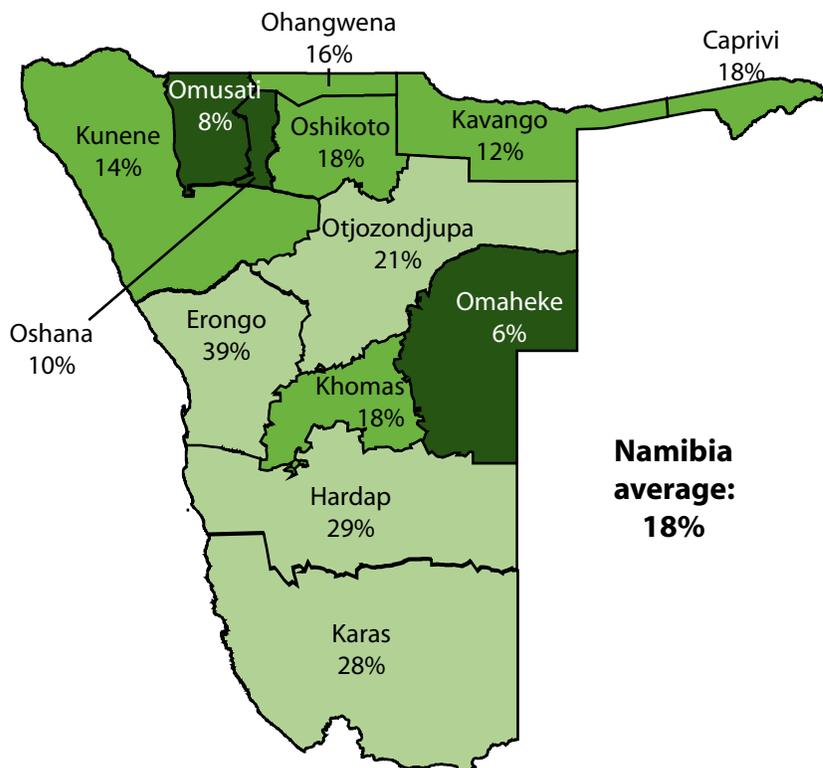
Nationwide, only 18% of all health facilities prescribe ART and/or provide medical follow-up. ART services are mostly available at hospitals (69%) and health centres (36%). ART is most available in the Erongo, Hardap and Karas regions. Twenty-two percent of private facilities and 21% of Mission/NGO facilities prescribe ART and/or provide medical follow-up, compared to 17% of MoHSS facilities and just 8% of MoD/Police facilities.

The quality of ART services varies among health care facilities. Nine in ten facilities prescribing ART and/or medical follow-up had the first-line adult regimen available on the day of the survey. ARV stock-outs are rare; overall, only 13% of facilities that prescribe ART and/or provide follow-up services reported they had stock-outs of first-line ARVs in the six months before the survey. National guidelines for ART are available in 90% of hospitals, 88% of health centres, and 78% of clinics that prescribe ART and/or provide medical follow-up.

Availability of Antiretroviral Therapy (ART)

(Table 8.4)

Percent of facilities that prescribe ART and/or provide follow-up (N=396)



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Courtesy of Photoshare.

Packages of antiretroviral drugs sit on a table, waiting to be dispensed to AIDS patients in Katutura Hospital, Windhoek



Preventing Mother-to-Child Transmission of HIV

Mother-to-child transmission (MTCT) of HIV occurs when the virus is passed from an HIV-infected mother to her baby during pregnancy, delivery, or breastfeeding. Services to prevent MTCT are most often offered in conjunction with antenatal and delivery services. Generally accepted standards of PMTCT are:

- HIV testing and counselling for pregnant women;
- Counselling HIV-positive women on infant feeding practices and maternal nutrition
- Providing prophylactic ARV drugs to HIV-positive women during pregnancy, labour, and delivery and to the newborn;
- Providing family planning counselling and/or referrals

The package of services varies greatly from facility to facility. As of 2009, 74% of all facilities nationwide offer at least one component of PMTCT services, and only half of these facilities offer all four components for the minimum PMTCT package (HIV testing with pre- and post-test counselling, ARV for mother and newborn, counselling on maternal nutrition and infant feeding, and FP counselling or services).

It is important that PMTCT services be offered at facilities that provide antenatal care (ANC). Eighty-eight percent of ANC facilities report that they offer PMTCT services. However, only half these facilities have all four components of the minimum package.

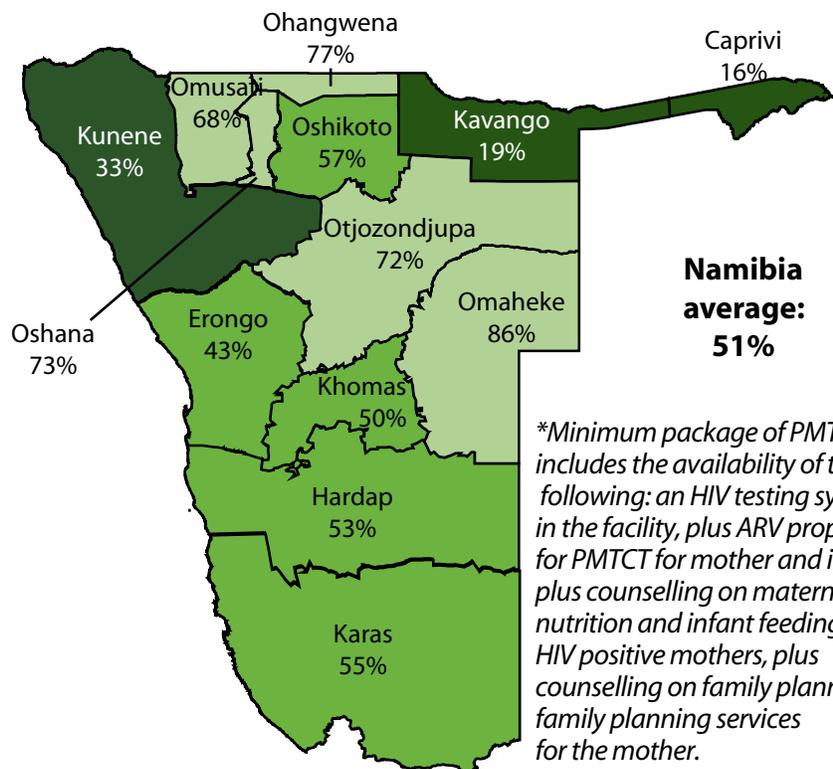
PMTCT+, an enhanced programme that includes ART for HIV-infected pregnant women

and their families, is far less available. Only 4% of all facilities in Namibia provide PMTCT+ services. Private health facilities are most likely to have all items for the PMTCT+ package.

Prevention of Mother-to-Child Transmission (PMTCT) Services

(Table 8.5)

Percent of facilities that have all four items for the minimum package of PMTCT* (N=295)



Putting the 2009 NAMIBIA HFC into Context: Knowledge of Mother-to-Child Transmission

According to the 2006-07 Namibia DHS, 88% of women and 77% of men know that HIV can be transmitted during breastfeeding. Fewer women (80%) and men (68%) know that antiretroviral drugs can reduce the risk of MTCT. Three-quarters of women and 60% men know both that HIV can be transmitted through breastfeeding and ARVs taken during pregnancy can reduce the risk of HIV transmission.

Among women who gave birth in the two years before the survey, 73% received counselling about HIV during ANC visits. The majority (62%) of women received HIV counselling, were tested for HIV, and received the results.

Youth-Friendly Counselling and Testing Services

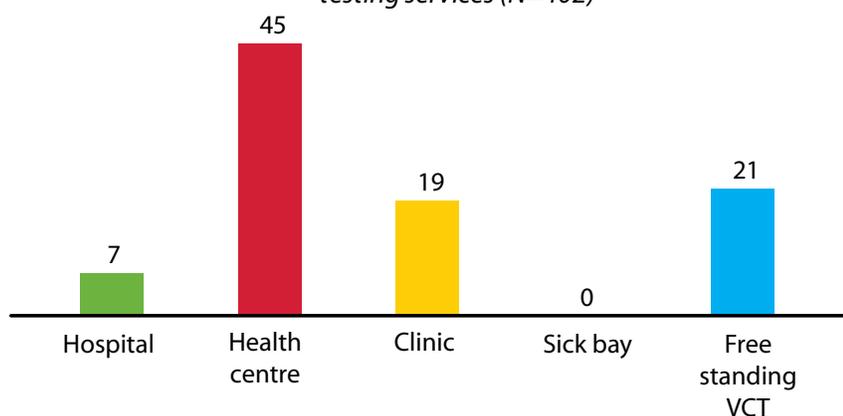
Youth-friendly HIV/AIDS services (YFS) help young adults overcome barriers to accessing HIV/AIDS services. Ideally, YFS involve young people in all aspects of the programme's planning, operations, and evaluation. The services should include staff who are sensitive to youth culture and ethnic cultures as well as to issues of gender, sexual orientation, and HIV status. YFS usually have flexible hours, convenient locations, and walk-in appointments.

The Namibia HFC assessed the availability of youth-friendly HIV testing services in Namibian health care facilities. Only 21% of facilities with an HIV testing system offer youth-friendly HIV testing services. Youth-friendly HIV testing services are most common in health centres. Youth friendly services vary widely by region, from a high of 63% of facilities with an HIV testing system in Omaheke to 7% in Kunene. Of the facilities with any YFS, 60% have at least one provider trained to provide youth-friendly services. Far fewer (39%) facilities have appropriate guidelines on site.

Availability of Youth-Friendly Services

(Table A-8.17.1)

Among facilities with an HIV testing system, percent offering youth-friendly HIV testing services (N=402)



Putting the NAMIBIA HFC into Context: HIV Knowledge among Youth in Namibia

About two-thirds of young people in Namibia are well informed HIV/AIDS. The 2006-07 Namibia DHS defined comprehensive knowledge as: knowing that consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the chances of getting the AIDS virus, knowing that a healthy-looking person can have the AIDS virus, and rejecting the two most common local misconceptions about AIDS transmission or prevention. In Namibia, the most common local misconceptions are that AIDS can be transmitted by mosquito bites and that a person can become infected by sharing food with a person who has AIDS. Young men and women with more education are most likely to have comprehensive knowledge of AIDS.

Most young men (91%) and young women (89%) know of at least one source for condoms. Young people living in urban areas and those from wealthier households are most likely to know a condom source.

Slightly less than one half of unmarried young women (46%) and unmarried young men (49%) reported having sex in the year before the survey. Among those who had sex in the year before the survey, 64% of women and 81% of men used a condom the last time they had sex.

Post-Exposure Prophylaxis

Post-exposure prophylaxis (PEP) is the preventive treatment with antiretrovirals for persons who may have been exposed to HIV. The risk of contracting HIV infection on the job is a threat to everyone working in health care facilities. PEP should also be available for rape victims.

Most (81%) health care facilities in Namibia offer PEP services to their staff. As expected, most PEP services are located in hospitals (96%) and health centres (91%). Availability of PEP services varies by region. Staff has access to PEP in 98% of facilities in Omusati, compared to a low of 34% in Caprivi.

However, among facilities reporting PEP services, only 28% have ARVs for PEP. Recordkeeping among facilities reporting PEP services is also low. Only 12% of facilities have any records/registers of staff receiving PEP, and only 1% has records monitoring full compliance for PEP regimen.

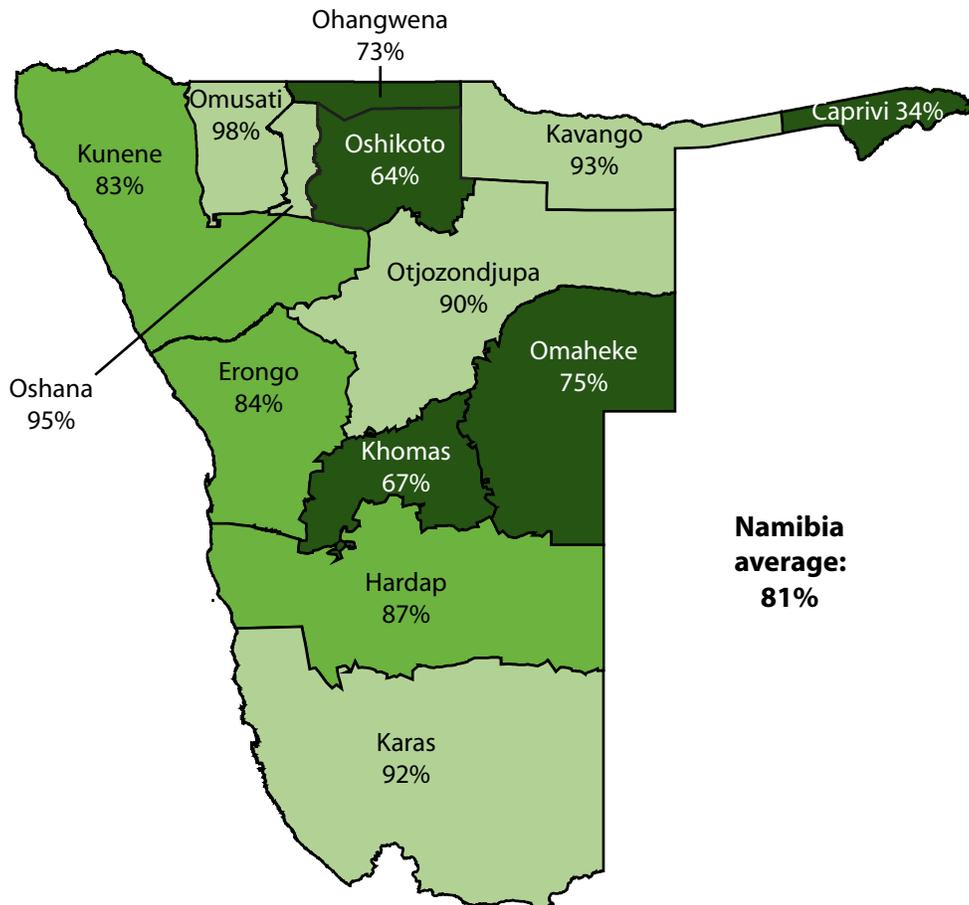


Photo by Dr. Paul Ametepi, ICF Macro

Availability of Post-Exposure Prophylaxis (PEP)

(Table A-8.20)

Percent of facilities offering PEP (N=411)



Infection Control in All Facilities

Infection prevention practices should be implemented in all health care facilities to protect both clients and providers from all infections, but especially from HIV/AIDS. The items needed to prevent infections include:

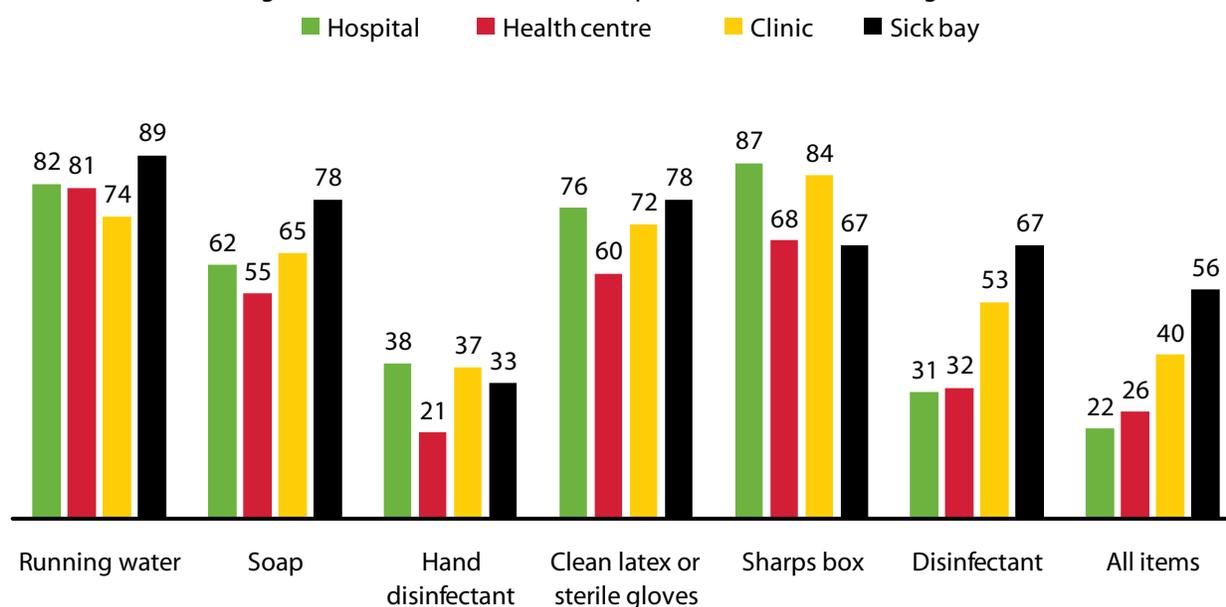
- running water and soap for hand washing or else hand disinfectant;
- clean latex or sterile gloves;
- “sharps” container for the immediate and safe disposal of needles and blades;
- disinfectant (hibitane/alcohol); and
- written guidelines to enforce infection prevention practices.

Three-quarters of all health facilities in Namibia have running water in all service areas, 64% have soap, and 35% have hand disinfectant. Overall, only 37% of facilities have all items needed for infection control in all service sites. Sick bays (56%) and clinics (40%) are much more likely to have all infection control items than health centres (26%) or hospitals (22%). Availability of infection control items varies by region, as well. Six in ten facilities in Kunene have all of the infection control items in all service sites compared to less than 10% in Otjozondjupa and Oshikoto. However, it is important to note that a facility may have all the items necessary for infection control in the facility, but does not have all of these items in all service sites.

Availability of Items for Infection Control

(Table A-3.21)

Among all health facilities in Namibia, percent with the following items (N=396)



Sexually Transmitted Infections in All Facilities

Almost all facilities (93%) offer STI services, usually in the general out-patient department, as well as in family planning service areas and the ANC service areas. STI services are available five days per week in 78% of facilities that offer STI services. About three-quarters of facilities offering STI services have STI services integrated into FP services or ANC services. More than half (62%) of facilities offer STI services in ANC, FP, and general outpatient areas.

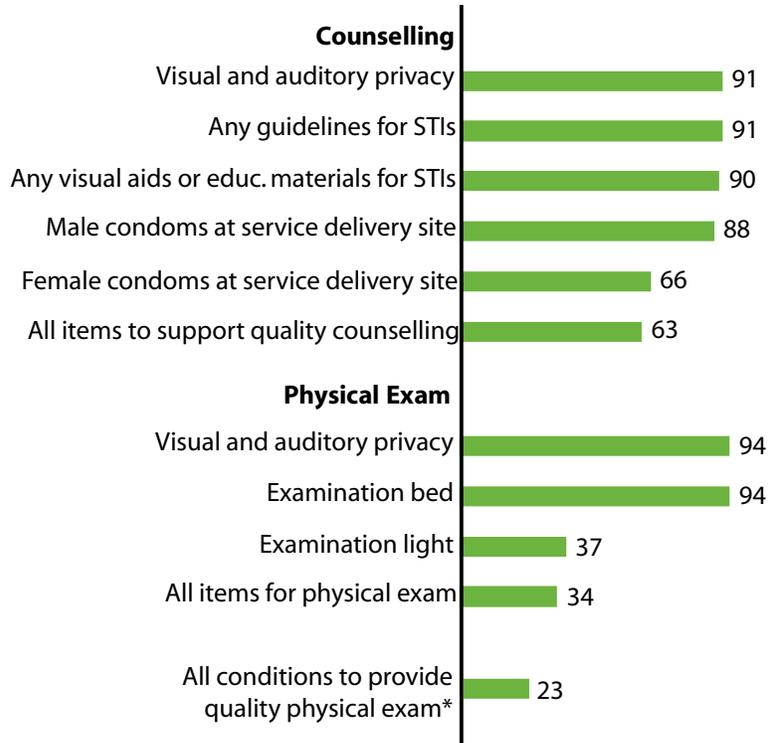
Most (88%) facilities that offer STI services use WHO's syndromic approach to diagnosing STIs. A similar percentage of facilities have guidelines for syndromic management of STIs.

Almost two-thirds of facilities offering STI services have all the items needed to support quality counselling (privacy, guidelines, visual aids or educational materials, individual client chart, and male or female condoms in service area). Fewer facilities (only 23%) have all the conditions needed to provide a quality physical examination (all infection control items, visual and auditory privacy, exam bed and exam light). Almost all (96%) of STI facilities have a passive partner follow-up system, meaning that they rely on the client to notify his or her partner and refer him/her for treatment.

Items to Support Quality STI Services

(Table A-7.2)

Among facilities offering STI services, percent with the following items (N=370)



*All items for infection control (soap, water, latex gloves, disinfecting solution, and sharps box), visual and auditory privacy, examination bed or couch, and examination light.

STI testing and medication

The testing capacity of facilities offering STI services varies widely. Most facilities can test for trichomoniasis (92%), syphilis (89%), or gonorrhoea (89%). Fewer (79%) can test for HIV/AIDS and about a quarter of facilities that offer STI services can test for chlamydia.

Most (88%) of facilities have medicines to treat the four major STIs: syphilis, gonorrhoea, trichomoniasis and chlamydia. Almost all (98%) of facilities have at least one medicine to treat syphilis and chlamydia. Slightly fewer can treat gonorrhoea (95%) and trichomoniasis (91%). All hospitals had at least one medicine for each of the four aforementioned STIs.

Management practices

STI-related record keeping is not consistently reliable. Less than half of facilities offering STI services had a client register with any entries within the week before the survey. Four in ten interviewed STI providers received training in any course related to HIV/AIDS in the year before the survey, while 22% had received any training in diagnosis and treatment for STIs.

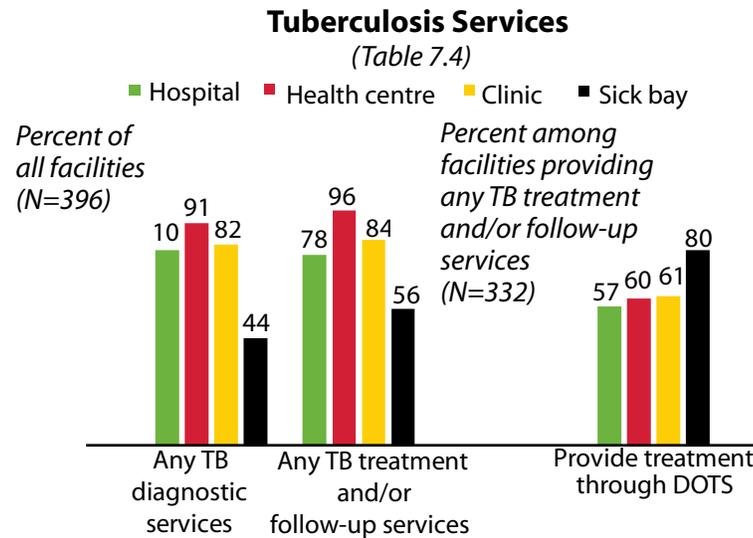
Twenty-two percent of interviewed STI providers received training in the diagnosis and treatment of STIs in the year before the survey. One-fifth of interviewed STI providers received training on the syndromic approach for diagnosing and treating STIs in the year before the survey. Almost 4 in 10 (39%) interviewed STI providers received training related to HIV/AIDS in the year before the survey.

Putting the NAMIBIA HFC into Context: STI Prevalence and Treatment in Namibia

According to Namibian health information system reports, STIs accounted for 3 percent of all outpatient visits in 2006 (MoHSS, 2006). According to the 2006-07 Namibia DHS, 7% of women and 4% of men reported having either an STI, abnormal discharge, or genital sore/ulcer in the past 12 months. These results, however, may underestimate the rate of STIs because many infections, especially in women, cause no symptoms. Among respondents reporting symptoms of STIs, about 6 in 10 sought care for their STI from a health facility or health professional.

Tuberculosis in All Facilities

Most (87%) facilities provide tuberculosis (TB) diagnosis, treatment, and/or follow-up services. TB services are available in 96% of health centres, 88% of clinics, 80% of hospitals, and 56% of sick bays. Facilities in Caprivi and Oshana are most likely to offer TB services.



Eighty-two percent of facilities offer any TB diagnostic services. Health centres (91%) are most likely to have TB diagnostic services. MoHSS (88%) and Mission/NGO facilities (89%) are more likely to offer TB diagnostic services than private (43%) or MoD/Police facilities (62%). Three-quarters (77%) of facilities report diagnosing TB using sputum microscopy, the recommended diagnostic procedure. However, less than half (48%) of those that reported using the sputum test had all the items needed for conducting TB sputum tests available on the day of the survey. Three-quarters (75%) of sick bays had all items needed to conduct the TB

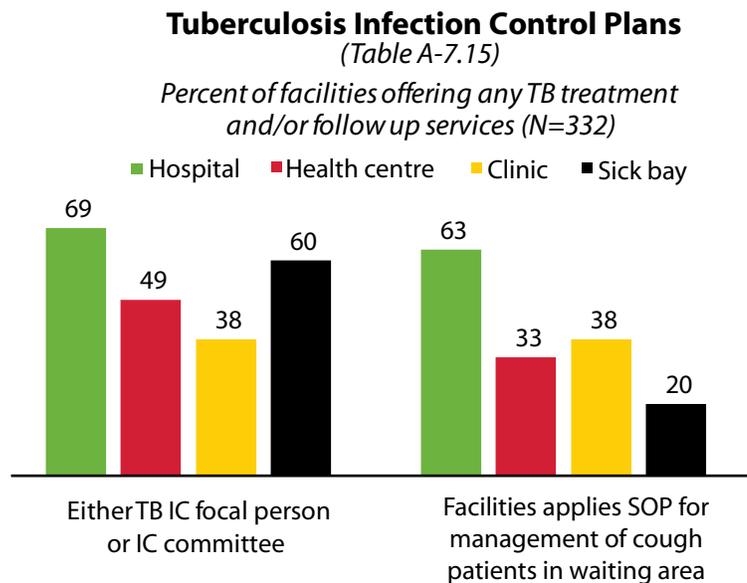
sputum test compared to less than half of hospitals, health centres and clinics.

Most (84%) of facilities in Namibia provide TB treatment and/or follow-up services. Yet, only 61% of these facilities follow DOTS (Directly Observed Treatment-Short Course). DOTS treatment is more common in sick bays (80%) than in clinics (61%), health centres (60%) and hospitals (57%).

All first-line TB medicines were available on the day of the survey in 71% of facilities that follow the DOTS strategy. All first-line TB medicines were most commonly found in hospitals (95%) and MoD/Police facilities (75%), but were found in only 44% of private facilities.

It is extremely important for TB patients to be screened for HIV, and vice versa, as these two infections often coexist. Among the facilities offering any TB services, 84% report routinely referring all TB cases for HIV testing. Another 5% of facilities refer only those suspected to be HIV-positive. Upon review of records, 68% of facilities offering any TB services had records of newly diagnosed TB clients referred for HIV testing. Three-quarters had records of current TB clients who were co-infected with HIV.

Thirty-eight percent of facilities offering TB services have a TB infection control (IC) focal person, while only 3% have a TB IC committee. Forty-three percent have either a TB IC focal person or IC committee.



Conclusions

The 2009 Namibia Health Facility Census provides important information for measuring progress in many of these areas. The findings from the Namibia HFC for HIV/AIDS will also serve to guide policy-makers and leaders as they evaluate existing programs and craft new ones to best achieve national goals. Listed below are the main conclusions and key recommendations based on the Namibia HFC results.

Conclusions:

1. The Namibia HFC findings show a mixed picture of HIV-related health services in Namibia. Currently, 98% of facilities offer HIV testing. Nine in ten offer care and support services (CSS) for those living with HIV. Three-quarters of facilities offer some services for preventing mother-to-child transmission (PMTCT) of HIV, but among those reporting that they offer PMTCT services only 51% offer all four of the components needed for the minimum PMTCT package. Only about two in ten facilities offer youth friendly HIV testing services or provide antiretroviral therapy, and just 7% provide all advanced care and support services for people with HIV/AIDS.
2. Namibian health care facilities do not meet international standards for infection prevention; this puts both clients and providers at risk for HIV infection and many other life-threatening illnesses. Overall, only 37% of all health facilities have all infection control items available in all service delivery areas.
3. Care and support (CSS) services, such as treating opportunistic infections or providing palliative care, are available in 90% of all health care facilities. Other HIV-related health services are less available and there is significant disparity in their availability among the regions. For example, only 18% of facilities offer ART, and just 7% provide advanced CSS.
4. Availability of medicines varies widely. For example, among facilities that provide CSS, 95% have at least two medicines on site for bacterial respiratory infections, and 98% can treat other bacterial infections. Nine in ten facilities can treat AIDS dementia complex, but only three in ten can treat topical fungal infections. No facilities have two medications to treat herpes, and only 9% can treat cryptococcus fungus.

