African Development Bank

THE DEVELOPMENT OF HARMONIZED MINIMUM STANDARDS FOR GUIDANCE ON HIV TESTING AND COUNSELLING AND PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV IN THE SADC REGION

PMTCT COUNTRY REPORT

NAMIBIA

Contact: Dr. Vincent U. Agu
Director, SAHARA and Team Leader
69-83 Plein Street
Cape Town 8001
South Africa
Phone: +27-21-466-7944
E-mail: vagu@hsrc.ac.za

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AfDB	African Development Bank
ART	Antiretroviral therapy
BCC	Behaviour Change Communication
CICT	Client Initiated Counselling and Testing
CT, C&T	Counselling and Testing
DHS	Demographic and Health Survey
PMTCT	Prevention of Mother To Child Transmission
HIV	Human Immunodeficiency Virus
HSRC	South African Human Sciences Research Council
MARP	Most-At-Risk Population
M&E	Monitoring and Evaluation
MoHSS	Ministry of Health and Social Services
MS	Member State
NAC	National AIDS Council
NGO	Non Governmental Organisation
PEP	Post-exposure Prophylaxis
PFP	Project Focal Person
PICT, PITC	Provider Initiated Counselling and Testing
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PSS	Psychosocial Support
RHS	Reproductive Health Services
SADC	Southern African Development Community
SAHARA	Social Aspects of HIV/AIDS Research Alliance
STI	Sexually Transmitted Infections
SWOT	Strengths, Weaknesses, Opportunities and Threats analysis
TAC	Technical AIDS Committee
TOT	Training of Trainers
TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
ZNASP	NAMIBIA National HIV and AIDS Strategic Plan

ACKNOWLEDGEMENTS

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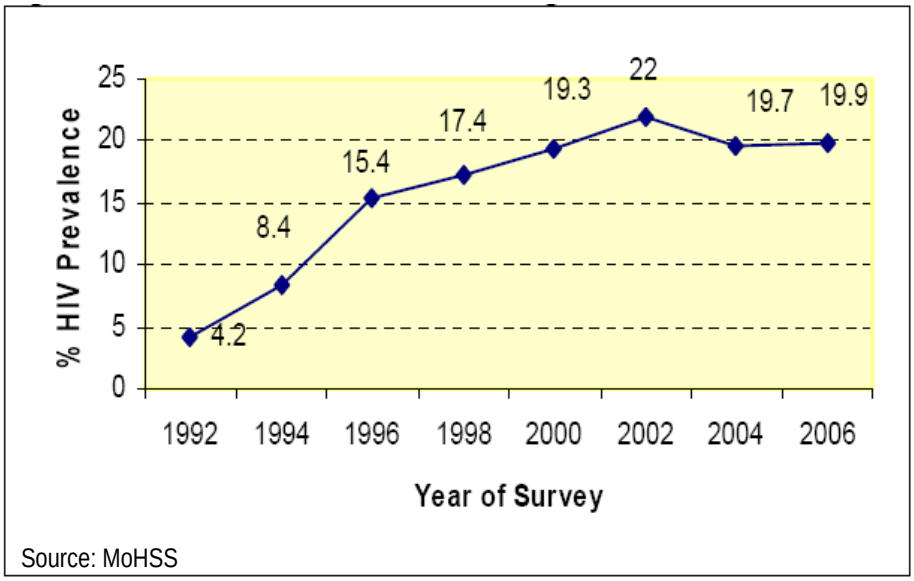
1. INTRODUCTION

1.1 HIV/AIDS and PMTCT in NAMIBIA

According to the 2008 UNGASS Country Progress Report for Namibia,[1] 19.9% of women attending ante natal clinics were HIV infected in 2006. There was a rapid increase in ANC HIV prevalence from 4.2% in 1992 to 22% in 2002. An apparent decrease since 2002 represents the first decrease since the start of ANC surveillance (Figure 1). However, HIV prevalence is still increasing in some regions and age groups.

Figure 1: HIV Prevalence Rate in Pregnant Women in Namibia, 1992 - 2006



Source: MoHSS

HIV infection prevalence among young women between 15 and 24, which can be used as a proxy for incidence, has shown a slight decline from 17.9 in 2002 to 15.2 in 2004, to 14.2 percent in 2006, but there is marked variation between sites and years.

The National Policy on HIV/AIDS was approved in March 2007 and Guidelines for the Prevention of Mother to Child Transmission published in July 2008.

The PMTCT programme in Namibia consists of a package of strategies that target pregnant women. It includes HIV counselling and testing, referral to HIV care/treatment for those found positive, provision of prophylactic ARV medication to HIV positive mothers before delivery and for infants within 72 hours of birth, infant feeding counselling, and DNA polymerase chain reaction (PCR) testing for infants born to HIV positive mothers.

The percentage of ANC clients receiving an HIV test improved from 79% in 2004/05 to 86% in 2006/07. The percentage of those tested who received post-test counselling improved from 38% to 58% and the percentage of HIV positive women who had a CD4 test increased from 29% to 70% over the same period. These positive trends are attributed to the roll out of PMTCT services, particularly the roll out of rapid testing. The opt-out strategy adopted by the MoHSS has also likely contributed to the high proportions of pregnant women enrolled in the PMTCT programme.

[1] Republic of Namibia United Nations General Assembly Special Session (UNGASS) Country Report Reporting Period April 2006 – March 2007 Ministry of Health and Social Services. 2008

1.2 Aim and Objectives of the Consultancy

The main aim of this consultancy is to develop regional harmonized minimum standards for policies, protocols and guidelines for PMTCT in the SADC region.

To achieve this, the project team of the Social Aspects of HIV/AIDS Research Alliance (SAHARA) - see appendix 1 - is reviewing and analysing policies, protocols and guidelines for PMTCT in each SADC member state (MS), in collaboration with the PMTCT national focal person in the MS.

The specific objectives are to:

- identify and assess policies, procedures and frameworks on PMTCT, and come up with best practices in implementation of PMTCT policies;
- conduct field visits to engage in policy dialogue with policy makers and other stakeholders (including discussions of implementation strategies and challenges, opportunities and lessons learnt, gather views of the service users/providers);
- review gender issues and consider how men and women are involved in PMTCT; and
- review and analyse proposed minimum standards for the PMTCT policies.

2. METHODOLOGY

The PMTCT national focal person in Namibia was tasked with three key responsibilities:

2.1: Identify policies, procedures and frameworks on PMTCT
2.2: Participate in the assessment of the policies, procedures and frameworks on PMTCT
2.3: Facilitate dialogues and stakeholders consultations on policies relating to PMTCT, including policy discussions on the development and implementation of policies, procedures and frameworks on PMTCT in the country.

A field guide, consisting of relevant tools and instructions for each of the task, was provided to the PFP by the SAHARA project team, and included tables for data collection and key questions to guide policy discussions with key stakeholders in the country. The filed guide was piloted in one of the Members states in collaboration with SADC.

Policy discussions, Facilitated by the PFP, were held with various key stakeholders in the country, including:

- government official(s) responsible for PMTCT policies, protocols and guidelines;
- civil society official(s) responsible for PMTCT policies, protocols and guidelines;
- representative(s) of international organizations responsible for PMTCT;
- representative(s) of private or informal sector responsible for PMTCT policies, protocols and guidelines; and
- Others as appropriate.

The policy discussions were scheduled at the convenience of the respondents and conducted in the community or at an office where there was an undisturbed atmosphere. The PFP received direction and guidance from SAHARA project team on how to conduct policy discussions. Selected respondents were invited by letter or email to participate in the discussions, and included officials from the national AIDS council and national AIDS coordination programmes; PMTCT programmes and administrative staff; primary stakeholders, such as technical partners, donors and implementing agencies; and civil society.

3. FINDINGS

3.1 SWOT analysis of PMTCT in Namibia

An analysis of collected data revealed the following strengths, weaknesses, opportunities and threats in regard to the PMTCT programme in Namibia (details are in appendix 2, 3, 4, 5)

STRENGTHS	WEAKNESSES
• Political will (President officiates at conference) • Participatory policy development • National policy on HIV/AIDS (2007) includes PMTCT policy • PMTCT guidelines (2008) • 92% of ANC attendees tested – 72% knew result • Training for adolescent friendly health services is ongoing	• PMTCT policy not separate • Poor referral systems (from ANC to ARV, and for follow-up) • Poor male involvement • NVP (it is not only NVP nowadays) uptake needs improvement • Infant formula not provided • People with disabilities not catered for • Few adolescents attend RHS • Staff shortages and high turnover • M&E system inadequate (what do we mean??)
OPPORTUNITIES	**THREATS**
• Government commitment - National HIV testing day • Scale-up NVP uptake (Not only rather talk about ARV prophylaxis) • Scale up registration for postnatal care/follow up for HIV positive mothers • Scale-up a one stop shop service delivery model, e.g. co-locating ANC and ART	Insufficient funding to fully implement international policy recommendations

3.2 Analysis of PMTCT policies and protocols.

Integration of PMTCT into paediatric AIDS treatment and care activities

- The current PMTCT model separates ANC from ART. PMTCT is available even in remote areas but most ART is restricted to the bigger health facilities. Whether someone who tests positive at ANC goes for ARV for PMTCT is unknown (It may not be applicable in all case I would rephrase that follow up of referral to ART client at ANC is poor).

CD4

- Initiation of ART is currently at CD4 <200 (but for pregnant women it is 250) but this is under review in light of recent WHO guidelines indicating that it should be made available at <350.

Infants and infant feeding

- Infant feeding, counselling and support are available.
- Infant feeding represents a challenge because there is no follow-up after the mother leaves the health facility.
- For HIV positive mothers who cannot afford infant formula, the WHO guidelines recommend 6 months exclusive breastfeeding but *current practice is to recommend 4 months. There are plans to change this to 6 months.*

Age of consent

- Generally, the HIV testing age, as stipulated in the HTC guidelines, is 16 years.

3.3 PMTCT policy gaps in Namibia

- High staff turnover (frequent rotation of hospital staff) means that people lose familiarity with guidelines.
- Namibia has to revise guidelines again and again to keep pace with HIV. (E.g. initiation of ART is currently at CD4 <200 but now the WHO says it must be <350; introduction of Tenofovir as a first line of treatment instead of AZT). (This recommendation is currently being reconsidered by the Technical Advisory Committee of HIV/AIDS Ministry of Health)
- Need to address cost implications of such policy changes.

3.4 PMTCT situation analysis in Namibia

See Appendix 3.

Highlighted best practices include:

- Letters of invitation given to women for their husbands to attend ANC
- Male partners who come to ANC are given letters to take to their work places, explaining absence from work.
- Women attending ANC with partners are attended to first so that they do not wait too long. This is done to specifically boost partner involvement.
- Partners are treated on site for STIs (no referral to an STI clinic necessary).

3.5 PMTCT approaches/ Models in Namibia

- Opt-out policy for ANC attendees.
- Group session for pre-test counselling.
- Couple counselling and testing.
- Current PMTCT model separates ANC from ART.
- Social mobilization.
- Advocacy.
- Male involvement - when males agree for wives to participate things are easier. This has proved to be the case in Caprivi region.

3.6 Key PMTCT policy discussion issues

See details in Appendix 7

4. RECOMMENDATIONS FOR MINIMUM STANDARDS

Among the challenges are:

- Male involvement.
- Issues related to community involvement as there are no strategies for community mobilisation.
- Staff shortages.
- Follow-up after delivery for both mother and baby.
- Infant feeding represents another challenge as we do not know what happens when the mother leaves the health facility.
- Training and retraining because health workers are continuously on the move in search of careers.
- Primary prevention is not strong enough – we are not keeping as many HIV negative people negative as we would like.
- Prevention of unplanned/unwanted pregnancies is problematic. Family planning access is limited and we need to improve on this. On the other hand ARV prophylaxis is well done.

- There are weak links when it comes to comprehensive care for mother and baby, children and partner. We have no way to tell whether someone who tests positive at ANC will reach an ART clinic (although they are referred there) and/or will get home-based care.

Regarding minimum standards:

- The WHO envisages revising its guidelines in 2009; this means that Namibia should also revise its guidelines. Namibia must also revise its guidelines to keep pace with what they have included but this does not mean that it must comply with the WHO guidelines 100%. WHO guidelines are normative for adoption and adaptation.
- The consultation process is in part about Namibianizing WHO standards.
- The situation in the country is one of resource shortages. Caesarean section is not a routine safe obstetric practice – primarily because it is expensive. If patients ask for a Caesarean section, it is not denied, although this depends on staff and resource availability. Normal vaginal delivery (NVD) is preferred.

APPENDICES

APPENDIX 1: SAHARA PROJECT TEAM

NAME	TITLE
Dr. Vincent Agu	Team Leader
Prof. Karl Peltzer	PMTCT Expert
Prof. John Seager	Monitoring and Evaluation Expert
Prof. Geoffrey Setswe	HTC Expert
Dr. Njeri Wabiri	Project Director
Ms. Mercy Banyini	Researcher

APPENDIX 2: ASSESSMENT OF PMTCT POLICIES, PROTOCOLS AND GUIDELINES

Prongs	Indicator
1: Primary prevention of HIV infection among women of childbearing age	
1.1 [Health education]	Y
1.2 [HIV testing and counselling]	Y
1.3 [Couple HIV counselling & testing]	Y
1.4 [Safer sex practices including dual protection (condom promotion]	Y
2: Preventing unintended pregnancies among women living with HIV	
2.1 [Family planning]	Y
2.2 [HIV testing and counselling]	Y
2.3 [Safer sex practices including dual protection (condom promotion]	Y
3: Preventing HIV transmission from a woman living with HIV to her infant	
[Quality antenatal and delivery care]	Y
3.1 [HIV testing and counselling]	Y (PI, Opt out)
3.2 [Retesting in late pregnancy]	Y
3.3 [HIV pre-test counselling]	Y (group education session)
3.4 [Post-HIV test counselling]	Y
3.6 [Male involvement]	Y (although it is promoted)
3.7 [Gender-based violence; stigma]	
3.8 [Involvement of PLHIV]	
3.9 [Clinical (staging) and immunological assessment of pregnant women]	Y
3.10 [ART for pregnant women eligible for treatment]	Y
3.11 [ARV prophylaxis for MTCT prevention for women not receiving ART and for all exposed children]	Y (long course ANC AZT +NVP at onset of labour and AZT/3TC tail 7 days)
3.12 [Safer obstetric practices]	Y
3.13 [Infant feeding counselling and support]	Y
4: Providing appropriate treatment, care and support to mothers living with HIV and their children and families	
Mothers	Y National policy on HIV/AIDS March 2007 p20
4.1 [ART for pregnant women eligible for treatment]	Y
4.2 [Co-trimoxazole prophylaxis]	Y
4.3 [Continued infant feeding counselling and support]	
4.4 [Nutritional counselling and support]	Y
4.5 [Sexual and reproductive health services including family planning]	Y

4.6 [Psychosocial support]	Y
4.7 [Tuberculosis screening]	Y
Children	
4.8 [ARV prophylaxis]	Y
4.9 [Routine immunization and growth monitoring and support]	Y
4.10 [Co-trimoxazole prophylaxis staring at 6 weeks]	Y
4.11a [Early diagnosis testing for HIV infection at 6 weeks where virological tests are available]	Y National policy on HIV/AIDS March 2007 p 21
4.11b [Antibody testing for young children at 18 months where virological testing is not available]	Y National policy on HIV/AIDS March 2007 p 21
4.12 [Antiretroviral therapy for eligible HIV infected children]	Y National policy on HIV/AIDS March 2007 p 21
4.13 [Continued infant feeding counselling and support]	Y
4.14 [Screening and management of tuberculosis and other opportunistic infections]	Y
4.15 [Prevention and treatment of malaria]	Y
4.16 [Nutrition care and support]	
4.17 [Psychosocial care and support]	
4.18 [Symptom management and palliative care if needed]	Y
4.19 [Diagnosis and management of common childhood infections and conditions and Integrated Management of Childhood Illness (IMCI)]	Y
PMTCT national policy	
Existence of national guidelines for the prevention of HIV infection in infants and young children in accordance with international or commonly agreed standards (WHO, 2004a)	July 2008 Guidelines for the prevention of Mother to child transmission of HIV 2nd ed. National policy on HIV/AIDS March 2007, ART guidelines 2007

APPENDIX 3: PMTCT INDICATORS IN NAMIBIA

Category HIV prevalence estimates	Estimate
Estimated adult HIV prevalence rate, 2007, 15-49 (UNICEF, 2008)	15.3%
Estimates based on sentinel surveillance data, 2007, 15-24 year-olds (SADC, 2008)	14.0%
PMTCT indicators	
Antenatal care coverage (UNICEF, 2008)	95%
The number and percentage of health care workers newly trained or retrained in the minimum package during the preceding 12 months. (WHO, 2004a)	257 health workers & 161 community counsellors trained on VCT. 221 health workers & 166 community counsellors trained on rapid testing of HIV/AIDS. PMTCT annual report 2006/7
The percentage of public, missionary and workplace venues (FP and PHC clinics, ANC/MCH, and maternity hospitals) offering the minimum package of services for the prevention of HIV infection in infants and young children in the preceding 12 months. (WHO, 2004a)	256 ANC clinics 335 health facilities in Namibia FY 07/08 219, HF offering PMTCT
The percentage of pregnant women making at least one ANC visit who have received an HIV test result and post-test counselling. (WHO, 2004a)	92% tested, 79% knew HIV status for financial year

	2006/7 Guidelines for prevention of MTCT
The percentage of HIV-positive pregnant women receiving a complete course of ARV prophylaxis to reduce MTCT in accordance with a nationally approved treatment protocol (or WHO/UNAIDS standards) in the preceding 12 months.	64% Guidelines for prevention of MTCT Now FY 07/08 70% but the report not yet published
The percentage of HIV-positive infants born to HIV-infected women. (WHO, 2004a)	16% for 2006/7 PMTCT annual report 2006/7 page 3
The percentage of infants born to HIV positive women receiving cotrimoxazole prophylaxis within 2 months of birth (UNICEF, 2008)	Data not available
The percentage of infants born to HIV positive women receiving a virological test for HIV diagnosis within 2 months of birth (UNICEF, 2008)	22% at 6 weeks FY 07/08 report not published
Percentage of people receiving antiretroviral therapy who are children (WHO/UNAIDS, 2006)	7%

APPENDIX 4: SUMMARY OF PMTCT IMPLEMENTATION CHALLENGES

Implementation challenges	Yes, No, N/A: & Extent of Challenge
Inadequate financial resources, which are often narrowly earmarked by donors	Y
Inadequate human resources; problems with lay counsellors	Y
Poor partner and sectoral coordination and donor support resulting in verticalisation of programmes and poor implementation of national policies	Y
Low coverage of PMTCT	N
Stigma and discrimination;	Y
Inadequate support for infant feeding which remains a complex issue, requiring further research	Y
Unequal emphasis on the needs of women, their children, partners and families, and insufficient follow up within a continuum of care and assurance of adequate care, treatment and diagnosis of exposed infants	Y
Insufficient integration of prevention of mother-to-child transmission services and insufficient linkages with other health and social services;	N
The need to decentralize implementation and service delivery, and focus on developing and strengthening of community structures and systems to include prevention of mother-to-child transmission services;	Y
Insufficient attention to, and services for primary prevention and prevention of unintended pregnancies, including access to reproductive health commodities;	Y
Programme monitoring, recording and reporting	Y
Quality assurance and impact assessment;	Y
Inadequate efforts to ensure male engagement;	Y
Impact of gender inequality and of gender-based violence	Y
Lack of capacity to cost plans	Y

Implementation challenges	Yes, No, N/A: & Extent of Challenge
Slow scale-up of provider-initiated testing and counselling services, where appropriate, and the limited creation of demand for these services.	Y
Slow scale-up of early infant diagnosis of HIV	N (92 HF FY07/08 report not yet published)
Other: Please include other challenges not covered above	Slow roll out of PMTCT services (although PMTCT annual report indicates this experts in the field say it is no longer that slow) No assessment to monitor PMTCT service implementation for those trained Unknown HIV status at delivery is a problem in Caprivi Poor male involvement in PMTCT NVP uptake in pregnant women need improvement Breast feeding- not known whether exclusive or mixed No registration for post natal care/follow up for HIV positive mothers Irregular monthly reports from health centers PMTCT annual report

APPENDIX 5: PMTCT IMPLEMENTATION NEEDS IN NAMIBIA

PMTCT implementation needs	Yes, No, N/A: & Additional comments
Need to speed up development of policies and guidelines	Update some existing policies & guidelines PMTCT Annual report
Need to improve M & E (PMTCT indicators, registers)	Y PMTCT Annual report p 4
Need to improve C & T (quality)	
Appropriate use of lay counsellors in the health care setting	
Improve integration of PMTCT into pediatric AIDS treatment and care activities	
Effective communication on PMTCT	
Scale up of co-trimoxazole prophylaxis	
Improve community support/male involvement	Y
Strengthen quality assurance for PMTCT services	

To roll out more efficacious regimen in all facilities providing PMTCT services	
To roll out early infant diagnosis	
Other: Please include any other needs not captured in the table	

APPENDIX 6: SUMMARY OF DIFFERENT POLICY DISCUSSIONS

FGD conducted on 10th February 2009. Participants from University of Namibia, Centers for Disease Control (CDC), Ministry of Health and Social Services (MoHSS) and National Health Training College (NHTC – GF)

1. Are you aware of the existence of approved PMTCT policies and guidelines? And when they were published?

   Although Namibia has no specific PMTCT policy the PMTCT policy is integrated within the National Policy on HIV/AIDS approved by the national assembly on March 14th 2007. Section 3.5 of the national policy has policy statements on PMTCT. Namibia also has guidelines on PMTCT that were launched in July 2008. As a matter of fact the first edition of these guidelines were in 2003 (but published in 2004). The revisions were in 2007 but published in 2008.

2. Was there a consultation process for developing PMTCT policy?
   There was a very involving consultation process in the development of PMTCT guidelines. To this end training partners, the NHTC, University of Namibia (UNAM), ITECH, UNICEF, WHO, CDC, USAID among others were involved. The technical advisory committee of the Ministry of Health and Social Services and Ministry staff from the Department of Special Programmes, NIP, Primary Health Care and the TB programme were all involved.

   There was a meeting of all the stakeholders in Okahandja (a town about 75 kilometres from Windhoek the capital) in November 2006 to kick start the process. This meeting involved more than 30 individuals from various relevant sectors. As a matter of fact this meeting considered all guidelines (and revision thereof) in the health sector. The ART and PMTCT guidelines touched on adult, paediatrics, post exposure and HIV testing and counselling (HCT) among others. This was followed by several smaller meetings working on the guidelines. For instance if we were working on TB in pregnancy we needed input from people in the TB programme such that there was no conflict between what they do in that programme and in PMTCT. There was sending of write-ups back and forth between Dr Foster (Deputy Permanent Secretary) and us to correct technical things and to correct even the English within the document.

3. Do the standards of PMTCT policies/comply with global minimum standards? Should they comply given the situation in your country? What is your view?

   Yes the guidelines comply with the global minimum standards. We do the revisions of the PMTCT guidelines in order to comply with the WHO – the revisions we were doing on the 1st edition of the PMTCT guidelines were for the document to be in agreement with the WHO revised Guidelines of 2006. The WHO envisages revising its guidelines in 2009; this means that we should also revise our guidelines. The HIV area is a fast evolving one and to be on top of things WHO revises its documents. Namibia must also revise its guidelines to keep pace with what they have included.

This does not mean that we must comply with the WHO guidelines 100%. Their guidelines are normative for adoption and adaptation. Their guidelines are generic and Namibia has to take from them what is relevant. The consultation process is in part about Namibianizing WHO standards. For example the medicine given to babies has been Namibianized. The WHO advises that it's best to go for infant formulae where the mother is HIV positive but we promote breastfeeding for HIV positive mothers who cannot afford infant formulae. The WHO guidelines recommend 6 months exclusive breastfeeding but we recommend 4 months – thus we have a shorter period of exclusive breastfeeding for such infants. It must also be said that there are plans to move exclusive breastfeeding to six (6) months. The situation in our country is one of resource shortages. Caesarean section is not practised as a safe obstetric practice in Namibia. This means that Caesarean section is not a priority for PMTCT because it is expensive for Namibia. Caesarean section is discouraged or at least it is not a routine procedure. Patients are not given the Caesarean section option unless they ask for it. If they ask for C/S, it is not denied although this depends on staff and resource availability. Normal vaginal delivery (NVD) is preferred.

4. Gender issues addressed (e.g. are both men and women are sufficiently informed and their voices heard)

   Mothers are often encouraged to bring partners but in very rare cases do men come. Men do not actually come in although they are welcomed and the challenge is to devise means and ways to bring them in. There is provision for couple and/or partner counselling and testing but only around 4% do come. Most health workers also have training in VCT partner counselling and partner testing. ANC has been regarded as women's service for many years. We need to provide specific packages for men at ANC sites. These would be information packages that men use to discuss PMTCT issues with others in the community. They would cover issues such as HIV in general, supporting women in pregnancy by explaining their roles, understanding pregnancy etc. May be there is a need for study looking at what men want.

   We have tried to encourage male involvement in several ways: In order to encourage male partners we have developed invitation letters to husbands and partners. Katutura Hospital PMTCT programme is trying to extend operational hours. Thus we are opening on Saturdays up to 13:00hours to try to bring in husbands and male partners who may be busy with their work from Monday to Friday.

   Last year (2008) there was a male conference where the President of Namibia officiated. It looked at issues such as men taking a lead, men being more involved in HIV/AIDs and PMTCT, men coming for counselling and testing etc. This conference recommended follow-up meetings/conferences at regional level but this has yet to be done.

   On the side of women, PMTCT uptake is increasing. Thus around 94% of women at ANC agree to be tested for HIV.

5. How men are involved in PMTCT, and identify best practices. (Note*: This is a very important question which should be addressed by asking a sample of men how they think men are being involved in PMTCT. They are important stakeholders)*

   There are several things that we regard as best practices when it comes to involving males in PMTCT in Namibia:

   - There is the letter of invitation given to women for their husbands (this letter is included on page 44 of the guidelines). This letter is taken to husbands/partners by women. It invites male partners to join their partners at ANC. Some male partners do come but there are no statistics on how many come. This has been mostly practised in the Caprivi (the region with the highest HIV infection rates) but there are plans to expand this to other regions.

- Those male partners that come to ANC are given letters to take to their work places. These letters inform employers that they attended PMTCT/ANC and should be not considered as unduly absent.
- Women that come with partners to ANC are attended to first so that they do not wait too long. This is done to specifically boost partner involvement.
- Partners are treated right there for STIs and there is no need to refer them to an STI clinic. This is actually in the guidelines.

6. What are views of people living with HIV and AIDS, those with disabilities and adolescent mothers

People living with HIV and AIDS have many views on their pregnancy situation. Some talk of pure negligence, mistakes, condom ruptures, partner refusal to use condoms. Some get pregnant purposely, while others say abortion is not an option as Namibia does not allow for abortions. People living with HIV and AIDS are very appreciative of PMTCT as they realize they can have a child that is HIV negative. But there are contentious issues. Thus there is the issue of breastfeeding versus formulae. The government does not provide formulae for infants born from mothers that are HIV positive. It also does not promote formulae feeding. The formula is expensive and not sustainable. There are also interruptions in the supply of formulae. Additionally conditions to satisfy acceptability, feasibility, affordability, safety and sustainability (AFASS) p25 criteria do not exist in Namibia.

We have little experience on the views of people living with disabilities and there is no study done on this. The Rehabilitation programme wants to conduct a three day information session with people living with disabilities. All we can say is that there is a lot of work to be done in this area as there are no counsellors trained in sign language and who can demonstrate condom use to those with impaired vision. There are big issues of access to information in the case of people living with disabilities.

Namibia does have an adolescent friendly programme and there are some health workers trained to deal with adolescents. There are more than five facilities training health workers on adolescent friendly services. There has been training held at Swakopmund, Grossbarmen, NHTC (Windhoek), Oshakati, Otjiwarongo, Keetmanshoop and Rundu. Despite this young people in general do not come for reproductive health services and this remains a challenge. Adolescents are not receiving as much attention as they should. Only a few facilities such as Katutura hospital has specific adolescent programme on PMTCT/ART. Omaheke also has one and a few others also have them. The challenge for adolescent friendly services is the need to meet certain criteria. Human and financial resources are the main impediments. Namibia's facilities were not built to accommodate services other than primary health care and to convert them is a challenge.

7. Are policies/guidelines easily available to all stakeholders?

Guidelines are easily available to stakeholders, although it depends who you define as a stakeholder. They are available to those who need to have them in both urban and rural areas. They are distributed within facilities up to clinic level. They are with Namibian Planned Parenthood Association (NAPPA), NTC, private doctors, private sector training etc. Reprints are usually slow but all relevant facilities have them, but they are not given to the man on the street.

8. Are there gaps in PMTCT policies? Please give examples

Namibia has staff shortages and there is high staff turnover. This means that people lose familiarity with guidelines. The content of the guidelines are quite comprehensive since Namibia uses WHO guidelines. Implementation might present another issue. HIV develops faster than many of us envisage so Namibia has to revise guidelines again and again to keep pace with HIV. This is a challenge. Examples include the fact that the CD4 count at initiation of ART is 200 but now the WHO says it must be 350. This is a major shift. It means that we must treat people before they are

sick. A second example is with Tenofovir which WHO is recommending as a first line of treatment instead of AZT. If Namibia changes, in terms of Namibian dollars, Tenofovir is more expensive. There are changes in medicines and criteria to start treatment that affects us.

9. What quality assurance challenges affect PMTCT?

Training is a challenge. As we revise our guidelines we need to both train and retrain people but it takes time to do this. There are staff that is trained in the old but not the new – they need retraining. It is not their fault that they need retraining but it a learning curve that takes time.

There are challenges with regard to quality data capture – how many women are seen in ANC clinics, how many are tested. Is this information summarised in a summary form and does it accurately reflect what is happening on the site/ground? These are important questions we cannot readily answer.

Many HIV positive mothers realise the importance of ARVs. They take and/or drink them but somehow they do not come to deliver in hospitals. Staff talks to them and explain things to them but they do not use this information. You can counsel such a mother but ultimately you do not get cooperation from her. These are issues related to behavioural change, where one does not always get positive results as expected.

Follow-up for post natal care for mothers and babies to come back after six (6) weeks is a challenge.

Partners do not like disclosing their HIV status.

10. PMTCT implementation coverage

PMTCT implementation coverage is high:

- 90%coverage of all health facilities
- 94% HIV testing uptake coverage
- 70% ARV prophylaxis coverage
- 95% infant ARV prophylaxis coverage
- 11% vertical transmission rate.

11. In your view what are the key Implementation challenges to scaling up PMTCT

Among the challenges are:

- Male involvement
- Issues related to community involvement as there are not strategies for community mobilisation
- Staff shortages
- Follow-up after delivery for both mother and baby. There are about 62,000 expected pregnancies each year. About 55,000 of these come for ANC, meaning that 7,000 pregnant mothers are not captured. Namibia needs to work hard on advocacy to capture them.
- Infant feeding represents another challenge as we do not know what happens when the mother leaves the health facility.
- Training and retraining constitutes another challenge as health workers are continuously on the move in search of careers.
- Primary prevention is not strong enough – we are not keeping as many HIV negative people negative as we would like.
- Prevention of unplanned/unwanted pregnancies is problematic. Family planning commodities accessibility is limited and we need to improve on this.
- On the other hand ARV prophylaxis is well done.
- There are weak links when it comes to comprehensive care for mother and baby, children and partner. We have no way to tell that if someone tests positive at ANC they will end up

at ART clinic (although they are referred there) and/or will get home-based care. Sometimes there are great distances between ANC and ART clinics and people must get on a bus and travel to an ART clinic. Many do not go because of affordability.

12. Is there a PMTCT implementation plan?

The implementation plan is integrated within the Reproductive Health programme. The following are the elements of the RH implementation plan:

- Documents (Standards, Norms, Legislation, Policies, Guidelines)
- Capacity building
- Social mobilization
- Procurement of medical equipment for Reproductive Health and Child Health programme
- Monitoring and evaluation

13. PMTCT service delivery models. What would you recommend?

The PMTCT model in existence is that ANC is separated from ART. You can find PMTCT even in remote areas but most ART is in bigger health facilities. Whether someone who tests positive at ANC goes for ARV for PMTCT is unknown.

What is needed is a one stop shop service delivery model. At Katutura ANC and ART are co-located and this allows for mothers who have tested positive to easily access ARVs. But co-locating ANC and ART is a challenge in most clinics.

14. Strategies to promote PMTCT uptake

- Social mobilization
- Advocacy
- Male involvement (when males agree for wives to participate things are easier. This has proved to be the case in Caprivi region)
- Need to organize national PMTCT day to AIDS awareness and profile of PMTCT. We should not just let it be absorbed under other programmes. We could also have an annual review day for PMTCT.