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

HTC COUNTRY REPORT

Namibia

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AfDB	African Development Bank
ART	Antiretroviral therapy
BCC	Behaviour Change Communication
CICT,CITC	Client Initiated Counselling and Testing
CT, C&T	Counselling and Testing
DHS	Demographic and Health Survey
HTC	HIV Testing and Counselling
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
NDHS	Namibia Demographic and Health Survey
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
RISDP	Regional Indicative Strategic Development Plan
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

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1. INTRODUCTION

1.1 HIV/AIDS and HTC in Namibia

The estimated HIV prevalence for adults (15-49) in 2007 was 15.3% (UNICEF, 2008). Estimates based on sentinel surveillance data in 2007 indicated a prevalence of 14.0% for 15-24 year-olds (SADC, 2008).[1]

NDHS figures indicate that 18 - 25% of the population was tested for HIV. NDHS figures indicate that slightly more females than males were tested (the female figure stands at 28%).

In July 2007, the president of Namibia launched the National HIV/AIDS Policy. It is expected to provide an environment that enables the national response.

1.2 Aim and Objectives of the Consultancy

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

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

The specific objectives are to:

- identify and assess policies, procedures and frameworks on HTC, and come up with best practices in implementation of HTC 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 HTC; and
- review and analyse proposed minimum standards for HTC policies.

2. METHODOLOGY

The HTC project focal person (PFP) in Namibia was tasked with three key responsibilities:

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

A field guide, consisting of relevant tools and instructions for each of the tasks, 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 HTC stakeholders in the country. The field guide was implemented in Botswana in collaboration with the SADC Secretariat. Lessons learnt were used to enrich fieldwork in the other MSs.

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

- government official(s) responsible for HTC policies, protocols and guidelines;
- civil society official(s) dealing with HTC policies, protocols and guidelines;
- representative(s) of international organizations involved in HTC;

[1] SADC. 2007 SADC HIV and AIDS Epidemic Report. September 2008.

- representative(s) of private or informal sector involved in HTC 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 the 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, HTC programme and administrative staff, primary stakeholders (such as technical partners, donors and implementing agencies), and civil society

Respondents, drawn from national and lower levels, included officials from the national AIDS council and national AIDS coordination programmes, HTC programmes and administrative staff, and primary stakeholders, such as technical partners, donors and implementing agencies. See appendix 1 for list and constituency of participants.

Unstructured discussions were held to collect information on structural and functional dimensions of the HTC programmes and on attitudes and perceptions of the various stakeholders regarding policies, protocols and guidelines for implementation and other programme aspects. Policy discussions were also held with counsellors and programme managers to identify issues affecting HTC access and uptake.

3. FINDINGS

3.1 SWOT analysis of HTC in Namibia

An analysis of collected data revealed the following strengths, weaknesses, opportunities and threats regarding HTC programming in Namibia (see details in Appendices 2, 3, 4 and 5)

STRENGTHS	WEAKNESSES
• Several HTC guidelines developed and in use • Over 500 community counsellors trained • Non-lab people involved in testing • Rapid testing available at 50% of facilities • Multisectoral technical working group on HTC • VCT also includes TB, STI, alcohol misuse • PLWHA involved in service delivery • Annual National HIV testing day	• No separate HTC policy • Lack of male-friendly service • Data management not standardised • Low uptake of HTC by couples • Poor infrastructure • Some programmes are too expensive (e.g. New Start) • Poor documentation of best practices
OPPORTUNITIES	**THREATS**
• HTC guidelines currently under review • Scale up testing on the annual National HIV Testing Day • Scale-up data management	• Programme dependency on donor funding

3.2 Assessment of HTC policies in Namibia

There is no specific HTC policy but the National Policy on HIV/AIDS has a section on HTC; the HTC guidelines operationalise what is in the National Policy on HIV/AIDS. Currently, all guidelines related to HTC are being revised and consolidated into one document.

3.3 HTC policy gaps in Namibia

- The current outreach guidelines do not specify the minimum package required to do VCT.
- At New Start (NGO) there is a very high turnover of staff owing to inequities in salaries and conditions of service with different service providers.
- Primary Health Care requires a minimum package to accompany counselling and testing otherwise they do not recommend CT. Additional services include immunization, STI, TB, ART - additional service is needed linking positive and negative test results to other services. If this minimum package is not available, VCT is not permitted, according to MoHSS.

3.4 HTC situation analysis in Namibia

- 306 of the 338 health facilities in Namibia (91%) offer VCT and 154 (50%) are doing rapid testing.
- Among 'New Start', 18 free standing facilities (including 6 integrated facilities) use rapid testing (RT). For the 6 facility-based programmes there is pilot training of health workers in provider-initiated testing and counselling (PITC) using the Training of Trainers (TOT) approach.
- In 2008, 138 000 people were tested in public health facilities (57 000 tested in 2006).
- 54 000 people underwent VCT in New Start facilities, 2008 (67 000 including re-tests).
- The overall trend is one of substantial increase in HIV testing.
- Namibia has a National HIV testing day (9 May) which was launched in 2008. On 9 May 2008 the target was to test 12,000 individuals in 3 days but 34,000 people were tested.
- Sign language training has begun for community counsellors in order to target visually impaired and deaf people.
- Mobile workplace testing has begun.
- Courses on stress management and burnout prevention have begun for VCT workers and 260 health workers have been trained in these areas so far.
- There is a draft counsellor supervision curriculum for health workers. So far, 214 health workers have been trained.
- NDHS figures indicate that 18 - 25% of the population had been tested for HIV and slightly more females than males were tested (the female figure is 28%).

3.5 HTC approaches Namibia

CT methods/approaches used in the country include:

- traditional one-one-one HTC
- CT is part of a prevention of mother-to-child transmission (PMTCT) programme;
- Provider-initiated CT;
- Couples counselling;
- Family counselling;

- Partner counselling (partners of HIV-positive people);
- Parallel rapid testing algorithm and tie-breaker if not concordant; and
- Alternative algorithms are being explored.

On the other hand, there is no Home-based CT and while there is group education there is no group counselling (pre-test)

Staff doing counselling includes

- Health workers;
- Professional counsellors (registered with the country's professional health authority);
- Lay counsellors; and
- Nurses.

The VCT model in use does not focus on testing alone but provides other services such as screening for TB, an STI questionnaire, male circumcision, information provision, an alcohol brief motivational intervention, etc.

- People living with HIV/AIDS are involved in service delivery but there is little involvement of young people in post test services.

- The CT service mainly targets people between 16 and 49 years. Generally, the HIV testing age, as stipulated in the HTC guidelines, is 16 years.

3.6 HTC policy discussion: Success, Challenges, Best practice views of stakeholders

A summary of the policy discussions is provided in Appendix 6

Successes

Among the achievements or strengths of Namibia's HTC programme are the following:

- There are a number of guidelines that have been developed under the HTC programme, including:

    - The Counselling and testing guidelines
    - Community counselling guidelines
    - Outreach guideline for testing
    - HIV rapid testing (Standing operating procedures – SOP)
    - The Health worker curriculum
- A curriculum on child counselling is in development.

- The community counselling concept, started in 2004, is one of the achievements. Non-laboratory people are involved in testing and few countries are doing this. Likewise, few countries are using nursing staff in testing. There must be a comprehensive quality assurance system for HIV testing to complement these programmes.

- The VCT model in use does not focus on testing alone but provides other services such as screening for TB, an STI questionnaire, male circumcision, information provision, an alcohol brief motivational intervention, etc.

Challenges

There are many areas needing improvements. These include:

- Data management – to recapture data the Ministry of Health and Social services uses a paper-based system, while other sectors do not. There is a need to harmonize systems. Double counting may be a problem where systems are different. Standardized indicators for reporting have been developed and this is a step forward.
- There is a need for a 'national brand' to avoid an 'us' and 'them' type of situation as may occur with New Start and other CT programmes.
- There is a low uptake by couples (only about 8%tested).
- There is poor male involvement in HTC. Among those tested, 35-42% are males.
- Infrastructure is an important impediment to HTC. The limited space in some facilities does not allow them to meet set guidelines or adhere to protocols.
- At New Start, there is concern over the high cost per client. PEPFAR recommends spending US$ 10-30 per client, whereas this programme costs US$ 52 per client, excluding test kits.
- With regard to (second) follow-up sessions there is no cross referral system in place. The Ministry of Health recommends and uses a one stop shop which is much easier. Thus individuals move from testing site to management site for pre ART. They get CT once they start on ARVs, however, even in integrated sites people may get lost as they move from one point to the other.
- Other mechanisms for (second) follow-up sessions include post test clubs that deal with accessing services as people deal with emotional and self-worth issues. Post test clubs or support groups are funded by SMA and among these Thusano stands out. Oshakati Hospital introduced a pre-HAART clinic where patients are introduced to and prepared for treatment. New Start has various initiatives, e.g. the Test Positive Club, which serves as a support group for all those tested positive. This is done at Tonateni VCT centre, in Rundu, where the clients are being introduced to AIDS and M&E training, and this helps them to access treatment.
- Inadequate post test counselling leads to many more people coming back as they continuously expose themselves. We have seen re-testers up to 3 to 4 times at some centres. In Walvis Bay, where procedures are a little better, the number of re-testers has fallen.
- Dependency on one or two major donors.
- Only those certified by MoHSS should prescribe ART and there is a perceived need to increase control of the private sector.
- Clinical supervision of counsellors is inconsistent.
- Quality assurance for rapid testing is not happening as it should. QA reporting and testing is a challenge.

Best practices

- There is a lack of documentation for best practices.

4. RECOMMENDATIONS FOR MINIMUM STANDARDS

4.1 Age of Consent in testing

- Age of Consent in testing should be 15 years.

4.2 Standards for service provision

- Standards for service provision should include trained personnel and the three "Cs" (i.e. confidentiality, counselling before testing and client consent)

4.3 Training of providers

- Training of providers should include RT, PITC, Counselling (pre, post and supportive) and certification (it must take 50 samples to be certified as rapid tester by NIP).

4.4 Accreditation of HTC sites

- Accreditation of HTC sites should include waiting room, appropriate lighting, windows and what is in the guide.

4.5 Quality assurance of HTC services

- Quality assurance of HTC services should include quarterly visits to sites, counsellor assessment, rapid testing assessment and three quality assurance supervisor reports.

4.6 Monitoring and evaluation of HTC policies

- Monitoring and evaluation of HTC policies should include built in QA as well as external QA proficiency panels. There should be a reference laboratory overseeing all sites. Counselling also needs internal and external QA (i.e. sit in sessions, Ministry of Health supervisors, coordination and standardized tool for QA). M&E also needs data documentation that specifies the number of clients counselled by age and gender. A technical working group to oversee M&E would be necessary.

4.7 Comprehensive HTC approaches

- Comprehensive HTC approaches should involve a minimum package linking testing to care in HTC services. HTC should only be seen as an entry to care, treatment and support. Comprehensive HTC approaches should involve **VCT, PITC and outreach**. This includes **RT, pre and post testing, referrals, and prevention, treatment, care and support.**

4.8 Referrals

- The outreach package should involve the same as above, i.e. **effective referrals, traceable referrals, referral directory that is localized and updated.** There should be a directory of services.

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 HTC POLICIES, PROTOCOLS AND GUIDELINES

	YES	NO	ADDITIONAL COMMENTS
Is HTC policy available?		✓	There is no HTC policy available in Namibia but work around HTC is guided by the National HIV Policy (2007). .
Has HTC policy been approved?		✓	
When was it approved?	N/A		
Are there HTC guidelines?	✓		HTC guidelines were published and became operational in 2006.
When were the guidelines published?	2006		
Was there a consultation process for developing HTC policy?	✓		In the development of many health policies, the government of the Republic of Namibia engaged in an extensive consultation process involving bilateral organizations, United Nations agencies, Non-governmental organizations and Community based organizations. In the case of the development of HTC guidelines, the stakeholders involved in the consultation process included the Ministry of Health and Social Services (MoHSS), the World Health organization (WHO), the United Nation's Children Fund (UNICEF), the University of Namibia (UNAM), Namibia Network of AIDS Service Organization (NANASO), National AIDS Executive Committee (NAEC), health workers and lay counsellors.
Are policies/guidelines easily available?	✓		HTC guidelines are easily available in Namibian urban areas, although they might be difficult to find in rural areas.
Is there an HTC implementation plan?	✓		With the promulgation of HTC guidelines, came an HTC implementation plan.
Which CT methods/approaches are used?			The most popular methods are client initiated and service provider initiated counselling and testing (CT).
Which types of staff do the counselling?			Almost all of the counselling is done by trained health workers and community counsellors.

APPENDIX 3: SUMMARY OF HTC IMPLEMENTATION CHALLENGES IN Namibia

Country	YES	NO	ADDITIONAL COMMENTS
Inadequate financial resources, which are often narrowly earmarked by donors	✓		
Inadequate human resources; problems with lay counsellors	✓		
Poor partner and sectoral coordination and donor support resulting in verticalisation of programmes and poor implementation of national policies		✓	
Stigma and discrimination	✓		But improving (NTD)
Inadequate support for infant feeding which remains a complex issue, requiring further research	✓		
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	✓		
Insufficient integration of HTC services and insufficient linkages with other health and social services;	✓		In process of strengthening referral system
The need to decentralize implementation and service delivery, and focus on developing and strengthening of community structures and systems to include HTC;	✓		
Programme monitoring, recording and reporting	✓		Needs strengthening
Quality assurance and impact assessment;		✓	But needs strengthening (impact assessment planned for 2009)
Inadequate efforts to ensure male engagement in HTC;	✓		
Impact of gender inequality and of gender-based violence	✓		
Lack of capacity to cost plans		✓	But could be strengthened
Slow scale-up of provider-initiated testing and counselling services, where appropriate, and the limited creation of demand for these services.	✓		
Poor partner and sectoral coordination and donor support resulting in verticalisation of programmes and poor implementation of national policies.	✓		Needs to be confirmed
Programme monitoring, recording and reporting	✓		Needs to be confirmed
Quality assurance and impact assessment	✓		Needs to be confirmed
Other: Distances, return for results (50% of public facilities rely on ELISA), and issues related to follow up counselling, certification of Health workers, QA supervision for both testing and counselling, lack of space.	✓		

APPENDIX 4: HTC IMPLEMENTATION NEEDS IN Namibia

	YES	NO	ADDITIONAL COMMENTS

Need to speed up development of HTC policies and guidelines	✓		No separate HTC policy in place.
Need to improve M & E (HTC indicators, registers)		✓	Generally done well, although there is room for improvement.
Need to improve C & T (quality)	✓		Need to enhance the quality of C&T.
Appropriate use of lay counsellors in the health care setting	✓		Guideline in place but still some difficulties.
Improve integration of HTC into AIDS treatment and care activities	✓		
Effective communication on HTC	✓		
Improve community support for HTC	✓		
Strengthen quality assurance for HTC services	✓		
Best practice/models in HTC	✓		Community counsellor programme
Other: Counselling of counsellors	✓		

APPENDIX 5: SUMMARY OF DIFFERENT POLICY DISCUSSIONS

Is HTC policy available? There is no HTC policy available in Namibia but work around HTC is guided by the National HIV Policy (2007). There is however in existence HTC guidelines that were published and became operational in 2006. In the development of many health policies, HTC included, the government of the republic of Namibia engage in an extensive consultation process involving bilateral organizations, United Nations agencies, Non-governmental organizations and Community based organizations. In the case of the development of HTC guidelines the stakeholders involved in the consultation process included the Ministry of Health and Social Services (MoHSS), the World Health organization (WHO), the United Nations Children's Fund (UNICEF), the University of Namibia (UNAM), Namibia Network of AIDS Service Organizations (NANASO), National AIDS Executive Committee (NAEC), health workers and lay counsellors.

HTC guidelines are easily available in Namibian urban areas, although they might be difficult to find in rural areas. With the promulgation of HTC guidelines, came an HTC implementation plan.

The most popular methods **are client initiated and service provider initiated counselling and testing (CT).** Almost all of the counselling is done by trained health workers and community counsellors.

HTC indicators
Indicator: with regard to HIV counselling and testing (HTC) Namibia does provide the following services:

- HIV testing and counselling
- Retesting at a later stage
- HIV pre-test counselling
- Post-HIV test counselling
- Involvement of PLHIV or PLWHA

Male involvement in HTC is encouraged but not prominent.

HTC implementation challenges in SADC countries

It seems that Namibia suffers from implementation challenges seen in other African countries but to different degrees. These include:

1. Inadequate financial resources, which are often narrowly earmarked by donors
2. Inadequate human resources; problems with lay counsellors
3. Stigma and discrimination
4. Inadequate support for infant feeding which remains a complex issue, requiring further research
5. 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
6. Insufficient integration of HTC services and insufficient linkages with other health and social services; and insufficient linkages with other health and social services;
7. The need to decentralize implementation and service delivery, and focus on developing and strengthening of community structures and systems to include HTC
8. Inadequate efforts to ensure male engagement in HTC;
9. Impact of gender inequality and of gender-based violence
10. Lack of capacity to cost plans
11. Slow scale-up of provider-initiated testing and counselling services, where appropriate, and the limited creation of demand for these services
12. Poor partner and sectoral coordination and donor support resulting in verticalisation of programmes and poor implementation of national policies: ***Need to be confirmed***
13. Programme monitoring, recording and reporting: ***Need to be confirmed***
14. Quality assurance and impact assessment;: ***not sure Need to be confirmed***

Other: Please include other challenges not covered above: Distances, return for results, issues related to follow up counseling.

HTC implementation needs in SADC countries

Since there is no separate HTC policy in place in Namibia, there is need to speed up its development.

Although there is always room for improvement, in regard to M & E (HTC indicators and registers), in general this is done well. There is definitely room for improvement when it comes to enhancing the quality of C & T. Namibia makes appropriate use of lay counsellors in the health care setting and it has largely integrated HTC into AIDS treatment and care activities, although there is room for improvement. Other implementation challenges Namibia faces in HTC include:

Effective communication on HTC
Improve community support for HTC
Strengthen quality assurance for HTC services
Best practice/models in HTC
Other: Please include any other needs not captured in the table: Counseling of counselors,

HTC FOCUS GROUP DISCUSSION

FGD conducted on 10th February 2009. Participants from Centre for Disease Control (CDC), Ministry of Health and Social Services (MOHSS - DSP) and Intra Health, The International Training and Education Center on HIV/AIDS (I TECH)

Among the great achievements or strengths of Namibia's HTC programme are the following:

- There are a number of guidelines that have been developed under the HTC programme. They include
  - The Counselling and testing guidelines
  - Community counselling guidelines
  - Outreach guideline for testing
  - HIV rapid testing (Standing operating procedures – SOP)
- There are a number of guidelines that have been developed under the HTC programme. They include:
  - The Health worker curriculum
  - Community counselling curriculum which has six (6) modules dealing with self awareness, basic counselling skills, VCT skills proper, couple counselling, rapid testing, HIV counselling and testing. Each of these modules run for a week (i.e. five working days)
- We also have a draft curriculum on child counselling that among others will provide psycho-social support to children. Given the rare skills in counselling children we consider this a major achievement. We believe this quite unique in Africa and we must just finalize the curriculum.

- The community counselling concept is one of our achievements that was started in 2004. Since then over 500 community counsellors have been trained. Because there is a shortage of health workers these community counsellors are important. They are non laboratory people that are involved in testing and we believe few countries are doing this. As a matter of fact few countries are also using nursing staff in testing. There must be a comprehensive quality assurance system for HIV testing to complement these.

- Among the 338 health facilities in Namibia, 154 are doing rapid testing. Rapid testing has been rolled out in public health facilities and as of December 2008 306 of the 338 public health facilities were offering VCT. We can say that 50% of the health facilities provide Rapid test and the other 50% carry out the ELISA (Enzyme Linked Immuninosorbent Assay) which is laboratory based test.

- Among New Start 18 free standing facilities (including 6 integrated facilities) all use rapid testing (RT). For the 6 facility based programmes there is pilot training of health workers in provider initiated testing and counselling (PITC). These are TOTs.

- Namibia has a steering committee on HTC. This is a formalized technical working group that involves all relevant stakeholders from the Ministry of Health and Social services, CBOs, NGOs, FBOs. Main task is to dialogue on things like service improvement and STI compliance.

- Namibia has a National HIV testing day which was launched in 2008 on the 9th of May, and the National HIV Testing Day will be held on the 9th of May each year onwards. The 9th of May 2008 targeted testing 12,000 individuals in 3 days but actually tested 34,000 people. This testing day is important in raising HTC and HIV awareness.

- We have started sign language training for community counsellors. We believe this is important to target citizens that are visually impaired and deaf people.

- Mobile workplace testing has been started

- In 2008 138,000 people were tested in public health facilities, this was twice the number of people tested in public health facilities in the previous year and a major jump from the 57,000 tested in 2006. In New Start facilities 54,000 people underwent VCT in 2008. If those that were retested are included then the figure is around 67,000 and this is quite a substantial increase over the 48,000 tested in the previous year. The overall trend is one of substantial increase in HIV testing.

- We have started doing something about VCT workers. Thus we have started courses on stress management and burnout prevention. So far 260 health workers have been trained in these areas. We also have draft counsellor supervision curriculum that will train health workers – mainly nurses- on how to supervise community counsellors. So far 214 health workers have been trained in this area.

- The VCT model that we use is not about testing alone but provides other services – screening for TB and STI, circumcision, information provision, alcohol brief motivation etc.

- NDHS figures indicate that 18 - 25% of the population was tested for HIV. NDHS figures indicate that slightly more females than males were tested (the female figure stands at 28%). But the NDHS figures are always for the last 12 months.

Where Namibia's HTC programme could be improved?

There are many areas crying out for improvements. They include:

- Data management – to recapture data the Ministry of Health and Social services uses paper based system while other sectors do not. There is need to harmonize systems. This will help us to know the actual percentage of people tested in Namibia. Double counting may be a problem where systems are different. So far we have worked on standardized indicators for reporting and this is a step forward.

- We need a national brand – not us and them type of situation, not New Start and CT

- There is a low uptake of couples (only about 8%tested)

- There is poor male involvement in HTC. Among those tested 35-42% are males.

- Infrastructure is an important impediment to HTC. Namibia cannot rollout testing on certain sites because of lack of space and dilapidated conditions. Although we said that 154 facilities are doing VCT some are not ideal. The limited space in some facilities does not allow facilities to meet set guidelines and adherence to protocols.

- At New Start we can talk of high cost per client. PEPFAR requires or recommends that we spend 10-30 US$ per client, but we spend US$ 52 per client testing kits not included. Unlike the MoHSS that use community counsellors (making their programme cost effective) New Start uses the best social workers, psychologists and costs escalate when costs of travelling, training and high staff turnover are added. New Start can only reduce costs by increasing the number of tests (taking advantage of economies of scale) but currently we are doing 4 clients per counsellor instead of the recommended 8 clients per counsellor per day.

- Although earlier on we mentioned outreach as an achievement, it is also an area of difficulty needing improvement. Primary Health Care requires a minimum package to accompany counselling and testing otherwise they do not recommend CT. Additional service include immunization, STI, TB, ART - we need to give additional service linking positive and negative test results to other services. If this minimum package is not met you are not allowed to do VCT by the Ministry of Health and Social Services.

What are the gaps in HTC policies?
The current outreach guidelines do not specify the minimum package required to do VCT. At New Start (NGO) there is a very high turnover. The reason for this is that there are 10 parties contracted to run New Start centres but among these there are inequities in salaries and conditions of service among partners and this leads to people leaving one partner and joining others.

What are the HTC implementation challenges?
Among the challenges is lack of documentation for best practices. Lack of time prevents documentation as staff are overworked and underpaid. Shortage of staff and lack of capacity means there are no people to document what is happening.

Another major challenge concerns the sustainability of the HTC programme. If one or two of the major donors were to pull out today what will happen to the New Start centres and the public health centres?

There is not much control of what private practitioners are doing. Namibia has started the Public –Private Partnership Mix to enable it to know what those in the private sectors are doing but there are no guidelines as of yet. ART guidelines are supposed to cater for both the public and private sectors but there is need for more certification and accreditation. Only those certified by MoHSS should prescribe ART, there is need to reign in the private sector.

Clinical supervision of counsellors is inconsistent (and in some cases not happening at all). The reason for this is that the number of trained health workers who can supervise counsellors is few. These cannot be supervised by untrained health workers.

Quality assurance for rapid testing is not happening as it should. QA reporting and testing is a challenge.
HIV Policy
There is no specific HTC policy but the National Policy on HIV/AIDS has a section on HTC; the HTC guidelines operationalize what is in the National Policy on HIV/AIDS. Currently, all guidelines related to HTC are being revised and consolidated into one document.

Describe the characteristics of HTC service users?

The CT service mainly targets the 16-49 years group of people. It targets all sexually active people which mean that it is not limited to the age 16-49 years.

The younger age groups used counselling and testing services more during the past year. This especially applies to stand alone facilities. Even the people that mostly attended the National Testing Day were young. There were people younger than 16 years old tested because when they come for the service, it is not denied to them. The HIV testing age as stipulated in the HTC guidelines is 16 years. At Newstart we receive more young people aged between 24– 35 on average while at public health facilities the mean age is 30 years.

It is mostly females who used counselling and testing services during the past year. This is partly because ANC is seen as a service for females. The other reason is that there are few male friendly services in Namibia. For instance there is no male equivalent of ANC and many males are uncomfortable with the idea of accompanying their female partners to ANC. Only Walvis Bay recorded more male (52%) than female (48%) attendance. This might reflect the fact that Walvis Bay is dominated by seafaring industry that mostly employs males. We need male friendly setup. This would suggest after hours testing and allocation of extra hours (Saturdays and Sundays) for testing. Definitely there is need to find why male uptake is so slow – an environment for attracting males needs to be created. ANC and VCT integration has brought the challenge that males do not feel welcomed.

HIV Counselling & Testing (CT) Services

Yes HIV testing is done on site and is facility based. Rapid HIV testing is available with clients being given their HIV test result in the same hour on the day of testing. If not on site clients have to wait for a HIV test result for two (2) weeks.

At new start we sit in and observe to ensure the quality of post (test) counselling sessions but there is a high percentage of retests. If you are not doing post tests properly you are bound to see many more people coming back as they continuously expose themselves. We have seen re-testers up to 3 to 4 times at some centres, but in Walvis Bay where things are done a little better the number of re-testers have fallen.

Yes, this is a tricky question – we ensure quality by sitting in and observing. We also have a risk reduction plan which was not done well initially but things have improved due to sit ins. Our aim with the risk reduction plan is to build quality of post test intervention.

On average counselling sessions last 45 to 60 minutes, post test counselling sessions range from 15 to 20 minutes or more. It all depends on the case you are dealing with.

With regards to treatment literacy for positive clients, we look at issues pertinent to the test. We consider CD4 test count then cover issues for treatment in detail. Before patients are referred to ART clinic they are given information. NAWA Life Trust – a Namibian NGO – produces treatment literacy material, Management Science produces videos on treatment literacy and Lironga Eparu (an NGO for PLWHIV) engage in treatment literacy.

With regard to (second) follow-up sessions there is no cross referral system in place. The Ministry of health recommends and uses a one stop shop which is much easier. Thus individuals move from testing site to management site for pre ART. They get CT once they start on ARVs, however even in integrated sites people may get lost as they move from one point to the other.

Other mechanisms for (second) follow-up sessions include post test clubs that deal with accessing services as people deal with emotions and self issues. Post test clubs or support groups are funded by SMA and among these Thusano stands out. Oshakati Hospital introduced a pre-HAART clinic where patients are introduced/prepared for treatment counselling. New Start has various initiatives e.g. Test Positive Club which serves as a support group for all those tested positive. This is done at Tonateni VCT centre, in Rundu....the clients are being introduced to AIDS and M&E training and this helps them to access treatment.

There is little involvement of young people in post test services. The exception is the multipurpose resource centres which have nurses involved in family planning. The next step will be rapid testing and much later on post test services.

Are you familiar with the CT methods/approaches used in the country?

CT methods/approaches used in the country include:

- traditional one-one-one HTC,
- CT is part of a prevention of mother-to-child transmission (PMTCT) programme,
- Provider-initiated CT,
- Couples counseling,
- Family counselling,
- Partner counselling (partners of HIV-positive people),
- Parallel rapid testing algorithm and tie breaker if not concordant
- We are exploring alternative algorithms

On the other hand there is no Home-based CT and while there is group education there is no group counselling (pre-test),

Which types of staff do the counselling?

Among staff doing counselling are

- Health workers,
- Professional counsellors (registered with the country's professional health authority)
- Lay counsellors
- Nurses

Yes people living with HIV/AIDS (PLWHIV/AIDS) are involved in service delivery

Do you know of HTC policies in this country?

The development of the various HTC guidelines and protocols is based on HTC policies contained in the country's policy on HIV/AIDS. The guidelines fits in with the national policy and the protocols in turn fit in with the guidelines.

Where are HIV Counselling & Testing (CT) services provided in this country?

HIV Counselling & Testing (CT) services are provided nationally (in all the 13 regions) but New Start operates in only 10 of the 13 regions. These services are provided in all districts but they are not provided in all constituencies. Thus HIV counselling & testing (CT) services are not provided in all clinics in the country.

Service Load

How many HIV counselling sessions were conducted (across all service delivery points combined) in the past year?_______________(Fuller to provide)

How many HIV tests were done (across all CT service delivery points combined) in the past year?
_______________(Fuller to provide)

Hours of Operation of HIV Counselling & Testing (CT) Services

Counselling and testing services are available five (5) days per week at service delivery points in Namibia but there are places where they are open for more days and/or hours. Thus for instance New Start CT services open in Katima Mulilo on Sundays. New Start also have a few sites which are open on Sundays. Some sites e.g. Marienthal are open every third Sunday of the month to accommodate people (especially men) who are very busy.

What are the service delivery points for providing HIV Counselling & Testing (CT) in this country?

Is it HTC clinics, hospitals, community health centres, clinics, (stand-alone) counselling and testing facilities or other fixed HTC service points? What is the approximate number of service delivery points in urban/rural areas?
Almost all urban areas and in many rural areas - Roll out list to be provided

What are the strategies to promote HTC uptake in the country?

- NAWA life – The field office of the US-based Johns Hopkins Center for Communication Programmes/Health Communication Partnership transformed itself into an NGO taking up the name Nawa Life Trust. This NGO support the 'Take Control' national HIV/AIDS media campaign under the Ministry of Information and Broadcasting, as well as the communication work of the Coalition for Responsible Drinking (CORD). At the local level, Nawa Life will help the 14 Community Action Forums (CAFs) – volunteer community groups at the grassroots level -- to conduct a variety of activities, including: community outreach and referrals, promoting HIV/AIDS testing, facilitating access to counselling and treatment services, lobbying for responsible drinking, and mitigating the negative impact of shebeens on residential communities.

Take control campaign - is a large-scale communication campaign using radio, television, print media, and events. Coordinated by the Ministry of Information and Broadcasting through a Task Force, the campaign aims to:

- Promote role-model specific HIV prevention behaviours by young people, parents, extended family members, and service providers.
- Empower youth to make informed choices about sexual relationships by ensuring that adults are aware of the specific information, skills, and services helpful in protecting young people from HIV infection.
- Engender support and understanding for people living with HIV/AIDS, orphans, and vulnerable children and survivors of abuse.
- Provide information about sexual health rights to young people and older age groups to facilitate positive behaviour choices.
- Develop with the active participation of young people messages focused on communication between partners and positive role-modeling behaviours to parents and service providers.
- Develop and distribute printed materials in English and local languages.

Other specific strategies employed by the Namibian government and the private sector are:

- Use of electronic and print media
- Use of interpersonal communication
- Streamline messaging

- Promotional campaigns such as the Taxi promotion campaign and the win a Bicycle campaign. These promotional campaigns depend on the availability of funds from cooperating partners.
- National HIV testing day
- The Ministry of Education has "Health days" in which they invite HTC professionals to talk to those working in the educational sector.

All the above mentioned strategies are separate strategies therefore it is imperative to have a single national strategy.

In your view what issues should proposed minimum standards for HTC in SADC critically consider under each of the following themes?

a) Age of Consent in testing should be 15 years

b) Standards for service provision should be trained personnel and the three "Cs" (i.e. confidentiality, counselling before testing and client consent)

c) Training of providers should include RT, PITC, Counselling (pre, post and supportive) and certification (it must take 50 samples to be certified as rapid tester by NIP).

d) Accreditation of HTC sites should include waiting room, appropriate lighting, windows and what is in the guide

e) Quality assurance of HTC services should include quarterly visits to sites, counsellor assessment, rapid testing assessment and three (3) quality assurance supervisor reports.

f) Monitoring and evaluation of HTC policies should include built in QA as well as external QA proficiency panels. There should be a reference laboratory overseeing all sites. Counselling also needs internal and external QA (i.e. sit in sessions, Ministry of Health supervisors, coordination and standardized tool for QA). M&E also needs data documentation that specifies the number of clients counselled by age and gender. A technical working group to oversee M&E would be necessary.

g) Comprehensive HTC approaches should involve a minimum package linking testing to care in HTC services. HTC should only be seen as an entry to care, treatment and support. Comprehensive HTC approaches should involve VCT, PITC and outreach. This includes RT, pre and post testing, referrals, and prevention, treatment, care and support.

h) Referral system should involve effective referrals, traceable referrals, referral directory that is localized and updated. There should be a directory of services.

i) Outreach package should involve the same as above i.e. effective referrals, traceable referrals, referral directory that is localized and updated. There should be a directory of services.