REPUBLIC OF NAMIBIA

NAMIBIA

Health Facility Census (HFC) 2009

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2009

Ministry of Health and Social Services (MoHSS)
Windhoek, Namibia

ICF Macro
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This report presents findings 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 that 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; the Government of the Republic of Namibia; and the World Health Organization.

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FOREWORD

The 2009 Namibia Health Facility Census (2009 NHFC) is the first facility-based survey to cover all health facilities, both public and private. More than 400 health facilities participated in the census.

The facilities surveyed include hospitals, health centres, clinics, free-standing voluntary HIV counselling and testing centres, and sick bays. These facilities are managed by the Ministry of Health and Social Services, missions and nongovernmental organisations (NGOs), the private sector, the Ministry of Defence, and the police.

The 2009 NHFC was designed to provide detailed information on the availability and quality of facility infrastructure, resources, and management systems and on services for child health, family planning, maternal health, and selected infectious diseases, namely sexually transmitted infections, tuberculosis, and malaria. The survey also provides information on the capacity of health facilities to provide quality HIV/AIDS services.

The survey collected several types of data, using checklists on general infrastructure and supplies, interviews with health care providers and clients, and direct observation of client-provider interactions. Together, these approaches provide a comprehensive overview of the health care system in Namibia.

The 2009 NHFC has collected important information for planners, policy-makers, and programme managers to assess the capacity of health facilities to provide quality services to the children, men, and women of Namibia. The information is also very useful in determining the strengths and weaknesses of health facilities in the endeavour to provide intervention measures for improving health care delivery.

It is against this background that the Ministry of Health and Social Services takes pride in presenting the results of this survey.

Dr. Richard Nchabi Kamwi, M.P.
Minister
Ministry of Health and Social Services

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The 2009 Namibia Health Facility Census (2009 NHFC) is yet another successful undertaking by the Ministry of Health and Social Services in collaboration with a number of stakeholders. The Ministry of Health and Social Services is grateful to all the development partners for their financial and technical contributions to the success of the 2009 NHFC.

We would like to recognize and acknowledge the technical assistance provided by ICF Macro through the worldwide Measure DHS project. Our sincere appreciation goes also to the survey Task Force Team for its active contributions, supervision, and guidance throughout the implementation of the survey.

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Finally we would like to thank the leadership of the Directorate of Special Programmes in the MoHSS for their commitment and unwavering support from the inception of the survey to its completion.

Mr. K.K. Kahuure
Permanent Secretary
Ministry of Health and Social Services

ABBREVIATIONS

AFHS	Adolescent Friendly Health Services
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infection
ART	Antiretroviral Therapy
ARV	Antiretroviral
AVD	Assisted Vaginal Delivery
BEOC	Basic Essential Obstetric Care
BEmOC	Basic Emergency Obstetric Care
BCG	Bacille de Calmette et Guerin
CBRP	Community-Based Resource Person
CEOC	Comprehensive Essential Obstetric Care
CEmOC	Comprehensive Emergency Obstetric Care
CHBC	Community Home-Based Care
CNR	Case Notification Rate
CPT	Cotrimoxazole Preventive Therapy
CS	Caesarean Section
CSS	Care and Support Services
CSSD	Central Sterile Sterilization Department
CT	Counselling and Testing
D&C	Dilation and Curettage
DDC	District Co-ordination Committee
DOT	Direct Observation of Treatment
DOTS	Direct Observed Therapy, Short Course
DPT	Diphtheria, Pertussis, Tetanus
DPT-HB	Diphtheria, Pertussis, Tetanus, and Hepatitis B vaccine
DSS	Demographic Surveillance System
EmOC	Emergency Obstetric Care
ELISA	Enzyme-linked Immunosorbent Assay
EPI	Expanded Programme on Immunisation
FP	Family Planning
HFC	Health Facility Census
HIV	Human Immunodeficiency Virus
HLD	High-level Disinfection
IC	Infection Control
ICPD	International Conference on Population and Development
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate

IPT	Intermittent Preventive Treatment
ITN	Insecticide-treated (bed) Net
IUCD	Intrauterine Contraceptive Device
IV	Intravenous
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MDR-TB	Multi-drug-Resistant Tuberculosis
MMR	Maternal Mortality Ratio
MoHSS	Ministry of Health and Social Services
MTP3	Third Medium-Term Plan on HIV/AIDS
NAMFISA	Namibia Financial Institutions Supervisory Authority
NDHS	Namibia Demographic and Health Survey
NHFC	Namibia Health Facility Census
NGO	Non-governmental organisation
NPC	National Planning Commission
NVDCP	National Vector Disease Control Programme
OI	Opportunistic Infection
OPD	Outpatient Department
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PCR	Polymerase chain reaction
PEP	Post-Exposure Prophylaxis
PHC	Primary Health Care
PID	Pelvic Inflammatory Disease
PITC	Provider-Initiated Testing and Counselling
PMTCT	Prevention of Mother-To-Child Transmission (of HIV)
PNC	Postnatal Care
PSEMAS	Public Service Medical Aid Scheme
QA	Quality Assurance
RDT	Rapid Diagnostic Test
RPR	Rapid Plasma Reagin
SP	Sulfadoxine-pyrimethamine (Fansidar)
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBA	Traditional Birth Attendant
TFP	Temporary methods of Family Planning
TST	Time-, Steam-, and Temperature-sensitive (tape)
TT	Tetanus toxoid
UNAIDS	United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children’s Fund

USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
VDRL	Venereal Disease Research Laboratory (test)
WHO	World Health Organization
YFS	Youth Friendly Services

KEY FINDINGS

The 2009 Namibia Health Facility Census (2009 NHFC) is an assessment of all health facilities in Namibia. It was designed to provide information on the general performance of facilities that offer maternal, child, and reproductive health services as well as services for specific infectious diseases, including sexually transmitted infections (STIs), HIV/AIDS, tuberculosis (TB), and malaria.

Information was collected, using facility audit questionnaires, interviews with health service providers, observations of client-provider consultations, and exit interviews with clients, to assess the capacity of facilities to provide good quality services and also to assess the existence and the strengths and weaknesses of infrastructure and systems to support these services. The health facility census also sought to assess adherence to standards in the delivery of curative care for sick children, family planning, and antenatal care (ANC).

The 2009 NHFC provides national- and regional-level 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.

The Directorate of Special Programmes (HIV/AIDS/TB/Malaria) in the Ministry of Health and Social Services (MoHSS) conducted the 2009 NHFC, with technical assistance from ICF Macro under the MEASURE DHS project. Financial support for the census came from the United States Agency for International Development, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the government of the Republic of Namibia, and the World Health Organization.

Below is a summary of the key findings of the 2009 NHFC:

FACILITY-LEVEL INFRASTRUCTURE, RESOURCES, AND SYSTEMS

- A full package of basic services—which includes outpatient care for sick children and for adult STIs, temporary methods of family planning, ANC, immunisation, and child growth monitoring—is available in seven of every ten facilities. Facility-based, 24-hour delivery services are available in nine of every ten hospitals, in about six of every ten health centres, and in three of every ten clinics.

- Three of every ten facilities have regular supplies of water and electricity as well as client comfort amenities such as a basic level of cleanliness. About six of every ten facilities have safe onsite water supply year-round, i.e., water from any source piped into the facility or water from a protected well/pump or other outlet that is within 500 meters of the facility.

- Two-thirds of facilities report holding routine management meetings at least once every six months; however, only one-third of facilities have documentation of a recent management meeting.

- Almost all hospitals, health centres, and clinics routinely charge some form of user fees for adult curative care.

- Almost all hospitals have functioning equipment (or chemicals) for the sterilisation or high-level disinfection (HLD) of re-useable instruments. Close to nine of every ten facilities have an adequate final disposal system for sharps waste.

CHILD HEALTH SERVICES

- Eight of every ten facilities offer all three basic child health services—outpatient curative care for sick children, childhood immunisations, and growth monitoring. Three-quarters

of facilities that offer child immunisation services and also store vaccines had all basic vaccines (BCG, DPT/pentavalent, polio, and measles) available on the day of the visit.

- Nine of every ten facilities offer outpatient curative care for sick children. Among the facilities offering outpatient curative care for sick children, close to nine of every ten have treatment guidelines for sick child services; however, less than one-third have Integrated Management of Childhood Illness (IMCI) counselling cards available for providers.

- All three first-line oral medicines (ORS, the first-line antimalarial (Coartem), and at least one oral antibiotic) are available in three-quarters of facilities that offer sick child services. Three-quarters of facilities offering services for sick children have all pre-referral medicines—at least one first-line injectable antibiotic (chloramphenicol, ampicillin, cloxacillin, or penicillin), at least one second-line injectable antibiotic (ceftriaxone or gentamicin), and intravenous solution with perfusion set.

- Three of every ten facilities offering curative care for sick children provide their staff with routine training related to child health services, and only 10 percent of interviewed child health service providers in these facilities reported receiving training in IMCI during the 12 months preceding the assessment.

- Complete evaluation of sick children for general danger signs (the sick child's inability to eat or drink, vomiting everything, and febrile convulsions) during sick child visits are not routinely done. During only 12 percent of all observed sick child consultations did providers evaluate sick children for all three of these IMCI general danger signs.

- About nine of every ten observed children diagnosed with pneumonia were given an antibiotic, while slightly over eight of every ten children with cough or other upper respiratory conditions also were provided antibiotics.

- Providers seldom give caretakers essential information for taking care of the sick child at home. For example, only one in every ten caretakers received all three IMCI recommendations regarding fluid intake, food intake, and symptoms for which the sick child must be brought back to see a health provider.

- Providers are taking advantage of sick child visits to promote preventive health interventions: About nine of every ten observed children had their immunisation status checked, and almost all sick children were weighed. Visual aids to educate caretakers are, however, available in only half of facilities that offer sick child services and are rarely used during consultations in any case (only 7 percent).

- Caretakers' major complaint about services is the waiting time to see a provider.

Family Planning Services

- Nine of every ten facilities in Namibia offer temporary modern methods of family planning (FP); the majority of these facilities (eight of every ten) offer FP services five or more days per week. The most commonly offered temporary FP methods are the progestin-only injectables, combined oral contraceptive pills, male condoms, and progestin-only oral contraceptive pills.

- Nearly all FP facilities assure both visual and auditory privacy during family planning counselling sessions. Visual aids for client education on family planning are widely available; however, only half of these facilities had family planning service guidelines available in the service delivery area on the day of the survey visit. Items for infection control (soap and running water or else hand disinfectant, clean latex gloves, disinfecting solution, and sharps box) are available in the family planning service area in about two-thirds of these facilities.

- In eight of every ten family planning facilities, family planning providers routinely diagnose and treat STIs. Generally, in these facilities medicines for treating syphilis, trichomoniasis,

chlamydia, and gonorrhoea are readily available.

- Up-to-date family planning registers are found in three-quarters of FP facilities.

- Only a small proportion of family planning facilities provide routine training for family planning service providers; however individual supervision of these providers is quite widespread.

- Few family planning clients have major issues with their visits to health facilities. Waiting time to see a provider is the problem that clients most often mention.

MATERNAL HEALTH SERVICES

- ANC services are available in eight of every ten facilities; they are least likely to be available in hospitals. Two-thirds of facilities offer ANC, postnatal care (PNC), and tetanus toxoid (TT) vaccine. Practically all ANC facilities provide TT services every day that ANC services are offered.

- Overall, only one-fifth of ANC facilities have visual aids, ANC guidelines, and individual client health passports —items considered important for provision of quality ANC counselling. Individual client health passports are more likely to be available than either ANC guidelines or visual aids.

- Most ANC facilities have the essential equipment and supplies (blood pressure apparatus, foetoscope, iron and folic acid tablets, and TT vaccine) for basic ANC. All infection control items (soap and running water or else hand disinfectant, latex gloves, disinfecting solution, and sharps box) are available in six of every ten ANC facilities. Hand disinfectant is the item most likely to be missing. Medicines for managing common complications of pregnancy (a broad spectrum antibiotic, an antihelminthic, a first-line antimalarial, an antihypertensive, and at least one medicine for treating each of the following STIs: trichomoniasis, gonorrhoea, chlamydia, and syphilis) are individually relatively available in most facilities; however, only one-quarter of ANC facilities have all these medicines.

- In nine of every ten facilities, ANC service providers routinely offer STI treatment. On the day of the survey visit, the great majority of ANC facilities (87 percent) had medicines to treat each of the four common STIs—syphilis, gonorrhoea, chlamydia, and trichomoniasis.

- Seven of every ten ANC facilities have up-to-date ANC registers, but up-to-date postnatal care registers are less widely found. Only 15 percent of ANC facilities have documentation indicating that they monitor ANC coverage.

- First-visit ANC clients are more likely to be counselled or educated on nutrition, pregnancy risk signs and symptoms, delivery plans, exclusive breastfeeding, and postpartum family planning during ANC consultations than are follow-up clients or even clients who are at least eight months pregnant. On average, delivery plans are discussed with only four of every ten ANC clients who are at least eight months pregnant.

- Normal delivery services are available in two-thirds of facilities, including 98 percent of hospitals. Caesarean sections are available almost exclusively in hospitals. The majority of facilities have transportation support for maternity emergencies; private facilities are less likely to have transportation support than MoHSS and mission/NGO facilities.

- Two-thirds of facilities that offer normal delivery services have all infection control items (soap and running water or else hand disinfectant, sharps box, disinfecting solution, and clean latex gloves) at the service site.

- All basic equipment and supplies for conducting normal deliveries (scissors or a blade, cord clamps or ties, a suction apparatus, antibiotic eye ointment for the newborn, and a disinfectant for cleaning the perineum) are available in the delivery area in only four of every ten facilities offering delivery services. The availability of each of these items individually ranges from 68 percent of facilities having

suction apparatus to 95 percent of facilities having scissors or a blade. A complete set of items to manage common complications and serious complications of delivery is not widely available in facilities offering normal delivery services.

- Newborn respiratory support (infant-sized Ambu bag or equivalent) is available in six of every ten facilities that offer delivery services, including 95 percent of hospitals. An external heat source is available in one-quarter of these facilities, including 98 percent of hospitals. Practices that are considered supportive of newborn health, such as weighing the newborn, providing vitamin A to the mother, and rooming-in, are common.

- Up-to-date delivery registers are available in half of delivery facilities, most commonly in hospitals. Overall, only one-fifth of delivery facilities conduct reviews of maternal and/or newborn deaths or near-misses. Among hospitals, however, 70 percent conduct such reviews.

STI and Tuberculosis Services

- STI services are available in over nine of every ten facilities. In almost all facilities offering STI services, these services are offered as part of general outpatient curative services. In about eight of every ten facilities, STI services are also available in FP services sites, and in three-quarters of facilities they are also available in ANC sites. Specialised STI clinics are not common.

- The syndromic approach is the most widely used method to diagnose and treat STIs in Namibian health facilities. On the day of the survey visit, about nine of every ten STI facilities had at least one medicine for treating each of the four common STIs.

- Nine of every ten STI facilities provide STI counselling under conditions that ensure both visual and auditory privacy. STI guidelines are available at the service delivery site in nine of every ten STI facilities. STI-related visual aids and educational materials also are widely available at STI service sites in these facilities. Nearly nine of every ten STI facilities have male condoms available at the STI services site; female condoms are less widely available.

- TB diagnosis, treatment, and/or follow-up services are available in 87 percent of facilities, including almost all health centres and eight of every ten hospitals. Six of every ten facilities that offer TB treatment and/or follow-up services say that they follow the DOTS strategy. Of facilities following the DOTS strategy, about six of every ten had all first-line TB medicines available on the day of the visit.

- On average, better than eight of every ten facilities that offer TB diagnostic, treatment, and/or follow-up services routinely refer all newly diagnosed TB cases for HIV testing.

HIV/AIDS Services

- Practically all health facilities in Namibia have an HIV testing system. Among these, eight of every ten have HIV testing capacity on-site or in an affiliated lab. Three-quarters of facilities with an HIV testing system have an informed consent policy for HIV testing, and nine of every ten have a register recording HIV test results.

- One-fifth of facilities with an HIV testing system have youth-friendly HIV testing services. Six of every ten facilities providing youth-friendly HIV testing services have at least one provider trained in youth-friendly services. Four of every ten facilities with an HIV testing system have guidelines or policies for youth-friendly services.

- Care and support services for HIV/AIDS clients are available in nine of every ten facilities. On average, seven of every ten facilities offer primary preventive treatment for opportunistic infections, such as cotrimoxazole preventive treatment.

- On average, 18 percent of all facilities provide antiretroviral therapy (ART) services, including seven of every ten hospitals and a little over one-third of health centres. Items to sup-

port ART services, such as national ART guidelines and other guidelines for the clinical management of ART, are widely available in these facilities.

- Services to prevent mother-to-child transmission (PMTCT) of HIV are available in three-quarters of all facilities, including eight of every ten hospitals and nine of every ten health centres. Only half of facilities reporting that they offer PMTCT actually offer all four components of the minimum PMTCT package, however. Close to nine of every ten ANC facilities report offering PMTCT services.

- Overall, services for post-exposure prophylaxis (PEP) for health workers are available in eight of every ten facilities in the country.

NAMIBIA

N
ANGOLA
ZAMBIA
Ohangwena
Caprivi
Omusati
Oshana
Oshikoto
Kavango
Kunene
Otjozondjupa
BOTSWANA
Atlantic Ocean
Erongo
Omaheke
Khomas
Hardap
Karas
SOUTH AFRICA
0
3,000
6,000
9,000 Kilometers

METHODOLOGY 1

Paul Ametepi, Efraim Dumeni

1.1 Overview

The 2009 Namibia Health Facility Census (2009 NHFC) is an assessment of all health facilities in Namibia, designed to provide information on the general performance of facilities that offer maternal, child, and reproductive health services as well as services for specific infectious diseases, including sexually transmitted infections (STIs), HIV/AIDS, tuberculosis (TB), and malaria.

Information to provide a comprehensive picture of the strengths and weaknesses of the service delivery environment for each assessed service was collected from facilities managed by both the public (government) and private sectors (non-governmental (NGO), private-for-profit organisations, and faith-based organisations) in all 34 districts of the country.

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. Findings can supplement household-based health information from the Namibia Demographic and Health Census conducted in 2006-07, which provides information on health and the utilisation of services by the overall population.

1.2 Institutional Framework and Objectives of the 2009 NHFC

The Directorate of Special Programmes (HIV/AIDS/TB/MALARIA) in the Ministry of Health and Social Services (MoHSS) implemented the 2009 NHFC. The census received technical support from ICF Macro under the MEASURE DHS project. 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 Organization.

The objectives of the 2009 NHFC were 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.

Data collection instruments were developed to respond to the following basic questions:

1. **To what extent are facilities prepared to provide high-priority services? What resources and support systems are available?**

For each high-priority service, the 2009 NHFC used *Facility Audit Questionnaires* and *Provider Interviews* to collect information on whether a facility has the capacity to provide the service at acceptable standards.

Capacity is measured by the presence of essential equipment and supplies in a location reasonable for providing a service. Quality of services, which is one aspect of capacity, is measured by the following characteristics of facilities: training and supervision of staff, availability of service delivery protocols and client education materials, availability and use of health information records, the service delivery environment, and facility systems for maintaining equipment and supplies.

The census assessed support systems for general management, quality assurance, logistics for medicines, equipment maintenance, infection control, and systems for monitoring activities (such as tracking service coverage rates and referrals). Interviewers asked whether a facility had these support systems in place and also recorded data on whether those systems were functioning.

A facility's basic infrastructure can affect the standard of health services provided and influence clients to use the facility. The 2009 NHFC collected data on whether facilities had electricity, water, and client amenities; it recorded what services the facility offered and on which days of the week; and it assessed staffing levels.

2. **To what extent does the service delivery process follow generally accepted standards of care?**

NHFC interviewers observed interactions between clients and providers to assess whether the process followed in service delivery meets standards for acceptable content and quality. Observers sat in on consultations for sick children, family planning services, and antenatal care (ANC). They recorded what information was shared between the client and the provider and what processes the provider followed when assessing the client, conducting procedures, and providing treatment.

3. **What issues affect clients' and service providers' satisfaction with the service delivery environment?**

Each observed client was subsequently asked to participate in an exit interview to ascertain the client's perception of information shared and services received. This information provides further insight on the quality of the client-provider interaction. Also, providers were interviewed about their satisfaction with the work environment.

1.3 2009 NHFC Content and Methods for Data Collection

1.3.1 Content of the 2009 NHFC

The 2009 NHFC focussed on basic health services, particularly those important for women and children. Four high-priority health services, all interrelated to some extent, were assessed: child health, family planning, maternal health, and specific infectious diseases (STIs, HIV/AIDS, TB, and malaria).

In each of these four areas, the census assessed whether components considered essential for quality health services were present and functioning. The components assessed are those commonly promoted in different programmes supported by the government and development partners. The 2009 NHFC also assessed whether more sophisticated components were present, such as higher-level diagnostic and treatment modalities or support systems for health services that are usually introduced after basic-level services have been put in place.

The *child health component* of the census was designed to assess the availability of preventive services (immunisation and growth monitoring) and outpatient curative care for sick children, with a focus on the process followed in providing services to sick children. Service provision was compared with the standards set in the guidelines for the World Health Organization's Integrated Management of Childhood Illness.

The *family planning component* focussed on the process followed in counselling and providing contraceptive methods to family planning clients.

The *maternal health component* assessed counselling and screening during ANC visits, the delivery service environment, and care during the postpartum period.

The *infectious disease component* assessed the availability of services for diagnosing and treating STIs as well as HIV/AIDS, TB, and malaria diagnostic and treatment programmes.

1.3.2 Methods for Data Collection

Four main types of data collection tools were used: *Facility Audit Questionnaires, Observation Protocols, Client Exit Interviews,* and *Health Worker/Provider Interviews.*

Using the *Facility Audit Questionnaires*, interviewers collected information on the availability of resources, support systems, and facility infrastructure elements necessary to provide a level of service that generally meets accepted national and international standards. The support services assessed were those that are commonly acknowledged as essential management tools for maintaining health services. The *Facility Audit Questionnaires* include MCH (including family planning), HIV/AIDS, laboratory, and pharmacy modules. The HIV/AIDS modules assessed systems in place for the provision of HIV/AIDS services, including HIV counselling and testing, care and treatment, referral, and follow-up. Interviewers also collected information on health facility policies and practices related to collecting and reporting HIV/AIDS-related records and statistics for services provided to clients through the health facility.

The *Observation Protocol* was tailored to the service being provided. For sick child, ANC, and family planning consultations, the observer assessed the extent to which service providers adhered to standards of care, based on generally accepted practices for good quality service delivery. The observations were recorded in a checklist. Observations included both the process used in conducting specific procedures and examinations and also the content of information (including history, symptoms, and advice) exchanged between the provider and the client.

After clients were observed receiving a service, they were asked to participate in an *Exit Interview* as they left the facility. The *Exit Interview* included questions on the client's understanding of the consultation or examination as well as on his or her recall of instructions received about treatment or preventive behaviour. The interviewer also elicited the client's perception of the service delivery environment.

In the *Health Worker/Provider Interview*, service providers were interviewed regarding their qualifications (training, experience, and continued in-service training), the supervision they had received, and their perceptions of the service delivery environment.

1.4 SAMPLING

Data were collected from all functioning health facilities in Namibia. 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 ANC clients.

1.4.1 Selection of Facilities

Since the total number of facilities in the country is relatively small, the 2009 NHFC visited all facilities. A master list of 446 health facilities in Namibia was obtained from the division of the MoHSS that is responsible for health facility registration in the country. The list included hospitals, health centres, clinics, stand-alone VCT centres, and sick bays; these facilities were under various management authorities, including government, private-for-profit, mission, NGOs, ministry of defence (MoD), and the Namibia police. Small doctor's consultation rooms were not included in the assessment.

Table 1.1 presents a breakdown of the facilities visited and results following contact with those facilities. Some of the facilities on the list were under construction when interviewers visited them; others on the list proved to be duplicates, while still others could not be enumerated for technical reasons. As a result, data were successfully collected from a total of 411 facilities, representing 92 percent of facilities on the master list. Table 1.2 presents the percent distribution by background characteristics of the facilities that were successfully assessed. Table A-1.1.1 provides additional information on the distribution of facilities in the master list and the facilities visited. Table 1.3 provides summary information on the percentages of facilities offering the various services assessed.

Table 1.1 Result of facility contact by background characteristics

Percent distribution of facilities according to result code by background characteristics. Namibia HFC 2009

	Percent distribution of result of contact									
Background characteristic	Facility missed	Complete	Respondent not available	Not open yet	Duplicates an existing facility	Closed	Consulting room[1]	Non-existent or other	Total percent[2]	Number of facilities
Type of facility										
Hospital	0	98	0	0	0	2	0	0	100	46
Health centre	0	96	0	0	4	0	0	0	100	49
Clinic	0	90	1	0	2	4	1	2	100	327
VCT	0	100	0	0	0	0	0	0	100	15
Sick bay	0	100	0	0	0	0	0	0	100	9
Managing authority										
MoHSS	0	97	1	0	1	1	0	0	100	314
Mission/NGO	2	88	0	0	8	0	0	2	100	48
Private	0	70	0	0	3	16	6	6	100	70
MoD/Police	0	100	0	0	0	0	0	0	100	14
Region										
Caprivi	0	91	6	0	0	3	0	0	100	32
Erongo	0	88	0	0	0	7	2	2	100	43
Hardap	0	100	0	0	0	0	0	0	100	23
Karas	0	93	0	0	0	0	4	4	100	28
Kavango	2	88	0	0	9	0	0	2	100	66
Khomas	0	73	0	0	4	18	0	4	100	49
Kunene	0	100	0	0	0	0	0	0	100	29
Ohangwena	0	97	0	3	0	0	0	0	100	34
Omaheke	0	100	0	0	0	0	0	0	100	16
Omusati	0	96	0	0	0	2	2	0	100	52
Oshana	0	100	0	0	0	0	0	0	100	21
Oshikoto	0	100	0	0	0	0	0	0	100	22
Otjozondjupa	0	97	0	0	0	0	3	0	100	31
Total	0	92	0	0	2	3	1	1	100	446

[1] A few facilities turned out to be consulting rooms and so were not included in the assessment.
[2] Due to rounding, some of the total percentages may not add up to exactly 100 percent.

Table 1.2 Distribution of facilities by background characteristics

Percent distribution of facilities and number of facilities, by background characteristics, Namibia HFC 2009

Background characteristics	Percent distribution of facilities	Number of facilities
Type of facility		
Hospital	11	45
Health centre	11	47
Clinic	72	295
Free-standing VCT	4	15
Sick bay	2	9
Managing authority		
MoHSS	74	306
Mission/NGO	10	42
Private	12	49
MoD/Police	3	14
Region		
Caprivi	7	29
Erongo	9	38
Hardap	6	23
Karas	6	26
Kavango	14	58
Khomas	9	36
Kunene	7	29
Ohangwena	8	33
Omaheke	4	16
Omusati	12	50
Oshana	5	21
Oshikoto	5	22
Otjozondjupa	7	30
Total	100	411

Table 1.3 Facilities providing specific services

Percentage and number of facilities providing specific services Namibia HFC 2009

Service provided	Percent of facilities offering services	Number of facilities offering services
Childhood immunisation (EPI)[1]	80	327
Curative care for sick children	85	348
Family planning (TFP)[2]	88	361
Antenatal care	74	303
Delivery	62	256
Sexually transmitted infections[3]	90	371
TB[4]	84	346
Reported HIV testing system[5]	98	402
HIV/AIDS care and support services[6]	87	359
Antiretroviral therapy (ART) services[7]	17	71
Minimum package of PMTCT[8]	37	151

[1] Routine series of DPT/Pentavalent, polio and measles available in the facility.
[2] TFP refers to temporary methods of family planning. Facility provides, prescribes or counsels clients on any of the following: contraceptive pills (combined or progestin-only), injectables (combined or progestin-only), implants, intrauterine contraceptive devices (IUCDs), male condoms, spermicides, diaphragm, or rhythm method.
[3] A client with signs and symptoms that may be a sexually transmitted infection may receive services for diagnosis and/or treatment from this facility.
[4] This may be diagnosis only, treatment and/or follow-up only, or both.
[5] Facility reports conducting the HIV 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.
[6] Providers assigned to this facility provide treatment for any opportunistic infections or symptoms related to HIV/AIDS (such as treatment for topical fungal infections, cryptococcal meningitis or Kaposi sarcoma), or provide (or prescribe) palliative care for patients (such as symptom or pain management, or nursing care for the terminally ill), or provide nutritional rehabilitation services, including the prescription or provision of fortified protein supplements, or provide care for paediatric HIV/AIDS patients.
[7] Facility reports that providers in the facility prescribe antiretroviral treatment and/or provide clinical follow-up for ART clients. Outreach ART facilities are not included in this definition since providers come to those facilities from another facility to provide the service.
[8] Minimum package of PMTCT includes the availability of the following in the facility: a documented HIV testing system, plus ARV prophylaxis for mother and infant, plus counselling on infant feeding and maternal nutrition for HIV-positive mothers, plus counselling or availability of family planning.

Throughout the report, indicators are presented by type of facility, managing authority, and region to allow for the analysis of geographical differentials. The regions, and the districts they comprise, are as follows:

Caprivi	Katima Mulilo
Erongo	Swakopmund, Walvis Bay, Omaruru, Usakos
Hardap	Aranos, Mariental, Rehoboth
Karas	Luderitz, Karasburg, Keetmaanshoop
Kavango	Rundu, Andara, Nyangana, Nankudu
Khomas	Windhoek district
Kunene	Opuwo, Outjo, Khorixas
Ohangwena	Engela, Eenhana, Okongo
Omaheke	Gobabis
Omusati	Tsandi, Outapi, Okahao, Oshikuku
Oshana	Oshakati
Oshikoto	Onandjokwe, Tsumeb
Otjozondjupa	Otjiwarongo, Grootfontein, Okahandja, Okakarara

1.4.2 Sample of Health Service Providers

A health service provider is defined as one who provides consultation services, counselling, health education, or laboratory services to clients. Health workers were not eligible for observation or interview if, for example, they only take measurements or complete registers and never provide any type of professional client services. The sample of health service providers was selected from providers who were present in the facility on the day of the census and who provided services that were assessed by the NHFC. In facilities with fewer than eight health service providers, efforts were made to interview all of the providers present on the day of the visit using the health worker interview questionnaire. In facilities with more than eight providers, efforts were made to interview an average of eight providers, including all providers whose work was observed. If interviewers observed fewer than eight providers, then they also interviewed a random selection of the remaining providers to obtain an average of eight provider interviews. Data were weighted during analysis to account for the differentials caused by over-sampling or under-sampling of providers with a particular qualification in a facility type or region. In a few cases the staff present on the day of the census may not be representative of the staff who normally provide the services being assessed.[1]

Table 1.4 provides general information on the weighted proportion of the providers interviewed as a percentage of the total number of providers assigned to facilities and present at the time of the census, by background characteristics and provider qualification. It also gives the weighted and unweighted number of interviewed providers used for the analysis. Tables A-1.2.1 and A-1.2.2 provide additional information on the unweighted and weighted number of interviewed providers.

[1] For example, the census may have taken place at the same time as a special training event for a group of specialists or on a day when evaluations took a certain type of provider away from services.

Table 1.4 Distribution of interviewed providers

Percent distribution and number of interviewed providers, by background characteristics, Namibia HFC 2009

Background characteristics	Percent distribution of interviewed providers	Number of interviewed providers	
		Weighted	Unweighted
Type of facility			
Hospital	38	634	369
Health centre	18	298	311
Clinic	40	674	903
Free-standing VCT	2	41	59
Sick bay	2	32	37
Managing authority			
MoHSS	74	1,236	1,286
Mission/NGO	14	242	210
Private	9	151	128
MoD/Police	3	50	55
Region			
Caprivi	3	55	76
Erongo	8	135	165
Hardap	8	127	144
Karas	6	103	94
Kavango	13	211	215
Khomas	13	213	146
Kunene	4	69	83
Ohangwena	8	133	166
Omaheke	3	50	58
Omusati	12	200	170
Oshana	8	133	107
Oshikoto	9	149	109
Otjozondjupa	6	101	146
Qualification of provider			
Specialists[1]	0	3	2
Medical doctors (non-specialists)	4	68	47
Medical assistants	0	7	11
Registered nurse/midwife	29	494	526
Enrolled nurse/midwife	34	564	574
Nurse assistant/auxiliary	1	21	19
Social worker	0	1	2
Pharmacy staff[2]	1	11	6
Other technical staff[3]	0	3	2
Community HIV counsellors	20	329	328
Other community providers[4]	5	91	105
Laboratory staff[5]	1	14	13
Other	4	72	44
Total	100	1,679	1,679

[1] Obstetrician/gynaecologists, surgeons, physician specialists, paediatricians, and pathologists
[2] Pharmacy staff include pharmacists and pharmacist assistants.
[3] Other technical staff include health inspectors/environmental health officers, environmental health assistants, occupational therapists, physiotherapists, and medical rehabilitation officers/instructors/workers.
[4] Other community providers include community health workers/home-based care givers/community-based resource person (CBRP), lifestyle ambassadors (TB/HIV), and field promoters.
[5] Laboratory staff include laboratory scientists, laboratory technologists, and laboratory technicians/assistants.

1.4.3 Sample for Observations and Exit Interviews

The sample for observations was mainly convenient, meaning that clients were selected for observation as they arrived, because in most cases it was not possible to know in advance how many eligible clients would attend the facility on the day of the census. Where many clients were present and

eligible for observation, the rule was to observe a maximum of five clients for each provider of a particular service, with a maximum of 15 observations in any one facility for each service. In practice, however, interviewers observed fewer clients than were eligible for observation at some facilities. This occurred primarily where multiple services were being offered to clients at the same time in different locations in the facility.

For antenatal care and family planning services, when several eligible clients were waiting (or were expected to come in for services on the day of the interview), interviewers tried to select two new clients for each follow-up case. The day's caseload and the logistics of organising observations did not always allow them to meet this objective.

For child health services, only children under age 5 years who presented with an illness (rather than an injury or a skin or eye infection exclusively) were selected for observation.

Interviewers attempted to conduct an exit interview with every observed ANC and family planning client, as well as with caretakers of observed sick children before they left the facility.

Table 1.5 shows the weighted percent distribution of observed consultations as well as the weighted and unweighted numbers of observed clients, by service. Details on the characteristics of these clients are presented in the relevant chapters of this report.

Table 1.5 Distribution of observed consultations

Percent distribution and number of observed consultations for outpatient curative care for sick children, family planning and antenatal care, by type of facility, Namibia HFC 2009

Type of facility	Percent distribution of observed consultations	Number of observed consultations	
		Weighted	Unweighted
OUTPATIENT CURATIVE CARE FOR SICK CHILDREN			
Hospital	7	108	98
Health centre	19	288	258
Clinic	74	1,148	1,222
Total	100	1,544	1,578
FAMILY PLANNING			
Hospital	11	112	55
Health centre	20	199	183
Clinic	68	672	780
Total	100	983	1,018
ANTENATAL CARE			
Hospital	8	70	42
Health centre	25	212	182
Clinic	67	577	655
Total	100	859	879

Interviewers compiled information on the total number of clients seen on the day of the assessment of each service of interest. The observations were weighted accordingly to adjust for over- or under-representation of observations. In a few cases the clients present on the day of the census might not be representative of the clients who normally receive the service being assessed.[2]

Tables A-1.4 through A-1.7 describe other aspects of service delivery, including the size of the facilities' catchment populations (Table A-1.4) and the median number of staff assigned to facilities and

[2] For example, if the assessment coincided with a special event, such as a health fair, or a specific campaign.

present on the day of the assessment, by provider and facility type (Tables A-1.5 through A-1.5.4). Tables A-1.6.1 and A-1.6.2 report the percentage of interviewed staff that provide counselling related to HIV testing and have received training on that topic. Table A-1.7 shows the median number of years of basic education and technical training (or qualification) as reported by the interviewed providers.

1.5 Census Implementation

1.5.1 Data Collection Instruments

The 2009 NHFC instruments were based on generic questionnaires developed by the MEASURE DHS project and were adapted for Namibian health services after consultation with technical specialists from the MoHSS, NGOs, and other key stakeholders knowledgeable about the health services and service programme priorities covered by the NHFC. All questionnaires were drafted in English. Clients exit interview questionnaires were translated into Damara, Oshiwambo, Kavango, Otjiherero, Silozi, and Afrikaana, the six vernacular languages commonly spoken in Namibia.

The 2009 NHFC instruments were pretested in two phases between February 16, 2009, and May 3, 2009. A total of 16 interviewers comprising nurses, nurse-midwives, and programme officers underwent two separate 1-week intensive training sessions in the application of the questionnaires. The instruments were then used to collect data, as pretest, in three facilities in Windhoek district. The questionnaires were then finalised for main fieldwork and data collection.

1.5.2 Training and Supervision of Data Collectors

Data collectors were primarily recruited in all 13 regions of the country from among nurses, nurse-midwives, and programme officers experienced in survey data collection. A total of 56 interviewers/data collectors completed a 3-week training programme from June 22 to July 10, 2009, at Heja Lodge, near Windhoek. Training included classroom lectures and discussions, practical demonstrations, role-playing, and field practice. A consultant from ICF Macro facilitated the training. At the end of the 3-week training, 12 teams were formed, each consisting of a team leader and three interviewers. Each team was allocated a vehicle and a driver. Additionally, the census had a pool of four interviewers on standby as reserves.

The Deputy Minister of Health, the Honourable Petrina Haingura, officially launched the census on the last day of the training, July 10, 2009. All relevant stakeholders were invited, including the news media.

Census sensitisation

Prior to the start of data collection, management of all health facilities in the country were informed about the census via government regional offices, private hospital head offices, and newspapers. The purpose of this prior contact was to seek the support and cooperation of the facilities in giving the interviewers access to the facilities. As a result no facility refused to participate.

1.5.3 Data Collection

Data collection commenced on July 13, 2009, and ended October 16, 2009. One interviewer in each team was selected to be the team leader, and he or she had the added responsibility of checking all administered questionnaires before leaving each facility. Each team was given a list of facilities to visit, giving each facility's name, type, and location. Information on the intended visits was passed on to the facilities at least one week before the visit.

All 12 data collection teams were assigned facilities in Khomas region during the first week of fieldwork. This approach ensured that all teams were within easy reach during the initial phase of fieldwork, should they encounter any unexpected challenges. A debriefing session was held after one week of data collection before the 12 teams were deployed to their respective regions.

On average, data collection took one day per facility. Every effort was made for teams to visit facilities on days when services of interest would be offered. Whenever any of the services of interest was not being offered on the day of the visit, the teams returned on a day when the service would be offered to observe and interview the clients who came on that day. If, however, the service was offered on the day of the visit but no clients came, the teams did not revisit the facility.

Each interviewer ensured that the respondent for each component of the facility audit was the most knowledgeable person for the particular service or system component being assessed. Informed consent was obtained from the facility in-charge, from all respondents for the *Facility Audit Questionnaires,* and from observed and interviewed providers and clients. Where relevant, the data collector indicated whether a specific item being assessed was observed, reported to be available but not observed, not available, or uncertain whether the item was available. Equipment, supplies, and resources for specific services were recorded as available only if they were in the relevant service delivery area or in an immediately adjacent room.

Fieldwork supervision was coordinated at MoHSS headquarters. Quality control was ensured by periodic field visits and spot checks by five national technical supervisors who were members of the NHFC Technical Working Group. Field check tables generated by the data entry programme were also used to check the quality of the collected data, and where necessary national staff communicated with team leaders and sorted out any emerging problems. In addition, there were regular teleconferences between the technical supervisors and the technical team at ICF Macro.

1.5.4 Data Management and Report Writing

Data management and analysis were carried out as follows:

- **Management of questionnaires in the field.** After completing data collection in each facility, the interviewers reviewed the questionnaires before handing them over to the team leader, who then reviewed them a second time. During routine supervisory visits, national supervisors reviewed completed questionnaires one final time and also picked up the questionnaires for completed facilities.

- **Data sorting and editing at headquarters.** Once the questionnaires from each facility were received at headquarters, the questionnaire receptionist sorted them to ensure that they were in the correct order and none were missing. The data entry supervisor/office editor then edited the questionnaires to eliminate any mistakes that would prevent the data entry programme from accepting information during data entry. Where there was a problem with the questionnaires from a facility, the data collection team was consulted so that the problem could be rectified.

- **Data entry.** Four data operators entered the data under the supervision of one data entry supervisor and office editor, the Census Technical Manager. The data operators used CSPro software, developed by ICF Macro, for data entry. They entered each questionnaire twice (100 percent verification) to ensure that the data had been accurately keyed in. Data entry took place from July to November 2009. MoHSS staff reviewed all ‘Other’ responses and recoded them into categories relevant for data analysis.

- **Data processing.** The design of the tabulation plan and the preparation of the programmes for producing statistical tables were carried out from October through December 2009. Data analysis, including clarification of unclear information, was carried out from December 2009 through May 2010. During data analysis the analysis plan was revised on the basis of feedback from the NHFC management team to ensure that the analysis was appropriate for the Namibian health system.

- **Development of the final report.** The final report was drafted with input from staff of the MoHSS, US Centers for Disease Control (CDC), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), and the Namibian National Institute of Pathology (NIP) during a 1-week report-writing workshop. ICF Macro provided technical guidance.

1.5.5 Data Analysis

The following conventions were observed during the analysis of the NHFC data:

- **Assessing the availability of items.** Unless specifically indicated, the 2009 NHFC considered only observed items to be available. Items that were reported as being available but were not observed or seen by the interviewers were not considered to be available.

- **Observations.** Many facilities provide routine services for clients, such as taking blood pressure, separately from the actual consultations, and there is often an interval between these events and the time when the primary provider assesses the client. It is not always logistically possible to follow a client through the entire system, so whenever these services were observed being provided outside the consultation room on the day of the census, the observed client was assumed to have received these services. Where this system is used, multiple providers contribute to the services that each client receives. The provider who ultimately diagnosed and prescribed was defined as the primary provider.

  Observers used a checklist to assess whether a practice occurred or a piece of information was shared between the provider and the client. They did not attempt to verify whether the practice was correct or if the information shared was correct or complete.

- **Provider information.** Frequently, providers indicated that they 'personally' provided a service that the facility did not offer. It may be that providers were indicating services that they provide outside the facility. For the 2009 NHFC, only providers that provide the service in the particular facility where he or she was found during the census were included in the analysis for that service.

- **Development of aggregate variables.** Aggregating the data into subsets makes it possible to analyse many pieces of information and to see how they relate to the overall capacity to provide services. It also enables analysts to monitor changes in a facility's capacity to provide services and in its adherence to standards because there may be improvements in some items but not in others. There are not yet generally accepted aggregates of the health information collected in the NHFC. The aggregate variables presented in this report represent an initial phase in the process of defining useful health information aggregates. They will be refined as users provide feedback on which aggregate variables are useful to policymakers and programme implementers.

Conventions followed in developing HIV/AIDS indicators

In large facilities HIV/AIDS services are frequently offered at a variety of service sites. For example, HIV testing may be offered to clients who come to a clinic for voluntary counselling and testing on HIV; HIV testing may also be offered to sick clients attending outpatient clinics and clients admitted to inpatient units. Among the items identified as supporting the quality of services related to HIV/AIDS, some need only be present at a single location in a facility, with the assumption that all service sites can access the item. Examples include medicines, laboratory tests, and facility-level policies. Record-keeping is necessary for clients who receive services from any site, but the records may be kept in different locations depending on the organisation of a facility and the security of the records. Likewise, some items such as service statistics and client records may be kept in one central location or in several places, depending on the organisation of a facility.

For this assessment it is assumed that, if a service site offering services knows where the records are, and the existence of records at that site is verified, this validates that records are being kept for clients receiving services from the service site.

It is not reasonable, however, to assume that providers will run around a facility in search of soap and water or hand disinfectant to clean their hands or to look for guidelines or protocols to remind them of important information when providing services to a client. Thus, some items need to be in the vicinity of each relevant service delivery area. These include infection control equipment and guidelines and protocols.

The analysis of the quality of HIV/AIDS and related services for this assessment follows the above general conventions when determining if a facility meets the standards defined as those necessary to provide quality services.

OVERVIEW OF THE HEALTH SYSTEM IN NAMIBIA 2

This chapter provides an overview of the health care system in Namibia and its general organisation as a context in which to view the findings of the 2009 Namibia Health Facility Census.

Information is presented regarding the following:

- Population and economic development
- Health indicators
- Health issues—response preparedness
- Health care systems

Information in this chapter is drawn from a variety of official sources from the government of the Republic of Namibia, such as Vision 2030, national development plans, the Poverty Reduction Strategy, the National Health Account, the Health Sector Strategic Plan, and the National Health Policy, and from international documents that include Namibia, such as the 2007 United Nations General Assembly Special Session (UNGASS) report on Millennium Development Goals (MDGs).

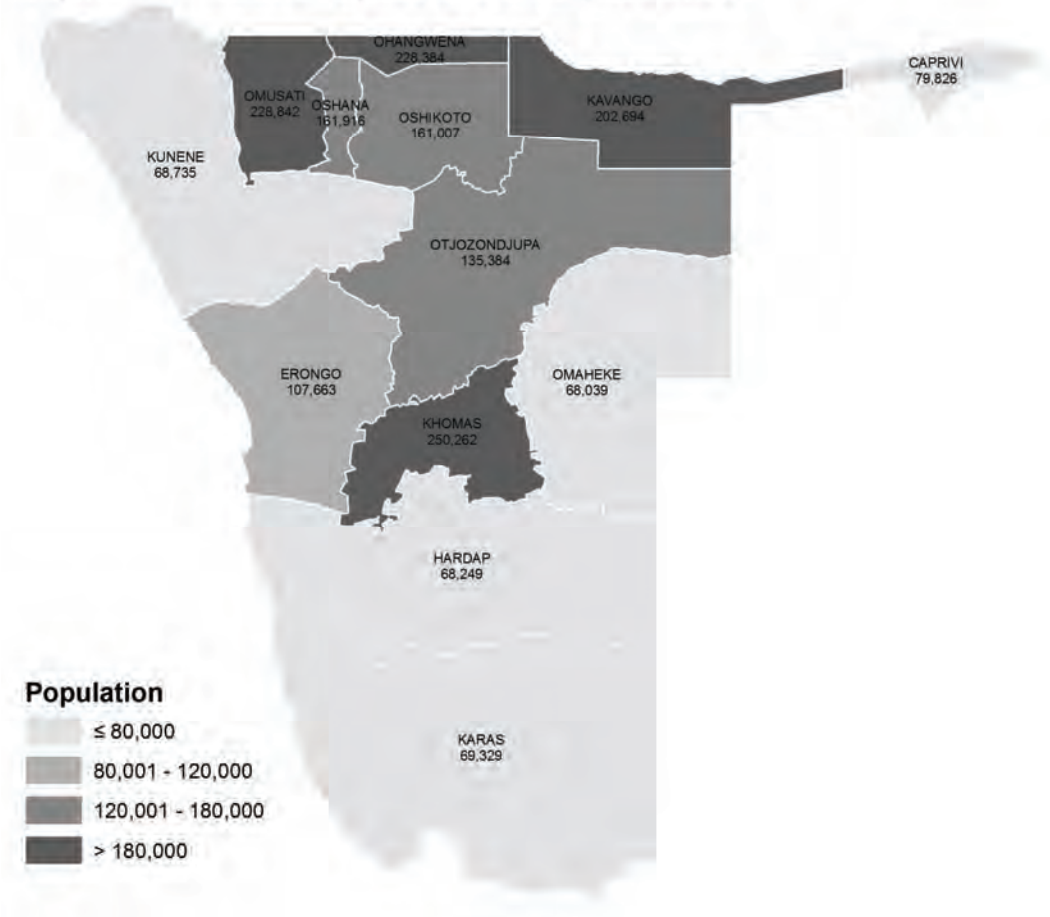
2.1 POPULATION AND ECONOMIC DEVELOPMENT

2.1.1 Population

Namibia is situated in the south-western part of Africa. It has a surface area of 824,116 km^2. The country is divided into 13 administrative regions. The population of Namibia was estimated at 1,830,330 in the 2001 census. The population is spread unevenly across the country. Sixty percent of the population lives in the north-central and north-eastern areas of the country. About two-thirds of the population lives in rural areas and engages in subsistence farming and livestock production. Namibia has a well-established network of modern infrastructure such as roads, rail, telecommunication, and port facilities.

According to the CBS population projections of 2001, the population of Namibia is expected to increase to 2,180,000 by 2011. Forty-three percent of the population is under the age of 15 years, while less than 4 percent of the population is over the age of 65 years. The average life expectancy has declined from 61 years in 1991 to about 48 years currently, mainly due to HIV/AIDS. About 17 percent of children under the age of 15 are orphaned, with one living parent or none (MoHSS and Macro International, 2008).

Figure 2.1 **Namibia regions and their population**



2.1.2 Economic Development

With a gross national income per capita of US$4,200 for 2008 (World Bank, 2008). Namibia is classified as an upper middle income country. The Namibian economy comprises two sub-economies. The first is the more formal and modern economic sector, which includes mining, livestock production, and fishing. The second sector is the informal, subsistence sector, consisting of agriculture and herding. The mining sector is a major contributor to the Gross Domestic Product, accounting for 13 percent in 2008 (ADB, 2008). Namibia is highly dependent on the Southern African Customs Union (SACU) revenue pool, which has resulted in a surplus of balance of payments in recent years. These revenues are expected to decline, however, owing to the current global economic challenges.

The country has one of the greatest income inequalities in the world, as evidenced by the Gini coefficient of 0.6, and the 37 percent unemployment rate (World Bank, 2008; NPC 2008). The income disparity is associated with Namibia's colonial history and the continued unequal distribution of productive resources and capital since independence. A Gini coefficient value of 0 indicates a completely equal distribution of income, while a value of 1 represents a completely unequal distribution (that is, one person has all the income). Namibia's Gini coefficient has improved somewhat, from 0.7 in 1993/94 to 0.6 in 2008, reflecting a reduction in the disparity between the rich and the poor. Still, the gap between the 'haves' and the 'have-nots', remains worrisome. To close this gap, ordinary people, especially at the household level, need access to productive resources in order to generate income.

2.2 HEALTH INDICATORS

2.2.1 Mortality and Morbidity

According to the 2001 census, life expectancy at birth was estimated at 50 years for females and 48 years for males. Life expectancies have declined significantly from the 1991 estimates, which were 63 years for females and 59 years for males. These, in turn, had declined from 1991, when life expectancy overall was an estimated 61 years.

Currently, the infant mortality rate stands at 46 deaths per 1,000 births, while the under-five mortality is at 69 deaths per 1,000 live births. The infant mortality rate decreased from 57 deaths per 1,000 live births to 46 in 2006-07. The under-five rate mortality rate decreased from 83 deaths per 1,000 live births in 1992 to 69 deaths per 1,000 live births in 2006-07 (MoHSS and Macro International, 2008). Namibia is unlikely, however, to reach its goals of reducing mortality to 19 infant deaths and 38 under-five deaths per 1,000 live births by 2015.

The proportion of children that are immunised against measles has increased from 76 percent in 1992 to 84 percent in 2006-07 (MoHSS and Macro International, 2008). Namibia is likely to be immunising up to 85 percent of children against measles by 2015.

2.2.2 Maternal Mortality

Maternal mortality has been on the rise since the beginning of the 1990s. In the 2006-07 Namibia Demographic and Health Survey, the maternal mortality ratio was estimated at around 449 deaths per 100,000 live births.[1] It is unlikely that the target of 337 deaths per 100,000 live births by 2015 will be met. Still, the proportion of births that occurred in a health facility is steadily increasing and is currently at around 80 percent, according to the 2006-07 NDHS. It is therefore likely that the target of 95 percent by 2015 will be achieved by 2012. The increase in deliveries taking place in health facilities, however, could not compensate for the combined effect of limited access to emergency obstetric care, HIV/AIDS, and poverty on maternal health.

Antenatal care (ANC) coverage is increasing; according to the 2006-07 NDHS, 70 percent of women with a live birth in the 5 years preceding the survey made four or more ANC visits. It is possible that the target of 80 percent by 2015 will be met very soon. Most MDG reproductive health indicators have improved, and reaching the set targets is likely for most of the indicators.

2.2.3 HIV/AIDS, Tuberculosis, Malaria, and Orphanhood

Namibia has a generalised, mature HIV/AIDS epidemic, with HIV transmitted primarily through sexual contact between men and women. The first case of HIV infection was reported in 1986. It is estimated that the HIV prevalence of the general population ages 15-49 years in Namibia was 13.3 percent in 2008-09, resulting in about 6,130 AIDS-related deaths in that year (MoHSS, 2009a). AIDS-related deaths account for approximately 23 percent of all deaths in Namibia (crude death rate from population projections for 2008-09). In the financial year 2008/09 approximately 5, 830 people were newly infected with HIV—an average of 16 new infections each day.

The HIV/AIDS prevalence rate among pregnant woman has gone down, from 12 percent in 2000 to 5 percent in 2008 for the age group 15-19 years, and from 20 percent to 14 percent for the age group 20-24 years. This suggests that, over all, the number of new infections is declining.

[1] The 2006-07 NDHS warns that the MMR of 449 maternal deaths per 100,000 live births should be viewed with caution because of the wide confidence intervals (between 341 and 557 maternal deaths per 100,000 live births).

Namibia offers provider-initiated testing and counselling (PITC) and voluntary counselling and testing, commonly known as VCT. Provider-initiated HIV testing and counselling involves the health care provider specifically recommending an HIV test to patients attending health facilities. In these circumstances, once specific pre-test information has been obtained, the HIV test would ordinarily be performed unless the patient declines it.

HIV counselling and testing is generally offered for two purposes—first, as a prevention strategy for people who want to know their HIV status and, second, as an entry point for treatment, care, and support. PITC is provided in health facilities. VCT is provided in community-based stand-alone sites and outreach posts, as well as in health facilities.

In March 2002 Namibia introduced services for prevention of mother-to-child transmission (PMTCT) of HIV as a pilot project at two state hospitals—Oshakati Hospital in the north and Katutura State Hospital in Windhoek. Since then services have been rolled out to all 34 district hospitals and 206 health facilities and clinics. Some 256 of the 335 health facilities in Namibia have ANC services. Of these 256, 74 percent (189 facilities) were providing PMTCT services in 2007. This translates to a coverage level of 56 percent of all health facilities in Namibia. PMTCT is integrated into ANC services, making it possible for pregnant women attending ANC to obtain PMTCT services easily. The 'opt-out' testing strategy has accelerated the uptake of PMTCT services.

Condoms play a fundamental role in combination HIV prevention strategies. The government provides condoms for free distribution in workplaces, communities, and health facilities by a wide range of service providers, including government agencies, civil society, the private sector, and development partners. Namibia also has a well-established condom social marketing programme that has contributed to scaling up condom distribution and availability nationwide. By 2007 Namibia had distributed a little over 21 million male condoms and about 340,000 female condoms (MoHSS, 2008a). Despite much improvement in condom availability, distribution, and education, rates of condom use have continued to be low and inconsistent. In the 2006-07 NDHS 41 percent of women and 57 percent of men reported using condoms at the last sex. Similarly, 62 percent of women and 78 percent of men ages 15-49 who had had sexual intercourse with a non-marital, non-cohabiting partner in the 12 months prior to the NDHS reported using a condom.

Approximately 250,000 children 18 or younger are orphans or vulnerable children. Around 69,000 of these children, or 28 percent, had been orphaned by AIDS by the end of the FY2008/09 (MoHSS, 2009a). Development partners give the country enormous support in the fight against HIV/AIDS. In addition, there is a political will and commitment from the government that fosters an environment in which partner organisations can thrive and continue investing resources in the country. Owing to this, various resources, ranging from human to financial, have been put in place at the national, regional, district, and facility levels in an effort to combat HIV/AIDS. Monitoring and evaluation systems also were put in place to ensure that evidence informs planning.

The tuberculosis (TB) burden in Namibia has increased notably over the last two decades. This increase has a direct correlation with the HIV epidemic, since HIV is the major risk factor for the development of TB. Approximately 59 percent of people with TB in Namibia are co-infected with HIV (MoHSS, 2010a). TB is a major threat to persons living with HIV/AIDS and has the capacity to reduce the success of the scale-up of antiretroviral therapy. The joint management of TB and HIV is considered an important component of the HIV treatment, care, and support strategy.

Namibia is experiencing a transition in the malaria epidemiological situation due to significant declines in both malaria morbidity and mortality. This was achieved through a combination of interventions, which includes malaria vector control, effective case management with artemisinin-based combination therapy, community mobilisation and advocacy, and epidemic monitoring and response.

This progress recently encouraged a call for malaria elimination in the country. Malaria control is constrained, however, by the lack of human resources at all levels—national, regional, district, and facility levels—especially the lack of epidemiologists, entomologists, surveillance officers, spray men, and statisticians. The programme has limited resources to achieve universal coverage in vector control. The programme is further challenged by inadequate cross-border malaria control and inadequate partnerships in malaria control. Still, for the past four years, there has been a consistent annual decline in the number of malaria cases and in deaths due to malaria.

2.2.4 Water and Sanitation

Increased access to clean drinking water is one of the Millennium Development Goals that Namibia, along with other nations worldwide, has adopted. The source of drinking water is an indicator of whether it is suitable for drinking. According to the 2006-07 NDHS, 88 percent of households in Namibia have access to an improved source of drinking water. By comparison, in 2000, 79 percent of households had access to an improved source. Urban households are more likely than rural households to have an improved water source. Generally, the water available to households in Namibia is safe; about 90 percent of households do not treat the water before drinking.

About 34 percent of households have access to improved sanitation facilities. Households in urban areas are more likely than those in rural areas to have improved facilities. There was no significant change in the proportion of households without toilet facilities between the 2000 NDHS and the 2006-07 NDHS.

2.3 Response Preparedness

The government has consistently focused its development strategies on combating ignorance, disease, and poverty. Investing in health is recognised as central to improving the quality of life, but the government faces socio-economic challenges in strengthening the country's health services. In response, the government has adopted the following enabling policies and strategies, which include commitments at both the national and international levels.

2.3.1 Vision 2030

Namibia Vision 2030 provides the long-term development framework for the country to become a more prosperous and industrialised nation, developed by its human resources, enjoying peace, harmony, and political stability. It clearly spells out the country's development programmes and strategies to achieve its national objectives. One main area of the Vision is to improve the quality of life of the people of Namibia to the level of their counterparts in the developed world by 2030. Vision 2030 advocates health for all, so that by 2030 Namibia is a healthy nation in which all preventable, infectious, and parasitic diseases are securely under control and where the people, sound of mind and body, are empowered physically and mentally to continue contributing effectively to the development process in their families, communities, and the nation as a whole.

2.3.2 Medium-term Expenditure Framework for 2008/09 to 2010/11

Health for all is one of the expenditure priorities in Namibia. Improving the health of the nation is a major facet of the fight against poverty. In addition to continuing current levels of service and ensuring that buildings and equipment are properly maintained, the government is making additional resources available to ensure that adequate ambulances and outreach services are available for patients who need them and to maintain its partnership with mission hospitals. Given the continuing scourge of HIV/AIDS in the nation, funding to prevent and treat the disease is being increased. In recognition of the fact that

disease does not stop at national borders, the government will be contributing to the Southern African Development Community Regional HIV/AIDS Fund.

2.3.3 National Development Plans

The national development plans are the main vehicle to translate the Vision 2030 into action and to make progress towards realising the Vision.

Namibia is currently implementing National Development Plan 3. One of its key result areas is quality of life, which is derived from the Vision 2030 objective that aims to ensure a healthy, food-secure, and breastfeeding nation, in which all preventable, infectious, and parasitic diseases are under control and in which people enjoy a high standard of living, with access to quality education, health, and other vital services, in a context of sustainable population growth and development.

Health is both a resource for and an outcome of sustainable development. The health of a population cannot be maintained without a responsive health system and a healthy environment. The government of the Republic of Namibia has put in place an integrated National Health Service to meet the needs of all Namibians and committed itself to achieving health for all Namibians by making health care accessible, affordable, and equitable.

2.3.4 National Health Policy

Health and social well-being are fundamental human rights. Consequently, the ultimate goal of the Namibian government and of the Ministry of Health and Social Services (MoHSS) in particular is to attain a level of health and social well-being for all Namibians that will enable them to lead economically and socially productive lives. This will be achieved by using a cost-effective developmental social welfare and primary health care approach, which includes promotive, preventive, curative, and rehabilitative services in collaboration with communities, individuals, and other partners.

2.3.5 Health Sector Strategic Plan

The Health Sector Strategic Plan is a medium-term plan with a span of five years, covering the years 2009 to 2013. In providing health and social services, the Ministry seeks to attain one overarching goal—to increase life expectancy from 49 years to 55 years by 2013. This strategic plan articulates and sets out the key objectives, activities, and resources necessary to effect the planned organisational transformation and to institutionalise the balanced scorecard[2] as the tool of strategy implementation that will transform the MoHSS into a leading public provider of quality health and social welfare services in Africa.

The strategic themes form the underpinning context and underlying tapestry for the initiatives that will transform the MoHSS into a world-class organisation. The strategic issues facing the Ministry are grouped into five broad categories: service provision, human resources management, infrastructure development and management, governance, and financial management.

2.4 Namibia Health Care System

The goal of health sector reform is to improve the quality of health services provided to communities. It is a sustained process to bring about fundamental and evidence-based changes in national

[2] The balanced score card, derived from a corporate sector, is a strategic planning and management system designed to align an institution's activities to the vision and strategy of the organisation; in so doing it improves internal and external communications, as well as monitors the organisation's performance against strategic goals.

health policy and institutional arrangements. Reforms involve district health services, secondary- and tertiary-level referral hospital services, the role of the central MoHSS, human resources development, central support systems, health care financing, the mix of public and private services, donor coordination, and combating HIV/AIDS. These nine elements are grouped into three components: district health services, secondary and tertiary health services, and central support to central ministries and the regions.

The MoHSS has adopted the primary health care (PHC) approach to the delivery of health services to the Namibian population. The approach reflects all eight components of PHC:

- Promotion of proper nutrition and adequate supply of safe water
- Maternal and child care, including birth spacing
- Immunisation against the major infectious diseases
- Basic housing and basic sanitation
- Prevention and control of locally endemic diseases
- Education and training in the prevention and control of prevailing community health problems
- Appropriate treatment for common diseases and injuries
- Active community participation in health and social matters

2.4.1 Regional Directorates

As part of the health sector reform, restructuring has meant that authority is to devolve to the 13 Regional Management Teams and their districts at the operational level. The 13 regional directorates oversee service delivery in 34 health districts. The role of the district is to ensure efficient and effective implementation of the regionally directed programmes and projects.

Public health services are provided through all district hospitals, health centres, and clinics. Three intermediate hospitals and one national referral hospital provide support to the district hospitals. Because of the vastness of the country, the sparse distribution of the population, and lack of access to permanent health facilities in some communities, outreach services are provided across the country.

Secondary and curative (care) services are maintained and strengthened to provide an integral national system of referral support for PHC services. The three intermediate/referral hospitals are Oshakati Hospital in Oshana region, Rundu Hospital in Kavango region, and Katutura Hospital in Khomas region. Windhoek Central Hospital serves as the overall national referral hospital.

2.4.2 Public-Private Partnership

Since PHC includes diverse interventions, both inter-sectoral and multi-sectoral collaboration have been recognised as important aspects of health and social care delivery. While the MoHSS provides policies and guidelines and the necessary basic resources, private and faith-based facilities continue to make important contributions to the well-being of the nation.

2.4.3 Overview of the Health System

While the health system is dominated by the public sector (both in terms of coordination, financing, and service delivery), it is pluralistic in nature and includes active public, not-for-profit, and for-profit sectors. The following sections provide an overview of each of these sectors.

Public sector

The Public sector provides universal coverage and is predominantly financed through general taxation. This sector is structured according to a three-tier hierarchy comprised of central, regional and district levels. The *central* level consists of eight national directorates, whose main functions include: policy formulation and review, policy planning and monitoring, strategic planning, resource mobilisation and allocation, and standard setting. The *regional* level oversees a total of 34 districts and consists of 13 directorates that are charged with functions that include the provision of leadership and management support to the entire region; translation of central level policies and strategies into operational plans for implementation at the regional and district levels; coordination of implementation of services, programs, and activities to ensure equity and access to care among districts; and provision of technical support to district level managers and staff. Largely responsible for service delivery, the *district* level functions include the implementation of the district health package and management of the district resources, such as financial and human resources. With 1 national referral hospital, 3 intermediate hospitals, 30 district hospitals, 44 health centers, and 265 clinics, the public sector is the lead provider of health care.

Because of the vastness of the country, the sparse distribution of the population, and lack of access to permanent health facilities in some communities, outreach services are provided across the country. Secondary and curative (care) services are maintained and strengthened to provide an integral national system of referral support for PHC services. The three intermediate/referral hospitals are Oshakati Hospital in Oshana region, Rundu Hospital in Kavango region, and Katutura Hospital in Khomas region. Windhoek Central Hospital serves as the overall national referral hospital.

In addition to its stewardship and service delivery role for the public sector, the government of the Republic of Namibia implements a medical scheme for civil servants, which is the largest insurance program in Namibia. This program, called the Public Service Medical Aid Scheme (PSEMAS), is financed both by employees and by the National Treasury.

Not-for-profit sector

The not-for-profit sector plays a significant role in health promotion and service delivery. Financed largely by external aid, NGOs are largely involved in the delivery of community-based health care. Churches manage mission health facilities under contractual arrangements with the government, which finances a significant share of their operating budgets.

For-profit sector

The for-profit sector plays three principal roles in health care; as financiers, risk-pooling agents, and health care providers.

- As financiers, employers contribute to both comprehensive and partial coverage of health insurance for employees and their dependents.

- As risk-pooling agents, there are a variety of medical schemes available—those with open policies (sold to any employer and individuals) and those with closed policies (limited to a single industry or employer). Medical schemes in Namibia contract administrative services

(including policy design, enrolment, claims payments, and financial reporting) through a third party. In addition, all schemes, with the exception of PSEMAS, contract with disease management firms for developing protocols and review of patient data to determine provider compliance, conducting the approvals process for pay-outs and reimbursements to public and private providers. All medical schemes are regulated by the Namibia Financial Institutions Supervisory Authority (NAMFISA), a government agency.

- As service providers, the for-profit sector is regulated by the Hospital and Health Facilities Act of 1994. In 2006, there were 844 private health facilities and private medical practitioners registered with the MoHSS. These include 13 hospitals, 75 primary care clinics, 8 health centers, 75 pharmacies, and 557 medical practitioners (including dentists, psychologists, and physiotherapists). The majority of these services are provided in urban areas.

FACILITY-LEVEL INFRASTRUCTURE, RESOURCES, AND SYSTEMS

3

Joyce Nangula Namuhuja, Greatjoy Mazibuko, Josua Nghipangelwa

3.1 Background and Basic Infrastructure and Resources to Support Utilisation of Services and Accessibility[1]

This chapter reports on resources and critical support systems and infrastructure at the facility level, all of which enhance the provision of good quality services. Although health services can be offered under a variety of conditions, certain elements of the infrastructure and components of the health system are essential to ensure the consistent quality of health services, their acceptability, and hence their utilisation.

The chapter is divided into three parts as follows.

The first part provides information on whether facilities have the staff and resources needed to support good quality services and appropriate service utilisation. This information includes availability of—

- A basic package of health services and qualified staff
- Facility infrastructure that supports client utilisation and ensures the delivery of satisfactory services
- Access to good 24-hour emergency services

The second part of the chapter considers management systems for supporting quality services and the appropriate utilisation of services. These include—

- Systems for addressing management issues
- Staff development through training and supervision
- Community participation and funding mechanisms to decrease financial barriers to utilisation

Finally, the chapter considers support systems that are critical to the quality of services at facilities, including—

- Logistics systems to support the maintenance of equipment and infrastructure
- Availability of medicines, vaccines, and contraceptive methods
- Systems and practices for infection control

[1] This chapter excludes free-standing VCT facilities since these are specialised facilities focusing mainly on HIV counselling and testing and are known not to offer any basic health services.

3.1.1 Availability of Services and Human Resources

The availability of a basic package of health services, the frequency with which these services are offered, the presence of qualified staff, and the accessibility of the health care system all contribute to client utilisation of services in a health facility. The Namibian health care service delivery system comprises a network of facilities providing both preventive and curative health services. Most hospitals, health centres, and clinics are expected to offer the full range of basic services. Such services include outpatient services for all age groups, maternal and child health care services such as antenatal care (ANC), delivery, postnatal care, family planning and gynaecological management, treatment of sexually transmitted infections (STIs), immunisation, and child growth monitoring. However, some facilities (such as the Communicable Diseases Clinics) specialise in HIV/AIDS-related service delivery and may not offer all the other services. If a facility does not offer all of these services, it should not be assumed that the facility is working below standard. It does mean, however, that clients may have to visit several different facilities to meet all of their family's basic health needs. Table 3.1 and Figure 3.1 provide details on the availability of basic services and qualified staff. Additional information describing specific services that are available, by type of facility, managing authority, and region, is provided in Tables A-3.1.1 and A-3.1.2.

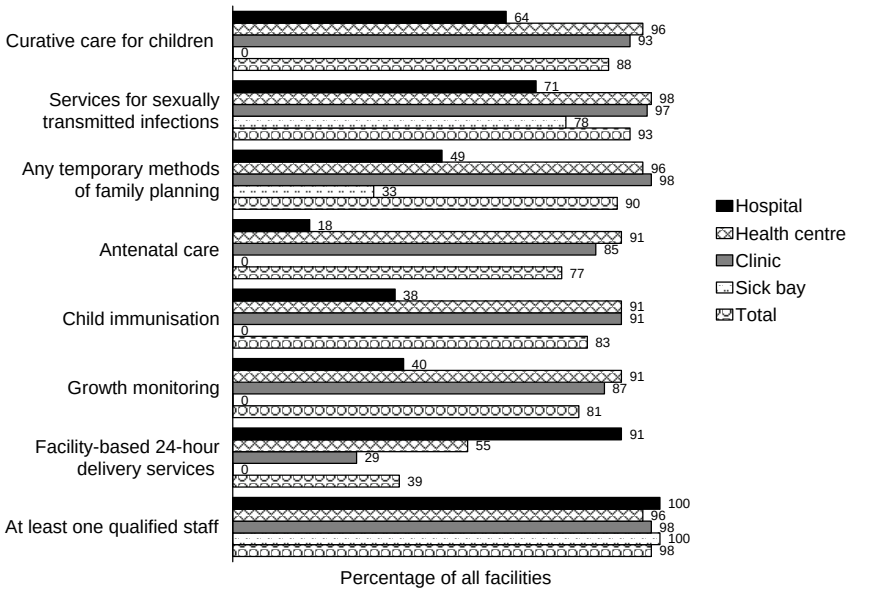
Table 3.1 Availability of basic services and qualified staff to meet client needs

Percentage of all facilities that provide basic services at minimum frequencies and 24-hour delivery services, with qualified staff, by background characteristics, Namibia HFC 2009

	Percentage of facilities with:				
Background characteristics	All basic services[1]	All basic services provided at minimum frequencies[2]	All basic services at minimum frequencies plus facility-based 24-hour delivery services	All basic services at minimum frequencies, plus facility-based 24-hour delivery services, and at least one qualified staff[3]	Number of facilities
Type of facility					
Hospital	11	11	11	11	45
Health centre	87	87	49	47	47
Clinic	80	75	25	24	295
Sick bay	0	0	0	0	9
Managing authority					
MoHSS	80	75	28	27	306
Mission/NGO	89	89	54	54	28
Private	22	22	2	2	49
MoD/Police	0	0	0	0	13
Region					
Caprivi	93	75	18	18	28
Erongo	44	44	11	11	36
Hardap	62	62	24	24	21
Karas	72	64	28	28	25
Kavango	88	86	51	51	57
Khomas	18	18	6	6	33
Kunene	82	82	50	36	28
Ohangwena	91	81	3	3	32
Omaheke	81	81	75	75	16
Omusati	80	80	12	12	49
Oshana	65	60	10	10	20
Oshikoto	86	77	18	18	22
Otjozondjupa	59	55	41	41	29
Total	71	67	26	25	396

[1] The basic services include: outpatient curative care services for sick children and for adult STIs, temporary methods of family planning, antenatal care, child immunisation, and growth monitoring.
[2] The services and defined minimum frequency are: outpatient curative care services for children offered at least five days per week, STI services at least one day per week, and preventive or elective services (any temporary methods of family planning, antenatal care, immunisation, and growth monitoring) at least one day per week.
[3] Qualified staff (Namibia specific) includes specialists (including surgeons, obstetrician/gynaecologists, paediatricians, physician specialists, and pathologists), medical officers, medical assistants, enrolled nurses, enrolled midwives, registered nurses, and registered midwives.

Figure 3.1 Availability of Services and Staff to Meet Basic Client Needs (N=396)



NHFC 2009

Basic services

The basic services of outpatient curative care for sick children and for adult sexually transmitted infections, temporary methods of family planning, antenatal care, child immunisation, and child growth monitoring are offered as a package by seven of every ten health facilities (including sick bays) in Namibia (Table 3.1). Clinics and health centres (80 percent and 87 percent, respectively) are more likely than hospitals and sick bays to offer the full package of services; similarly, MoHSS- and mission/NGO-managed facilities (80 percent and 89 percent, respectively) are more likely than private and MoD/Police facilities to offer the package of basic services. At the regional level, facilities in Caprivi, Kavango, Kunene, Ohangwena, Omaheke, Omusati, and Oshikoto regions (ranging between 80 and 93 percent) are more likely to offer all basic services than facilities in other regions, particularly Khomas region (18 percent).

Looking at the individual services by type of facility, sick bays in general do not offer any of the child health services or ANC (0 percent of sick bays), and hospitals are less likely than health centres or clinics to offer these basic services (Figure 3.1, Tables A-3.1.1 and A-3.1.2). For example, only 18 percent of hospitals offer ANC services, compared with 85 percent of clinics and 91 percent of health centres. Although there are wide variations in the availability of the individual services by type of facility, the ‘big picture’, showing 77 percent of all facilities offering ANC and 93 percent of all facilities offering STI services (Tables A-3.1.1 and A-3.1.2), indicates that health care services are fairly widely available in health care facilities in Namibia.

The findings also show that almost all facilities have at least one qualified provider assigned to or employed by the facility.

Basic services at minimum frequencies

The 2009 NHFC defines services at minimum frequencies as follows: outpatient curative care services for children offered at least five days per week; STI services at least one day per week; preventive or elective services (any temporary methods of family planning, ANC, child immunisations, and child growth monitoring) at least one day per week. Overall, two-thirds (67 percent) of all facilities offer the full range of basic services at minimum frequencies. The availability and distribution of basic services at minimum frequencies follow a pattern similar to that of the availability of services in general (Table 3.1).

Basic services at minimum frequencies plus 24-hour delivery services

About one-fourth of all facilities offer the full range of services at minimum frequencies and also offer 24-hour facility-based delivery services (Table 3.1). About the same proportion of facilities (25 percent) offers all of these services and also has at least one qualified provider working in the facility. In general, health centres (47 percent), facilities managed by missions/NGOs (54 percent), and facilities in Kavango (51 percent) and Omaheke (75 percent) regions are more likely than others to offer basic services at minimum frequencies, offer 24-hour delivery services, and also have at least one qualified provider working at the facility. Additional information on facility-based, 24-hour delivery services is presented in Tables A-3.1.1 and A-3.1.2. It is of interest that, although clinics are not expected to offer 24-hour delivery services, 29 percent report doing so.

3.1.2 Facility Infrastructure Supportive of Client Utilisation and Quality Services

Relatively good health services can be provided even in minimal service delivery settings. However, both clients and providers are more likely to be satisfied with a facility if basic amenities and infrastructure components, such as a constant and clean supply of water, regular electricity supply, and a clean environment for clients, are available. These components also help staff provide better services. Table 3.2 provides summary information on these infrastructure components by facility type, managing authority, and region. Additional information is available in Tables A-3.2 and A-3.3.

Eighty-four percent of facilities have client comfort amenities (basic level of cleanliness, no broken equipment, and no obvious dirt or boxes lying around). There is little difference by type of facility; however, private facilities (92 percent) are more likely to have client comfort amenities than facilities managed by other authorities, particularly MoD/Police facilities. At the regional level, facilities in Otjozondjupa (52 percent) are least likely to have client comfort amenities.

Regular water supply, defined as year-round water supplied in the facility by tap or water from a protected well or pump with water outlet within 500 metres of the facility, is available in over half (57 percent) of all facilities. MoD/Police and private facilities are more likely to have regular water supply than other facilities. Clinics are less likely than other facility types to have regular water supply.

Just a little over half of all facilities (55 percent) report having regular electricity, i.e., the facility is connected to a central power grid, uses solar energy, or has a functioning generator with fuel, and power is routinely available during regular service hours. All sick bays and practically all hospitals have regular electricity. By comparison, electricity is available in about half of health centres and clinics. MoD/Police and private facilities are more likely than government facilities to have regular electricity. There are wide variations at the regional level; for example, only 21 percent of facilities in Caprivi have regular electricity compared with 81 percent of facilities in Erongo region.

Table 3.2 Service and facility infrastructure

Percentage of facilities with client comfort amenities, a regular water supply onsite, and regular electricity, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities with: All client comfort amenities[1]	Regular water supply[2]	Regular electricity or generator[3]	All basic client amenities, regular electric and water supply	Number of facilities
Type of facility					
Hospital	84	64	91	51	45
Health centre	89	68	55	30	47
Clinic	83	54	47	26	295
Sick bay	89	67	100	67	9
Managing authority					
MoHSS	84	55	47	24	306
Mission/NGO	82	57	71	36	28
Private	92	67	84	59	49
MoD/Police	62	69	92	46	13
Region					
Caprivi	86	46	21	4	28
Erongo	78	78	81	56	36
Hardap	95	57	67	38	21
Karas	80	48	52	20	25
Kavango	77	33	51	12	57
Khomas	91	67	67	39	33
Kunene	89	43	39	14	28
Ohangwena	91	34	34	9	32
Omaheke	94	69	50	44	16
Omusati	96	78	61	49	49
Oshana	100	80	50	45	20
Oshikoto	73	59	64	27	22
Otjozondjupa	52	66	66	41	29
Total	84	57	55	30	396

[1] Facility has basic level of cleanliness; i.e., the floors are swept and there is no obvious dirt or waste, all counters, tables, and chairs are clean with no obvious dust or waste, and there is no broken equipment, papers, or boxes lying around making the facility cluttered and dirty.
[2] Year-round water supplied in facility by tap or water from protected pump/well and available within 500 metres of facility.
[3] Electricity routinely available during service hours or a backup generator with fuel available on day of visit.

Looking at client comfort amenities, regular water supply, and regular electricity together, only 30 percent of facilities have all three items. Overall, hospitals and sick bays, facilities in the private sector, and those in Erongo are more likely than others to have all items.

3.1.3 Infrastructure and Resources to Support Quality 24-Hour Emergency Services

Not all types of health facilities are expected to provide 24-hour care; however, it is useful to assess all facilities' capacity to provide emergency services for 24 hours a day. For purposes of the 2009 Namibia HFC, a facility is said to have basic 24-hour emergency service capacity if it offers emergency on-site treatment and it has the capacity to monitor a seriously ill client overnight until it is possible to refer the client to an inpatient setting or another facility. This means that the facility must have at least two qualified providers, a duty schedule indicating that providers are on site or on call 24 hours a day, available overnight beds, 24-hour emergency communication, and an on-site water source at least some times during the year. Table 3.3 and Figure 3.2 provide information on facilities that have the items described above and meet the above requirements and those that also have a regular, year-round supply of water and electricity.

Overall, only 17 percent of all facilities have all the basic components to support 24-hour emergency services. As expected, hospitals (73 percent) are most likely to have 24-hour emergency service capacity. At the regional level, facilities in Omaheke (63 percent) and Otjozondjupa (45 percent)

region are more likely to meet all the criteria than facilities in other regions. There is less variation by managing authority, although government and private facilities (16 and 18 percent, respectively) are less likely than mission/NGO (25 percent) and MoD/Police facilities (31 percent) to have 24-hour emergency service capacity.

The basic components described above for 24-hour services, plus a regular supply of water and electricity, are available at only 9 percent of facilities (Table 3.3). As expected, hospitals are more likely than other facility types to have the basic components to support 24-hour emergency services, plus regular water and electricity supply.

Looking at the individual components, all hospitals and practically all health centres have at least two qualified providers assigned or employed (Figure 3.2 and Table A-3.2), while clinics are least likely to meet this criterion (62 percent). A review of the availability of overnight beds shows that all hospitals and seven of every ten health centres are equipped with overnight beds.

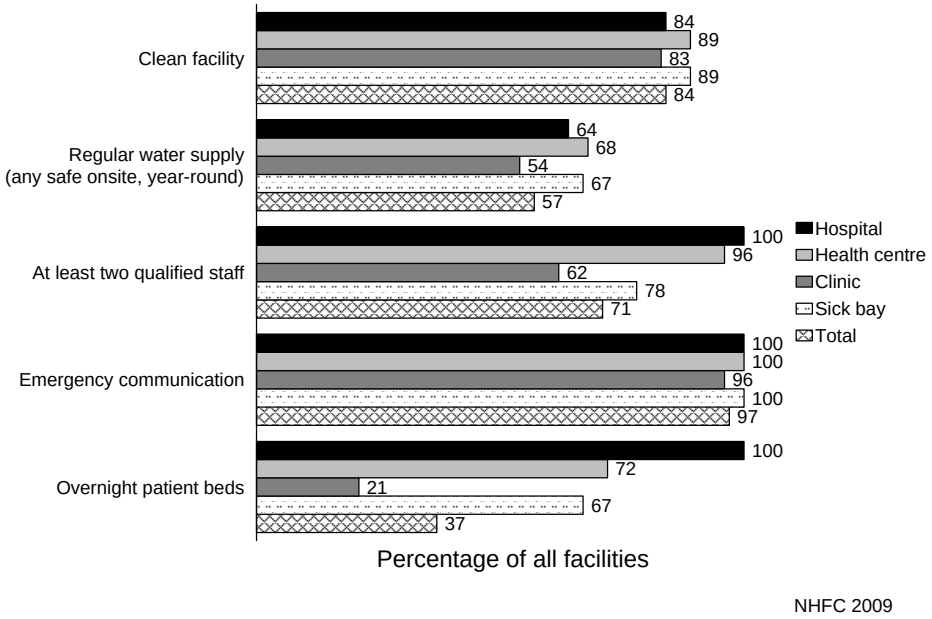
Table 3.3 Service and facility infrastructure to support quality 24-hour emergency services

Percentage of all facilities with basic components to support 24-hour emergency services and regular supplies of water and electricity, by background characteristics, Namibia HFC 2009

	Percentage of facilities with:		
Background characteristics	Basic components to support 24-hour emergency services[1]	Basic components to support 24-hour emergency services plus regular water and electricity[2]	Number of facilities
Type of facility			
Hospital	73	58	45
Health centre	40	11	47
Clinic	5	1	295
Sick bay	22	22	9
Managing authority			
MoHSS	16	7	306
Mission/NGO	25	14	28
Private	18	14	49
MoD/Police	31	23	13
Region			
Caprivi	0	0	28
Erongo	17	11	36
Hardap	14	10	21
Karas	20	16	25
Kavango	12	4	57
Khomas	18	3	33
Kunene	7	4	28
Ohangwena	6	3	32
Omaheke	63	25	16
Omusati	10	8	49
Oshana	15	15	20
Oshikoto	27	14	22
Otjozondjupa	45	24	29
Total	17	9	396

[1] At least two qualified providers assigned to or employed by facility, observed duty schedule indicating staff are on site or on call 24 hours a day, overnight beds, 24-hour emergency communication, and onsite water source at least some times during the year.
[2] All basic components plus year-round onsite water source and electricity routinely available during service hours or backup generator with fuel available.

Figure 3.2 **Availability of Items to Support Quality 24-hour Emergency Services (N=396)**



It is common for health facilities to have health workers living on facility premises. Overall, 55 percent of facilities have providers living on-site. Twenty-four hour emergency communication is widely available in all facility types.

Key Findings

Basic services: A full package of basic services (outpatient care for sick children and services for adult STIs, temporary methods of family planning, ANC, child immunisation, and child growth monitoring) is available in seven of every ten health facilities; health centres are more likely than other facility types to offer all these basic services. Two-thirds of facilities offer these services at minimum frequencies.

A full package of services available at the minimum frequency, together with 24-hour facility-based delivery services, is available in one-quarter of all health facilities.

Infrastructure and emergency services: Eight of every ten facilities have the basic client comfort amenities, and approximately six of every ten facilities have a regular, year-round water supply. Half of all facilities have regular electricity.[2]

All basic client amenities, a year-round water supply, and regular electricity are all available in 30 percent of facilities. Infrastructure to support provision of 24-hour emergency services is mostly available in hospitals and in facilities in Omaheke and Otjozondjupa regions.

[2] The facility is connected to a central power grid or uses solar energy or has a functioning generator with fuel, and power is routinely available during regular service hours.

3.2 MANAGEMENT SYSTEMS TO SUPPORT AND MAINTAIN QUALITY SERVICES AND APPROPRIATE CLIENT UTILISATION

Basic management and administrative systems are required to ensure that health services can consistently provide, as planned, an acceptable level of quality.

3.2.1 Management Meetings, Quality Assurance, and Referral Systems

Information on the availability of functioning systems for each of the assessed components is shown in Table 3.4. Further information on the components is shown in Figures 3.3 and 3.4 and Tables A-3.4 and A-3.5.

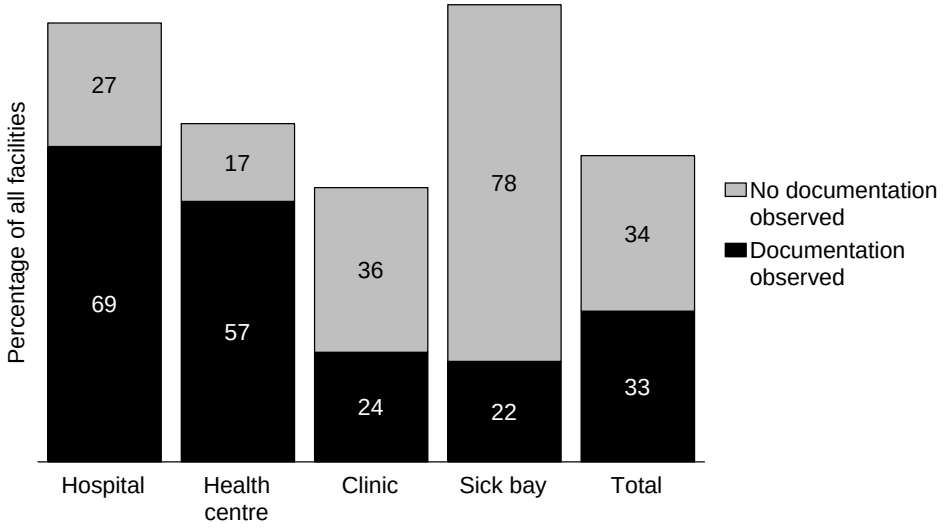
Table 3.4 Management, quality assurance, and referral systems

Percentage of facilities with documentation of management committee meetings, quality assurance (QA) activities, and referral systems, by background characteristics, Namibia HFC 2009

	Percentage of facilities with:						
Background characteristics	Management committee meetings at least every six months and observed documentation of a recent meeting	Facility reports QA activities; documentation observed	Refers clients outside facility and referral form observed[1]	Refers clients but no referral form observed[2]	Never refers clients outside facility	Don't know/ missing	Number of facilities
Type of facility							
Hospital	69	44	80	16	0	4	45
Health centre	57	17	94	4	0	2	47
Clinic	24	9	93	4	0	3	295
Sick bay	22	11	100	0	0	0	9
Managing authority							
MoHSS	32	13	94	2	0	4	306
Mission/NGO	50	21	96	4	0	0	28
Private	24	14	71	27	2	0	49
MoD/Police	38	8	92	8	0	0	13
Region							
Caprivi	32	0	100	0	0	0	28
Erongo	17	6	92	8	0	0	36
Hardap	33	19	90	10	0	0	21
Karas	28	8	84	12	0	4	25
Kavango	25	23	98	2	0	0	57
Khomas	42	18	82	15	3	0	33
Kunene	18	4	100	0	0	0	28
Ohangwena	56	16	63	3	0	34	32
Omaheke	69	44	94	6	0	0	16
Omusati	33	8	98	2	0	0	49
Oshana	30	5	100	0	0	0	20
Oshikoto	50	9	91	9	0	0	22
Otjozondjupa	21	28	97	3	0	0	29
Total	33	14	92	5	0	3	396

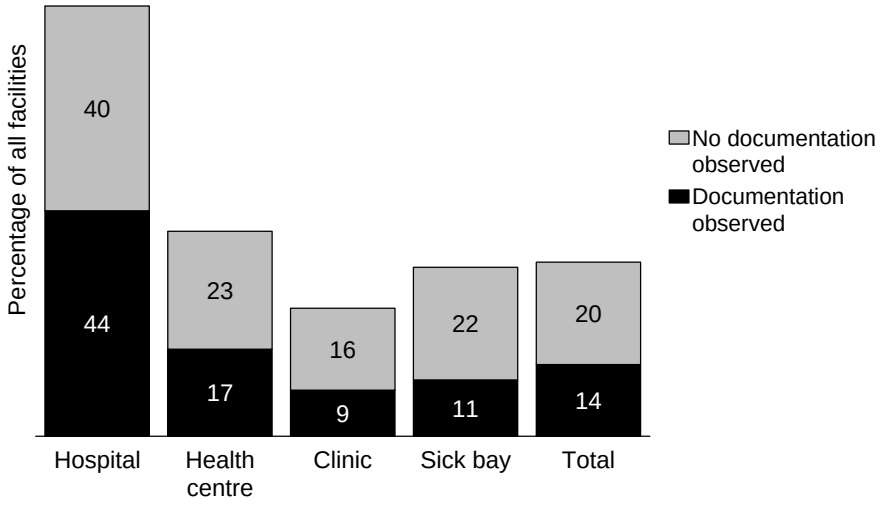
[1] The facility reports that they refer clients outside the facility for services when necessary and have a pre-printed referral form, or the facility reports that they routinely send the referred client with their medical record or file to the referral facility.
[2] The facility reports that they refer clients outside the facility but do not have a referral form to show, or they report that they write a referral note on a prescription form, letterhead, or a blank sheet of paper, or they use only verbal means to refer clients.

Figure 3.3 **Routine Management Committee Meetings at Least Every Six Months (N=396)**



NHFC 2009

Figure 3.4 **Quality Assurance Activities (N=396)**



NHFC 2009

Management meetings

To function well, a health facility must have an established system in place for considering and addressing management and administrative issues. This may involve meetings to discuss scheduling and day-to-day issues or meetings to discuss broader management issues such as financing, utilisation, or plans for health-related campaigns. There must, however, be regularly scheduled meetings with specific staff having defined areas of responsibility. In Namibia service delivery at the district level is managed by District Co-ordination Committees (DCCs). The 2009 Namibia HFC looked for evidence of a functioning management system in the form of regular management committee meetings, held at least every six months, and asked for some official documentation of proceedings. The system is considered to be functioning if there is a record of committee meetings with documented decisions and follow-up on issues that are discussed.

Overall, 67 percent of health facilities report having routine management committee meetings at least every six months; however, only 33 percent have documentation of a recent meeting (Table 3.4, Figure 3.3). Hospitals and health centres are most likely to have regular management committee meetings and also have documentation of recent meetings. For example, 96 percent of hospitals report having regular management committee meetings, and 69 percent had records of recent meetings. All sick bays report having routine management committee meetings; however, only 22 percent had documentation of recent meetings available.

Quality assurance

Quality assurance (QA), an important component of service delivery, refers to a system for monitoring the quality of care, identifying problems, and instituting changes to resolve those problems. Quality assurance systems require an established standard against which quality is measured; there must also be systematic methods to assess results and develop interventions. The following are examples of QA activities and approaches:

- A *supervisory checklist for health systems*, which looks for the presence of equipment and supplies, the completeness of HMIS accounts, and other process indicators.
- A *supervisory checklist for health service provision*, which verifies specific content in client assessments, treatments, or consultations. This is often used for observing the provision of care.
- A *facility-wide review of mortality*, a structured system to review the records of each client who dies. There will normally be a committee established for this purpose.
- *Audits of medical records or registers*, which check medical records for the presence of specific items or information and may assess if protocols were followed.

Table 3.4, Table A-3.5, and Figure 3.4 provide information on facilities reporting QA activities and the specific QA activities that they implement.

Only one-third of health facilities in the country report QA activities, and only 14 percent both report QA activities and have documentation of their QA activities (Tables 3.4 and A-3.5 and Figure 3.4). Hospitals (84 percent) are most likely to report QA activities, and they are also most likely to have documentation (44 percent). There is little variation by managing authority; however, at the regional level, facilities in Caprivi and Kunene regions are particularly less likely to have QA activities than facilities elsewhere.

Referral systems

When clients are referred to another facility without any formal documentation, they risk being refused services or having services delayed while the referral facility reassesses them as totally new clients. Thus, having a systematic means to refer clients to a higher-level (or another) facility is an important aspect of quality of care. Also, if clients are confident that they will be assisted in gaining access to higher-level (or other) facilities when needed, they may be less likely to bypass lower level facilities for their health care needs. The 2009 Namibia HFC collected information on whether facilities have any official printed referral forms, which at a minimum document the reason for referral and list any treatment already provided to the client. Also included in this category are facilities that routinely give referred clients their records or a referral note written on a prescription form or letterhead.

Ninety-two percent of facilities report that they refer clients outside the facility and also have supporting documents in the form of referral forms or other documents (Table 3.4). Hospitals are slightly less likely than health centres, clinics, or sick bays to refer clients outside and to have referral forms or documents available. Government, MoD/Police and mission/NGO facilities do not differ in the availability of referral forms (92 to 96 percent) and are all more likely than private facilities to refer clients and have referral forms. At the regional level, facilities in Ohangwena region (63 percent) are least likely to refer clients and have client referral forms.

3.2.2 Supportive Management for Providers

The 2009 Namibia HFC collected information on whether facilities have supervisory and staff development activities, which are important for supporting quality health care. Summary information on supportive management practices at the facility level is provided in Table 3.5, with further details provided in Tables A-3.6 and A-3.7.

External supervision

Supervision from external managers has many benefits. It can help ensure that system-wide standards and protocols are followed at the facility level and promote an organisational culture that expects such standards and protocols to be implemented. It provides an opportunity to expose staff to a wider scope of ideas and relevant experiences, including on-the-job training for some providers. It can also act as a motivator for service providers, especially if the supervisor is supportive. For the purposes of the 2009 Namibia HFC, a facility reporting at least one supervisory visit by external supervisors during the six months preceding the survey is defined as having routine external supervision.

Overall, three-quarters of facilities have routine external supervision; sick bays are markedly less likely to have routine supervision than other facility types (Table 3.5). By managing authority, mission/NGO facilities (96 percent) are more likely than facilities managed by other authorities to have routine external supervision. At the regional level, facilities in Omaheke (94 percent), Ohangwena (88 percent), and Hardap (86 percent) regions are most likely to have routine external supervision, while facilities in Khomas (52 percent) are least likely.

Table 3.5 Supportive management practices at the facility level

Percentage of facilities that had an external supervisory visit during the 6 months preceding the survey, and percentage of facilities where at least half of the interviewed health service providers report receiving routine training related to their work and personal supervision, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities with external supervisory visit during the 6 months preceding the survey	Number of facilities	Percentage of facilities where staff report receiving routine:			Percentage of facilities with supportive management practices[3]	Number of facilities where at least one eligible health service provider was interviewed[4]
			Training[1]	Personal supervision[2]	Training and personal supervision		
Type of facility							
Hospital	71	45	89	87	78	56	45
Health centre	87	47	91	85	77	64	47
Clinic	73	295	87	80	71	60	295
Sick bay	44	9	78	56	33	22	9
Managing authority							
MoHSS	79	306	93	84	78	66	306
Mission/NGO	96	28	75	96	71	68	28
Private	35	49	63	53	37	18	49
MoD/Police	54	13	77	69	46	31	13
Region							
Caprivi	75	28	96	89	86	75	28
Erongo	64	36	75	69	56	42	36
Hardap	86	21	81	90	71	67	21
Karas	76	25	92	92	84	68	25
Kavango	74	57	84	77	63	54	57
Khomas	52	33	79	67	61	42	33
Kunene	79	28	89	68	57	57	28
Ohangwena	88	32	88	94	84	72	32
Omaheke	94	16	94	94	88	88	16
Omusati	76	49	90	90	84	69	49
Oshana	80	20	100	85	85	65	20
Oshikoto	73	22	91	91	82	59	22
Otjozondjupa	66	29	90	55	52	34	29
Total	74	396	87	81	72	59	396

[1] A facility has routine staff training if at least half of interviewed providers reported they had received pre- or in-service training related to their work during the 12 months preceding the survey. This refers to structured sessions and does not include individual instruction received during routine supervision.
[2] A facility has routine staff supervision if at least half of interviewed providers reported they had been personally supervised at least once during the 6 months preceding the survey.
[3] A facility has supportive management practices if it had at least one external supervisory visit during the 6 months preceding the survey and staff received routine training and personal supervision.
[4] Interviewed providers who did not personally provide one of the services assessed by the NHFC (e.g., administrators who might have been interviewed) are excluded.

Training

To maintain levels of knowledge and technical competence achieved during basic training, health service providers must continually be exposed to current and new information. The 2009 Namibia HFC assessed whether, during the 12 months preceding the survey, providers had received any formal or structured pre-service or in-service training related to the services that they offer. While it is recognised that providers may receive new information and individual instruction related to their work during routine supervisory visits, the 2009 Namibia HFC only assessed structured 'classroom-type' training. If at least half of the health service providers interviewed at a facility reported receiving in-service or pre-service training relevant to their jobs at any time during the 12 months preceding the survey, that facility is defined by the 2009 Namibia HFC as having routine staff training.

Overall, 87 percent of facilities satisfy these criteria for routine staff training (Table 3.5). Sick bays are less likely than the other facility types to have routine staff training. Government facilities (93 percent) are more likely to have routine staff development activities than private (63 percent),

MoD/Police (77 percent), and mission/NGO (75 percent) facilities. At the regional level, nearly all facilities in Caprivi (96 percent) and all in Oshana (100 percent) have routine staff training.

Supervision of health service providers

In addition to general facility-level supervision, the work of individual health workers must be assessed so that each provider's strengths and weaknesses can be identified and appropriate support provided. If at least half of the interviewed health service providers in a facility reported being personally supervised at least once during the six months preceding the survey, the 2009 Namibia HFC defines the facility as providing routine staff supervision. Eight of every ten facilities meet the criteria for routine staff supervision (Table 3.5). As with routine staff training, sick bays are less likely to have routine staff supervision (56 percent) than other facility types, at 80 to 87 percent. Mission/NGO (96 percent) facilities are most likely to have routine staff supervision, while private faculties (53 percent) are least likely. At the regional level, the weakest level of supervision is among facilities in Otjozondjupa, where only 55 percent meet the criterion.

Overall, seven of every ten facilities meet the criteria for both routine staff training and personal supervision, and only six of every ten facilities have the complete package of supportive management practices.[3]

3.2.3 Management Practices Supporting Community Involvement

Encouraging community input into a facility's functions makes the facility more accountable to the community it serves; it also helps the facility to better understand the community's needs. This increases chances for better health-seeking behaviour, which in turn may improve the health of the population. Government policy recommends establishing an interface with communities, starting at the clinic level.

Community representation

Overall, 41 percent of facilities have routine community participation in some management meetings (Table 3.6). Other than in sick bays, where community participation in management meetings is reported in 56 percent of facilities, community participation in management meetings does not vary much by type of facility. Not surprisingly, it is least common in private facilities (24 percent). Community participation is most common in MoD/Police facilities (54 percent). At the regional level, facilities in Omaheke (69 percent) and Ohangwena (72 percent) regions are most likely to have routine community participation in management meetings. Not all facilities reporting routine community participation in management meetings, however, have documentation to support that claim. For example, only 17 percent of facilities overall reported meetings at least every six months and had some observed documentation of a recent meeting.

Client feedback

The 2009 Namibia HFC also assessed whether facilities have a system to elicit and review client opinion. Of all facilities, only 12 percent have such a system (Table 3.6). Hospitals (29 percent) are more likely than other types of facilities to have client feedback systems. Among the different management authorities, government facilities (9 percent) are at best half as likely as other management types (18-23 percent) to elicit and review client opinion. Client feedback systems, although uncommon in every region, are virtually non-existent in several regions, including Caprivi and Kunene (both 0 percent), Erongo and Otjozondjupa (both 3 percent), and Karas (4 percent).

[3] A facility has supportive management practices if it had at least one external supervisory visit during the six months preceding the survey as well as routine staff training and staff supervision.

Table 3.6 Management practices supporting community feedback

Percentage of facilities that have routine community participation in management meetings at least every 6 months, a system of acquiring client opinion and feedback, or any mechanism for obtaining community input, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities: Where community participation in some management meetings is routine	With meetings at least every 6 months and observed documentation of a recent meeting	Where client opinion is elicited and a system for review implemented[1]	That have any mechanism for obtaining community input on services[2]	Number of facilities
Type of facility					
Hospital	44	16	29	62	45
Health centre	43	15	21	53	47
Clinic	39	18	7	41	295
Sick bay	56	22	11	67	9
Managing authority					
MoHSS	42	20	9	45	306
Mission/NGO	43	7	21	54	28
Private	24	2	18	37	49
MoD/Police	54	23	23	69	13
Region					
Caprivi	32	14	0	32	28
Erongo	39	6	3	39	36
Hardap	52	10	19	57	21
Karas	36	12	4	40	25
Kavango	25	11	14	32	57
Khomas	21	3	24	39	33
Kunene	32	18	0	32	28
Ohangwena	72	50	13	75	32
Omaheke	69	38	50	81	16
Omusati	63	33	14	65	49
Oshana	45	15	10	50	20
Oshikoto	27	9	9	32	22
Otjozondjupa	28	7	3	31	29
Total	41	17	12	45	396

[1] Some mechanism for eliciting client opinion is reported, and there is documentation indicating that client opinions are reviewed.
[2] Either community representation at management meetings or a system for eliciting and reviewing client opinion is in place.

3.2.4 Funding Mechanisms that Decrease Financial Barriers to Utilisation of Health Services

User fees may have a positive effect on the use of health care services by increasing the funds available to the facility; they may also have a negative effect by deterring poor clients from using services. Exemption from the payment of user fees is provided for certain services that include, but are not limited to, notifiable diseases, preventive and promotive services, and chronic diseases and for vulnerable groups and pensioners. However, providing exemptions or discounts for poor clients can result in budget shortages if there is no system for reimbursing these exempted or discounted costs. In any case, health facilities, if they charge for any services, should clearly display their fees for service. This improves accountability, reduces the likelihood of corruption, and helps clients calculate the costs that they will incur in seeking services. Furthermore, it is Namibia government policy to accept patients who are unable to pay in public facilities, and a waiver mechanism is in place.

User fees and additional sources of funding

All facilities in Namibia are expected to charge some form of user fees. User fees were introduced to enhance efficiency by encouraging patients and clients to enter the health services at lower level facilities and hence contribute to the decongestion of secondary and tertiary level facilities.

Furthermore, user fees were designed to improve the patient's understanding that he or she needs to value the services received, an understanding that should contribute to better compliance, cooperation, and quality assurance. According to government policy, the fees vary among clinics, health centres, and hospitals and differ between state and private patients. Services such as routine immunisation for infants are free in government facilities.

Table 3.7 summarises information on facilities charging routine user fees for adult curative care and those with external funding sources. Details on these funding options and functions for which facilities charge fees appear in Tables A-3.8 and A-3.9.

Ninety-five percent and above of hospitals, health centres and clinics routinely charge some form of user fees for adult curative services (Table 3.7). Sick bays do not charge for these services. All MoHSS and mission/NGO facilities and 73 percent of private facilities charge for adult curative services; MoD/Police facilities do not. Among facilities charging for adult curative services, only 26 percent display all fees. Some 26 percent charge for medicines and 59 percent charge for client consultations (Table A-3.9). Nine percent reported having fees for laboratory tests.

Table 3.7 Funding mechanism utilised in facilities

Percentage of facilities with routine user fees for adult curative care and any external source of revenue or funding, and percentage of facilities charging user fees that post all fees, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities with any routine user fee for adult curative care	Percentage of facilities with any external source of revenue or funding during 2009 financial year[1]	Number of facilities	Percentage of facilities that post all fees	Number of facilities having any user fees
Type of facility					
Hospital	98	100	45	43	44
Health centre	96	91	47	27	45
Clinic	95	91	295	24	280
Sick bay	0	78	9	-	0
Managing authority					
MoHSS	100	92	306	25	305
Mission/NGO	100	96	28	25	28
Private	73	92	49	36	36
MoD/Police	0	62	13	-	0
Region					
Caprivi	96	100	28	44	27
Erongo	69	83	36	44	25
Hardap	95	95	21	40	20
Karas	96	88	25	38	24
Kavango	98	86	57	18	56
Khomas	82	85	33	30	27
Kunene	100	100	28	21	28
Ohangwena	100	94	32	28	32
Omaheke	100	94	16	31	16
Omusati	98	100	49	6	48
Oshana	90	80	20	22	18
Oshikoto	100	95	22	14	22
Otjozondjupa	90	93	29	35	26
Total	93	92	396	26	369

[1] This includes any revenue or funding from sources such as MoHSS and other public ministries, insurance schemes, reimbursement by employers, government contribution to private for-profit organisations, out-of-pocket revenue, donor agencies, community programmes, and private/philanthropic agencies.

Ninety-two percent of all the facilities reported an external source of revenue or funding during the 2008-09 financial year (Table 3.7). This includes funding from the MoHSS and other public ministries, insurance schemes, reimbursement by employers, government contribution to private for-profit organisations, out-of-pocket revenue, donor agencies, community programmes, and private/philanthropic

agencies (Table 3.7 and Table A-3.8). Facilities in Oshana (80 percent) and Erongo (83 percent) are the least likely among the regions to report external sources of revenue or funding.

3.2.5 Maintenance and Repair of Equipment and Infrastructure

To provide quality services, a facility must have the means to ensure that the facility's equipment and infrastructure are in good working condition. Some equipment requires routine preventive maintenance, while others may require minor repairs or replacement. Buildings and infrastructure also require routine maintenance and periodic repair. For the purposes of the 2009 Namibia HFC, infrastructure refers to buildings and road networks within the facility complex. Summary information on systems for maintenance and equipment repair or replacement is provided in Table 3.8. Detailed information on what systems are used and which people are responsible for maintaining a facility's equipment is provided in Tables A-3.10 and A-3.11.

Table 3.8 Facility systems for maintenance and repair of equipment and infrastructure

Among facilities with major equipment, percentage that have a preventive maintenance program for that equipment, and percentage of all facilities that have a system for repairing or replacing small equipment and a system for maintenance and repair of building or infrastructure, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities with preventive maintenance program for major equipment[1]	Number of facilities with major equipment[2]	Percentage of facilities with: System for repair or replacement of small equipment[3]	Percentage of facilities with: System for maintenance and repair of building or infrastructure	Number of facilities
Type of facility					
Hospital	67	45	100	51	45
Health centre	42	12	98	26	47
Clinic	53	38	98	23	295
Sick bay	33	3	89	33	9
Managing authority					
MoHSS	45	49	98	16	306
Mission/NGO	73	11	100	61	28
Private	78	32	96	73	49
MoD/Police	17	6	85	31	13
Region					
Caprivi	0	1	100	7	28
Erongo	45	11	97	28	36
Hardap	44	9	100	29	21
Karas	73	11	100	36	25
Kavango	62	13	98	37	57
Khomas	92	12	91	52	33
Kunene	25	4	93	7	28
Ohangwena	33	6	97	19	32
Omaheke	43	7	100	25	16
Omusati	57	7	98	18	49
Oshana	60	5	100	30	20
Oshikoto	67	3	100	36	22
Otjozondjupa	56	9	100	24	29
Total	57	98	98	27	396

[1] Equipment such as generator, steriliser, electric autoclave, x-ray machines, ultrasound equipment, or CT scans.
[2] Includes only facilities with a functioning generator, electric autoclave or steriliser, x-ray machine, ultrasound equipment, or CT scans, and facilities where C-sections are performed.
[3] Equipment such as stethoscopes, blood pressure cuffs, and sphygmomanometers.

Major equipment

Fifty-seven percent of facilities that have major equipment[4] report having a system for preventive maintenance of the equipment (Table 3.8). Clinics and hospitals (53 and 67 percent, respectively) are more likely than health centres (42 percent) and sick bays (33 percent) to have a system for preventive maintenance. Furthermore, mission/NGO facilities as well as private facilities with major equipment are more likely than government facilities to have a system for preventive maintenance. Twenty-four percent of facilities have on-site staff responsible for routine maintenance of major equipment, while 23 percent use external technicians; another 8 percent use both systems (Table A-3.10).

Small equipment

Regarding small equipment, such as stethoscopes and sphygmomanometers, 98 percent of all facilities report having systems for their repair or replacement (Table 3.8). Such systems are widespread among facilities of all types; however, sick bays seem somewhat less likely than other facility types to have a system for repair or replacement of small equipment. It follows, therefore, that MoD/Police facilities are less likely than facilities managed by other authorities to have a system for repair or replacement of small equipment. There is little difference among regions. Facilities use different methods to maintain or replace small equipment, including on-site repair, sending equipment outside for repair or replacement, and purchasing or paying for new equipment from funds on hand (Table A-3.10). The 2009 Namibia HFC findings show that only 18 percent of facilities report on-site repair, while 79 percent of facilities send outside for repair or replacement.

Infrastructure

Twenty-seven percent of all facilities report having a system for maintenance and repair of facility infrastructure (Table 3.8). Half of hospitals have such a system. Private and mission/NGO facilities (73 and 61 percent, respectively) are more likely to have such a system than government facilities. There is wide variation among regions; the proportion of facilities with a system for maintenance and repair of buildings or infrastructure ranges from 7 percent in the Caprivi and Kunene regions to 52 percent in Khomas.

[4] Examples of such major equipment are generators, sterilisers, autoclaves and x-ray machines.

Key Findings

Management meetings: About seven of every 10 facilities report having routine management meetings; however, only one-third of facilities report having routine management meetings and also have documentation of a recent meeting. Hospitals and health centres are more likely than other facility types to have routine management meetings and also to have supporting documentation of recent meetings.

Quality assurance: One-third of facilities report quality assurance activities; however, only 14 percent of facilities both report having QA activities and have documentation of QA activities. Hospitals are more likely than other facility types to report QA activities and have documentation of QA activities.

Referral system: Nine of every ten facilities refer clients outside and had observed referral forms or documents. These are mostly sick bays, health centres, and clinics.

External supervision: Three-quarters of facilities report receiving external supervision during the six months preceding the survey. Sick bays, as well as facilities in Omaheke, Ohangwena, and Hardap regions are most likely than others to have external supervision.

Staff training: About 9 of every 10 facilities have routine staff training activities, i.e., at least half of interviewed providers in these facilities report receiving formal pre-service or in-service training related to their work in the 12 months preceding the assessment.

Community participation: Four of every ten facilities have routine community participation in management meetings, and only one in every ten facilities has any formal means for seeking client feedback. MoD/Police-managed facilities are more likely to have community participation in management meetings than those of any other managing authority.

User fees: Nine of every ten facilities routinely charge user fees for adult curative services; among these, one-quarter charge for medicines and six in every ten charge for consultations.

Maintenance and repair: Virtually all facilities have a system for maintenance and repair of small equipment such as stethoscopes and sphygmomanometers. Among facilities having large equipment, such as sterilisers, autoclaves, generators, and x-ray machines, a little over half have a system for the preventive maintenance and repair of this equipment.

One-fourth of all facilities have a system for maintenance and repair of buildings or infrastructure. MoHSS facilities are least likely to have systems for maintenance and repair of building or infrastructure.

3.3 Logistics Systems for Vaccines, Contraceptives, and Medicines

To ensure that necessary pharmaceutical commodities are available for daily use, facilities must have storage conditions that protect such commodities from damage. In addition, these facilities must have monitoring systems that minimise waste resulting from commodity expiration, and systems to monitor stock and ensure timely ordering and resupply. Summary information on storage conditions and stock monitoring for vaccines is presented in Table 3.9. Information on contraceptive methods, medicines, and anti-retroviral medicines (ARVs) is presented in Table 3.10, and that on inventory systems for stored medicines is shown in Figure 3.5. Details on each element assessed for vaccine storage conditions are presented in Figure 3.6, and details for vaccine stock monitoring systems are shown in Figure 3.7. Similar information on storage conditions and stock monitoring systems for contraceptive methods is provided in Figure 3.8. Tables A-3.12 and A-3.13 present additional information on storage conditions and stock monitoring systems for medicines, contraceptives, vaccines, and ARVs. Details on commodity ordering systems and storage are provided in Tables A-3.14 through A-3.17.

Table 3.9 Storage conditions and stock monitoring systems for vaccines

Among facilities that routinely store vaccines, percentage with adequate systems for monitoring storage temperature and stocks, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities with: Adequate cold chain monitoring system[1]	Vaccine stock monitoring system[2]	Number of facilities with stored vaccines observed
Type of facility			
Hospital	32	89	28
Health centre	69	89	45
Clinic	62	81	261
Managing authority			
MoHSS	63	83	284
Mission/NGO	67	93	27
Private	22	74	23
Region			
Caprivi	69	85	26
Erongo	45	68	22
Hardap	30	80	20
Karas	35	50	20
Kavango	66	80	56
Khomas	33	90	21
Kunene	63	88	24
Ohangwena	83	93	29
Omaheke	79	100	14
Omusati	72	74	43
Oshana	69	94	16
Oshikoto	73	95	22
Otjozondjupa	38	95	21
Total	60	83	334

[1] Functioning thermometer in vaccine refrigerator, up-to-date temperature chart, and refrigerator temperature between 2° to 8°C at time of survey.
[2] No expired items present, and items stored by expiration date.

Table 3.10 Storage conditions and stock monitoring systems for contraceptives, medicines, and ARVs

Among facilities that store methods of contraception, medicines, and ARVs, percentage with good storage conditions and adequate stock monitoring systems in place, by background characteristics, Namibia HFC 2009

Background characteristics	Contraceptive methods: Percentage with all assessed items for system for storing methods[1]	Percentage with all assessed items for system for monitoring stock[2]	Number of facilities with stored contracep-tive methods observed	Medicines: Percentage with all assessed items for system for storing medicines[1]	Percentage with all assessed items for system for monitoring stock[2]	Number of facilities with stored medicines observed	ARVs: Percentage with all assessed items for system for storing ARVs[1]	Percentage with all assessed items for system for monitoring stock[2]	Number of facilities with stored ARVs observed
Type of facility									
Hospital	92	84	25	80	73	45	71	95	41
Health centre	91	89	46	85	78	46	92	97	39
Clinic	89	77	289	81	69	288	93	93	163
Sick bay	75	100	4	89	44	9	-	-	0
Managing authority									
MoHSS	89	78	294	80	71	305	89	94	210
Mission/NGO	86	86	28	64	64	28	81	100	16
Private	94	78	36	100	71	42	94	88	16
MoD/Police	83	100	6	85	38	13	100	100	1
Region									
Caprivi	81	85	26	96	79	28	100	92	13
Erongo	88	76	34	83	67	36	100	89	19
Hardap	80	75	20	67	76	21	100	100	11
Karas	74	70	23	92	72	25	89	100	18
Kavango	86	75	56	65	51	57	81	97	31
Khomas	92	92	26	93	78	27	73	100	11
Kunene	96	84	25	89	61	28	87	87	15
Ohangwena	97	90	30	90	81	31	92	92	25
Omaheke	100	93	15	93	87	15	86	93	14
Omusati	93	65	46	78	73	49	84	89	38
Oshana	88	76	17	70	40	20	93	100	15
Oshikoto	90	81	21	73	73	22	85	85	13
Otjozondjupa	96	84	25	86	90	29	95	100	20
Total	89	79	364	81	70	388	89	94	243

[1] Items are stored in dry location, off the ground, and protected from water, sun, insect pests, and rodents.
[2] No expired items present and items stored by expiration date. Information not available for ARVs stored by expiration date; this statistic is therefore representing only 'no expired items present'.

Figure 3.5 **Inventory System Used for Stored Medicines (N=388)**

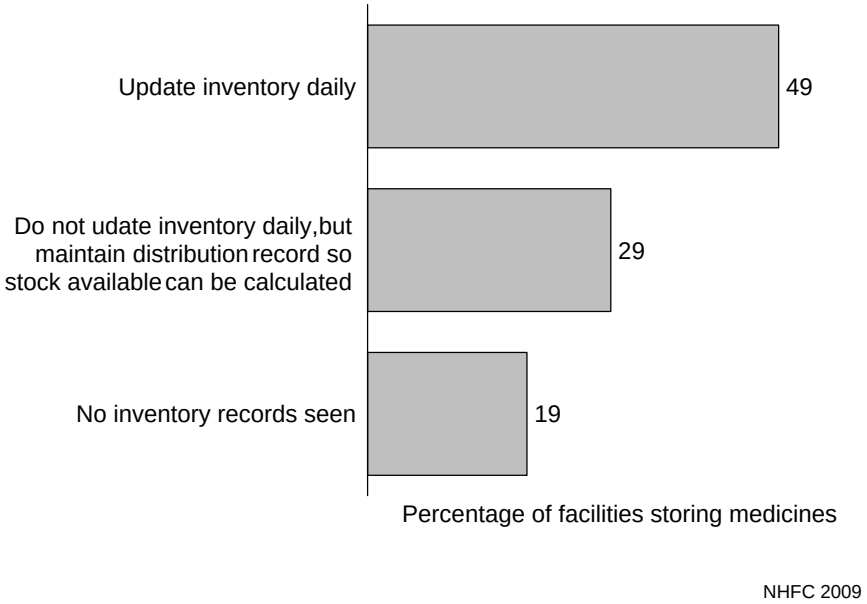


Figure 3.6 **Elements for Monitoring Vaccine Storage Conditions (N=334)**

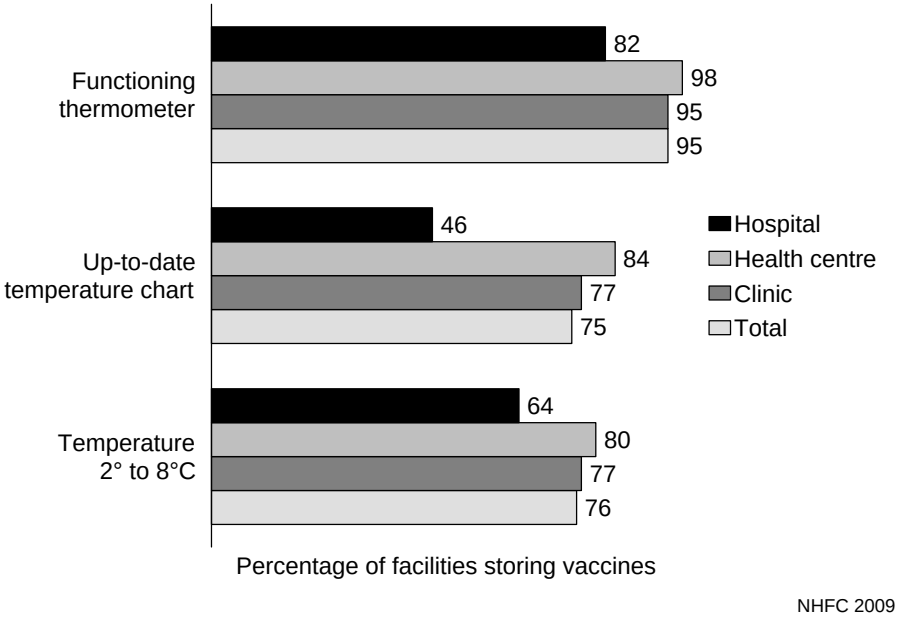
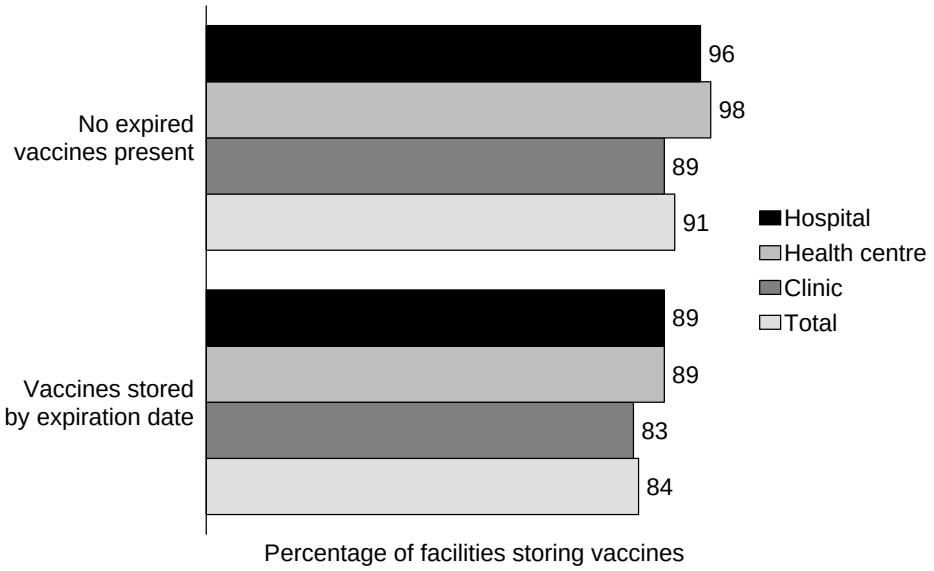
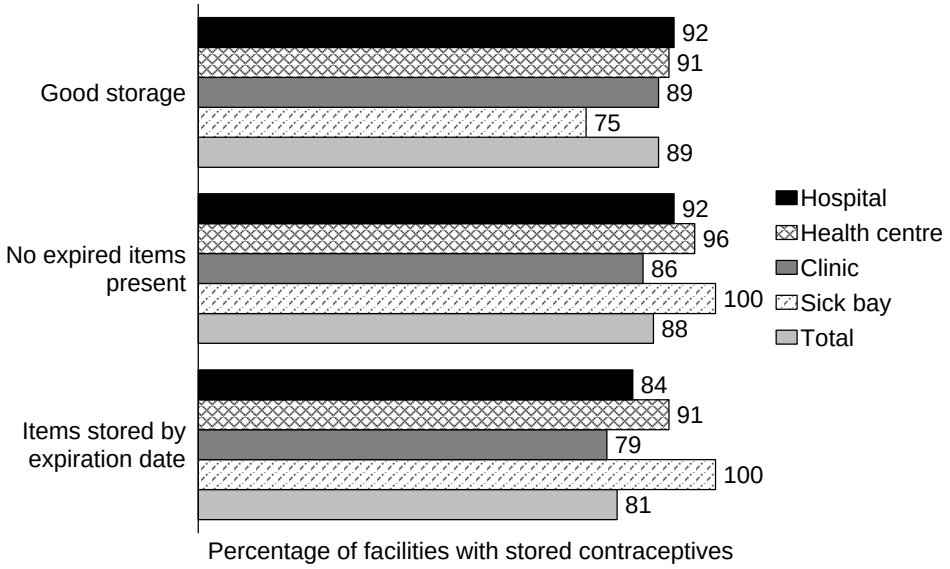


Figure 3.7 **Elements for Monitoring Vaccine Stock and Condition (N=334)**



NHFC 2009

Figure 3.8 **Elements for Storing and Monitoring Stock of Contraceptives (N=364)**



NHFC 2009

All commodities were assessed to ensure the presence of a valid expiration date on at least one unit. For selected vaccines, contraceptive methods, and medicines, the entire stock was assessed for the validity of the expiration date, for storage by expiration date, and for concordance with the inventory. If any of the checked items were found to be out of compliance, the stock monitoring system for that commodity was marked as not functioning.

It is common for facilities not to update their inventory daily, but rather to maintain a daily register (e.g., stock cards) of distributed items to tally the distributed items and update the inventory only

periodically, often monthly. Information on the inventory system used for medicines is presented in Figure 3.5. Forty-nine percent of facilities update the inventory daily. Twenty-nine percent use daily distribution registers (or records) and update inventory records only periodically (as opposed to daily). Facilities taking this approach were defined as having an up-to-date inventory if there was a register/stock card where the current inventory could be quickly calculated and if this tallied with actual commodity stocks.

3.3.1 Storage and Stock Monitoring Systems for Vaccines

Vaccines must be stored at an appropriate temperature to maintain their potency. It is the guidance of the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) to monitor refrigerator or cold box temperatures at least twice daily and to record the temperature on a graph as proof of monitoring (WHO, 1998). To assess facilities' vaccine storage conditions, the following were checked: (1) the presence of a functioning thermometer in the vaccine refrigerator, (2) a temperature of 2° to 8°C at the time of the survey (the UNICEF recommendation for vaccine storage at the health centre level), and (3) a temperature graph, completed twice a day, for the prior 30 days. Any facility satisfying all three items checked is considered as having an adequate cold chain monitoring system.

Storage conditions

Among facilities that routinely store vaccines and where vaccines were observed, 60 percent had an adequate cold chain monitoring system (Table 3.9). Health centres and clinics, mission/NGO and MoHSS facilities, and facilities in Ohangwena, Omaheke, Omusati, and Oshikoto regions are most likely to meet all three criteria for monitoring storage temperatures.

Looking at the individual components, between 82 and 98 percent of facilities that store vaccines have a functioning thermometer (Figure 3.6 and Table A-3.12); however, the other components for adequately monitoring vaccine storage are more often lacking. For example, only 64 percent of hospitals that store vaccines had temperatures in the storage refrigerator in the recommended range of 2°-8°C. Only 46 percent of hospitals that store vaccines had an up-to-date temperature chart. These data suggest that lower level facilities that store vaccines are doing a better job than hospitals.

Virtually all facilities that store vaccines position their vaccine refrigerator so that it is protected from direct sunlight (Table A-3.12).

Stock monitoring systems

A facility is considered to have an adequate vaccine stock monitoring system if (1) no expired items are present and (2) items are stored by expiration date. Vaccine stock monitoring systems were assessed for the following vaccines: tetanus toxoid (TT), BCG, polio, measles, and DPT/Pentavalent. Information on stock monitoring systems for these vaccines is presented in Table 3.9. Eight of every ten facilities that store vaccines have an adequate vaccine stock monitoring system. There is little variation by type of facility; however, private facilities seem somewhat less likely to have adequate stock monitoring systems than facilities managed by other authorities. There is also some variation among regions. Facilities in Erongo, Karas, and Omusati regions have weaker stock monitoring systems than facilities in other regions. The component driving this indicator down is storage of vaccines by expiration date; facilities are less likely to store items by expiration date than to have no expired vaccines in stock (Figure 3.7, Table A-3.12).

3.3.2 Storage and Stock Monitoring Systems for Contraceptive Methods, General Medicines, and ARVs

Storage conditions

To prevent chemical deterioration and contamination, facilities must store contraceptives and medicines away from direct sunlight, in dry conditions, and in an area protected from rodents and insect pests. Overall, storage conditions for contraceptives are good[5] in nine of every ten facilities that store contraceptives (Table 3.10 and Figure 3.8). Storage conditions for medicines are good in 81 percent of facilities that store medicines (Table 3.10). There was evidence of rodents or other pests in the storage area for contraceptives, medicines, and ARVs in 6, 7, and 7 percent, respectively, of facilities that store these commodities (Table A-3.13).

The storage conditions were also assessed for ARVs in health facilities with stored ARVs. Similar to storage conditions for contraceptives, the storage conditions for ARVs are good in nine of every ten facilities, with clinics and health centres being more likely to have good storage conditions (93 and 92 percent, respectively) than hospitals (Table 3.10).

Stock monitoring systems

Stock monitoring practices were assessed for contraceptive methods, medicines, and ARVs. Eight of every ten facilities with stored contraceptive methods observed had all items for adequate stock monitoring systems; seven of every ten facilities with stored medicines observed had all the items for an adequate stock monitoring system (Table 3.10).

Facilities in Khomas, Ohangwena, and Omaheke regions are those most likely to have adequate stock monitoring for contraceptives, while facilities in Omaheke and Otjozondjupa regions are most likely to have an adequate stock monitoring system for medicines (Table 3.10).

Key Findings

Vaccine storage: Six of every ten facilities that store vaccines have all the necessary components to adequately monitor the cold chain, that is, a functioning thermometer in the refrigerator, an up-to-date temperature chart, and refrigerator temperature between 2° - 8°C on the day of the visit. Practically all facilities had a functioning thermometer, three-quarters had an up-to-date temperature chart, and three-quarters had temperature readings between 2° and 8°C on the day of the visit.

All facilities that store vaccines position their vaccine refrigerators so that they are protected from direct sunlight.

Storage of contraceptives: Nine of every ten facilities that store contraceptives had good storage conditions; the same proportion had no expired items present, and eight of every ten stored items by expiration date.

Stock monitoring: Eight of every ten facilities with stored contraceptive methods observed had all items for adequate stock monitoring systems; seven of every ten facilities with stored medicines observed had all the items for an adequate stock monitoring system.

[5] Items are stored in dry location, off the ground and protected from water and direct sunlight, and there is no evidence of rodents or other pests in the storage location.

3.4 SYSTEMS FOR INFECTION CONTROL

Universal precautions refer to infection control measures that can prevent cross-infection from blood and other body fluids. All health workers who may come into contact with body fluids should exercise these universal precautions, working under the assumption that anyone may have an infectious condition (CDC, 1987; JHPIEGO, 2003).

The 2009 Namibia HFC assessed conditions for infection control in all service delivery areas covered by the survey. The survey examined conditions to see whether providers could reasonably be expected to wash their hands between seeing different clients. It also checked for the presence of a safety box for secure disposal of sharp items such as disposable needles and blades, which may be contaminated with HIV or other blood-borne infections.

Summary information on facilities' capacity to process equipment for reuse is presented in Table 3.11, and aggregate information on equipment processing capacity and infection control measures available in service delivery areas is presented in Table 3.12. Figures 3.9 and 3.10 present details on the individual elements considered necessary for processing equipment and maintaining infection control in service delivery areas. Further information on processing methods, storage conditions for processed items, and infection control measures can be found in Tables A-3.18 through A-3.21.

Table 3.11 Capacity for processing of equipment: All methods

Percentage of facilities with the equipment, knowledge, timer, and guidelines to support quality sterilisation or high-level disinfection (HLD) of equipment, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities with: Equipment	Equipment and knowledge of process time[1]	Equipment, knowledge of process time, and automatic timer[2]	Written guidelines for sterilisation or HLD present[3]	Number of facilities
Type of facility					
Hospital	96	87	78	38	45
Health centre	17	15	9	4	47
Clinic	6	4	2	1	295
Sick bay	11	0	0	0	9
Managing authority					
MoHSS	11	10	8	3	306
Mission/NGO	32	29	18	14	28
Private	47	37	24	16	49
MoD/Police	15	8	8	0	13
Region					
Caprivi	4	4	4	0	28
Erongo	19	17	14	8	36
Hardap	33	33	5	14	21
Karas	28	28	28	4	25
Kavango	16	9	5	4	57
Khomas	27	21	15	15	33
Kunene	11	7	7	4	28
Ohangwena	13	13	13	0	32
Omaheke	19	19	13	0	16
Omusati	10	8	8	0	49
Oshana	15	15	10	15	20
Oshikoto	14	14	9	9	22
Otjozondjupa	28	21	21	3	29
Total	17	15	11	5	396

[1] Processing area has functioning equipment and power source for method and reports the correct processing time (or the equipment automatically sets the time) and processing temperature (if applicable) for at least one method. Definitions for capacity for each method assessed were functioning equipment and processing conditions as follows:

- Dry heat sterilisation: temperature 160°-169°C and processed for at least 120 minutes or temperature of at least 170°C and processed for at least 60 minutes.
- Autoclave: process wrapped items at least 30 minutes, unwrapped items at least 20 minutes
- Boiling or steaming: process at least 20 minutes
- Chemical high-level disinfection (HLD): with chlorine base or glutaraldehyde solution and soaked for at least 20 minutes.

[2] This refers to a passive timer that can be set to indicate when a set time has passed. This may be a part of the sterilisation or HLD equipment.

[3] Hand-written guidelines that are pasted on walls are acceptable.

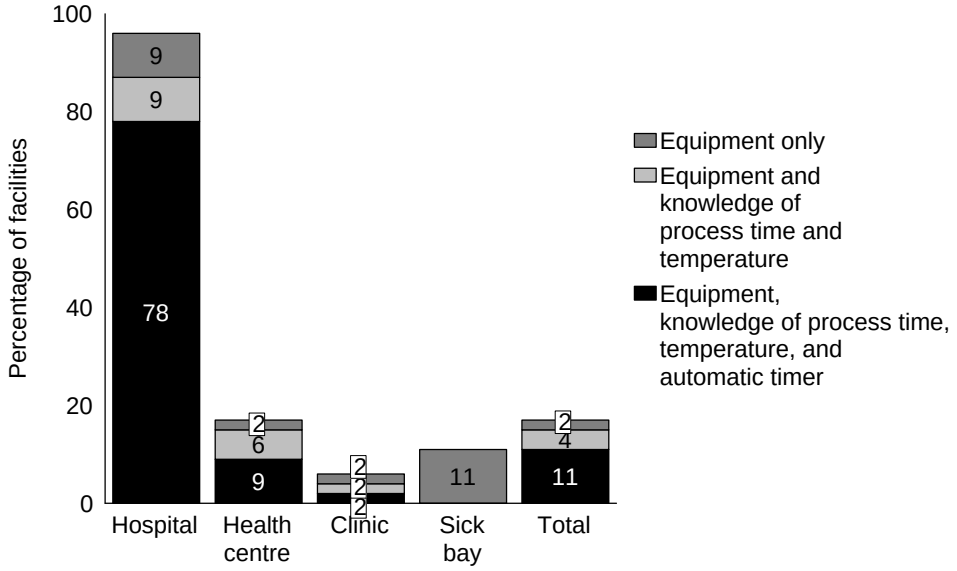
Table 3.12 Infection control and hazardous waste control

Percentage of facilities that have all items for infection control in all assessed service delivery areas, adequate disposal system for infectious and sharps waste, and infection control guidelines, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage with all items for infection control in all assessed service delivery areas[1]	Percentage with adequate final waste disposal system[2] for infectious waste	Percentage with adequate final waste disposal system[3] for sharps waste	Percentage with guidelines for disinfection and sterilisation in any assessed sterilisation area	Number of facilities
Type of facility					
Hospital	22	78	78	38	45
Health centre	26	68	85	4	47
Clinic	40	62	88	1	295
Sick bay	56	56	67	0	9
Managing authority					
MoHSS	33	63	88	3	306
Mission/NGO	32	61	79	14	28
Private	59	78	82	16	49
MoD/Police	54	46	77	0	13
Region					
Caprivi	54	68	86	0	28
Erongo	47	44	56	8	36
Hardap	52	86	95	14	21
Karas	36	68	76	4	25
Kavango	56	47	81	4	57
Khomas	45	85	88	15	33
Kunene	61	46	93	4	28
Ohangwena	22	66	100	0	32
Omaheke	38	75	100	0	16
Omusati	27	53	90	0	49
Oshana	10	65	80	15	20
Oshikoto	5	68	86	9	22
Otjozondjupa	3	100	100	3	29
Total	37	64	86	5	396

[1] Soap and running water or else hand disinfectant, sharps box, disinfecting solution, and latex gloves in all assessed service areas.
[2] Infectious waste is collected and disposed of externally, or incinerated, or burned in a protected area or pit, or dumped in a protected area or covered pit, and there is no unprotected infectious waste observed in any service site or waste disposal area on day of survey.
[3] Sharps waste is collected and disposed of externally, or incinerated, or burned in a protected area or pit, or dumped in a protected area or covered pit, and there is no unprotected sharps waste observed in any service site or waste disposal area on day of survey.

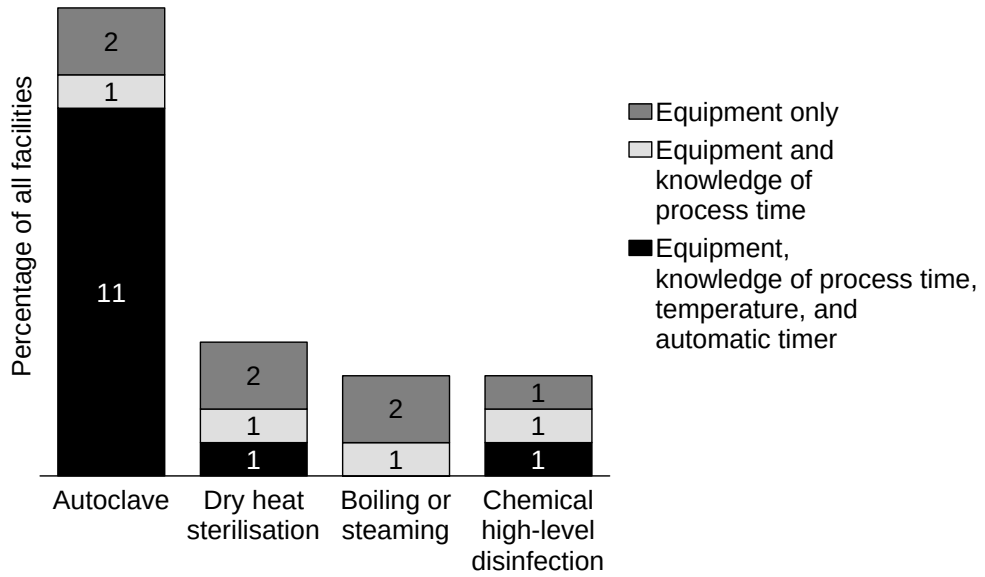
Figure 3.9 **Capacity to Sterilise or HLD Process Equipment (Any Method) (N=396)**



Note: Temperature does not apply to chemical HLD.

NHFC 2009

Figure 3.10 **Facilities with Indicated Elements for Processing Equipment Using Indicated Method (N=396)**



Note: A facility may have more than one method. NHFC 2009

3.4.1 Capacity for Adherence to Standards for Quality Sterilisation or High-Level Disinfection Processes

For most examination equipment, either sterilisation or high-level disinfection (HLD) procedures are sufficient to prevent the spread of infection. However, to effectively kill the spores that cause illnesses such as tetanus, dry-heat sterilisation, an autoclave system, or the less frequently used chemical sterilisation[6] is required. This type of system is necessary for processing surgical equipment that will be reused, such as blade handles and scissors used to cut the umbilical cord. Depending on the size of the facility, different types of equipment may be processed using different methods; also, equipment may be processed at more than one location in the same facility. The information presented in this chapter refers to the primary site in the facility where equipment is processed.

Namibia has a system whereby the final processing of equipment for reuse takes place in central locations known as Central Sterile Sterilisation Department (CSSD) in a few facilities, mostly hospitals that serve lower level facilities in a designated geographic area. The lower level facilities (health centres and clinics) send contaminated equipment to these central locations for final processing, and the processed equipment is then sent back to these lower level facilities for reuse. Data from the 2009 NHFC show that, overall, 17 percent of all facilities have functioning equipment or the necessary chemicals for the processing method used. A smaller proportion of facilities (15 percent) have the equipment as well as have correct knowledge of the processing time and temperature for the method used in the facility. When an automatic timer is added to the assessment (where applicable), the proportion of facilities having all items (equipment, correct knowledge plus automatic timer, where applicable) drops to 11 percent of facilities (Table 3.11, Figure 3.9). Written guidelines for sterilisation or HLD processing in any service area were found in only 5 percent of facilities overall and in 38 percent of hospitals.

[6] With formaldehyde or glutaraldehyde (Cidex®).

Looking at the data by type of facility, as expected, practically all hospitals have the equipment required for the processing method used. In addition, hospitals, far more than other facility types, have correct knowledge of processing time as well as have an automatic timer, if applicable.

The data also show that the most commonly used method for processing equipment is autoclaving (Figure 3.10); other methods of processing equipment are rarely used. Overall, only 14 percent of facilities have the necessary equipment for autoclaving. Hospitals are more likely than other types of facilities to have the equipment for autoclaving (data not shown). Only 11 percent of facilities (but 78 percent of hospitals) have an automatic timer in addition to the equipment and the correct knowledge of processing time, temperature, and pressure for autoclave processing. Four percent of facilities have equipment for dry heat sterilisation, 3 percent have equipment for boiling, and 3 percent have equipment for chemical high-level disinfection (Figure 3.10).

3.4.2 Appropriate Storage Conditions for Processed Items

Facilities must be able to store processed items under sterile conditions. To maintain sterility or HLD status, items must be (1) stored in a dry location; (2) either wrapped in sterile, dry cloth or placed in a sterile or HLD-processed container that can clasp shut; and (3) marked with the processing date, because the sterile/HLD status cannot be ensured after one week unless the item is also sealed in plastic. Other common storage procedures that may be accepted in some settings (such as keeping processed but unwrapped items in an autoclave or on a tray covered with a clean cloth) do not ensure sterile/HLD status.

The data show that 83 percent of the facilities (all hospitals, 91 percent of health centres, 80 percent of clinics, and 56 percent of sick bays) had processed items present on the day of the visit (Table A-3.19).

Among facilities with processed and stored items observed, 83 percent had processed items stored under sterile/HLD conditions (i.e., wrapped and sealed with time-steam-temperature strip or placed in a sterile/HLD container that clasps shut, and stored in a dry, clean area). Hospitals and health centres are more likely than clinics and sick bays to adequately store processed items. By managing authority, MoD/Police facilities are less likely than others to store processed items under sterile conditions. At the regional level, facilities in Kunene and Kavango regions are among the least likely to store processed items under sterile/HLD conditions.

Seventy-three percent of facilities had processed items stored under sterile/HLD conditions and also had processing dates on the sterilised items. Once again, hospitals and health centres are more likely than others to have processed items stored under sterile conditions. Compared with facilities of other managing authorities, MoD/Police facilities are least likely to store processed items under sterile condition and also have processing dates.

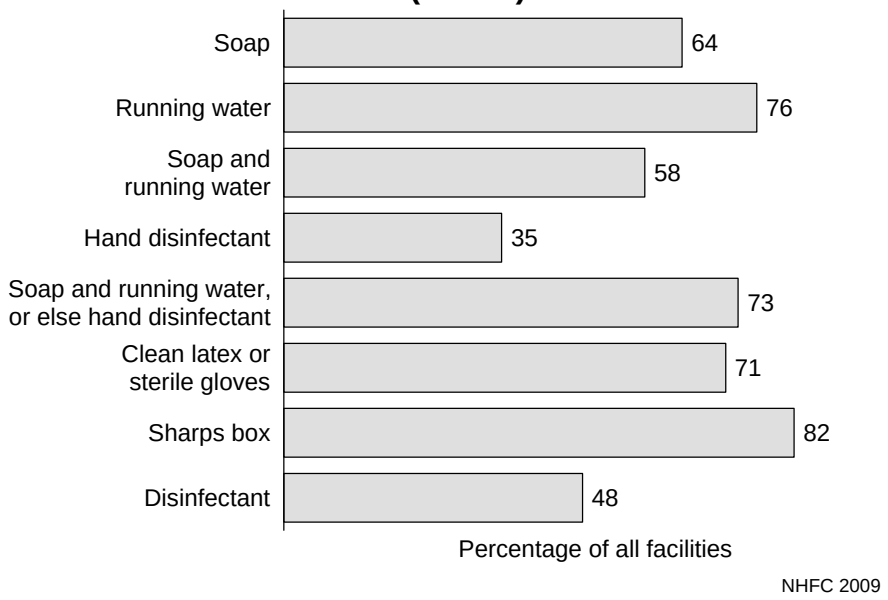
3.4.3 Infection Control in Service Delivery Area

Hospital-acquired (nosocomial) infections often complicate the delivery of health care worldwide. Strict compliance with infection control guidelines and constant vigilance are necessary to prevent such infections. The items considered relevant and necessary to prevent these infections include soap, hand disinfectant, running water, safety boxes for appropriate disposal of sharps waste, disinfecting solution, and latex gloves. The presence of running water in a service delivery area does not necessarily imply that providers will wash their hands how and when they should; however, having running water and soap available in the area where services are provided, or in an immediately adjacent area, increases the likelihood that providers will use them. Hand disinfectants are another effective means to clean hands after examining patients. The presence of waste receptacles (pedal bins) also is assessed.

For the 2009 Namibia HFC, *all* of these items (excluding waste receptacles) must be present in *all* service delivery sites for a facility to qualify as meeting infection control standards. As shown in Table 3.12, only 37 percent of facilities have *all* infection control items available in *all* assessed service delivery sites (22 percent of hospitals, 26 percent of health centres, 40 percent of clinics, and 56 percent of sick bays).[7] Figure 3.11 and Tables A-3.20 and A-3.21 break down the availability of specific infection control items in different service sites.

Running water is available in all sites in three-fourths of facilities; soap is less widely available—in 64 percent of all facilities. Together, soap and running water are available at all sites in about six of every ten facilities. Hand disinfectant is the least available item, available at all sites in less than 40 percent of facilities. Altogether, soap and running water or else hand disinfectant was available in all sites in 73 percent of facilities.

Figure 3.11 **Availability of Infection Control Items in All Assessed and Relevant Service Delivery Areas in a Facility (N=396)**



3.4.4 Adequate Disposal of Hazardous Waste

Hazardous waste includes infectious waste (such as bandages, cotton wool that may be contaminated with blood or other bodily fluids), and sharps waste (such as needles, blades, ampoules, and syringes). Appropriate final disposal of hazardous waste is another important aspect of infection control. The most effective means for hazardous waste disposal is incineration or else burning and subsequent burial of the remains. Directly burying items (without burning) in deep pits is also an effective means of disposal. When assessing whether facilities have adequate waste disposal systems, the most important issue is verifying that there is a disposal process that eliminates the possibility of contamination through contact. If the waste is visible and not protected from rodents, other animals, or people, either before or after being removed, burned, or buried, there is an increased chance that people might inadvertently come in contact with it, risking infection. Details on waste disposal systems are provided in Figure 3.12, Table 3.12, and Tables A-3.22.1 and A-3.22.2.

[7] These findings are prior to the implementation of the Infection Control Assessment Tool (ICAT) in November 2009 and therefore may be lower than what is currently available in Namibian health facilities.

After determining what system each facility used for disposal of hazardous waste, interviewers assessed the disposal site (or location where waste is stored prior to disposal) for any unprotected potentially hazardous waste.

Infectious waste

The disposal system for infectious waste is considered adequate if the waste is collected and disposed of externally, incinerated in the facility or burned in a protected area or pit, or dumped in a protected area or covered pit, *and* there is no unprotected infectious waste observed in any service site or waste disposal area on the day of the survey. By these criteria, two-thirds (64 percent) of facilities have an adequate disposal system for infectious waste (Table 3.12). Hospitals are more likely than other facility types to have adequate final waste disposal systems for infectious waste. At the regional level, facilities in Erongo, Kavango, Kunene, and Omusati (between 44 and 53 percent) are less likely than facilities in other regions to have an adequate infectious waste disposal system.

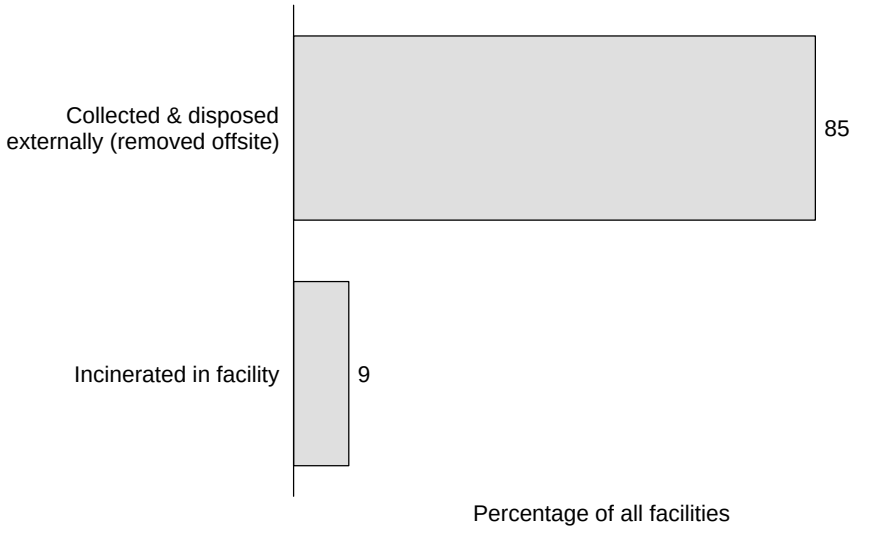
The data also show that removal of infectious waste offsite for final disposal is the most common means of waste disposal in Namibian health facilities (40 percent of Namibian health facilities) (Table A-3.22.1). Twenty-three percent burn the waste, protected, on facility grounds, 15 percent incinerate the waste on facility grounds and 12 percent burn the waste, unprotected, on facility grounds.

In terms of removing the waste offsite, there is little difference by type of facility; however, mission/NGO facilities as well as facilities in Caprivi and Oshikoto are less likely than others to remove infectious waste offsite for final disposal. These facilities are likely to burn the waste, protected and on facility grounds (50 percent of mission/NGO facilities, 50 percent of facilities Oshikoto and 61 percent of facilities in Caprivi). Hospitals are more likely to incinerate infectious waste on facility grounds (51 percent of hospitals).

Sharps waste

Most facilities treat sharps waste differently from the way that they treat other waste. The disposal system for sharps waste is considered adequate if sharps waste is collected and disposed of externally, incinerated in the facility or burned in a protected area or pit, or dumped in a protected area or covered pit, *and* there is no unprotected sharps waste observed in any service site or waste disposal area on the day of the survey. Eighty-six percent of facilities have an adequate disposal system for sharps waste (Table 3.12). Health centres and clinics are more likely to have adequate sharps waste disposal systems than hospitals or sick bays. Private facilities and MoHSS facilities are among those most likely to have adequate systems in place. At the regional level, as with systems for infectious waste disposal, facilities in Erongo are among those least likely to have adequate systems for disposal of sharps waste. Sharps waste is removed offsite for final disposal in 85 percent of all facilities and in the remainder is incinerated in the facility (Figure 3.12 and Table A-3.22.2). Hospitals, however, are more likely to incinerate sharps waste than remove offsite. Other methods of sharps disposal—burning on protected or unprotected ground or dumping in a protected or unprotected area without burning—are not used.

Figure 3.12 **Waste Disposal Methods for Sharps Waste (N=396)**



Note: Other methods were not used.

NHFC 2009

Key Findings

Processing of equipment: The Namibian health care delivery system is organised such that the final processing of equipment for reuse takes place in a central location (CSSD) in a few secondary/tertiary level facilities. The majority of hospitals assessed meet the criteria for the processing of equipment for reuse. Autoclaving is the most commonly used method for processing equipment.

Storage of processed equipment: Eight of every ten facilities where processed items were observed under storage store the items under sterile/HLD conditions. Hospitals are more likely than other facilities to store processed items under appropriate conditions.

Infection control items: All the relevant infection control items were available at all service delivery sites in just over one-third (37 percent) of all facilities. Running water is widely available; however, soap or hand disinfectant is less available at service delivery sites.

Hazardous waste disposal: Two-thirds of all facilities have adequate final waste disposal systems for infectious waste, while nearly nine of every ten facilities have adequate sharps waste disposal systems. Hazardous waste is removed offsite for final disposal in most facilities. Hospitals are more likely to incinerate hazardous waste (both infectious waste and sharps waste) than do open burning.

CHILD HEALTH SERVICES 4

Tamsin Bowra, Leena Haidula, Emgard Kaune

4.1 BACKGROUND

4.1.1 NHFC Approach to Collecting Child Health Information

The World Health Organization (WHO) estimates that over 10.5 million children under age 5 die annually from preventable diseases. The United Nations Children's Fund (UNICEF) reported that in 2008 approximately 8.8 million children died before their fifth birthdays (UNICEF, 2009). Many sick children who are brought to health care providers do not receive adequate assessment and treatment (WHO, 1999). It is not uncommon for providers to treat the symptoms that are most evident without conducting a full assessment of a child's health status or acting to prevent further diseases. For this reason WHO and other agencies developed the Integrated Management of Childhood Illness (IMCI) strategy (WHO, 1997). This strategy advocates using every visit to a health care provider as an opportunity, not only to conduct a full assessment of the child's current health and possible underlying problems, but also to provide interventions, such as immunisation and growth monitoring, that can prevent illness or minimise its progression.

The IMCI strategy aims to reduce morbidity and mortality among children under age 5 years through the following three activities:

1. Improving health workers' case management skills through training and supportive supervision

2. Improving health systems, including equipment, supplies, organisation of work, and referral systems

3. Improving childcare at the community and household levels in line with key family practices

Training, follow-up training, and supportive supervision, through a holistic approach, help health workers assess and appropriately treat major childhood illnesses (including diarrhoea, malaria, pneumonia, measles, and other severe infections). At the time of the 2009 NHFC, 20 of 34 health districts in Namibia were implementing the IMCI strategy at the health facility and community/household levels. WHO recommends that at least 60 percent of providers be trained in IMCI case management to ensure a critical mass for proper management of sick children. By employing the IMCI framework, the 2009 NHFC is expected to provide useful baseline measures that can later be used to judge progress in implementing the IMCI strategy across Namibian health facilities. Therefore, this census uses IMCI protocols whenever possible in examining the delivery of child health services at the health facility level.

This chapter uses information obtained from the 2009 NHFC to address the following four central questions:

- What is the availability of outpatient curative services relevant to child health?

- To what extent do facilities offering immunisation services for children have the capacity to support good quality vaccination services?

- To what extent do facilities providing outpatient care for sick children have the capacity to support good quality services that adhere to IMCI guidelines?

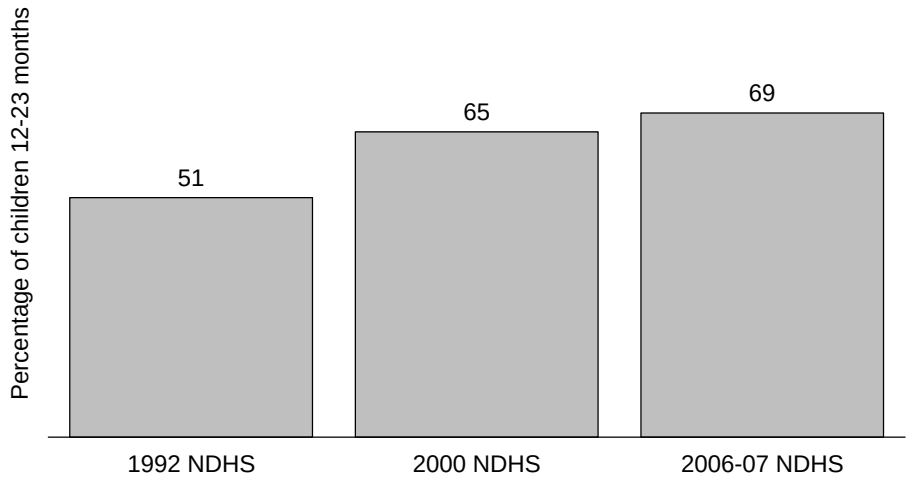
- To what extent do health workers who treat sick children on an outpatient basis adhere to standards for good quality service provision?

4.1.2 Health Situation of Children in Namibia

Vaccine coverage

Immunisation against vaccine-preventable diseases is vital to reducing child morbidity and mortality. The Expanded Programme on Immunisation (EPI) under the Ministry of Health and Social Services (MoHSS) is aimed at ensuring that all children are fully immunised by their first birthday. Children should receive one dose of tuberculosis vaccine (BCG); three doses of the vaccine against diphtheria, pertussis, tetanus, hepatitis B, and Haemophilus influenza type b [(DPT-HB + Hib1) or pentavalent]; four doses of oral polio vaccine (OPV); and one dose of measles vaccine. According to the 2006/2007 Namibia Demographic and Health Survey (NDHS) (MoHSS and Macro International, 2008), however, only 69 percent of children 12-23 months were fully immunised, compared with the EPI target of 95 percent for all antigens (polio, measles, DPT, BCG) as stated in the 2009 MoHSS EPI Draft Policy. Figure 4.1 shows immunisation coverage rates for children 12-23 months in Namibia since 1992.

Figure 4.1 **Children 12-23 Months Who Received All Immunisations, Namibia 1992-2006/07**



NDHS = Namibia Demographic and Health Survey

NHFC 2009

Measles epidemics have recently been reported in a few regions in Namibia, mainly in the northern regions bordering Angola. Some of the reasons for these epidemics could be related to health systems failure, including problems with maintenance of the cold chain, resulting in intermittent supply of potent vaccines. Another possible reason could be the failure to achieve high coverage with the first dose at 9 months. If the national campaigns[1] failed to add to the number of fully vaccinated children, then the

[1] The campaigns, normally conducted every 3-5 years for measles, are part of the measles control strategy to mop up children who missed the first dose and those who do not sero-convert with the first dose.

threshold level of immunisation that would prevent an outbreak may not have been reached. These disease outbreaks may be an indication of the extra efforts needed to reach remote/underserved areas and to address the missed opportunities associated with routine immunisation schedules.

Nutritional status

Malnutrition is an underlying factor in a large proportion of the illnesses that cause death among children under 5 years of age. The 2006-07 NDHS found that three in ten children under 5 years in Namibia are stunted (short for their age) and one in ten is severely stunted. The prevalence of stunting is higher among rural children (31 percent) than among urban children (24 percent) (MoHSS and Macro International 2008).

Childhood mortality and morbidity

The 2006-07 NDHS provides household-based child mortality data as well as information on what illnesses children experienced and whether they received health care during the two weeks preceding the household survey visit. Key findings include the following:

- The infant mortality rate was estimated at 46 deaths per 1,000 live births for the period 2002-2006, which is slightly less than the 51 deaths per 1,000 live births estimated for the period 1997-2001.

- The under-five mortality rate was estimated at 69 deaths per 1,000 live births in 2002-2006, similar to the 68 deaths per 1,000 live births recorded between1997-2001.

- Twelve percent of children under age 5 had diarrhoea during the two weeks preceding the survey. The age group most affected by diarrhoea was children age 6-23 months. Of all children who had diarrhoea during the two weeks preceding the survey, approximately 60 percent were seen by health professionals.

- The recommended treatment for diarrhoeal diseases—other than dysentery, for which antibiotics are recommended—is fluid replacement. Oral rehydration therapy (ORT) was given to 69 percent of children with diarrhoea. Altogether, 73 percent of children with diarrhoea received some form of ORT or increased fluids. However, 20 percent of children with diarrhoea were given antibiotics.

- Twelve percent of children under age 5 slept under a mosquito net of some type on the night before the survey; 11 percent slept under an insecticide-treated net (ITN) the night before the survey.

- Of the 17 percent of children under age 5 who had fever in the two weeks preceding the 2006-07 NDHS, 56 percent sought treatment from a health facility or provider.

- Seventeen percent of children under age 18 are orphaned (i.e., one or both parents are dead).

- Among all children born in the 5 years preceding the survey with a reported birth weight, 14 percent had a low birth weight (less than 2.5 kg).

4.2 AVAILABILITY OF CHILD HEALTH SERVICES

The 2009 NHFC assessed the availability of three basic child health services: outpatient curative care for sick children, routine childhood immunisation services under EPI, and routine growth monitoring services. Table 4.1 provides information on the availability of these services. Tables A-4.1 and A-4.2 provide further details on the frequency of child health services and on community outreach services.[2]

Table 4.1 Availability of child health services

Percentage of facilities offering specific child health services at the facility, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities that provide: Curative outpatient care for sick children	Growth monitoring	Childhood immunisation[1]	All 3 basic child health services	Number of facilities
Type of facility					
Hospital	66	41	39	32	44
Health centre	98	93	93	93	46
Clinic	93	88	91	87	293
Managing authority					
MoHSS	98	90	91	88	306
Mission/NGO	96	93	96	93	28
Private	43	37	43	31	49
Region					
Caprivi	100	100	100	100	27
Erongo	69	56	63	50	32
Hardap	100	80	85	80	20
Karas	80	72	80	72	25
Kavango	100	95	100	95	56
Khomas	61	61	61	52	31
Kunene	96	86	86	86	28
Ohangwena	100	91	91	91	32
Omaheke	94	81	81	81	16
Omusati	96	90	90	88	49
Oshana	89	83	89	83	18
Oshikoto	100	91	95	91	22
Otjozondjupa	89	85	78	78	27
Total	91	83	85	81	383

[1] Childhood immunisation refers to the routine provision of DPT/Pentavalent, polio, and measles vaccinations to children.

According to findings of the 2009 NHFC, health services in Namibian facilities are relatively integrated; 81 percent of facilities report offering all three basic child health services as a package (Table 4.1). Outpatient curative care services are available in 91 percent of facilities, growth monitoring in 83 percent of facilities, and childhood immunisation in 85 percent of facilities.

Among facility types, hospitals and, among managing authorities, private facilities are least likely to offer all three basic services (32 percent and 31 percent, respectively). All three basic child health services are available in approximately 90 percent of facilities of the Ministry of Health and Social Services (MoHSS) and facilities managed by mission/non-governmental organisations (NGOs). At the regional level all three services as a package are most likely to be offered in facilities in Caprivi (100 percent) and Kavango (95 percent) and least likely to be offered in Erongo (50 percent) and Khomas (52 percent).

[2] Community outreach refers to any services provided outside of the facility. For immunisations this might include activities related to campaigns, such as the polio eradication campaign.

Outpatient curative care for sick children is the most commonly provided of the three basic services. Outpatient curative care is almost universally available in MoHSS and mission/NGO health facilities and in Caprivi, Hardap, Kavango, Kunene, Ohangwena, Omaheke, Omusati, and Oshikoto regions.

There is considerable variation in the availability in growth monitoring services in the different facility types, among managing authorities, and by region. For example, only 56 percent of facilities in Erongo region report offering growth monitoring, compared with 100 percent in Caprivi region. There is relatively less variation in immunisation services by region; however, by facility type and managing authority, hospitals and private facilities are less likely than others to offer child immunisation services (Table 4.1).

Information on the frequency of the availability of child health services is shown in Table A-4.1. The majority of facilities offer each of the services five or more days per week, especially curative outpatient care for sick children, which practically all facilities offer five or more days a week.

On average, only two in every ten facilities offer any of the child services on an outreach basis (Table A-4.2). Health centres are most likely to offer these services on outreach. These outreach services are virtually unavailable in Caprivi and Khomas regions (each 0 percent) and are most likely to be offered in Oshana region (approximately 50 percent).

Key Findings

Availability of child health services: Eight of every ten facilities in Namibia offer all three basic child health services (curative outpatient care for sick children, growth monitoring, and childhood immunisation). Outpatient curative care is available in nine of every ten facilities, while growth monitoring and immunisation are each available in a little over eight of every ten facilities.

Facilities in Khomas and Erongo regions are least likely to offer all three basic child health services, whereas facilities in Caprivi and Kavango regions are most likely to provide these services.

4.3 Capacity to Provide Quality Immunisation Services

This section of the report addresses the following elements, which are important for quality immunisation services:

- Capacity to maintain the quality of vaccines
- Availability of vaccines and vitamin A
- Availability of equipment and supplies for vaccination sessions
- Availability of administrative components for monitoring immunisation activities

4.3.1 Capacity to Maintain the Quality of Vaccines

A lack of vaccine refrigerators, electricity, or other fuel (such as liquefied petroleum gas) are some of the reasons that facilities cannot or do not store vaccines. If a facility cannot maintain the cold chain and safely store vaccines, it must collect vaccines from a central location or a nearby facility with a refrigerator and then use mobile vaccine carriers and icepacks to maintain their temperature on the day(s) of service. The logistical considerations for maintaining the cold chain frequently result in limited

availability of vaccination services. Information on vaccine storage conditions, with details on elements assessed, is provided in Chapter 3, in Table 3.9, and in Table A-3.12.

Temperature monitoring is extremely important in ensuring potent and effective vaccines (WHO, 2000a; WHO, 2004a). Overall, only 60 percent of facilities with stored vaccines observed on the day of the assessment had an adequate cold chain monitoring system[3] in place, and 83 percent had an adequate vaccine stock[4] observed on the day of the survey (Chapter 3, Table 3.9, and Table A-3.12). Hospitals (32 percent), private facilities (22 percent), and facilities in Hardap (30 percent) and Khomas regions (33 percent) are among the least likely in each of their categories to have an adequate system to monitor vaccine storage temperature. Facilities in Ohangwena region (83 percent) and Omaheke region (79 percent) are most likely to have an adequate system to monitor vaccine storage temperature. Thus, facilities storing vaccines are more likely to have adequate systems to monitor vaccine stocks than to monitor vaccine temperature.

4.3.2 Availability of Vaccines and Vitamin A

The availability of child vaccines was assessed at eligible facilities (i.e., facilities that provide immunisation services and also report that they store vaccines). The findings are summarised in Table 4.2 and Figure 4.2. Additional information on vaccine and vitamin A availability by facility type, managing authority, and region is found in Table A-4.3.

The 2009 NHFC looked for evidence that facilities with vaccine storage capacity have all basic child vaccines and all components for providing quality child immunisation services.

Vaccines

All basic EPI vaccines for the seven major childhood diseases[5] are available in three-quarters of facilities that offer child immunisation services and also store vaccines; the individual vaccines were each available in between 84 percent (BCG) and 94 percent (DPT/pentavalent) of facilities that offer child immunisation services and store vaccines (Figure 4.2, Table 4.2, Table A-4.3).

There are variations by facility type, managing authority, and region in terms of availability of these vaccines. Compared with hospitals, health centres and clinics are more likely to have all basic child vaccines (59 percent of hospitals compared with 86 percent of health centres and 75 percent of clinics). Private facilities are much less likely to have all basic child vaccines (11 percent) than are mission/NGO (93 percent) and MoHSS (79 percent) facilities.

Vitamin A

Vitamin A is essential for the functioning of the immune system, for healthy growth and development, and for protection from respiratory infections and night blindness. Many countries have added vitamin A supplementation to their EPI programmes because WHO recommends routinely distributing high-dose vitamin A capsules to children. In Namibia the policy is to provide high-dose vitamin A once every six months, starting at age 9 months and continuing until age 59 months.

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[3] There must be a functioning thermometer in the vaccine refrigerator, an up-to-date temperature chart, and refrigerator temperature between 2° and 8°C at the time of assessment.
[4] No expired items present, and items stored by expiration date.
[5] Polio, diphtheria, whooping cough, tetanus, measles, tuberculosis, and hepatitis B.

According to findings of the assessment, vitamin A is widely available in health facilities in Namibia (93 percent), although private facilities are less likely to have vitamin A available in the same area with vaccines (26 percent) than are mission/NGO and MoHSS facilities, where vitamin A is universally available (Table A-4.3).

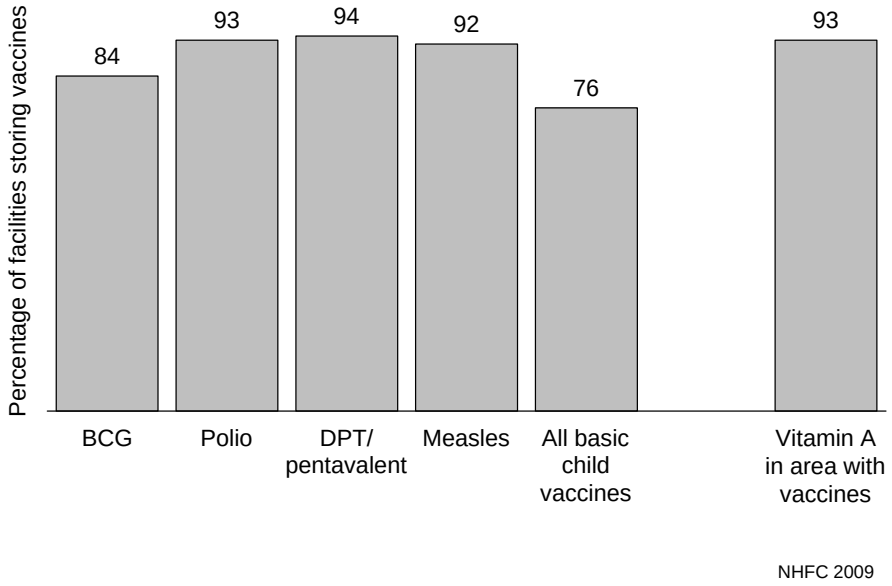
Table 4.2 Health system components required for childhood immunisation services

Among facilities offering child immunisation services, percentage that have all equipment, items for preventing infection, and records indicating good administrative practices and, among facilities offering child immunisation services and storing vaccines, percentage that have all basic child vaccines and all components for providing quality child immunisation services, by background characteristics, Namibia HFC 2009

	Percentage of facilities offering child immunisation with:					Percentage of facilities offering child immunisation services and storing vaccine with:		
Background characteristics	All equipment[1]	All items for infection control[2]	Administrative components[3]	All equipment, all items for infection control, and administrative components	Number of facilities offering child immunisation services[4]	All basic child vaccines[5]	All components for providing quality child immunisation services (including vaccines)	Number of facilities offering child immunisation services and storing vaccines
Type of facility								
Hospital	65	82	18	6	17	59	6	17
Health centre	79	49	65	28	43	86	28	43
Clinic	79	63	49	27	267	75	21	261
Managing authority								
MoHSS	82	61	52	27	279	79	21	275
Mission/NGO	70	59	56	33	27	93	33	27
Private	38	76	0	0	21	11	0	19
Region								
Caprivi	93	74	33	22	27	73	19	26
Erongo	70	65	55	30	20	33	11	18
Hardap	94	82	59	41	17	82	41	17
Karas	80	75	55	35	20	65	30	20
Kavango	79	84	54	43	56	75	32	56
Khomas	63	58	42	11	19	44	6	18
Kunene	83	92	29	21	24	71	17	24
Ohangwena	62	45	69	24	29	86	21	29
Omaheke	100	92	92	85	13	100	85	13
Omusati	80	52	41	9	44	81	7	43
Oshana	88	19	56	19	16	87	20	15
Oshikoto	86	33	38	10	21	95	10	21
Otjozondjupa	48	10	38	0	21	90	0	21
Total	78	62	49	26	327	76	21	321

[1] Blank immunisation cards, syringes and needles, and vaccine carriers with ice packs (or facility reports purchasing ice).
[2] Soap and running water or else hand disinfectant, latex gloves, sharps container, and decontaminant.
[3] Tally sheet or register where vaccines provided are recorded and documentation of either DPT/pentavalent dropout rate or measles coverage.
[4] Includes all facilities offering immunisations at the facility, some of which also offer immunisation services through village outreach activities.
[5] BCG, DPT/Pentavalent, polio, and measles vaccines.

Figure 4.2 **Availability of Vaccines among Facilities Offering Child Immunisation Services and Storing Vaccines (N=321)**



4.3.3 Availability of Equipment, Supplies, and Administrative Systems for Vaccination Sessions

Information on the availability of all the components assessed for quality immunisation services is provided in Table 4.2 and Figure 4.3. Details on the availability of items by facility type, managing authority, and region are available in Table A-4.4.

Overall, just one-fourth of facilities that offer immunisation services had all equipment, items for infection control, and administrative components for providing quality child immunisation services available on the day of the assessment. Health centres and clinics were relatively more likely to have all these items—28 percent and 27 percent, respectively, compared with only 6 percent of hospitals. None of the private facilities had all these items, primarily because they had lacked administrative components, while 27 percent of MoHSS and one-third of mission/NGO facilities had these items.

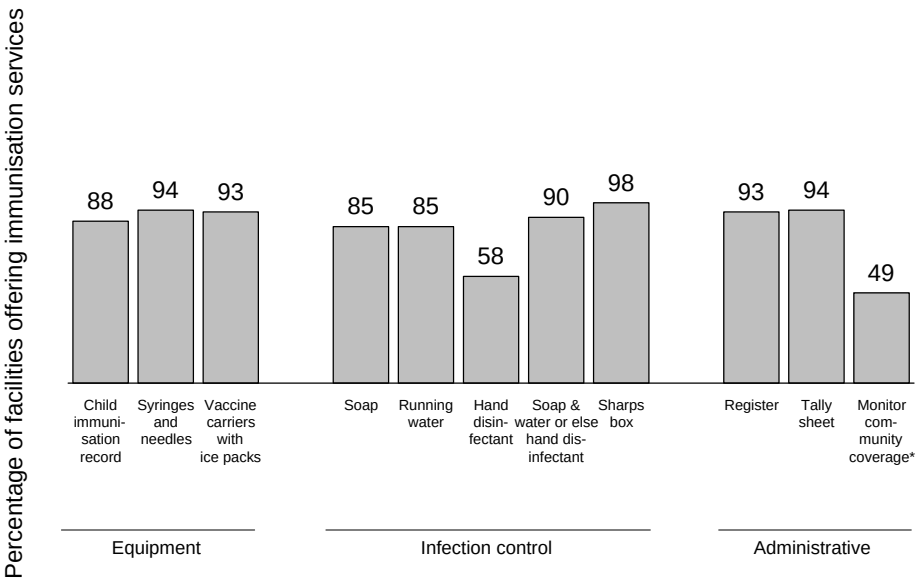
Equipment

Among facilities that offer child immunisation services, 78 percent had all the equipment[6] necessary to provide quality services (Table 4.2). MoHSS facilities are much more likely to have all equipment available (82 percent) than private facilities (38 percent). Similarly, facilities in Caprivi, Hardap, and Omaheke regions are much more likely than those in Otjozondjupa, at the opposite extreme (48 percent), to have all equipment (Table 4.2).

As for specific equipment, syringes and needles and vaccine carriers with ice packs were available at 94 and 93 percent of facilities, respectively, while blank immunisation cards were available at 88 percent of facilities (Table A-4.4).

[6] Blank immunisation cards, needles and syringes, and vaccine carriers with ice packs.

Figure 4.3 **Availability of Equipment and Supplies for Immunisation Services (N=327)**



* Measles coverage or DPT/pentavalent dropout rate is documented and was observed NHFC 2009

Infection control

Infection control is crucial to quality care during immunisations. Among facilities offering child immunisation services, 62 percent have all infection control items[7] (Table 4.2). Private health facilities are more likely to have all infection control items available (76 percent) than MoHSS and mission/NGO facilities (61 percent and 59 percent, respectively). Health facilities in Kunene and Omaheke (each 92 percent) are most likely to have all infection control items, while facilities in Otjozondjupa and Oshana (10 percent and 19 percent, respectively) are least likely to do so.

Looking at individual infection control items, sharps box, latex gloves, and either soap and water or else hand disinfectant were almost universally available in health facilities. Hand disinfectant was least likely to be available (58 percent) (Figure 4.2, Table A-4.4).

Administrative components

Measures often used for monitoring immunisation coverage include measles vaccine coverage rates and the pentavalent (DPT-HB + Hib) dropout rate—the difference between the number of children who receive the first dose of pentavalent vaccine (DPT-HB + Hib1) and the number who complete all three doses (DPT-HB + Hib3). Measures of immunisation coverage require an estimate of a target population, which the National Planning Commission/Central Bureau of Statistics provides based on projections of household census results. The 2009 NHFC specifically assessed whether DPT/pentavalent dropout rates or measles coverage information was readily available in Namibian health facilities.

Findings from the assessment indicate that, on the day of the assessment, half of facilities offering immunisation services had administrative components[8] for providing quality child immunisation services (Table 4.2). Health centres are more likely to have these administrative components available (65 percent)

[7] Soap and running water or else hand disinfectant, latex gloves, sharps container, and decontaminant.
[8] Tally sheets or registers where vaccines are recorded and documentation of either DPT/pentavalent dropout rate or measles coverage.

than other facility types. As indicated earlier, private facilities are lacking these administrative components when considered together, although the individual components of register and tally sheets are available in 38 percent and 19 percent of private facilities; monitoring of community coverage is the item missing in all private facilities (Table A-4.4). Facilities in Omaheke region are by far the most likely to have administrative components (92 percent), while facilities in Kunene region (29 percent) are the least likely (Table 4.2).

Key Findings

Vaccines: Three-quarters of facilities that offer child immunisation services and also store vaccines had all the basic child vaccines available on the day of the assessment. Nine of every ten facilities had vitamin A available in the area with other vaccines.

Equipment and supplies: About eight of every ten eligible facilities had all equipment for immunisations (syringes and needles, blank immunisation cards, and vaccine carriers with ice packs), and six in every ten had all infection control items available on the day of the assessment. Administrative components (tally sheets or registers, documentation of measles coverage or DPT/pentavalent dropout rates) were available in only half of eligible facilities.

4.4 Capacity to Provide Quality Outpatient Care for Sick Children

To improve the diagnosis of illnesses and to minimise missed opportunities in the provision of preventive interventions, IMCI standards recommend that any consultation for a sick child include:

- Assessing immunisation status and providing vaccines that are due
- Assessing nutritional status and counselling caretakers on identified problems
- Assessing overall health status
- Ensuring that the child receives the first dose of any prescribed medicine, including antibiotics, at the facility and leaves the facility with the necessary medications
- Ensuring that caretakers know how to administer medications and treatments, know how to treat local infections at home, know about appropriate foods, and know how much food the child needs both during this illness and when not sick
- Ensuring that caretakers know when to return, either because signs indicate that the child must be seen immediately or because of scheduled follow-up

The 2009 NHFC assessed the availability of equipment, supplies, and health system components necessary to adhere to IMCI guidelines and to support quality outpatient care for sick children (WHO, 1997; WHO, 1999). Assessed elements are as follows:

- Infrastructure and resources to support quality assessment and counselling
- Equipment and supplies for adhering to IMCI guidelines for assessment of the sick child
- Essential medicines for treating sick children in keeping with IMCI guidelines
- IMCI job aids, including the chart booklet, recording form, and mother/caretaker cards

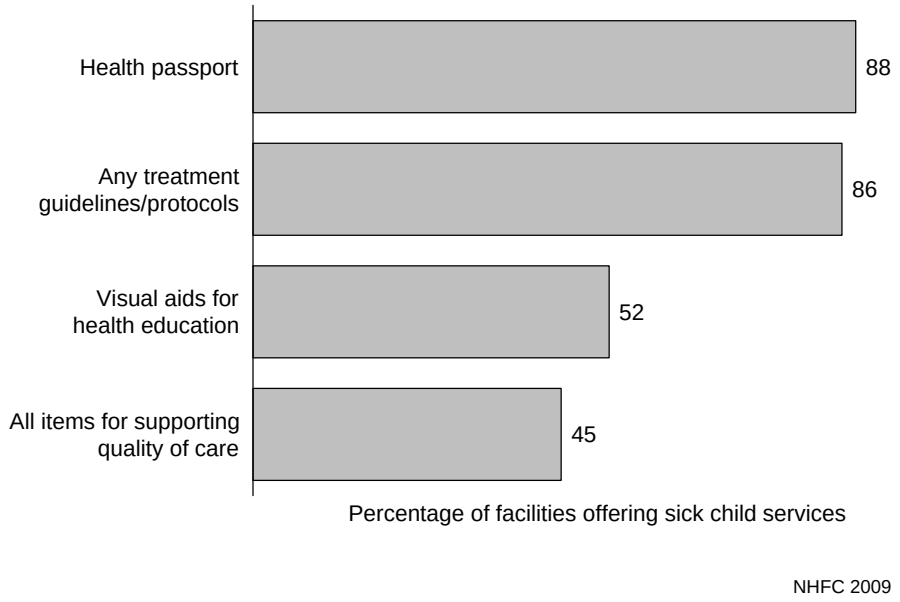
4.4.1 Infrastructure and Resources to Support Quality Assessment and Counselling for the Sick Child

To support quality assessment and counselling, ideally, the following should be readily available in areas where sick children receive services: items for infection control, including soap and running water or else hand disinfectant, sharps containers, and disinfectant; items to support quality services, such as individual child health cards; treatment guidelines and protocols; and visual aids. Figure 4.4 provides information on the availability of these items, with further details in Tables A-4.5 and A-4.6.

Treatment guidelines,[9] which are necessary for quick reference, are available in 86 percent of facilities offering sick child services (Figure 4.4). Health centres and clinics are more likely to have treatment guidelines than hospitals (Table A-4.5). MoHSS- and mission/NGO-managed facilities are more likely than private facilities to have treatment guidelines available. Individual child health passports, important for continuity of care, are available in 88 percent of all facilities, while visual aids are available in about half of facilities. All items to support quality child health services are available in only 45 percent of facilities offering sick child services.

The MoHSS is promoting IMCI nationwide; hence, items such as IMCI chart booklets, IMCI counselling cards for providers, IMCI mother cards, and other visual aids are expected to be widely available in health facilities. Findings of the 2009 NHFC, however, show that less than half of facilities offering curative care for sick children had IMCI chart booklets, less than one-third had IMCI counselling cards, only 8 percent had IMCI mother cards, and 36 percent had other visual aids available (Table A-4.6). IMCI chart booklets are more likely to be available in health centres (64 percent) than in other facility types. Facilities in Oshana region (88 percent) are more likely than those in other regions to have IMCI chart booklets.

Figure 4.4 **Availability of Items to Support Quality of Care for Sick Children (N=347)**



[9] Any treatment guidelines or protocols on the management of childhood illnesses, including guidelines on malaria.

4.4.2 Equipment and Supplies for Assessing and Providing Preventive Care for the Sick Child

The 2009 NHFC also assessed the availability of equipment and supplies necessary for evaluating the status of sick children and for providing preventive interventions, as established by IMCI guidelines. Figure 4.5 summarises information on these items. Table A-4.5 provides details by type of facility, and Table A-4.7 provides information on the availability of sick child and EPI services on the same day in the same facility.

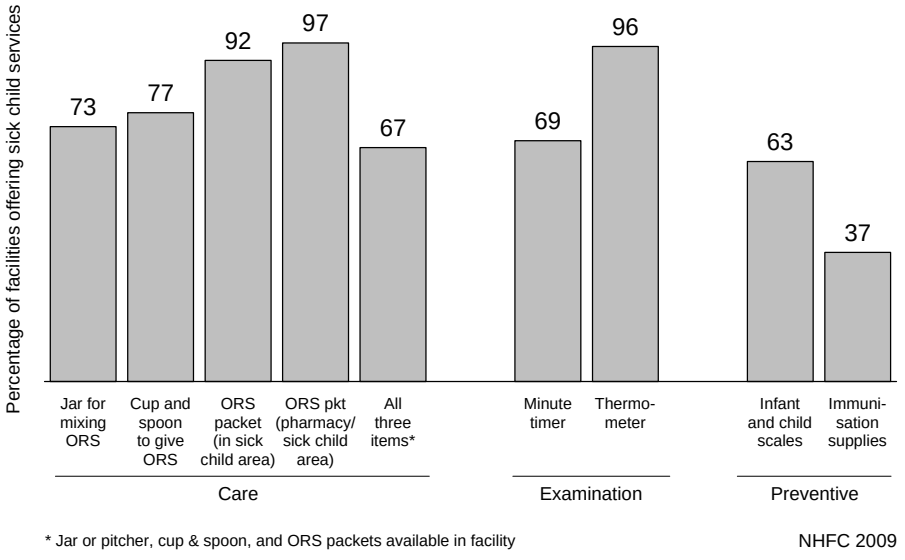
Approximately nine of every ten facilities report providing immunisation services every day that sick child services are offered; on the day of the assessment, a similar proportion of facilities were actually providing both services (Table A-4.7). Health centres and clinics are more likely than hospitals to offer EPI services on the same day that services for sick children are offered.

Overall, three-quarters of facilities offering sick child services had infants scales (100 gram gradations), while about eight of every ten had a scale for weighing older children (250 gram gradations). Only 63 percent had both types of scales (Figure 4.5, Table A-4.5).

Although a sick child can be assessed with little equipment, certain minimum equipment is considered to be necessary for good quality care. The 2009 NHFC assessed whether facilities had a thermometer, supplies and equipment for providing oral rehydration solution (ORS), and some type of minute timer for counting respiration rates. Thermometers and ORS packets were universally available, while timers (either a personal wristwatch or a facility-provided timer) were available in 69 percent of the facilities.

Overall, only 46 percent of facilities had all assessed equipment[10] at the service delivery point on the day of the assessment.

Figure 4.5 **Availability of Equipment and Supplies for Assessing Health Status and Management of the Sick Child (N=347)**



[10] Thermometer, timer, jar or pitcher for mixing ORS, cup and spoon for giving ORS, ORS packet.

4.4.3 Essential Medicines for Treating Sick Children

IMCI guidelines have defined first-line, pre-referral, and other important medications for managing a child's various illnesses. The 2009 NHFC assessed the availability of all these essential medicines. Summary information is provided in Table 4.3 and in Figures 4.6 through 4.8. Table A-4.8 provides details on available medicines by type of facility.

First-line medicines

First-line medicines include ORS packets, at least one oral antibiotic for respiratory infections, and first-line antimalarial medicine. All three first-line medicines are available in 75 percent of facilities; hospitals (93 percent) and mission/NGO-run facilities (85 percent) are more likely to have the first-line medicines than other facility types and managing authorities (Table 4.3, Figure 4.6, Table A-4.8). The oral antibiotic chloramphenicol is less widely available in Namibian facilities (13 percent in general, but available in 90 percent of hospitals) (Table A-4.8). Other first-line antibiotics (amoxicillin, augmentin and cotrimoxazole) are more widely available. The first-line antimalarial in Namibia is Coartem®, which is widely available (in 77 percent of facilities). Fansidar® (Sulfadoxine and Pyrimethamine) is available in also available in 74 percent of facilities. Since malaria is a problem only in certain regions of the country, facilities in some regions may not stock these medicines.

Pre-referral medicines

Pre-referral medicines[11] include emergency injectable medications and intravenous solution with a perfusion set; these allow for urgent treatment and rehydration before either admitting a sick child or referring a sick child to another facility, if necessary. It should be noted that MoHSS policy authorises hospitals, health centres, and clinics to provide rapid rehydration for severely dehydrated children using intravenous solutions.

The 2009 NHFC assessed health facilities for whether they had all pre-referral medicines available on the day of the visit. About three-quarters of facilities offering outpatient curative care for sick children had all pre-referral medicines (Table 4.3, Figure 4.7, Table A-4.8). All hospitals and the majority of health centres and clinics had all pre-referral medicines. Private facilities (29 percent) were less likely to have pre-referral medicines available than facilities managed by other authorities. There is some regional variation in the availability of pre-referral medicines; only 45 percent of facilities in Karas had pre-referral medicines available compared with 92 percent of facilities in Otjozondjupa and 93 percent of facilities in Caprivi. Penicillin is the most common pre-referral medicine available (85 percent of facilities), while only 10 percent of facilities had injectable chloramphenicol. Almost all facilities assessed (94 percent) had intravenous solution with perfusion sets (Figure 4.7).

Other essential medicines and vitamin A

Some other medicines are less crucial for treating serious illness but nonetheless are important for managing common symptoms and illnesses. These include fever-reducing medicines (paracetamol or aspirin), vitamin A, iron tablets or supplements, antibiotic eye ointment, and de-worming medicines (mebendazole or albendazole). Only 12 percent of health facilities nationally had all of these other essential medicines, ranging from zero percent of facilities in Erongo region to 27 percent of facilities in Omaheke region (Table 4.3, Figure 4.8, Table A-4.8). Aspirin or paracetamol, vitamin A, and either mebendazole or albendazole were widely available in facilities. In contrast, iron tablets were available in only 15 percent of all health facilities (Table A-4.8). This is of major concern because of the importance of iron in treating anaemia both in sick children and in pregnant women.

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[11] All pre-referral medicines means: having at least one first-line injectable antibiotic (chloramphenicol, ampicillin, cloxacillin, or penicillin); at least one second-line injectable antibiotic (ceftriaxone or gentamycin); and intravenous solution (normal saline, lactated Ringer's solution, or else dextrose and saline 0.9 percent) with a perfusion set.

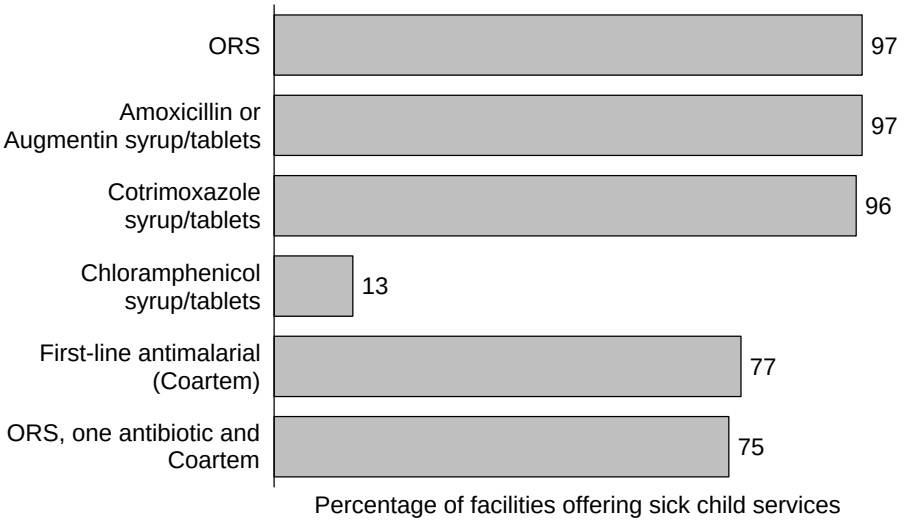
Table 4.3 Medicines and supplies to support quality care for sick children

Percentage of facilities offering sick child services that have first-line, pre-referral, and other medicines and supplies, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities with: First line medicines[1]	Pre-referral medicines[2]	All other medicines[3]	Number of facilities offering curative outpatient care for sick children
Type of facility				
Hospital	93	100	21	29
Health centre	84	80	11	45
Clinic	72	70	11	273
Managing authority				
MoHSS	78	76	12	299
Mission/NGO	85	81	11	27
Private	29	29	10	21
Region				
Caprivi	96	93	4	27
Erongo	55	82	0	22
Hardap	45	80	10	20
Karas	55	45	10	20
Kavango	91	79	16	56
Khomas	58	53	11	19
Kunene	70	74	4	27
Ohangwena	88	72	9	32
Omaheke	80	87	27	15
Omusati	72	60	9	47
Oshana	56	69	19	16
Oshikoto	95	77	23	22
Otjozondjupa	75	92	25	24
Total	75	74	12	347

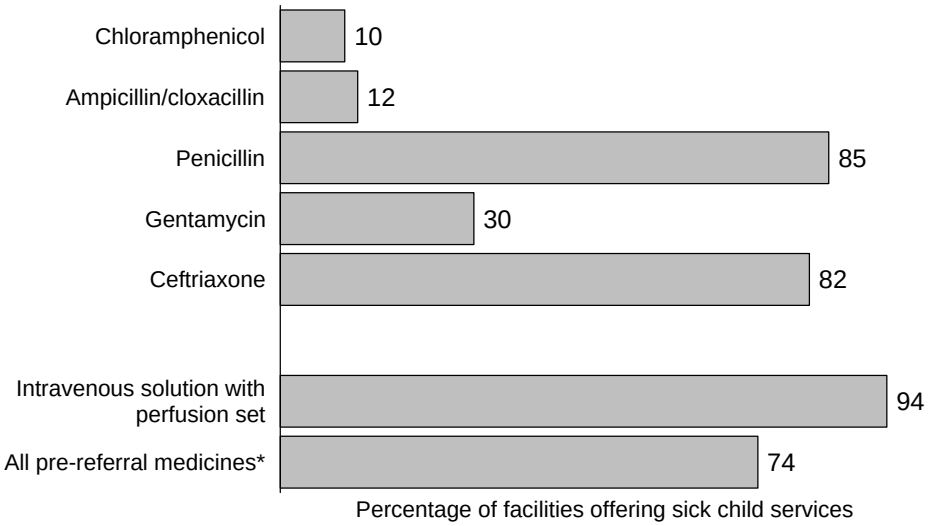
[1] ORS, Coartem, and at least one oral antibiotic (amoxicillin, amoxicillin clavulinate, cotrimoxazole, or chloramphenicol).
[2] (1) Injectable chloramphenicol or at least one first-line injectable antibiotic (ampicillin or cloxacillin or penicillin), and (2) at least one second-line injectable antibiotic (ceftriaxone or gentamycin), and (3) intravenous solution (normal saline (0.9% NS), or dextrose and normal saline (5% D/NS) or lactated Ringer's solution or plasma expanders or 5% D/W), with perfusion set and sterile syringes.
[3] Aspirin or paracetamol, vitamin A, iron tablets, mebendazole or albendazole, and an antibiotic eye ointment.

Figure 4.6 Availability of First-line Medicines for Treating Sick Children (N=347)



NHFC 2009

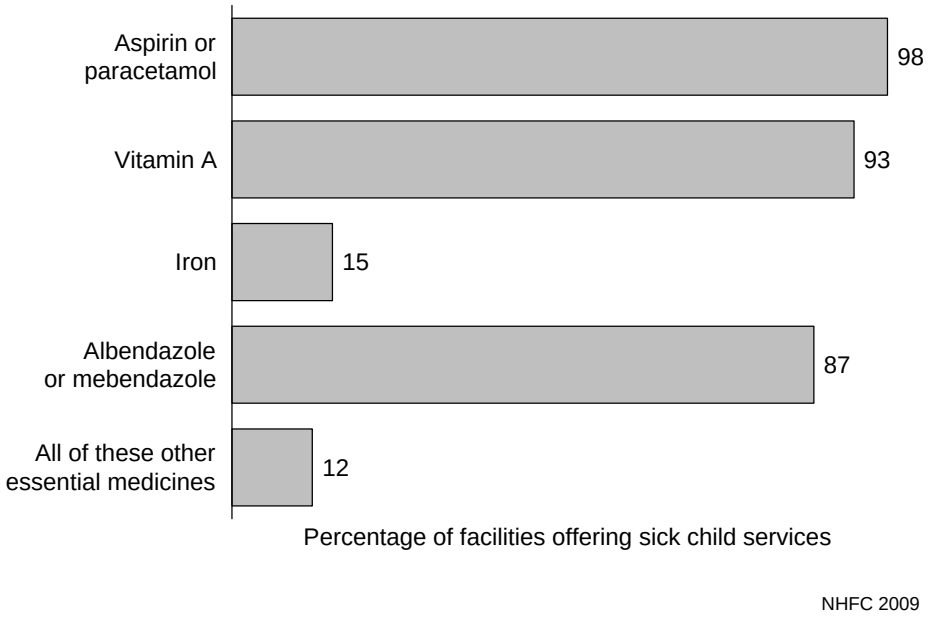
Figure 4.7 Availability of Pre-referral Injectable Medicines (N=347)



* Injectable chloramphenicol or ampicillin or cloxacillin or penicillin, and either gentamycin or Ceftriaxone, and intravenous solution with perfusion set.

NHFC 2009

Figure 4.8 **Availability of Other Essential Medicines (N=347)**



Key Findings

First-line medicines: IMCI first-line medicines are available in three-quarters of facilities offering outpatient curative care services for sick children; pre-referral medicines are available in a similar proportion of facilities. Hospitals are more likely to have these medicines than other facility types.

Among regions the availability of first-line medicines ranges from a high of 96 percent of facilities in Caprivi region to a low of 45 percent of facilities in Hardap. Similar regional variation exists for pre-referral medicines.

4.5 Management Practices Supportive of Quality Sick Child Services

Management practices that support quality curative care for sick children include documentation and record-keeping, practices related to user fees, and staff supervision and development. Summary information on the availability of these items is presented in Table 4.4. Table A-4.9 provides sick child client utilisation statistics, and Tables A-4.10 and A-4.11 provide more details on fees and other payment systems. Figure 4.9 summarises information on training received by child health service providers, while Tables A-4.12 through A-4.15 provide details on training and supervision from the perspective of the child health service provider.

Table 4.4 Management practices supportive of quality child health services

Percentage of facilities offering curative outpatient care for sick children that have an up-to-date client register and charge user fees for sick child services, and percentage where health service providers report receiving routine training related to their work and personal supervision, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities offering curative outpatient care for sick children with:		Number of facilities offering curative outpatient care for sick children	Percentage of facilities where child health service providers report receiving routine:		Number of facilities with interviewed child health service providers
	Up-to-date patient register[1]	User fees for sick child services		Training related to child health[2]	Personal supervision[3]	
Type of facility						
Hospital	86	100	29	17	90	29
Health centre	84	98	45	36	89	45
Clinic	85	99	273	30	77	272
Managing authority						
MoHSS	89	99	299	29	80	298
Mission/NGO	81	100	27	26	96	27
Private	33	95	21	43	57	21
Region						
Caprivi	81	96	27	23	77	26
Erongo	95	100	22	23	82	22
Hardap	70	100	20	10	80	20
Karas	85	100	20	30	95	20
Kavango	77	100	56	32	79	56
Khomas	68	100	19	42	63	19
Kunene	85	100	27	15	67	27
Ohangwena	91	100	32	13	88	32
Omaheke	100	100	15	47	100	15
Omusati	94	96	47	36	89	47
Oshana	81	100	16	81	94	16
Oshikoto	86	100	22	41	86	22
Otjozondjupa	92	92	24	13	42	24
Total	85	99	347	29	80	346

[1] Register has entry within past seven days that indicates child's age and diagnosis or symptom.
[2] A facility has routine staff training if at least half of interviewed providers reported that they had received pre- or in-service training related to their work during the 12 months preceding the survey. This refers to structured training sessions and does not include individual instruction received during routine supervision.
[3] A facility has routine staff supervision if at least half of interviewed providers reported that they had been personally supervised at least once during the six months preceding the survey.

4.5.1 Facility Documentation and Records

An up-to-date register is defined as a register that has an entry within the past seven days that indicates the child's age and diagnosis (or the symptoms) for which the child was brought to the facility. Eighty-five percent of facilities providing outpatient curative care for sick children have up-to-date registers (Table 4.4). There is little variation among the types of health facilities; in contrast, among management authorities, private facilities (33 percent) are less likely than MoHSS (89 percent) and mission/NGO (81 percent) facilities to have up-to-date registers. By region, availability of up-to-date registers range from 68 percent in Khomas region to 100 percent in Omaheke region; this could be due to the fact that there is a higher proportion of private facilities in Khomas region (Table 4.4).

4.5.2 Practices Related to User Fees

User fees may have a positive effect on health services by increasing the funds available to the facility, if the revenue is channelled back to the facility. On the flip side, they may have a negative effect on utilisation by deterring poor clients from using services. This is of major concern in Namibia, a country with high levels of poverty. In any case, posting user fees in facilities that charge fees is an element of quality of care, since it increases accountability and makes clients aware of costs associated with services.

In Namibia MoHSS policy is to charge user fees for all services except preventive services (antenatal care, prevention of mother-to-child transmission of HIV, HIV counselling and testing, postnatal care, family planning, and immunisation). Exemptions are offered for senior citizens and vulnerable groups (such as people with disabilities, orphans, and vulnerable children). Services should not be denied to patients who cannot afford the fees.

In line with the MoHSS policy on user fees, 99 percent of facilities offering sick child services charge some form of user fee for sick child services (Table 4.4). Fifty-eight percent of facilities charge for consultations, 20 percent charge for medicines and client charts or records, 23 percent charge for client registration, and 3 percent charge for laboratory tests (Table A-4.10).

Among facilities charging user fees for sick child services, 70 percent do not post any fees at all (Table A-4.10); only one-quarter post all fees; and 3 percent post only some fees. Hospitals (52 percent) and private facilities (40 percent) are most likely to display all user fees.

Discounts or fee exemptions are not common. Only half of facilities offering sick child services and charging any user fees offer discounts or exemptions to clients (Table A-4.10). When asked what the standard practice is if a child is unable to pay for the services for which fees are accessed, 6 of 10 facilities that charge user fees said they exempt the fee and provide the service, but expect payment later (data not shown). Only 3 percent report that they will not provide the service if a client is unable to pay; these are mostly private facilities (25 percent) and facilities in Khomas (21 percent).

Caretakers of sick children were interviewed as they left the facility after receiving services. Among other things, they were asked whether they belonged to any pre-payment schemes and whether they paid any fees for the services they received. Among interviewed caretakers, 84 percent of those who did not belong to any programme paid out-of-pocket fees, compared with only 4 percent of those belonging to a pre-payment scheme (Table A-4.11).

4.5.3 Training and Supervision

Training

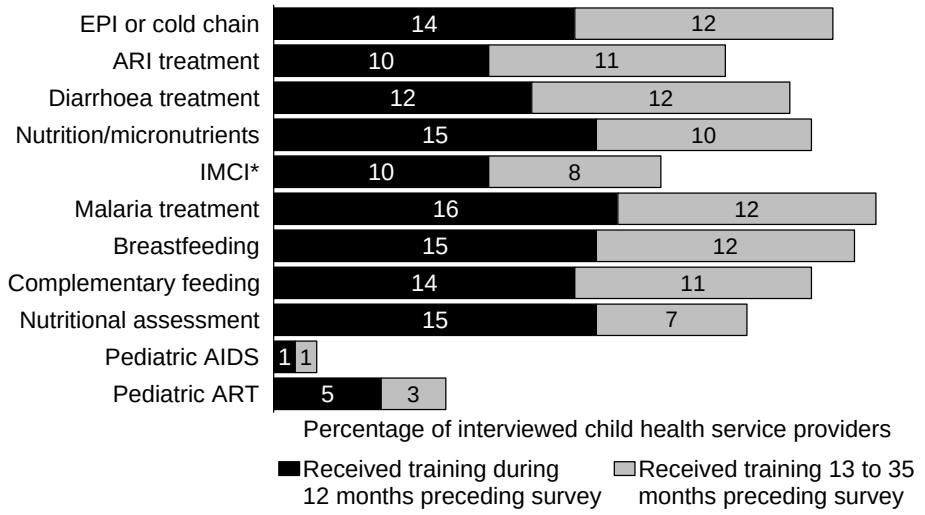
The 2009 NHFC considers a facility to have routine staff training or staff development if at least half of interviewed providers report receiving pre- or in-service training related to their work during the 12 months preceding the survey. The training must be structured and classroom-based; individualised or one-on-one instruction received during supervision does not count.

By this definition, only three of every ten facilities that offer services for sick children qualify as providing routine staff training. Clinics and health centres (30 and 36 percent, respectively) as well as private facilities (43 percent) are most likely to provide routine staff training (Table 4.4). Among regions eight of every ten facilities in Oshana region meet the criteria for offering routine staff training compared with, at the other extreme, only one in every ten facilities in Hardap.

Of interviewed child health service providers, 32 percent report receiving structured training related to their work during the 12 months preceding the survey (Table A-4.12). Health service providers in Oshana region (73 percent) are most likely to have received training during the 12 months preceding the survey, compared with only 15 percent of health service providers in Kunene and Hardap at the other end of the range.

Regarding specific training topics, 14 percent of interviewed child health service providers report receiving training in the preceding 12 months in EPI/cold chain; 10 percent received recent training in acute respiratory infection (ARI) treatment; and 15 percent received recent training in nutrition/ micronutrient deficiencies (Figure 4.9). Additional training information is provided in Tables A-4.13 and A-4.14.

Figure 4.9 **Training Received by Interviewed Child Health Service Providers, by Topic and Timing of Most Recent Training (N=919)**



* Integrated Management of Childhood Illness

NHFC 2009

Supervision

If at least half of interviewed service providers at a facility report having been personally supervised at some time during the six months preceding the survey, the facility is considered to have routine staff supervision. Overall, 80 percent of facilities meet this criterion. Hospitals (90 percent) and health centres (89 percent) are more likely than clinics (77 percent) to have routine staff supervision (Table 4.4). In addition, MoHSS- and mission/NGO-managed facilities are more likely than private facilities to have routine staff supervision. There is some regional variation; over 90 percent of facilities in Karas, Omaheke, and Oshana regions have routine supervision, while only 42 percent of facilities in Otjozondjupa do.

Among interviewed child health service providers, seven of every ten said that they had been personally supervised during the six months preceding the assessment (Table A-4.12). Among those who had been supervised, the reported median number of times supervised during the six months preceding the assessment was three (Table A-4.15).

Key Findings

Client registers: A little more than eight of every ten facilities providing outpatient curative care for sick children have up-to-date client registers; private facilities are less likely than facilities managed by other authorities to have up-to-date registers.

User fees: All Namibian health facilities providing services for sick children charge some type of user fees, with the largest percentage (58 percent) charging for client consultations. Among facilities charging user fees, only one-quarter display all fees. Discounts and exemptions are not common.

Training and supervision: Only three of every ten facilities meet the criteria for providing routine staff training, while eight of every ten facilities meet the criteria for routine staff supervision.

4.6 ADHERENCE TO GUIDELINES FOR SICK CHILD SERVICE PROVISION

To assess whether providers adhere to standards for quality services, the 2009 NHFC observed sick child consultations using checklists based on IMCI guidelines. Observers noted what information the provider shared and whether recommended procedures were carried out. Table 4.5 summarises providers' assessments, examinations, and subsequent treatments, classified by diagnosis or major symptoms. Figures 4.10 through 4.14 show what practices were observed during sick child consultations. Tables A-4.16 through A-4.22 provide details on observed practices and on information reported by caretakers during interviews.

4.6.1 Full Assessment of Illnesses

When there are not enough qualified[12] curative care providers, less qualified persons can be trained to provide EPI and growth monitoring services as well as initial consultation services for sick children. This assumes, however, that seriously ill children, with illnesses beyond the scope of these staff members' training, will be identified and referred to an appropriately trained provider. Hence, it is important to know how many facilities depend on referral systems for the management of severe illnesses. As documented elsewhere in this report (Chapter 3), 98 percent of all facilities in Namibia have at least one qualified health provider assigned to the facility (Figure 3.1).

The IMCI strategy in Namibia was introduced in 1999, with the main focus on facility-based IMCI. Later in the same year the focus was expanded to household and community IMCI. The IMCI strategy is implemented in 20 of the 34 health districts in Namibia (MoHSS, 2009b). IMCI protocols for assessing a sick child provide valid guidelines for provision of quality services, regardless of whether a provider has been trained in the IMCI strategy or not.

IMCI general danger signs

According to IMCI guidelines, providers should check for the following general danger signs whenever assessing a sick child: whether the child is unable to eat or drink, whether the child vomits everything, whether the child has had febrile convulsions at home or a convulsion is observed in the facility, and whether the child is lethargic or unconscious.[13] If there is any doubt about the child's ability to drink, the provider should attempt to give the child something orally. Overall, only 12 percent of observed sick children were assessed for all three general danger signs (Table 4.5). In general, 44 percent were assessed for whether they could eat or drink anything (including breastfeeding), 50 percent for whether they vomited everything, and 18 percent for convulsions (Figure 4.10, Table A-4.16).

[12] Qualified health care provider (Namibia specific) includes specialists (including surgeons, obstetrician/gynaecologists, paediatricians, physician specialists and pathologists), medical officers, medical assistants, enrolled nurse/midwives, and registered nurse/midwives.

[13] Assessment for lethargy is not a part of the observation checklist because there is often not an observable component for this assessment.

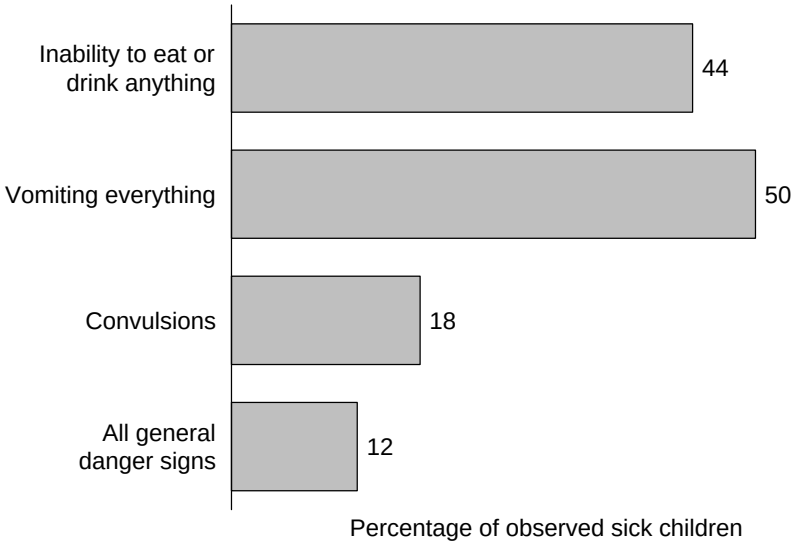
Table 4.5 Assessments, examinations, and treatment of children, classified by diagnosis or major symptom

Percentage of observed children diagnosed by the provider with the indicated illness or symptom for whom the indicated IMCI assessment, physical examination, and/or treatment was provided, Namibia HFC 2009

	Respiratory illness			Febrile illness			Intestinal illness				
Item	Pneumonia or bronchial pneumonia	Bronchial spasm/ asthma	Cough or other upper respiratory illness	Fever	Measles	Malaria	(Any diarrhoea or dysentery) with dehydration	(Any diarrhoea or dysentery) without dehydration	Any ear infection	Any throat diagnosis	All observed children
IMCI assessment											
Three main symptoms[1]	63	39	48	49	59	50	70	68	51	30	49
Three general danger signs[2]	22	0	11	16	30	26	29	10	13	16	12
Current eating or drinking habits	64	27	48	68	59	57	78	55	53	47	51
Advise continued feeding and increased food or fluids	31	13	18	37	59	33	49	26	22	30	20
Physical exam											
Temperature	100	100	100	100	100	100	100	100	98	98	100
Respiratory rate	67	56	39	53	0	42	46	34	36	45	40
Dehydration	40	17	24	31	0	27	82	58	18	17	28
Anaemia	56	16	36	33	30	31	53	35	45	33	38
Ear	17	0	10	10	0	10	17	10	43	20	12
Oedema	19	0	7	12	0	14	16	8	13	9	8
Body muscle	46	16	25	39	30	28	40	24	36	21	28
Referred for any lab test	3	0	1	1	0	2	3	1	7	0	2
Treatment											
Refer/admit	24	47	7	13	100	4	42	8	14	1	11
Any antibiotic	86	82	83	81	30	71	61	76	82	96	75
Injectable antibiotic	4	0	0	0	0	0	0	0	0	1	1
Oral antibiotic	82	82	83	81	30	71	61	76	82	95	75
First line antimalarial[3]	2	0	5	15	0	51	9	5	2	8	4
Any antimalarial[4]	4	0	10	19	0	87	15	8	5	9	8
Oral antimalarial	4	0	10	18	0	85	15	7	5	9	8
Injectable antimalarial	0	0	0	1	0	2	0	1	0	0	0
Oral bronchodilator	0	6	1	1	0	0	2	0	2	4	1
Oral medication for symptomatic treatment[5]	80	87	92	90	30	93	64	83	90	96	87
Oral rehydration (ORS)	23	0	22	31	30	33	74	83	17	20	26
Intravenous fluid	2	0	1	1	0	0	20	0	0	1	1
Described signs or symptoms for immediately seeking help	48	5	31	41	0	29	39	30	37	35	33
Discussed follow-up visit	70	51	50	60	0	60	49	51	68	50	54
Number of children[6]	123	13	815	214	2	126	53	278	50	59	1,544

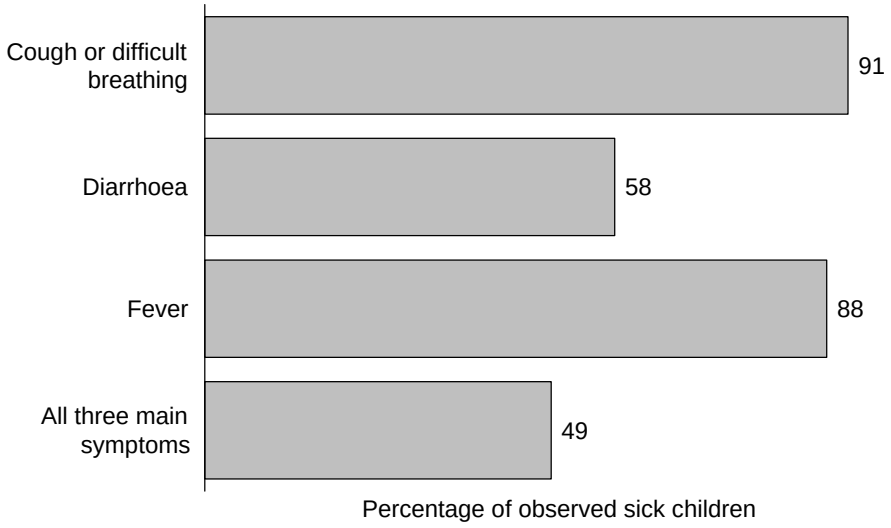
[1] The three IMCI main symptoms are: cough/difficult breathing, diarrhoea, and fever.
[2] The three IMCI general danger signs are: inability to eat/drink, vomiting everything, and febrile convulsions.
[3] First-line antimalarial is Coartem.
[4] "Any antimalarial" refers to either first-line or to artesunate, amodiaquine, and Fansidar given not as a combination, or to other antimalarial not recommended by the MoHSS, such as chloroquine.
[5] This may be an antipyretic, cough medicine, or other general treatment for symptoms.
[6] Child may be classified by more than one diagnosis, therefore the number of children in the individual columns may add up to more than 1,544.

Figure 4.10 **Danger Signs Assessed during Observed Sick Child Consultations (N=1,544)**



NHFC 2009

Figure 4.11 **Main Symptoms Assessed during Observed Sick Child Consultations (N=1,544)**



NHFC 2009

Figure 4.12 **Elements of Physical Examination Conducted during Observed Sick Child Consultations (N=1,544)**

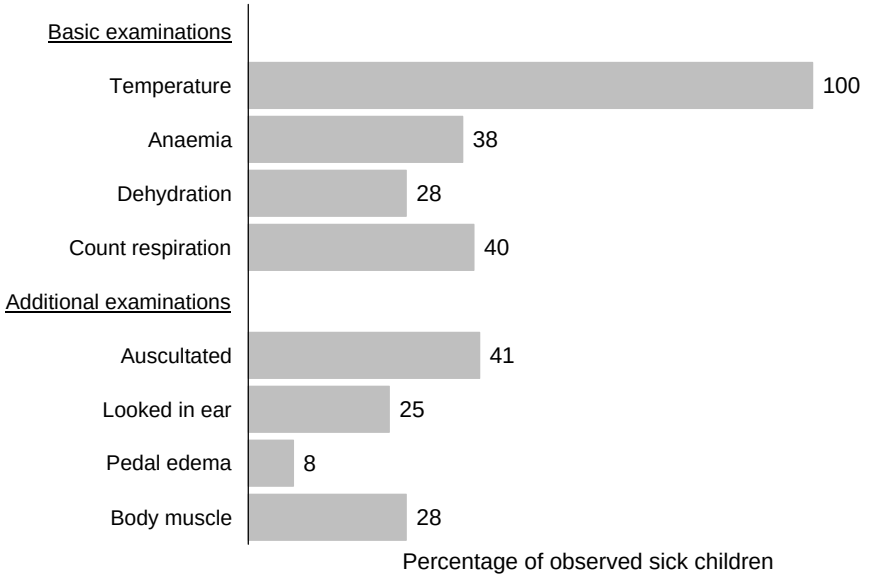


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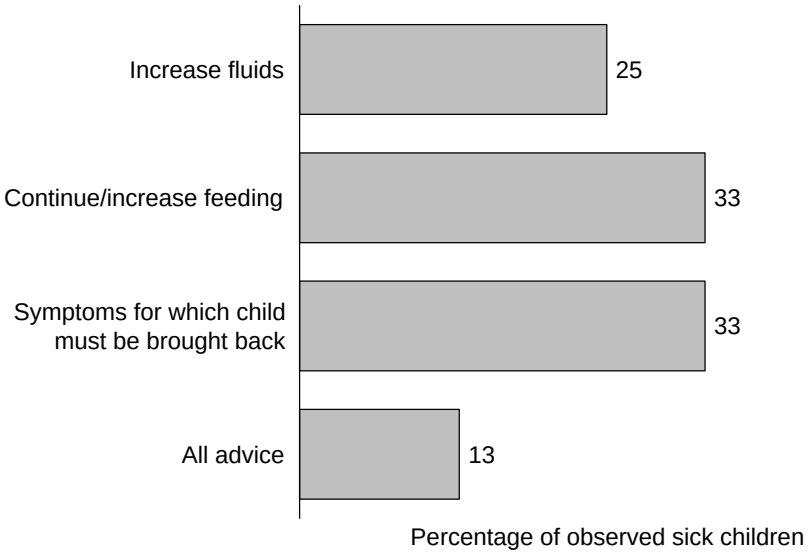
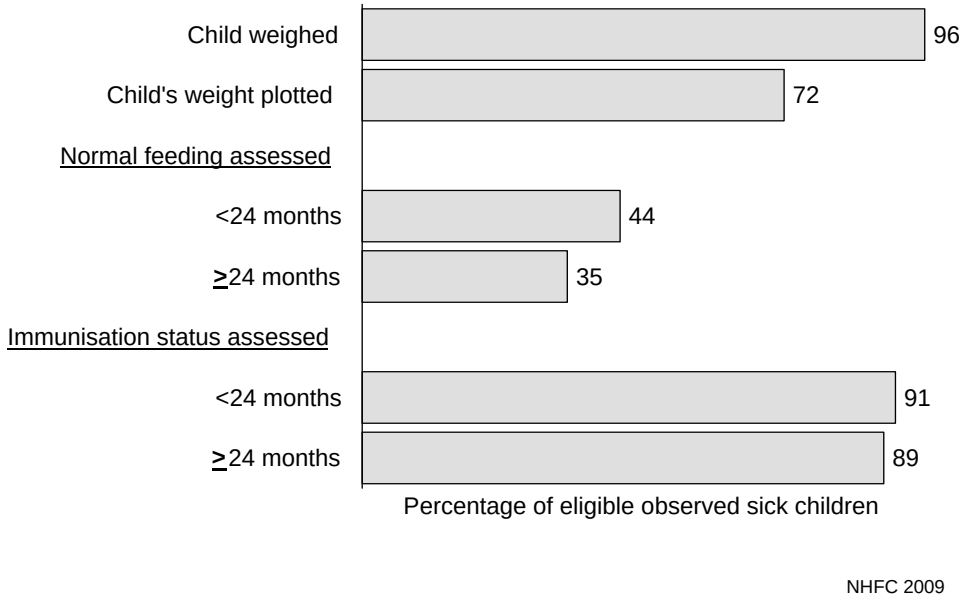
Figure 4.13 **Essential Advice Provided to Caretakers of Observed Sick Children (N=1,544)**



NHFC 2009

Figure 4.14 **Observed Preventive Assessments of Sick Children (<24 months N=924; ≥24 months N=620)**



IMCI main signs and symptoms

IMCI guidelines call for each child to be evaluated for three main symptoms—cough or difficulty breathing, diarrhoea, and fever—regardless of the reason for the consultation. This information may be shared when the child's caretaker discusses the reason for the visit or, if it is not spontaneously mentioned, the provider may probe for symptoms.

Providers assessed all three main symptoms for half of all observed sick children (Table 4.5, Figure 4.11, Table A-4.16). Fever and respiratory symptoms were the symptoms most commonly assessed (for 88 and 91 percent, respectively, of all sick children) (Table A-4.16). Diarrhoea was assessed in six of every ten sick children. One in every four sick child was assessed for ear pain and/or discharge, another common childhood condition (Table A-4.16).

Physical examination

After obtaining information on the various signs and symptoms of illness, the provider should conduct a physical examination. This should include a hands-on evaluation of the child to (1) verify the presence or absence of fever, by touch or by measuring the child's temperature; (2) assess the state of dehydration by pinching the skin; (3) visually check if the child has anaemia by looking at the palms, conjunctiva, or mouth; and (4) count the rate of respirations if a respiratory problem is suspected.

Providers carried out all four of these evaluations during only one of every ten observed sick child consultations (Table A-4.16). The one universal physical examination was the checking of temperature (Figure 4.12). Respiratory rate was counted for 40 percent of all observed sick children. Only 28 percent of sick children were evaluated for dehydration.

Looking inside the ear and feeling behind the ear was done for 25 percent of observed sick children. Pedal oedema was rarely assessed (8 percent of consultations). Musculature and general nutritional and physical status were assessed in approximately three of every ten consultations. Additional information on physical examinations appears in Table A-4.16.

Assessment of feeding during illness

There is a direct relationship between nutritional status and health. It is not uncommon for a child to be caught in a cycle of malnutrition and illness, in which malnutrition makes a child more susceptible to illness, and the illness contributes to further malnutrition. Aggravating this cycle is the tendency for sick children to eat and drink less. It is also not uncommon for caretakers to limit a sick child's consumption of food and liquids.

During observed sick child consultations, providers asked about normal feeding practices (that is, when the child is not sick) in about four of every ten consultations, regardless of the age of the child (Table A-4.19). This assessment was least common in health centres, where only 26 percent of observed sick children were assessed. By comparison, in hospitals 53 percent of sick children's caretakers were asked about normal feeding, and in clinics 36 percent were asked.

Essential advice to caretakers

According to the IMCI strategy, a sick child's caretaker should receive the following essential advice before leaving the health facility: (1) give the sick child extra fluids during the illness; (2) continue to feed the sick child; and (3) watch for signs and symptoms indicating that the child should be taken immediately to a health care provider.

Findings varied from one facility type to another; however, overall, providers offered caretakers of sick children all three elements of the essential advice during only 13 percent of observed consultations (Figure 4.13, Table A-4.16).

4.6.2 Classification-Specific Assessments and Treatments

At the end of each sick child consultation, providers were asked about the child's diagnosis or major symptoms for which the child was seen at the facility that day, and the treatment prescribed, if any.[14] IMCI guidelines indicate specific symptoms or diagnoses for which antibiotics should be prescribed or for which children should be admitted to the facility or referred to a higher level of care.

Although a simple observation does not provide enough information to determine the appropriateness of diagnosis and treatment, certain interventions can reasonably be expected for a given diagnosis. It is important to note that the 2009 NHFC did not evaluate the appropriateness of providers' specific actions.

Some 11 percent of sick children were either admitted or referred to see another provider (Table 4.5).

Respiratory illness

Providers should thoroughly examine children with severe respiratory illnesses and hospitalise if indicated. In most of these cases, recourse to antibiotics is warranted.

Temperature was checked in all children who were eventually diagnosed with pneumonia; respiratory rate was checked in two-thirds of all children diagnosed with pneumonia (Table 4.5). Overall, one-quarter of children diagnosed with pneumonia were either referred or hospitalised, and 86 percent were put on an oral or injectable antibiotic (Table 4.5).

[14] A sick child may be classified with more than one diagnosis.

All children diagnosed with cough or other upper respiratory illness had their temperatures checked, and 83 percent were put on antibiotics (Table 4.5). With antibiotic resistance growing worldwide, rational use of antibiotics should be encouraged to ensure that these drugs are not overused.

Fever

For children with severe febrile illness, IMCI guidelines recommend the use of an antipyretic and an antimalarial if the child tests malaria-positive on a rapid diagnostic test (RDT), followed by referral to appropriate facilities for further treatment.[15] All children diagnosed with fever, malaria, and/or measles had their temperatures taken (Table 4.5). Thirteen percent of children diagnosed with fever were either referred or admitted, and 81 percent were given some form of antibiotic. Nineteen percent received an antimalarial, albeit only 15 percent got the first-line antimalarial. Ninety percent received medication for symptomatic treatment (an antipyretic, cough medicine, or other general treatments for symptoms).

Malaria

Among children diagnosed with malaria, half were assessed for all three IMCI main symptoms, and one-quarter were assessed for all three IMCI general danger signs. Temperature was assessed for all, and anaemia in about one-third. Overall, 87 percent received some form of antimalarial medicine, although only half got the first-line treatment of Coartem®. Seven of every ten received an antibiotic, while 93 percent received oral medication for symptomatic treatment (Table 4.5).

Diarrhoea

There were two categories of diagnoses: (1) any diarrhoea or dysentery, with dehydration; and (2) any diarrhoea or dysentery, without dehydration. Eight of every ten children in the first category were evaluated for dehydration, compared with six of every ten children in the second category. The findings suggest that a good number of observed children were diagnosed as dehydrated (or not dehydrated) without the provider actually checking. Forty-two percent of children in the first category were either admitted or referred, compared with one in every ten children in the second category (Table 4.5).

Sixty-one percent of children in the first category and 76 percent in the second category were given antibiotics. These high rates are of concern because using antibiotics inappropriately can prolong the episode and ultimately lead to drug resistance. These findings further indicate that antibiotics may be over-prescribed in Namibia. Oral rehydration salts (ORS) were prescribed for 74 percent of children in the first category (diarrhoea or dysentery, with dehydration), and 20 percent received intravenous fluids. Eighty-three percent of children in the second category were prescribed ORS.

Overall adherence to standards

From this brief review, it appears that the type of physical examination conducted, the treatment provided (including referrals), as well as assessments of main symptoms and danger signs, and advice regarding eating and drinking during illness do not vary appropriately with the type and severity of illness or diagnosis.

4.6.3 Other Observed Practices

IMCI guidelines recommend that the first dose of any prescribed medicine, particularly antibiotics, should be administered at the facility so that treatment can begin immediately. This practice also provides an opportunity to emphasize the correct dosage to the caretaker and to ensure that the child

[15] At the time of the 2009 NHFC data collection, the IMCI guidelines and the 2005 Namibia National Malaria Policy recommended diagnoses of malaria based on symptoms and suggested use of RDT only where applicable, that is, at the hospital level.

is able to take the medicine. Among observed sick children who were prescribed or provided oral medicines, 42 percent were observed to receive the first dose at the facility (Table A-4.18). This practice was generally uncommon across all facility types.

Practically all caretakers of sick children (95 percent) were told or instructed by providers how to administer medicine at home; however, only 17 percent of caretakers were asked to repeat the instructions to ensure that they understood them (Table A-4.18). Caretakers in health centres and clinics (each 97 percent) were more likely than those in hospitals (57 percent) to be told or instructed how to administer the medicine.

During exit interviews with caretakers of sick children who received medicine and/or prescription for home treatment, 96 percent reported being told or instructed by a provider how to administer the medicine at home; these caretakers also said they felt comfortable that they knew how to provide the medicine to the sick child at home (Table A-4.18).

4.6.4 Reducing Missed Opportunities for Promoting Child Health

The IMCI approach recommends evaluating children's growth to provide an objective assessment of their current nutritional status and to detect any chronic latent nutritional problems. Growth monitoring includes comparing the child's current weight with a standard (based on either height or age), eliciting information on feeding patterns to determine whether the diet is adequate for the child's age, and determining whether current feeding patterns pose any risk to the child's health. The provider should take advantage of the consultation with the sick child and the caretaker to provide advice if there appears to be any nutritional problem or to offer encouragement for continuing good practices if the growth of the child is proceeding well.

Findings of the 2009 NHFC show that practically all sick children were weighed; however, providers plotted the weight against a standard in only 72 percent of cases (Figure 4.14). Overall, normal feeding practices were assessed for four of every ten observed sick children overall—44 percent of children under 24 months and 35 percent of children 24 months and older (Table A-4.19).

Observers also monitored whether providers checked the immunisation status of sick children receiving services in the facility. Overall, the immunisation status was assessed for nine of every ten observed sick children, regardless of age (Table A-4.19).

Key Findings

IMCI Assessments: Assessment of sick children for IMCI general danger signs (inability to eat and drink, vomiting, and febrile convulsion) during sick child visits is poor. All three general danger signs were assessed during only one of every ten observed sick child consultations, while all three main symptoms were assessed during half of sick child consultations.

Treatment: The use of antibiotics in children diagnosed with pneumonia or other upper respiratory illnesses is common. For example, 8 in 10 children diagnosed with cough or other upper respiratory illness other than pneumonia, were given antibiotics.

Information to caregivers: Providers seldom gave caretakers essential information on caring for the sick child. Providers offered caretakers of sick children all three elements of essential advice during only 1 out of 10 of observed consultations.

All caretakers of sick children were observed being told or instructed by providers how to administer medicine at home; however, providers asked fewer than two in ten of caretakers to repeat the instructions.

4.6.5 Counselling on Child Health Issues and Supporting Continuity of Care

Visual aids

Visual aids for client education are an important part of service provision. The 2009 NHFC assessed the availability and use of visual aids during client consultations. Findings of the 2009 NHFC indicate that, overall, half of all facilities offering sick child services had visual aids available (Figure 4.4). However, the actual use of visual aids during sick child consultations is poor: Visual aids were used during only 7 percent of all observed consultations (Table 4.6).

Supporting continuity of care

Often, health services are organised so that certain client parameters such as a client's temperature and weight are measured, other routine services are provided, and information is recorded on the client's health card before the provider responsible for the consultation sees the client. Making appropriate use of client cards by documenting events during consultations increases the accountability of the health care provider as well as the likelihood that the provider will have all relevant information, both during the current visit and on subsequent visits, which contributes to continuity of care.

During almost all sick child consultations, providers referred to the client card and also wrote on the client card after the consultation (Table 4.6). These activities were least likely to take place during sick child consultations in private facilities.

Table 4.6 Provider practices related to health education and continuity of care

Percentage of observations of sick children in which the provider used visual aids for health education of caretakers, the provider referred to the child health card, and the provider wrote on the child health card, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of observations where visual aids were used for health education	Use of individual health card: Percentage of observations where provider referred to card during consultation	Use of individual health card: Percentage of observations where provider wrote on card after consultation	Number of observed sick children
Type of facility				
Hospital	14	98	100	108
Health centre	3	94	97	288
Clinic	8	93	97	1,148
Managing authority				
MoHSS	6	95	99	1,352
Mission/NGO	15	93	97	131
Private	12	56	65	61
Region				
Caprivi	26	98	100	29
Erongo	6	99	100	67
Hardap	9	75	99	76
Karas	13	90	90	76
Kavango	5	93	96	359
Khomas	7	82	91	109
Kunene	16	95	99	99
Ohangwena	20	99	100	120
Omaheke	1	99	99	112
Omusati	4	98	99	276
Oshana	1	100	100	61
Oshikoto	6	98	100	69
Otjozondjupa	0	87	100	90
Total	7	94	98	1,544

Key Findings

Visual aids: Visual aids for client education are available in half of facilities offering services for sick children; however, the actual use of visual aids is uncommon. Visual aids were used during less than one in every ten sick child consultations.

Sick child service providers referred to client cards during almost all consultations and, equally, wrote on client cards after consultation.

4.7 Caretaker Opinion from Exit Interviews

Before leaving the facility, caretakers of observed sick children were interviewed about their opinions of the consultation process, the perceived quality of the provider's service, and the principal problems encountered on the day of the visit. The interviewer read a list of issues commonly related to client satisfaction and asked the caretaker to rate whether each issue posed a major problem, a minor problem, or no problem at all. Tables A-4.18 as well as A-4.21 through A-4.23 provide information on caretakers' opinions and personal characteristics.

4.7.1 Major Problems during Visit

As expected, some caretakers were disgruntled with some aspects of their experience in the facility. For example, 27 percent of caretakers considered the time that they waited to see the provider to be a major problem (Table A-4.21). This is more likely in health centres (37 percent of caretakers) than in other facility types.

Approximately one of every ten caretaker considered availability (or, in fact, lack) of medicines to be a major problem. A similar proportion considered days that the facility is open and the hours that the facility is open to be major problems. Caretakers did not consider other issues (such as provider's attitude, cleanliness of facility, and privacy) to be major problems for them during the visit.

4.7.2 Choice of Facility

When asked about their choice of health facility, 11 percent of interviewed caretakers said the facility was not the one closest to home (Table A-4.22). When asked why they did not visit the facility closest to home, the most common reason cited was that it was inconvenient due to location of work (17 percent of clients). Thirteen percent said they were referred and therefore by-passed the facility closest to their homes.

4.7.3 Caretaker Characteristics

Twelve percent of interviewed caretakers had no education, close to one-third had primary education, while a little over half had secondary education. Only one percent had tertiary or university education (Table A-4.23). Caretakers with secondary or tertiary/university education are more likely to be seen in private facilities.

Key Findings

Major problems: Caretakers considered only a few issues to be major problems. Their major complaint was the length of the wait to see a provider.

Nearest facility: Eleven percent of caretakers said the facility visited was not the one closest to home. The most common reasons cited for not visiting the facility nearest home was referral and inconvenience as a result of work.

Caretaker characteristics: Approximately one of every ten interviewed caretakers had no education, about one-third had primary education, and a little over half had secondary education.

FAMILY PLANNING SERVICES 5

Philomena Ochurus, Frieda Taapopi, Aina Kuutondokwa

5.1 BACKGROUND

5.1.1 NHFC Approach to Collection of Family Planning Service Information

Family planning is profoundly important for maternal and child health, and it is a key element in upholding reproductive rights.

The use of contraceptive methods to plan families may be desirable for many reasons, including the following:

- Couples may wish to limit the size of their families or delay desired pregnancies.
- Spacing births benefits maternal and child health. Studies have shown that spacing births at least two to three years apart contributes significantly to decreasing infant mortality (Govindasamy et al., 1993; Rutstein, 2000). Although there are fewer studies on the effects of spacing births on maternal health, it is generally accepted that too frequent births result in maternal depletion of essential minerals and vitamins.
- Preventing pregnancies that may worsen chronic or acute illnesses, such as HIV/AIDS, can benefit women's health.

Key factors contributing to the appropriate, efficient, and continuous use of contraceptives include the following (Murphy and Steele, 2000):

- Availability of a variety of contraceptive methods to address clients' preferences and ensure that clients can find methods that suit them
- Counselling and screening of clients for appropriateness of methods
- Client education, using visual aids to increase information retention regarding options, side effects, and appropriate use of the method
- Availability of infrastructure and resources necessary to provide quality family planning services, including guidelines and protocols, trained staff, a service delivery setting that allows client privacy, equipment for client examination and procedures for preventing infections
- Availability of other health services relevant for family planning clients, including education and services for sexually transmitted infections (STIs)
- Programmes for people with special needs to improve their access to and appropriate utilisation of family planning services

Wherever maternal health, reproductive health, or child health services are provided, facilities should strive to increase the appropriate use of family planning and contraceptive services, including counselling.

The family planning component of the 2009 NHFC gathered information on the following:

- Availability of family planning services
- Quality and standards related to services offered
- Management and technical components supporting quality services
- Providers' adherence to guidelines and standards for service provision

This information was gathered using *Facility Audit Questionnaires*, *Observation Protocols*, and *Provider Interview Questionnaires*. Also, through client exit interviews information was also collected from family planning clients as they left the service facilities. These questionnaires asked clients about their perceptions and experiences regarding the provision of services, their knowledge of a variety of issues related to their consultation, and their interactions with service providers.

This chapter provides detailed information on how family planning services are delivered and about how programmes can improve the availability and quality of these services. It uses information obtained by the 2009 NHFC to address the following central questions about the delivery of family planning services:

- What is the availability of family planning services?
- To what extent do the facilities offering family planning services have the infrastructure, resources, and supportive management required to support quality services?

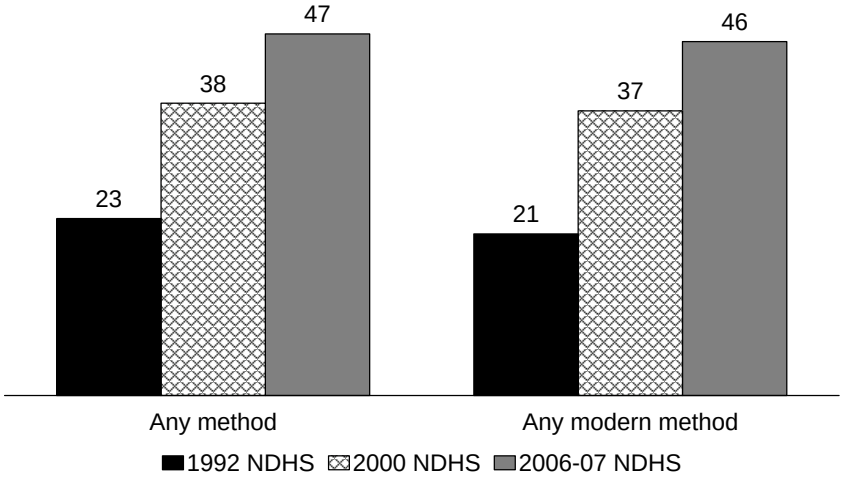
5.1.2 Family Planning Services in Namibia

As a signatory to the 1994 International Conference on Population and Development (ICPD) in Cairo, the government of the Republic of Namibia recognised family planning as a human right. In 1995 the government launched the National Policy for Reproductive Health which states that family planning services should be available, accessible, acceptable, and affordable to all women and men of reproductive age at all public health facilities (MoHSS, 2001). The First and Second National Development Plans (NDP I [1995-2000] and NDP II [2001-2006]), which aimed to integrate population and development objectives, embodied many of the government's family planning policies and programmes.

Furthering its commitment to integrate population and development, the government launched the National Population Policy for Sustainable Human Development in 1997. This policy seeks to slow the rate of population growth by increasing the uptake of family planning and raising the status of women, as well as by developing and utilising human resources. The ultimate goal of the policy is increased quality of life for the people of Namibia.

As shown in Figure 5.1, the current contraceptive use rates are considerably higher than in previous years. The increase in the contraceptive prevalence rate can be attributed in large part to the government's commitment to provide family planning services free of charge at all government health facilities. Widespread use of modern methods is considered to be the principal reason for fertility decline and corresponding reductions in the annual population growth rate in Namibia.

Figure 5.1 **Trends in Contraceptive Use among All Women Age 15-49, Namibia 1992, 2000, and 2006-07**



5.2 AVAILABILITY OF FAMILY PLANNING SERVICES

The following definitions are used in this chapter:

- A facility is said to *provide* a family planning method if the facility reports that it stocks the method and makes it available to clients when they visit the facility, and these clients do not have to leave the facility to obtain the method elsewhere.

- A facility is said to *offer* a family planning method if the facility reports that it provides the method, prescribes the method for clients to obtain elsewhere, or counsels clients on the method (e.g., periodic abstinence). Thus, the group defined as offering a method encompasses but is not limited to the group defined as providing the method.

Family planning methods differ in how they function and in their effectiveness, side effects, and mode of administration. In view of these differences, their acceptability and desirability to users also differs. To meet varying needs and demands for contraception, a variety of methods should be available at a frequency that meets common needs.

To understand the context of modern contraceptive use in Namibia, the 2009 NHFC assessed the availability of family planning services in health care facilities in Namibia.[1] Tables 5.1 through 5.4 summarise information on the availability, frequency, infrastructure and resources, and management practices for family planning services. Figure 5.2 provides details on the availability of different methods of contraception in facilities that provide those methods, and Tables A-5.1 through A-5.4 provide further details on method availability in facilities that provide specific methods according to type of facility and region.

[1] Information is presented in this chapter for hospitals, health centres, clinics, and sick bays. Free-standing voluntary counselling and testing (VCT) facilities are excluded.

Table 5.1 Availability of family planning services

Percentage of all facilities offering temporary methods of family planning (FP) and sterilisation, by background characteristics, Namibia HFC 2009

Background characteristics	Temporary methods of family planning (FP)				Number of facilities
	Percentage offering any modern method of FP[1]	Percentage offering counselling on periodic abstinence method	Percentage offering any temporary method of FP[2]	Percentage offering male or female sterilisation	
Type of facility					
Hospital	49	33	49	44	45
Health centre	96	49	96	26	47
Clinic	98	45	98	34	295
Sick bay	33	0	33	0	9
Managing authority					
MoHSS	96	47	96	36	306
Mission/NGO	96	46	96	32	28
Private	69	31	69	27	49
MoD/Police	31	0	31	0	13
Region					
Caprivi	93	57	93	4	28
Erongo	86	50	86	31	36
Hardap	90	29	90	14	21
Karas	92	56	92	56	25
Kavango	96	42	96	35	57
Khomas	76	48	76	27	33
Kunene	96	18	96	43	28
Ohangwena	91	41	91	22	32
Omaheke	94	56	94	88	16
Omusati	94	43	94	39	49
Oshana	85	60	85	30	20
Oshikoto	91	41	91	36	22
Otjozondjupa	86	28	86	28	29
Total	90	43	90	33	396

[1] Facility provides, prescribes, or counsels clients on any of the following: contraceptive pills (combined or progestin-only), injectables (combined or progestin-only), implants, intrauterine contraceptive devices (IUCDs), male condoms, spermicides, or diaphragm.
[2] Facility offers counselling on periodic abstinence method and/or provides, prescribes, or counsels clients on any of the following: contraceptive pills (combined or progestin-only), injectables (combined or progestin-only), implants, IUCDs, male condoms, spermicides, or diaphragm.

5.2.1 Contraceptive Method Mix and Method Availability

A facility that offers a wide variety of family planning methods is best able to meet clients' needs. However, some variation is expected in the methods offered because of differences in provider qualifications and training, as well as the infrastructure required to provide certain methods safely. Methods that can be provided safely with minimal training are pills, injectables, and condoms, as well as counselling on periodic abstinence. Safely providing implants, IUCDs, tubal ligation, and vasectomy, requires a higher level of skills and more developed infrastructure.

Ninety percent of all facilities in Namibia offer some type of modern method of family planning; however, the availability of these services varies by facility type and region. Practically all clinics and health centres (98 percent and 96 percent, respectively) in Namibia offer some modern method of family planning, compared with only half of hospitals and one-third of sick bays.[2] The vast majority of facilities managed by the Ministry of Health and Social Services (MoHSS) and by mission/non-governmental

[2] Because only three of the nine sick bays assessed provide family planning, this report will only briefly touch on family planning services at those facilities.

organisations (NGOs) offer modern methods (each 96 percent), compared with 69 percent of private facilities and one-third of facilities managed by the Ministry of Defence (MoD) or the police.

At the regional level the percentage of facilities that offer modern methods ranges from 76 percent in Khomas to 96 percent in Kavango and Kunene.

Counselling on the periodic abstinence method is offered at 43 percent of all facilities. One-third of all facilities offer permanent family planning methods (vasectomy or tubal ligation).

Among facilities that offer family planning methods, the most common methods offered are the two- or three-monthly progestin-only injectables and the male condom (each 99 percent), the combined oral contraceptive (97 percent), and the progestin-only oral pill (94 percent). Eighty-six percent of facilities that offer family planning services offer the female condom, while only 25 percent offer the intrauterine contraceptive device (IUCD) (Table A-5.1).

Emergency contraception technically is not considered a family planning method but rather a backup means of preventing unintended pregnancy after unprotected sexual intercourse. Findings from the 2006-07 Namibia Demographic and Health Survey (NDHS) indicate that few women have ever used emergency contraception (that is, among currently married and sexually active unmarried women age 15-49 who have ever used a contraceptive method). This can be attributed to the fact that emergency contraception has until now been given only in cases of rape. In 2010, however, the government is introducing emergency contraception for use by the general public. The 2009 NHFC finds that 36 percent of facilities (including 57 percent of hospitals) that offer any family planning service report offering emergency contraception as well (Table A-5.1).

5.2.2 Frequency of Family Planning Services

In addition to offering a range of methods, it is important that facilities offering family planning services do so regularly enough to meet clients' needs. With the exception of hospitals, the majority of facilities that offer family planning services do so five or more days per week (Table 5.2). Private facilities are more likely to offer family planning services five or more days per week (88 percent) than MoHSS and mission/NGO facilities. All four of the MoD/Police facilities offering family planning services offer these services five or more days a week. Frequency of services varies regionally, from a low of 60 percent of facilities in Kavango region offering services five or more days a week to 97 percent in Ohangwena region.

Table 5.2 Frequency of availability of family planning services

Among facilities offering temporary methods of family planning (TFP), percentage offering any temporary methods on the indicated number of days per week, by background characteristics, Namibia HFC 2009

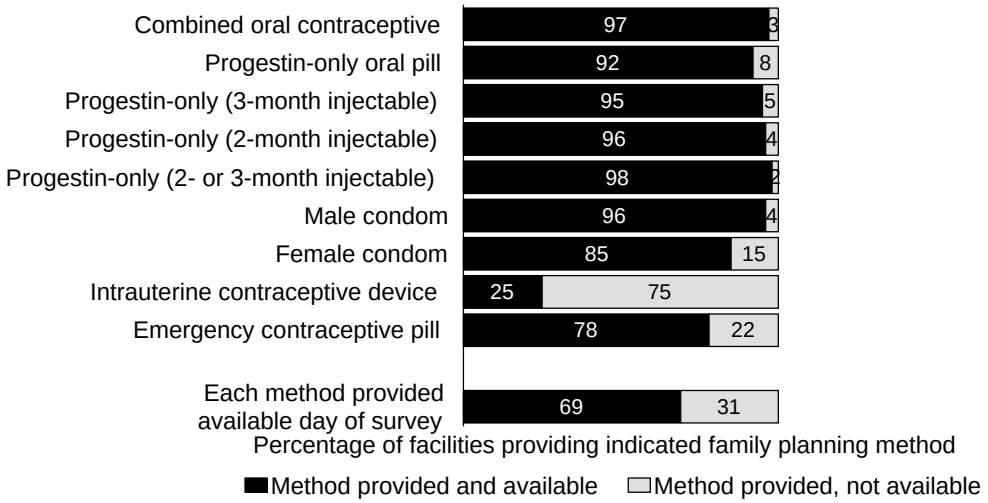
Background characteristics	Percentage of facilities where TFP[1] services are offered: 1-2 days per week	3-4 days per week	5 or more days per week	Number of facilities offering TFP
Type of facility				
Hospital	27	9	64	22
Health centre	13	4	82	45
Clinic	16	2	82	288
Sick bay	0	0	100	3
Managing authority				
MoHSS	16	2	81	293
Mission/NGO	22	11	67	27
Private	12	0	88	34
MoD/Police	0	0	100	4
Region				
Caprivi	12	15	73	26
Erongo	16	0	84	31
Hardap	16	5	79	19
Karas	22	0	78	23
Kavango	31	7	60	55
Khomas	8	0	92	25
Kunene	19	0	81	27
Ohangwena	3	0	97	29
Omaheke	13	0	87	15
Omusati	11	0	89	46
Oshana	6	0	94	17
Oshikoto	25	5	70	20
Otjozondjupa	12	0	88	25
Total	16	3	81	358

[1] Includes contraceptive pills (combined or progestin-only), injectables (combined or progestin-only), implants, intrauterine contraceptive devices (IUCDs), male condoms, spermicides, diaphragm, or periodic abstinence method.

5.2.3 Availability of Family Planning Methods On the Day of the Survey

Stock-outs of family planning methods can contribute to discontinuation, unwillingness to adopt any type of contraception, and unintended pregnancies. The 2009 NHFC assessed the availability of contraceptive methods on the day of the visit, among facilities that report *providing* these methods. As seen in Figure 5.2, the majority of facilities providing the most popular methods had them in stock on the day of the visit. For example, 97 percent of facilities that *provide* oral contraceptive pills had them available on the day of the assessment. In addition, 98 percent of facilities that *provide* progestin-only (2- or 3-month) injectables had them available in the facility on the day of the assessment.

Figure 5.2 **Temporary Methods of Family Planning Provided and Availability of Method on Day of Visit**



The denominator for each method is different. For example, the denominator for combined oral contraceptive is 339 facilities.

NHFC 2009

There are some gaps, however. Among the facilities that report *providing* progestin-only oral contraceptives, 92 percent had the method in stock on the day of the visit (Figure 5.2). Similarly, among the facilities that report *providing* female condoms, 85 percent had female condoms in stock. And only 25 percent of facilities that report *providing* the IUCD had them in stock on the day of the survey. Of the facilities that report *providing* emergency contraceptive pills, 78 percent had them in stock at the time of the visit.

Additional information on the availability of methods by facility type and region can be found in Tables A-5.1 through A-5.4. Regionally, availability of all provided methods on the day of the survey ranged from 96 percent of facilities reporting family planning provision in Caprivi region to 52 percent of facilities in Erongo region and 53 percent in Oshana region (Table A-5.4).

Key Findings

Availability of family planning services: Nine of every ten facilities in Namibia *offer* (i.e., provide, prescribe, or counsel for) a modern method of family planning; MoHSS- and mission/NGO-managed facilities are most likely to offer family planning services. The most commonly offered methods are the progestin-only injectables, male condoms, combined oral contraceptives, and progestin-only oral pills. Just 25 percent of facilities that offer family planning services offer the IUCD. Only one-third of facilities that offer family planning services provide permanent methods.

FP services are available five or more days a week in eight of every ten facilities that offer such services.

The majority of facilities providing the most popular methods had them in stock on the day of the visit.

5.3 Components Supporting Quality Family Planning Services

Facilities must have adequate infrastructure and resources available to support quality counselling and services for family planning clients. They should also have the equipment and supplies needed to

provide each family planning method they offer. Because family planning clients are sexually active, it is also important to make services for sexually transmitted infections (STIs), HIV counselling and testing services, and antiretroviral therapy (ART) services available to those who need them.

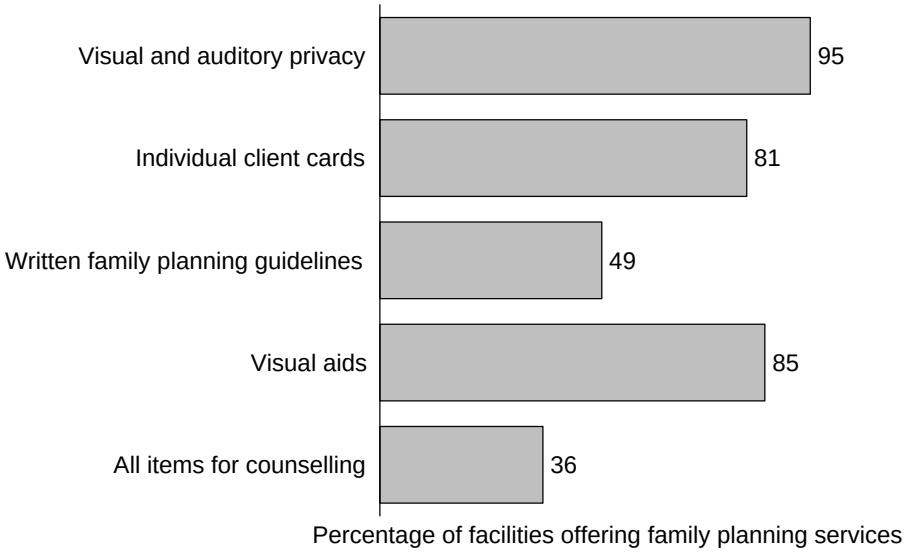
5.3.1 Infrastructure and Resources to Support Quality Family Planning

To provide quality counselling to family planning clients, facilities should ensure some level of privacy and should have individual client health cards or records, family planning guidelines or protocols, and relevant visual aids for client education. Since counselling about family planning often takes place in a location different from where procedures (such as IUCD insertions and removals) are conducted, the conditions for counselling are assessed separately from those for procedures. Table 5.3 provides aggregate information on the availability of items needed to support quality counselling; information on the availability of each specific item needed for counselling is provided in Figure 5.3. Details on the availability of specific items for counselling are provided by facility type in Table A-5.5; Tables A-5.6 and A-5.7 provide details on the availability of visual aids and guidelines by facility type.

Only 36 percent of facilities offering temporary family planning methods have all items (including privacy, individual client cards, written guidelines, and visual aids) to support quality family planning counselling (Table 5.3). This is principally because many facilities do not have written family planning guidelines available at the service delivery site (Figure 5.3, Table A-5.5).

None of the hospitals in Namibia that offers temporary family planning methods has all items to support quality family planning counselling. Health centres and clinics fare somewhat better, with all the necessary items available at 38 percent of health centres and 39 percent of clinics. MoHSS facilities that offer temporary family planning are the most likely to have all items to support quality counselling (42 percent). By comparison, only 6 percent of private facilities and 19 percent of mission/NGO facilities that offer family planning have all the necessary items (Table 5.3). Facilities in Oshana region are most likely (76 percent) to have all of these items, while facilities in Otjozondjupa are least likely (12 percent) to have these items.

Figure 5.3 **Items to Support Quality Counselling for Family Planning (N=358)**



NHFC 2009

Family planning is often a sensitive issue to discuss. Counselling clients under conditions where they cannot be overheard improves communication and, ultimately, the likelihood that the method provided is suitable for the client. Privacy for counselling is almost universally available, with 95 percent of facilities counselling family planning clients under conditions where both visual and auditory privacy are possible (Figure 5.3).

Individual client cards or records are important for monitoring a client over time. Because facilities often do not store clients' records, but rather give them to the clients to keep, the 2009 NHFC assessed the availability of blank cards for new family planning clients. Blank individual client cards were available at 81 percent of facilities that offer family planning. Health centres (84 percent) and clinics (83 percent) are more likely to have blank client cards than hospitals (59 percent) or sick bays (33 percent) (Table A-5.5).

The 2009 NHFC assessed whether facilities have written family planning guidelines or protocols with information on eligibility screening and correct procedures for different methods. The guidelines were considered available for use only if they were in the family planning service delivery area or an immediately adjacent area. About half of facilities that offer family planning have family planning guidelines or protocols available at the service site or immediately adjacent (Figure 5.3). Health centres (53 percent) and clinics (52 percent) are more likely to have family planning guidelines than hospitals (9 percent) and sick bays (0 percent) (Table A-5.5).

Visual aids are also important elements in good family planning counselling. They are available in the family planning service delivery area in 85 percent of facilities that offer family planning, including approximately 89 percent of health centres, 86 percent of clinics, and 68 percent of hospitals (Figure 5.3, Table A-5.5).

5.3.2 Infrastructure and Resources for Examinations

Uniquely among temporary family planning methods, the IUCD requires a pelvic examination before insertion. In addition, a physical examination may occasionally be helpful to evaluate problems with a method or simply for routine checkups unrelated to use of family planning methods. Such examinations require an adequate level of infection control as well as the infrastructure and items needed to examine the client.

Table 5.3 provides aggregate information on items for infection control and pelvic examinations. Figure 5.4 gives information on the availability of each specific item needed for infection control as well as for pelvic examinations. Details on the availability of specific items are provided by facility type in Table A-5.5.

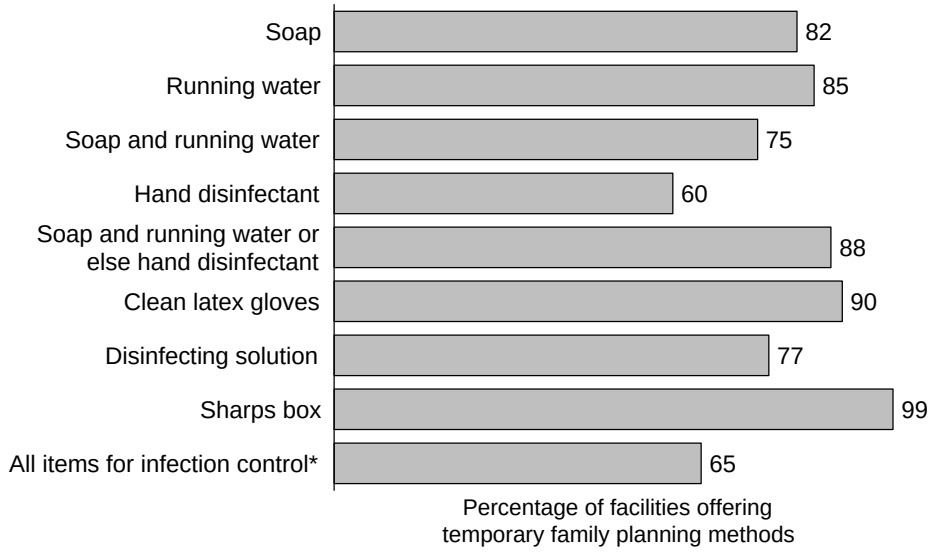
Table 5.3 Availability of infrastructure and resources to support services for temporary family planning methods

Percentage of facilities offering temporary family planning (TFP) methods that have the infrastructure and resources to support quality counselling, infection control, pelvic examination, and STI treatment, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities with: All items to support quality counselling[1]	All items for infection control[2]	Conditions for quality pelvic examination[3]	FP providers routinely treating STIs	Number of facilities offering TFP
Type of facility					
Hospital	0	50	14	36	22
Health centre	38	62	2	62	45
Clinic	39	67	2	88	288
Sick bay	0	67	0	67	3
Managing authority					
MoHSS	42	65	0	84	293
Mission/NGO	19	56	4	74	27
Private	6	74	21	65	34
MoD/Police	0	75	0	75	4
Region					
Caprivi	58	73	0	92	26
Erongo	19	71	3	65	31
Hardap	37	95	5	84	19
Karas	17	65	9	70	23
Kavango	38	84	4	84	55
Khomas	20	76	8	60	25
Kunene	30	78	0	93	27
Ohangwena	62	48	0	90	29
Omaheke	47	87	0	100	15
Omusati	28	67	0	83	46
Oshana	76	35	0	71	17
Oshikoto	50	20	5	95	20
Otjozondjupa	12	20	0	72	25
Total	36	65	3	81	358

[1] Visual and auditory privacy, individual client cards, written guidelines related to family planning, and visual aids related to family planning.
[2] Soap and running water or else hand disinfectant, clean latex gloves, disinfecting solution, and sharps box.
[3] Private room offering visual and auditory privacy, examination bed, examination light, and vaginal speculum.

Figure 5.4 Items for Infection Control in Examination of Family Planning Clients (N=358)



* Soap and running water or else hand disinfectant, latex gloves, disinfecting solution, sharps box NHFC 2009

Items for pelvic examination

The 2009 NHFC assessed four items needed to conduct a quality pelvic examination for family planning clients: visual and auditory privacy, an examination bed or couch, an examination light, and a vaginal speculum. Only 3 percent of facilities that offer any temporary method of family planning services have all these items available at the service site, including 14 percent of hospitals and only 2 percent of health centres and clinics (Table 5.3). Seven of the 13 regions actually have no facilities that meet the requirements. The items most commonly missing are vaginal speculums and examination lights; these are available in only 4 percent and 36 percent, respectively, of family planning facilities overall, although the availability of these items varies greatly by type of facility (Table A-5.5).

Infection control

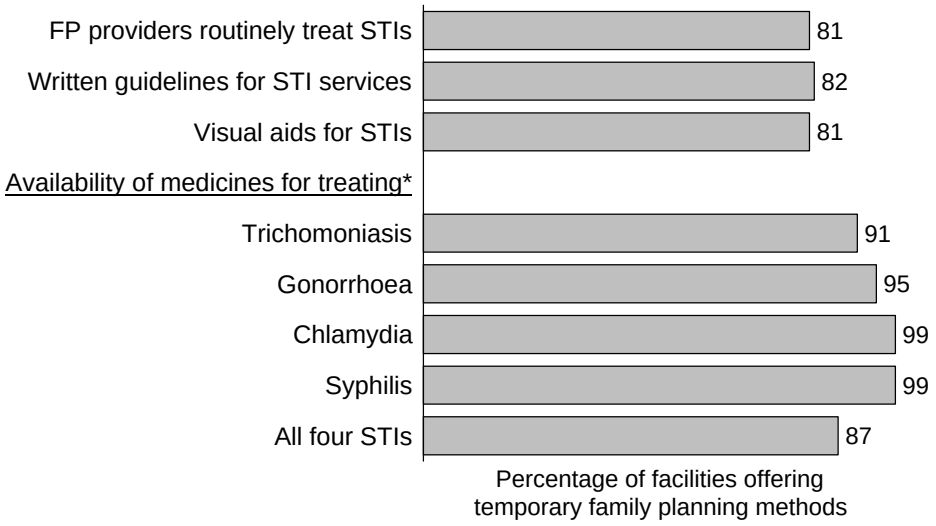
The 2009 NHFC assessed the presence of items for infection control in areas where family planning examinations (such as pelvic examinations and the provision of implants, IUCDs, and injectables) most often take place. Items assessed for infection control were hand-washing supplies (running water and soap or else hand disinfectant), clean or sterile latex gloves, disinfecting solution, and a sharps box. All these items are available in the family planning service area in approximately two-thirds of facilities. Half of hospitals in Namibia have all the assessed infection control items available at the family planning service site compared with over 60 percent of each other facility type. Private and MoD/Police facilities are more likely than facilities managed by the MoHSS and mission/NGO-managed facilities to have all the assessed infection control items (Table 5.3).

At the regional level Hardap region has the highest proportion of facilities with all the assessed infection control items, while Oshikoto and Otjozondjupa regions have the lowest coverage, each at only 20 percent (Table 5.3).

5.3.3 Provision of STI Treatment for Family Planning Clients

Counselling for STI prevention, STI diagnosis, and treatment are essential components of quality family planning care since family planning clients are sexually active. Figure 5.5 provides information on the availability of items needed to provide STI services to family planning clients. Table A-5.8 provides details, by type of facility, on the availability of medicines for treating specific STIs.

Figure 5.5 **Conditions to Support Quality STI Services for Family Planning Clients (N=358)**



* Among facilities offering FP and where FP providers routinely treat STIs (N=290)

NHFC 2009

STI services by family planning providers

Family planning providers in 81 percent of facilities that offer family planning services routinely diagnose and treat STIs (Tables 5.3, Figure 5.5, and Table A-5.8). This is more likely to be the case in clinics than in other types of facilities; this may be because the lower level facilities have integrated services by virtue of limited numbers of service providers. Regionally, all family planning facilities in Omaheke region have family planning providers who routinely treat STIs, while the rest of the regions range between 60 percent in Khomas region and 95 percent in Oshikoto region. MoHSS facilities (84 percent) are somewhat more likely than private facilities (65 percent) and mission/NGO facilities (74 percent) to have family planning providers diagnose and treat STIs (Table 5.3).

Medicines to treat STIs

Medicines for treating four common STIs (specifically, trichomoniasis, gonorrhoea, chlamydia, and syphilis) are individually available in nearly all facilities where family planning providers routinely treat STIs (Figure 5.5). In fact, 87 percent of these facilities had all medicines necessary to treat all four common STIs available on the day of the survey.

Guidelines

The majority of facilities (82 percent) that offer family planning services have written guidelines for diagnosing and treating STIs available in the family planning service area (Figure 5.5). Guidelines for the World Health Organization (WHO) syndromic approach are found in family planning service areas in 75 percent of facilities. Clinics and health centres (79 and 69 percent, respectively) are relatively more likely to have the WHO guidelines than hospitals and sick bays (45 and 33 percent, respectively). Guidelines for the diagnosis and treatment of STI other than the WHO syndromic approach guidelines were available in about half of facilities (Table A-5.6).

Visual aids

STI- and HIV-related visual aids for client education were available in 81 percent of facilities that offer family planning (Figure 5.4), but only about one-third have informational materials on STIs for clients to take home (Table A-5.7).

Key Findings

Items to support quality counselling: Only one-third of the facilities offering temporary family planning have all items needed to support quality counselling; in fact, no hospitals meet the criteria. Family planning guidelines at the family planning service delivery site is the item most frequently missing.

Infection control: Approximately two-thirds of family planning facilities in Namibia have all relevant infection control items available at the family planning service area; health centres and clinics fared better than other types of facilities.

Visual aids: Eight of every ten facilities that offer family planning services have STI- related visual aids for client education.

STI services by family planning service providers: Family planning providers in eight of every ten family planning facilities routinely diagnose and treat STIs. Medicines for treating all four common STIs (trichomoniasis, gonorrhoea, chlamydia, and syphilis) are available in 87 percent of facilities where family planning providers routinely treat STIs.

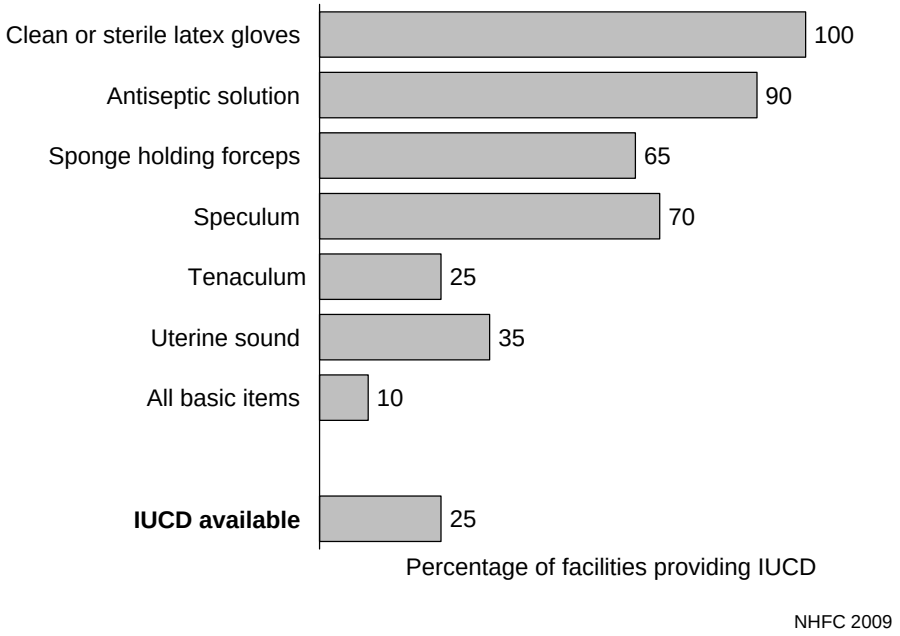
5.3.4 Availability of Equipment and Supplies for Specific Methods

A variety of equipment and supplies is desirable in order for facilities to effectively provide different contraceptive methods safely and to monitor clients. Figure 5.6 shows aggregate information on the availability of items for providing IUCDs. Tables A-5.9-A-5.11 provide additional details on the availability of equipment and supplies for specific methods—including implants as well as IUCDs—and for pelvic examinations.

As indicated in Figure 5.6, among facilities that *provide* IUCDs (i.e., excluding facilities that only prescribe the method or refer clients elsewhere), only 25 percent actually had IUCDs available in the facility on the day of the survey. An even smaller proportion (10 percent) had all the basic equipment needed for IUCD insertion and/or removal. Latex gloves, as one of the basic items, were universally available, while tenaculums were available in only 25 percent of the facilities providing IUCDs.

Among facilities offering methods that contain oestrogen, the great majority (94 percent) have an apparatus to measure blood pressure at the family planning service delivery site, including 95 percent of hospitals, 94 percent of clinics, and 88 percent of health centres (Table A-5.9). Almost all facilities providing injectable contraceptives have sterile needles and syringes (Table A-5.9).

Figure 5.6 **Equipment for IUCD Insertion and Removal (N=20)**



Key Findings

Items to support provision of services: The great majority of facilities offering oestrogen-containing methods have a blood pressure apparatus available at the family planning service delivery site.

Almost all facilities providing injectable contraceptives have sterile needles and syringes.

Only 25 percent of facilities that *provide* IUCDs had IUCDs available in the facility on the day of the survey; only 10 percent had all the basic equipment needed for IUCD insertion and/or removal.

5.4 Management Practices That Support Quality Family Planning Services

Management practices that support quality family planning services include proper documentation and record-keeping, practices related to user fees, and staff supervision and development.

Table 5.4 provides summary information on management practices. Utilisation statistics for family planning services are provided in Table A-5.12. Information on user fees for family planning services appears in Tables A-5.13 through A-5.15. Details on staff training and supervisory activities are provided in Figure 5.7 and Tables A-5.16 through A-5.18.

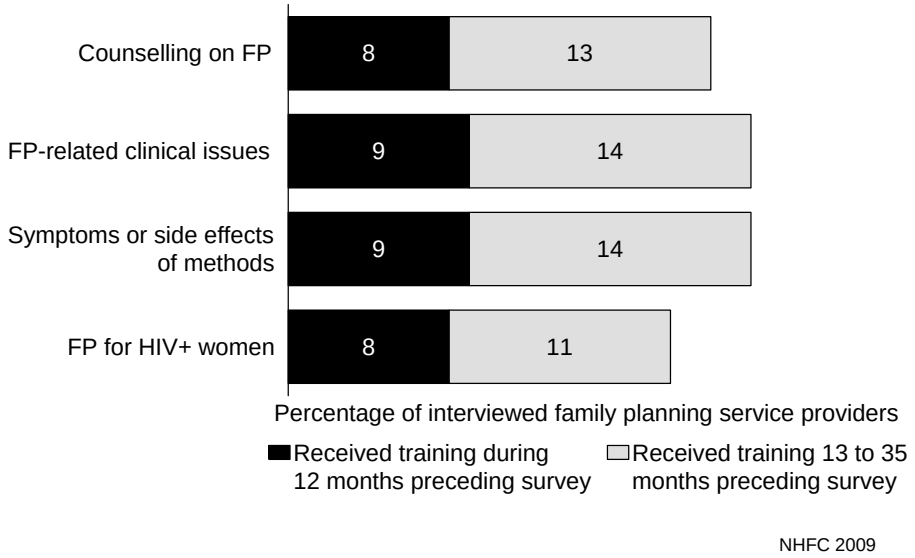
Table 5.4 Management practices to support services for temporary family planning methods

Percentage of facilities offering temporary family planning (TFP) methods that have an up-to-date client register and that charge user fees for FP services, and percentage of facilities where interviewed FP service providers report routine training and supervision, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities that offer TFP methods with:		Number of facilities offering TFP	Percentage of facilities where staff report receiving routine:		Number of facilities with interviewed FP service providers[4]
	Observed up-to-date client register[1]	User fees for FP services		Training[2]	Personal supervision[3]	
Type of facility						
Hospital	50	23	22	5	86	22
Health centre	73	2	45	9	91	45
Clinic	77	7	288	7	76	287
Sick bay	33	0	3	0	100	3
Managing authority						
MoHSS	77	2	293	7	80	292
Mission/NGO	89	0	27	4	96	27
Private	41	59	34	12	47	34
MoD/Police	25	0	4	0	100	4
Region						
Caprivi	96	0	26	12	76	25
Erongo	58	10	31	3	71	31
Hardap	58	26	19	0	79	19
Karas	70	26	23	9	87	23
Kavango	76	5	55	5	80	55
Khomas	68	36	25	16	68	25
Kunene	67	0	27	11	67	27
Ohangwena	90	0	29	3	86	29
Omaheke	87	0	15	13	100	15
Omusati	72	2	46	2	89	46
Oshana	88	0	17	18	94	17
Oshikoto	100	0	20	0	85	20
Otjozondjupa	48	0	25	4	44	25
Total	74	8	358	7	78	357

[1] Register has entry within past seven days and indicates visit status (first or follow-up) and service provided.
[2] A facility has routine staff training if at least half of interviewed providers reported that they had received pre- or in-service training related to their work during the 12 months preceding the survey. This refers to structured sessions and does not include individual instructions received during routine supervision.
[3] A facility has routine staff supervision if at least half of interviewed providers reported that they had been personally supervised at least once during the six months preceding the survey.
[4] Includes only providers of family planning services in facilities offering family planning services.

Figure 5.7 **Training Received by Interviewed Family Planning Service Providers, by Topic and Timing of Most Recent Training (N=788)**



5.4.1 Facility Documentation and Records

The 2009 NHFC assessed the availability of up-to-date family planning client registers, which are the most common source of data for health information systems. A register was defined as up-to-date if there was an entry within the past seven days with information indicating the method or service provided and the client's status (that is whether it was a first visit or a follow-up visit).

Three-quarters of facilities offering family planning services had up-to-date client registers, including the majority of mission/NGO and MoHSS facilities (89 percent and 77 percent, respectively) (Table 5.4). Fewer than half of private facilities and only one-quarter of MoD/Police facilities had up-to-date client registers. Availability of up-to-date registers varies across regions. All facilities in Oshikoto region have up-to-date client registers, but only about half of facilities in Otjozondjupa (48 percent) have the registers.

5.4.2 Practices Related to User Fees

According to the National Policy on Family Planning in Namibia, family planning services in MoHSS facilities should be free of charge. There should be no charge for any MoHSS-supplied contraceptive method, even when provided through a private facility. According to the 2009 NHFC findings, a small proportion of facilities (8 percent) do charge fees for certain aspects of family planning services such as registration, consultations, client passports, and tests. Six of every ten private facilities charge user fees for the various components of a family planning visit (Table 5.4).

About half of private facilities charge for consultations and methods (56 and 50 percent, respectively); a smaller proportion charge for tests, registration, and client passports (35 percent, 21 percent, and 15 percent, respectively) (Table A-5.13). No mission/NGO or MoD/Police facilities report charging fees, but 2 percent of MoHSS facilities charge fees for family planning services. Hospitals are the most likely to charge user fees (23 percent). Among regions facilities in Khomas are most likely to charge user fees (36 percent). In 7 of the 13 regions no facilities report charging user fees (Table 5.4).

5.4.3 Training and Supervision

Training

Since the types of contraceptive methods offered and conditions for providing methods change over time, continual training for providers is important. Training aims to improve the quality of counselling, management of complications or side effects, and providers' judgment and skills in assessing which contraceptive methods are most suitable for individual clients.

A facility is considered to provide routine staff development activities if at least half of the interviewed family planning service providers at that facility have received any structured training relevant to family planning during the 12 months preceding the survey; this includes both pre-service and in-service training but excludes individual instruction received during routine supervision. Overall, only 7 percent of facilities meet these criteria for providing routine staff development activities. Facilities in Oshana and Khomas regions (18 percent and 16 percent, respectively) are relatively more likely to provide routine staff development than facilities in other regions; no facilities in Hardap and Oshikoto meet the criteria for training (Table 5.4).

Among the interviewed family planning service providers, only a small percentage (11 percent) reported receiving any family planning-related training during the 12 months preceding the survey; only 15 percent received training during the period 13 to 35 months preceding the survey (Table A-5.16). This reflects the small proportion of facilities meeting the criteria of providing routine staff development. The topics covered—counselling on family planning, family planning-related clinical issues, symptoms or side effects of methods, and family planning for HIV-positive women—received nearly equal attention, with only 8 to 9 percent of providers trained on each in the 12 months prior to the survey and 11 to 14 percent of providers trained on each in the 13 to 35 months prior (Figure 5.7).

Supervision

Supervision of individual staff members helps to promote adherence to standards and to identify and solve problems that contribute to poor services. If at least half of the interviewed family planning service providers at a facility were personally supervised during the six months preceding the survey, the facility is considered to have routine staff supervision. Supervision of family planning providers is common. About three-quarters of family planning facilities meet the criteria for routine staff supervision. Compared with other facility types and managing authorities, clinics and private facilities are least likely to have routine staff supervision. All facilities in Omaheke region and 94 percent in Oshana region meet the criteria for routine supervision. In contrast, only 44 percent of facilities in Otjozondjupa region meet the criteria (Table 5.4).

Key Findings

Up-to-date client registers: Up-to-date client registers were available in about three-quarters of facilities offering family planning services on the day of the survey; Mission/NGO and MoHSS facilities are more likely than other managing authorities to have up-to-date client registers.

User-fees: Only 8 percent of facilities offering family planning services charge a user fee for family planning services; these are mostly hospitals, private facilities, and those in Khomas, Hardap, and Karas regions.

Staff development: Only 7 percent of facilities offering family planning services meet the criterion for providing routine staff development activities, whereas about three-quarters meet the criterion for having routine staff supervision.

5.5 Adherence to Standards for Quality Service Provision

To assess whether family planning providers adhere to service standards, NHFC personnel observed family planning client-provider interactions using observation check-lists that are based on commonly accepted guidelines for screening, counselling, and conducting procedures for family planning clients. The observers collected information to address the following questions:

- Did providers talk about topics essential to determining the appropriateness of the methods discussed, and, where appropriate, did they conduct the physical examination needed to screen clients for method appropriateness?

- Did the conditions and procedures followed for provision of specific methods meet NHFC criteria for quality service provision?

The observers noted what information the provider shared with a client and where appropriate, whether an examination was conducted prior to dispensing a method. They did not assess whether the information was correct or whether findings were appropriately interpreted. Table A-5.19 gives information on the proportions of first and follow-up visits and the percentage of clients who reported having never been pregnant. Information on clients' family planning use and the principal reason for visiting the facility are provided in Table A-5.20. Table A-5.21 gives details on family planning clients who received, were prescribed, or continued using their main method at the end of the visit.

Exit interviews were conducted with all observed family planning clients, both new and continuing. These clients were asked questions regarding the method they received to ascertain their understanding and knowledge of that method. Clients who left the facility with only a prescription for a method also were asked questions about that method. When two methods were prescribed or received, the client was asked questions about both methods.

Figures 5.8 and 5.9 provide information on observed conditions and content of family planning counselling. Details on consultations for first-visit clients are provided in Tables A-5.23 and A-5.24. Information from observations of specific methods or examinations is provided in Tables A-5.25 through A-5.27.

Figure 5.8 **Observed Conditions and Content of Family Planning Counselling (N=983)**

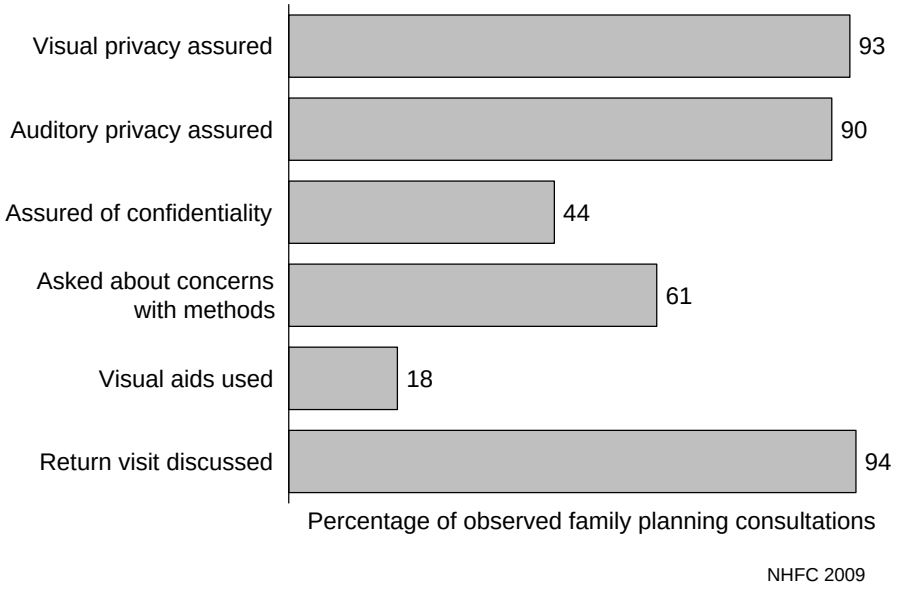
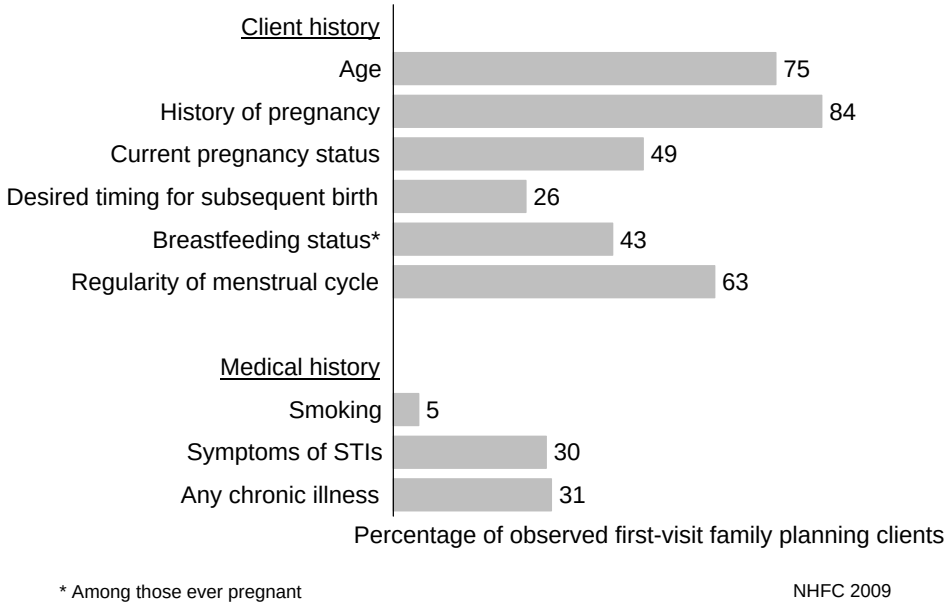


Figure 5.9 **Observed Elements of Client History-taking for First-visit Family Planning Clients (N=161)**



5.5.1 Counselling and Client Assessment

Sixteen percent of observed female family planning clients were making their first visit; the remaining 84 percent were follow-up visits. Only 12 percent of all observed clients had never been pregnant. Private facilities had a greater proportion of clients who had never been pregnant, at 32 percent, compared with only 18 and 11 percent of clients at mission/NGO and MoHSS facilities (Table A-5.19).

Privacy is important to family planning counselling; most of the family planning counselling sessions were conducted under conditions that assured visual (93 percent) and auditory (90 percent) privacy. By comparison, clients were assured of confidentiality during just 44 percent of consultations, and providers explicitly asked or discussed with clients any concerns that they may have with their family planning methods in 61 percent of the consultations. Overall, only 32 percent of observed family planning consultations met all conditions for quality counselling (Table A-5.22,).

Visual aids were used in 18 percent of family planning consultations; they were more likely to be used in hospitals than in other types of facilities. The need for return visits was discussed with 94 percent of clients (Figure 5.8, Table A-5.22).

Frequently, health services are organised so that measurements of blood pressure and weight and other routine activities take place before the client sees the provider, and the information is recorded on individual client cards. Thus, client cards play an important role in making this information available to providers during consultations and also in avoiding unnecessarily collection of this information multiple times. Client cards are also crucial for monitoring family planning clients over time. In 84 percent of consultations family planning providers reviewed individual client cards (health passports), and they wrote on the cards during or after 99 percent of consultations (Table A-5.22).

During a family planning visit, especially during a client's first visit, providers are expected to elicit information about the client's personal and health history to help them make an informed recommendation on contraceptive methods. This constitutes screening clients for the medical appropriateness of specific methods. During observed counselling sessions providers assessed most first-visit clients for pregnancy history and age (84 and 75 percent, respectively). In addition, they asked 63 percent of first-visit clients about regularity of menstrual cycles. Providers were less consistent in assessing the client's desired timing for a subsequent birth (26 percent of family planning consultations). Current pregnancy status was assessed in only 49 percent of first visits, and only 43 percent of the first-time clients were asked their breastfeeding status (Figure 5.9).

Clients' medical history was assessed infrequently; approximately one of every three first-time clients was asked about current symptoms that would suggest STIs or asked about any chronic illnesses. Only 5 percent were asked about smoking (Figure 5.9).

Only 13 percent of first-visit clients were asked about their partner's attitude towards family planning or partner status (i.e., asked about other partners for self or partner, and about absence of partner). Considering the current drive toward reducing HIV/AIDS rates, condoms were not discussed as frequently as would be expected. Providers talked about any issues related to STIs during only half of first visits, and only half of first consultations involved a discussion about using condoms to prevent STIs or as a dual-purpose method to prevent both pregnancy and STIs (Table A-5.24).

Key Findings

Conditions of client counselling: About nine of every ten observed family planning counselling sessions were conducted under conditions that assured privacy; however, clients were assured of confidentiality in fewer than half of family planning counselling sessions.

During observed counselling sessions family planning providers were likely to assess first-visit clients for pregnancy history and age; however, they were less consistent in assessing the client's desired timing for a subsequent birth. Despite the current drive toward reducing HIV/AIDS rates, condoms were discussed only in about half of the counselling sessions.

5.5.2 Method-Specific Assessments and Examinations

Almost all family planning clients using oestrogen-containing methods had their blood pressure measured,[3] and 82 percent were weighed as part of the consultations. All clients visiting hospitals were weighed and had their blood pressure measured (Table A-5.25).

5.5.3 Counselling of Clients

Whether they are new or continuing users of contraception, family planning clients should receive certain information during their visits to a health facility. The provider should explain or review with the client how to use the method, the possible side effects, what to do for problems, and when the client should return for a follow-up visit.

After their consultations were observed, family planning clients were interviewed about issues commonly related to client satisfaction. Specifically, they were asked if they had a problem with their method upon their arrival at the facility and, if so, whether the provider had discussed and addressed the problem. Details on components of counselling that were observed and reported by clients are presented in Table A-5.26.

Comparing observations of consultations with what clients reported at exit interviews reveals some minor discrepancies. Among users of hormonal methods, client reports agree with the observational data on whether the provider discussed a follow-up visit, which was almost universal (observed in 95 percent of consultations and reported by 95 percent of clients at exit interviews). Client reports and observational data in other areas, however, were somewhat inconsistent. For example, there was a small difference concerning discussion of side effects. While 46 percent of clients reported that providers explained possible side effects, observers say providers offered this information during 41 percent of interactions (Table A-5.26).

5.6 Client Opinion from Exit Interviews

Exit interviews with clients collected their opinions of the services that they received on that day. Details on client opinions are provided in Tables A-5.28 and A-5.29. Table A-5.30 provides information on the educational backgrounds and other characteristics of the clients who were observed and interviewed.

5.6.1 Major Problems during Visit

During exit interviews clients were asked about issues commonly related to client satisfaction. They were asked to rate whether specific issues posed a *major* problem, a *minor* problem, or no problem at all for them during the visit. Few issues were considered major problems, and by only a small proportion of clients. Waiting time to see a provider was the greatest problem—considered a major issue by 18 percent of all family planning clients. All other issues were major to no more than 6 percent (Table A-5.28).

5.6.2 Nearest Facility

Only 12 percent of clients said that the facility was not the one closest to their home. This implies that approximately 90 percent of family planning clients visited the facility closest to their home. Although the actual numbers are small, clients reporting that this was not the closest facility were more likely to be found at private facilities (Table A-5.29).

[3] If the client attended a facility where measuring blood pressure is standard procedure before the consultation, the client was assumed to have had her blood pressure measured, even if this was not observed for the particular client.

Key Findings

Major problems during visit to facility: Few issues were considered major problems for interviewed family planning clients. Waiting time to see a provider was the most cited problem.

Nearest health facility: Most interviewed family planning clients (88 percent) were visiting the facility closest to their home.

MATERNAL HEALTH SERVICES 6

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6.1 Background on Maternal and Newborn Health Care in Namibia

This chapter provides an overview of maternal and newborn health services in Namibia. It highlights the key aspects of maternal and newborn care, including the availability of staff and services for antenatal care (ANC), safe delivery, postnatal care (PNC), and management of obstetric complications. The chapter addresses the following central questions about maternal and newborn health services:

1. What is the availability of ANC services, and to what extent do facilities have the capacity to support quality ANC services?
2. Is there evidence that health service providers adhere to service standards for ANC?
3. To what extent is PNC[1] available where ANC is offered, and to what extent do facilities have the capacity to support quality PNC services?
4. What is the availability of delivery services, and to what extent do facilities have the capacity to support quality delivery services?
5. What are the common newborn care practices in facilities providing delivery services?

To determine which aspects of maternal health to assess, the 2009 Namibia Health Facility Census (NHFC) draws on the findings and recommendations of Safe Motherhood initiatives such as the Maternal and Neonatal Health Project, which is promoted by the World Health Organization (WHO) and other international organisations.

Maternal health status and health care utilisation

Complications of pregnancy and childbirth are among the leading causes of morbidity and mortality among Namibian women. Recent estimates suggest that there are 449 maternal deaths per 100,000 live births, an increase from 271 per 100,000 in 2000 and 225 per 100,000 in 1992 (Ministry of Health and Social Services (MoHSS), 1993; MoHSS, 2003; MoHSS and Macro International, 2008). According to the *Report on Needs Assessment for Emergency Obstetrics Care* (MoHSS, 2006a) the leading direct causes of maternal death in Namibia are severe eclampsia (33 percent), haemorrhage (25 percent), and obstructed/prolonged labour (25 percent). HIV/AIDS is the leading indirect cause of maternal mortality (37 percent).

Namibian women's rate of use of maternal health services is among the highest in Africa. Findings of the 2006-07 Namibia Demographic and Health Survey (NDHS) show that 7 in 10 women age 15-49 who had a live birth in the five years preceding the survey had made four or more ANC visits

[1] The 2009 NHFC accepted any report of offering routine out-patient postnatal examination and services as PNC. Details on the content of PNC were not collected. Capacity was assessed by whether the facility could identify and manage postnatal infections and whether the newborn's weight could be measured.

(MoHSS and Macro International, 2008). However, most women seek antenatal care relatively late in pregnancy, with a median gestation of 4.7 months at first visit.

The 2006-07 NDHS also shows that 33 percent of mothers age 15-49 with a live birth in the five years preceding the survey received two or more doses of tetanus toxoid (TT) vaccine during the pregnancy for the last live birth.

According to the 2009 National HIV Estimates and Projections report (MoHSS, 2009a), the national HIV prevalence estimate is 13.3 percent. The 2008 Namibia Antenatal Sentinel Surveillance Report estimates a prevalence of 17.8 percent among pregnant women, down from 19.9 in 2006.

Delivery in a health facility is less common than antenatal care. According to the 2006-07 NDHS, about 80 percent of live births in the five years preceding the survey took place in a health facility, with the vast majority (76 percent) taking place in a public facility. Eighty-one percent of all live births were assisted by a skilled provider,[2] 11 percent were assisted by a relative, and 7 percent by a traditional birth attendant (TBA). Less than 1 percent of live births were delivered with no one assisting.

The above aggregate figures conceal some variations. Regionally, for example, the proportion of births in a health facility ranges from 54 percent in Kunene to 95 percent in Khomas region. Children born in urban areas are more likely to be delivered in a health facility than those born in rural areas. In addition, almost all births among mothers with a secondary education or higher occur in a health facility, whereas only half of births among uneducated women occur in a health facility (MoHSS and Macro International, 2008).

Newborn health status

Newborn health is directly linked to maternal health; hence improving birth outcomes depends on improving maternal health care during pregnancy, delivery, and the postnatal period. In Namibia common causes of newborn deaths include infections, prematurity, asphyxia, diarrhoea, and congenital anomalies. Findings from the 2006-07 NDHS show a decrease in the infant mortality rate (IMR) from 51 per 1,000 live births in 2000 to 46 in 2006-07. However, the neonatal mortality rate increased from 20 per 1,000 live births in 2000 to 24 in 2006-07. Rural areas had higher neonatal mortality rates than urban areas (MoHSS and Macro International, 2008). The MoHSS Strategic Plan 2009-2013 includes an objective to decrease mortality rates. Indicators under this objective include the maternal mortality ratio (MMR), the IMR, and the neonatal mortality rate. The goal is to reduce the MMR from 449 to 100 per 100,000 live births by 2013; to reduce the IMR from 45 to 20 per 1,000 live births by 2013; and to reduce the neonatal mortality rate from 24 to 15 per 1,000 live births by 2013. The Road Map for Accelerating the Reduction of Maternal and Neonatal Morbidity and Mortality brings these goals together to focus and intensify interventions.

Maternal health policy framework

The Road Map for Accelerating the Reduction of Maternal and Neonatal Morbidity and Mortality highlights the mission ‘To provide an integrated, affordable, accessible, quality health and social welfare service that is responsive to the needs of the Namibian population’. The key objectives are as follows:

[2] Skilled provider includes doctor and nurse/midwife.

- To provide quality maternal health care services at all levels of health care delivery
- To increase the utilisation of maternal and neonatal health services
- To provide quality neonatal/newborn services at all levels of health care delivery
- To provide adolescent-friendly health services (AFHS) at all levels of health care delivery

Organisation of maternal health services in Namibia

For effective management, different maternal health services are provided in different health facilities. Clinics and health centres manage common and low-risk clinical issues, while hospitals manage the more difficult clinical issues.

6.1.1 Definition of Maternal Health Concepts Used during Collection of 2009 Namibia HFC Information

Maternal health is not only a women's issue; a mother's health has a direct bearing on the health of her newborn as well. According to WHO, about 15 percent of all pregnancies involve life-threatening complications (WHO, 2000b). Many complications and subsequent poor outcomes for women and newborns can be prevented or minimised by providing quality care, including early detection of problems and appropriate and timely interventions.

With growing evidence on best practices related to maternal morbidity and mortality, some conventional maternal health practices and interventions have been re-examined in recent years. Subsequently, there have been changes in programmes, policies, and strategies.

Antenatal care (ANC): All pregnant women are at risk of developing complications. It is, therefore, important to ensure that all pregnant women have access to preventive interventions, early diagnosis and treatment, and emergency care when needed. It is now emphasised that ANC should include birth preparedness, early detection of complications, and skilled and timely interventions to avoid adverse maternal and neonatal outcomes.

Delivery care: Any delivery may have complications. Hence, the emphasis should be on using skilled and trained delivery care providers and ensuring that all women have access to life-saving emergency interventions at the time of labour and delivery. Since in many countries deliveries occur at home attended by traditional birth attendants (TBAs), extensive efforts and funds were previously directed towards upgrading the skills of TBAs. However, evidence now shows that in almost all cases the level of skill attained by so-called 'skilled' TBAs is less than what is considered safe. In essence, in-service training for TBAs cannot improve their skills to the level of competency needed.

A skilled attendant, as defined by WHO and other international bodies, is a 'health professional—such as a midwife, doctor, clinical officer, or nurse—who has been educated and trained to proficiency in the skills needed to manage normal pregnancies, childbirth, and the immediate postnatal period, and in the identification, management, and referral of complications in women and newborns' (WHO, 2004b).

Postnatal care (PNC): There is an increasing emphasis on ensuring that women receive PNC within 48 hours after delivery for early diagnosis of postnatal complications. PNC also provides an opportunity to counsel the new mother on family planning, to teach her how to care for herself and her newborn during the postnatal period, to promote exclusive breastfeeding, and to assess the newborn for problems.

Newborn care: More attention has also been given recently to newborn care, with an increased awareness of the need to discourage some common practices that are detrimental to newborn health. The aim is to promote practices that contribute to improved newborn health.

Emergency obstetric care (EmOC): EmOC refers to care provided in health facilities to manage and treat direct obstetric emergencies that cause the vast majority of maternal deaths during pregnancy, labour and delivery, and during the postpartum period. Facilities are considered either basic or comprehensive EmOC if they provide a series of services or interventions known as signal functions over a designated 3-month period. The 6 signal functions that define a basic EmOC (BEmOC) are parenteral administration of antibiotics, oxytocic drugs, and anticonvulsants; manual removal of the placenta; removal of retained products of conception; and assisted vaginal delivery. Comprehensive EmOC (CEmOC) includes the 6 signal functions plus performance of caesarean sections and blood transfusions.

6.2 Availability and Capacity to Provide Quality Maternal and Newborn Care Services

6.2.1 Availability of Antenatal and Postnatal Care Services

ANC is designed to promote healthy behaviours and preparedness during pregnancy, childbirth, and the postpartum period. It is also important for the early detection and treatment of complications. Information on the availability of ANC, PNC, and TT vaccine services in Namibian health facilities is provided in Table 6.1. Table A-6.1 provides information on the availability of various family health services on the day of the survey. Additional information on the availability of ANC and TT services is provided in Table A-6.2.

Table 6.1 Availability of antenatal care, postnatal care, and tetanus toxoid vaccine

Percentage of facilities offering antenatal care (ANC), postnatal care (PNC), and tetanus toxoid vaccine (TT), and percentage offering all three services, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities offering the indicated services				Number of facilities
	ANC	PNC	TT vaccine	ANC, PNC, and TT	
Type of facility					
Hospital	18	20	16	16	44
Health centre	93	87	91	85	46
Clinic	86	76	83	73	293
Managing authority					
MoHSS	86	77	83	75	306
Mission/NGO	93	79	93	79	28
Private	29	27	22	22	49
Region					
Caprivi	96	93	96	93	27
Erongo	56	59	53	53	32
Hardap	85	90	80	75	20
Karas	76	76	72	72	25
Kavango	95	89	95	89	56
Khomas	29	26	26	26	31
Kunene	89	79	82	71	28
Ohangwena	91	66	91	66	32
Omaheke	81	81	81	81	16
Omusati	84	61	82	61	49
Oshana	78	72	78	72	18
Oshikoto	91	86	86	82	22
Otjozondjupa	67	52	59	48	27
Total	79	71	76	68	383

Note: There are three facilities with PNC that have no ANC but are included in the ANC denominator.

Approximately eight of every ten facilities in Namibia offer ANC services, seven of every ten offer PNC, and three-quarters offer TT vaccine; 68 percent offer all three services (Table 6.1). ANC services are available mostly in clinics (86 percent) and health centres (93 percent) rather than hospitals (18 percent). In addition, mission/NGO-managed facilities (93 percent) and MoHSS facilities (86 percent) are more likely than private facilities (29 percent) to offer ANC. Regional comparisons find that over 90 percent of facilities in Caprivi, Kavango, Ohangwena, and Oshikoto offer ANC services compared with 56 to 89 percent of facilities in other regions. Khomas is the outlier, with only three of every ten facilities offering ANC services.

Among facilities offering ANC services, about two-thirds offer the services one or two days per week, 10 percent offer the services three or four days per week, and only two of every ten offer ANC services five or more days per week (Table A-6.2).

Eighty-six percent of facilities offering ANC report offering TT services five or more days per week, while eight percent provide TT services one or two days per week (Table A-6.2). Practically all ANC facilities (95 percent) provide TT every day that ANC is offered.

Key Findings

Service availability: Eight of every ten facilities offer ANC services. Clinics and health centres are more likely than hospitals to offer ANC. At the regional level facilities in the Caprivi, Kavango, Ohangwena, and Oshikoto regions are more likely to offer ANC services than facilities in other regions, while Khomas region has the lowest percentage of facilities offering ANC services.

Two of every ten ANC facilities offer ANC services five or more days per week, and 95 percent of ANC facilities offer tetanus toxoid vaccine every day that ANC is offered.

6.2.2 Infrastructure and Resources to Support Quality Assessment and Counselling in ANC and PNC

To support quality assessment and counselling of ANC clients, the following are necessary: individual client cards, ANC guidelines or protocols, and visual aids for client education. Table 6.2, Figure 6.1, and Table A-6.3 present information on the availability of these items.

An individual ANC card is used to monitor maternal and foetal condition during pregnancy and to keep track of the care given. It is an important tool for identifying risk factors for referral, assessing quality of care, ensuring standardisation of antenatal care, and helping in planning. Blank individual client cards (health passports) are available in nine of every ten facilities offering ANC services (Figure 6.1, Table A-6.3).

Written ANC guidelines, which include details on how to manage common pregnancy-related problems, are available in only one-third of facilities offering ANC services, with hospitals being least likely to have ANC guidelines available. Visual aids for ANC client counselling are available in about half of facilities that offer ANC services (Figure 6.1, Table A-6.3).

Overall, only two of every ten facilities has all three items—client cards, ANC guidelines, and visual aids—to support quality ANC assessment and counselling. All three items together are least likely to be found in hospitals (11 percent) and in facilities in Otjozondjupa region (6 percent). Availability of all items is also low in private facilities (7 percent) (Table 6.2).

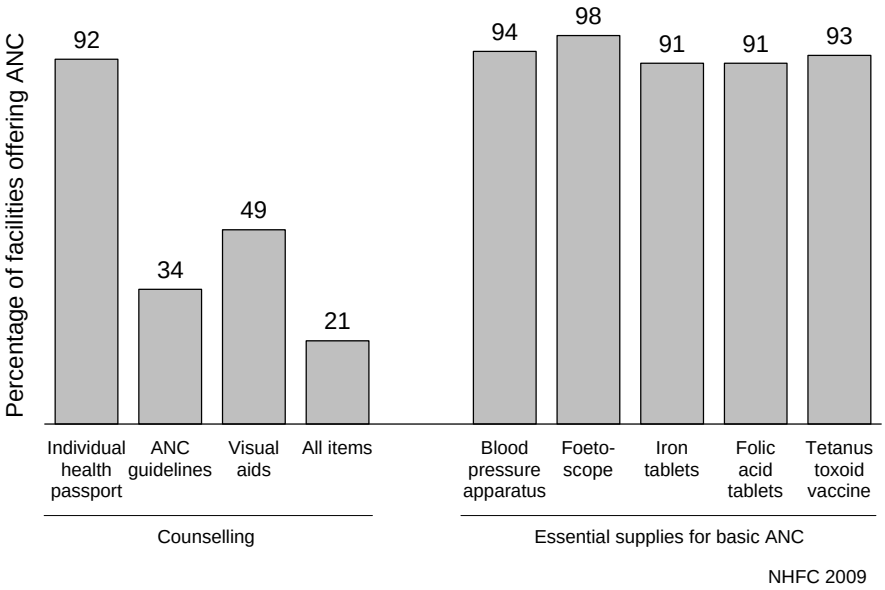
Table 6.2 Resources to support quality counselling and examinations for antenatal and postnatal care

Among facilities offering antenatal care (ANC), percentage with all items to support quality counselling for ANC and postnatal care (PNC), infection control, physical examinations, and basic ANC interventions, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities offering ANC services with				Number of facilities offering ANC
	All items to support quality counselling[1]	All items for infection control[2]	All items for physical examination[3]	All essential supplies for basic ANC[4]	
Type of facility					
Hospital	11	44	44	89	9
Health centre	30	49	44	93	43
Clinic	20	63	30	74	253
Managing authority					
MoHSS	22	61	32	78	265
Mission/NGO	19	50	8	69	26
Private	7	79	86	57	14
Region					
Caprivi	12	73	15	85	26
Erongo	21	68	42	68	19
Hardap	16	84	68	68	19
Karas	32	74	63	79	19
Kavango	23	83	15	81	53
Khomas	11	56	67	67	9
Kunene	12	84	12	64	25
Ohangwena	34	41	34	79	29
Omaheke	31	85	77	92	13
Omusati	27	56	24	76	41
Oshana	21	21	50	79	14
Oshikoto	15	15	20	80	20
Otjozondjupa	6	6	22	72	18
Total	21	61	32	77	305

[1] Visual aids for health education, guidelines for ANC, and individual client card or record.
[2] Soap and running water or else hand disinfectant, clean latex gloves, disinfecting solution, and sharps box.
[3] Private room offering visual and auditory privacy, examination table, and examination light.
[4] Iron and folic acid tablets, tetanus toxoid vaccine, blood pressure apparatus, and foetoscope (Pinard).

Figure 6.1 **Availability of Items to Support Quality ANC Services (N=305)**



6.2.3 Infrastructure and Resources for Examinations for ANC and PNC

The 2009 NHFC assessed whether facilities have the necessary supplies, equipment, and conditions for infection control and for conducting client examinations in the ANC service area. Aggregate information on these elements is provided in Table 6.2, and summary information on specific equipment and supplies is given in Figure 6.1. Table A-6.3 provides details on each item by facility type.

Infection control

Six of every ten facilities offering antenatal care have all items necessary for infection control in the ANC service delivery area[3] (Table 6.2). Clinics are more likely than other facility types to have all items for infection control available. Private facilities are more likely than facilities managed by MoHSS or missions/NGOs to have these items. Only 6 percent of facilities in Otjozondjupa region have all items. As is evident in Table A-6.3, each of these items is available in between 61 percent (hand disinfectant) and 90 percent (latex gloves) of ANC facilities.

Just 13 percent of facilities providing ANC services have a table cloth/plastic on one or more surfaces, which is prohibited under infection control policies; the small proportion of such facilities indicates general compliance with the policy.

Client examinations

The basic physical examinations performed during ANC visits include palpating the abdomen, examining the breasts, and sometimes conducting a pelvic examination. Hence, visual and auditory privacy, an examination bed/table, and an examination light are necessary. Practically all facilities that provide ANC services can ensure both visual and auditory privacy during a client's physical examination. In addition, an examination bed/couch (where a client can lie down flat for examination) is available in almost all ANC facilities. However, only 35 percent have an examination light (Table A-6.3). Consequently, only 32 percent of all facilities have all three items needed for physical examinations.

Private facilities are far more likely to have all items for physical exam (86 percent) than MoHSS facilities (32 percent) or mission/NGO facilities (8 percent) (Table 6.2).

6.2.4 Essential Equipment and Supplies for Basic ANC

A functioning blood pressure apparatus and foetoscope are essential equipment that should be available at all times in ANC service areas. Other essential ANC supplies include iron tablets, folic acid tablets, sulfadoxine-pyrimethamine (SP), blood specimen bottles for the Rapid Plasma Reagin (RPR) test apparatus, dip sticks for urine protein testing, and TT vaccine. The 2009 NHFC assessed the availability of five of these items: a blood pressure apparatus, a foetoscope, iron tablets, folic acid tablets, and TT vaccine. Each individual item was available in 91 to 98 percent of ANC facilities (Figure 6.1).

Three-quarters of ANC facilities had all five essential items (Table 6.2, Table A-6.3). There is not much variation in availability among regions; however, facilities in Omaheke region (92 percent) stand out compared with facilities in Kunene, at the other end of the range, where only 64 percent of facilities have all essential supplies.

[3] Soap and running water or else hand disinfectant, clean latex gloves, disinfecting solution, and sharps box.

Key Findings

Guidelines: ANC guidelines are available in only one-third of facilities offering ANC services.

Infection control: Six of every ten facilities had all assessed items for infection control in the ANC service area; clinics and private facilities were more likely than others to have all items available. Less than 10 percent of facilities in Otjozondjupa region had all assessed infection control items.

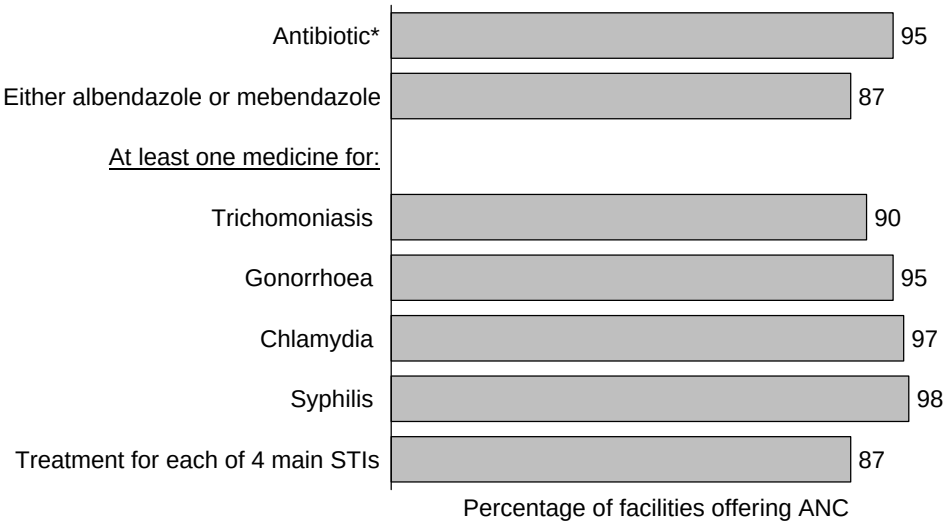
Privacy: Practically all ANC facilities can ensure both visual and auditory privacy during a client's physical examination.

Essential supplies: The essential supplies of a blood pressure apparatus, a foetoscope, iron tablets, folic acid tablets, and TT vaccine were each individually available in over 90 percent of ANC facilities.

6.2.5 Additional Equipment and Supplies for Quality ANC and PNC Services

Other elements that support quality antenatal and postnatal care services include diagnostic capacity and availability of medicines to treat common infections. Figures 6.2 and 6.3 provide summary information on the medicines and laboratory capacities available in facilities. Aggregate information is available in Table 6.3, and Tables A-6.4 through A-6.9 provide details on each item assessed, by type of facility.

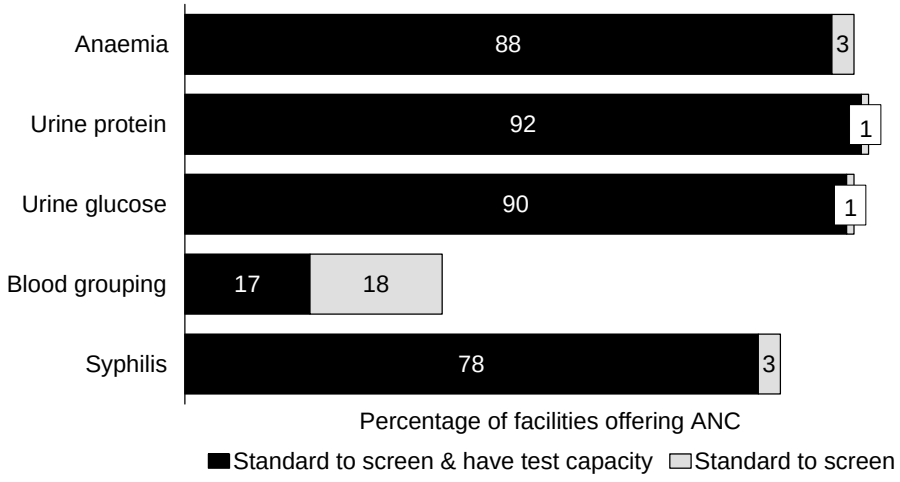
Figure 6.2 **Medicines for Managing Common Problems and Complications of Pregnancy (N=305)**



* Amoxicillin or augmentin or cotrimoxazole

NHFC 2009

Figure 6.3 Facilities with Standard to Routinely Screen ANC Clients and Capacity to Conduct Indicated Tests (N=305)



Note: "Standard to screen" in this figure is the sum of both bars. For example, for anaemia, the "Standard to screen" will be 91 percent, while "Standard to screen & have test capacity" will be 88 percent.

NHFC 2009

Table 6.3 Facility practices and resources for diagnosis and management of common problems and complications of pregnancy

Among facilities offering antenatal care (ANC), percentage where ANC providers can diagnose and treat sexually transmitted infections (STIs), percentage with medicines to manage common complications of pregnancy, and percentage with the capacity to conduct specific diagnostic tests, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage where ANC providers routinely treat STIs	Percentage with all medicines for treating pregnancy complications[1]	Percentage with capacity for conducting the indicated diagnostic test					Number of facilities offering ANC
			Anaemia[2]	Urine protein[3]	Urine glucose[4]	Blood grouping[5]	Syphilis[6]	
Type of facility								
Hospital	56	78	89	78	78	33	89	9
Health centre	81	44	95	100	100	56	95	43
Clinic	94	20	94	98	98	57	92	253
Managing authority								
MoHSS	92	25	95	98	98	55	94	265
Mission/NGO	85	23	96	100	100	65	96	26
Private	100	29	71	79	79	57	64	14
Region								
Caprivi	100	46	100	100	100	100	100	26
Erongo	89	21	89	95	95	26	47	19
Hardap	79	21	89	89	89	5	89	19
Karas	89	42	58	100	100	11	95	19
Kavango	91	19	100	100	100	68	100	53
Khomas	100	56	67	56	56	22	67	9
Kunene	100	32	100	100	100	60	100	25
Ohangwena	93	17	100	100	100	83	100	29
Omaheke	100	77	100	100	100	100	100	13
Omusati	88	10	95	100	100	68	90	41
Oshana	93	14	100	100	100	0	100	14
Oshikoto	95	10	100	100	100	80	100	20
Otjozondjupa	78	11	100	100	100	22	83	18
Total	91	25	94	98	98	56	92	305

[1] At least one broad-spectrum antibiotic (amoxicillin or cotrimoxazole) and either albendazole or mebendazole and methyldopa (Aldomet) and first-line antimalarial and at least one medicine for treating each of the following—trichomoniasis, gonorrhoea, chlamydia, and syphilis—all present.
[2] Includes any test—haemoglobinometer or calorimeter or centrifuge with capillary tubes or filter paper methods.
[3] Dip sticks for urine protein or else acetic acid for checking urine albumin and flame for heating acetic acid
[4] Dip sticks for urine glucose or Benedict's solution for urine glucose testing with stove for boiling Benedict's solution were assessed.
[5] Anti-A, Anti-B, Anti-AB, and Anti-D reagents, plus an incubator, Coomb's reagent and glass slides all present.
[6] Either Venereal Disease Research Laboratory (VDRL) test or polymerase chain reaction (PCR) test with functioning rotator or shaker, or RPR test.

Sexually transmitted infections (STIs), pre-eclampsia and eclampsia (hypertensive disorders of pregnancy), anaemia, and vaginal infections can directly affect both maternal and newborn health. Basic essential obstetric care (BEOC) requires that a facility provide early treatment for complications of pregnancy to prevent these conditions from progressing to more serious conditions. Standards for treatment may vary depending on ANC policies and the qualifications of the service provider.

Treatment of STIs

Antenatal care service providers in 91 percent of facilities offering ANC services routinely treat STIs (Table 6.3). This is more likely to be the case in health centres (81 percent) and clinics (94 percent) than in hospitals (56 percent). Facilities in Otjozondjupa and Hardap regions are the least likely to have ANC providers who routinely offer STI services.

Trichomoniasis, chlamydia, gonorrhoea, and syphilis are four of the most commonly seen STIs in health facilities. Most ANC facilities (87 percent) have at least one medicine to treat each of these STIs (Figure 6.2, Table A-6.4). Health centres (93 percent) are more likely than other facility types to have at least one medicine for each of these STIs.

Management of pregnancy complications

A facility is considered to have all medicines for managing common complications of pregnancy if it has all of the following: at least one broad-spectrum antibiotic[4], albendazole or mebendazole, methyldopa (Aldomet), the first-line antimalarial, and at least one medicine for treating each of the four common STIs (gonorrhoea, syphilis, chlamydia, and trichomoniasis).

Only one-quarter of facilities offering ANC had all medicines for managing pregnancy complications (Table 6.3). However, there is wide variation in the availability of all medicines by facility type and region. For example, only 20 percent of clinics but 78 percent of hospitals have all medicines for managing pregnancy complications. Further, facilities in Khomas (56 percent) and Omaheke (77 percent) are more likely than those in other regions to have all medicines; for example, approximately one of every ten facilities in Omusati, Oshikoto, and Otjozondjupa have all medicines for managing pregnancy complications.

There is also wide variation in the availability of individual medicines. For example, 95 percent of facilities have a broad-spectrum antibiotic, compared with 76 percent that have a first-line antimalarial available (Figure 6.2, Table A-6.4). Methyldopa, for the management of elevated blood pressure during pregnancy, is largely available in hospitals (89 percent) but less so in clinics (33 percent), perhaps because clinics are not expected to manage pregnancy-induced hypertension.

Testing capacity

The 2009 NHFC also assessed whether facilities have the capacity[5] to test ANC and PNC clients for anaemia, urine protein, and urine glucose and the lab capacity to diagnose syphilis and other common STIs.

Ninety-four percent of ANC facilities have the capacity to test for anaemia, 98 percent have the capacity to test for urine protein and urine glucose, and 92 percent have the capacity to diagnose syphilis (Table 6.3, Tables A-6.5 through A-6.9). Only 56 percent, however, have the capacity to do blood

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[4] Amoxicillin or amoxicillin/clavulinate or cotrimoxazole.

[5] Facility has the capacity to conduct the test in-house or in an affiliated laboratory, or facility has a system to have the test done elsewhere and receive results back.

grouping. Mission/NGO-managed facilities are most likely to have the capacity to conduct each of these tests.

Capacity to conduct a test does not necessarily imply that facilities offer or provide these tests to clients. Figure 6.3 and Tables A-6.5 through A-6.9 present information on proportions of facilities that report routinely screening ANC clients for these conditions, along with the proportions that actually have the testing capacity. For example, as shown in Table A-6.9, while 92 percent of ANC facilities have the capacity to test for syphilis, only 81 percent report that they routinely screen ANC clients for the condition. Further, 78 percent have the laboratory capacity to conduct syphilis diagnostic tests and also routinely screen ANC clients for syphilis. Private facilities are least likely to have the capacity to test for syphilis and to have the standard of routinely screening ANC clients for syphilis.

Ninety-four percent of ANC facilities have the capacity to test for anaemia, and 91 percent have the standard to screen ANC clients for anaemia. In combination, 88 percent of ANC facilities have both the capacity to conduct anaemia tests and the standard to screen (Table A-6.5).

While 56 percent of facilities offering ANC services have the capacity to do blood grouping and Rh factor testing, only 35 percent report that they have the standard to offer blood grouping and Rh factor testing to ANC clients; further, only 17 percent have the capacity to conduct the tests and also have the standard to offer these tests. A higher proportion of mission/NGO facilities have the capacity to conduct blood grouping and Rh factor testing (65 percent); however, private facilities are more likely both to have the capacity to conduct the tests and to have it as a standard to offer these tests (Table A-6.8). These generally low percentages can be explained by the fact that not all laboratories are expected to do these tests, especially if the laboratory is in a district with a blood transfusion facility. Blood grouping and Rh factor testing are, by mandate, part of blood transfusion services. In addition, some district laboratories are not able to conduct these tests and therefore refer these services to the national lab in the region.

In general, compared with other managing authorities, MoHSS and mission/NGO facilities are more likely than facilities under other management to also to have the capacity to conduct tests for anaemia, urine protein, urine glucose, and syphilis and also to screen ANC clients routinely with these tests.

Key Findings

STI services by ANC providers: Antenatal care service providers in majority of facilities offering ANC services routinely treat STIs. Health centres and clinics are more likely to have ANC providers that routinely treat STIs than are hospitals.

Medicines to treat common STIs: Among facilities offering ANC services, only one-quarter have all medicines to manage pregnancy complications. However, there is wide variation in the availability of all medicines by facility type and region, as well as in the availability of the individual medicines.

Laboratory testing capacity: Close to 9 in 10 of ANC facilities have the capacity to conduct anaemia tests and the standard to routinely screen ANC clients for anaemia.

6.3 MANAGEMENT PRACTICES SUPPORTIVE OF QUALITY MATERNAL HEALTH SERVICES

Management practices that support quality antenatal and postnatal care services include documentation and record-keeping, posting of user fees, as well as staff supervision and development. Table 6.4 and Figure 6.4 provide summary information on facility management practices and training received by ANC service providers. Tables A-6.10 through A-6.12.2 provide details on ANC service utilisation, user fees, and clients' out-of-pocket payments for ANC services. Table A-6.13 provides information on supportive management for ANC service providers, while Tables A-6.14.1 through A-6.15 provide detailed information on training and supervision.

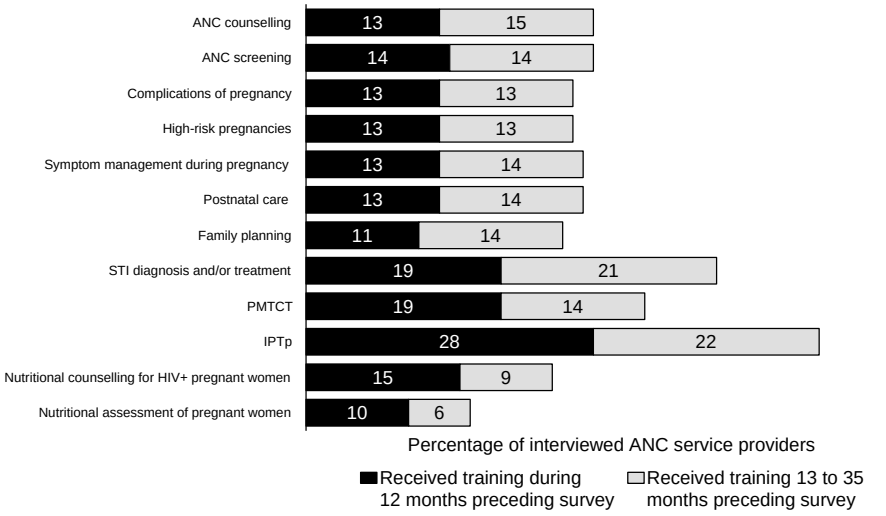
Table 6.4 Management practices supportive of quality maternal health services

Percentage of facilities offering antenatal care (ANC) that have an up-to-date client registers, documentation of monitoring ANC coverage, and user fees for ANC, and percentage of these facilities where interviewed ANC providers report receiving routine training related to their work and personal supervision, by background characteristics, Namibia HFC 2009

	Observed up-to-date client registers[1]		Percentage of facilities offering ANC that have:			Percentage of facilities offering ANC where staff report receiving routine:		
Background characteristics	ANC	Postnatal care (PNC)	Documentation of monitoring ANC coverage	User fees for ANC	Number of facilities offering ANC	Training related to ANC[2]	Personal supervision[3]	Number of facilities with interviewed ANC providers[4]
Type of facility								
Hospital	67	67	11	22	9	38	88	8
Health centre	77	51	26	14	43	56	91	43
Clinic	68	24	14	11	253	55	76	249
Managing authority								
MoHSS	70	29	15	8	265	56	80	260
Mission/NGO	92	42	23	0	26	54	96	26
Private	14	14	0	100	14	29	21	14
Region								
Caprivi	88	50	27	0	26	64	76	25
Erongo	68	21	0	5	19	56	78	18
Hardap	63	26	32	68	19	12	76	17
Karas	58	42	37	26	19	58	84	19
Kavango	74	28	13	4	53	42	74	53
Khomas	22	22	0	56	9	44	44	9
Kunene	44	20	0	20	25	48	64	25
Ohangwena	86	10	3	3	29	41	90	29
Omaheke	77	31	38	31	13	77	100	13
Omusati	56	27	7	0	41	76	90	41
Oshana	93	57	0	0	14	79	86	14
Oshikoto	80	35	35	0	20	68	89	19
Otjozondjupa	72	22	22	0	18	50	50	18
Total	69	29	15	12	305	54	78	300

[1] Register has entry within past seven days that indicates, at a minimum, whether this was the first or a follow-up visit for ANC and, for PNC register, number of days postpartum.
[2] A facility has routine staff training if at least half of interviewed providers reported that they had received pre- or in-service training related to their work during the 12 months preceding the survey. This refers to structured sessions and does not include individual instructions received during routine supervision.
[3] A facility has routine staff supervision if at least half of interviewed providers reported that they had been personally supervised at least once during the six months preceding the survey.
[4] Includes only providers of ANC in facilities offering ANC services.

Figure 6.4 **Training Received by Interviewed ANC Service Providers, by Topic and Timing of Most Recent Training (N=559)**



* IPTp = Intermittent preventive treatment in pregnancy

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6.3.1 Facility Documentation and Records

A client register was considered up-to-date if it had an entry within the seven days prior to the assessment that indicated the type of client visit (first visit or follow-up visit). Among facilities offering ANC services, seven of every ten had up-to-date ANC registers, and three of every ten had up-to-date PNC registers (Table 6.4). Health centres were more likely to have up-to-date ANC registers than other facility types (77 percent of health centres versus 67 percent of hospitals, for example). Private facilities were less likely to have up-to-date ANC and PNC registers (14 percent each) than MoHSS facilities (70 percent with up-to-date ANC registers, and 29 percent with up-to-date PNC registers).

According to findings of the assessment, health facilities in the country rarely monitor ANC coverage rates. Only 15 percent of ANC facilities had documentation of this activity (Table 6.4). Not a single facility in Erongo, Khomas, Kunene, or Oshana reported monitoring ANC coverage; in other regions levels ranged from 3 to 38 percent.

6.3.2 Practices Related to User Fees

User fees may have a positive effect on service utilisation by increasing the funds available to the facility. At the same time, however, they may have a negative effect by deterring poor clients from using these services. Displaying user fees (or advertising that there are no fees for certain services) contributes to the quality of care by letting clients know the cost of services before the service is rendered. It may also contribute to transparency and thus facilitate clients' utilisation of health care services.

In Namibia ANC services are supposed to be provided free of charge in all government and mission/NGO facilities. According to findings of the assessment, overall, 12 percent of ANC facilities charge for ANC services; this includes no mission/NGO facilities and 8 percent of MoHSS facilities but all private facilities (Table 6.4). Five regions have no facilities that charge for ANC services; in the remaining regions levels range from 4 percent of facilities in Kavango to 68 percent in Hardap.

Information on specific items for which facilities charge is presented in Table A-6.11. Among ANC facilities that charge user fees, on average, only 25 percent of facilities publicly display all fees.

ANC clients were interviewed as they left the facility after receiving services. They were asked, among other things, if they paid any out-of-pocket fees for the services that they had received. Ten percent of first-visit ANC clients and only 2 percent of follow-up clients reported paying out-of-pocket user fees, which averaged 47 Namibian dollars (Tables A-6.12.1 and A-6.12.2). For first visits out-of-pocket fees paid by clients were higher in health centres (approximately N$82) than in clinics (N$46).

6.3.3 Training and Supervision

Training

Service providers were interviewed and information gathered on their qualifications and on the training and supervision that they had received. Generally, a facility is classified as providing routine staff development activities if at least half of interviewed ANC providers said that they had received structured training relevant to ANC during the 12 months preceding the survey. This includes formal pre-service and in-service training, but it excludes individual instruction received during routine supervision. Half of ANC facilities meet these criteria (Table 6.4). Health centres and clinics are more likely than hospitals to have staff development activities. Facilities managed by the MoHSS or by mission/NGOs are more likely than private facilities to have routine staff development activities.

Interviewed ANC service providers most often reported training in intermittent preventive treatment (IPT) of malaria for pregnant woman (28 percent of interviewed ANC service providers), STI diagnosis and treatment (19 percent of ANC providers), prevention of mother-to-child transmission (PMTCT) of HIV (19 percent), and nutritional counselling for HIV-positive pregnant women (15 percent) (Figure 6.4, Tables A-6.14.1 and A-6.14.2).

Supervision

Supervising individual staff members helps to promote adherence to standards and to identify problems that contribute to poor services. Providers were asked whether they had been supervised by a supervisor at least once during the six months preceding the assessment. A facility is considered to have routine staff supervision if at least half of interviewed providers report that they have been personally supervised at least once during the six months preceding the survey. The data show that supervision of ANC providers is quite common, with 78 percent of facilities meeting the criteria for routine staff supervision (Table 6.4). Mission/NGO as well as MoHSS facilities are most likely to have routine staff supervision (96 and 80 percent, respectively). The rate of personal supervision at private facilities is very low, with only 21 percent of facilities meeting the criteria.

The median number of times a provider was supervised during the 6-month period was three (Table A-6.15). Reported numbers were high at MoHSS- and mission/NGO-managed facilities (74 and 80 percent of interviewed ANC providers) and relatively low at privately managed facilities (30 percent of interviewed ANC providers) (Table A-6.13).

Key Findings

Up-to-date client registers: Seven of every ten ANC facilities have up-to-date ANC client registers, but only three of every ten have up-to-date PNC client registers. Private facilities are less likely than MoHSS or mission/NGO facilities to have up-to-date ANC and PNC registers.

User-fees: Overall, one of every ten ANC facilities charges fees for ANC services. Those charging fees include all private facilities but just 8 percent of MoHSS-managed facilities; ANC services are supposed to be provided at no cost to clients in MoHSS-managed and mission/NGO facilities.

Staff development activities: Half of ANC facilities have routine staff development activities, and three-quarters have routine staff supervision.

6.4 Adherence to Standards for Quality ANC Service Provision

To assess whether ANC providers adhere to service standards, NHFC personnel observed ANC consultations, using checklists based on elements of focused ANC. The observers noted whether providers shared information on a topic and whether a physical examination was conducted. They did not assess whether the information shared was correct, whether an examination was properly done, or whether findings were appropriately interpreted.

6.4.1 Appropriate Assessment and Examination for ANC Clients

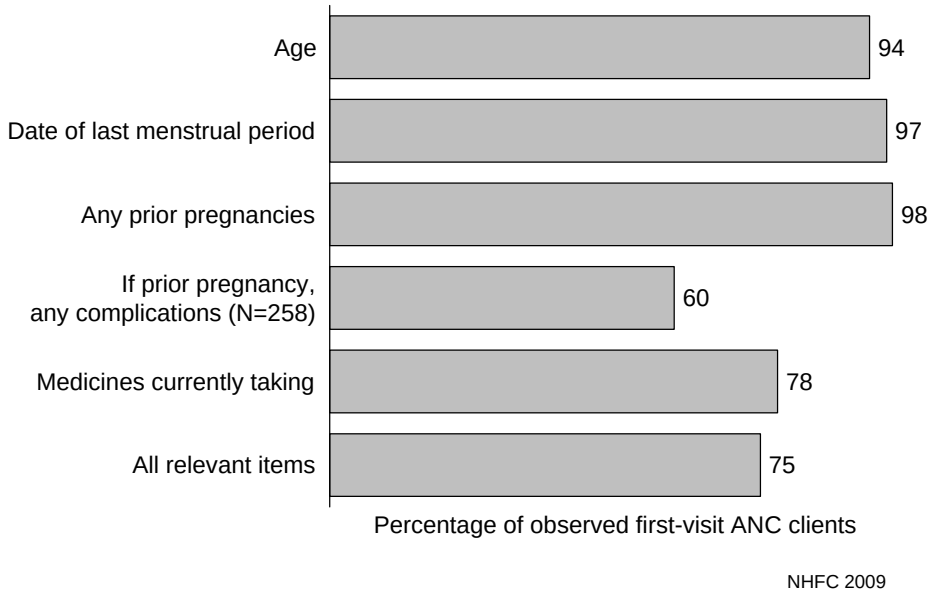
Summary information from the observation of ANC consultations is provided in Figures 6.5 through 6.8. Tables A-6.16 through A-6.22 provide details on assessments, examinations, and interventions for ANC clients.

Client history

During a woman's first ANC visit, the provider is expected to elicit a basic medical history to assess the client for pre-existing risk factors. During observed consultations, the majority of first-visit ANC clients were asked about their age (94 percent), date of last menses (97 percent), and any additional information or problems related to prior pregnancies (98 percent). They were asked less often about any complications during prior pregnancies (60 percent of clients with previous pregnancies) and what medicines the client was taking (78 percent). Three-quarters of first-visit ANC clients were assessed for all five of these items (Figure 6.5).[6]

[6] The denominator includes first-visit clients with no previous pregnancy (requiring only 4 of the items to be true), as well as first-visit clients with a previous pregnancy (requiring all 5 items to be true). Because of the high percentage of clients with no previous pregnancy that have all 4 items, the percentage with 'all relevant' items is higher than 60 percent.

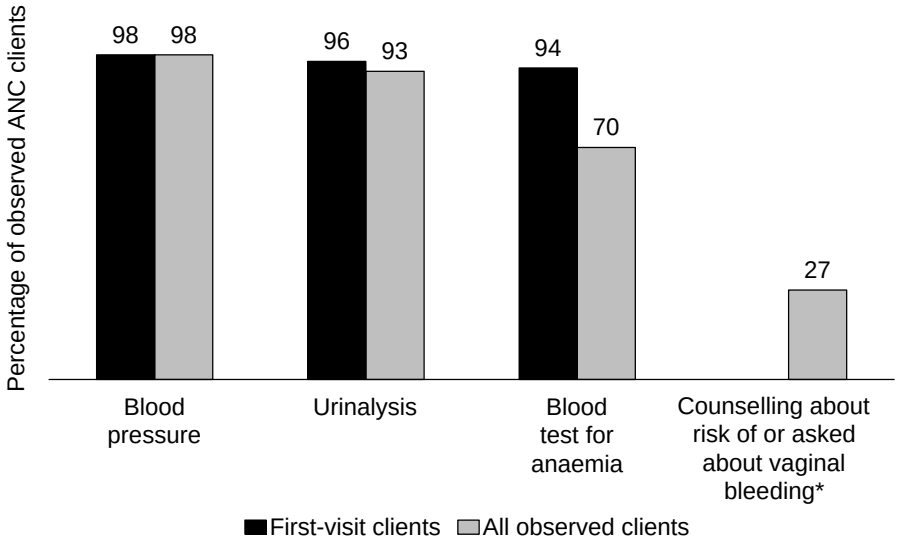
Figure 6.5 **Content of Client History Assessed for First-visit ANC Clients (N=390)**



Monitoring progress of pregnancy

All ANC clients should receive periodic assessments to monitor the progress of their pregnancies and to identify any danger signs or risk factors. This includes monitoring for both maternal and foetal conditions, such as the assessment of blood pressure and vaginal bleeding. Figure 6.6 provides information on the percentage of first-visit and all ANC clients who received these assessments during their visits. Tables A-6.17 and A-6.18 provide this information by facility type.

Figure 6.6 **ANC Assessments for First-visit (N=390) and All Observed ANC Clients (N=859)**



* This information was not collected for first-visit ANC clients.

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Laboratory testing capability is necessary (and required in some cases) for facilities to be able to provide certain screening and preventive interventions. If a facility itself does not have the capacity to provide the service, it should have a referral system in place to provide ANC clients with access to the service.

To meet defined minimum standards, each ANC visit should include the following components: counselling on vaginal bleeding as a risk factor for which help should be sought, measuring blood pressure, and conducting urinalysis to check for urine protein and glucose. First-visit clients should also be tested for anaemia.

According to findings of the 2009 NHFC, providers are more likely to measure blood pressure, conduct blood tests, or conduct urinalysis than to counsel clients about vaginal bleeding (Figure 6.6, Table A-6.17).

All ANC clients (first-visit and follow-up clients) had their blood pressure measured during an ANC visit (Table A-6.18). Ninety-four percent of first-visit and 70 percent of all observed ANC clients had their blood tested for anaemia. However, across all facility types, only a small proportion of all ANC clients (27 percent) were counselled or asked about vaginal bleeding (Figure 6.6). Six of every ten ANC clients who were at least five months pregnant were asked if they felt foetal movements (Table A-6.18).

Three-quarters of all ANC clients were either given or prescribed iron pills or folic acid tablets. Only half of observed ANC clients received explanations about the purpose of the iron or folic acid pills (Table A-6.18).

Key Findings

Content of ANC: During ANC visits 94 percent or more of first-visit clients were asked about their age, date of last menses, and any additional information or problems related to prior pregnancies; only six of every ten who had ever been pregnant were asked about any complications during prior pregnancies.

Assessment during visit: All ANC clients (first-visit and follow-up) had their blood pressure measured during the observed ANC visit; Ninety-five percent of first-visit clients and two-thirds of all observed ANC clients were tested for anaemia. Only one-quarter were asked or counselled about vaginal bleeding.

Three-quarters of all ANC clients were either given or prescribed iron pills or folic acid tablets; only half of observed clients received an explanation of their purpose.

6.4.2 Counselling to Promote a Healthy Outcome

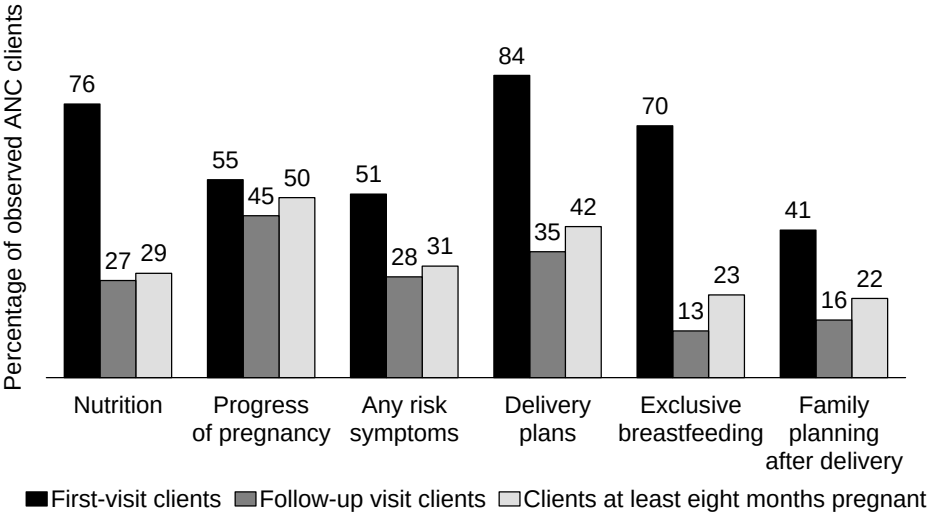
Counselling topics

ANC providers are expected to routinely counsel clients on nutritional needs during pregnancy as well as on signs and symptoms that may indicate a problem with the pregnancy. It is reasonable to assume that all topics may not be discussed during every visit, since most women make multiple ANC visits. Thus, the content of counselling for first and follow-up visits is assessed separately.

Observations reveal that nutritional issues were discussed during three-quarters of first-visit consultations and only one-quarter of follow-up consultations (Figure 6.7). Progress of the pregnancy was discussed with 55 percent of first-visit clients and with 45 percent of follow-up clients. Delivery plans were discussed with 84 percent of first-visit clients but only 35 percent of follow-up clients.

Unfortunately, delivery plans were discussed with only 42 percent of ANC clients who were at least eight months pregnant. Exclusive breastfeeding was discussed with only 23 percent of ANC clients who were at least eight months pregnant, although 70 percent of first-visit clients did receive such counselling.

Figure 6.7 **Counselling Topics Discussed during Observed First Visits (N=390) and Follow-up Visits (N=469) and with ANC Clients at Least Eight Months Pregnant (N=288), When Relevant**



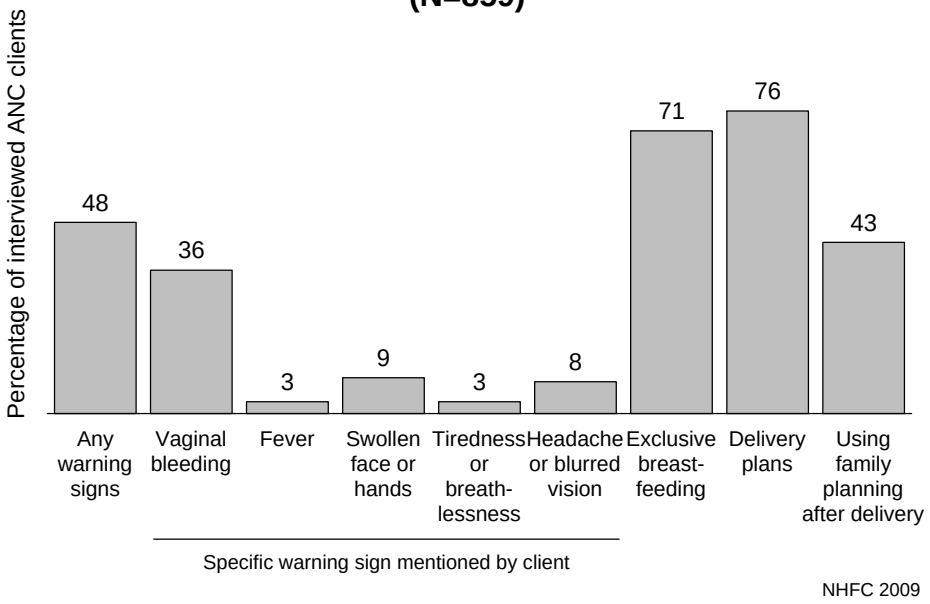
NHFC 2009

Family planning after childbirth was even less widely discussed with ANC clients; it was addressed with only four of every ten first-visit clients, with less than two of every ten follow-up clients, and with just two of every ten clients who were at least eight months pregnant (Figure 6.7). Only three of every ten ANC clients at least eight months pregnant received any counselling on pregnancy risk symptoms.

Observed ANC clients were interviewed as they left the facility after receiving services. They were asked, among other things, about health topics that were discussed during the current or previous ANC visits to the facility. Three-quarters of interviewed clients reported that a provider discussed delivery plans with them; four of every ten said that a provider discussed family planning, while seven of every ten said that a provider discussed exclusive breastfeeding during the current or a previous ANC visit (Figure 6.8).

Interviewed clients were also asked to mention specific warning signs that were discussed during the current or any previous ANC visit. Forty-eight percent said that they had discussed warning signs and symptoms of some kind during the current visit or previous ANC visits; however, few were able to name specific danger signs that they had discussed. Vaginal bleeding was the most commonly mentioned danger sign (36 percent of interviewed clients) (Figure 6.8). Other danger signs, such as fever, headache, and swollen face or hands, were each mentioned by less than one of every ten interviewed ANC clients.

Figure 6.8 **Topics Reported by Interviewed Clients as Having Been Discussed Either during This or a Previous ANC Visit (N=859)**



Malaria is endemic in only certain parts of the country; therefore, information on malaria is not expected to be a component of ANC counselling in most facilities. Information on insecticide-treated nets (ITNs) and intermittent prophylactic treatment (IPT) is presented in Tables A-6.19.1 and 6.19.2.

Not surprisingly, only a small proportion of observed clients were counselled on ITNs. Only 16 percent of first-visit ANC clients received counselling on the importance of using ITNs (Table A-6.19.1). These clients are mostly in Caprivi (84 percent), Kavango (14 percent), Kunene (12 percent), Ohangwena (64 percent), Oshana (11 percent) and Oshikoto (27 percent) regions. Ten percent of first-visit ANC clients were given an ITN free of charge, and mainly in Caprivi, Ohangwena and Oshikoto regions.

In addition, only 12 percent of first-visit and 16 percent of follow-up ANC clients were either prescribed or given IPT (Table A-6.19.2). There is some regional variation; ANC clients in Kavango, Kunene, Ohangwena, Omusati and Oshikoto are more likely to have been given or prescribed IPT.

Key Findings

ANC Counselling: First-visit ANC clients, in general, received more extensive counselling in all topics compared with clients on follow-up visits.

The counselling topics most commonly discussed with first-visit ANC clients were nutrition, delivery plans and exclusive breastfeeding. The topic most commonly discussed with follow-up clients, including clients at least eight months pregnant, was the progress of the pregnancy.

On average, counselling on family planning after childbirth and exclusive breastfeeding were the topics least discussed with follow-up clients during observed ANC visits.

6.4.3 Supporting a Continuum of Care

A continuum of care, including monitoring changes between visits, is important to quality ANC. One of the more reliable ways to achieve a continuum of care is to maintain a record of relevant history and findings, as well as of interventions or treatments provided. Frequently, health services are organised so that a client's vital signs (blood pressure and weight) are measured and the information recorded on the client's card or chart before the client sees the main ANC provider. Details on providers' use of individual client cards during ANC visits are provided in Table A-6.24.

Providers looked in the health passports of all first-visit clients during the consultation and also wrote in the health passports of all first-visit ANC clients. Providers looked in the health passports of nine of every ten follow-up clients during the consultation, to check history from previous visits; still, providers ended up writing in the health passports of all observed follow-up clients.

Providers at MoHSS and mission/NGO facilities looked at and wrote in all clients' health passports. This pattern changes for private facilities, however. Providers in privately managed facilities looked at the health passports of only 42 percent of first-visit clients, but they did write in the health passports of all first-visit clients. For follow-up clients, providers in private facilities looked in and wrote in the health passports of only 22 percent of follow-up clients.

Outcome of ANC visit

Information on the outcome of observed ANC visits is presented in Table A-6.25.

Eighty-four percent of all observed ANC clients went home after their meeting with the provider, while 13 percent were referred elsewhere in the same facility. Intra-facility referrals were far more likely at hospitals—65 percent of ANC clients observed at hospitals. Some regional differences stand out. Clients were more likely to be referred within a facility in Khomas (53 percent), Kunene (22 percent), and Hardap (20 percent) than in regions such as Caprivi, Oshana, and Otjozondjupa, where there were no intra-facility referrals.

Overall, only 2 percent of observed ANC clients were referred to another facility, although in Hardap region 13 percent of clients were referred elsewhere.

6.5 Client Opinion of Service Provision

6.5.1 Major Problems during Visit

As part of the exit interview, observed ANC clients were asked their opinion of the services that they had received and about any problems that they had encountered that day. The most common client concern was the waiting time to see the provider, reported by 27 percent of interviewed clients (Table A-6.26). There is little difference by type of facility. The interviewed clients did not consider other areas of possible concern, such as availability of medicines, cost of services, and attitude of providers, to be major problems.

6.5.2 Nearest Facility to Home

One of every ten interviewed ANC clients reported that the facility they were currently visiting was not the one closest to their home. The most common reason cited by those clients for not visiting the nearest facility to their home was that the nearest facility either had no services or poor services (approximately three of every ten such clients) (Table A-6.27). The second most frequently cited reason

was that the nearest facility was inconvenient to visit due to work (18 percent of clients for whom this was not the closest facility).

Hardap region (22 percent), as well as Otjozondjupa and Omusati regions (both 13 percent), had the highest proportion of clients who bypassed their closest facility. In both Hardap and Otjozondjupa the vast majority (84 and 86 percent, respectively), of these clients reported that this was because their closest facility had no or poor service.

6.5.3 Client Educational Characteristics

One of every ten observed ANC clients had no education; about one-quarter had primary education; and two-thirds had secondary education (Table A-6.28). Clients interviewed in hospitals were the most likely to have secondary education, while those interviewed in health centres and clinics were more likely to have only primary education.

Two-thirds of clients with primary, informal, or no education at all can read and write, while one-third cannot read or write.

6.6 Availability of Delivery Services and Capacity to Provide Quality Delivery Care

The 2009 NHFC assessed the availability of emergency obstetric care, the presence of standards, equipment, and supplies, and health system components to support quality delivery services. The following aspects were assessed:

- Availability of delivery services
- Home delivery care practices
- Infrastructure and resources to support quality delivery services
- Practices related to signal functions
- Documentation of delivery procedures and outcomes

6.6.1 Availability of Delivery Services

Table 6.5 provides information on the availability of maternal health services as well as details on the availability of emergency transport and services supporting safe home delivery. Additional information on emergency maternity transportation systems is provided in Table A-6.29.

Table 6.5 Availability of maternal health services

Percentage of facilities that offer specific maternity services, transportation for maternity emergencies, and services supporting safe home delivery and traditional birth attendants (TBAs), by background characteristics, Namibia HFC 2009

	Facility-based maternity services						Services supporting safe home delivery		
Background characteristics	Antenatal care (ANC)	Normal delivery services	Caesarean section	ANC and normal delivery services	ANC, normal delivery services, and Caesarean section	Transportation support for maternity emergencies[1]	Any home delivery services[2]	Documented official program supportive of TBAs[3]	Number of facilities
Type of facility									
Hospital	18	98	80	18	18	84	41	2	44
Health centre	93	83	2	80	0	89	37	17	46
Clinic	86	60	0	58	0	82	25	14	293
Managing authority									
MoHSS	86	71	7	62	1	88	31	14	306
Mission/NGO	93	89	18	86	14	93	39	21	28
Private	29	27	20	4	2	47	4	0	49
Region									
Caprivi	96	85	4	81	0	100	26	30	27
Erongo	56	41	13	22	0	72	25	3	32
Hardap	85	65	10	60	5	100	45	0	20
Karas	76	68	16	56	4	96	52	0	25
Kavango	95	79	5	73	4	93	43	18	56
Khomas	29	26	13	13	6	45	6	0	31
Kunene	89	89	11	79	0	86	11	4	28
Ohangwena	91	63	3	53	0	94	31	34	32
Omaheke	81	100	13	81	0	88	31	6	16
Omusati	84	63	4	57	2	73	18	22	49
Oshana	78	72	11	61	0	50	44	17	18
Oshikoto	91	64	14	55	5	95	14	14	22
Otjozondjupa	67	70	19	48	0	85	26	0	27
Total	79	67	9	56	2	83	28	13	383

[1] The facility has an ambulance, or there is a system in place whereby the facility provides some support for emergency transportation to a referral site.
[2] This may be either a routine service or services only for emergency cases.
[3] Any official activity with TBAs for which the facility has any documentation.

Normal delivery

Two-thirds of all facilities offer services for normal deliveries (Table 6.5). Normal delivery services are universally available in hospitals (98 percent) but not as widely available in health centres (83 percent) and clinics (60 percent). There is a large difference in availability of delivery services by managing authority; only one-quarter of private facilities offer normal delivery services, compared with nine of every ten mission/NGO facilities and seven of every ten MoHSS facilities. There are also notable variations among regions; for example, all facilities in Omaheke region offer normal delivery services, whereas only one-quarter of facilities in Khomas region and four of every ten facilities in Erongo region offer services for normal deliveries.

Caesarean sections

Caesarean section deliveries are available in only a small proportion of facilities—only one of every ten. As expected, mainly hospitals (80 percent) provide caesarean section services. Only 7 percent of government facilities provide the service, compared with 18 percent of mission/NGO facilities and 20 percent of private facilities. This is because most government facilities are lower-level health centres that are not expected to offer this service under normal circumstances. Overall, only 2 percent of all facilities offer ANC, normal delivery services, and caesarean sections together.

Transport for maternity emergencies

Transportation during maternity emergencies is crucial to the welfare of both the mother and newborn. One way of improving outcomes during such emergencies is to provide rapid transport to a facility where the appropriate service is available. Without a facility-supported emergency transportation system, the expectant mother and her family are forced to find their own means of transport during an emergency. Even when a facility does not offer delivery services but does offer ANC, it is desirable to have emergency transport available. For many home deliveries, the facility where a woman receives ANC may be the nearest health care delivery site where emergency help can be sought.

Eighty-three percent of all facilities have a system of emergency transportation[7] to another facility during maternity emergencies (Table 6.5). There is little variation among types of facilities in the availability of such a system; however, private facilities are significantly less likely than facilities managed by other authorities to have transportation support for maternity emergencies (47 percent of private facilities versus 88 and 93 percent of MoHSS and mission/NGO facilities, respectively). Khomas region has the smallest percentage of facilities with transportation support for maternity emergencies (45 percent).

Among facilities with transportation support for maternity emergencies, 27 percent have an ambulance or other facility-based vehicle, and 86 percent report using a vehicle that is based at another facility; 3 percent hire vehicles, and 16 percent have other arrangements to support the cost of emergency transportation (Table A-6.29). Khomas region has one of the smallest percentages of facilities with an ambulance or other facility-based vehicle among facilities that provide emergency transportation support. Karas region is among the most prepared—96 percent of facilities have emergency transportation support and, among those, 54 percent have an ambulance or other facility-based vehicle.

6.6.2 Domiciliary Care Practices

In Namibia most deliveries take place at health centres and hospitals. Although traditional birth attendants (TBAs) are not officially recognised health care workers, they are present in the community, and efforts are made to train them to refer pregnant women to health facilities and to assist in case of emergency deliveries. Research has shown that every pregnancy is at risk; therefore, every pregnant woman should receive skilled care during labour and delivery. The concept of domiciliary care operates on the understanding that skilled care can be provided at the community level with linkages to facilities.

According to findings of the 2009 NHFC, only 28 percent of facilities in Namibia have services supporting safe home delivery (Table 6.5). Hospitals (41 percent) and health centres (37 percent) are relatively more likely than clinics (25 percent) to provide home delivery services. Further, MoHSS (31 percent) and mission/NGO facilities (39 percent) are more likely than private facilities (4 percent) to provide home delivery services.

Only 13 percent of facilities have documentation of official support for TBAs; the highest levels of support are in Caprivi, Ohangwena, and Omusati regions, where between 22 and 34 percent of facilities have official programs supportive of TBAs.

[7] The facility has an ambulance, or there is a system in place whereby the facility provides some support for emergency transport to a referral site. Referral facilities are counted as having an emergency transportation system, since they can provide all relevant services.

Key Findings

Services for normal deliveries: Nearly seven of every ten facilities, mostly hospitals and health centres, offer services for normal deliveries, A larger proportion of MoHSS and mission/NGO facilities offer delivery services than do private facilities.

Caesarean sections: Only one of every ten facilities, mostly hospitals and private facilities provides caesarean section.

Transportation support: MoHSS and mission/NGO facilities are more likely than private facilities to have transportation support for maternity emergencies.

Home delivery services: About three of every ten facilities provide home delivery services.

6.6.3 Infrastructure and Resources to Support Quality Delivery Services

In addition to basic infrastructure that assures privacy and supports infection control, several types of equipment and medicines are needed to support safe deliveries. Tables 6.6 and 6.7 provide aggregate information on infrastructure, equipment, and supplies for basic delivery services, including emergency medicines. Figures 6.9 through 6.11 summarise the individual items available, and Tables A-6.30 through A-6.41 provide details on elements assessed for delivery services and on sterilisation and high-level disinfection (HLD) procedures for delivery equipment. Figure 6.12 provides information on equipment for emergency obstetric care. Information on supportive management and supervision is provided in Tables A-6.42 through A-6.44.

Table 6.6 Availability of elements for quality delivery services

Among facilities offering delivery services, percentage that have infection control items, capacity for sterilisation or high-level disinfection (HLD), infrastructure and furnishings, and other elements to support quality delivery services, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities offering delivery services with: All items for infection control[1]	Capacity for sterilisation/ HLD processing[2]	All delivery room infrastructure and furnishings[3]	All other elements to support quality[4]	Number of facilities offering delivery services
Type of facility					
Hospital	74	74	72	21	43
Health centre	66	8	45	13	38
Clinic	62	1	29	1	175
Managing authority					
MoHSS	64	11	38	4	218
Mission/NGO	64	12	16	16	25
Private	77	62	92	23	13
Region					
Caprivi	78	4	17	0	23
Erongo	77	38	54	8	13
Hardap	85	8	85	23	13
Karas	65	35	41	12	17
Kavango	82	7	20	9	44
Khomas	50	25	88	0	8
Kunene	72	8	4	4	25
Ohangwena	40	15	60	0	20
Omaheke	69	13	69	0	16
Omusati	71	10	29	3	31
Oshana	38	8	62	0	13
Oshikoto	29	14	14	14	14
Otjozondjupa	42	26	53	11	19
Total	65	14	38	6	256

[1] Soap and running water or else hand disinfectant, clean or sterile latex gloves, disinfecting solution for decontaminating reusable items, and sharps box.
[2] In location where delivery services equipment is processed, equipment and knowledge of minimum processing time for sterilizing or HLD processing and an automatic timing device were available.
[3] Bed, examination light, and privacy (both visual and auditory).
[4] Guidelines, partographs, and delivery provider on site or on call 24 hours a day, with duty schedule observed.

Infection control

Infection is one of the most common causes of maternal and neonatal morbidity and mortality; infection control practices are therefore essential for quality delivery care. Among facilities offering delivery services, 65 percent had all the items for infection control[8] available in the delivery services area on the day of the survey visit (Table 6.6, Table A-6.30). Hospitals were more likely than other facility types to have all infection control items available. There were notable variations by region, in the availability of all infection control items ranging from a low of 29 percent of facilities in Oshikoto to a high of 85 percent of facilities in Hardap.

Although available at the delivery services site in 78 percent of facilities that offer delivery services, disinfecting solution is the item most frequently missing among assessed items.

Covered waste receptacles with plastic liners, also considered important for infection control, are available in only three of every ten facilities that offer delivery services. Overall, only two of every ten facilities offering delivery services have all items for infection control and a waste receptacle at the delivery services site.

Sterilisation of delivery equipment

The 2009 NHFC assessed the systems in place for the final processing and storage of delivery equipment. Findings are presented in Table 6.6 and Tables A-6.31 through A-6.33.2.

Among facilities offering delivery services, 20 percent reported that they process equipment in the facility (3 percent sterilise or high-level disinfect (HLD) delivery equipment in the delivery area and 17 percent do so in the main facility area), while 76 percent process their equipment outside the facility. Four percent report that they do not process any equipment (Table A-6.31).[9] Among facilities offering delivery services that process equipment in the facility, 56 percent use either dry heat or autoclave; 4 percent use boiling/steaming or HLD, and 40 percent report some type of sterilisation or HLD processing but were missing either equipment or appropriate knowledge (Table A-6.32).

Thirty-seven percent of facilities offering delivery services that process equipment in the facility have written guidelines for sterilisation or HLD processing available in the area where delivery equipment is processed (Table A-6.32). Availability of guidelines for sterilisation or HLD processing varies by facility type and managing authority. For example, guidelines are more likely to be available in hospitals than in health centres and clinics, while MoHSS facilities are less likely than facilities managed by other authorities to have guidelines.

Overall, by 2009 NHFC definitions,[10] 14 percent of facilities that offer delivery services have the capacity for sterilisation or HLD processing at the location where delivery service equipment is processed (Table 6.6). Hospitals (74 percent) were more likely than other facility types, and private facilities (62 percent) were more likely than those managed by other facilities, to have the capacity to sterilise/HLD delivery equipment. At the regional level sterilisation/HLD capacity ranged from a low of 4 percent of delivery facilities in Caprivi to a high of 38 percent of delivery facilities in Erongo.

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[8] Soap and running water or else hand disinfectant, clean or sterile latex gloves, disinfecting solution for reusable items, and, a sharps box.

[9] Sterilisation and HLD processing are part of a centralised process at the hospitals, hence the high proportions of facilities that send equipment outside for sterilisation and HLD processing.

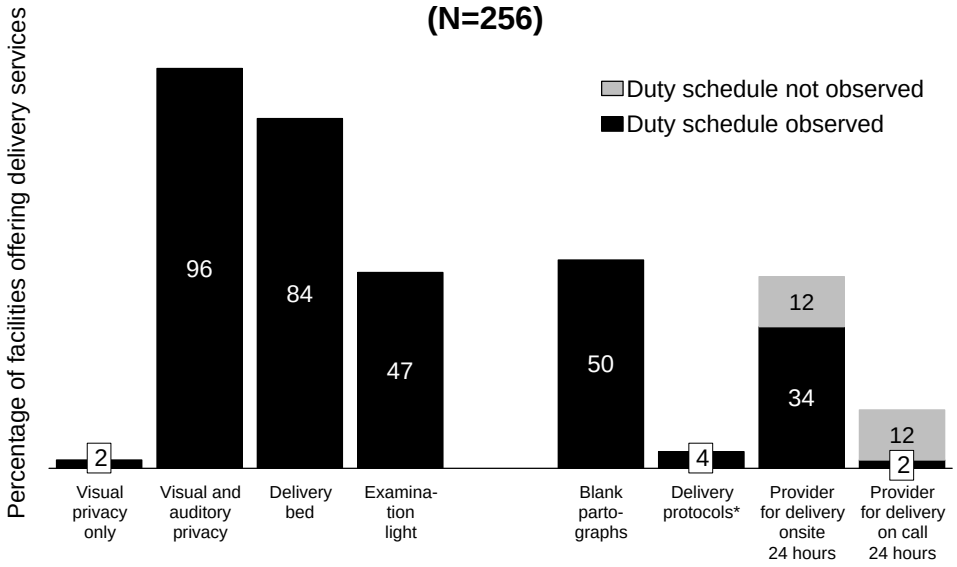
[10] In location where equipment for delivery services is processed, equipment and knowledge of minimum processing time (and pressure, where applicable) for sterilising or HLD processing, and an automatic timer were all available.

Infrastructure for delivery

Items to support quality delivery services were also assessed; findings are presented in Table 6.6 and Figure 6.9.

A bed, examination light, and privacy (both visual and auditory) are considered basic delivery room infrastructure and equipment. Overall, 96 percent of facilities had privacy, and 84 percent had a bed in the delivery area; however, only 47 percent had an examination light (Figure 6.9). Looking at availability of all items together, only 38 percent of facilities that offer delivery services had all these basic items available in the delivery area. Hospitals, private facilities, and facilities in Khomas and Hardap regions were more likely than other facilities to have all assessed items. At the other end of the scale, clinics, mission/NGO facilities, and facilities in Kunene were among the least likely delivery facilities to have all assessed items.

Figure 6.9 **Items to Support Quality Delivery Services (N=256)**



* Essential maternal and neonatal care clinical guidelines for Namibia NHFC 2009

Elements to support quality delivery services

The partograph[11] is promoted internationally as a way to improve the quality of care during labour; it provides guidelines for the early identification of complications. Half of delivery facilities have blank partographs available (Figure 6.9); they are more likely to be found at hospitals (91 percent) than in health centres (68 percent) or clinics (36 percent) (Table A-6.30).

Regarding the actual use of partographs, 31 percent of interviewed delivery service providers reported that they had used a partograph to monitor labour during the week preceding the visit, and 17 percent reported using it two to four weeks prior, but not in the past week (Table A-6.45). Thirty-five percent reported last using a partograph more than six months before the survey. Five percent had never used a partograph to monitor labour.

[11] The partograph is a tool that can be used by midwifery personnel to assess the progress of labour and to identify when intervention is necessary.

Only 19 percent of delivery service providers reported having received training on the use of the partograph during the 12 months preceding the survey (Figure 6.13, Table A-6.43.1).

Guidelines and protocols on delivery were not widely available in facilities offering delivery services; only 4 percent of facilities offering delivery services had delivery guidelines and protocols available in the delivery service area (Figure 6.9).

In Namibia general practitioners (including medical officers), clinical officers, registered nurses and midwives, enrolled nurses and midwives, and obstetricians/gynaecologists are the principal staff members who provide delivery services in health facilities. Forty-six percent of facilities report having a delivery service provider *on site* 24 hours a day; however, only 34 percent had a duty schedule to support that claim (Figure 6.9). Only 14 percent of facilities report having a delivery service provider *on call* 24 hours a day; only 2 percent of facilities had a duty schedule to support that claim.

Key Findings

Infection control: Sixty-five percent of all facilities offering delivery services had all items for infection control. Hospitals were more likely than other facility types, and facilities in Hardap region are more likely than those in other regions, to have all assessed infection control items.

Processing of equipment: Seven of every ten delivery facilities sterilise/HLD process delivery equipment in the facility; only one-quarter send delivery equipment outside for processing. By the 2009 NHFC definition, however, less than 15 percent of delivery facilities that report processing delivery equipment at the facility have the capacity for sterilisation/HLD processing of delivery equipment.

Only 10 percent of facilities offering delivery services and reporting that they process delivery equipment at the facility have written guidelines for sterilisation or HLD processing available in the area where delivery equipment is processed. Written guidelines for sterilisation or HLD processing are available mainly in hospitals (40 percent).

Partographs: Half of delivery facilities have blank partographs available; they are more likely to be available in hospitals (91 percent) than in health centres or clinics.

Availability of delivery service providers: One-third of delivery facilities report having a delivery service provider on site 24 hours a day and had a duty roster available as evidence of that. Only 2 percent had a delivery service provider on call and had a supporting duty schedule.

Essential supplies for delivery services

Tables 6.7, Table A-6-35, and Figures 6.10 and 6.11 provide information on the availability of essential supplies for normal delivery and the availability of additional medicines and supplies to manage complications of delivery.

Scissors or a blade, cord clamps or ties, a suction apparatus, antibiotic eye ointment for the newborn, and a disinfectant for cleaning the perineum are considered basic items for conducting a normal delivery. Availability of individual items ranges from 65 percent of facilities having antibiotic eye ointment for the newborn in the delivery room to 95 percent having scissors or a blade (Figure 6.10). However, all these items are available in the delivery area in only 40 percent of facilities offering delivery services (Table 6.7), including 84 percent of hospitals, 45 percent of health centres, and 29 percent of clinics. Private facilities (54 percent) are more likely than MoHSS facilities (40 percent) and mission/NGO facilities (32 percent) to have all of these essential supplies.

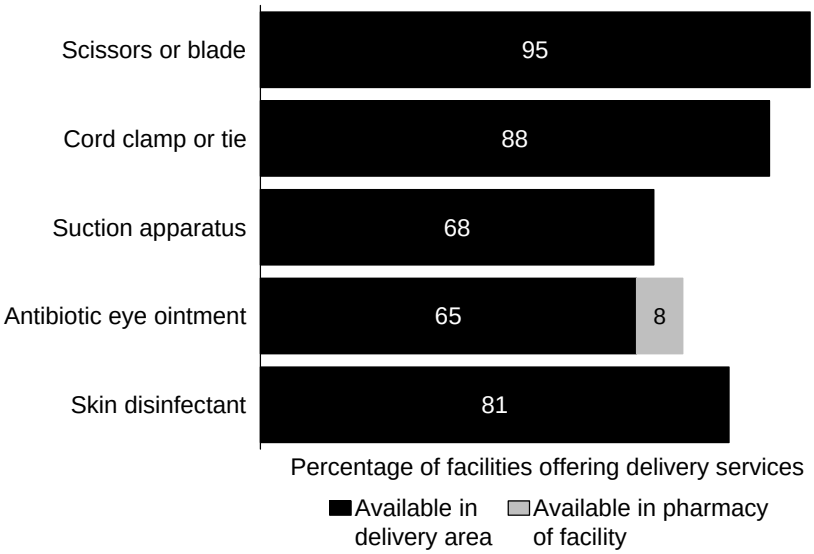
Table 6.7 Availability of medicines and supplies for normal and complicated delivery

Percentage of facilities offering delivery services that have all essential supplies for delivery and additional medicines and supplies for complications, by background characteristics, Namibia HFC 2009

Background characteristics	All essential supplies for delivery[1]	Additional medicines and supplies for:		Number of facilities offering delivery services
		Common complications[2]	Serious complications[3]	
Type of facility				
Hospital	84	88	91	43
Health centre	45	37	37	38
Clinic	29	29	25	175
Managing authority				
MoHSS	40	38	34	218
Mission/NGO	32	40	48	25
Private	54	77	69	13
Region				
Caprivi	22	39	61	23
Erongo	69	85	46	13
Hardap	69	69	38	13
Karas	41	65	41	17
Kavango	25	32	23	44
Khomas	75	75	50	8
Kunene	24	8	16	25
Ohangwena	15	15	35	20
Omaheke	81	63	25	16
Omusati	42	13	23	31
Oshana	31	23	38	13
Oshikoto	36	43	57	14
Otjozondjupa	63	74	79	19
Total	40	40	38	256

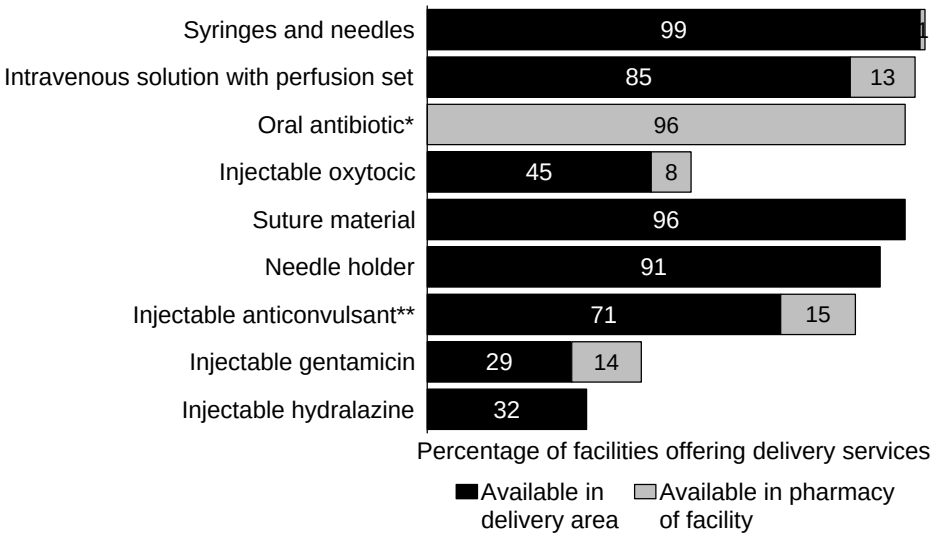
[1] Scissors or blade, cord clamp, suction apparatus, antibiotic eye ointment for newborn, and skin disinfectant.
[2] Needles and syringes, intravenous solution with infusion set, injectable oxytocic, suture material, and needle holder all located in delivery room area; oral antibiotic (cotrimoxazole or amoxicillin) located in pharmacy or delivery room area.
[3] Injectable anticonvulsant (magnesium sulphate or diazepam) in delivery room area and injectable antibiotic (penicillin or ampicillin or gentamicin) in delivery room area or pharmacy.

Figure 6.10 **Essential Supplies for Delivery (N=256)**



NHFC 2009

Figure 6.11 **Additional Medicines and Supplies for Managing Complications of Delivery (N=256)**



* Oral amoxicillin, Augmentin, ampicillin, or cotrimoxazole
** Diazepam or magnesium sulphate

NHFC 2009

Additional supplies and medicines for complications

The MoHSS guidelines on emergency obstetric care state that facilities at the clinic and health centre level should have equipment and drugs for obstetric emergencies (oxygen, lactated Ringer's solution, magnesium sulphate, hexoprenaline, phytonadione (Konakion), oxytocin (Syntocinon), Syntometrine). District hospitals should in addition have equipment and drugs for obstetric emergencies, and also a fully equipped resuscitation trolley and defibrillator. In addition to the equipment and drugs required at the clinic and regional levels, Regional hospitals should also have the capacity to manage

severe illness in pregnant women. National referral hospitals should have all the capabilities and the capacity to manage extremely ill or difficult obstetric cases. In addition, a policy recommendation from the MoHSS Report on Needs Assessment for Emergency Obstetrics Care is that selected health centres in each health region should be upgraded to function as basic emergency obstetric care (BEmOC) facilities, and at least one hospital in each region should be upgraded to provide comprehensive emergency obstetric care (CEmOC), especially in the high population density areas in the north (MoHSS, 2006a).

To manage delivery complications, facilities need additional medicines and supplies, as discussed above, beyond the essential supplies. Only four of every ten facilities offering delivery services had all supplies[12] to manage common complications (Table 6.7). These additional supplies and medicines are available primarily in hospitals (88 percent) rather than in health centres (37 percent) or clinics (29 percent). Availability of the medicines and supplies for common complications varies significantly among regions, with only 8 percent of facilities in Kunene but 85 percent of facilities in Erongo having them. Private facilities (77 percent) were more likely than those managed by other authorities to have these medicines and supplies.

All medicines and supplies for managing serious complications[13] are available in 38 percent of facilities that offer delivery services, with the highest levels found in hospitals (91 percent), private facilities (69 percent), and facilities in Otjozondjupa (79 percent). MoHSS facilities (34 percent) are the least likely to have the medicines and supplies for managing serious complications of delivery, probably because the majority are lower-level facilities. Injectable anticonvulsants for controlling seizures in severe pre-eclampsia and eclampsia are available in the delivery service area or pharmacy in 86 percent of all facilities that offer delivery services, and injectable antibiotics (e.g., gentamicin) for treating sepsis are available in 43 percent of such facilities, although only 29 percent keep them in the delivery area (Figure 6.11, Table A-6.35). Hydralazine, commonly used to manage elevated blood pressure during labour and delivery, is found in the delivery areas of only 32 percent of facilities.

Key Findings

Equipment: Basic equipment and supplies for conducting normal deliveries (including scissors or blades, cord clamps or ties, and a disinfectant) were all available in only 40 percent of facilities offering delivery services. Hospitals, private facilities, and facilities in Omaheke are more likely than other facilities to have these basic supplies on hand.

Emergency equipment

Facilities that manage complicated deliveries should have the capacity to offer comprehensive essential obstetric care. In Namibia complicated deliveries are primarily managed in hospitals. Health centres and clinics are expected to refer clients to designated referral facilities. In cases where life-saving emergency obstetric care is required, the capacity to perform surgical procedures, including caesarean sections, and to transfuse blood is essential.

Caesarean sections and blood transfusion services

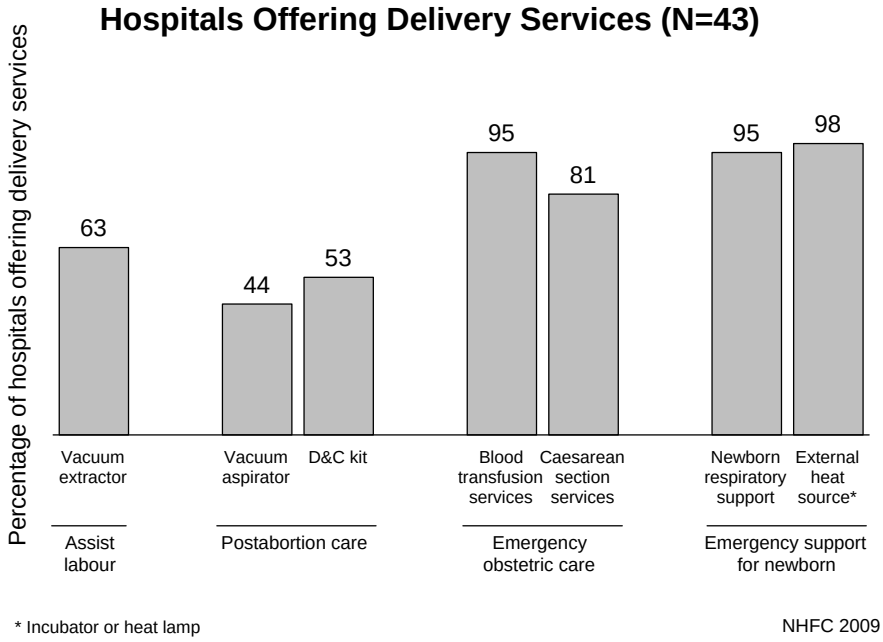
Only 9 percent of all facilities—that is, 14 percent of delivery facilities—provide caesarean section services (Table 6.5, Table A-6.36). Only 17 percent of delivery facilities offer blood transfusion

[12] Needle and syringes, intravenous solution with infusion set, injectable oxytocic, suture material, and needle holder in delivery room or area, and oral antibiotic either in delivery room or in pharmacy area.
[13] Injectable anticonvulsant (magnesium sulphate or diazepam) in the delivery room area and injectable antibiotic (penicillin or ampicillin or gentamicin) in delivery room area or pharmacy.

services (Table A-6.36). Caesarean section and blood transfusion services are limited almost entirely to hospitals (Table 6.5, Figure 6.12 and Table A-6.36). Because MoHSS facilities comprise mostly lower-level facilities, it is not surprising that only 12 percent of MoHSS facilities (compared with 85 percent of private facilities, for example) offer blood transfusion and 10 percent of MoHSS facilities provide caesarean sections (compared with 77 percent of private facilities). Facilities in Khomas and Erongo are more likely to offer these services than facilities in other regions, perhaps because these regions have more private facilities.

The basic items needed to perform caesarean sections[14] are available at the service delivery site or immediately adjacent in 86 percent of facilities that offer caesarean sections (Table A-6.37). Only about half of these facilities, however, have an anaesthetist available (with observed duty schedule).

Figure 6.12 **Emergency Equipment and Services Available in Hospitals Offering Delivery Services (N=43)**



Assisted vaginal delivery

In Namibia medical officers and obstetrician/gynaecologists perform assisted vaginal deliveries. Hospitals (63 percent) are the only facility type to have vaginal extractors for assisted vaginal deliveries. Seven of every ten private facilities have this equipment (Table A-6.36).

Postabortion care

The ability to provide care for a woman after an incomplete abortion is vital to prevent complications. To remove any retained products of conception, facilities should be able to provide manual vacuum aspiration or dilatation and curettage (D&C) services. Vacuum aspirators and D&C kits are available in 7 and 9 percent, respectively, of all health facilities that offer delivery services; all of these are hospitals (Table A-6.36).

[14] Operating table and examination light, a scrub area next to or immediately adjacent to the operating room, and sterilised instruments.

Key Findings

Caesarean sections and blood transfusion services: These services are available mostly in hospitals, and are most widely available in Khomas and Erongo regions.

Among facilities that provide caesarean sections, close to nine of every ten has all the needed equipment to provide this service.

Assisted vaginal delivery and post-abortion care services also are almost exclusively available in hospitals.

6.7 NEWBORN CARE PRACTICES

The 2009 Namibia HFC assessed newborn care practices and the availability of equipment and supplies for supporting newborn care. The assessment noted the availability of emergency respiratory support units (an infant-sized Ambu bag) and external heat sources (including incubators, or heat lamp) to maintain body heat in infants, especially premature newborns. Details on emergency support for newborns and on newborn care practices are provided in Tables A-6.36, A-6.38, and Figure 6.12.

Equipment

Six of every ten facilities offering delivery services have an emergency respiratory support system for the newborn (Table A-6.36). Hospitals (95 percent) and health centres (82 percent) are more likely than clinics to have emergency respiratory support available. Facilities in Caprivi and Kavango are the least likely to have this service (26 and 30 percent). Also, private facilities (92 percent) are more likely than MoHSS facilities (61 percent) and mission/NGO facilities (60 percent) to have a respiratory support system for newborns.

An external heat source[15] is available in only 26 percent of facilities offering delivery services. A heat source is most likely to be available in hospitals (98 percent), private facilities (85 percent), and facilities in Khomas (75 percent) (Table A-6.36). Facilities in the Caprivi, Kunene, and Omusati regions are less likely than facilities in other regions to have an external heat source.

Newborn care practices

Using catheter suction to stimulate respiration in newborns that are in some distress is a common practice in many health facilities. This should not be a routine practice, however, since it may injure the newborn and also may increase the risk of mother-to-child transmission of HIV if the mother is infected with HIV. Among facilities offering delivery services, 45 percent report routinely using catheter suction (Table A-6.38). This practice is more common in hospitals (65 percent) and health centres (63 percent) than in clinics (35 percent).

Hypothermia contributes to the morbidity and mortality of newborns. It can be prevented by avoiding a full-immersion bath during the first few hours after birth and instead drying the newborn and either immediately giving the infant to the mother for skin-to-skin contact or else wrapping the newborn in a warm blanket. Overall, four of every ten facilities that offer delivery services report routinely practicing full-immersion bathing. The practice is more common in hospitals (86 percent) than in other facility types.

[15] An incubator or heat lamp

Since low birth weight is a risk indicator for infant death, weighing the newborn provides information essential to postnatal care. Although 90 percent of facilities indicate that they routinely weigh newborns, only 78 percent have a functioning infant scale in the delivery service area.

Vitamin A supplementation in poorly nourished children has been shown to decrease the risk of infection and death. Newborns can receive a healthy amount of vitamin A through breast milk, but pregnant women are also at risk of developing vitamin A deficiency and therefore need vitamin A supplementation after delivery. Eighty-five percent of facilities report routinely providing vitamin A to new mothers. Eighty-three percent of facilities have vitamin A available in the delivery area and 95 percent have vitamin A available either in the delivery room or in the pharmacy.

Ninety-one percent of delivery care facilities routinely provide newborns with Bacillus Calmette-Guérin (BCG) vaccine for tuberculosis and oral polio vaccine (OPV).

Worldwide, exclusive breastfeeding is promoted; providing prelacteal liquids is discouraged. As noted previously (Figure 6.7), seven of every ten first-visit ANC clients were counselled on exclusive breastfeeding, but only one-quarter of ANC clients who were at least eight months pregnant were counselled on exclusive breastfeeding. Providing prelacteal liquids to infants is practiced in only 6 percent of facilities.

Rooming-in, where the infant stays with the mother to promote breastfeeding and mother-child bonding, is practised in 87 percent of health facilities. Rooming-in is practised at all hospitals and health centres and at eight of every ten clinics.

Key Findings

Emergency respiratory support: Emergency respiratory support for newborns is available at six of every ten health facilities that offer delivery services and is nearly universal in hospitals.

Newborn practices: Practices that are considered supportive of newborn health, such as weighing the infant, providing vitamin A to the mother, and rooming-in, are common in Namibia.

As for potentially harmful practices, routine suctioning of a newborn with a catheter is carried out by just under half of delivery facilities, especially the hospitals and health centres. Providing prelacteal fluids to newborns is uncommon.

6.8 Management Practices Supportive of Quality Delivery Services

Tables 6.4 and 6.8 provide information on management practices related to delivery services. Table A-6.34 provides information on the availability of delivery service providers. Tables A-6.41 provides information on charging of fees for delivery services while Table A-6.42 provides information on supportive management for providers of delivery services. Appendix Tables A-6.43.1 through A-6.44 provide information on supervision and staff development from the provider's perspective.

Table 6.8 Management practices supportive of quality facility-based delivery services

Among facilities offering delivery services, percentage with up-to-date client registers, documentation of delivery coverage, mortality review, and user fees, and percentage where interviewed providers of delivery services report receiving routine training and supervision, by background characteristics, Namibia HFC 2009

	Percentage of facilities offering delivery services with:					Percentage of facilities where staff report receiving routine:		
Background characteristics	Observed up-to-date delivery register[1]	Documentation of monitoring delivery coverage	Facility review of maternal and/or newborn deaths or near-misses	User fee for delivery	Number of facilities offering delivery services	Training related to delivery services[2]	Personal supervision[3]	Number of facilities with interviewed providers of normal delivery services[4]
Type of facility								
Hospital	98	0	70	81	43	51	91	43
Health centre	76	29	32	63	38	32	89	37
Clinic	29	15	7	49	175	42	77	162
Managing authority								
MoHSS	45	16	19	54	218	42	80	207
Mission/NGO	48	12	36	60	25	42	100	24
Private	77	0	23	92	13	55	64	11
Region								
Caprivi	57	17	4	39	23	52	81	21
Erongo	77	0	15	69	13	54	92	13
Hardap	77	38	31	77	13	23	85	13
Karas	88	35	24	76	17	71	82	17
Kavango	36	14	27	52	44	40	76	42
Khomas	63	0	38	75	8	29	71	7
Kunene	28	8	12	32	25	29	63	24
Ohangwena	25	0	20	90	20	26	84	19
Omaheke	63	31	13	81	16	46	100	13
Omusati	23	10	16	42	31	48	90	29
Oshana	23	0	15	31	13	33	83	12
Oshikoto	57	14	36	43	14	62	100	13
Otjozondjupa	63	26	37	63	19	32	63	19
Total	47	15	21	56	256	42	81	242

[1] Register has an entry in the past 30 days that at minimum indicates delivery outcome.
[2] A facility has routine staff training if at least half of interviewed providers reported that they had received pre- or in-service training related to their work during the 12 months preceding the survey. This refers to structured sessions and does not include individual instruction received during routine supervision.
[3] A facility has routine staff supervision if at least half of interviewed providers reported that they had been personally supervised at least once during the six months preceding the survey.
[4] Includes only providers of delivery services in facilities offering delivery services.

6.8.1 Facility Documentation and Records

A delivery register is considered up-to-date if there is an entry in the past 30 days (based on the assumption that there should be at least one delivery per month in facilities that provide the service) and if the entry describes the birth outcome. About one-half of facilities offering delivery services had an up-to-date delivery register available (Table 6.8). Up-to-date delivery registers were available in almost all hospitals and in three-quarters of health centres but in only three of every ten clinics.

Facilities frequently have catchment populations for whom they are responsible for providing services. The 2009 Namibia HFC assessed whether facilities have any documentation indicating that they monitor the proportion of deliveries in their catchment area that take place under skilled care (or, for some programme strategies, deliveries that are attended by skilled providers affiliated with the facility). Only 15 percent of facilities offering delivery services had documentation showing that they monitor delivery coverage in their catchment areas (Table 6.8). Although all levels of health facilities have poor

documentation, hospitals fared worst (0 percent). No facilities in Erongo, Khomas, Ohangwena, or Oshana regions had documentation of monitoring coverage.

6.8.2 Systems for Quality Assurance, Including Maternal Death Reviews

One indicator of quality assurance for delivery services is systematic review of all maternal and/or newborn deaths or near-misses to identify avoidable factors contributing to these deaths. This helps to develop interventions that prevent the occurrence of deaths in future. While the 2009 NHFC did not assess the quality of these review programmes, it did enquire whether facilities implemented the process or not. Overall, only two of every ten facilities providing delivery services conduct reviews of maternal and/or newborn deaths or near-misses (Table 6.8). The practice is most common in hospitals (70 percent) that provide delivery services. These reviews are least likely in private facilities (23 percent) and in facilities in the regions of Caprivi (4 percent), Erongo (15 percent), Kunene (12 percent), Omaheke (13 percent), Omusati (16 percent), and Oshana (15 percent).

6.8.3 Practices Related to User Fees

Fifty-six percent of facilities offering delivery services charge some form of user fees for delivery-related services (Table 6.8). Private facilities (92 percent) are more likely to charge user fees than are MoHSS facilities (54 percent) or mission/NGO facilities (60 percent). These fees are more likely to be charged in facilities in Ohangwena (90 percent) than in other regions. By type of facility, hospitals (81 percent) and health centres (63 percent) are more likely than clinics (49) to charge user fees.

Three percent of delivery facilities charge a fixed fee covering both ANC and normal delivery services, while about 8 percent charge for medicines, and 4 percent charge for laboratory tests (Table A-6.41). Thirty-two percent report that they have discounts or exemptions for delivery services.

Among the facilities that routinely charge for delivery services, one-quarter publicly post all the fees.

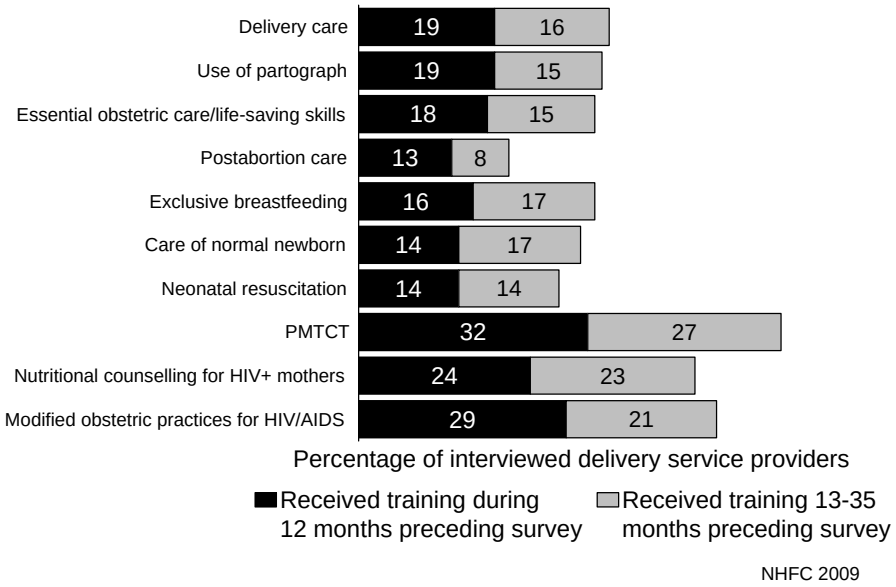
6.8.4 Training and Supervision

A facility is defined as providing routine staff development activities if at least half of the delivery service providers interviewed said that they had received structured training relevant to delivery services during the 12 months preceding the assessment. Only formal pre-service and in-service training is considered relevant and not individual instruction that occurs during routine supervision.

Only 42 percent of facilities meet these criteria, including half of hospitals, 42 percent of clinics, and 32 percent of health centres (Table 6.8). Private facilities (55 percent) are more likely to provide staff development than MoHSS and mission/NGO facilities (each 42 percent). Facilities in Karas (71 percent) and Oshikoto (62 percent) stand out as more likely than facilities in other regions to provide routine staff development.

Figure 6.13 presents information on the specific training topics reported by interviewed providers and when this training was offered. Between 13 and 32 percent of interviewed providers reported receiving training on specific topics (such as delivery care or use of the partograph) during the 12 months preceding the survey. Providers were most likely to have recently received HIV/AIDS-related training, such as preventing mother-to-child transmission (PMTCT) (32 percent of interviewed providers) and modified obstetric practices related to HIV/AIDS (29 percent of providers).

Figure 6.13 **Training Received by Interviewed Delivery Service Providers, by Topic and Timing of Most Recent Training (N=543)**



A facility is defined as having routine staff supervision if at least half of the interviewed delivery service providers reported being personally supervised during the six months preceding the survey. Eight of every ten delivery facilities meet that criterion (Table 6.8).

Key Findings

Up-to-date client registers: Nearly half of facilities offering delivery services had up-to-date delivery registers available. Delivery registers are universally available in hospitals.

Only 15 percent of facilities offering delivery services have documentation showing that they monitor delivery coverage in their catchment areas. Although all levels of health facilities have poor documentation, hospitals fare worst (0 percent).

Review of maternal deaths: Only two of every ten facilities offering delivery services conduct reviews of maternal and/or newborn deaths or near-misses. Those that do are mainly hospitals.

Staff development: Only four of every ten delivery facilities provide routine staff development, while eight of every ten facilities provide personal supervision.

6.9 Availability of Emergency Obstetric Care

6.9.1 The Signal Functions for EmOC

Outcome indicators of maternal health, such as the maternal mortality ratio, require large numbers of observations in the denominator, and they are only amenable to change in the long term, over a minimum of four to five years. In recognition of these limitations, process indicators have been developed that better facilitate data collection and interpretation. These indicators, called the UN Process Indicators, which have been accepted by UN organisations, measure certain types of obstetric services that have a direct bearing on maternal outcomes, including mortality and morbidity. Availability of these

critical services, or ‘signal functions’, is proven to significantly reduce maternal deaths and improve birth outcomes for the newborn. They consist of:

1. Administration of parenteral antibiotics
2. Administration of parenteral oxytocic drugs
3. Administration of parenteral anticonvulsants for pre-eclampsia and eclampsia
4. Manual removal of the placenta
5. Removal of retained products of conception
6. Assisted vaginal delivery
7. Blood transfusions
8. Surgery (caesarean section)

Facilities are considered basic EmOC if they provide first six functions over a designated 3-month period and comprehensive EmOC if they provide all eight functions over a designated 3-month period.

The 2009 NHFC examined the availability of EmOC services among hospitals, health centres, and clinics that provide delivery services. Since clinics are not expected to provide comprehensive emergency obstetric services, they are excluded from subsequent analysis. Table 6.9 and Figure 6.14 show the proportion of hospitals and health centres offering delivery services that reported 1) ever performing the signal functions and 2) performing any of these signal functions at least once during the three months preceding the assessment.

According to findings of the assessment, for hospitals and health centres there are substantial differences in the proportions reporting that they ever perform these signal functions and the proportions that performed any of the signal functions at least once during the preceding three months (Table 6.9, Figure 6.14).

Hospitals are more likely to have performed any of the signal functions than health centres. There is no clear pattern by managing authority. According to report, the signal functions most often performed at least once during the three months preceding the assessment were administration of parenteral oxytocic drugs (59 percent), administration of parenteral antibiotics (47 percent), and caesarean section (38 percent) (Table 6.9).

None of the assessed facilities reported performing all of the first six signal functions in the three months preceding the assessment.

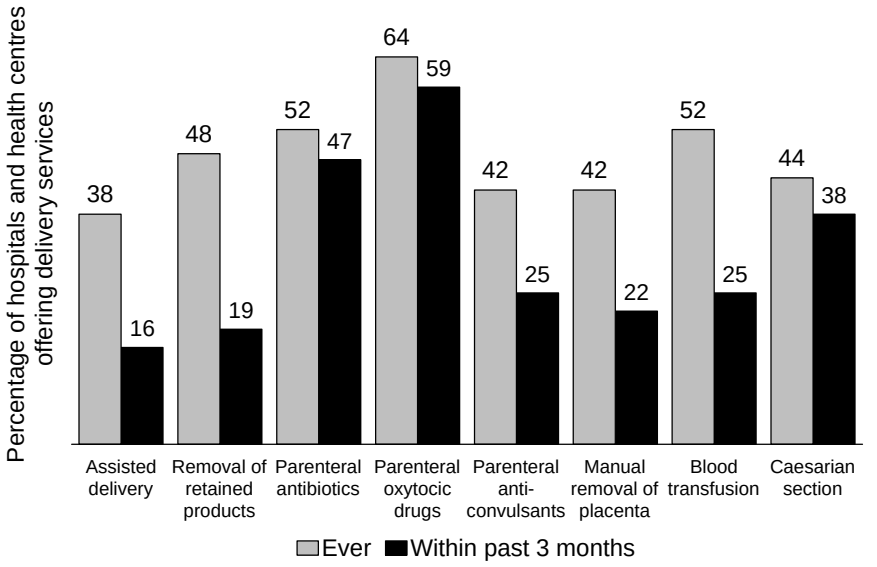
Table 6.9 Signal functions for emergency obstetric care

Among hospitals and health centres offering delivery services, percentage that report performing the signal functions for emergency obstetric care (EmOC) at least once during the three months preceding the survey, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of hospitals and health centres that administered or carried out:								Number of hospitals and health centres offering delivery services
	Parenteral antibiotics	Parenteral oxytocics	Anti-convulsants/ sedatives	Manual removal of placenta	Removal of retained products	Assisted vaginal delivery (AVD)	Blood transfusion	Caesarean section	
Type of facility									
Hospital	72	93	42	33	35	30	47	70	43
Health centre	18	21	5	11	0	0	0	3	38
Managing authority									
MoHSS	44	57	28	25	15	10	26	28	61
Mission/NGO	60	60	30	10	20	20	20	50	10
Private	50	70	0	20	40	50	20	90	10
Region									
Caprivi	25	50	50	25	0	0	25	25	4
Erongo	67	83	17	67	33	17	50	67	6
Hardap	75	100	75	25	50	0	25	50	4
Karas	57	57	29	14	29	14	14	43	7
Kavango	33	50	25	17	8	8	17	17	12
Khomas	75	100	50	25	50	25	75	100	4
Kunene	50	67	0	0	17	0	17	50	6
Ohangwena	60	80	0	60	20	0	20	0	5
Omaheke	67	33	33	67	0	0	0	67	3
Omusati	33	56	22	0	0	11	11	22	9
Oshana	17	33	17	0	0	17	17	33	6
Oshikoto	50	50	17	0	50	33	33	33	6
Otjozondjupa	44	44	22	33	11	56	33	44	9
Total	47	59	25	22	19	16	25	38	81

Note: None of the hospitals and health centres offering delivery services reported administering or carrying out all six basic emergency obstetric care procedures (BEmOC), i.e., all of the first six procedures (left to right), in the three months preceding the survey. Similarly, none reported applying or carrying out all eight comprehensive emergency obstetric care procedures (CEmOC), i.e., all Basic EmOC procedures plus blood transfusion and caesarean section, in the three months preceding the survey.

Figure 6.14 **Emergency Obstetric Practices in Hospitals and Health Centres Offering Delivery Services (N=81)**



NHFC 2009

Key Findings
Signal functions: Hospitals are most likely to apply or carry out signal functions for emergency obstetric care. None of the hospitals or health centres reported applying or carrying out all of the eight or six signal functions in the three months preceding the assessment.

STIs, TUBERCULOSIS, AND MALARIA 7

Dalleen McToyah Witbooi, Yvonne Benetha Bayer, Igna Kahundu Simataa, Calvin Mulemwa Kulatau

7.1 BACKGROUND

7.1.1 NHFC Approach to Collection of Information on Services for Sexually Transmitted Infections, Tuberculosis, and Malaria

Sexually transmitted infections

Sexually transmitted infections (STIs) are a public health concern all over the world. They cause a great deal of morbidity and facilitate transmission of HIV (Wasserheit, 1992). The impact of STIs on health can be severe and life-threatening. Potential consequences include pelvic inflammatory disease (PID); infertility in both women and men; ectopic pregnancy; and adverse pregnancy outcomes such as miscarriage, stillbirth, preterm birth, and congenital infection. Although most STIs can affect both men and women, the consequences in women are more common and more severe than those in men. It is estimated that in developing nations STIs are the second leading cause of poor health among women age 15-44 (Musgrove, 1993).

Conventional STIs and HIV infection share similar risk factors, and an untreated STI can increase a person's chances of becoming infected with HIV during unprotected sex with an HIV-positive partner. In fact, the two most significant factors contributing to the horizontal spread of HIV are 1) presence of an STI and 2) having more than one sexual partner. STIs are of critical concern in Namibia, being one of the countries in sub-Saharan Africa most affected by the HIV/AIDS epidemic. According to Namibian health information system reports, STIs accounted for 3 percent of all outpatient visits in 2006 (MoHSS, 2006b). This figure does not include patients attending private health facilities and clients obtaining services through the informal health sector, and thus it may underestimate the burden of STIs in Namibia.

Because there is a certain degree of stigma associated with STIs, some clients with symptoms of an STI may be reluctant to seek care. Effective case management, however, is the pillar of any STI prevention and control programme.

Tuberculosis

Tuberculosis (TB) is the seventh most significant cause of premature mortality and disability worldwide. With the advent of HIV/AIDS, TB, especially multidrug-resistant tuberculosis (MDR-TB), is re-emerging as a communicable disease of public health significance. This is because TB is one of the most common opportunistic infections for people with AIDS. Because of the powerful interaction between TB and HIV, the incidence of TB is rising in sub-Saharan Africa and may rise in Asia, although globally it has shown a tendency to decline (WHO, 2007). TB, while curable, is the most common cause of death from infectious diseases worldwide, and Namibia continues to have one of the highest TB case notification rates in the world. Recognizing the significant impact of HIV on the Namibian people, the government of the Republic of Namibia aims to reduce TB prevalence to a level at which it is no longer a public health problem by 2015. To achieve this goal, the national tuberculosis and leprosy programme is guided by the Second Medium Term Strategic Plan for Tuberculosis and Leprosy (2010-2015).

Malaria

Malaria is a disease that disproportionately affects sub-Saharan Africa. Some 90 percent of cases occur in the region. Every year, malaria affects an estimated 300-500 million people worldwide, resulting in over one million deaths. Although the disease affects all age groups, pregnant women and young children are at highest risk of death if infected.

Despite the still large numbers, malaria incidence has shown a continued downward trend in Namibia since 2001. As a result, Namibia, along with Botswana, South Africa, and Swaziland, is considered a low-transmission country with the potential to move into the malaria elimination phase over the next five to seven years.

Malaria control is coordinated by the MoHSS National Vector Disease Control Programme (NVDCP), with local activities implemented by regional health offices. NVDCP has a National Malaria Policy (MoHSS, 2005) and a Roll Back Malaria (RBM) strategic plan in place. A new National Malaria Elimination Strategy has been developed to cover the years 2009-2013.

Considering the impact of STIs, TB, and malaria on the health of Namibia's people, it is of utmost importance that the health care system appropriately prevents, diagnoses, and treats these diseases. This chapter uses data from the 2009 NHFC to address the following central questions:

- To what extent are STI services available, and to what extent do facilities offering STI services have the capacity to support quality STI services?
- To what extent do STI service providers adhere to standards for good quality service provision?
- Do facilities have management practices that support good quality STI services, and how do clients feel about the STI services offered?
- To what extent are TB services available, and to what extent do facilities offering TB services have the capacity to implement the directly observed therapy, short course (DOTS) strategy?
- Do facilities have management practices that support good quality TB services?
- Do facilities have the resources and supplies to diagnose and manage TB?
- To what extent are facilities able to offer TB/HIV services?
- To what extent are malaria services available, and to what extent do facilities offering malaria services have the capacity to support quality services?
- Do facilities have trained providers to provide quality malaria services?
- To what extent are insecticide-treated nets (ITNs) available in facilities and to what extent are they distributed free of charge to antenatal care (ANC) clients?

7.1.2 Health Situation Regarding STIs in Namibia

WHO estimates that worldwide over 340 million new cases of four curable STIs—gonorrhoea, chlamydia, syphilis, and trichomoniasis—occurred in 1999 in men and women age 15-49.[1]

In the 2006-07 Namibia Demographic and Health Survey (NDHS), 7 percent of women and 4 percent of men reported having an STI or symptoms suggestive of an STI in the 12 months preceding the survey (MoHSS and Macro International, 2008). More than 60 percent of these people reported having sought medical advice or treatment for the STI/symptoms. In the 2005/06 fiscal year, 80,000 people in Namibia were treated for new STIs. Considering the percentage of people with symptoms who seek medical advice or treatment, the actual number of cases was likely significantly higher. STIs as a whole rank eighth among all conditions for which people seek hospital consultations in Namibia. According to the Namibian health information system, STIs accounted for 3 percent of all outpatient department (OPD) attendances in 2006. This figure does not include partner(s) who are referred for treatment or patients attending private health facilities and the informal sector.

STI services are widely available at all types of facilities in the country, and guidelines and policies have been developed to address the case management of STIs. In fact, in April 1999 the Ministry of Health and Social Services (MoHSS) published national guidelines for management of STIs, which use the syndromic approach.

7.1.3 Health Situation Regarding Tuberculosis in Namibia

The World Health Organization estimates that in 2009 there were 9.4 million new TB cases worldwide (WHO, 2010). An estimated 11–13 percent of new cases were HIV-positive and the African Region accounted for approximately 80 percent of these cases. Globally, there were approximately 1.3 million TB-related deaths among HIV-negative people and 380,000 TB-related deaths among HIV-positive people.

During the period from January to December 2009, Namibia reported 13,332 TB cases of all forms of TB, which translated into a case notification rate of 634 per 100,000 population, compared to 13,737 cases reported in 2008 (CNR 665/100,000) (MoHSS, 2010a). The regions of Karas, Erongo, and Hardap continue to have the highest numbers of case notification rates of all forms of TB, while Khomas, Kavango, and Erongo still have the highest disease burden. During the last ten years, an average of 1,200 people have died from TB each year in Namibia.

Using the DOTS strategy, the internationally recommended strategy for TB control, cure rates of 80 to 90 percent have been achieved globally for passively diagnosed cases of smear-positive pulmonary TB. Based on the successes of these programmes, WHO has adopted DOTS as its strategy for global TB control.

[1] These are the most recent available data. New estimates, through 2005, are under development for publication.

The national and global target for TB case management is to achieve a treatment success rate of at least 87 percent among new patients with infectious TB (MoHSS, 2010a). According to the latest country TB data, which shows a treatment success rate of 82 percent among new sputum smear positive PTB cases in the cohort of 2008 (an improvement from 76 percent in 2006), Namibia is demonstrating progress towards achieving the target of an 87 percent treatment success rate. The defaulter rate in this category has dropped to 4 percent from the previous 5 percent, while the case fatality rate increased slightly to 6 percent from 5 percent previously. TB treatment results for all forms of TB for the 2008 cohort shows that about one in every six TB patients failed and discontinued treatment, and about one in every ten patients died during treatment. In addition, Namibia is experiencing an emerging burden of drug-resistant TB, including extensively drug-resistant TB (XDR-TB), which was first reported in 2007. The standard first line anti-TB treatment is increasingly becoming ineffective because patients are developing drug-resistant tuberculosis.

The generalised HIV epidemic, along with other socio-economic factors, compounds the effects of TB in Namibia (MoHSS, 2010a). Provider-initiated HIV counselling and testing (PICT) for TB patients is therefore one of the key TB/HIV collaborative interventions. Coverage of HIV testing for TB patients continues to improve, with 74 percent of TB patients registered in 2009 with a known HIV status result, compared to 67 percent in the previous year. The actual proportion of patients tested is likely to be higher since some patients are tested later in the course of their TB treatment in addition to those tested through PICT or tested prior to attending TB Care. The prevalence of HIV among tested TB patients in 2009 remained stable at 58 percent compared to 59 percent in 2008. These national figures mask regional variations in both testing rates and HIV prevalence among TB patients. The proportion of patients with known HIV status ranges from 96 percent in Kunene region to 59 percent in Khomas region, while the prevalence of HIV among TB patients was between 75 percent in Caprivi region and 40 percent in Omaheke region.

There also has been significant improvement in HIV care for TB/HIV patients (MoHSS, 2010a). Although the percentage of HIV-positive TB patients starting cotrimoxazole preventive therapy (CPT) decreased to 78 percent in 2009 from 98 percent in 2008, there was an overall increase from 31 percent in 2007. Furthermore, 35 percent of the HIV-positive TB patients either commenced or continued antiretroviral therapy (ART) in 2009 compared to 37 percent in 2008.

7.1.4 Health Situation Regarding Malaria in Namibia

Sub-Saharan Africa carries 90 percent of the global burden of malaria (Ministry of Health and Social Services, National Malaria Policy, March 2005). In Namibia, malaria remains a major health problem, with more than 600,000 cases recorded every year. As noted in the 2006-07 NDHS, malaria was the leading cause of illness and death from 1999 to 2002. It continues to be a public health concern in the country. Sixty-five percent of the Namibian population lives in malaria endemic regions and thus is at risk of malaria. The rest of the country is virtually free of malaria.

The average annual incidence of malaria for the years 1993-2003 was 212 per 1,000 population nationwide and ranged from 943 per 1,000 population in Kavango to less than 1 per 1,000 population in the non-endemic regions of Karas and Hardap. The incidence of malaria is two to three times higher among children under the age of five years than in the rest of the population. Although local data are not available, it is well established that pregnant women are also at higher risk of malaria than most other people.

The government of Namibia has instituted a number of initiatives to control malaria, including changing the first-line treatment of malaria from the ineffective chloroquine and sulphadoxine/ pyrimethamine (SP, or Fansidar) to artemisinin-based combination therapy and distributing insecticide-treated mosquito bed nets to pregnant women and children under age 5. Unfortunately, the ITN

distribution programme has not been very effective; one of the major obstacles is the shortage of resources for distribution to the intended recipients in the affected communities.

7.2 AVAILABILITY OF STI SERVICES

Integrating STI diagnosis and treatment into routine or relevant health services increases opportunities for case detection and follow-up on treatment. The 2009 NHFC assessed STI service availability and service delivery conditions in Namibian health facilities. Most commonly, clients seeking health care specifically for symptoms of STIs are seen in a general outpatient department. Clients seeking services for ANC or family planning may also obtain STI services, such as screening and treatment, from these service sites. Integrating STI screening and treatment into ANC and family planning may increase early detection and improve follow-through on treatment because clients may be more comfortable discussing STI symptoms during a regular ANC or family planning visit with a familiar provider. If clients must go elsewhere for STI services, they are more likely to decide not to seek follow-up care.

Table 7.1 provides information on the availability of STI services. Tables A-7.1 through A-7.3 provide additional information on the availability of STI services and on whether facilities have the systems and items needed to support quality counselling and examination. Table A-7.4 provides information on user fees for STI services.

Table 7.1 Availability of services for sexually transmitted infections

Percentage of facilities offering services for sexually transmitted infections (STIs) and, among these, percentage where STI services are provided in the indicated service area and percentage where STI services are offered five or more days per week, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities offering STI services as a primary service	Number of facilities	Percentage of facilities offering STI services in: Primary service location[1] General outpatient department	Special clinic[2]	Family planning (FP) service area[3]	Antenatal care (ANC) service area[3]	OPD, FP, and ANC service areas	Percentage of facilities where services for STIs are available at least 5 days per week	Number of facilities offering STI services
Type of facility									
Hospital	71	45	88	6	25	13	0	78	32
Health centre	98	47	96	2	61	76	52	85	46
Clinic	97	295	94	2	88	84	72	76	285
Sick bay	78	9	100	0	14	0	0	86	7
Managing authority									
MoHSS	99	306	93	3	81	80	67	77	302
Mission/NGO	100	28	93	7	71	79	64	71	28
Private	59	49	93	0	76	48	31	86	29
MoD/Police	85	13	100	0	18	9	9	91	11
Region									
Caprivi	96	28	70	11	89	96	59	89	27
Erongo	92	36	94	3	61	55	39	76	33
Hardap	100	21	100	0	76	71	62	76	21
Karas	88	25	95	5	73	77	55	68	22
Kavango	100	57	98	0	81	84	74	86	57
Khomas	67	33	91	9	64	36	27	95	22
Kunene	100	28	89	4	89	89	79	79	28
Ohangwena	100	32	91	0	81	84	69	78	32
Omaheke	94	16	100	0	100	87	87	67	15
Omusati	96	49	96	2	81	77	66	89	47
Oshana	90	20	94	0	67	72	50	89	18
Oshikoto	95	22	95	5	90	90	90	71	21
Otjozondjupa	93	29	100	0	67	52	44	30	27
Total	93	396	94	3	78	75	62	78	370

[1] Services may be available at multiple sites in the same facility if they are integrated. In small facilities one service site and one provider may provide services for general outpatients, ANC, and FP clients. The two columns do not add up to 100 percent because of missing values.
[2] These could be specialised STI clinics in the facility. In some cases the specialised clinic is the gynaecologic clinic for females and the urology clinic for males.
[3] In these facilities providers of FP and ANC services are reported to routinely diagnose and treat STI.

STI services may include diagnosis only, treatment only, or both diagnosis and treatment. According to findings of the 2009 NHFC, 93 percent of health facilities in Namibia offer STI services (Table 7.1). Practically all health centres and all clinics offer STI services, compared with seven of every ten hospitals and approximately eight of every ten sick bays. Among facilities offering STI services, 94 percent offer STI services as part of general outpatient curative services, and only 3 percent offer the services through special STI clinics. STI services are integrated into family planning services in 78 percent of facilities and into ANC services in 75 percent of facilities. About six of every ten facilities that offer STI services make STI services available in all three areas: general outpatient, family planning, and ANC. Health centres and clinics are the facility types most likely to integrate STI services with family planning and ANC services.

Seventy-eight percent of facilities offering STI services have services available at least five days per week.

Key Findings

STI service availability: Nine of every ten facilities in Namibia offer STI services. In almost all these facilities, STI services are part of general outpatient curative services. Specialised STI clinics are rare.

About six of every ten facilities that offer STI services integrate these services into ANC and family planning services, as well as providing them in general outpatient care.

7.3 Capacity to Provide Quality STI Services

The 2009 NHFC assessed the systems, infrastructure, equipment, and supplies necessary for supporting quality STI services. While STI services are provided at multiple sites in large facilities, information on whether facilities have the capacity to provide quality STI services comes from the outpatient department, which is the main STI service area. Facilities with quality STI services provide an environment with the visual and auditory privacy necessary for counselling, history-taking, and examination. They also provide materials, supplies, and equipment that facilitate diagnosis and treatment.

Table 7.2 and Figure 7.1 provide information on whether facilities have the infrastructure and resources to support quality counselling and examinations for STIs. Table 7.3 summarises information on management practices supportive of services for STIs.

Tables A-7.1 through A-7.5 provide details on the availability of services, system components, infrastructure and resources, specific tests and medicines for diagnosis and treatment, user fees, and supportive management for STI services. Table A-7.6 offers details on training for STI service providers; Table A-7.7 gives information on supportive supervision for those providers.

Table 7.2 Availability of infrastructure and resources to support quality counselling and examinations for sexually transmitted infections

Among facilities offering services for sexually transmitted infections (STIs), percentage with all components to support counselling, diagnosis, and treatment for STIs, by background characteristics, Namibia HFC 2009

Background characteristic	All items to support quality counselling[1]	All conditions to provide quality physical examination[2]	Method for diagnosing STIs			Testing capacity for:[4]				Wet mount capacity[9]	Medicines to treat 4 major STIs[10]	Number of facilities offering STI services
			Etiologic	Syndromic[3]	Clinical	Syphilis[5]	Gonorrhoea[6]	Chlamydia[7]	HIV[7]			
Type of facility												
Hospital	38	44	47	91	53	91	81	19	72	91	100	32
Health centre	63	28	28	87	65	96	96	17	89	98	93	46
Clinic	67	20	15	87	60	89	89	24	78	93	85	285
Sick bay	14	0	57	100	57	57	57	14	86	57	86	7
Managing authority												
MoHSS	68	20	18	90	59	93	91	25	80	94	91	302
Mission/NGO	71	21	11	75	71	96	100	14	75	100	82	28
Private	14	55	45	76	55	52	69	10	62	76	55	29
MoD/Police	18	9	55	91	73	64	64	18	91	64	82	11
Region												
Caprivi	81	7	7	85	56	100	100	100	100	100	100	27
Erongo	48	39	36	91	82	45	61	15	85	61	79	33
Hardap	67	57	76	100	76	95	95	0	100	95	90	21
Karas	41	55	36	77	55	95	95	0	32	95	91	22
Kavango	70	18	18	81	67	98	98	16	70	98	82	57
Khomas	55	50	41	82	50	82	73	64	86	86	86	22
Kunene	68	14	7	96	29	100	86	0	46	100	86	28
Ohangwena	69	16	6	97	59	100	81	31	88	100	97	32
Omaheke	73	60	20	80	47	100	100	100	100	100	87	15
Omusati	64	9	9	87	68	85	98	0	70	98	85	47
Oshana	56	6	17	94	83	94	94	0	94	94	83	18
Oshikoto	86	0	10	86	62	100	100	0	100	100	95	21
Otjozondjupa	33	4	7	89	33	78	74	15	85	74	85	27
Total	63	23	20	88	60	89	89	23	79	92	88	370

[1] Visual and auditory privacy, any guidelines, any visual aids or educational materials, individual client charts, and condoms in STI service delivery area.
[2] All infection control items (soap, water, latex gloves, disinfecting solution, and sharps box), visual and auditory privacy, examination bed or couch, and examination light.
[3] This refers specifically to following the WHO syndromic approach algorithms.
[4] Capacity to conduct a test does not mean the facility routinely utilizes the test.
[5] Either venereal disease research laboratory (VDRL) test or reactive protein reagin (RPR) test kit.
[6] Gram stain reagents and functioning microscope or culture capacity.
[7] Geimsa stain for chlamydia.
[8] ELISA, Western Blot, or Rapid test in facility or in an affiliated external laboratory.
[7] Functioning microscope and slides.
[10] At least one medicine to treat each of four major STIs—syphilis, gonorrhoea, trichomoniasis, and chlamydia.

Figure 7.1 Items to Support STI Services (N=370)

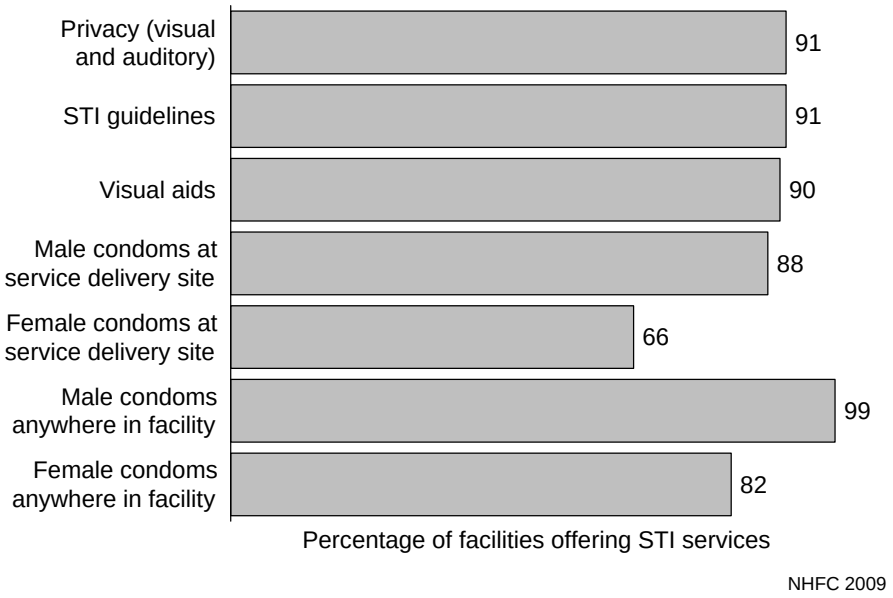


Table 7.3 Management practices supportive of quality services for sexually transmitted infections

Percentage of facilities offering services for sexually transmitted infections (STIs) that have client registers, and percentage where interviewed STI providers report receiving routine training on STIs and personal supervision, by background characteristics, Namibia HFC 2009

Background characteristics	Observed client register with probable STI client recorded		Number of facilities offering STI services	Percentage of facilities where interviewed STI service providers report receiving routine:		Number of facilities with interviewed providers of STI services[3]
	Entry within past 7 days	Most recent entry >7 days ago		Training[1]	Personal supervision[2]	
Type of facility						
Hospital	50	28	32	75	94	32
Health centre	54	35	46	72	89	46
Clinic	40	49	285	64	74	283
Sick bay	14	57	7	29	43	7
Managing authority						
MoHSS	44	47	302	71	80	300
Mission/NGO	46	50	28	54	96	28
Private	24	17	29	31	34	29
MoD/Police	18	55	11	45	64	11
Region						
Caprivi	44	52	27	77	77	26
Erongo	45	39	33	55	70	33
Hardap	33	52	21	38	81	21
Karas	9	32	22	71	90	21
Kavango	47	46	57	60	74	57
Khomas	36	27	22	77	64	22
Kunene	71	29	28	61	68	28
Ohangwena	22	63	32	59	88	32
Omaheke	60	33	15	60	100	15
Omusati	34	55	47	77	89	47
Oshana	44	44	18	89	83	18
Oshikoto	57	43	21	71	81	21
Otjozondjupa	44	56	27	63	48	27
Total	42	45	370	65	77	368

[1] A facility has routine staff training if at least half of interviewed providers reported that they had received pre- or in-service training related to their work during the 12 months preceding the survey. This refers to structured sessions and does not include individual instruction received during routine supervision.
[2] A facility has routine staff supervision if at least half of interviewed providers reported that they had been personally supervised at least once during the six months preceding the survey.
[3] Includes providers offering STI services in facilities offering STI services in any clinic assessed in survey (e.g., outpatient, ANC, FP).

7.3.1 System Components to Support Utilisation of Services

As a result of the stigma frequently associated with having an STI, as well as the lack of symptoms in many infected people, special efforts are needed to promote early diagnosis and to encourage clients to seek modern medical help for STI symptoms. The 2009 NHFC assessed the existence of programme strategies and service delivery components that contribute to the availability and improved utilisation of STI services.

To interrupt STI transmission effectively, partners of clients with STIs must be tested, and if they are infected, treated. The client is usually asked to notify the partner(s) and ask him or her to be examined; this process is referred to as passive follow-up. Under certain circumstances the local health authorities may take the initiative to contact the partner, inform him or her about the possibility of STI infection, and recommend the appropriate course of action; this is known as active follow-up. Passive follow-up is the most widely used system of client notification, with almost all facilities (96 percent) reporting that they use passive follow-up. One-quarter (26 percent) of facilities also report using active follow-up to notify partners of STI clients, while 4 percent of facilities have no follow-up system in place (Table A-7.2).

The 2009 NHFC also assessed facilities on user fees for STI services (Table A-7.4). Half of facilities charge a consultation fee, 25 percent charge for client registration, and 21 percent charge for medications; only 4 percent charge for tests. MoD/Police facilities do not charge fees for STI services.

The majority of facilities offering STI services do not post their fees in public view; only 26 percent post all fees, and 3 percent post some fees but not all.

7.3.2 Infrastructure and Resources to Support Quality Assessment and Counselling

Complete privacy is needed to facilitate good counselling and open communication between providers and STI clients. Privacy may encourage clients to use services and providers to adhere to protocols and standards; without privacy, a client may not speak openly and may decline examination. Likewise, some providers may not feel comfortable asking the appropriate questions or carrying out the necessary examinations. Since counselling for the diagnosis and prevention of STIs often takes place in a different location from the physical examination, the conditions for counselling are assessed separately from those for physical examinations.

Nine of every ten STI facilities provide counselling for STIs under conditions that assure both visual and auditory privacy (Figure 7.1, Table A-7.2,). Health centres and clinics are the most likely to offer counselling services that assure visual and auditory privacy.

Similarly, nine of every ten STI facilities have STI guidelines (including guidelines for the syndromic approach) in the STI service delivery area. The syndromic approach offers a specific protocol for prescribing medicines for treating sexually transmitted infections based on the symptoms observed (WHO, 2001). Health centres and clinics are more likely to have STI guidelines of any kind, including guidelines for syndromic diagnosis, than hospitals and sick bays.

STI-related visual aids for client education are available in 90 percent of facilities offering STI services, while about three-quarters have educational materials specific to HIV/AIDS (Table A-7.2). Compared with sick bays, health centres, and clinics, hospitals are less likely to have visual aids and HIV/AIDS-specific educational materials at STI service sites.

Having condoms available at the service delivery site allows the provider to readily offer them to clients, demonstrate their use, and ensure that the client leaves the health facility with them. While male condoms are available somewhere in nearly all facilities (except in sick bays), 88 percent of STI facilities have male condoms available at the STI service site (Table A-7.2). Female condoms are less available; eight of every ten STI facilities have them available at the facility, and 66 percent have them available at the STI service delivery area.

Overall, six of every ten STI facilities have *all* of the items needed to support quality counselling (Table 7.2). These items include visual and auditory privacy, STI guidelines, visual aids for client education, and male or female condoms at the STI service site, as well as individual client cards, which are available at 85 percent of facilities. Clinics and health centres are the most likely to have all these items to support quality STI counselling.

Key Findings

Systems: Facilities offering STI services predominantly use the system of passive follow-up to notify partners of STI clients; only one-quarter of facilities report also using active follow-up.

User fees for STI services are quite common. Half of STI facilities charge consultation fees, and one-fourth charge registration fees, while two of every ten charge for medicines.

Infrastructure and resources: A little over six of every ten STI facilities have all necessary items to support quality STI counselling, such as individual client cards, visual and auditory privacy, STI guidelines, visual aids for client education, and male or female condoms.

7.3.3 Infrastructure and Resources for Examinations and Treatment

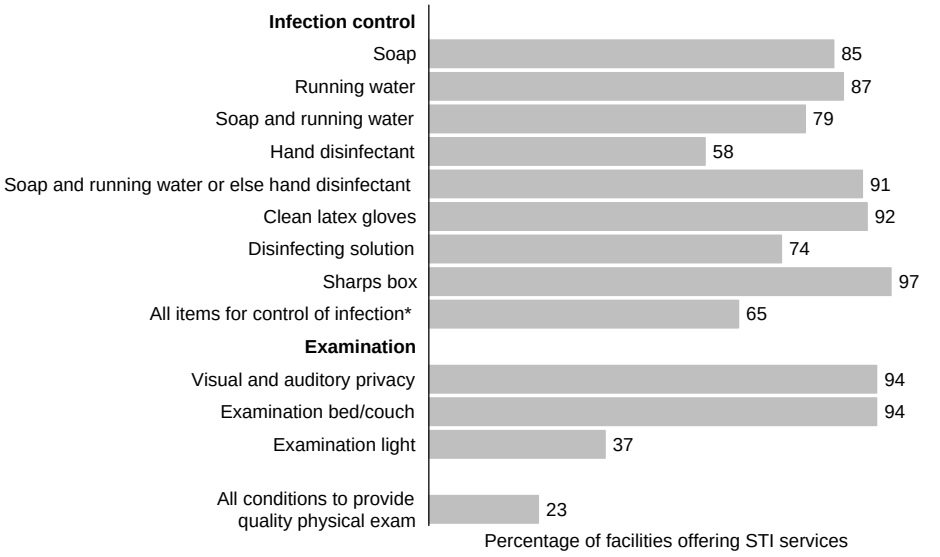
Facilities can better diagnose and treat STIs when there is adequate infection control, infrastructure for physical examinations, effective laboratory diagnostic support, and medicines available for treating specific STIs.

Infection control

Items considered important for infection control include soap and running water or else hand disinfectant, latex gloves, disinfecting solution, and sharps containers at the STI service delivery site. Sixty-five percent of facilities that offer STI services have all of these infection control items available in the STI service area (Figure 7.2, Table A-7.2). Sharps boxes are universally available, while latex gloves and items to wash or disinfect hands (soap and running water or else hand disinfectant) are available in nine of every ten facilities. Least available is hand disinfectant, found in 58 percent of facilities.

Waste receptacles are another important item for infection control; a waste receptacle with a lid and plastic liner are available at the service site in only 35 percent of facilities offering STI services (Table A-7.2). Only 25 percent of STI facilities have all necessary items for infection control as well as a waste receptacle at the service site.

Figure 7.2 **Items to Support Quality Examinations for STIs (N=370)**



*Soap and running water or hand disinfectant, latex gloves, disinfecting solution, sharps box

NHFC 2009

Physical examination

Quality physical examinations require visual and auditory privacy, an examination bed or couch, and an examination light. All three items are available in only 34 percent of facilities offering STI services (Table A-7.2). The great majority of STI facilities (94 percent) can assure both visual and auditory privacy for client examinations; an equal proportion has an examination bed or couch for client examination. Only 37 percent of facilities have an examination light, however. Half of hospitals and half of health centres have all items for physical examinations compared with 30 percent of clinics.

STI diagnosis

WHO recommends two approaches to diagnose STIs—the etiologic approach and the syndromic approach—and to provide STI services at primary care facilities (WHO, 2001). The etiologic approach uses laboratory tests to diagnose STIs; this is more accurate than syndromic diagnosis. However, many health care facilities in developing countries lack the equipment and trained personnel required for etiological diagnosis of STIs. The syndromic approach, which is recommended for facilities without a laboratory, assesses the presence of specific symptoms and signs and then uses an algorithm to determine what treatments should be provided. When neither an etiologic nor a syndromic approach is used, providers typically must diagnose and prescribe treatment based on their clinical judgment and clients' symptoms, an approach referred to as clinical diagnosis. Studies have shown that, when providers lack laboratory results or a specific protocol such as the syndromic approach to guide STI diagnosis and prescriptions, they often give the wrong treatment (Lande, 1993).

The most reliable means to ensure that clients receive a desired laboratory test is for the facility to conduct the test on site. Another option is to collect the specimen and send it to another facility for testing. The least reliable means is to refer the client to another facility for the laboratory test, because the client may decide not to take the test at all. Table A-7.3 provides information on the availability of specific tests for diagnosis and of medicines for treatment of STIs.

Findings from the 2009 NHFC indicate that the syndromic approach is the most common method used to diagnose and treat STIs in Namibia, employed by about nine of every ten facilities that provide STI services (Table 7.2). Only 20 percent of facilities report that they use the etiologic approach, mainly hospitals (47 percent) and sick bays (57 percent) rather than health centres (28 percent) and clinics (15 percent). Despite low use of the etiologic approach, approximately nine of every ten facilities have the capacity to test for gonorrhoea and syphilis, either in the facility or in an affiliated external laboratory, and eight of every ten have the capacity to test for HIV. Laboratory capacity to test for chlamydia is least common (23 percent).

STI treatment

Medicines for treating the most common STIs—syphilis, gonorrhoea, trichomoniasis, and chlamydia—are adequately available in Namibian health facilities. Eighty-eight percent of facilities offering STI services have in stock at least one medicine to treat each of those four STIs (Table A-7.3). Hospitals and health centres are the most likely to have medicines to treat each of the four STIs. The medicines most widely available are penicillin (available in 95 percent of STI facilities), metronidazole (91 percent), and ciprofloxacin, clotrimazole, and amoxicillin (each available in 88 percent of facilities).

Key Findings

Infection control: Items for infection control (soap and running water or else hand disinfectant, latex gloves, disinfecting solution, and sharps containers) are all available at the STI service delivery site in two-thirds of STI facilities. Sharps boxes are universally available. In contrast, hand disinfectant is available at the service site in only six of every ten STI facilities.

Physical examination: The majority of STI facilities can assure both visual and auditory privacy for client examinations and have an examination bed or couch at the service site. An examination light is lacking in most facilities, however.

STI diagnosis and treatment: The majority of STI facilities use the syndromic approach for diagnosing and treating STIs. Approximately nine of every ten facilities have the laboratory capacity to test for gonorrhoea and syphilis, either in the facility or in an affiliated external laboratory.

Medicines to treat four common STIs are available in most Namibian health facilities; close to nine of every ten STI facilities have in stock at least one medicine to treat each of the four common STIs.

7.4 Management Practices Supportive of Quality Services

Management practices to support quality STI services include proper documentation practices, staff supervision, and staff development. Summary information on management practices supportive of quality services for STIs as well as summary information on training topics for STI service providers is provided in Table 7.3. Tables A-7.5 through A-7.8 provide additional information on supportive management of service providers, including training and supervision, as well as information on utilisation of services.

7.4.1 Facility Documentation and Records

WHO considers record-keeping and reporting on STIs and STI service utilisation to be key elements in STI surveillance, necessary for improving STI programme management (UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance, 1999). A register for STI services is considered up-to-date if there is an entry during the past seven days and if symptoms or a diagnosis

consistent with STIs is recorded. Because most STI services are provided in outpatient departments, the outpatient records were used during data collection.

Only four of every ten facilities offering STI services have up-to-date registers; another 45 percent have registers with the most recent entry made more than seven days earlier (Table 7.3). MoD/Police facilities are least likely to have up-to-date client registers compared with facilities managed by other authorities. With the exception of Kunene, where 71 percent of facilities have up-to-date registers, and Karas, where only 9 percent of facilities have up-to-date registers, most regions range between 22 and 60 percent of facilities having up-to-date client registers.

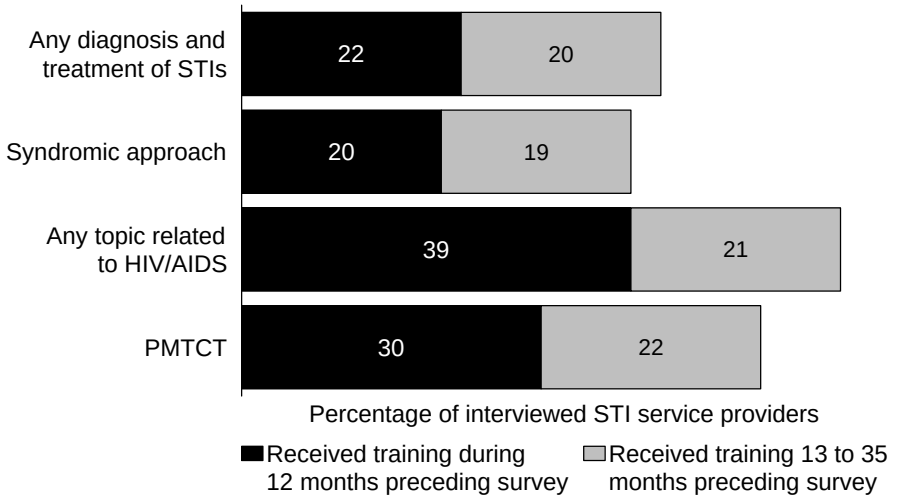
7.4.2 Training and Supervision

Training

A facility is considered to provide routine training and staff development if at least half of the interviewed STI providers have received training related to STIs during the 12 months preceding the survey. This includes pre-service and in-service training, but it excludes individual instruction received during discussions with supervisors. Sixty-five percent of STI facilities meet this criterion (Table 7.3). Hospitals (75 percent) and health centres (72 percent) are more likely to have routine training and staff development than other facility types. Also, MoHSS as well as mission/NGO facilities are more likely to provide routine staff training than private and MoD/Police facilities.

Among interviewed STI service providers, 56 percent reported having received training related to STIs during the 12 months preceding the survey (Table A-7.5). Regarding the specific training received, four of every ten STI service providers reported having received HIV/AIDS-related training during the 12 months preceding the survey (Figure 7.3, Table A-7.6). Twenty-two percent received training on any STI diagnosis and treatment; 20 percent received training on the syndromic approach to STIs during the 12 months preceding the survey.

Figure 7.3 **Training Received by Interviewed STI Service Providers, by Topic and Timing of Most Recent Training (N=930)**



PMTCT = Prevention of mother-to-child transmission

NHFC 2009

Supervision

Supervising individual staff members promotes adherence to standards and the identification of problems that contribute to poor quality services. If at least half of interviewed STI service providers in a facility report that they have been personally supervised any time during the six months preceding the survey, the facility is considered (by 2009 NHFC definition) to provide routine staff supervision. By this definition 77 percent of facilities provide routine staff supervision (Table 7.3). Mission/NGO facilities are the most likely to provide routine supervision (96 percent). In contrast, only 34 percent of private facilities meet the criterion for routine supervision. STI service providers who received supervision during the preceding six months were supervised about four times during that period (Table A-7.7).

Key Findings

Up-to-date client registers: Up-to-date STI client registers are not readily available; only four of every ten facilities that offer STI services have up-to-date client registers; MoD/Police facilities are among the least likely to have up-to-date registers.

Staff development: Two-thirds of STI facilities meet the criterion for providing routine training and staff development. Close to six of every ten interviewed STI service providers reported receiving STI-related training during the preceding 12 months. HIV/AIDS-related topics were the most common.

About eight of every ten STI facilities provide routine staff supervision.

7.5 Resources for Diagnosis and Management of Tuberculosis

Tuberculosis, especially multi-drug-resistant tuberculosis (MDR-TB), is a re-emerging communicable disease of public health significance. To control TB infection and to prevent its most severe complications, universal BCG vaccination at birth is mandatory in many developing countries, including Namibia. TB is also one of the most common opportunistic infections for HIV-infected people. WHO recommends the directly observed treatment, short course (DOTS) approach to treating TB. The 2009 NHFC assessed the capacity of Namibian health facilities to provide TB services, including their testing capacity and the availability of medications for treatment.

TB diagnosis, treatment, and/or treatment follow-up services are available in about nine of every ten Namibian health facilities (Table 7.4). Practically all health centres and about nine of every ten clinics offer TB services, compared with 80 percent of hospitals. Sick bays are least likely to offer these services. Availability of TB services is similar in MoHSS and mission/NGO facilities, and these facilities are more likely than MoD/Police facilities and private facilities to offer TB services. At the regional level eight or nine of every ten facilities offer TB services in 11 of the 13 regions. Exceptions with lower rates are Khomas and Kunene regions.

Table 7.4 Availability of services for tuberculosis

Percentage of facilities providing any tuberculosis (TB) diagnostic services, any treatment and/or follow-up services, any TB diagnostic, treatment and/or follow-up services, and, among facilities offering any TB treatment and/or follow-up services, percentage following the directly observed therapy, short course (DOTS) treatment strategy or other treatment strategies, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage offering: Any TB diagnostic services	Percentage offering: Any TB treatment and/or follow-up services	Percentage offering: Any TB diagnostic, treatment and/or follow-up services	Number of facilities	Among facilities providing any TB treatment and/or follow-up services, percentage following: Treatment through DOTS[1]	Among facilities providing any TB treatment and/or follow-up services, percentage following: Treatment other than DOTS[2]	Number of facilities offering any TB treatment and/or follow-up services
Type of facility							
Hospital	80	78	80	45	57	43	35
Health centre	91	96	96	47	60	40	45
Clinic	82	84	88	295	61	39	247
Sick bay	44	56	56	9	80	20	5
Managing authority							
MoHSS	88	91	93	306	61	39	279
Mission/NGO	89	93	93	28	58	42	26
Private	43	37	51	49	50	50	18
MoD/Police	62	69	69	13	89	11	9
Region							
Caprivi	96	93	96	28	31	69	26
Erongo	86	86	94	36	71	29	31
Hardap	90	86	90	21	67	33	18
Karas	84	88	88	25	86	14	22
Kavango	89	91	93	57	63	37	52
Khomas	55	45	55	33	80	20	15
Kunene	43	68	71	28	37	63	19
Ohangwena	94	91	94	32	72	28	29
Omaheke	88	88	88	16	93	7	14
Omusati	84	92	94	49	29	71	45
Oshana	95	95	95	20	37	63	19
Oshikoto	91	91	91	22	75	25	20
Otjozondjupa	72	76	79	29	86	14	22
Total	82	84	87	396	61	39	332

[1] Treatment strategy followed is either direct-observe two months with four months of follow-up, or direct-observe six months.
[2] The facility provides follow-up treatment to clients after the client has completed the first two months of direct observation elsewhere, or the facility diagnoses and treats while the client is on admission, discharging the client for follow-up treatment elsewhere, or the facility provides full treatment to the client upon diagnosing TB with no routine direct observation phase, or the facility diagnoses and prescribes or provides medicines only, with no follow-up.

7.5.1 Tuberculosis Diagnosis

TB diagnosis among all facilities

Overall, eight of every ten facilities report that they offer TB diagnostic services (Table 7.4). MoHSS and mission/NGO facilities are about twice as likely as private facilities to offer TB diagnostic services. With the exception of Kunene and Khomas regions, where only about half of facilities offer TB diagnostic services, the great majority of facilities in the other regions offer TB diagnostic services.

Seventy-seven percent of all facilities report diagnosing TB using sputum tests.[2] The use of X-ray for TB diagnosis is reported in only 7 percent of facilities and is limited mostly to hospitals (27 percent) (Table A-7.13). A small proportion of facilities (2 percent) rely on clinical symptoms for diagnosing TB.

TB diagnosis using sputum tests

Among facilities that report diagnosing TB using sputum, only half had available on the day of the visit all items for conducting the sputum tests (including a functioning microscope, glass slides, and all stains for the AFB or Ziehl-Neelson test) (Table A-7.13). Except for sick bays, where three-fourths have all items for testing, only half of other facility types have all of the items needed. Private facilities and those managed by the MoD/Police are more likely to have all items than mission/NGO and MoHSS facilities.

Half of facilities that report diagnosing TB using the sputum test have a documented system for sending sputum elsewhere for diagnosis.

Records of sputum test results are available at 83 percent of these facilities. However, there is a large gap in the availability of test result records between private facilities (25 percent) and facilities managed by MoD/Police, mission/NGOs, and MoHSS, all above 85 percent. Variation also exists among facilities of different types; sick bays and health centres are more likely to have observed records of test results than hospitals, for example. There are also regional variations; the availability of records of test results ranges from 47 percent of facilities in Oshana region to 100 percent of facilities in Caprivi, Kunene, Omaheke, Omusati, and Oshikoto regions.

TB diagnosis among facilities offering TB diagnostic, treatment, and/or follow-up services

Among the facilities offering TB diagnostic, treatment and/or treatment follow-up services, three of every ten have the capacity to stain[3] sputum for TB diagnosis; a little over nine of every ten have the capacity to conduct sputum microscopy[4] (Table A-7.9). Overall, only three of every ten have the capacity to conduct microscopic sputum examination and also the capacity to stain sputum for TB diagnosis.

7.5.2 Tuberculosis Treatment and Items to Support Treatment

The modern treatment strategy for TB is based on standardised short-course chemotherapy regimens and proper case management to ensure completion of treatment and, ultimately, to cure the patient. The directly observed treatment, short course (DOTS) strategy is the most cost-effective public health strategy to fight tuberculosis. Namibia adopted the DOTS strategy the same year it was launched by WHO, in 1993. Implementation started in one region and expanded to cover all regions by 1995 (MoHSS, 2006b).

According to the 2009 NHFC findings, 84 percent of all facilities in Namibia report offering TB treatment and/or treatment follow-up services (Table 7.4). Better than nine of every ten health centres report offering the service, compared with eight of every ten hospitals and clinics. At the regional level facilities in Khomas and Kunene regions (45 and 68 percent, respectively) are among the least likely to offer TB treatment and/or follow-up services. Ninety percent and above of facilities in Caprivi, Kavango, Ohangwena, Omusati, Oshana, and Oshikoto offer the service.

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[2] Includes diagnosing TB using sputum microscopy, sputum culture, or any sputum-based TB rapid test, either in the facility or in an affiliated external laboratory.
[3] Glass slides and all stains for AFB or Ziehl-Neelson test.
[4] Have a functioning microscope.

Six of every ten facilities offering TB treatment and/or follow-up services report following the DOTS treatment strategy. Other than sick bays (where 80 percent follow DOTS treatment), there is not much variation by facility type. Facilities managed by the MoD/Police, while few in number, are more likely to follow the DOTS strategy than MoHSS, private, and mission/NGO facilities. There is, however, significant variation at the regional level, where the proportion of facilities following the DOTS strategy ranges from a low of 29 percent of facilities in Omusati to a high of 93 percent of facilities in Omaheke.

Among facilities following the DOTS strategy for TB treatment, about nine of every ten report being part of the national DOTS programme (Table A-7.11). Private and mission/NGO facilities are among the least likely to be part of the national DOTS programme. Also, only half of facilities in Caprivi and Oshikoto regions report being part of the national DOTS programme compared with over eight of every ten facilities in the other regions.

Client registers

Several items are crucial for successful implementation of DOTS and other TB treatment strategies, including up-to-date client registers, treatment protocols or guidelines, and first-line TB medicines.

Among facilities following the DOTS treatment strategy, eight of every ten have up-to-date DOTS client registers (Table A-7.11). Availability of up-to-date DOTS client registers is highest in hospitals (90 percent) and lowest in sick bays (50 percent). MoHSS and mission/NGO facilities are about twice as likely as private facilities to have up-to-date client registers.

Among facilities offering any type of TB treatment and/or follow-up services, two-thirds have up-to-date client records or registers available. Health centres and mission/NGO facilities are more likely than private facilities to have updated registers. For example, 85 percent of mission/NGO facilities have updated registers, whereas only 22 percent of private facilities do.

Treatment protocols

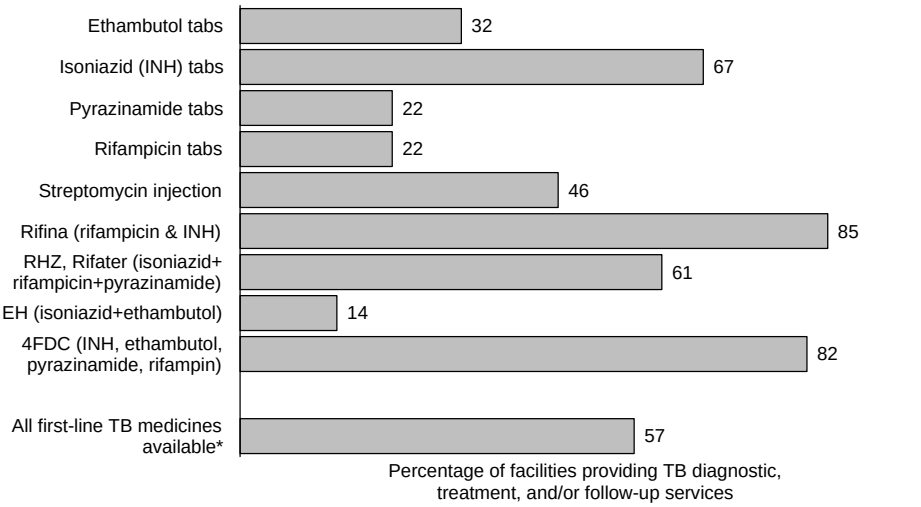
TB treatment protocols are widely available. Practically all facilities following DOTS TB treatment have a treatment protocol available (Table A-7.11). Similarly, treatment protocols are universally available in facilities offering any type of TB treatment and/or follow-up services (Table A-7.12). Treatment protocols are equally available in all facility types. Private facilities are less likely to have treatment protocols than facilities managed by other authorities.

Medicines

First-line anti-TB medicines were available on the day of the survey in 71 percent of facilities that follow DOTS treatment (Table A-7.11). Clinics and sick bays are less likely than hospitals and health centres to have first-line medicines. In addition, private facilities are less likely than others to have first-line TB medicines. At the regional level the proportion of facilities having all TB medicines ranges from 50 percent of facilities in Caprivi to 100 percent of facilities in Hardap and Khomas regions.

Figure 7.4 provides additional information on the availability of TB medications among facilities providing TB diagnostics, treatment, and/or follow-up services.

Figure 7.4 **Availability of First-line Anti-TB Medicines among Facilities Providing TB Diagnostic, Treatment, and/or Follow-up Services (N=345)**



* Any combination of pyrazinamide, rifampicin, ethambutol, isoniazid, and streptomycin. If medicines provided are prepackaged for individual DOT clients, medicines had to be available for all DOTS clients currently on treatment from facility.

NHFC 2009

Infection control

Measures to reduce tuberculosis transmission include the following:

- Early identification, diagnosis, and treatment of tuberculosis suspects, and separation of pulmonary tuberculosis suspects from others until a diagnosis is confirmed or excluded
- Natural ventilation
- Personal protection, including protection of the HIV-positive person from possible exposure to tuberculosis (for example, transfer of the HIV-infected worker from medical wards) and isoniazid preventative therapy, if eligible

The 2009 NHFC assessed facilities offering any TB diagnostic, treatment and/or follow-up services for the availability of a TB infection control focal person, a TB infection control committee, and TB Infection Control Plans.

Thirty-eight percent of facilities offering those TB services have a TB infection control (IC) focal person, and only 3 percent have a TB IC committee (Table A-7.15). Forty-three percent have either a TB IC focal person or IC committees in place, implying that more than half of facilities offering TB services have neither. Hospitals are more likely to have a TB IC focal person or committee than other facility types.

About one-quarter of TB facilities report having a TB infection control plan, while 40 percent report that they apply standard operating procedures for management of coughing patients in waiting areas. Hospitals (63 percent), more than other facility types, are likely to apply standard operating procedures. Only 15 percent of facilities offering TB services use N95 respirators (for use by health personnel as a TB control measure). Slightly fewer—13 percent—reported using N95 respirators and actually had the respirators available during the visit. Hospitals (60 percent) are more likely to report

using the respirators and to have had them than other facility types. Sick bays do not use N95 respirators and do not have them available.

Training and supervision

A facility is considered to provide routine training and staff development if at least half of the interviewed providers of TB services have received work-related training during the preceding 12 months. This includes pre-service and in-service training, but it excludes individual instruction received during discussions with supervisors.

The 2009 NHFC interviewed both laboratory TB diagnostic service providers and clinician TB service providers. Among laboratory service providers, only 13 percent report receiving pre- or in-service training related to their work during the preceding 12 months; these providers are found exclusively in hospitals. Also, they are more likely to be in mission/NGO-managed facilities than in government or private facilities (Table A-7.10.1). In contrast to the low level of training, supervision is quite common. Eight of every ten interviewed laboratory TB service providers report being personally supervised during the preceding six months. However, supervision is limited to providers in government and mission/NGO facilities.

Thirty-seven percent of clinician providers of TB services report receiving pre- or in-service training during the 12 months preceding the visit (Table A-7.10.2). Seven of every ten interviewed clinician providers reported being supervised during the preceding six months. Only 28 percent of clinician providers received both training and supervision during the indicated time periods.

7.5.3 Tuberculosis and HIV/AIDS Services

Because TB is a common opportunistic infection in people who are HIV-positive, it is recommended that newly diagnosed TB patients be screened for HIV and vice versa. According to WHO, ‘HIV testing for TB patients is increasing quickly in the African region; however, little effort has yet been made to screen HIV-infected people for TB, though this is a relatively efficient method of case-finding’ (WHO, 2007). The 2009 NHFC assessed the availability of a system in which newly diagnosed TB patients are tested or referred for HIV testing.

Among facilities offering TB services, 84 percent report that they routinely refer all newly diagnosed TB clients for HIV testing (Table A-7.14). However, only 68 percent of facilities have registers recording this. Health centres are slightly more likely than other facility types to refer newly diagnosed TB cases for HIV testing. Health centres are also more likely to have registers of clients referred for HIV testing.

Mission/NGO facilities are more likely to refer TB clients for HIV testing and also more likely to have records of such referrals than facilities managed by other authorities. With only 36 percent reporting that they routinely refer newly diagnosed TB cases for HIV testing, private facilities are the least likely among the lot to do so. Private facilities are also the least likely to have records of newly diagnosed TB clients referred for HIV testing.

Three-fourths of TB facilities have records that identify which current TB clients are also infected with HIV. Such records are most likely to be available in health centres and in mission/NGO facilities.

Key Findings

Service availability: TB services (diagnosis, treatment, and/or follow-up services) are available in about nine of every ten facilities in the country, including all health centres and nine of every ten clinics. MoHSS and mission/NGO facilities are more likely than others to offer these services.

Six of every ten facilities that offer TB treatment and/or follow-up services follow the DOTS treatment strategy. Among these, nine of every ten report being part of the national DOTS programme, and seven of every ten have TB medicines available in the facility.

Training: Pre- or in-service training is uncommon among TB service providers; only 13 percent of interviewed laboratory service providers and 37 percent of clinician TB service providers report receiving pre- or in-service training during the preceding 12 months.

Client registers: Eight of every ten facilities following the DOTS treatment strategy have up-to-date DOTS client registers. Availability of up-to-date DOTS client registers is highest in hospitals and lowest in sick bays.

TB Infection control: Only four of every ten facilities offering TB services have a TB infection control focal person in place, and only 3 percent have TB infection control committees. TB infection control plans are available in only one-fourth of TB facilities, while four of every ten facilities report that they apply standard operating procedures for management of coughing patients in waiting areas.

Referral for HIV testing: A little over eight of every ten facilities offering TB services routinely refer newly diagnosed TB patients for HIV testing. However, only about seven of every ten of these facilities have registers showing client referrals for HIV testing.

7.6 THE MALARIA CONTROL STRATEGY

Namibia's National Malaria Control Programme (NMCP) is part of the Roll Back Malaria initiative. The ultimate goals of malaria control are to prevent mortality, reduce morbidity, and avoid socio-economic loss due to malaria. The four basic malaria strategies are:

- To provide early diagnosis and prompt treatment
- To plan and implement selective and sustainable preventive measures, including vector control
- To detect early and contain, and to prevent epidemics
- To strengthen capacities in basic and applied research

The current malaria treatment policy

In 2005 it was decided at a consensus meeting to change the first-line malaria treatment to artemisinin-based combination therapy (ACT). The current malaria treatment policy recommends—

- As first-line treatments, generally artemether/lumefantrine (Coartem) for uncomplicated malaria, Fansidar for children below 5 kg body weight (age 2-6 months), and quinine for pregnant women
- Quinine as generally the second-line treatment for malaria

- In all patients parenteral quinine for the treatment of severe malaria

- Fansidar (Sulphadoxine-pyrimethamine or SP) for intermittent preventive treatment (IPT) during pregnancy; the recommended dosage is three tablets to be taken orally at around 26-36 weeks gestation and repeated four weeks later. In regions where the prevalence of HIV is more than 10 percent, a third dose can be offered.

7.6.1 Malaria Diagnosis

The diagnosis of malaria is based on taking a good history, doing a thorough clinical examination, and conducting laboratory investigations. The 'gold standard' of laboratory malaria diagnosis is the examination by microscope of blood smears for malaria parasites (i.e., microscopy). The reliability of microscopy depends heavily on the expertise and experience of the person who makes the stains and examines the blood smears. Malaria rapid diagnostic tests (RDTs) are an alternative to microscopy where good-quality microscopy services cannot be readily provided. Most RDTs detect the presence of antigens produced by malaria parasites that are present in the blood of infected or recently infected individuals. Most RDTs can detect only one species (*Plasmodium falciparum*). This is the type of RDT widely used in Namibia.

7.7 Availability of Services for Malaria

The 2009 NHFC assessed the availability of services for malaria in Namibian health facilities, specifically—

- Availability of malaria services, including laboratory diagnosis and treatment, among all facilities

- Distribution of free ITNs to ANC clients

- Provision of malaria training for providers

7.7.1 Malaria Diagnosis and/or Treatment

Findings from the 2009 NHFC indicate that malaria services are widely available in the country. Close to nine of every ten facilities in the country offer malaria treatment services and 95 percent of facilities have laboratory diagnostic capacity[5] for malaria (Table 7.5). Sick bays, however, are significantly less likely than other facility types to offer malaria services, particularly laboratory diagnostic capacity, which is available in less than half of sick bays. Private facilities are also less likely than the others to have malaria services. For example, only 41 percent of private facilities offer malaria treatment services, compared with over 90 percent of MoHSS and mission/NGO facilities.

Diagnostic capacity

Among the facilities offering malaria services (treatment and/or diagnosis), nine of every ten have microscopic laboratory diagnostic capacity (blood smear), and about three-quarters have malaria rapid diagnostic tests (Table 7.5).

[5] Laboratory diagnostic capacity means that the facility has a functioning microscope, glass slides, and stains or else a malaria rapid diagnostic test available either in the facility laboratory or in an affiliated external laboratory.

Table 7.5 Malaria diagnosis and/or treatment services

Percentage of facilities offering malaria treatment services, percentage that have malaria laboratory diagnostic capacity, percentage offering malaria diagnosis and/or treatment services, and, among facilities offering malaria diagnosis and/or treatment services, percentage having the indicated components for supporting malaria services, by background characteristics, Namibia HFC 2009

	Percentage of facilities that:				Among facilities offering malaria diagnosis and/or treatment services, percentage with:						
Background characteristics	Offer malaria treatment services	Have lab diagnostic capacity for malaria[1]	Offer malaria diagnosis and/or treatment services	Number of facilities	Observed malaria treatment protocol in any relevant unit	First-line anti-malaria medicine in the facility[2]	Stock-out of first-line anti-malarial in 6 months preceding survey	Diagnostic capacity for malaria (blood smear)	Other diagnostic capacity for malaria (rapid test)	Treatment protocol in any relevant unit and first-line medicines in facility	Number of facilities offering malaria diagnosis and/or treatment services
Type of facility											
Hospital	82	98	100	45	53	93	2	89	56	51	45
Health centre	98	100	100	47	91	83	2	96	83	81	47
Clinic	86	96	97	295	88	70	2	92	76	66	287
Sick bay	78	44	78	9	43	57	0	57	43	29	7
Managing authority											
MoHSS	94	99	100	306	92	79	2	92	77	73	306
Mission/NGO	96	96	100	28	96	86	0	89	79	82	28
Private	41	80	84	49	20	32	0	93	54	2	41
MoD/Police	69	62	85	13	45	55	0	64	55	27	11
Region											
Caprivi	100	96	100	28	89	93	4	96	96	86	28
Erongo	47	94	94	36	68	47	0	68	82	29	34
Hardap	81	95	95	21	65	45	5	100	95	35	20
Karas	72	92	96	25	79	54	8	96	13	46	24
Kavango	100	93	100	57	88	95	0	82	82	86	57
Khomas	52	82	85	33	54	54	0	96	64	29	28
Kunene	100	100	100	28	100	75	0	100	46	75	28
Ohangwena	100	100	100	32	97	91	0	100	91	88	32
Omaheke	88	100	100	16	88	75	0	100	75	75	16
Omusati	98	98	98	49	90	75	2	100	69	69	48
Oshana	100	95	100	20	85	60	10	90	50	50	20
Oshikoto	100	100	100	22	100	95	0	100	91	95	22
Otjozondjupa	93	100	100	29	76	76	0	76	93	59	29
Total	87	95	97	396	83	74	2	91	74	65	386

[1] Laboratory diagnostic capacity means a functional microscope, slides, and stains must all be available or rapid malaria test kit available either in the facility laboratory or in an affiliated external laboratory.
[2] First-line antimalarial is Coartem for patients other than pregnant women and children under 6 months.

First-line medicines

For most patients the recommended first-line treatment for malaria is Coartem. Among facilities offering malaria diagnosis and/or treatment services, about three-quarters had Coartem available in the facility on the day of the visit. Sick bays were less likely to have malaria medicines than other facility types. Private facilities were much less likely (32 percent) to have Coartem than mission/NGO (86 percent) and MoHSS (79 percent) facilities. Regional availability varies substantially, from 95 percent of facilities having the first-line malaria drug in Kavango and Oshikoto down to only 45 percent in Hardap.

Findings from the 2009 NHFC indicate that stock-outs of first-line medicines are rare, as only 2 percent of facilities overall reported such stock-outs during the six months preceding the survey; all of these were at MoHSS facilities.

Treatment guidelines/protocols

Treatment guidelines/protocols are essential tools in the provision of quality services. The 2009 NHFC assessed the availability of malaria treatment guidelines or protocols at facilities where malaria

services are provided. Overall, about eight of every ten facilities that offer malaria services have malaria treatment guidelines or protocols available in the facility (Table 7.5). Private facilities are least likely to have treatment guidelines or protocols (20 percent), especially in comparison with mission/NGO (96 percent) and MoHSS (92 percent) facilities. Among the regions facilities in Kunene and Oshikoto (both 100 percent) are most likely to have treatment guidelines or protocols, and facilities in Erongo (68 percent), Hardap (65 percent), and Khomas (54 percent) are among the least likely to have them.

Overall, about two-thirds of facilities offering malaria services have both first-line medicines available and treatment guidelines or protocols available. The great majority of mission/NGO and MoHSS facilities (82 and 73 percent, respectively) have both key components, compared with only 2 percent of private facilities.

7.7.2 Malaria-related Training for Providers

Ongoing training for service providers ensures that providers continue to learn the latest information pertaining to the services that they provide. However, among facilities offering malaria diagnosis and/or treatment services, few (only 3 percent overall) have at least one clinician[6] provider who had received malaria-related training during the preceding 12 months (Table 7.6).

Less than half (43 percent) of health facilities have at least one nurse[7] provider who had received malaria-related training in the preceding 12 months—a low percentage but still significantly higher than that for clinicians. Health centres are more likely to have at least one recently trained nurse provider of malaria services than other facility types. Similarly, mission/NGO and MoHSS facilities are more likely than facilities managed by other authorities to have at least one recently trained nurse provider of malaria services. Among regions, facilities in Oshana (75 percent) and Oshikoto (73 percent) are the most likely to have at least one recently trained nurse; at the other end of the scale is Karas region (21 percent).

[6] Clinician providers include all specialists, medical officers, and medical assistants.
[7] Nurse providers include registered nurses/midwives and enrolled nurses/midwives.

Table 7.6 Provision of insecticide treated nets and malaria-related training for providers

Among facilities offering malaria diagnosis and/or treatment services, percentage that distribute insecticide-treated nets (ITNs) to ANC clients and percentage where providers have received appropriate pre- or in-service malaria-related training, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities offering malaria diagnosis and/or treatment services that:		At least 1 clinician provider[1] of malaria diagnosis or treatment services has received malaria-related pre- or in-service training in:		At least 1 nurse provider[2] of malaria diagnosis or treatment services has received malaria-related pre- or in-service training in:		Number of facilities offering malaria diagnosis and/or treatment services
	Distribute free ITNs to ANC clients	Have ITNs in facility	Preceding 12 months	Preceding 13-35 months	Preceding 12 months	Preceding 13-35 months	
Type of facility							
Hospital	7	7	11	9	49	24	45
Health centre	45	32	4	4	70	13	47
Clinic	39	29	2	1	38	24	287
Sick bay	0	0	0	14	14	29	7
Managing authority							
MoHSS	40	29	4	1	47	26	306
Mission/NGO	50	43	0	4	54	18	28
Private	0	2	5	5	15	0	41
MoD/Police	0	0	0	9	18	27	11
Region							
Caprivi	75	68	4	4	46	46	28
Erongo	0	0	0	6	32	15	34
Hardap	0	0	5	5	25	15	20
Karas	4	0	4	4	21	13	24
Kavango	18	21	4	2	30	32	57
Khomas	0	0	14	4	36	11	28
Kunene	32	43	0	0	32	50	28
Ohangwena	72	38	0	3	53	25	32
Omaheke	69	6	0	0	69	6	16
Omusati	54	25	4	0	54	19	48
Oshana	50	65	0	0	75	15	20
Oshikoto	91	77	0	0	73	18	22
Otjozondjupa	21	10	7	7	38	21	29
Total	35	26	3	2	43	23	386

[1] Clinician providers include all specialists, medical officers, and medical assistants.
[2] Nurse providers include registered nurses/midwives and enrolled nurses/midwives.

Key Findings

Services: Malaria diagnosis and/or treatment services are almost universally available in Namibian health facilities. Close to nine of every ten offer treatment services, while a little over nine of every ten have laboratory diagnostic capacity for malaria.

Treatment guidelines: Malaria treatment guidelines or protocols are available in eight of every ten facilities, and first-line antimalarial medicine is available in a little over seven of every ten facilities that offer malaria services. Stock-outs of antimalarial medicines are rare and are reported almost exclusively by MoHSS facilities.

Training: Only a small proportion of facilities offering malaria services have at least one recently trained clinician provider of malaria services; a higher proportion of facilities—although still not the majority—have at least one recently trained nurse provider.

7.8 MALARIA SERVICES FOR ANC CLIENTS

The use of insecticide-treated bed nets (ITNs) can reduce malaria transmission among the population in general and in pregnant women and children in particular. ITNs in Namibia are being promoted through three main channels:

- **Community-based campaigns in the public sector.** This is intended for rapid scaling up to achieve wide coverage. Although the ITNs are purchased through the public sector, private-sector service providers participate in their distribution. So far, the main focus of these campaigns has been on vulnerable groups, particularly pregnant women and children.

- **Facility-based routine distribution to pregnant women through antenatal clinics.** This is mainly intended for maintenance of coverage. The policy is that pregnant women who attend antenatal clinics should be provided with mosquito nets, either free of charge or at subsidised price. In practice, whether a pregnant woman attending an antenatal clinic gets a free net or pays for it depends on the source of the net. Public sector nets (e.g., those bought using funds from The Global Fund to Fight AIDS, Tuberculosis and Malaria) are distributed free of charge to the end user. Both public and private health service providers participate in this activity.[8]

- **Commercial sales in the private, for-profit sector.**[9]

The 2009 NHFC assessed facilities offering malaria diagnosis and/or treatment services for the availability of ITNs and their provision, free of charge, to ANC clients.

Among all facilities offering malaria services, about one-third offer ITNs to ANC clients free of charge. Health centres (45 percent) and clinics (39 percent) are relatively more likely than hospitals (7 percent) and sick bays (0 percent) to provide free nets. Free distribution varies widely among regions, from zero percent of facilities in Erongo, Hardap, and Khomas to 91 percent of facilities in Oshikoto.

Table 7.6 also shows that, although 35 percent of facilities offering malaria services report offering free ITNs to ANC clients, only 26 percent of facilities actually had ITNs in the facility on the day of the visit. Health centres (32 percent) and clinics (29 percent) were more likely to have ITNs in the facility than hospitals (7 percent). This can be explained by the fact that only a small proportion of hospitals offer ANC services (see Chapter 6, Table 6.1). Mission/NGO (43 percent) and MoHSS (29 percent) facilities were more likely to have ITNs than private facilities (2 percent). Availability by region also varied drastically, in a pattern similar to that of facilities offering free ITNs to ANC patients.

[8] There is the intention to distribute ITNs to children through the Extended Programme of Immunisation; however, this has not started yet.

[9] Social marketing, where ITNs were sold to the public at subsidised price to promote their use, was done in the past. It is very rarely done now.

Key Findings

Service availability: About two-thirds of facilities offering malaria services report that they offer ITNs to ANC clients free of charge; however, only one-quarter of facilities offering malaria services had ITNs available in the facility on the day of the visit. Health centres and clinics are the facility types most likely to offer ITNs to ANC clients. Mission/NGO and MoHSS facilities are more likely to have ITNs than private facilities.

HIV/AIDS SERVICES 8

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8.1 BACKGROUND

An international technical working group, comprised of representatives from the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United States Agency for International Development (USAID), and other entities, including non-governmental organisations (NGOs) that implement HIV/AIDS services, has developed common indicators for measuring the quality of HIV/AIDS services provided through the formal health sector. These indicators fall under the following broad categories:

- Capacity to provide basic services for HIV/AIDS, including HIV counselling and testing
- Capacity to provide advanced services for HIV/AIDS, including antiretroviral therapy (ART)
- Availability of record-keeping systems for monitoring HIV/AIDS care and support
- Capacity to provide services for prevention of mother-to-child transmission (PMTCT) of HIV
- Availability of youth-friendly services (YFS)

The 2009 Namibia Health Facility Census (2009 NHFC) measured components of each of these indicators in all health facilities in Namibia.

8.1.1 HIV/AIDS in Namibia

The first case of HIV/AIDS in Namibia was reported in 1986. Since then the rate of HIV infection has continued to rise in the country (MoHSS, 2008c). 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, 2009a). An estimated 6,100 people died of AIDS and AIDS-related illnesses between March 2008 and April 2009. The epidemic has disproportionately affected men and women in the prime of life. It is estimated that during 2008-09 there were 95,000 adult females (age 15 or older) and 66,000 adult males living with HIV in Namibia. During the same period approximately 11,600 mothers were in need of services to prevent mother-to-child transmission of HIV. There are about 13,000 children living with HIV. The epidemic has resulted in major social consequences arising from the deaths of adults and the resulting massive burden of orphans and vulnerable children. Approximately 69,000 children in Namibia are orphaned by AIDS. The epidemic has also imposed a burden on the limited resources of the country, with funds being diverted to interventions for HIV prevention and AIDS care at the expense of other concerns.

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 in the development and implementation of sector-related HIV/AIDS activity plans

in accordance with sectoral obligations as contained in the Third Medium-Term Plan on HIV/AIDS (MTP3).

8.2 Definitions of HIV/AIDS Indicators

The 2009 NHFC assessed the following HIV/AIDS-related services:

HIV testing system: The NHFC defines a facility as having an HIV testing system if clients are offered an HIV test conducted within the facility or in an affiliated lab, or the facility has a system for referring clients to an external testing site and receiving test results back from that external site to follow up with clients after testing. A facility that simply refers clients elsewhere, expecting the other location to counsel and follow up on test results, is not defined as having an HIV testing system or offering HIV counselling and testing.

Care and support services (CSS): Care and support services include any services that are directed towards improving the lives of persons living with HIV and AIDS. These most often include treatment for opportunistic infections and illnesses that are commonly associated with or worsened by HIV infection, such as tuberculosis (TB), sexually transmitted infections (STIs), and malaria. CSS also may include palliative care and socio-economic and psychological support services.

Antiretroviral therapy (ART): This refers to providing antiretroviral (ARV) medicines to treat HIV-positive persons and AIDS patients.

Post-exposure prophylaxis (PEP): This refers to providing prophylactic ARV drugs to persons who have been exposed to HIV.

Prevention of mother-to-child transmission (PMTCT): A facility is defined as offering PMTCT services if it offers any activities related to the prevention of mother-to-child transmission of HIV in pregnant or recently delivered women. Such activities include HIV testing and pre- and post-test counselling for pregnant women, counselling on infant feeding practices (including counselling about exclusive breastfeeding), family planning counselling and/or referral, and providing prophylactic ARV drugs to HIV-positive women and their newborn babies. PMTCT *plus* services include the provision of care and treatment, including ART as appropriate, to all HIV-positive women and HIV-infected members of their families.

Youth-friendly services (YFS) pertaining to HIV counselling and testing services: This refers to specific programmatic strategies to encourage adolescents to utilise HIV services, particularly HIV counselling and testing services.

8.3 Basic-Level Services for HIV/AIDS

8.3.1 Counselling and Testing

According to the 2010 National Strategic Framework for HIV and AIDS, Namibian health facilities offer client-initiated (voluntary) counselling and testing (VCT), and provider-initiated testing and counselling (PITC). PITC is recommended for all patients attending health facilities regardless of their health conditions, age, or symptoms, including men prior to surgical circumcision.

Generally accepted definitions for HIV counselling and testing services include the following key elements:

- Counselling must take place before testing. The counsellor must ascertain that the client is taking the test voluntarily and understands that he/she can interrupt or stop the process at any point.

- The counsellor shall ascertain that the client's mental state is sound and that he/she is not under the influence of any substance or undue pressure from any source. In case of doubt the counsellor should consult or refer the client to senior colleagues.

- Where HIV testing involves a person who is unable to provide consent, a close relative or next-of-kin shall be given information and asked to provide consent.

- The client must receive an assurance that test results are confidential and that no one will be told the results without his/her consent.

- Both HIV-positive and HIV-negative clients must receive post-test counselling on preventive measures, as well as treatment and follow-up as appropriate.

- Same-day test results are encouraged.

- HIV testing sites must participate in the external quality assurance programme offered by the Namibia Institute of Pathology (NIP).

- HIV testing sites should strictly follow the Namibian HIV Rapid Testing Algorithm.

Counselling and testing can be provided in almost any setting, wherever a client or provider determines that the service is necessary. Therefore, during the 2009 NHFC information was gathered from different types of health facilities, namely, hospitals, health centres, clinics, sick bays, and free-standing VCT sites.

Several elements have been defined as important for supporting the quality of testing and providing results. For example, service sites must have guidelines and protocols and appropriate record-keeping systems, including records of referrals to laboratory facilities for HIV testing. Table 8.1 and Figure 8.1 present information on the availability of HIV testing services. Table 8.1 also presents information on the availability of support systems for quality HIV counselling and testing, such as informed consent policy or documents and record-keeping systems.

Testing systems

Findings of the 2009 NHFC indicate that HIV testing systems are almost universally available in Namibia (Table 8.1). Among the different facility types, sick bays (and MoD/Police facilities among the different managing authorities) are the least likely to have an HIV testing system. Private facilities (88 percent) are also less likely, compared with MoHSS and mission/NGO facilities (both 100 percent), to have HIV testing systems. Among the regions, facilities in Khomas region (86 percent) are less likely to have an HIV testing system than most other regions, where HIV testing systems are almost universally available.

Among facilities with a testing system, the majority conduct testing in the facility or in an affiliated laboratory (81 percent) (Table 8.1). All of such free-standing VCT facilities and nine of every ten such health centres conduct testing in the facility or an affiliated laboratory. Facilities with testing systems in Karas (36 percent) and Kunene regions (48 percent) are less likely than such facilities in other regions to have testing done in either the facility or an affiliated laboratory. A little over one in every ten facilities with an HIV testing system have HIV testing at an external testing site and have supporting records available, while 7 percent report testing in an external site but do not have supporting records. Notable are facilities in Kunene, where over half report external testing but with no supporting records.

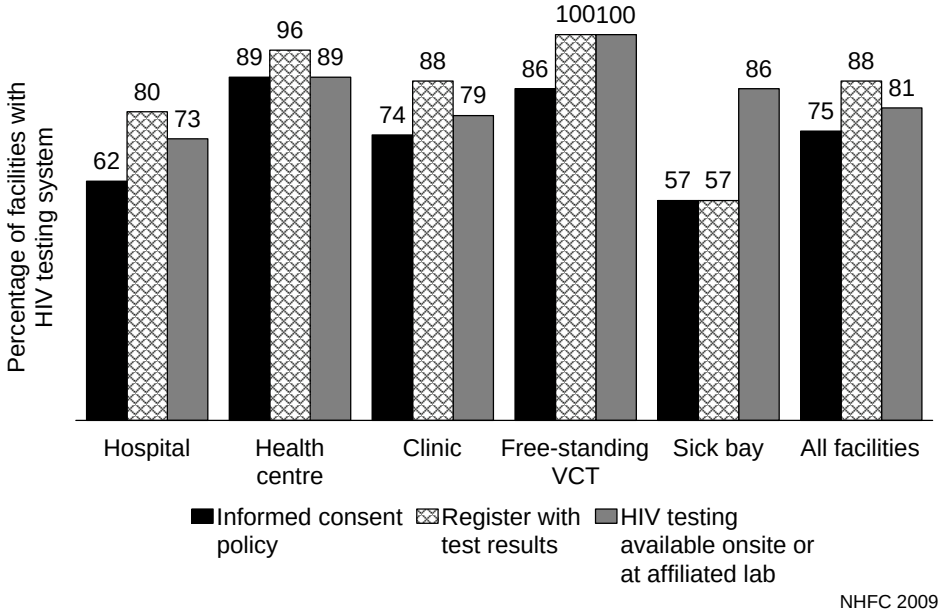
Table 8.1 System for testing and for offering results of HIV tests

Percentage of facilities reporting an HIV testing system and, among these, percentage conducting HIV test in facility or at external site and percentage with policies and records in any relevant site, by background characteristics, Namibia HFC 2009

			Percentage of facilities with an HIV testing system having indicated items							
Background characteristics	Percentage of facilities reporting an HIV testing system[1]	Number of facilities	HIV test available in facility or affiliated lab[2]	HIV test available in external testing site, records observed[3]	HIV test available in external testing site, no records observed[4]	Informed consent policy for HIV testing[5]	Register with HIV test results	Record for clients receiving HIV test results[6]	All items for HIV testing[7]	Number of facilities with an HIV testing system
Type of facility										
Hospital	100	45	73	16	11	62	80	76	47	45
Health centre	100	47	89	9	2	89	96	98	85	47
Clinic	98	295	79	13	8	74	88	84	67	289
Free standing VCT	93	15	100	0	0	86	100	93	86	14
Sick bay	78	9	86	14	0	57	57	57	29	7
Managing authority										
MoHSS	100	306	80	12	7	80	89	86	73	306
Mission/NGO	100	42	83	12	5	88	100	98	83	42
Private	88	49	77	14	9	28	72	60	12	43
MoD/Police	79	14	91	9	0	64	73	73	45	11
Region										
Caprivi	97	29	100	0	0	79	100	96	79	28
Erongo	95	38	89	11	0	72	89	81	61	36
Hardap	100	23	100	0	0	83	91	91	74	23
Karas	96	26	36	48	16	68	92	92	60	25
Kavango	100	58	71	22	7	64	91	90	57	58
Khomas	86	36	97	3	0	65	87	81	55	31
Kunene	100	29	48	0	52	79	69	66	41	29
Ohangwena	100	33	88	6	6	88	91	91	85	33
Omaheke	100	16	100	0	0	88	88	100	88	16
Omusati	100	50	70	28	2	70	84	74	68	50
Oshana	100	21	95	5	0	86	81	76	71	21
Oshikoto	100	22	100	0	0	91	100	100	91	22
Otjozondjupa	100	30	83	10	7	70	83	73	67	30
Total	98	411	81	12	7	75	88	84	67	402

[1] 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 the test results to the facility.
[2] HIV testing is confirmed in facility or in affiliated laboratory.
[3] HIV testing not available in facility, but there are observed records of testing conducted outside facility, with test results.
[4] HIV testing not available in facility, and there are no observed records of testing conducted outside facility.
[5] Having either the Namibia national guidelines for voluntary HIV counselling and testing or other HIV counselling and testing guidelines counts as having an informed consent policy for HIV testing. Availability of an informed consent document for the client to sign or keep or any other informed consent document also counts as having an informed consent policy.
[6] If rapid test is done, record with client identifier and results is sufficient.
[7] HIV test available in facility or records showing test done elsewhere and results are received by facility, informed consent policy in any relevant service site, observed register with HIV test results, and observed register for clients receiving HIV test results.

Figure 8.1 **Components of HIV Testing Services (N=402)**



Informed consent policy

An informed consent policy[1] for HIV testing is available in three-quarters of facilities that have an HIV testing system (Table 8.1, Figure 8.1). Free-standing VCT facilities and health centres are more likely than other facility types to have an informed consent policy. By managing authority, private facilities (28 percent) are least likely to have an informed consent policy for HIV testing. Availability of an informed consent policy ranges from a low of 64 percent of facilities in Kavango to a high of 91 percent of facilities in Oshikoto region.

Registers of test results

Registers with HIV test results are not universally available in facilities with HIV testing systems. While, overall, close to nine of every ten facilities have registers with test results readily available, availability ranges from 57 percent of sick bays to 100 percent of free-standing VCT facilities. Private facilities and facilities managed by MoD/Police (72 and 73 percent, respectively) are less likely than MoHSS and mission/NGO facilities (89 and 100 percent, respectively) to have registers with test results.

Most facilities (84 percent) with an HIV testing system have records of clients receiving their HIV test results. Availability is similar to that of registers of test results, described in the preceding paragraph.

Overall, two-thirds of facilities with an HIV testing system have all items for HIV testing.[2]

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[1] Having either the Namibia national guidelines for voluntary HIV counselling and testing or other HIV counselling and testing guidelines counts as having an informed consent policy for HIV testing. Availability of an informed consent document for clients to sign or keep or any other informed consent document also counts as having an informed consent policy.

[2] A facility with an HIV testing system is defined as having all items for HIV testing if all of the following are available: an HIV testing system, an informed consent policy in any relevant service site, an observed register with HIV test results, and an observed register showing clients receiving HIV test results.

Visual and auditory privacy in counselling and testing area

Visual and auditory privacy in the HIV counselling and testing areas is available in eight of every ten facilities with HIV testing systems (Table A-8.1). Sick bays and hospitals (71 and 73 percent, respectively) are less likely to provide privacy than free-standing VCT facilities and health centres (93 and 94 percent, respectively). Private facilities are also less likely to have visual and auditory privacy at counselling and testing sites than MoHSS facilities and facilities managed by other authorities.

Additional information on components of HIV counselling, such as policy on confidentiality, a written policy on routine provision of pre- and post-test counselling for HIV testing, and up-to-date records of clients receiving pre- and post-test counselling is provided in Table A-8.1.

Key Findings

Testing systems: HIV testing systems are almost universally available in Namibian health facilities; however, MoD/Police and private facilities are less likely than facilities managed by other authorities to have HIV testing systems. Regionally, facilities in Khomas region are less likely than facilities in other regions to have HIV testing systems.

Registers of test results: Registers with HIV test results are not universally available in facilities that offer HIV testing services. As with the availability of testing systems, MoD/Police and private facilities are the least likely to have registers of HIV test results.

Privacy: Most facilities that have HIV testing services are able to assure both visual and auditory privacy.

8.3.2 HIV/AIDS Care and Support Services

The provision of care and support is in alignment with the National HIV and AIDS Policy of 2007, which requires all patients to be provided adequate and effective palliative care at all times. The care and support intervention in the 2010-2016 National Strategic Framework for HIV and AIDS aims to scale up the provision of quality care and support by the pre-ART and ART programmes and to do so in a manner that is equitable across all regions of the country. In keeping with the 2007 National HIV and AIDS Policy, palliative care shall continue to be emphasised, particularly in regards to pain management as well as clinical and psychological, spiritual, social, and prevention services. The considerable scale-up of the ART programme has resulted in the requirement for new and additional forms of support from community home-based care (CHBC) providers—for instance, support with respect to HIV prevention, adherence to treatment and treatment literacy. Components of CHBC that specifically relate to not only HIV and AIDS include treatment adherence and treatment literacy for people on ART but also reproductive health as part of the double intervention strategy, nutritional support for people on treatment, and referrals to VCT, TB, and ART service providers, amongst other components (GRN, 2010).

Basic clinical care and support services for HIV/AIDS

People living with HIV/AIDS are at higher risk of developing infections such as TB and STIs as a result of their suppressed immune systems. These are known as opportunistic infections. Also, if they contract malaria, people living with HIV are likely to experience more severe forms of the disease because of their weakened immune systems.

One of the important HIV/AIDS care and support strategies is the immediate treatment of opportunistic infections among HIV/AIDS clients. Facilities that offer care and support services for

HIV/AIDS clients should also be able to offer services for TB, STIs, and malaria. The 2009 NHFC assessed the availability of several services among a subset of facilities that offer care and support services (CSS) for HIV/AIDS patients. Table 8.2 presents information on the availability of HIV/AIDS care and support services, and Table 8.3 shows summary information on the availability of specific basic clinical care and support services for HIV/AIDS among all facilities.

Table 8.2 Availability and documentation of HIV/AIDS care and support services

Percentage of facilities offering HIV/AIDS care and support services (CSS)[1] and, among these, percentage with the indicated record-keeping systems, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities offering HIV/AIDS care and support services (CSS)	Number of facilities[2]	Register with HIV/AIDS-related client diagnosis observed in any eligible service site	Record system for individual client appointments observed in any relevant outpatient service site	Number of facilities offering HIV/AIDS CSS
Type of facility					
Hospital	98	45	48	70	44
Health centre	98	47	48	35	46
Clinic	88	295	47	14	259
Sick bay	67	9	67	17	6
Managing authority					
MoHSS	92	306	51	23	281
Mission/NGO	89	28	68	36	25
Private	80	49	13	23	39
MoD/Police	77	13	50	30	10
Region					
Caprivi	96	28	0	22	27
Erongo	89	36	34	28	32
Hardap	100	21	52	24	21
Karas	88	25	5	23	22
Kavango	77	57	59	32	44
Khomas	85	33	25	29	28
Kunene	89	28	92	24	25
Ohangwena	97	32	55	16	31
Omaheke	94	16	13	33	15
Omusati	86	49	40	19	42
Oshana	100	20	85	5	20
Oshikoto	100	22	86	27	22
Otjozondjupa	90	29	69	27	26
Total	90	396	48	24	355

[1] Providers working in the facility provide treatment for any opportunistic infections or symptoms related to HIV/AIDS (such as treatment for topical fungal infections, cryptococcal meningitis, or Kaposi sarcoma) or provide (or prescribe) palliative care for patients (such as symptom or pain management or nursing care for the terminally ill), or provide nutritional rehabilitation services, including the prescription or provision of fortified protein supplements, or provide care for paediatric HIV/AIDS patients.

[2] Total excludes free-standing VCT facilities since they are not expected to offer HIV/AIDS care and support services.

Table 8.3 Availability of HIV testing systems and basic clinical care and support services for HIV/AIDS

Percentage of facilities that report an HIV testing system and offer treatment for various illnesses, by background characteristics, Namibia HFC 2009

	Percentage of facilities with:							
Background characteristics	HIV testing system[1]	TB treatment and/or follow-up	Treatment of STIs	Treatment of malaria	Preventive treatment for TB with INH[2]	Primary preventive treatment for opportunistic infections (such as CPT)[3]	All services	Number of facilities
Type of facility								
Hospital	100	78	91	82	69	76	49	45
Health centre	100	96	98	98	68	89	68	47
Clinic	98	84	98	86	59	71	47	295
Free standing VCT	93	0	20	0	0	0	0	15
Sick bay	78	56	89	78	0	22	0	9
Managing authority								
MoHSS	100	91	100	94	66	76	55	306
Mission/NGO	100	62	71	64	48	55	48	42
Private	88	37	78	41	31	55	12	49
MoD/Police	79	64	86	64	0	29	0	14
Region								
Caprivi	97	90	93	97	59	62	48	29
Erongo	95	82	92	45	50	84	24	38
Hardap	100	78	91	74	74	78	61	23
Karas	96	85	96	69	65	81	50	26
Kavango	100	90	98	98	48	48	31	58
Khomas	86	42	72	47	42	53	25	36
Kunene	100	66	100	97	31	55	21	29
Ohangwena	100	88	97	97	82	91	82	33
Omaheke	100	88	94	88	81	81	81	16
Omusati	100	90	98	96	74	80	66	50
Oshana	100	90	95	95	48	67	48	21
Oshikoto	100	91	100	100	86	91	77	22
Otjozondjupa	100	73	93	90	33	60	33	30
Total	98	81	94	84	58	70	47	411

[1] 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.
[2] This is the provision of isoniazid, either routinely to all HIV/AIDS clients regardless of their clinical condition or only selectively or sometimes to HIV/AIDS clients depending on their clinical condition.
[3] This refers to primary preventive treatment, such as cotrimoxazole preventive treatment (CPT), either routinely to all HIV/AIDS clients regardless of their clinical condition or only selectively or sometimes to HIV/AIDS clients depending on their clinical condition.

Nine of every ten facilities (excluding free-standing VCT facilities) offer HIV/AIDS care and support services (CSS) (Table 8.2). HIV/AIDS care and support services are universally available in hospitals and health centres, in 88 percent of clinics, but in only 67 percent of sick bays. Among the facilities that offer HIV/AIDS CSS, only half have a register with HIV/AIDS-related client diagnoses observed at eligible service sites. Private facilities are significantly less likely than facilities managed by other authorities to have such registers available (13 percent of private facilities versus 50 percent and above of facilities managed by other authorities). There is also significant variation by region, ranging from zero percent of facilities in Caprivi having registers to 92 percent of facilities in Kunene region.

Availability of a recording system for individual client appointments is rare and varies. Overall, only one-fourth of facilities offering CSS have such a system, with a range from less than 20 percent of clinics and sick bays to 70 percent of hospitals.

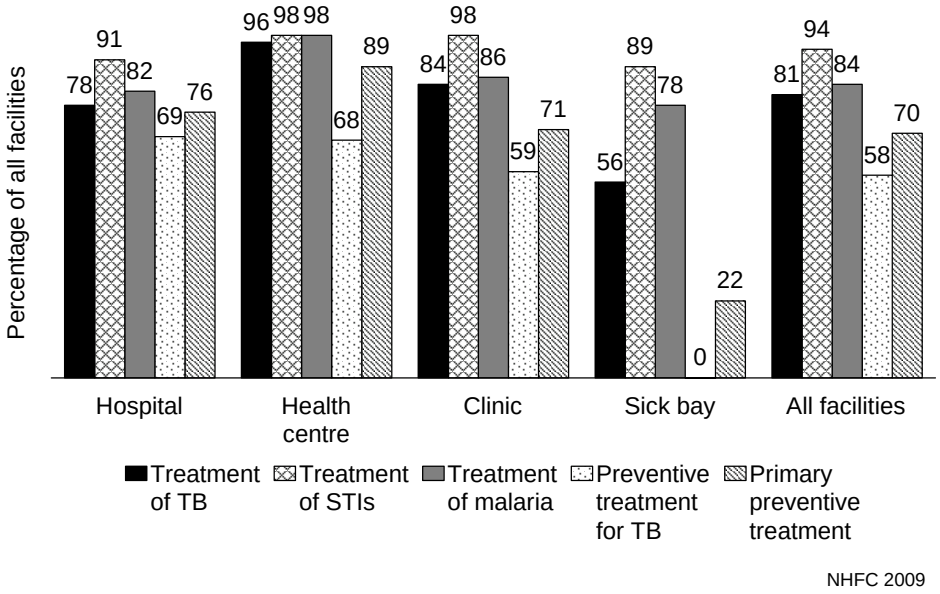
Overall, at least half of interviewed providers of TB, malaria, or STI services report receiving pre- or in-service training related to one of these topics during the three years preceding the survey at 81

percent of facilities offering HIV/AIDS CSS (Table A-8.7). In 73 percent of the facilities at least half of the service providers report that they were personally supervised at least once during the three months preceding the survey.

Malaria services

Information in Table 8.3 and Figure 8.2 also shows that 84 percent of all facilities offer malaria treatment services; this includes 82 percent of hospitals, 86 percent of clinics, 78 percent of sick bays, and almost all health centres. MoHSS facilities are more likely to offer malaria treatment services than facilities managed by other authorities. Regionally, availability of malaria treatment services ranges from 45 percent of facilities in Erongo to 100 percent in Oshikoto.

Figure 8.2 **Availability of Basic Medical Care and Support Services for HIV/AIDS (N=411)**



Additional information in Table A-8.5 shows percentages of facilities providing malaria diagnosis and treatment among facilities offering HIV/AIDS CSS. Eighty-nine percent of HIV/AIDS CSS facilities offer malaria treatment services, while 97 percent have laboratory diagnostic capacity for malaria. Among facilities offering HIV/AIDS CSS and offering malaria treatment services, 87 percent have a malaria treatment protocol, 80 percent had Coartem® available in the facility on the day of the visit, and 72 percent have both the treatment protocol and Coartem.

Sexually Transmitted Infections

Generally accepted standards for quality STI services include—

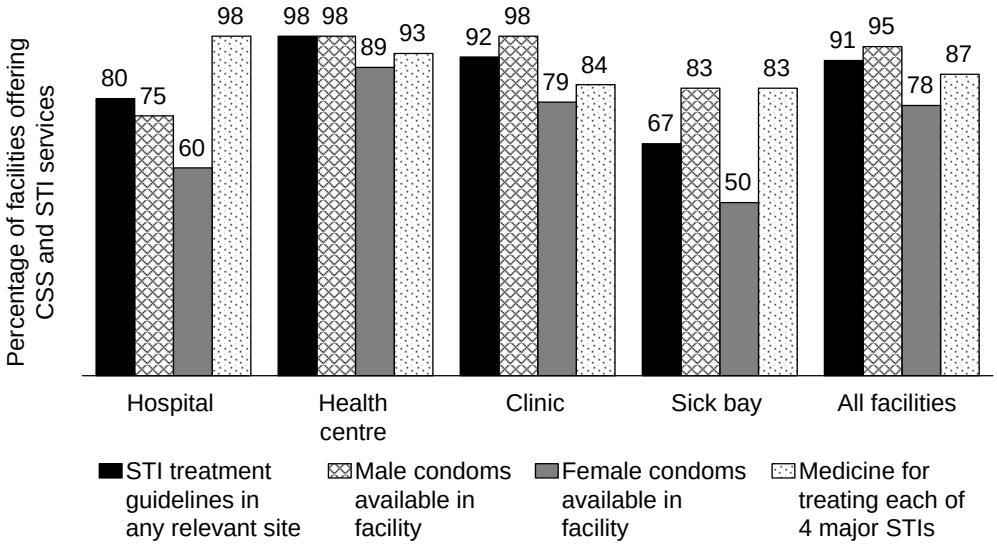
- Availability of diagnostic and treatment guidelines in all STI service sites
- Provision of appropriate treatment before the client leaves the facility

In addition, laboratory diagnosis is important, as it may be the only way to confirm the presence or absence of an STI. International experts advocate that all newly diagnosed HIV/AIDS clients be screened for STIs, particularly syphilis.

Overall, the availability of STI treatment services is high (94 percent of all facilities) (Table 8.3, Figure 8.2). Free-standing VCT facilities (20 percent) are less likely than other facility types to offer STI treatment services. Also, mission/NGO facilities (71 percent) and private facilities (78 percent) are less likely than MoHSS facilities (100 percent) to offer STI treatment services. At the regional level only Khomas region has less than 90 percent of facilities offering STI treatment services; in Khomas only seven of every ten facilities offer STI treatment services.

Additional information in Table A-8.6 and Figure 8.3 show that almost all facilities (98 percent) offering HIV/AIDS CSS also provide STI treatment services; however, medicines to treat common STIs are not readily available in all these facilities. The data show that 87 percent of the facilities offering both HIV/AIDS CSS and STI treatment have medicines for treating each of the four major sexually transmitted infections.[3] Among these facilities STI treatment protocols are available in nine of every ten, and male condoms are almost universally available. About eight of every ten of these facilities have all items[4] for STI services.

Figure 8.3 **Availability of Items in Facilities Offering HIV/AIDS Care and Support Services (CSS) and STI Services (N=349)**



NHFC 2009

Primary preventive treatment and treatment of opportunistic infections

Primary preventive treatment, such as cotrimoxazole prophylactic treatment (CPT), is an integral component of the HIV/AIDS care and support package in Namibia.

Generally accepted standards for rolling out cotrimoxazole prophylaxis programmes include—

- Availability of protocols and guidelines for cotrimoxazole prophylaxis
- Availability of medicines (cotrimoxazole) in the health facilities
- Training for health workers involved in CPT programmes

[3] At least one medicine for treating each of the following: syphilis, gonorrhea, chlamydia, and trichomoniasis.
[4] Observed treatment protocols in any relevant STI service site, medicines to treat four major STIs, and male condoms in the facility, either at the service site or in the pharmacy.

Table 8.3 shows that 70 percent of all facilities offer primary preventive treatment for opportunistic infections, such as CPT. Health centres (89 percent) are more likely to have the service than hospitals (76 percent) and clinics (71 percent). Only one of every five sick bays has the service. Fifty-five percent of private and mission/NGO facilities provide primary preventive treatment services compared with three-fourths of MoHSS facilities. The availability of primary preventive treatment services for opportunistic infections varies by region, from 48 percent of facilities in Kavango to 91 percent in Ohangwena and Oshikoto.

Additional information in Table A-8.9 shows that, among facilities offering HIV/AIDS CSS, 61 percent offer primary preventive treatment routinely, 17 percent offer it selectively, and 7 percent routinely refer clients elsewhere. Among those facilities offering HIV/AIDS CSS and reporting that they ever offer primary preventive treatment (i.e., routinely or selectively), only 5 percent have a protocol for CPT at the service site.[5] Cotrimoxazole is available in the majority (89 percent) of these facilities. One-quarter of the facilities have at least one interviewed provider of CPT trained during the preceding three years.

Table A-8.13 presents information on the availability of medicines for the treatment of opportunistic infections. The majority of facilities providing CSS have at least one medicine for treating bacterial infections, including pneumonia, for the management of chronic diarrhoea, and for basic pain management (each 98 percent); however, only three of every ten facilities (but all hospitals) have at least one medicine for treating topical fungal infections.

Key Findings

HIV/AIDS care and support services: HIV/AIDS CSS are almost universally available in Namibia. Still, only half of facilities offering HIV/AIDS CSS have observed registers showing HIV/AIDS-related client diagnoses at eligible service sites. Private facilities are less likely than those managed by other authorities to have such client registers.

Most facilities offering HIV/AIDS CSS have providers of TB, malaria, or STI services who have recently received pre- or in-service training related to their work. Similarly, most of these facilities have providers who report being regularly supervised in their work.

Malaria services: Overall, a little over eight of every ten facilities offer malaria treatment services. Private facilities are slightly less likely than others to offer malaria services. At the regional level the availability of malaria treatment services ranges from 45 percent of facilities in Erongo to 100 percent of facilities in Oshikoto. Among facilities offering HIV/AIDS care and support services, nine of every ten offer malaria treatment services, and almost all have malaria laboratory diagnostic capacity.

Sexually transmitted infections: The availability of STI treatment services is high in Namibian health facilities. Private and mission/NGO facilities are less likely than those managed by the MoHSS to offer STI services. Only Khomas region has less than 90 percent of facilities offering STI services.

Almost all facilities offering HIV/AIDS care and support services also offer STI services.

Primary preventive treatment: Primary preventive treatment for opportunistic infections, such as cotrimoxazole preventive treatment, is available in seven of every ten facilities overall. This service is also widely available among facilities offering HIV/AIDS care and support services; however, only six in every ten routinely offer it, while a little under two in every ten offer the service only selectively.

[5] There is not a stand-alone CPT guideline or protocol; however, CPT guidelines are usually part of other documents, such as the National ART Guidelines and the Integrated Management of Adult and Adolescent Illness (IMAI) guidelines. The 2009 NHFC therefore assessed the availability of any guideline that will have information on CTP.

HIV/AIDS and tuberculosis collaboration

TB is the most common opportunistic infection associated with HIV/AIDS, and it is among the leading causes of morbidity and mortality among people infected with HIV. It is estimated that, worldwide, more than 21 million people are co-infected with HIV and TB. People who are HIV-positive and infected with TB are up to 50 times more likely to develop active TB in a given year than people who are HIV-negative (WHO, 2007).

TB diagnosis and treatment is an important component of care for HIV/AIDS clients. To improve compliance with full treatment and avoid the proliferation of drug-resistant strains of TB, WHO advocates the Directly Observed Therapy, Short course (DOTS) strategy for TB treatment.

In 2008 Namibia reported 13,737 cases of all forms of TB. This translates into a case notification rate (CNR) of 665 cases per 100,000 population compared with 15,244 cases reported in 2007 (CNR of 722 per 100,000) (MoHSS, 2010b). Coverage of HIV testing for TB patients continued to improve: Of TB patients registered in 2008, 67 percent were tested for HIV, compared with 54 percent in the previous year. Approximately 59 percent of people with TB in Namibia are co-infected with HIV. Co-infection is a major threat to people living with HIV; it increases mortality and threatens efforts toward the national response to HIV/AIDA.

Generally accepted standards for good quality TB services include the following key elements:

- Diagnosis based on sputum smear, with back-up or confirmation using X-rays
- Records that indicate newly identified cases, monitor the course of treatment, and monitor client adherence to the treatment protocol
- Standard guidelines and protocols for the TB diagnostic and treatment regimes
- A continuous supply of the TB treatment regime for each patient

According to findings of the 2009 NHFC, eight of every ten facilities offer TB treatment and/or treatment follow-up services (Table 8.3, Figure 8.2). Health centres are the most likely to offer TB treatment and/or follow-up services, while sick bays are the least likely. (Free-standing VCT facilities are not expected to, and they do not, offer the service.) Private facilities (37 percent) are least likely to offer TB treatment and/or treatment follow-up services compared with MoHSS (91 percent) and mission/NGO (62 percent) facilities. Facilities in Khomas (42 percent) and Kunene (66 percent) regions are the least likely to offer TB treatment and/or follow-up services, while in seven other regions close to 90 percent of facilities offer these services.

Availability of preventive treatment for TB with isoniazid is low compared with preventive treatment for opportunistic infections such as CPT. A little less than six of every ten facilities offer TB preventive treatment, including 69 percent of hospitals, 68 percent of health centres, and 59 percent of clinics. Only 31 percent of private facilities offer TB preventive treatment compared with 48 percent of the mission/NGO and 66 percent of MoHSS facilities. The availability of TB preventive treatment services ranges from 31 percent of facilities in Kunene region to 86 percent in Oshikoto.

Additional information in Table A-8.8 shows that, among facilities offering HIV/AIDS CSS, 47 percent routinely offer TB preventive treatment services, 17 percent selectively offer the service, and 12 percent routinely refer clients elsewhere for the service. Among HIV/AIDS CSS facilities that ever offer TB preventive treatment services (i.e., routinely or selectively), only 5 percent have the necessary guidelines or protocols available; three-quarters, however, have isoniazid available in the facility. Only

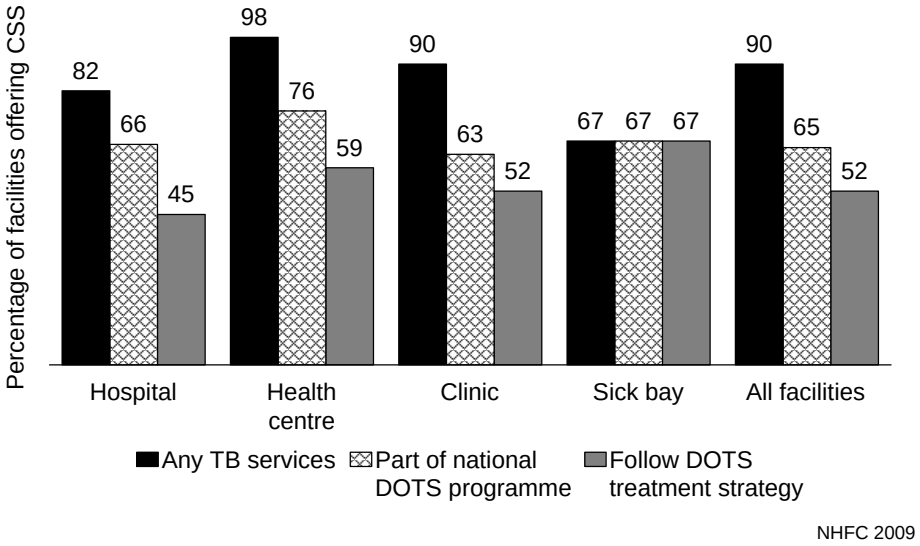
one-fourth have at least one interviewed provider of TB preventive treatment receiving any training related to his/her work during the preceding three years.

DOTS among facilities offering HIV/AIDS CSS

Table A-8.2 and Figure 8.4 show the availability of TB services, including treatment using DOTS, among facilities offering HIV/AIDS CSS. Overall, nine of every ten such facilities provide TB diagnostic or treatment services. Private and MoD/Police facilities are less likely than MoHSS and mission/NGO facilities to offer TB services.

Among facilities that offer HIV/AIDS CSS, two-thirds (65 percent) report that they are part of the national DOTS programme. Aside from three-quarters of health centres reporting that they are part of the national DOTS programme, there is no difference among the other facility types. However, private facilities are significantly less likely to report being part of the national DOTS programme. Facilities in Khomas (39 percent) and Oshikoto (36 percent) are the least likely to report being part of the national DOTS programme.

Figure 8.4 **TB Services in Facilities Offering HIV/AIDS Care and Support Services (CSS) (N=355)**



A facility is defined as following the DOTS treatment strategy if the treatment strategy used is either direct observation of treatment for two months with four months of follow-up or direct observation for six months. Half of facilities offering HIV/AIDS CSS meet this definition of following the DOTS treatment strategy. While all the numbers are low, sick bays (67 percent) are more likely to follow DOTS treatment than the other facility types, particularly hospitals (45 percent). Private facilities are less likely than facilities managed by other authorities to follow the DOTS treatment strategy. Less than 40 percent each of facilities in Caprivi, Khomas, Kunene, Omusati, and Oshana follow the DOTS treatment strategy.

Among facilities offering HIV/AIDS CSS and also following the DOTS treatment strategy, two-thirds have DOTS client registers available (Table A-8.2). Similar to findings reported above, private facilities are the least likely to have DOTS client registers. Although facilities in Khomas are among those least likely to follow the DOTS treatment strategy, those who do so have DOTS client registers (91 percent). In contrast, none of the facilities in Caprivi has a DOTS client register.

TB treatment guidelines or protocols are, however, readily available. Almost all of the facilities offering CSS and following the DOTS treatment strategy have TB treatment guidelines or protocol. First-line TB medicines are not as widely available; only seven of every ten facilities offering HIV/AIDS CSS and following the DOTS treatment strategy have all first-line TB medicines available.

All together, a little fewer than six of every ten facilities offering HIV/AIDS CSS and following the DOTS treatment strategy have all items for TB, defined as having observed DOTS client registers, observed TB treatment protocols, and all first-line TB medicines available in the facility.

Any TB treatment among facilities offering HIV/AIDS CSS

According to findings reported in Table A-8.3, close to nine of every ten facilities that offer HIV/AIDS CSS also offer TB treatment services.[6] Private facilities (41 percent) and facilities in Khomas region (50 percent) are less likely to offer any TB treatment services than others.

Among facilities offering HIV/AIDS CSS and also offering any TB treatment services, six of every ten follow the DOTS treatment strategy, two of every ten provide only treatment follow-up services, and the remaining two of every ten use other treatment approaches.[7] Treatment protocols are widely available in these facilities; however, client treatment registers and first-line medicines are not as widely available. Less than half (45 percent) had observed client treatment registers, TB treatment protocols, and all first-line TB medicines available in the facility on the day of the visit.

TB diagnosis among facilities offering HIV/AIDS CSS

Table A-8.4 presents information on resources and supplies for diagnosing TB, among facilities that offer HIV/AIDS CSS. Eighty-five percent of facilities offering HIV/AIDS CSS offer TB diagnostic services.[8] Eighty percent use sputum for TB diagnosis, 7 percent use X-rays, and 2 percent use clinical symptoms for diagnosis of TB.

Among facilities that report diagnosing TB using sputum tests, however, only half have all items necessary for conducting the sputum test. Ninety-six percent have a reported system for sending sputum elsewhere for testing, and 82 percent have records of sputum test results.

Just a little over half of the facilities offering HIV/AIDS CSS and reporting that they diagnose TB using X-rays actually have X-ray capacity with a functioning X-ray machine with films.

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[6] This refers to any TB treatment services, including DOTS and non-DOTS.

[7] Facility does not provide directly observed treatment for TB patients, or patients are treated only while inpatient but discharged to a different facility for follow-up treatment services.

[8] Facility conducts sputum test or X-ray or both, either in the facility or in an external laboratory, and, if in an external lab, there is record of TB test results, or else providers in the facility diagnose TB based on clinical symptoms.

Key Findings

HIV/AIDS and TB collaboration: Tuberculosis treatment and/or treatment follow-up services are available in eight of every ten facilities. Health centres are more likely than other facility types to offer these services, while private facilities are less likely than facilities managed by other organisations. Facilities in Kunene and Khomas are less likely than facilities in other regions to offer TB treatment and/or treatment follow-up services.

Preventive treatment for TB using isoniazid is available in a little under six of every ten facilities. The service is less likely to be available in private facilities than in facilities managed by other authorities.

About two-thirds of facilities offering HIV/AIDS CSS offer TB preventive services, either routinely or selectively. However, isoniazid is actually available in only three-fourths of the facilities that offer HIV/AIDS CSS and isoniazid preventive treatment.

DOTS among facilities offering HIV/AIDS CSS: Diagnostic or treatment services for TB are available in nine of every ten facilities that offer HIV/AIDS CSS. Two-thirds of facilities offering HIV/AIDS CSS report that they are part of the national DOTS programme. Private facilities are the least likely to report being part of the national DOTS programme.

About half of facilities offering HIV/AIDS CSS follow the DOTS treatment strategy. Private facilities are least likely to follow the DOTS treatment strategy, and fewer than four in every ten facilities in Caprivi, Khomas, Kunene, Omusati, and Oshana follow the DOTS treatment strategy.

DOTS treatment registers are not widely available in facilities offering HIV/AIDS CSS and also following the DOTS treatment strategy. TB treatment guidelines or protocols are, however, readily available; almost all facilities offering CSS and following the DOTS treatment strategy have TB treatment guidelines or protocol.

TB diagnosis among facilities offering HIV/AIDS CSS: A little over eight in every ten facilities offering HIV/AIDS CSS offer TB diagnostic services. The majority use sputum for TB diagnosis, less than 10 percent use X-rays, and only 2 percent use clinical symptoms for diagnosis of TB. All items to carry out sputum tests for TB are available in just about half of facilities that report diagnosing TB using sputum.

8.4 Advanced-Level Services for HIV/AIDS

Persons in an advanced stage of HIV/AIDS are usually seriously ill and require a more advanced level of treatment and follow-up than is available at many health facilities. Hospitals should be fully capable of providing all of the advanced care and support services needed for monitoring and treating HIV/AIDS clients. As services expand, however, it is expected that many of these services will become available outside of hospitals in lower-level facilities as well. Current programmes are focusing on increasing staff training, developing protocols and guidelines, ensuring adequate laboratory and medical equipment, and implementing record-keeping for HIV/AIDS services.

The activities and services assessed for advanced-level care and support include—

- Laboratory diagnostic capacity and the availability of medicines for treating severe opportunistic infections
- Availability of services or a formal referral system for psychosocial and socio-economic care and support
- Antiretroviral therapy (ART)
- Post-exposure prophylaxis (PEP)

8.4.1 Advanced-Level Treatment of Opportunistic Infections and Palliative Care for HIV/AIDS

For the purpose of this assessment, a facility must meet the following requirements to be classified as having advanced-level treatment capacity:

- At least one medicine (or in some cases two medicines) for the treatment of an indicated condition is available.
- Protocols or guidelines for treating common opportunistic infections are available in each service area.
- At least one recently trained provider for an indicated service is available in the facility.
- Laboratory diagnostic capacity exists for common HIV/AIDS-related illnesses.

Table A-8.12 shows the availability of advanced CSS for HIV/AIDS. Among facilities that offer HIV/AIDS CSS, two of every ten report that they provide systemic intravenous treatment for specific fungal infections. This includes nine of every ten hospitals but just 22 percent of health centres.

Treatment for Kaposi's sarcoma is reported to be available in 18 percent of facilities, while 29 percent offer palliative care, such as pain management or nursing care for the terminally ill. Eighty-one percent provide nutritional rehabilitation services, and 98 percent provide psychosocial support services. Only 7 percent of facilities offering CSS provide all advanced CSS as defined.

Trained staff and staff supervision

As part of the 2009 NHFC, providers were interviewed and asked questions pertaining to training that they have received as part of their work in these facilities. Table A-8.10 presents information on the availability of recently trained providers of HIV/AIDS services. Among facilities reporting that they offer CSS, seven of every ten have at least one interviewed provider who has been trained in psychosocial counselling during the preceding three years. Training on opportunistic infections and palliative care is not as common; only 25 percent of CSS facilities have at least one interviewed provider trained in opportunistic infections, and 12 percent have at least one interviewed provider trained in palliative care. In addition, only 23 percent of facilities have at least one interviewed provider with recent training in AIDS in children.

Two-thirds of facilities offering HIV/AIDS CSS have supervised providers (Table A-8.10).

Guidelines

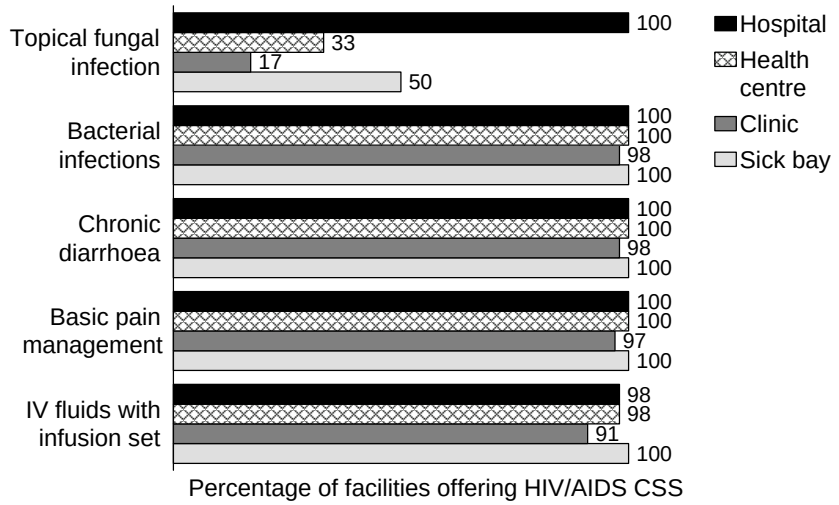
The 2009 NHFC also assessed facilities for availability of specific guidelines. Guidelines for the management of opportunistic infections are rare in Namibian health facilities; only one of every ten facilities offering HIV/AIDS CSS has a guideline for opportunistic infections at any service site in the facility. Guidelines for symptomatic or palliative care also are rare; only 18 percent of these facilities have any guidelines for palliative care (Table A-8.11). Guidelines for the clinical management of HIV/AIDS in children and for the clinical management of HIV/AIDS in adults are more readily available. Each of these guidelines is available in over 50 percent of facilities offering HIV/AIDS CSS. About eight of every ten facilities have confidentiality guidelines.

Treatment for opportunistic infections

The 2009 NHFC assessed facilities for the availability of medicines to manage several opportunistic infections and conditions. Availability of medicines to treat topical fungal infections is generally low (30 percent of facilities offering HIV/AIDS CSS); hospitals are more likely to have at least one medicine to treat topical fungal infections (Table A-8.13, Figure 8.5). Also, private facilities (72 percent) are more likely to have at least one medicine to treat topical fungal infections than MoHSS (23 percent) and mission/NGO (28 percent) facilities. More facilities have at least one medicine to manage bacterial infections, manage chronic diarrhoea, and also have IV fluids.

Additional information is presented in Table A-8.14 showing proportions of facilities having at least two medicines available to manage additional conditions.

Figure 8.5 Availability of Medicines to Treat Common HIV/AIDS-related Conditions in Facilities Offering Care and Support Services (CSS) (N=355)



NHFC 2009

Laboratory capacity for monitoring HIV/AIDS clients

Overall, the majority of health facilities offering HIV/AIDS CSS have laboratory capacity for monitoring HIV/AIDS clients. For example, approximately nine of every ten facilities have culture media and an incubator (Table A-8.15). Similar proportions have the capacity or a documented system to test for haemoglobin or haematocrit, serum creatinine, liver function, and serum glucose. Slightly lower

proportions of facilities have the capacity or system to conduct other tests such as white cell count and enzyme-linked immunosorbent assay (ELISA) for HIV. Only half have the capacity for all of these laboratory tests excluding the spinal tap.

Home-based care

Only one-fourth of facilities offering HIV/AIDS CSS report that they offer home-based care (HBC) services (Table A-8.16). Home-based care is least available from facilities in Ohangwena. Close to four of every ten facilities report that they offer HBC through referrals and can name a referral service site where they refer clients. Only two of every ten facilities have an interviewed provider with recent training in community home-based care for HIV/AIDS clients.

Key Findings

Advanced-level treatment of opportunistic infections: Systemic intravenous treatment for specific fungal infections and treatment for Kaposi's sarcoma are each available in only two of every ten facilities. Many more facilities provide psychosocial support services and nutritional rehabilitation services. Seven of every ten HIV/AIDS care and support facilities have at least one interviewed provider trained in psychosocial counselling during the preceding three years. Training on opportunistic infections and palliative care is less common.

Guidelines for the management of opportunistic infections or of symptomatic or palliative care are not common in facilities. Guidelines for the clinical management of HIV/AIDS are more readily available.

Laboratory capacity for monitoring HIV/AIDS clients: The majority of health facilities offering HIV/AIDS CSS have laboratory capacity for monitoring HIV/AIDS clients.

Home-based care: Only one-fourth of facilities offering HIV/AIDS CSS report that they offer home-based care services.

8.4.2 Antiretroviral Therapy

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.

Elements identified as important for providing good quality ART services include the following:

- Staff trained in the provision of relevant services
- Protocols and guidelines for relevant CSS
- A consistent supply of ARV medicines and good storage practices to maintain their quality and security
- A system for making client appointments for routine follow-up services
- An individual client record to assure continuity of care for the client
- Good record-keeping systems to track ART compliance

Antiretroviral drugs inhibit the replication of HIV and can significantly prolong and improve the quality of life of HIV-positive people. ART is, therefore, a treatment option that is beneficial and important to effective care and treatment programmes in Namibia. Table 8.4 presents information on systems and items to support antiretroviral combination therapy services.

Table 8.4 Systems and items to support antiretroviral combination therapy services

Percentage of facilities offering antiretroviral therapy (ART) and, among these, percentage with indicated programme components, by background characteristics, Namibia HFC 2009

	Percentage of facilities that:						Percentage of facilities prescribing ART and having:					
Background characteristics	Prescribe ART only	Provide medical follow-up services only	Prescribe ART and provide medical follow-up services	Prescribe ART and/or provide medical follow-up services	Are an outreach site for providers from outside facility	Number of facilities	National ART guideline	Other guidelines[1]	No stock-outs of normally stocked 1st-line ARVs during the 6 months preceding the survey	Laboratory capacity for monitoring ART[2]	All items to support ART[3]	Number of facilities prescribing ART and/or providing medical follow-up services
Type of facility												
Hospital	16	0	53	69	0	45	90	74	97	97	10	31
Health centre	2	17	17	36	36	47	88	71	94	94	0	17
Clinic	1	3	4	8	19	295	78	39	70	87	4	23
Sick bay	0	0	0	0	0	9	-	-	-	-	-	0
Managing authority												
MoHSS	2	5	10	17	21	306	94	70	94	94	6	53
Mission/NGO	4	4	14	21	29	28	83	83	83	100	17	6
Private	6	0	16	22	2	49	45	9	55	82	0	11
MoD/Police	0	0	8	8	0	13	100	100	100	100	0	1
Region												
Caprivi	0	11	7	18	0	28	80	80	100	100	0	5
Erongo	6	19	14	39	3	36	71	50	86	100	7	14
Hardap	0	5	24	29	24	21	67	83	100	100	17	6
Karas	8	8	12	28	28	25	100	43	57	43	0	7
Kavango	0	2	11	12	21	57	86	71	86	100	14	7
Khomas	6	0	12	18	6	33	83	50	67	83	0	6
Kunene	4	4	7	14	39	28	100	50	100	100	0	4
Ohangwena	0	3	13	16	22	32	100	80	100	100	20	5
Omaheke	0	0	6	6	25	16	100	0	100	100	0	1
Omusati	2	0	6	8	14	49	100	50	75	100	0	4
Oshana	5	0	5	10	10	20	100	100	100	100	0	2
Oshikoto	9	5	5	18	36	22	100	100	100	100	0	4
Otjozondjupa	0	0	21	21	24	29	83	50	100	100	0	6
Total	3	4	11	18	18	396	86	62	87	93	6	71

[1] Other guidelines such as guidelines for management of HIV/AIDS for workplace programs, guidelines for the clinical management of HIV/AIDS infection in adults and in children, guidelines for home-based care services, and protocol for adherence counselling.
[2] Either the laboratory in the facility conducts CD4, viral load, or total lymphocyte count (TLC) tests, or there is a system for sending blood samples for outside testing and receiving results.
[3] Observed record of individual client appointments; individual client records or charts; current register of ART clients; at least half of interviewed ART service providers have received pre- or in-service training related to ART services in the 12 months preceding the survey,, specifically on adherence counselling and nutritional rehabilitation; at least half of interviewed ART service providers had been supervised during the 3 months preceding the survey; first-line ART regimen available with no stock-outs of these first-line ARVs during the 6 months preceding the survey; up-to-date pharmacy stock cards for ARVs; ARVs stored with limited access; lab capacity for monitoring ART; and guidelines observed at all ART sites on the following topics: opportunistic infections, symptomatic/palliative care, care for children (and adults) living with HIV/AIDS, and either the national ART guideline or other ART treatment guideline.

Service availability

Overall, 18 percent of facilities in Namibia (excluding free-standing VCT facilities) prescribe ART and/or provide ART follow-up services; these are mainly hospitals (69 percent) and health centres (36 percent). MoHSS, mission/NGO, and private facilities are about equally likely to prescribe ART and/or provide ART follow-up services. At the regional level, even though the percentages are low (between 28 and 39 percent), facilities in Erongo, Hardap, and Karas regions are the most likely to provide these services, while in Omaheke, Omusati, and Oshana 10 percent or less of facilities provide ART services.

Eighteen percent of all facilities (excluding free-standing VCT facilities) are an outreach site for providers from other facilities. These are mainly health centres (36 percent) and clinics (19 percent) and no hospitals. By managing authority, these outreach facilities are comprised of MoHSS facilities (21

percent) and mission/NGO (29 percent) facilities. There are no outreach facilities in Caprivi region, and only a small proportion of facilities in Erongo (3 percent) and Khomas (6 percent) are outreach sites.

Guidelines

Close to nine of every ten facilities that prescribe ART and/or provide follow-up services have the national ART guidelines available in the facility (Table 8.4). Hospitals and health centres are more likely than clinics to have the national ART guidelines. Less than 50 percent of private facilities have the national ART guidelines compared with over 90 percent of MoHSS facilities. At the regional level facilities in Hardap and Erongo regions (67 and 71 percent, respectively) are slightly less likely than facilities in other regions of the country to have the national ART guidelines.

Information was also collected on the availability of guidelines other than the national ART guidelines, specifically, guidelines for the management of HIV/AIDS for workplace programmes, guidelines for the clinical management of HIV/AIDS infection in adults and children, guidelines for home-based care services, and protocols for adherence counselling. Approximately six of every ten facilities that provide ART services have any of these other guidelines, including 70 percent of MoHSS facilities but only 9 percent of private facilities.

Antiretroviral medicines

The availability of first-line adult antiretroviral medicines in ART facilities on the day of the assessment was generally good but not universal. Overall, nine of every ten ART facilities had ARVs available (Table A-8.18.2). Practically all hospitals and over 90 percent of health centres had ARVs available, compared with a little less than eight of every ten clinics. MoHSS and mission/NGO facilities are more likely than private facilities to have first-line adult ARV medicines available.

Three-fourths of ART facilities had up-to-date pharmacy stock cards or a computerised system for monitoring ARV stock available. Hospitals are significantly more likely than other facility types to have ARV stock cards, while private facilities are less likely than facilities managed by other authorities to have ARV stock cards. Additional information on the availability of ARV medicines is provided in Table A-8.18.2

Stock-outs of ARV medicines are not common. Overall, nine in every ten facilities that prescribe ART and/or provide follow-up services reported no stock-outs of generally stocked ARV medicines during the six months preceding the assessment (Table 8.4). Hospitals and health centres are more likely than clinics to report no stock-outs (97 and 94 percent, respectively); also, MoHSS and mission/NGO facilities (55 percent) are more likely to report no stock-outs than private facilities. Among the regions, facilities in Karas and Khomas regions were the least likely to report no stock-outs of ARV medicines during the six months preceding the assessment.

Laboratory capacity for monitoring ART clients

Ninety-three percent of facilities prescribing ART and/or providing ART medical follow-up services have laboratory capacity for monitoring ART clients[9] (Table 8.4). There is little variation by type of facility; however, clinics that prescribe ART and/or provide ART follow-up services are slightly less likely than hospitals and health centres to have this laboratory capacity. Private facilities that prescribe ART and/or provide follow-up services are also slightly less likely than facilities managed by other authorities to have laboratory capacity for monitoring ART. At the regional level the availability of ART

[9] Laboratory capacity is defined as having a laboratory in the facility to conduct CD4 tests, viral load tests, or total lymphocyte count, or there is a system for sending blood samples outside for testing and receiving results.

monitoring laboratory capacity ranges from a low of 43 percent in Karas region to a high of 100 percent of facilities in 11 regions. Additional information on laboratory capacity is provided in Table A-8.18.2, showing the proportion of facilities having in-house laboratory capacity and of those with a system for outside testing and having records of test results.

Trained and supervised staff

Providers of specific services were interviewed as part of the assessment. By 2009 NHFC definitions a facility is considered to have trained providers if at least one interviewed provider of a service has received training related to their work during the 12 months preceding the survey. Among facilities prescribing ART and/or providing medical follow-up services, 45 percent have a trained provider of ART adherence counselling services, while half have a trained provider of ART prescription and clinical services (Table A-8.18.1).

Interviewed providers were also asked about supervision that they have received as part of their work. If at least half of interviewed providers of a particular service report that they have been supervised in the three months preceding the assessment, the facility is considered to have supervised staff. Among ART facilities three-fourths have supervised providers.

Key Findings

ART service availability: Just about two of every ten facilities either prescribe ART and/or provide ART follow-up services. These are mainly hospitals and health centres. The proportions are generally low, but facilities in Erongo, Hardap, and Karas regions are more likely than facilities in other regions to offer ART services.

Guidelines: The national ART guideline is available in the majority of facilities providing ART services, although there are some variations among the different facility types, managing authorities, and regions.

Antiretroviral medicines: Overall, nine of every ten ART facilities had first-line ARVs available in the facility on the day of the assessment. However, private facilities were less likely than others to have ARVs available. Stock-outs of ARVs are not common.

Laboratory capacity for monitoring ART clients: Ninety-three percent of facilities prescribing ART and/or providing ART medical follow-up services have laboratory capacity for monitoring ART clients.

8.4.3 Prevention of Mother-to-Child Transmission (PMTCT) of HIV

The transmission of HIV from mother to child is an important mode of transmission of HIV infection in Namibia. The government of Namibia is promoting a 4-pronged strategy for prevention of mother-to-child transmission (PMTCT) that consists of the following:

- Primary prevention of HIV, including HIV risk assessment and risk reduction counselling, HIV testing and counselling, partner notification services, screening for STIs, etc.
- Prevention of unintended pregnancies among HIV-positive women by providing appropriate counselling and support to women living with HIV so they can make informed decisions about their reproductive lives

- Use of a comprehensive package of services that includes ARV drugs in HIV-positive pregnant women to prevent the transmission of HIV from HIV-positive mothers to their infants (mother-to-child transmission of HIV)

- Comprehensive HIV care, treatment, and support for the HIV-positive woman and her family

The services are often offered in conjunction with antenatal and delivery services and may include a variety of activities. The degree to which a facility offers the total package is often determined by the level of staffing and whether the facility offers both antenatal care (ANC) and delivery services.

Generally accepted standards for PMTCT include the following:

- 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

Table 8.5 presents information on the availability of PMTCT services among all facilities, and Table 8.6 presents information on the availability of PMTCT services among facilities that offer antenatal care (ANC) services. Additional services (referred to as PMTCT plus, or 'PMTCT +') include making HIV care and treatment (including treatment with antiretroviral drugs, where indicated) available to all eligible women identified through PMTCT services as well as to their HIV-infected family members.

PMTCT service availability among all facilities

Three-fourths of all facilities (excluding free-standing VCT facilities) report that they offer PMTCT services. This includes eight of every ten hospitals, nine of every ten health centres, and about seven of every ten clinics.

Among the facilities that report offering PMTCT services, the availability of the various components of the PMTCT package varies quite widely, as follows:

- Ninety-five percent have an HIV testing system available.

- Fifty-six percent provide ARV prophylaxis to the mother and newborn to prevent the transmission of the virus from the mother to the infant.

- Ninety-four percent provide counselling on maternal nutrition and infant feeding.

- All provide family planning services or counselling.

Overall, only half of all facilities that report offering PMTCT services actually provide all four components of PMTCT services usually referred to as the minimum package of PMTCT services. Health centres (74 percent) are more likely to provide the minimum package of PMTCT services than hospitals (67 percent) and clinics (44 percent). MoHSS and mission/NGO facilities are more likely than private facilities to provide the minimum package of PMTCT services. At the regional level, facilities in Caprivi (16 percent), Kavango (19 percent), and Kunene (33 percent) regions are among the least likely to provide the minimum package, while Omaheke region, at 86 percent of facilities, is the most likely.

Table 8.5 Availability of services for prevention of mother-to-child transmission (PMTCT) of HIV/AIDS

Percentage of facilities reporting that they offer PMTCT services and, among these, percentage with specific PMTCT programme components, percentage with a minimum package of PMTCT services, and, among facilities with the minimum package of PMTCT services, percentage having all items for PMTCT +, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities reporting PMTCT services	Total number of facilities	Percentage of facilities offering any PMTCT services that offer indicated specific services						Percentage of facilities with a provider of PMTCT trained in the 3 years preceding the assessment	Number of facilities offering any PMTCT services	Percentage of facilities offering minimum PMTCT package that have all items for PMTCT+[3]	Number of facilities offering minimum PMTCT package
			Documented HIV testing system[1]	ARV prophylaxis to prevent MTCT	Counselling on maternal nutrition and infant feeding	FP services or counselling	All 4 items for minimum PMTCT package[2]	ARV therapeutic treatment for HIV-infected women and family				
Type of facility												
Hospital	80	45	89	86	92	97	67	22	97	36	21	24
Health centre	91	47	98	77	98	100	74	21	95	43	22	32
Clinic	73	295	95	47	93	100	44	6	73	216	3	95
Sick bay	0	9	-	-	-	-	-	-	-	0	-	0
Managing authority												
MoHSS	85	306	95	56	93	100	51	8	79	259	8	132
Mission/NGO	89	28	92	68	96	100	64	16	84	25	19	16
Private	20	49	90	40	100	90	30	60	80	10	33	3
MoD/Police	8	13	100	0	0	100	0	0	0	1	-	0
Region												
Caprivi	89	28	100	16	96	100	16	16	76	25	50	4
Erongo	64	36	100	43	96	96	43	9	74	23	20	10
Hardap	71	21	100	53	100	100	53	40	73	15	38	8
Karas	88	25	82	73	91	100	55	14	82	22	17	12
Kavango	82	57	91	23	85	100	19	11	74	47	0	9
Khomas	18	33	100	50	100	100	50	50	83	6	33	3
Kunene	64	28	67	50	94	100	33	6	61	18	0	6
Ohangwena	94	32	93	87	97	100	77	3	77	30	4	23
Omaheke	88	16	100	86	100	100	86	7	79	14	8	12
Omusati	84	49	100	71	93	100	68	5	85	41	4	28
Oshana	75	20	100	87	87	100	73	7	100	15	9	11
Oshikoto	95	22	100	57	95	100	57	5	90	21	8	12
Otjozondjupa	62	29	100	72	100	100	72	0	78	18	0	13
Total	74	396	95	56	94	100	51	10	79	295	10	151

[1] Facility conducts the test in the facility or in an affiliated external laboratory or else has an agreement with a testing site that is expected to return the test results to the facility.
[2] Minimum package of PMTCT services includes the availability of the following: an HIV testing system in the facility, ARV prophylaxis for PMTCT for mother and infant, counselling on maternal nutrition and infant feeding for HIV-positive mothers, and counselling on family planning or family planning services for the mother.
[3] All components for the minimum package of PMTCT services are available and the facility offers ARV therapy for HIV-infected women and their HIV-infected children and other family members.

PMTCT service availability among facilities offering ANC services

Conventionally, PMTCT services tend to be offered from antenatal care (ANC) service sites by ANC service providers. As shown in Chapter 6, Table 6.1, approximately eight of every ten facilities (excluding free-standing VCT facilities and sick bays) offer antenatal care services.[10] This section of the report looks at the availability of PMTCT services among facilities offering ANC services. Among facilities offering ANC services (including one MoD/police facility), 88 percent report that they offer PMTCT services (Table 8.6). All hospitals and health centres offering ANC services report that they also offer PMTCT services. However, only 85 percent of clinics that offer ANC services also offer PMTCT services, despite the expectation that all facilities offering ANC will offer PMTCT services.

Among facilities offering ANC services, only 57 percent of private facilities report offering PMTCT services compared with approximately nine of every ten MoHSS facilities and mission/NGO facilities. Among the regions, facilities in Kunene (60 percent) and Khomas (67 percent) are the least likely to report that they offer PMTCT services.

[10] For this section of the report, the total number of facilities offering ANC services includes one Ministry of Defense facility that offers the service. The total number of facilities offering ANC in this section is, therefore, one facility more than the number reported in Chapter 6.

Table 8.6 Availability of services for prevention of mother-to-child transmission of HIV/AIDS among facilities offering ANC services

Among facilities offering ANC services, percentage of facilities reporting that they offer PMTCT services and, among these, percentage with specific PMTCT programme components, percentage with the minimum package of PMTCT services, and, among facilities with the minimum package of PMTCT services, percentage having all items for PMTCT+, by background characteristics, Namibia HFC 2009

Background characteristic	Percentage of facilities reporting PMTCT services	Total number of facilities offering ANC services	Percentage of facilities offering any PMTCT services that offer indicated specific services						Percent of facilities with a provider of PMTCT trained in the 3 years preceding the survey	Number of facilities offering ANC and any PMTCT services	Percentage of facilities offering minimum PMTCT package that have all items for PMTCT+[3]	Number of facilities offering ANC and a minimum PMTCT package
			Docu-mented HIV testing system[1]	ARV prophylaxis to prevent MTCT	Counselling on maternal nutrition and infant feeding	Family planning counselling or services	All 4 items for minimum PMTCT package [2]	ARV therapeutic treatment for HIV-infected women and family				
Type of facility												
Hospital	100	9	89	100	100	100	89	44	89	9	38	8
Health centre	100	43	98	77	98	100	74	21	95	43	22	32
Clinic	85	254	95	47	93	100	44	6	72	216	3	95
Managing authority												
MoHSS	89	265	96	53	94	100	50	7	76	235	9	117
Mission/NGO	92	26	92	67	96	100	63	13	83	24	13	15
Private	57	14	88	50	100	100	38	75	75	8	33	3
MOD	100	1	100	0	0	100	0	0	0	1	-	0
Region												
Caprivi	96	26	100	16	96	100	16	16	76	25	50	4
Erongo	90	20	100	39	94	100	39	6	72	18	14	7
Hardap	74	19	100	50	100	100	50	36	71	14	29	7
Karas	100	19	84	68	95	100	58	16	74	19	18	11
Kavango	85	53	91	22	87	100	20	9	73	45	0	9
Khomas	67	9	100	50	100	100	50	50	67	6	33	3
Kunene	60	25	67	40	93	100	27	0	53	15	0	4
Ohangwena	93	29	96	85	100	100	81	4	74	27	5	22
Omaheke	100	13	100	85	100	100	85	8	77	13	9	11
Omusati	93	41	100	71	92	100	68	5	84	38	4	26
Oshana	100	14	100	86	86	100	71	7	100	14	10	10
Oshikoto	100	20	100	60	95	100	60	5	85	20	8	12
Otjozondjupa	78	18	100	64	100	100	64	0	71	14	0	9
Total	88	306	95	54	94	100	50	10	76	268	10	135

[1] Facility conducts the test in the facility or in an affiliated external laboratory or else has an agreement with a testing site that is expected to return the test results to the facility.
[2] Minimum package of PMTCT services includes the availability of the following: an HIV testing system in the facility, ARV prophylaxis for PMTCT for mother and infant, counselling on maternal nutrition and infant feeding for HIV-positive mothers, and counselling on family planning or family planning services for the mother.
[3] All components for the minimum package of PMTCT services are available and the facility offers ARV therapy for HIV-infected women and their HIV-infected children and other family members.
Note: Total includes one MoD/Police facility.

Looking at the individual components of PMTCT services, almost all (95 percent) the facilities offering ANC and reporting that they also offer PMTCT services have an HIV testing system (Table 8.6). All facilities offering ANC and reporting that they also offer PMTCT services provide family planning services. More than nine of every ten provide nutritional services. However, just half of these facilities provide ARV prophylaxis to prevent the transmission of HIV from the mother to the newborn. All hospitals and three-fourths of health centres provide ARV prophylaxis, but the service is less common in clinics, where less than half provide the service.

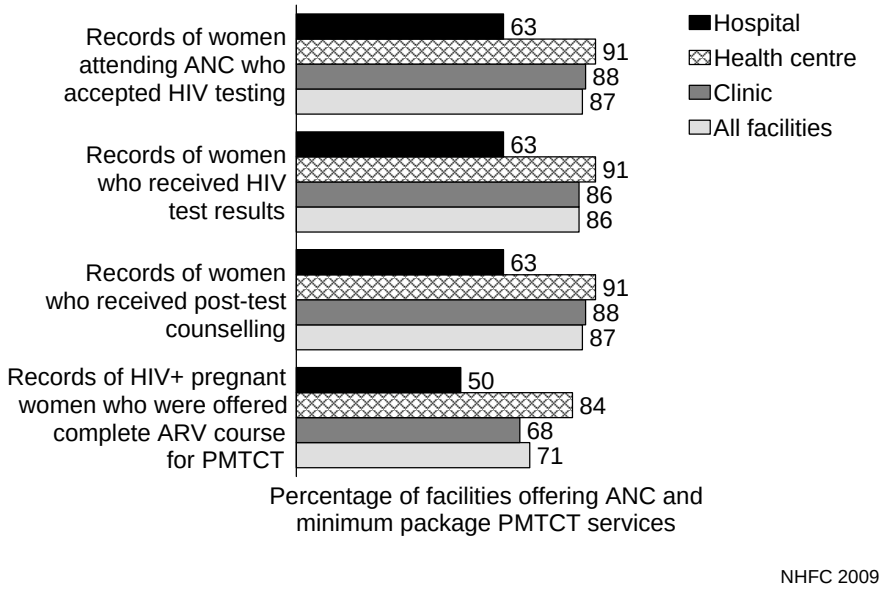
Overall, half of facilities offering ANC and reporting that they offer PMTCT services actually have all four components of the minimum package of services for PMTCT.[11] This includes nine in ten hospitals, three-fourths of health centres, and less than half of clinics.

Mission/NGO facilities (63 percent) are slightly more likely than either MoHSS or private facilities to provide the minimum package of PMTCT services. Availability of the minimum package of services for PMTCT in the regions ranges from a low of 16 percent of facilities in Caprivi region to a high of 85 percent of facilities in Omaheke region.

[11] An HIV testing system, ARV prophylaxis to mother and infant, counselling on maternal nutrition and infant feeding, and family planning counselling or services.

Additional information on the availability of PMTCT services and items to support PMTCT services is provided in Table A-8.21.2 and Figure 8.6. Only 44 percent of facilities offering ANC services provide the minimum package of PMTCT services (see also Table 8.6). This includes about nine of every ten hospitals, three-fourths of health centres, and a little less than four of every ten clinics. Mission/NGO facilities (58 percent) are more likely than MoHSS (44 percent) or private facilities (21 percent) to provide the minimum package of PMTCT services. Also, complete records are not universally available in facilities that provide the minimum package of PMTCT services, particularly in private facilities. However, PMTCT guidelines are universally available in these facilities.

Figure 8.6 **Record-keeping in ANC Facilities Offering Minimum Package PMTCT Services (N=135)**



Key Findings

PMTCT service availability: Three-fourths of all facilities report that they offer PMTCT services; however, the availability of the four components of the minimum package varies quite substantially, from less than 60 percent of facilities providing ARV prophylaxis to all of them providing family planning services. Overall, only half of facilities that report offering PMTCT services actually provide all four components of the minimum package of PMTCT services.

PMTCT service availability among facilities offering ANC services: About eight of every ten facilities offer ANC services. Among these, close to nine of every ten report that they offer PMTCT services. Private facilities that offer ANC services are less likely than others to offer PMTCT services.

Overall, about half of facilities offering ANC services actually provide the minimum package of PMTCT services. This includes nine in ten hospitals, three-fourths of health centres, and less than half of clinics. PMTCT guidelines are universally available in these facilities.

8.4.4 Post-Exposure Prophylaxis

Evidence is available from biomedical studies that there may be a window of opportunity to abort HIV infection by inhibiting viral replication shortly after exposure to HIV. Accidental exposure to HIV is

predominantly via percutaneous and mucocutaneous routes. The risk of HIV infection among health care providers from needle sticks or exposure to infected bodily fluids has led to the need for post-exposure prophylaxis (PEP). The service must be available not only to health care providers but also to anyone at risk as a result of inadvertent exposure (such as sexual assault victims and accident victims). Even facilities that do not officially offer HIV/AIDS-related services should have access to PEP, because it is frequently not known which clients are infected with HIV.

Data from the 2009 NHFC show that PEP for staff[12] is available at 81 percent of all facilities Table A-8.20). Clinics and free standing VCT facilities are slightly less likely than the other facility types to have PEP services for staff. Also, private facilities are slightly less likely than others to have PEP services. At the regional level, availability of PEP services ranges from one-third of facilities in Caprivi region to 90 percent and above of facilities in Karas, Kavango, Omusati, Oshana and Otjozondjupa regions.

Among facilities where staff members have access to PEP, specific guidelines for PEP are universally available; however, records of staff receiving PEP services are rarely available. Overall, just about three of every ten of these facilities have observed antiretroviral medicines for PEP available. These medicines are more available in hospitals (84 percent) than in other types of facilities.

8.4.5 Youth-Friendly Services (YFS)

Designated youth-friendly services (YFS) are meant to help young people overcome barriers to accessing health care, including HIV/AIDS services. Ideally, YFS involve young people in all aspects of a programme's planning, operations, and evaluation. The services should include workers who are members of the target population and sensitive to youth culture, ethnic cultures, and issues of gender, sexual orientation, and HIV status. YFS should provide outreach services for homeless youth and tailored support groups for substance users and teen parents. The services usually have convenient locations and flexible hours, including walk-in appointments, to improve access by youth. The 2009 NHFC assessed the availability of youth-friendly HIV counselling and testing services as well as the availability of items to support the provision of these services, such as service guidelines and trained providers.

Among the facilities that have an HIV testing system, two of every ten provide youth-friendly HIV testing services (Table A-8.17.1). Hospitals and sick bays are among the least likely to offer youth-friendly HIV testing services. Private facilities and MoD/Police facilities and among the regions facilities in Kunene are among the least likely to offer youth-friendly HIV testing services.

Among facilities (including free-standing VCT facilities) having youth-friendly HIV testing services, about four of every ten have a youth-friendly policy or guideline available. Sixty percent of these facilities have at least one trained provider of youth-friendly services.[13] Overall, only three of every ten facilities offering youth-friendly HIV testing services have all items[14] for youth-friendly services.

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[12] A facility is defined as having access to PEP if the facility provides services for post-exposure prophylaxis to staff, or there is a system to refer staff elsewhere for those services.

[13] At least one interviewed provider reports having received training related to youth-specific services during the three years preceding the survey, or the facility in-charge reports that there is a trained provider but that provider was not available on the day of the visit.

[14] A facility is regarded as having all items for youth-friendly services if it offers youth-friendly HIV testing services, has an observed youth-friendly policy or guidelines, and has at least one provider trained in YFS.

8.4.6 Record Keeping and Reporting

Table A-8.23 presents information on the availability of record-keeping systems for monitoring HIV/AIDS treatment, care, and support services.

Among facilities with an HIV testing system, 36 percent have records indicating clients receiving pre- and post- test counselling and receiving their HIV test results. About seven of every ten report that they submit reports for HIV testing services; this is the case in all free-standing VCT facilities and almost all health centres; however, about seven of every ten hospitals and health clinics and less than six of every ten sick bays report submitting any reports.

Among the facilities prescribing ART and/or providing ART medical follow-up services, three-fourths have records indicating the number of clients receiving antiretroviral treatment, while seven of every ten report that they submit reports of ART services outside the facility. Among facilities offering HIV/AIDS CSS, six of every ten have records documenting clients treated for HIV/AIDS-related illnesses, while 85 percent report that they submit reports outside the facility of treating HIV/AIDS related illnesses.

Key Findings

Post-exposure prophylaxis services: Staff have access to PEP services in eight of every ten facilities. Private facilities are slightly less likely than others to have PEP services for their staff. Among PEP facilities, specific PEP guidelines are universally available; however, records of staff receiving PEP services are rare.

Youth-friendly services: Among facilities with HIV testing systems, only two of every ten provide youth-friendly HIV testing services. Hospitals are among the least likely to provide youth-friendly HIV testing services. Among facilities offering youth-friendly HIV testing services, about four of every ten have a youth-friendly policy or guideline available, and six of every ten have at least one provider recently trained in the provision of youth-friendly services.

Record-keeping and reporting: Overall, record-keeping and reporting systems for HIV/AIDS-related services are uncommon. Among facilities with an HIV testing system, providing ART services, and offering HIV/AIDS CSS, only three of every ten have records of HIV/AIDS-related services offered and routinely submit reports on these services outside the facility.

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ADDITIONAL TABLES

Appendix A

Chapter 1

Table A-1.1.1 Distribution of facility sample frame and final sample selection by region

Number of facilities of each type that were in the sample frame, number selected for the survey sample, and percentage of eligible facilities of each type that were included in the sample, by region, Namibia HFC 2009

Region/ Number of facilities	Type of facility: Hospital	Health centre	Clinic	Free standing VCT	Sick bay	Total
Caprivi						
Sample frame	1	3	26	1	1	32
Visited	1	3	23	1	1	29
Erongo						
Sample frame	7	2	30	2	2	43
Visited	6	2	26	2	2	38
Hardap						
Sample frame	2	4	14	2	1	23
Visited	2	4	14	2	1	23
Karas						
Sample frame	4	3	20	1	0	28
Visited	4	3	18	1	0	26
Kavango						
Sample frame	4	10	50	1	1	66
Visited	4	8	44	1	1	58
Khomas						
Sample frame	5	3	37	3	1	49
Visited	5	3	24	3	1	36
Kunene						
Sample frame	3	3	22	1	0	29
Visited	3	3	22	1	0	29
Ohangwena						
Sample frame	3	2	28	1	0	34
Visited	3	2	27	1	0	33
Omaheke						
Sample frame	1	2	13	0	0	16
Visited	1	2	13	0	0	16
Omusati						
Sample frame	4	6	41	1	0	52
Visited	4	6	39	1	0	50
Oshana						
Sample frame	2	5	11	1	2	21
Visited	2	5	11	1	2	21
Oshikoto						
Sample frame	3	3	16	0	0	22
Visited	3	3	16	0	0	22
Otjozondjupa						
Sample frame	7	3	19	1	1	31
Visited	7	3	18	1	1	30
TOTAL						
Sample frame	46	49	327	15	9	446
Visited	45	47	295	15	9	411
Percentage of total for facility type included in NHFC sample	98	96	90	100	100	92

Table A-1.1.2 Distribution of facility staff sample frame and final sample selection by type of facility

Number of providers of each type that were present the day of the survey (sample frame), number selected for interview (NHFC sample), and percentage of eligible providers of each type that were interviewed, by type of facility and provider qualification, Namibia HFC 2009

	Type of facility										
	Hospital		Health centre		Clinic		Free standing VCT/ Sick bay		Total		Percentage of total for facility type included in NHFC sample
Types of providers	Sample frame	NHFC sample	Sample frame	NHFC sample	Sample frame	NHFC sample	Sample frame	NHFC sample	Sample frame	NHFC sample	
Specialists[1]	7	1	0	0	1	1	0	0	8	2	25
Medical doctors (non-specialists)	88	26	21	11	20	14	0	0	129	51	40
Medical assistants	4	2	6	5	4	4	0	0	15	12	80
Registered nurse/midwife	414	189	131	95	259	237	4	4	814	531	65
Enrolled nurse/midwife	327	87	176	120	407	360	9	9	928	583	63
Nurse assistant/Auxiliary	19	4	12	5	15	9	0	0	47	19	40
Social worker	3	0	2	0	0	0	2	2	7	2	29
Pharmacy staff[2]	53	4	8	3	5	0	0	0	67	7	10
Other technical staff[3]	12	0	3	2	1	0	0	0	17	2	12
Community HIV counsellors	96	33	84	53	237	198	49	39	472	329	70
Other community providers[4]	15	4	48	16	160	87	2	0	225	107	48
Laboratory staff[5]	99	26	3	3	0	0	1	0	103	29	28
Total	1,157	377	498	313	1,122	919	76	59	2,907	1,708	59

[1] Specialists include obstetrician/gynaecologists, surgeons, physician specialists, paediatricians, and pathologists.
[2] Pharmacy staff include pharmacists and pharmacist assistants.
[3] Other technical staff include health inspectors/environmental health officers, environmental health assistants, occupational therapists, physiotherapists, and medical rehabilitation officers/instructors/workers.
[4] Other community providers include community health workers/home-based care giver/CBRP, lifestyle ambassadors (TB/HIV), and field promoters.
[5] Laboratory staff include laboratory scientists, laboratory technologists, and laboratory technician/assistants.

Table A-1.2.1 Distribution of interviewed health care providers—unweighted

Number of interviewed health care providers by type of provider and type of facility, *Unweighted* Namibia HFC 2009

Background characteristics	Type of facility					Total
	Hospital	Health centre	Clinic	Free standing VCT	Sick bay	
Qualification of provider						
Specialists[1]	1	0	1	0	0	2
Medical doctors (non-specialists)	24	11	12	0	0	47
Medical assistants	1	5	4	0	1	11
Registered nurse/midwife	189	96	231	4	6	526
Enrolled nurse/midwife	83	119	356	9	7	574
Nurse assistant/auxiliary	4	5	9	0	1	19
Social worker	0	0	0	2	0	2
Pharmacy staff[2]	3	3	0	0	0	6
Other technical staff[3]	0	2	0	0	0	2
Community HIV counsellors	34	52	196	42	4	328
Other community providers[4]	3	15	87	0	0	105
Laboratory staff[5]	10	3	0	0	0	13
Other	17	0	7	2	18	44
Total interviewed staff	369	311	903	59	37	1,679

[1] Specialists include obstetrician/gynaecologists, surgeons, physician specialists, paediatricians, and pathologists.
[2] Pharmacy staff include pharmacists and pharmacist assistants.
[3] Other technical staff include health inspectors/environmental health officers, environmental health assistants, occupational therapists, physiotherapists, and medical rehabilitation officers/instructors/workers.
[4] Other community providers include community health workers/home-based care giver/CBRP, lifestyle ambassadors (TB/HIV), and field promoters.
[5] Laboratory staff include laboratory scientists, laboratory technologists, and laboratory technician/assistants.

Table A-1.2.2 Distribution of interviewed health care providers—weighted

Number of interviewed health care providers by type of provider and type of facility, *weighted* Namibia HFC 2009

Background characteristics	Type of facility					Total
	Hospital	Health centre	Clinic	Free standing VCT	Sick bay	
Qualification of provider						
Specialists[1]	2	0	1	0	0	3
Medical doctors (non-specialists)	46	13	10	0	0	68
Medical assistants	1	4	2	0	1	7
Registered nurse/ midwife	251	80	157	2	4	494
Enrolled nurse/ midwife	199	107	247	5	5	564
Nurse assistant/ auxiliary	4	7	9	0	1	21
Social worker	0	0	0	1	0	1
Pharmacy staff[2]	7	4	0	0	0	11
Other technical staff[3]	0	3	0	0	0	3
Community HIV counsellors	61	62	172	31	4	329
Other community providers[4]	4	18	70	0	0	91
Laboratory staff[5]	12	2	0	0	0	14
Other	47	0	6	1	18	72
Total interviewed staff	634	298	674	41	32	1,679

[1] Specialists include obstetrician/gynaecologists, surgeons, physician specialists, paediatricians, and pathologists.
[2] Pharmacy staff include pharmacists and pharmacist assistants.
[3] Other technical staff include health inspectors/environmental health officers, environmental health assistants, occupational therapists, physiotherapists, and medical rehabilitation officers/instructors/workers.
[4] Other community providers include community health workers/home-based care giver/CBRP, lifestyle ambassadors (TB/HIV), and field promoters.
[5] Laboratory staff include laboratory scientists, laboratory technologists, and laboratory technician/assistants.

Table A-1.3 Sample of observed and interviewed clients

Number of clients attending facility on the day of the survey eligible for observation, number whose consultation was observed, and percentage of eligible clients who were observed, by type of service and type of facility, Namibia HFC 2009

Type of facility	Total number of clients present on the day of the survey (eligible for observation)	Actual number of clients observed	Percentage of eligible clients who were observed
OUTPATIENT CURATIVE CARE FOR SICK CHILDREN			
Type of facility			
Hospital	199	98	49
Health centre	524	258	49
Clinic	2,087	1,222	59
Total	2,810	1,578	56
FAMILY PLANNING			
Type of facility			
Hospital	234	55	24
Health centre	417	183	44
Clinic	1,409	780	55
Total	2,060	1,018	49
ANTENATAL CARE			
Type of facility			
Hospital	242	42	17
Health centre	487	182	37
Clinic	1,324	655	49
Total	2,053	879	43

Table A-1.4 Facility catchment area

Median population of assigned catchment areas for facilities providing data on a known catchment population, by background characteristics, Namibia HFC 2009

Background characteristics	Median population in catchment area	Number of facilities providing data on known catchment population
Type of facility		
Hospital	37,600	30
Health centre	9,700	42
Clinic	4,225	254
Free standing VCT	39,350	5
Sick bay	600	6
Managing authority		
MoHSS	5,400	274
Mission/NGO	7,325	31
Private	1,250	23
MoD/POLICE	525	9
Region		
Caprivi	2,600	26
Erongo	3,050	25
Hardap	4,200	20
Karas	4,725	21
Kavango	4,233	56
Khomas	12,050	17
Kunene	2,600	26
Ohangwena	9,400	32
Omaheke	4,700	14
Omusati	5,600	46
Oshana	13,100	16
Oshikoto	8,700	20
Otjozondjupa	5,700	18
Total	5,042	337

Table A-1.5.1 Staffing patterns for SPA facilities

Median number[1] of health care providers assigned/seconded to or employed by the facility by type of provider and type of facility, Namibia HFC 2009

	Median number of providers assigned/seconded to each facility				
Type of facility	Medical doctors (non-specialists)	Registered nurse/ midwife	Enrolled nurse/ midwife	Nurse assistant/ auxiliary	Number of facilities
Facility type					
Hospital	5	19	26	2	45
Health centre	-	3	5	-	47
Clinic	-	1	2	-	295
Free standing VCT	-	-	-	-	15
Sick bay	-	1	2	-	9
Total	na	na	na	na	411

[1] Numbers were provided by facility administrators.

Table A-1.5.2 Staffing patterns for SPA facilities

Median number[1] of selected other clinical/technical health care providers assigned/seconded to or employed by the facility by type of provider and type of facility, Namibia HFC 2009

Type of facility	Median number of selected technical health care providers assigned/seconded to each facility					Number of facilities
	Laboratory staff (lab in facility)	Pharmacy staff[2]	Community HIV counsellors	Other community providers[3]	Other technical staff[4]	
Facility type						
Hospital	2	3	2	-	2	45
Health centre	-	-	2	2	-	47
Clinic	-	-	1	1	-	295
Free standing VCT	-	-	-	-	-	15
Sick bay	-	-	-	-	-	9
Total	na	na	na	na	na	411

[1] Numbers were provided by facility administrators.
[2] Pharmacy staff include pharmacists and pharmacist assistants.
[3] Other community providers include community health workers/home-based care givers/CBRP, lifestyle ambassadors (TB/HIV), and field promoters.
[4] Other technical staff include health inspectors/environmental health officers, environmental health assistants, occupational therapists, physiotherapists, and medical rehabilitation officers/instructors/workers.

Table A-1.6.1 HIV/AIDS counselling and related training: Provider type

Percentage of interviewed staff who report that they provide counselling related to HIV testing, and among these, percentage who have received training during the three years preceding the survey, Namibia HFC 2009

Qualification of interviewed staff	Percentage who report providing counselling related to HIV testing	Number of interviewed staff	Percentage who have received training on HIV counselling related to testing during the 3 years preceding the survey in the last:[2]		Number of interviewed staff who provide HIV counselling
			12 months	13-35 months	
Qualification of provider					
Specialists[1]	100	3	36	0	3
Medical doctors (non-specialists)	53	68	29	12	36
Medical assistants	75	7	56	22	5
Registered nurse/midwife	61	494	23	25	303
Enrolled nurse/midwife	50	564	21	18	283
Nurse assistant/auxiliary	52	21	6	17	11
Social worker	100	1	50	50	1
Pharmacy staff[3]	0	11	-	-	0
Other technical staff[4]	50	3	0	0	2
Community HIV counsellors	100	329	49	40	328
Other community providers[5]	18	91	27	13	16
Laboratory staff[6]	0	14	-	-	0
Other	11	72	49	10	8
Total	59	1,679	32	27	996

[1] Obstetrician/gynaecologists, surgeons, physician specialists, paediatricians, and pathologists
[2] In-depth (or comprehensive) training for HIV/AIDS counsellors or refreshing training on HIV/AIDS counselling or HIV/AIDS training of trainers course (TOT) or supervisors training course for counsellors at district and regional level (VCT). These are country-specific courses defined by the MoHSS, which may be organised by the MoHSS or other agencies, such as WHO or NGOs.
[3] Pharmacy staff include pharmacists and pharmacist assistants.
[4] Other technical staff include health inspectors/environmental health officers, environmental health assistants, occupational therapists, physiotherapists, and medical rehabilitation officers/instructors/workers.
[5] Other community providers include community health workers/home-based care giver/CBRP, lifestyle ambassadors (TB/HIV), and field promoters.
[6] Pharmacy staff include pharmacists and pharmacist assistants.

Table A-1.6.2 HIV/AIDS counselling and related training: Facility type

Percentage of interviewed staff who report that they provide counselling related to HIV testing, and among these, percentage who have received training during the three years preceding the survey, Namibia HFC 2009

Type of facility	Percentage who report providing counselling related to HIV testing	Number of interviewed staff	Percentage who have received training on HIV counselling related to testing during the 3 years preceding the survey in the last:[1]		Number of interviewed staff who provide HIV counselling
			12 months	13-35 months	
Hospital	47	634	24	25	295
Health centre	62	298	36	27	186
Clinic	68	674	33	27	462
Free standing VCT	96	41	43	51	39
Sick bay	45	32	41	19	14
Total	59	1,679	32	27	996

[1] In-depth (or comprehensive) training for HIV/AIDS counsellors or refreshing training on HIV/AIDS counselling or HIV/AIDS training of trainers course (TOT) or supervisors training course for counsellors at district and regional level (VCT). These are country-specific courses defined by the MoHSS, which may be organised by the MoHSS or other agencies, such as WHO or NGOs.

Table A-1.7 Education levels of interviewed health service providers

Median number of years of basic schooling, and median number of years study for technical qualification, as reported by interviewed health service providers, by type of provider, Namibia HFC 2009

Type of provider	Median number of years of basic education prior to technical training[6]	Number of interviewed providers with information for basic education
Qualification of provider		
Specialists[1]	-	3
Medical doctors (non-specialists)	-	68
Medical assistants	14	7
Registered nurse/midwife	10	493
Enrolled nurse/midwife	13	564
Nurse assistant/auxiliary	8	21
Social worker	-	1
Pharmacy staff[2]	14	11
Other technical staff[3]	-	3
Community HIV counsellors	12	328
Other community providers[4]	12	91
Laboratory staff[5]	14	14
Other	14	72
Total	13	1,677

[1] Specialists include obstetrician/gynaecologists, surgeons, physician specialists, paediatricians, and pathologists.
[2] Pharmacy staff include pharmacists and pharmacist assistants.
[3] Other technical staff include health inspectors/environmental health officers, environmental health assistants, occupational therapists, physiotherapists, and medical rehabilitation officers/instructors/workers.
[4] Other community providers include community health workers/home-based care giver/CBRP, lifestyle ambassadors (TB/HIV), and field promoters.
[5] Laboratory staff include laboratory scientists, laboratory technologists, and laboratory technician/assistants.
[6] This refers to the total number of years of schooling, from primary through secondary and any additional schooling.

Chapter 3

Table A-3.1.1 Availability of basic services by type of facility

Percentage of facilities offering basic services, the indicated packages of basic services at minimum frequencies, 24-hour delivery services, with qualified employed, assigned or seconded staff, by type of facility, Namibia HFC 2009

Services	Type of facility				Total percentage
	Hospital	Health centre	Clinic	Sick bay	
Services					
Curative care for children	64	96	93	0	88
Sexually transmitted infections (STI)	71	98	97	78	93
Family Planning (FP)	49	96	98	33	90
Antenatal care (ANC)	18	91	85	0	77
Child immunisation (EPI)	38	91	91	0	83
Growth monitoring (GM)	40	91	87	0	81
Packages of services available					
All basic services at any frequency[1]	11	87	80	0	71
Facility-based 24-hour delivery services	91	55	29	0	39
At least one qualified staff[2]	100	96	98	100	98
All services, minimum frequency[3]	11	87	75	0	67
All services, minimum frequency and 24-hour delivery services	11	49	25	0	26
All services, minimum frequency, 24-hour delivery services, and at least one qualified staff	11	47	24	0	25
Number of facilities	45	47	295	9	396

[1] Any level of each of the following services offered at the facility: outpatient curative care services for children, any STI services, any temporary methods of family planning, antenatal care, child immunisation, and child growth monitoring.
[2] Qualified staff (Namibia specific) includes all specialists (including surgeons, obstetrician/gynaecologists, paediatricians, physician specialists and pathologists), medical officers, medical assistants, registered nurse/midwives, and enrolled nurse/midwives.
[3] Outpatient curative care services for children provided five days per week, STI services offered at least one day per week, preventive or elective services (temporary methods of family planning, antenatal care, child immunisation, and growth monitoring) provided at least one day per week.

Table A-3.1.2 Availability of basic services by region

Percentage of facilities offering basic services, the indicated packages of basic services at minimum frequencies, 24-hour delivery services, with qualified employed, assigned or seconded staff, by region, Namibia HFC 2009

Services	Region													Total percentage
	Caprivi	Erongo	Hardap	Karas	Kavango	Khomas	Kunene	Ohangwena	Omaheke	Omusati	Oshana	Oshikoto	Otjozondjupa	
Services														
Curative care for children	96	64	95	80	98	58	96	100	94	96	80	100	83	88
Sexually transmitted infections (STI)	96	92	100	88	100	67	100	100	94	96	90	95	93	93
Family Planning (FP)	93	86	90	92	96	76	96	91	94	94	85	91	86	90
Antenatal care (ANC)	93	53	81	76	93	27	89	91	81	84	70	91	62	77
Child immunisation (EPI)	96	56	81	80	98	58	86	91	81	90	80	95	72	83
Growth monitoring (GM)	96	50	76	72	93	58	86	91	81	90	75	91	79	81
Packages of services available														
All basic services at any frequency[1]	93	44	62	72	88	18	82	91	81	80	65	86	59	71
Facility-based 24-hour delivery services	25	25	48	44	63	18	64	13	88	18	25	27	66	39
At least one qualified staff[2]	100	100	100	100	98	94	82	100	100	100	100	100	100	98
All services, minimum frequency[3]	75	44	62	64	86	18	82	81	81	80	60	77	55	67
All services, minimum frequency and 24-hour delivery services	18	11	24	28	51	6	50	3	75	12	10	18	41	26
All services, minimum frequency, 24-hour delivery services, and at least one qualified staff	18	11	24	28	51	6	36	3	75	12	10	18	41	25
Number of facilities	28	36	21	25	57	33	28	32	16	49	20	22	29	396

[1] Any level of each of the following services offered at the facility: outpatient curative care services for children, any STI services, any temporary methods of family planning, antenatal care, child immunisation, and child growth monitoring.
[2] Qualified staff (Namibia specific) includes all specialists (including surgeons, obstetrician/gynaecologists, paediatricians, physician specialists and pathologists), medical officers, medical assistants, registered nurse/midwives, and enrolled nurse/midwives.
[3] Outpatient curative care services for children provided five days per week, STI services offered at least one day per week, preventive or elective services (temporary methods of family planning, antenatal care, child immunisation, and growth monitoring) provided at least one day per week.

Table A-3.2 Facility infrastructure supportive of client utilisation and quality services

Percentage of all facilities with client amenities, regular electricity and water supply, and staff and furnishings to support quality 24-hour emergency services, by type of facility, Namibia HFC 2009

Items	Type of facility				Total percentage
	Hospital	Health centre	Clinic	Sick bay	
Client comfort amenities					
Clean facility[1]	84	89	83	89	84
Facility infrastructure					
No electricity or generator	0	4	5	0	5
Generator observed with fuel	78	23	7	33	18
Regular electricity or generator	91	55	47	100	55
Any safe onsite water[2]	78	85	77	67	78
Regular water supply (any safe onsite and year-round)	64	68	54	67	57
Regular water and electricity[3]	60	34	30	67	35
All client amenities, regular water and electricity	51	30	26	67	30
Staff and furnishings					
At least two qualified staff[4]	100	96	62	78	71
Duty staff on site 24 hours[5]	89	51	6	56	22
Duty staff on-call 24 hours[5]	2	4	4	0	4
Qualified staff living onsite	71	62	51	67	55
Qualified staff living onsite, no duty roster seen or no duty roster and not part of network	4	15	44	11	36
Emergency communication[6]	100	100	96	100	97
Overnight patient beds[7]	100	72	21	67	37
Basic components supporting 24-hour emergency services[8]	73	40	5	22	17
Basic plus regular water and electricity[9]	58	11	1	22	9
Electricity check					
Regular electricity[10]	64	43	44	89	47
Electricity[11]	100	96	93	100	94
Number of facilities	45	47	295	9	396

[1] The floors are swept with no obvious dirt or waste, all counters, tables and chairs are clean with no obvious dust or waste, and there are no broken equipment, papers or boxes lying around making facility cluttered and dirty.
[2] Piped water from a protected or unknown source, or water from protected well/pump and water outlet within 500 meters of facility
[3] Year-round, onsite water and electricity routinely available during service hours or a generator with fuel available.
[4] Qualified staff includes specialists (including surgeons, obstetrician/gynaecologists, paediatricians, physician specialists and pathologists), medical officers, medical assistants, registered nurse/midwives, and enrolled nurse/midwives.
[5] A duty schedule or other documentation of official duty status was observed.
[6] Communication device either in facility or within a 5-minute walk and available 24 hours a day.
[7] Either routine inpatient services or beds for overnight care for emergencies.
[8] At least two qualified staff assigned to, or employed by facility, duty staff on site or on call 24 hours a day, overnight beds, access to 24-hour emergency communication, and any onsite water source
[9] At least two qualified staff assigned to, or employed by facility, duty staff on site or on call 24 hours a day, overnight beds, access to 24-hour emergency communication, and regular water and electricity
[10] Facility reports it is connected to a central electric grid or has solar power or both, and never interrupted during regular service hours.
[11] Facility reports it is connected to a central electric grid or to a solar grid or both.

Table A-3.3 Facility infrastructure supportive of client utilisation and quality services, by region

Percentage of all facilities with client amenities, regular electricity and water supply, and staff and furnishings to support quality 24-hour emergency services, by region, Namibia HFC 2009

Items	Region													Total percentage
	Caprivi	Erongo	Hardap	Karas	Kavango	Khomas	Kunene	Ohangwena	Omaheke	Omusati	Oshana	Oshikoto	Otjozondjupa	
Client comfort amenities														
Clean facility[1]	86	78	95	80	77	91	89	91	94	96	100	73	52	84
Facility infrastructure														
No electricity or generator	11	0	0	4	5	3	0	3	0	16	0	0	3	5
Generator observed with fuel	0	6	38	32	19	21	14	13	38	14	20	9	28	18
Regular electricity or generator	21	81	67	52	51	67	39	34	50	61	50	64	66	55
Any safe onsite water[2]	82	100	67	60	65	76	68	59	100	88	95	91	79	78
Regular water supply (any safe onsite and year-round)	46	78	57	48	33	67	43	34	69	78	80	59	66	57
Regular water and electricity[3]	7	69	38	28	12	39	14	16	50	51	45	41	52	35
All client amenities, regular water and electricity	4	56	38	20	12	39	14	9	44	49	45	27	41	30
Staff and furnishings														
At least two qualified staff[4]	29	75	76	84	51	76	29	88	88	88	90	86	86	71
Duty staff on site 24 hours[5]	4	17	43	28	21	24	14	9	69	12	20	27	34	22
Duty staff on-call 24 hours[5]	0	11	5	4	0	3	0	0	0	2	0	0	24	4
Qualified staff living onsite	82	42	48	68	79	18	82	44	88	41	35	32	59	55
Qualified staff living onsite, no duty roster seen or no duty roster and not part of network	79	22	14	48	58	6	68	34	25	27	20	14	24	36
Emergency communication[6]	93	97	100	100	93	97	93	100	100	96	100	95	100	97
Overnight patient beds[7]	29	36	38	48	40	27	29	19	94	24	20	32	76	37
Basic components supporting 24-hour emergency services[8]	0	17	14	20	12	18	7	6	63	10	15	27	45	17
Basic plus regular water and electricity[9]	0	11	10	16	4	3	4	3	25	8	15	14	24	9
Number of facilities	28	36	21	25	57	33	28	32	16	49	20	22	29	396

[1] The floors are swept with no obvious dirt or waste, all counters, tables and chairs are clean with no obvious dust or waste, and there are no broken equipment, papers or boxes lying around making facility cluttered and dirty.
[2] Piped water from a protected or unknown source, or water from protected well/pump and water outlet within 500 meters of facility.
[3] Year-round, onsite water and electricity routinely available during service hours or a generator with fuel available.
[4] Qualified staff includes specialists (including surgeons, obstetrician/gynaecologists, paediatricians, physician specialists and pathologists), medical officers, medical assistants, registered nurse/midwives, and enrolled nurse/midwives.
[5] A duty schedule or other documentation of official duty status was observed.
[6] Communication device either in facility or within a 5-minute walk and available 24 hours a day
[7] Either routine inpatient services or beds for overnight care for emergencies
[8] At least two qualified staff assigned to, or employed by facility, duty staff on site or on call 24 hours a day, overnight beds, access to 24-hour emergency communication, and any onsite water source
[9] At least two qualified staff assigned to, or employed by facility, duty staff on site or on call 24 hours a day, overnight beds, access to 24-hour emergency communication, and regular water and electricity

Table A-3.4 Routine management meetings

Percentage of facilities reporting they have routine management meetings at specific intervals, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage			Number of facilities
	Monthly or more often	Every 2-3 months	Every 4-6 months	
Type of facility				
Hospital	93	2	0	45
Health centre	62	11	2	47
Clinic	47	8	4	295
Sick bay	100	0	0	9
Managing authority				
MoHSS	52	7	4	306
Mission/NGO	64	7	4	28
Private	61	10	0	49
MoD/POLICE	100	0	0	13
Region				
Caprivi	71	0	0	28
Erongo	56	0	0	36
Hardap	57	19	0	21
Karas	60	12	0	25
Kavango	49	0	0	57
Khomas	61	6	0	33
Kunene	25	4	0	28
Ohangwena	66	13	9	32
Omaheke	63	13	19	16
Omusati	47	12	8	49
Oshana	50	5	10	20
Oshikoto	68	23	0	22
Otjozondjupa	66	3	0	29
Total	56	7	3	396

Table A-3.5 Quality assurance activities with documentation observed

Among facilities that report having quality assurance (QA) activities, percentage that both reported and had documentation for supervisory checklist, mortality reviews, audit of medical records, or registers and a QA committee, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage reporting routine QA activities	Number of facilities	Percentage with documentation of any QA activity during past 1 year	Number of facilities reporting quality assurance activities
Type of facility				
Hospital	84	45	53	38
Health centre	40	47	42	19
Clinic	25	295	35	74
Sick bay	33	9	33	3
Managing authority				
MoHSS	31	306	44	94
Mission/NGO	43	28	50	12
Private	45	49	32	22
MoD/POLICE	46	13	17	6
Region				
Caprivi	7	28	0	2
Erongo	42	36	13	15
Hardap	43	21	44	9
Karas	36	25	22	9
Kavango	33	57	68	19
Khomas	48	33	38	16
Kunene	7	28	50	2
Ohangwena	44	32	36	14
Omaheke	50	16	88	8
Omusati	24	49	33	12
Oshana	25	20	20	5
Oshikoto	45	22	20	10
Otjozondjupa	45	29	62	13
Total	34	396	41	134

Table A-3.6 Supportive management practices: training and supervision at the facility level

Percentage of facilities where none, at least half, or all of the providers interviewed reported receiving training related to their work during the 12 months preceding the survey and personal supervision during the 6 months preceding the survey, by background characteristics, Namibia HFC 2009

Background characteristics	Received training related to their work during the 12 months preceding the survey[1]			Were personally supervised during the 6 months preceding the survey			Number of facilities with interviewed providers[2]
	None	At least 50 percent	All	None	At least 50 percent	All	
Type of facility							
Hospital	2	62	27	0	62	24	45
Health centre	0	49	43	4	51	34	47
Clinic	10	33	54	16	34	45	295
Sick bay	11	44	33	11	22	33	9
Managing authority							
MoHSS	4	39	54	9	41	43	306
Mission/NGO	7	43	32	4	39	57	28
Private	33	33	31	41	31	22	49
MoD/POLICE	8	46	31	8	38	31	13
Region							
Caprivi	4	43	54	7	36	54	28
Erongo	17	50	25	19	44	25	36
Hardap	5	38	43	10	48	43	21
Karas	4	28	64	4	52	40	25
Kavango	11	37	47	14	32	46	57
Khomas	21	42	36	27	45	21	33
Kunene	11	14	75	21	18	50	28
Ohangwena	0	50	38	0	44	50	32
Omaheke	6	38	56	6	25	69	16
Omusati	6	33	57	8	33	57	49
Oshana	0	35	65	10	40	45	20
Oshikoto	0	50	41	5	64	27	22
Otjozondjupa	7	45	45	21	41	14	29
Total	8	39	49	12	39	41	396

[1] Training includes only structured pre- or in-service sessions and does not include individual instruction received during routine supervision.
[2] Interviewed providers who do not personally provide any of the assessed services (i.e., managers other than those for clinical services who might have been interviewed) are excluded.

Table A-3.7 Supportive management practices: training and supervision at the individual provider level

Among interviewed health service providers, percentage who reported receiving training related to their work and personal supervision during specific time periods, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of providers who received: Training during the 12 months preceding the survey[1]	Personal supervision in the 6 months preceding the survey	Training during the 12 months and personal supervision during the 6 months preceding the survey	Most recent training in the 13-59 months preceding the survey	Number of interviewed health service providers[2]
Type of facility					
Hospital	78	73	57	12	623
Health centre	79	78	62	15	297
Clinic	79	74	59	16	672
Sick bay	61	62	38	27	32
Managing authority					
MoHSS	82	75	62	13	1,231
Mission/NGO	71	81	59	22	201
Private	60	57	33	14	142
MoD/POLICE	57	66	37	29	49
Region					
Caprivi	79	72	61	18	52
Erongo	70	70	55	21	129
Hardap	62	82	54	25	119
Karas	83	74	64	9	102
Kavango	72	75	51	16	207
Khomas	71	64	41	12	192
Kunene	90	69	61	8	67
Ohangwena	79	79	65	16	129
Omaheke	87	90	78	12	50
Omusati	85	83	71	13	197
Oshana	91	80	72	9	131
Oshikoto	81	68	59	15	149
Otjozondjupa	83	56	47	8	100
Total	78	74	58	14	1,623

[1] Training includes only structured pre- or in-service sessions and does not include individual instruction received during routine supervision.
[2] Interviewed providers who do not personally provide any of the assessed services (i.e., managers other than those for clinical services) who might have been interviewed) are excluded. Providers include community health workers who were at the facility on the day of the survey and were interviewed.

Table A-3.8 Funding options

Among facilities charging user fees for adult curative care, percentage that use systems to decrease out-of-pocket fees for clients or to reimburse deferred client fees, and percentage that publicly post fees, by background characteristics, Namibia HFC 2009

	System for decreasing out-of-pocket fees		System for reimbursement of deferred client fees				Fees are posted publicly		
Background characteristics	Discount/ exemption for some clients	Client can prepay for multiple visits one service	Reimburse-ment by employer of client	Reimburse-ment by insurance	Reimburse-ment by community programs	Facility has any system to decrease out-of-pocket costs to client[1]	All fees	Some fees	Number of facilities charging any user fees for adult curative care
Type of facility									
Hospital	57	7	23	23	0	75	43	9	44
Health centre	67	4	7	4	2	73	27	2	45
Clinic	56	2	8	5	1	64	24	2	280
Managing authority									
MoHSS	57	1	8	1	1	65	25	1	305
Mission/NGO	68	0	4	4	4	68	25	0	28
Private	58	19	28	61	3	83	36	19	36
Region									
Caprivi	93	0	0	0	0	93	44	0	27
Erongo	48	12	0	4	0	52	44	8	25
Hardap	85	0	5	15	0	85	40	5	20
Karas	54	4	0	8	4	63	38	4	24
Kavango	63	2	0	4	4	64	18	2	56
Khomas	70	7	22	41	0	85	30	15	27
Kunene	43	0	0	0	0	43	21	0	28
Ohangwena	47	3	13	0	0	63	28	3	32
Omaheke	44	13	6	6	0	50	31	0	16
Omusati	44	0	0	2	0	44	6	0	48
Oshana	72	0	0	0	0	72	22	6	18
Oshikoto	91	5	5	9	5	91	14	0	22
Otjozondjupa	15	0	81	8	0	88	35	0	26
Total	58	3	9	7	1	67	26	3	369

[1] Discounts or exemptions, prepayment system, reimbursement by employer, insurance or community programmes.

Table A-3.9 Components for which fees are charged

Among facilities charging user fees for adult curative care, percentage charging for client charts and records, consultations, medicines, lab tests and registration, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities charging for the indicated item:					Number of facilities charging any user fees for adult curative care
	Health passport	Consultation	Medicine	Lab tests	Registration	
Type of facility						
Hospital	34	52	39	27	48	44
Health centre	36	51	16	7	38	45
Clinic	27	61	26	6	20	280
Managing authority						
MoHSS	27	55	20	4	24	305
Mission/NGO	61	54	18	11	43	28
Private	25	92	86	47	31	36
Region						
Caprivi	0	96	0	0	4	27
Erongo	48	64	20	20	8	25
Hardap	45	75	55	40	60	20
Karas	21	50	42	13	17	24
Kavango	29	57	39	9	30	56
Khomas	30	74	52	30	48	27
Kunene	68	64	14	0	18	28
Ohangwena	28	56	6	0	31	32
Omaheke	25	81	38	13	13	16
Omusati	8	50	25	0	13	48
Oshana	22	44	6	0	33	18
Oshikoto	64	27	0	0	27	22
Otjozondjupa	12	35	35	4	42	26
Total	29	59	26	9	26	369

Table A-3.10 Facility systems for maintenance and repair of equipment

Among facilities with large equipment, percentage with preventive maintenance programs for the equipment, percentage where onsite staff or external technicians perform maintenance, and among facilities with systems for repairing small equipment, percentage that use different methods to repair and replace equipment, by background characteristics, Namibia HFC 2009

	Percentage of facilities where preventive maintenance of major equipment is performed by:[1]						Percentage reporting method used for maintenance or replacement of small equipment[2]				
Background characteristics	Onsite staff	External technicians	Both onsite and external technicians	Don't know who repairs	No routine mainte-nance	Number of facilities with major equipment	Onsite repair	Send outside for repair or replace	Purchase or pay for from funds on hand	Replaced by MoHSS or donors	Number of facilities with system for small equipment repair
Type of facility											
Hospital	31	20	13	2	33	45	71	64	9	2	45
Health centre	17	25	0	0	58	12	20	80	11	9	46
Clinic	21	29	3	0	47	38	9	81	10	12	288
Sick bay	0	0	33	0	67	3	25	88	0	13	8
Managing authority											
MoHSS	20	18	4	2	55	49	15	82	5	12	301
Mission/NGO	18	45	9	0	27	11	32	75	18	11	28
Private	38	28	13	0	22	32	28	62	36	2	47
MoD/POLICE	0	0	17	0	83	6	18	91	0	9	11
Region											
Caprivi	0	0	0	0	100	1	21	96	0	0	28
Erongo	27	9	9	0	55	11	14	74	20	11	35
Hardap	0	33	11	0	56	9	10	86	48	0	21
Karas	36	27	0	9	27	11	12	80	16	4	25
Kavango	23	38	0	0	38	13	30	75	11	9	56
Khomas	42	25	25	0	8	12	30	90	10	0	30
Kunene	0	0	25	0	75	4	8	19	0	88	26
Ohangwena	0	33	0	0	67	6	16	77	0	6	31
Omaheke	29	14	0	0	57	7	19	94	13	0	16
Omusati	14	43	0	0	43	7	8	90	4	13	48
Oshana	40	0	20	0	40	5	10	95	0	0	20
Oshikoto	33	0	33	0	33	3	23	82	14	0	22
Otjozondjupa	33	22	0	0	44	9	21	76	3	0	29
Total	24	23	8	1	43	98	18	79	10	11	387

[1] Major equipment refer to generators, sterilisers, and other large equipment where routine maintenance is recommended to extend the life of the machine.
[2] Minor or small equipment refers to stethoscopes, sphygmomanometers, other small equipment where either minor repairs or replacement are common when equipment is broken.

Table A-3.11 Facility systems for maintenance and repair of buildings

Among facilities with systems for maintenance and repair of buildings and infrastructure, percentage where onsite staff and outside workers are responsible for making repairs, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage where repairs on building or infrastructure are made by:			Number of facilities with system for maintenance and repair
	Onsite staff	Persons hired from outside	Both onsite staff and externally hired	
Type of facility				
Hospital	52	22	17	23
Health centre	17	75	8	12
Clinic	22	70	9	69
Sick bay	33	33	33	3
Managing authority				
MoHSS	14	72	10	50
Mission/NGO	29	71	0	17
Private	44	39	17	36
MoD/POLICE	50	25	25	4
Region				
Caprivi	50	0	0	2
Erongo	60	30	10	10
Hardap	17	83	0	6
Karas	44	33	11	9
Kavango	10	86	5	21
Khomas	41	35	24	17
Kunene	50	0	50	2
Ohangwena	17	33	50	6
Omaheke	25	75	0	4
Omusati	11	89	0	9
Oshana	33	50	17	6
Oshikoto	25	75	0	8
Otjozondjupa	14	86	0	7
Total	28	59	11	107

Table A-3.12 Storage conditions and stock monitoring systems for vaccines

Among facilities that routinely store vaccines, percentage with adequate storage conditions and stock monitoring systems for vaccines, by background characteristics, Namibia HFC 2009

	Stock condition					Stock monitoring system			
Background characteristics	Functioning thermometer in refrigerator	Up-to-date temperature chart	Temperature 2°-8°C at time of visit	Adequate cold chain monitoring system[1]	Refrigerator protected from sun	No expired vaccines present (for vaccines in stock)	Vaccines stored by expiration date (whether expired or not)	Stock card present (for vaccines in stock)	Number of facilities with stored vaccines observed
Type of facility									
Hospital	82	46	64	32	96	96	89	29	28
Health centre	98	84	80	69	100	98	89	27	45
Clinic	95	77	77	62	97	89	83	25	261
Managing authority									
MoHSS	95	79	76	63	97	89	85	27	284
Mission/NGO	100	74	89	67	96	100	93	22	27
Private	78	35	57	22	96	96	74	9	23
Region									
Caprivi	96	85	73	69	96	85	85	8	26
Erongo	95	55	82	45	91	82	68	45	22
Hardap	90	35	80	30	95	95	80	30	20
Karas	80	50	55	35	100	85	50	25	20
Kavango	98	71	88	66	96	93	80	18	56
Khomas	81	48	62	33	100	95	95	19	21
Kunene	96	83	71	63	100	88	100	63	24
Ohangwena	100	100	83	83	100	93	93	14	29
Omaheke	93	93	79	79	93	100	100	57	14
Omusati	100	91	79	72	95	81	77	28	43
Oshana	100	94	75	69	94	94	94	31	16
Oshikoto	95	86	82	73	100	100	95	5	22
Otjozondjupa	90	71	57	38	100	100	95	10	21
Total	95	75	76	60	97	91	84	25	334

[1] There is a functioning thermometer in refrigerator, temperature chart is up-to-date, and refrigerator temperature reads between 2°and 8°C at the time of the visit.
[2] There were no stored vaccines or the vaccine storage area was not observed for 1 facility that store vaccines.

Table A-3.13 Storage conditions and stock monitoring systems for contraceptive methods, medicines, and antiretroviral medicines (ARVs)

Among facilities that store clinical methods of contraception, medicines, and ARVs, percentage with proper storage conditions and stock monitoring systems for commodities, by background characteristics, Namibia HFC 2009

	Proper storage condition					Stock monitoring systems[1]						
Background characteristics	Off the ground	Protected from water	Protected from sun	No evidence of pests or rodents	Good storage[2]	No items out of stock (for items normally carried)	No expired items present (for items in stock)	Items stored by expiration date (whether expired or not)	Stock card present (for items in stock)	Inventory up-to-date (for items with stock card)	No out of stock (Col A <> 5 & (Col B =2 for items with stock card))	Number of facilities with stored commodities observed
CONTRACEPTIVE METHODS												
Type of facility												
Hospital	92	100	100	100	92	-	92	84	20	-	-	25
Health centre	96	100	98	96	91	-	96	91	43	-	-	46
Clinic	96	99	100	93	89	-	86	79	28	-	-	289
Sick bay	75	75	100	100	75	-	100	100	0	-	-	4
Managing authority												
MoHSS	96	99	99	94	89	-	88	80	32	-	-	294
Mission/NGO	96	100	100	86	86	-	89	93	25	-	-	28
Private	97	100	100	97	94	-	86	78	8	-	-	36
MoD/POLICE	83	83	100	100	83	-	100	100	17	-	-	6
Region												
Caprivi	96	96	100	88	81	-	92	88	50	-	-	26
Erongo	94	97	100	94	88	-	79	79	32	-	-	34
Hardap	90	100	100	85	80	-	95	75	15	-	-	20
Karas	74	100	100	96	74	-	87	74	39	-	-	23
Kavango	98	100	100	88	86	-	88	75	36	-	-	56
Khomas	92	100	100	96	92	-	92	96	31	-	-	26
Kunene	100	100	96	100	96	-	92	84	48	-	-	25
Ohangwena	100	97	100	100	97	-	93	90	0	-	-	30
Omaheke	100	100	100	100	100	-	93	93	53	-	-	15
Omusati	98	100	98	96	93	-	72	67	35	-	-	46
Oshana	100	100	100	88	88	-	100	76	6	-	-	17
Oshikoto	95	100	100	95	90	-	86	86	10	-	-	21
Otjozondjupa	100	100	100	96	96	-	96	88	12	-	-	25
Total	96	99	99	94	89	-	88	81	29	-	-	364
MEDICINES												
Type of facility												
Hospital	84	100	100	93	80	2	78	96	89	78	0	45
Health centre	85	96	100	100	85	4	80	98	93	54	0	46
Clinic	88	98	97	91	81	8	80	86	87	51	1	288
Sick bay	89	100	100	100	89	0	78	56	67	56	0	9
Managing authority												
MoHSS	87	98	98	93	80	7	80	90	95	56	1	305
Mission/NGO	75	100	100	79	64	7	79	82	82	64	0	28
Private	100	100	100	100	100	10	83	88	48	38	2	42
MoD/POLICE	92	100	92	92	85	8	62	54	62	46	0	13
Region												
Caprivi	100	100	100	96	96	4	89	89	93	25	0	28
Erongo	89	94	97	94	83	19	69	92	81	53	3	36
Hardap	81	100	95	90	67	5	86	90	90	57	0	21
Karas	92	100	100	96	92	12	88	84	84	52	4	25
Kavango	68	96	98	88	65	7	72	74	91	53	0	57
Khomas	93	100	100	100	93	4	81	93	81	67	4	27
Kunene	96	100	93	100	89	7	64	93	93	32	0	28
Ohangwena	94	100	97	97	90	10	81	97	97	90	0	31
Omaheke	100	93	100	100	93	0	93	87	93	67	0	15
Omusati	88	100	96	88	78	6	80	94	100	71	0	49
Oshana	80	100	100	90	70	0	65	70	70	55	0	20
Oshikoto	77	100	100	77	73	9	86	86	77	27	0	22
Otjozondjupa	97	93	100	93	86	0	97	93	72	45	0	29
Total	87	98	98	93	81	7	80	88	88	54	1	388

Continued…

Table A-3.13—*Continued*

Background characteristics	Proper storage condition					Stock monitoring systems[1]						Number of facilities with stored commoditie s observed
	Off the ground	Protected from water	Protected from sun	No evidence of pests or rodents	Good storage[2]	No items out of stock (for items normally carried)	No expired items present (for items in stock)	Items stored by expiration date (whether expired or not)	Stock card present (for items in stock)	Inventory up-to-date (for items with stock card)	No out of stock (Col A <> 5 & (Col B =2 for items with stock card))	
	ARVS[2]											
Type of facility												
Hospital	78	100	100	88	71	78	95	-	88	39	66	41
Health centre	95	100	100	97	92	74	97	-	85	26	51	39
Clinic	97	99	99	94	93	72	93	-	79	21	45	163
Sick bay	-	-	-	-	-	-	-	-	-	-	-	0
Managing authority												
MoHSS	94	99	99	93	89	73	94	-	84	24	50	210
Mission/NGO	88	100	100	94	81	94	100	-	88	31	81	16
Private	94	100	100	100	94	69	88	-	38	25	19	16
MoD/POLICE	100	100	100	100	100	0	100	-	100	0	0	1
Region												
Caprivi	100	100	100	100	100	62	92	-	77	8	38	13
Erongo	100	100	100	100	100	79	89	-	95	68	53	19
Hardap	100	100	100	100	100	82	100	-	73	45	27	11
Karas	89	100	100	100	89	50	100	-	56	11	22	18
Kavango	87	97	97	90	81	94	97	-	84	26	71	31
Khomas	91	100	100	82	73	82	100	-	64	18	27	11
Kunene	87	100	100	87	87	87	87	-	80	20	47	15
Ohangwena	96	100	100	96	92	52	92	-	88	48	48	25
Omaheke	93	93	100	93	86	50	93	-	86	21	43	14
Omusati	89	100	97	92	84	66	89	-	89	3	47	38
Oshana	100	100	100	93	93	93	100	-	87	7	60	15
Oshikoto	100	100	100	85	85	85	85	-	85	23	69	13
Otjozondjupa	95	100	100	95	95	85	100	-	70	30	60	20
Total	93	99	99	93	89	74	94	-	81	25	49	243

[1] Only selected items were evaluated for the stock maintenance system. Contraceptive items assessed were oral pills, progestin injectable, IUCD, and condoms.
[2] Items stored off the ground, protected from water, protected from sun, and no evidence of pests or rodents in storage area.
[4] There were no stored ARVs or the storage area for ARVs was not observed for 4 facilities that stored ARVs.

Table A-3.14 Reported reliability of ordering system for comities: orders placed by facility

Percentage of facilities providing vaccinations, contraceptive methods, medicines or ARVs, where decision on when to order the commodity are made by facility staff, and among these, percentage that consider receipt of supplies to be reliable and that received their most recent order during the 4 weeks preceding the survey visit, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities where staff members determine and place commodity orders	Number of facilities providing vaccinations, contraceptive methods, medicines or ARVs	Receipt of ordered commodity:[1]			Most recent order received during the 4 weeks preceding the survey visit	Number of facilities that determine and place commodity orders
			Always receive correct amount	Sometimes receive correct amount	Never receive correct amount		
VACCINES							
Type of facility							
Hospital	94	17	-	-	-	81	16
Health centre	100	43	-	-	-	79	43
Clinic	98	261	-	-	-	69	256
Sick bay	-	0	-	-	-	-	0
Managing authority							
MoHSS	99	275	-	-	-	70	271
Mission/NGO	96	27	-	-	-	73	26
Private	95	19	-	-	-	83	18
MoD/POLICE	-	0	-	-	-	-	0
Region							
Caprivi	96	26	-	-	-	60	25
Erongo	100	18	-	-	-	83	18
Hardap	100	17	-	-	-	82	17
Karas	100	20	-	-	-	65	20
Kavango	98	56	-	-	-	76	55
Khomas	94	18	-	-	-	59	17
Kunene	96	24	-	-	-	26	23
Ohangwena	100	29	-	-	-	83	29
Omaheke	100	13	-	-	-	85	13
Omusati	100	43	-	-	-	65	43
Oshana	100	15	-	-	-	93	15
Oshikoto	100	21	-	-	-	71	21
Otjozondjupa	90	21	-	-	-	84	19
Total	98	321	-	-	-	71	315
CONTRACEPTIVE METHODS							
Type of facility							
Hospital	95	19	-	-	-	72	18
Health centre	100	45	-	-	-	69	45
Clinic	96	288	-	-	-	60	277
Sick bay	67	3	-	-	-	50	2
Managing authority							
MoHSS	98	290	-	-	-	60	283
Mission/NGO	100	27	-	-	-	63	27
Private	85	34	-	-	-	79	29
MoD/POLICE	75	4	-	-	-	33	3
Region							
Caprivi	96	26	-	-	-	72	25
Erongo	81	31	-	-	-	64	25
Hardap	100	19	-	-	-	63	19
Karas	95	22	-	-	-	43	21
Kavango	96	55	-	-	-	75	53
Khomas	92	25	-	-	-	70	23
Kunene	96	25	-	-	-	29	24
Ohangwena	100	29	-	-	-	52	29
Omaheke	100	15	-	-	-	67	15
Omusati	100	46	-	-	-	59	46
Oshana	100	17	-	-	-	71	17
Oshikoto	100	20	-	-	-	50	20
Otjozondjupa	100	25	-	-	-	76	25
Total	96	355	-	-	-	62	342

Continued…

Table A-3.14—*Continued*

Background characteristics	Percentage of facilities where staff members determine and place commodity orders	Number of facilities providing vaccinations, contraceptive methods, medicines or ARVs	Receipt of ordered commodity:[1]			Most recent order received during the 4 weeks preceding the survey visit	Number of facilities that determine and place commodity orders
			Always receive correct amount	Sometimes receive correct amount	Never receive correct amount		
MEDICINES							
Type of facility							
Hospital	100	45	22	73	4	78	45
Health centre	96	46	18	73	7	84	44
Clinic	93	288	26	66	4	70	267
Sick bay	100	9	44	56	0	56	9
Managing authority							
MoHSS	93	305	21	72	4	72	284
Mission/NGO	96	28	26	74	0	78	27
Private	98	42	44	37	12	80	41
MoD/POLICE	100	13	46	46	8	54	13
Region							
Caprivi	100	28	14	79	4	57	28
Erongo	61	36	18	59	9	77	22
Hardap	100	21	29	52	19	81	21
Karas	100	25	32	60	4	72	25
Kavango	98	57	34	57	4	82	56
Khomas	96	27	27	54	15	58	26
Kunene	96	28	19	78	0	85	27
Ohangwena	100	31	16	81	0	77	31
Omaheke	87	15	54	46	0	77	13
Omusati	100	49	22	78	0	57	49
Oshana	100	20	35	60	5	85	20
Oshikoto	95	22	24	71	5	76	21
Otjozondjupa	90	29	12	85	4	69	26
Total	94	388	25	67	5	73	365
ARVS							
Type of facility							
Hospital	100	41	56	32	12	71	41
Health centre	95	39	73	22	3	68	37
Clinic	85	168	59	32	6	39	142
Sick bay	-	0	-	-	-	-	0
Managing authority							
MoHSS	88	214	61	30	6	47	188
Mission/NGO	94	16	67	20	13	47	15
Private	94	17	56	38	6	81	16
MoD/POLICE	100	1	100	0	0	100	1
Region							
Caprivi	93	14	54	31	15	54	13
Erongo	47	19	56	33	11	67	9
Hardap	73	11	50	38	13	75	8
Karas	83	18	67	20	13	80	15
Kavango	87	31	74	19	4	44	27
Khomas	92	12	55	36	9	45	11
Kunene	75	16	67	17	17	42	12
Ohangwena	100	25	20	76	0	44	25
Omaheke	100	14	79	14	7	57	14
Omusati	97	38	73	22	0	38	37
Oshana	100	16	56	38	6	38	16
Oshikoto	100	13	62	23	15	23	13
Otjozondjupa	95	21	70	20	5	70	20
Total	89	248	61	30	7	50	220

[1] Based on orders received during the 3 months preceding the survey.

Table A-3.15 System for ordering vaccines and contraceptive methods for facilities placing their own orders

Among facilities that provide vaccinations or contraceptive methods and order their own supplies, percentage reporting that they use specific criteria to decide how much to order and when to order, by background characteristics, Namibia HFC 2009

Background characteristics	Amount ordered based on:[1]				Number of facilities
	Maintaining a fixed stock	Same amount ordered each time	Utilisation	Other	
VACCINES					
Type of facility					
Hospital	31	0	69	0	16
Health centre	28	0	72	0	43
Clinic	36	1	63	0	256
Sick bay	-	-	-	-	0
Managing authority					
MoHSS	35	1	63	0	271
Mission/NGO	23	0	77	0	26
Private	39	0	61	0	18
MoD/POLICE	-	-	-	-	0
Region					
Caprivi	68	0	32	0	25
Erongo	56	6	39	0	18
Hardap	59	6	35	0	17
Karas	70	0	30	0	20
Kavango	20	0	80	0	55
Khomas	41	0	59	0	17
Kunene	13	0	87	0	23
Ohangwena	21	0	79	0	29
Omaheke	15	0	85	0	13
Omusati	40	2	58	0	43
Oshana	7	0	87	7	15
Oshikoto	10	0	90	0	21
Otjozondjupa	42	0	58	0	19
Total	34	1	64	0	315
CONTRACEPTIVE METHODS					
Type of facility					
Hospital	50	6	44	0	18
Health centre	40	2	58	0	45
Clinic	31	1	68	0	277
Sick bay	50	0	50	0	2
Managing authority					
MoHSS	35	1	64	0	283
Mission/NGO	26	0	74	0	27
Private	28	3	69	0	29
MoD/POLICE	33	0	67	0	3
Region					
Caprivi	56	0	44	0	25
Erongo	40	12	48	0	25
Hardap	47	5	47	0	19
Karas	62	0	38	0	21
Kavango	21	0	79	0	53
Khomas	48	0	52	0	23
Kunene	13	0	88	0	24
Ohangwena	28	0	72	0	29
Omaheke	33	0	67	0	15
Omusati	30	0	70	0	46
Oshana	6	0	94	0	17
Oshikoto	10	0	90	0	20
Otjozondjupa	56	0	44	0	25
Total	34	1	65	0	342

Table A-3.16 System for ordering medicines and ARVs for facilities placing their own orders

Among facilities that provide medicines or ARVs and order their own supplies, percentage reporting that they use specific criteria to decide how much to order and when to order, by background characteristics, Namibia HFC 2009

	Amount ordered based on:[1]					Stock orders placed routinely:					
Background characteristics	Maintaining a fixed stock	Same amount ordered each time	Utilisation	Other	Don't know/ missing	When stock falls to a pre-determined level	Fixed time	When needed	Other	Don't know/ missing	Number of facilities
					MEDICINES						
Type of facility											
Hospital	42	0	51	0	7	27	53	11	0	9	45
Health centre	50	0	45	0	5	20	52	23	0	5	44
Clinic	34	0	63	0	3	25	42	28	0	5	267
Sick bay	56	0	33	11	0	33	33	33	0	0	9
Managing authority											
MoHSS	39	0	56	0	4	24	48	22	0	7	284
Mission/NGO	30	0	70	0	0	22	59	19	0	0	27
Private	24	0	73	0	2	27	15	56	0	2	41
MoD/POLICE	62	0	31	8	0	46	23	31	0	0	13
Region											
Caprivi	50	0	50	0	0	18	64	18	0	0	28
Erongo	50	0	50	0	0	36	27	36	0	0	22
Hardap	48	0	48	5	0	33	38	29	0	0	21
Karas	36	0	52	0	12	20	40	24	0	16	25
Kavango	21	0	71	0	7	18	30	43	0	9	56
Khomas	46	0	50	0	4	27	38	31	0	4	26
Kunene	30	0	67	0	4	7	63	26	0	4	27
Ohangwena	42	0	58	0	0	55	10	26	0	10	31
Omaheke	46	0	54	0	0	31	46	23	0	0	13
Omusati	43	0	53	0	4	4	73	16	0	6	49
Oshana	10	0	80	0	10	0	70	20	0	10	20
Oshikoto	5	0	95	0	0	14	57	29	0	0	21
Otjozondjupa	73	0	27	0	0	77	15	4	0	4	26
Total	38	0	58	0	4	25	44	26	0	5	365
					ARVS						
Type of facility											
Hospital	41	0	59	0	0	22	51	17		7	41
Health centre	24	0	73	3	0	30	16	51	3	0	37
Clinic	26	2	71	1	0	32	13	55	1	0	142
Sick bay	-	-	-	-	-	-	-	-	-	-	0
Managing authority											
MoHSS	28	2	70	1	0	29	21	47	1	2	188
Mission/NGO	20	0	80	0	0	33	20	47	0	0	15
Private	38	0	56	6	0	25	13	56	6	0	16
MoD/POLICE	100	0	0	0	0	100	0	0	0	0	1
Region											
Caprivi	23	0	77	0	0	23	8	69	0	0	13
Erongo	33	11	56	0	0	33	22	44	0	0	9
Hardap	63	0	25	13	0	75	13	0	13	0	8
Karas	60	7	33	0	0	13	40	40	0	7	15
Kavango	15	4	81	0	0	22	15	63	0	0	27
Khomas	36	0	64	0	0	18	45	36	0	0	11
Kunene	0	0	92	8	0	8	33	50	8	0	12
Ohangwena	36	0	64	0	0	56	16	24	0	4	25
Omaheke	29	0	71	0	0	14	29	57	0	0	14
Omusati	27	0	73	0	0	22	11	62	3	3	37
Oshana	6	0	94	0	0	6	25	69	0	0	16
Oshikoto	15	0	85	0	0	8	23	69	0	0	13
Otjozondjupa	45	0	55	0	0	80	15	5	0	0	20
Total	29	1	69	1	0	30	20	47	1	1	220

Table A-3.17 System for ordering medicines and ARVs where order is placed by external authorities

Among facilities providing medicines and ARVs where stock orders are placed by external authorities, percentage where the amount provided is based on activity level or a fixed supply is provided, by background characteristics, Namibia HFC 2009

Background characteristics	System for determining amount provided: Based on activity level	Fixed supply	Don't know/ missing	Number of facilities where external authorities decide how much to order
MEDICINES				
Type of facility				
Hospital	100	0	0	1
Health centre	100	0	0	1
Clinic	46	29	25	24
Managing authority				
MoHSS	46	29	25	24
Mission/NGO	100	0	0	1
Private	100	0	0	1
Region				
Caprivi	-	-	-	0
Erongo	46	15	38	13
Hardap	-	-	-	0
Karas	100	0	0	2
Kavango	100	0	0	1
Khomas	50	50	0	2
Kunene	0	100	0	1
Omaheke	50	0	50	2
Omusati	100	0	0	1
Oshikoto	100	0	0	1
Otjozondjupa	0	100	0	3
Total	50	27	23	26
ARVS				
Type of facility				
Hospital	100	0	0	2
Health centre	0	50	50	2
Clinic	46	21	33	24
Managing authority				
MoHSS	46	21	32	28
Mission/NGO	-	-	-	0
Private	-	-	-	0
Region				
Caprivi	0	0	100	1
Erongo	44	11	44	9
Hardap	67	33	0	3
Karas	33	33	33	3
Kavango	67	33	0	3
Khomas	0	0	100	2
Kunene	50	25	25	4
Omaheke	-	-	-	0
Omusati	0	100	0	1
Oshikoto	100	0	0	1
Otjozondjupa	100	0	0	1
Total	46	21	32	28

Table A-3.18 Knowledge and capacity for autoclave processing of equipment

Among facilities with a functioning autoclave machine, percentage where the informant's response to questions on processing temperature and pressure was excellent or good, Namibia HFC 2009

Items	Percentage of facilities providing indicated response
Temperature	
Excellent[1]	66
Good[2]	23
Don't know/invalid	11
Pressure	
Excellent[3]	68
Don't know/invalid	32
Temperature and pressure	
Both excellent	58
Both al least good	9
Don't know/invalid response for temperature or pressure	32
Total number of facilities with functioning autoclave	53

[1] Autoclave had automatic temperature control, or response was 121°C to 132°C.
[2] Response was more than 132°C but was less than 361°C (high cutoff point was selected to include any response that appeared valid).
[3] Either automatic machine or response was PPI of 15-30 or ATM of 1 or 2.

Table A-3.19 Storage conditions for sterilised or high-level disinfected items

Percentage of facilities with sterilised or disinfected (HLD) items present and among these, percentage with specific storage conditions for processed items, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities with sterilised or HLD items present	Number of facilities	Among facilities with sterilised or HLD items, percentage with: Sterile/HLD status storage conditions[1]	Clean, but not sterile, storage conditions[2]	Processing dates observed on processed and stored items	Sterile/HLD status storage conditions and processing dates on sterilised items	Number of facilities with stored processed items
Type of facility							
Hospital	100	45	96	38	96	91	45
Health centre	91	47	93	40	84	81	43
Clinic	80	295	80	29	79	69	235
Sick bay	56	9	40	60	40	40	5
Managing authority							
MoHSS	87	306	85	28	85	76	265
Mission/NGO	89	28	80	36	76	68	25
Private	63	49	84	61	65	61	31
MoD/POLICE	54	13	43	71	43	43	7
Region							
Caprivi	86	28	79	50	88	79	24
Erongo	81	36	90	34	76	72	29
Hardap	100	21	95	62	76	76	21
Karas	80	25	85	40	95	80	20
Kavango	75	57	70	23	77	60	43
Khomas	73	33	75	58	63	63	24
Kunene	93	28	69	0	100	69	26
Ohangwena	91	32	97	7	97	97	29
Omaheke	100	16	81	19	88	75	16
Omusati	84	49	88	24	78	78	41
Oshana	90	20	78	22	44	39	18
Oshikoto	82	22	83	83	89	78	18
Otjozondjupa	66	29	100	26	89	89	19
Total	83	396	83	32	81	73	328

[1] Items are wrapped and sealed with time-steam-temperature (TST) tape or are in a sterile/HLD box that clasps shut, and storage area is dry and clean.
[2] Items may be wrapped but not sealed, unwrapped on a tray under a cloth, unwrapped on a tray in the steriliser of autoclave, or sitting in disinfecting solution, and storage area is dry and clean.

Table A-3.20 Specific items for infection control that were available in ALL relevant service areas

Percentage of facilities where the indicated infection control items were either observed (or reported available when the service being assessed was not being offered at the time of the survey) in ALL of the service delivery areas assessed for that facility, by background characteristics, Namibia HFC 2009

	Percentage of facilities with these items in **ALL** service areas:[1]										
Background characteristics	Running water	Soap	Soap and running water	Hand disinfectant	Soap and running water or else hand disinfectant	Clean latex or sterile gloves	Sharps box	Disinfectant (Hibitane/ Alcohol)	All items present in all relevant sites	Waste receptacle[2]	Number of facilities
Type of facility											
Hospital	82	62	60	38	71	76	87	31	22	9	45
Health centre	81	55	53	21	70	60	68	32	26	4	47
Clinic	74	65	58	37	74	72	84	53	40	17	295
Sick bay	89	78	78	33	78	78	67	67	56	22	9
Managing authority											
MoHSS	74	60	54	32	71	68	81	44	33	12	306
Mission/NGO	61	50	32	25	50	71	79	61	32	0	28
Private	94	90	88	61	96	90	94	63	59	39	49
MoD/POLICE	92	85	85	31	85	77	69	62	54	15	13
Region											
Caprivi	75	54	54	32	64	86	86	75	54	25	28
Erongo	97	67	64	47	78	72	83	56	47	25	36
Hardap	62	76	52	90	90	86	86	62	52	19	21
Karas	88	64	64	24	88	68	80	44	36	20	25
Kavango	77	58	51	53	74	81	89	70	56	7	57
Khomas	94	88	88	45	97	70	88	58	45	24	33
Kunene	86	82	79	46	86	93	100	71	61	11	28
Ohangwena	53	50	41	22	63	34	56	28	22	19	32
Omaheke	81	31	31	44	56	94	88	63	38	19	16
Omusati	82	80	69	14	86	84	82	31	27	8	49
Oshana	80	85	70	10	70	65	85	10	10	5	20
Oshikoto	36	27	23	9	27	32	73	41	5	5	22
Otjozondjupa	62	45	45	21	48	52	72	10	3	14	29
Total	76	64	58	35	73	71	82	48	37	15	396

[1] Survey criteria required that the item be available in the service delivery room or immediately adjacent, and the item must be observed. If the service was not being provided on the day of the survey, a report that an item was normally available when services were being offered was noted and included in this table. In most cases this added only 0-1 percentage points. Items assessed for each service were: soap, running water, hand disinfectant, clean latex or sterile gloves, disinfectant and sharps box in immunisation area, injection room, consultation area for sick children, and consultation/examination area for STI services, family planning, antenatal care, delivery services, general outpatient area, and VCT sites where blood is drawn or HIV testing is conducted.

[2] Waste receptacle with plastic liner and lid. This is not a component of the aggregate because, while important for infection control, it has not been commonly introduced.

Table A-3.21 Availability of supplies for preventing nosocomial infections

Percentage of facilities with infection control supplies available in facility stores, by back ground characteristics Namibia HFC 2009

Background characteristics	Percentage of facilities with the following items in store						All items for infection control indicator[2]	Number of facilities
	Hand washing soap	Hand disinfectant	Latex gloves	Needles/ syringes	Disinfectant	All items present in stores[1]		
Type of facility								
Hospital	53	91	100	98	93	53	18	45
Health centre	70	49	96	98	85	38	4	47
Clinic	73	61	92	93	79	40	2	295
Sick bay	56	22	100	67	67	22	0	9
Managing authority								
MoHSS	72	66	96	96	84	43	2	306
Mission/NGO	61	43	86	100	71	25	11	28
Private	63	59	80	80	71	37	12	49
MoD/POLICE	69	23	92	77	77	23	0	13
Region								
Caprivi	86	71	100	89	89	50	0	28
Erongo	83	72	89	94	92	53	6	36
Hardap	57	86	95	100	90	48	10	21
Karas	56	88	100	100	92	52	4	25
Kavango	75	81	96	95	91	54	5	57
Khomas	61	45	82	79	67	30	6	33
Kunene	43	54	89	100	89	11	0	28
Ohangwena	88	56	94	91	88	50	6	32
Omaheke	75	94	94	94	88	69	6	16
Omusati	82	53	98	98	69	35	2	49
Oshana	65	25	95	75	50	20	5	20
Oshikoto	73	23	77	100	59	18	5	22
Otjozondjupa	48	48	97	100	79	31	0	29
Total	70	62	93	94	81	41	4	396

[1] (Hand washing soap or hand disinfectant), disinfectant, needles and syringes, and latex gloves are available in facility stores.
[2] Soap and running water or else hand disinfectant, sharps box, disinfecting solution and latex gloves in all relevant service areas within facility, plus (soap or hand disinfectant), disinfectant for cleaning surfaces, needles and syringes, and latex gloves are in stock and facility has functioning equipment for sterilisation or high level disinfection of equipment.

Table A-3.22.1 Waste disposal methods: infectious waste

Percentage of facilities that use specific methods to dispose of infectious waste, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities in which infectious waste is:							Number of facilities
	Report no waste	Removed offsite	Burned in incinerator in facility	Burned unprotected on flat ground in facility	Burned on protected ground or in pit in facility	Dumped in unprotected area in facility without burning	Other response/ missing	
Type of facility								
Hospital	0	36	51	0	2	0	11	45
Health centre	0	40	21	11	19	0	9	47
Clinic	0	40	8	14	27	1	9	295
Sick bay	11	44	0	11	22	0	11	9
Managing authority								
MoHSS	0	37	15	14	24	1	9	306
Mission/NGO	0	14	25	11	50	0	0	28
Private	0	76	12	0	4	0	8	49
MoD/POLICE	8	38	0	8	15	0	31	13
Region								
Caprivi	4	11	4	14	61	0	7	28
Erongo	0	53	11	0	0	0	36	36
Hardap	0	52	19	5	14	0	10	21
Karas	0	48	20	0	12	0	20	25
Kavango	0	26	16	11	42	0	5	57
Khomas	0	91	0	0	3	0	6	33
Kunene	0	32	11	21	11	4	21	28
Ohangwena	0	25	44	31	0	0	0	32
Omaheke	0	50	6	6	38	0	0	16
Omusati	0	22	14	22	31	4	6	49
Oshana	0	40	15	10	30	0	5	20
Oshikoto	0	14	9	27	50	0	0	22
Otjozondjupa	0	72	17	0	10	0	0	29
Total	0	40	15	12	23	1	9	396

Table A-3.22.2 Waste disposal methods: sharps waste

Percentage of facilities that use specific methods to dispose of sharps waste, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities in which sharps waste is: Report no waste	Removed offsite	Burned in incinerator in facility	Burned on protected ground or in pit in facility	Other response/ missing	Number of facilities
Type of facility						
Hospital	0	38	51	0	11	45
Health centre	0	83	13	0	4	47
Clinic	0	93	2	0	4	295
Sick bay	11	78	0	0	11	9
Managing authority						
MoHSS	0	86	8	0	5	306
Mission/NGO	0	79	18	0	4	28
Private	0	84	10	0	6	49
MoD/POLICE	8	85	0	0	8	13
Region						
Caprivi	4	89	0	0	7	28
Erongo	0	64	11	0	25	36
Hardap	0	81	14	0	5	21
Karas	0	68	16	4	12	25
Kavango	0	88	11	0	2	57
Khomas	0	97	0	0	3	33
Kunene	0	89	11	0	0	28
Ohangwena	0	94	6	0	0	32
Omaheke	0	94	6	0	0	16
Omusati	0	90	4	0	6	49
Oshana	0	90	10	0	0	20
Oshikoto	5	82	9	0	5	22
Otjozondjupa	0	83	17	0	0	29
Total	1	85	9	0	5	396

Chapter 4

Table A-4.1 Frequency of availability of child health services

Among facilities offering outpatient care for sick children, routine growth monitoring services, routine child immunisation services, and BCG immunisation, percentage providing the service at the facility at specific frequencies, by background characteristics, Namibia HFC 2009

	Curative outpatient care for sick children			Growth monitoring				Routine series of child immunisation[1]				BCG immunisation			
Background characteristics	1-2	5+	Number of facilities offering curative outpatient care for sick children	1-2	3-4	5+	Number of facilities offering growth monitoring	1-2	3-4	5+	Number of facilities offering routine series of immunisation	1-2	3-4	5+	Number of facilities offering BCG immunisation
Type of facility															
Hospital	3	90	29	11	11	78	18	6	12	82	17	4	4	92	25
Health centre	0	100	45	2	2	95	43	5	2	93	43	0	2	98	44
Clinic	2	98	273	4	2	94	258	8	1	91	267	5	0	95	243
Managing authority															
MoHSS	2	98	299	4	1	95	275	5	1	94	279	3	0	96	274
Mission/NGO	0	100	27	4	8	88	26	19	7	74	27	7	7	85	27
Private	5	95	21	11	11	78	18	19	10	71	21	18	0	82	11
Region															
Caprivi	0	100	27	0	4	96	27	0	4	96	27	0	4	96	27
Erongo	0	100	22	6	11	83	18	20	10	70	20	7	0	93	14
Hardap	0	100	20	0	0	100	16	0	0	100	17	0	0	100	19
Karas	5	95	20	11	0	89	18	10	0	90	20	0	0	100	15
Kavango	0	100	56	2	4	94	53	7	4	89	56	4	4	93	56
Khomas	0	100	19	11	5	84	19	5	5	89	19	0	0	100	9
Kunene	0	96	27	0	0	100	24	0	0	100	24	0	0	100	24
Ohangwena	6	91	32	10	3	86	29	14	0	86	29	14	0	86	29
Omaheke	0	100	15	0	0	100	13	0	0	100	13	0	0	100	14
Omusati	0	100	47	0	0	100	44	0	0	100	44	0	0	100	45
Oshana	6	94	16	7	0	93	15	13	0	88	16	12	0	88	17
Oshikoto	9	91	22	20	0	80	20	29	0	71	21	14	0	86	22
Otjozondjupa	0	100	24	0	0	100	23	5	0	95	21	5	0	95	21
Total	2	98	347	4	2	93	319	7	2	91	327	4	1	95	312

Note: Some facilities may offer the service less than one day per week so percentage may not add up to 100 percent.
[1] Pentavalent, polio and measles vaccines only. BCG may not be offered on the same schedule as other routine vaccines.

Table A-4.2 Availability of child health services through village outreach activities

Among all facilities, percentage offering curative care for sick children, routine growth monitoring, and child immunisation through outreach services to villages, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities offering indicated services through outreach				Number of facilities
	Sick child services	Growth monitoring	Routine series of child immunisation without BCG[1]	All child immunisation including BCG[2]	
Type of facility					
Hospital	14	14	0	14	44
Health centre	46	46	0	50	46
Clinic	16	14	1	16	293
Managing authority					
MoHSS	20	18	1	21	306
Mission/NGO	39	43	0	43	28
Private	0	0	0	0	49
Region					
Caprivi	0	0	0	4	27
Erongo	22	9	6	16	32
Hardap	20	20	0	20	20
Karas	16	16	4	12	25
Kavango	16	18	0	18	56
Khomas	0	0	0	0	31
Kunene	7	4	0	11	28
Ohangwena	13	16	0	19	32
Omaheke	25	25	0	25	16
Omusati	41	41	0	43	49
Oshana	50	44	0	50	18
Oshikoto	18	18	0	18	22
Otjozondjupa	22	15	0	19	27
Total	19	17	1	20	383

[1] Oral polio vaccine (OPV), DPT/pentavalent, and measles but no BCG vaccine offered through outreach at least one day per month.
[2] OPV, DPT/pentavalent, measles, and BCG vaccines offered through outreach at least one day per month.

Table A-4.3 Availability of child vaccines and Vitamin A

Among facilities offering child immunisation services and routinely storing vaccines, percentage with all valid child vaccines and vitamin A observed on the day of the survey, by background characteristics Namibia HFC 2009

Background characteristics	Percentage of facilities offering immunisation services and storing vaccines with vaccines and vitamin A observed						Number of facilities offering child immunisation services and storing vaccines
	BCG	Polio	Penta-valent[1]	Measles	All basic child vaccines available[2]	Vitamin A in area with vaccines	
Type of facility							
Hospital	88	88	76	71	59	82	17
Health centre	93	98	100	95	86	98	43
Clinic	83	93	95	93	75	93	261
Managing authority							
MoHSS	87	93	95	93	79	97	275
Mission/NGO	100	100	96	93	93	100	27
Private	21	79	79	79	11	26	19
Region							
Caprivi	92	81	96	88	73	96	26
Erongo	44	94	94	78	33	94	18
Hardap	88	94	94	88	82	82	17
Karas	75	95	95	80	65	80	20
Kavango	93	91	93	91	75	98	56
Khomas	50	83	83	89	44	61	18
Kunene	75	88	88	92	71	96	24
Ohangwena	90	93	97	97	86	100	29
Omaheke	100	100	100	100	100	100	13
Omusati	88	100	98	95	81	95	43
Oshana	87	100	100	100	87	100	15
Oshikoto	100	100	95	100	95	95	21
Otjozondjupa	90	95	95	95	90	90	21
Total	84	93	94	92	76	93	321

[1] Pentavalent = DPT + Hepatitis B + Haemophilus Influenza B
[2] BCG, polio, DPT/pentavalent, and measles vaccines.

Table A-4.4 Equipment, supplies, and recordkeeping systems for child immunisation services

Among facilities offering child immunisation services, percentage with equipment and supplies, infection control items, and recordkeeping systems observed, by background characteristics, Namibia HFC 2009

	Equipment and supplies			Items for infection control							Recordkeeping system			
Background characteristics	Blank child immunisation record	Syringes and needles	Vaccine carriers with ice pack[1]	Soap	Running water	Hand disinfectant	Soap & Water or else hand disinfectant	Latex gloves	Sharps box	Decontaminant	Register	Tally sheet	Monitoring of community coverage[2]	Number of facilities offering child immunisation services
Type of facility														
Hospital	82	88	94	88	100	76	94	94	100	88	76	76	18	17
Health centre	81	95	100	86	98	49	93	93	95	58	100	98	65	43
Clinic	90	94	92	85	82	59	89	90	99	72	93	94	49	267
Managing authority														
MoHSS	89	95	96	84	86	58	91	90	99	70	97	99	52	279
Mission/NGO	93	81	93	89	70	44	70	96	93	78	100	100	56	27
Private	81	95	48	95	90	76	100	95	100	76	38	19	0	21
Region														
Caprivi	100	96	96	63	78	52	78	96	100	93	96	100	33	27
Erongo	85	90	85	90	95	85	95	80	95	75	85	90	55	20
Hardap	100	94	100	88	82	100	100	94	100	82	88	82	59	17
Karas	90	100	90	85	100	85	100	95	100	75	90	80	55	20
Kavango	84	98	93	77	86	79	93	98	98	91	96	96	54	56
Khomas	84	95	74	95	100	47	95	74	95	68	68	63	42	19
Kunene	88	100	96	100	92	58	100	100	100	92	96	96	29	24
Ohangwena	90	79	90	90	69	55	93	83	97	52	97	100	69	29
Omaheke	100	100	100	85	92	85	100	100	100	92	100	100	92	13
Omusati	86	98	95	93	86	36	93	95	100	59	95	98	41	44
Oshana	94	100	94	94	88	25	81	94	100	19	100	100	56	16
Oshikoto	100	86	100	81	71	19	67	76	95	62	100	100	38	21
Otjozondjupa	62	86	95	76	81	38	71	76	95	33	90	100	38	21
Total	88	94	93	85	85	58	90	91	98	71	93	94	49	327

[1] If a facility reported it purchased ice for the vaccines, this was accepted in place of the ice pack.
[2] Measles coverage or DPT/pentavalent dropout rate was documented

Table A-4.5 Availability of equipment and supplies for assessment of the sick child

Among facilities that provide curative outpatient care for sick children, percentage with observed items in the service delivery area to support infection control, quality of services, preventive services, and assessment of the sick child, by type of facility, Namibia HFC 2009

Items	Hospital	Health centre	Clinic	Total percentage
Infection control items				
Soap	93	87	84	85
Running water	100	98	82	86
Hand disinfectant	79	51	58	59
Soap & running water, or else hand disinfectant	97	93	89	90
Latex gloves	97	93	90	91
Sharps container	97	96	99	98
Decontaminant	76	60	71	70
All items for infection control	69	51	62	61
Waste receptacle with plastic liner and lid	41	42	33	35
All items for infection control including waste receptacle	34	27	22	24
Items to support quality of care				
Health passport	72	89	90	88
Treatment guidelines/standards (any)	76	96	86	86
Visual aids for health education	24	76	52	52
All items to support quality of care	21	71	43	45
Preventive measures				
Capacity to provide vaccinations[1]	14	36	40	37
Infant weighing scale	52	93	76	76
Child weighing scale	69	87	79	79
Both infant and child weighing scale	38	82	63	63
All preventive measures	3	31	25	24
Equipment for assessment				
Thermometer	97	93	96	96
Timer[2]	79	71	68	69
Pitcher for mixing ORS	48	84	74	73
Cup/spoon for giving ORS	45	82	79	77
ORS packet in sick child service area	79	98	92	92
ORS packet in facility (pharmacy or sick child service area)	100	100	96	97
All three Oral rehydration therapy (ORT)	38	78	68	67
All equipment for assessment	34	56	46	46
ORT Corner observed	24	56	46	45
Number of facilities offering sick child services	29	45	273	347

[1] Vaccines, equipment, vaccine carriers and immunisation cards infection control items all available. Register and monitoring of coverage were not considered essential for providing vaccines for sick children on the day of survey.

[2] Either a minute timer or wristwatch with a second hand that could be used to time one minute; includes facility equipment or one owned by staff.

Table A-4.6 Availability of guidelines and teaching materials

Among facilities providing curative outpatient care for sick children, percentage where guidelines and client educational aids were observed to be available, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities offering sick child services with:					Number of facilities offering sick child services
	Treatment guidelines[1]	IMCI chart booklet	IMCI counselling cards for provider	IMCI mother cards	Other visual aids	
Type of facility						
Hospital	76	10	17	7	17	29
Health centre	93	64	42	16	51	45
Clinic	85	39	27	7	36	273
Managing authority						
MoHSS	90	43	28	9	35	299
Mission/NGO	78	37	48	7	44	27
Private	24	5	5	0	43	21
Region						
Caprivi	89	59	33	4	44	27
Erongo	82	50	36	14	36	22
Hardap	75	45	35	5	35	20
Karas	70	10	10	0	35	20
Kavango	80	41	32	11	25	56
Khomas	74	42	32	16	63	19
Kunene	85	22	22	4	19	27
Ohangwena	91	44	19	0	28	32
Omaheke	93	60	47	33	47	15
Omusati	94	15	15	2	32	47
Oshana	94	88	50	19	56	16
Oshikoto	100	73	50	9	59	22
Otjozondjupa	79	17	8	8	33	24
Total	85	40	28	8	36	347

[1] Any guidelines on management of childhood illnesses, or guideline on management of malaria

Table A-4.7 Availability of immunisation services and outpatient care for sick children on the same day

Among facilities offering curative outpatient care for sick children, percentage reporting that child immunisation (EPI) is available every day that sick child services are offered, and percentage where both sick child and EPI services were observed being offered the day of the survey, by background characteristics, Namibia HFC 2009

Background characteristics	Among facilities offering sick child services, percentage where: EPI services are reported to be available every day that sick child services are offered	On day of survey, both sick child and EPI services were available	Number of facilities offering sick child services
Type of facility			
Hospital	41	48	29
Health centre	93	91	45
Clinic	92	89	273
Managing authority			
MoHSS	89	88	299
Mission/NGO	93	78	27
Private	67	76	21
Region			
Caprivi	100	89	27
Erongo	77	64	22
Hardap	85	85	20
Karas	85	95	20
Kavango	86	84	56
Khomas	84	89	19
Kunene	81	89	27
Ohangwena	84	81	32
Omaheke	87	87	15
Omusati	94	94	47
Oshana	94	100	16
Oshikoto	91	82	22
Otjozondjupa	88	83	24
Total	88	86	347

Table A-4.8 Availability of medicines for treatment of the sick child

Among facilities that provide curative outpatient care for sick children, percentage where first-line, pre-referral, and other essential medications are available, by type of facility, Namibia HFC 2009

Items	Hospital	Health centre	Clinic	Total percentage
First-line oral medicines				
Oral rehydration solution (ORS)	100	100	96	97
Antibiotic: Amoxicillin or Augmentin syrup/ tabs	100	98	96	97
Antibiotic: Cotrimoxazole syrup/tabs	100	98	96	96
Antibiotic: Chloramphenicol syrup/tabs	90	13	5	13
Any of above antibiotics	100	100	98	98
First-line antimalarial: Coartem[1]	93	84	74	77
All first-line oral medicines[2]	93	84	72	75
Other antimalarial				
Cotexin, Arinate, Artesunate	0	2	0	1
Fansidar	93	80	71	74
Pre-referral medicines				
Injectable Chloramphenicol	34	13	6	10
Injectable Ampicillin or Cloxacillin	97	22	1	12
Injectable Penicillin	100	96	82	85
Injectable Gentamycin	100	44	20	30
Injectable Ceftriaxone	100	84	79	82
Intravenous solution with perfusion set[3]	100	98	92	94
Sterile syringes	100	100	100	100
All pre-referral medicines[4]	100	80	70	74
Other essential medicines				
Aspirin or Paracetamol (antipyretic)	100	100	98	98
Vitamin-A (any dose)	93	96	93	93
Iron tablet	21	13	15	15
Albendazole or Mebendazole (deworming)	93	96	85	87
All other essential medicines	21	11	11	12
Number of facilities offering sick child services	29	45	273	347

[1] Coartem is the recommended first-line treatment for malaria in Namibia.
[2] ORS and at least one oral antibiotic and Coartem
[3] Intravenous solutions include: normal saline (0.9%NS) or dextrose and normal saline (5%D/NS) or Ringers lactate or plasmas expanders or 5%D/W.
[4] [Injectable Chloramphenicol or (at least one first-line injectable antibiotic (ampicillin or cloxacillin or penicillin) and at least one second-line injectable antibiotic (ceftriaxone or gentamycin))], and intravenous solution [normal saline (0.9%NS) or dextrose and normal saline (5%D/NS) or Ringers lactate or plasmas expanders or 5%D/W], with perfusion set and sterile syringes

Table A-4.9 Facility utilisation statistics for outpatient care for sick children

Among facilities providing curative outpatient care for sick children, the median number of sick-child consultations per month, by background characteristics, Namibia HFC 2009

Background characteristics	Median monthly number of sick-child consultations	Number of facilities providing consultation data
Type of facility		
Hospital	91	27
Health centre	189	44
Clinic	59	256
Managing authority		
MoHSS	65	296
Mission/NGO	94	26
Private	10	5
Region		
Caprivi	53	27
Erongo	59	21
Hardap	30	17
Karas	26	16
Kavango	88	53
Khomas	167	12
Kunene	31	26
Ohangwena	129	32
Omaheke	73	15
Omusati	66	46
Oshana	101	16
Oshikoto	89	22
Otjozondjupa	60	24
Total	69	327

[1] Median value for the average of the number of months out of the past 12 months for which data were available. Data are from health information system monthly reports available at the facility on the day of the survey. Data were requested for the 12 months preceding the survey, but frequently some months were missing. Information from the months for which data were available was summed and an average monthly number of clients calculated for each facility. This number was then used to calculate the median number of clients per month.

Table A-4.10 Information on user fees for outpatient care for sick children

Percentage of facilities offering curative outpatient care for sick children that charge user fees for specific items, and among facilities with any user fees for sick child services, percentage that publicly post fees, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities charging for the indicated item:							Number of facilities offering sick child services	Discount or exemptions offered	Percentage where fees are posted in public view			Number of facilities having any user fees for sick child services
	Client chart or record	Consultation	Medicines	Lab tests	Registration	Other charges	No charges or don't know			All fees are posted	Some fees are posted	No fees are posted	
Type of facility													
Hospital	31	45	28	10	28	17	0	29	55	52	3	45	29
Health centre	16	62	18	0	33	9	2	45	41	23	5	73	44
Clinic	20	59	20	3	21	4	1	273	52	25	3	72	269
Managing authority													
MoHSS	18	56	14	1	24	5	1	299	49	27	2	71	295
Mission/NGO	37	56	37	0	15	11	0	27	41	15	4	81	27
Private	24	90	81	48	24	14	5	21	80	40	20	40	20
Region													
Caprivi	4	89	0	0	7	0	4	27	62	35	0	65	26
Erongo	27	55	14	5	18	0	0	22	59	45	9	45	22
Hardap	20	75	25	0	15	25	0	20	80	35	10	55	20
Karas	20	70	25	15	15	25	0	20	65	40	5	55	20
Kavango	18	45	46	4	20	5	0	56	50	21	2	77	56
Khomas	37	63	37	21	37	5	0	19	68	26	16	58	19
Kunene	59	56	4	0	30	4	0	27	44	22	0	78	27
Ohangwena	16	50	3	0	25	3	0	32	47	31	3	66	32
Omaheke	7	100	20	0	7	13	0	15	47	27	0	73	15
Omusati	6	43	26	0	30	2	4	47	51	11	0	87	45
Oshana	6	75	6	0	63	0	0	16	13	19	6	75	16
Oshikoto	45	55	5	5	23	9	0	22	55	23	0	77	22
Otjozondjupa	8	38	21	4	17	0	8	24	14	32	0	68	22
Total	20	58	20	3	23	6	1	347	51	27	3	70	342

Table A-4.11 Out-of-pocket payments for sick child consultations

Among interviewed caretakers of sick children, percentage who reported belonging to a program to prepay or defer child health costs and percentage who reported paying any out-of-pocket fees for sick child services on the day of the survey; and among caretakers who paid any fees for services, median amount (Namibia dollars) paid, by type of facility, Namibia HFC 2009

Type of facility	Percentage who belong to prepayment or cost deferral program	Percentage who paid any out-of-pocket fees this visit among those who:[1]		Number of interviewed caretakers	Median out-of-pocket fees (N$) paid by caretakers who paid anything for child health services on the day of survey, among those who:[1]		Number of interviewed caretakers providing valid responses for out-of-pocket payments who:	
		Belong to program	Do not belong to program		Belong to program	Do not belong to program	Belong to program	Do not belong to program
Hospital	5	4	69	108	9	8	4	75
Health centre	3	3	84	288	5	8	8	240
Clinic	6	4	85	1,148	5	5	47	973
Total	5	4	84	1,544	5	5	59	1,288

[1] Includes any amount paid out-of-pocket including consultation, laboratory test, medicines, or other.

Table A-4.12 Supportive management for providers of child health services

Among interviewed child health service providers, percentage who received training related to their work and personal supervision during the specified time periods, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of interviewed service providers who received:				Number of interviewed child health service providers[2]
	Training related to child health during the 12 months preceding the survey[1]	Personal supervision during the 6 months preceding the survey	Training related to child health during the 12 months and personal supervision during the 6 months preceding the survey	Most recent training in the 13-35 months preceding the survey	
Type of facility					
Hospital	34	72	26	11	303
Health centre	38	76	31	11	201
Clinic	29	72	20	13	415
Managing authority					
MoHSS	31	73	24	12	731
Mission/NGO	38	81	34	12	135
Private	33	46	8	4	53
Region					
Caprivi	27	70	23	20	31
Erongo	27	67	20	7	64
Hardap	15	79	12	9	83
Karas	31	75	18	23	48
Kavango	29	76	23	13	134
Khomas	39	57	20	10	79
Kunene	15	72	9	15	35
Ohangwena	22	77	20	11	90
Omaheke	25	92	23	5	25
Omusati	35	83	28	18	107
Oshana	73	84	63	7	53
Oshikoto	48	67	36	13	108
Otjozondjupa	24	50	15	3	62
Total	32	73	24	12	919

[1] This refers to structured training sessions (either in-service or pre-service) and does not include individual instruction received during routine supervision.
[2] Includes only providers of child health services in facilities offering child health services.

Table A-4.13 Training for child health service providers (I)

Among interviewed child health service providers, percentage who received pre- or in-service training on specific topics related to child health during the 12 months or 13-35 months preceding the survey, by background characteristics, Namibia HFC 2009

Background characteristics	EPI/Cold chain		ARI treatment[1]		Diarrhoea treatment		Nutrition/ micronutrient deficiencies		IMCI[2]		Malaria treatment for children		Number of interviewed child health service providers[3]
	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	
Type of facility													
Hospital	12	9	12	7	13	8	19	9	8	7	16	10	303
Health centre	17	14	14	17	16	17	18	12	15	10	20	15	201
Clinic	14	13	5	10	9	12	10	11	8	9	13	13	415
Managing authority													
MoHSS	15	13	9	11	11	13	14	11	10	9	16	13	731
Mission/NGO	13	8	9	8	10	8	19	8	4	5	14	14	135
Private	13	4	15	5	18	4	19	4	13	4	13	2	53
Region													
Caprivi	17	16	5	18	7	20	7	20	3	14	11	26	31
Erongo	15	11	7	11	9	10	10	10	8	6	13	8	64
Hardap	4	8	4	6	4	6	6	3	4	5	3	4	83
Karas	10	21	16	17	17	19	17	18	15	14	19	12	48
Kavango	14	9	9	8	11	9	12	10	6	6	14	15	134
Khomas	26	13	17	11	19	12	18	18	11	18	17	6	79
Kunene	6	6	0	4	2	10	4	5	6	7	3	11	35
Ohangwena	3	15	5	13	8	14	5	12	3	8	7	14	90
Omaheke	15	5	5	0	5	0	5	2	7	8	15	5	25
Omusati	16	16	6	15	8	16	14	15	8	5	18	15	107
Oshana	37	21	29	21	28	29	48	13	31	12	49	23	53
Oshikoto	18	10	15	9	17	12	27	6	15	8	24	16	108
Otjozondjupa	9	1	4	2	11	1	12	3	8	4	7	1	62
Total	14	12	10	11	12	12	15	10	10	8	16	12	919

[1] Acute respiratory infection
[2] Integrated management of childhood illness
[3] Includes only providers of child health services in facilities offering child health services

Table A-4.14 Training for child health service providers (II)

Among interviewed child health service providers, percentage who received pre- or in-service training on specific topics related to child health during the 12 months or 13-35 months preceding the survey, by background characteristics, Namibia HFC 2009

Background characteristics	Breastfeeding		Complementary feeding for infant		Nutritional assessment		Paediatric AIDS training		Paediatric ART training		Number of interviewed child health service providers[1]
	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	
Type of facility											
Hospital	21	9	20	9	15	8	2	2	4	2	303
Health centre	17	13	16	13	22	7	1	0	5	5	201
Clinic	10	14	9	13	11	7	1	1	5	2	415
Managing authority											
MoHSS	14	13	12	12	14	8	1	1	4	3	731
Mission/NGO	19	12	21	11	17	6	2	1	4	1	135
Private	22	6	23	1	15	1	4	3	18	1	53
Region											
Caprivi	9	22	7	22	12	16	0	0	4	0	31
Erongo	8	12	9	11	6	8	2	1	6	5	64
Hardap	7	5	7	5	7	4	0	0	0	2	83
Karas	20	20	19	19	17	10	5	4	12	4	48
Kavango	12	10	12	11	9	7	1	1	5	0	134
Khomas	17	23	14	21	9	12	1	5	7	5	79
Kunene	6	13	2	15	4	5	0	0	2	0	35
Ohangwena	8	13	4	10	9	10	2	2	4	1	90
Omaheke	13	2	10	5	2	2	0	0	12	0	25
Omusati	12	18	15	18	13	10	0	2	3	5	107
Oshana	35	16	37	11	68	4	4	0	10	11	53
Oshikoto	30	10	28	6	24	5	2	1	3	2	108
Otjozondjupa	15	0	14	2	14	1	0	1	1	1	62
Total	15	12	14	11	15	7	1	1	5	3	919

[1] Includes only providers of child health services in facilities offering child health services

Table A-4.15 Supportive supervision for child health service providers

Among interviewed child health providers who were personally supervised in the 6 months preceding the survey, median number of times they were supervised, and percentage who reported specific activities by the supervisor during the last visit, by background characteristics, Namibia HFC 2009

Background characteristics	Median number of times staff were supervised in the 6 months preceding the survey	Percentage of providers reporting that during the last supervisory visit, the supervisor:						Number of providers of child health services who were supervised in the 6 months preceding the survey[1]
		Checked records	Observed work	Provided feedback	Provided updates	Discussed problems	Delivered supplies	
Type of facility								
Hospital	4	96	86	90	78	86	30	217
Health centre	4	93	83	89	73	86	33	153
Clinic	3	92	71	84	70	86	36	297
Managing authority								
MoHSS	3	93	75	86	74	87	34	533
Mission/NGO	3	93	91	89	70	81	31	109
Private	3	93	100	95	82	97	23	24
Region								
Caprivi	2	88	60	68	66	80	47	22
Erongo	4	99	79	86	68	86	25	43
Hardap	3	91	80	93	71	87	23	66
Karas	3	98	92	90	72	98	36	36
Kavango	3	89	86	84	64	75	43	102
Khomas	4	82	74	81	70	87	43	45
Kunene	3	93	71	88	61	92	37	25
Ohangwena	3	96	65	90	79	81	28	69
Omaheke	3	100	88	94	86	91	37	23
Omusati	3	98	78	92	79	91	21	89
Oshana	6	97	81	89	90	90	39	45
Oshikoto	3	92	77	83	70	89	34	72
Otjozondjupa	3	91	79	84	79	84	40	31
Total	3	93	78	87	73	86	33	667

[1] Includes only providers of child health services in facilities offering child health services

Table A-4.16 Observed assessments, examinations, and treatments for sick children

Percentage of observed children for whom the indicated assessment, examination, or intervention was a component of their consultation, by type of facility, Namibia HFC 2009

Components of consultation	Hospital	Health centre	Clinic	Total percentage
Consultation conducted by specialist/medical officer/ medical assistant	35	6	3	6
Consultation conducted by registered nurse/midwife	37	37	41	40
Consultation conducted by enrolled nurse/midwife	26	58	55	53
History: assessment of general danger signs				
Inability to eat or drink anything	43	46	44	44
Vomiting everything	51	50	50	50
Convulsions	25	14	18	18
All general danger signs	22	9	11	12
History: assessment of main symptoms				
Cough or difficult breathing	95	88	91	91
Diarrhoea	53	63	57	58
Fever	92	86	88	88
All three main symptoms[1]	50	53	48	49
Ear pain or discharge	30	25	23	24
All 3 main symptoms plus ear pain/discharge[2]	13	18	16	16
Blood in stool	20	13	13	13
All 3 main symptoms + ear pain/discharge + blood in stool	8	4	4	4
Physical examination				
Felt temperature	71	31	42	42
Measured temperature (observed or system)[3]	99	100	100	100
Any assessment of temperature	99	100	100	100
Assessed anaemia: Looked at palms	23	16	20	19
Assessed anaemia: Looked at eye conjunctiva or mucosa of mouth	27	26	29	28
Any assessment of anaemia	41	35	38	38
Assessed dehydration	38	26	28	28
Counted respiratory rate	36	33	42	40
All key physical checks[4]	12	8	9	9
Auscultated	47	37	42	41
Check mouth and throat	57	59	55	56
Looked in ear	33	19	25	25
Felt behind ear	22	12	17	17
Checked for pedal oedema (press both feet)	16	4	9	8
Removed clothing and observed musculature	38	21	29	28
All physical checks[5]	1	0	1	1
Essential advice				
Increase fluids	22	15	28	25
Continue feeding	36	19	36	33
Symptoms for immediate return	32	26	35	33
All three essential messages	16	5	14	13
Drinking/feeding practice during illness				
Feeding/breastfeeding practices	43	37	46	44
Observed if child can drink or suck	18	17	19	19
Both assessments of drinking/feeding status	15	10	11	11
Number of observed children	108	288	1,148	1,544

[1] Assessed cough, diarrhoea, fever.
[2] Assessed cough, diarrhoea, fever, and ear symptoms.
[3] Either the provider or another health worker is observed measuring the child's temperature, or the facility has a system in which all sick children have their temperature measured prior to being seen by a provider.
[4] Counted respiratory rate, assessed presence of fever (either measured or by touch), and assessed presence of anaemia (either palms or mucosa).
[5] Counted respiratory rate, assessed presence of fever (either measured or by touch), assessed presence of anaemia (either palms or mucosa), auscultated, checked mouth and throat, checked ear, checked feet (pedal oedema), and checked musculature.

Table A-4.17 Children sent home with diagnosis and appropriate treatment

Percentage of observed children sent home after consultation with indicated diagnoses, and among these, percentage who received appropriate treatment, by type of facility, Namibia HFC 2009

Item	Hospital	Health centre	Clinic	Total percentage
Child diagnosis				
Diarrhoea without dysentery or amoebiasis	19	25	19	20
Pneumonia	7	6	8	7
Malaria	16	6	9	9
Diarrhoea, pneumonia, or malaria	41	33	32	33
Number of observed children sent home after consultation	73	260	1,056	1,389
Among children with indicated diagnosis, percent who received correct treatment				
Diarrhoea without dysentery or amoebiasis	81	77	86	84
Pneumonia	31	96	95	91
Malaria/fever	61	32	51	50
Diarrhoea, pneumonia, or malaria	67	75	81	79
Among children sent home, percentage with:				
Malaria diagnosis	16	6	9	9
Namibia treatment guidelines for malaria[1] were followed	0	0	7	6

[1] Child has been sick for not more than a day, diagnosed with malaria at the facility, prescribed Coartem, caretaker counselled on signs and symptoms for which to immediately bring child back, caretaker feels comfortable/confident about how to proceed with treatment at home.

Table A-4.18 Prescriptions and medicines provided for the observed sick child

Percent of interviewed caretakers of sick children, percentage who reported child received dose of medicine or injection at the facility; among observed sick children who were prescribed or provided oral medicines, percentage whose caretakers were told how to administer medicine and percentage who received first dose at facility; and among interviewed caretakers of children who received medicine or prescription, percentage who had medicine or prescription on departure from the facility, percentage who reported being told how to administer the medicine at home, and percentage who felt they understood how to administer each of the medicines at home, by type of facility, Namibia HFC 2009

Components of consultation	Hospital	Health centre	Clinic	Total percentage
Child was provided a dose of oral medicine at the facility	30	33	36	35
Child received injection at the facility or prescription for injection	4	3	4	4
Number of interviewed caretakers of sick children	108	288	1,148	1,544
Observed during consultation				
Caretaker told how to administer medications[1]	57	97	97	95
Caretaker asked to repeat instructions	13	16	17	17
Child received first dose of prescribed oral medicine at facility	33	52	40	42
Antibiotic was prescribed	74	85	79	80
Number of observed sick children who were prescribed or provided oral medicines	86	267	1,078	1,431
Observed/reported during exit interview				
Caretaker has all medicines	72	96	94	93
Caretaker has some medicines and some prescriptions	0	1	3	3
Caretaker has only prescriptions	28	3	3	4
Child received or was prescribed an injectable medicine	4	2	4	4
Reported by caretaker				
Was told how to give the medicine at home	76	97	98	96
Feels comfortable in knowledge of how much of each medicine to give at home	84	95	98	96
Number of interviewed caretakers of sick children who received prescription, medicine, or both to be taken at home	88	274	1,084	1,445

[1] Caretaker of sick child told how to administer oral treatment(s)

Table A-4.19 Observed preventive assessments for sick children

Percentage of observed children whose weight, feeding and immunisation status were assessed during the consultation and whose caretakers were interviewed, by type of facility, Namibia HFC 2009

Components of consultation	Hospital	Health centre	Clinic	Total percentage
Preventive measures				
Child weighed	99	99	95	96
Weight plotted	71	82	69	72
Normal feeding assessed (<24 months)	51	36	46	44
Normal breastfeeding assessed (<24 months)	38	23	35	33
Normal feeding assessed (≥24 months)	53	26	36	35
Any age normal feeding/breastfeeding practices assessed	52	32	42	41
Immunisation status assessed (<24 months)	88	93	90	91
Immunisation status assessed (≥24 months)	91	93	88	89
Any age immunisation status assessed	89	93	89	90
Number of observed children whose caretakers were interviewed				
Number of observed children <24 months old	75	180	670	924
Number of observed children ≥24 months old	33	108	478	620
Number of observed children	108	288	1,148	1,544

Table A-4.20 Topics discussed and immunisations received by sick children

Percentage of interviewed caretakers of observed children who reported that a provider discussed selected topics; and percentage of interviewed caretakers of young children (< 24 months) who brought an immunisation card to the facility and reported that the child received an immunisation during that visit, by type of facility, Namibia HFC 2009

Components of consultation	Hospital	Health centre	Clinic	Total percentage
Topics discussed by provider				
Weight or nutritional status of the child	24	21	34	31
General feeding practices	32	29	28	28
Give more food or liquid during the illness	16	23	21	21
Give same as usual amount of food or liquid during the illness	6	4	7	7
Was told what the illness was	49	38	49	47
Number of interviewed caretakers	108	288	1,148	1,544
Caretaker reports child <24 month received immunisation	1	9	8	8
Number of caretakers of children <24 months	75	180	670	924

Table A-4.21 Feedback from caretakers of sick children on service problems

Percentage of interviewed caretakers of sick children who considered specific service issues to be a major problem for them the day of the visit, by type of facility, Namibia HFC 2009

Client service issue	Hospital	Health centre	Clinic	Total percentage
Behaviour/attitude of provider	9	2	3	4
Insufficient explanation about child's illness	5	4	6	6
Waiting time to see provider	28	37	24	27
Quality of examination and treatment	7	5	5	5
Availability of medicines	3	8	10	9
Days facility is open	10	5	10	9
Hours facility is open	12	6	10	10
Cleanliness of facility	14	5	5	6
Cost of services	29	4	3	5
Insufficient visual privacy	10	2	2	3
Insufficient auditory privacy	7	2	2	3
Number of interviewed caretakers of sick children	108	288	1,148	1,544

Table A-4.22 Caretaker choice of facility

Among interviewed caretakers of sick children, percentage who reported this was not the closest health facility to their home, and among these, the main reasons why they did not go to the closest facility, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of interviewed caretakers who report this is not the closest facility to their home	Number of interviewed caretakers of sick children	Percentage of caretakers who say the main reason they did not go to the nearest facility is:													Number of interviewed caretakers for whom this was not the closest facility
			Inconvenient operating hours	Bad reputation	Don't like personnel	No medicines	Prefer anonymity	More expensive	Was referred to this facility	Inconvenient for visit/work location	No/poor staff	Long wait	No/poor service	Other	Don't know/ missing	
Type of facility																
Hospital	39	108	4	4	3	15	0	9	52	1	1	0	5	2	4	42
Health centre	10	288	3	10	0	9	0	0	0	9	21	20	3	22	3	30
Clinic	9	1,148	5	8	1	7	10	6	1	26	3	8	3	20	2	103
Managing authority																
MoHSS	10	1,352	3	6	1	8	7	6	14	19	7	9	3	15	2	138
Mission/NGO	9	131	9	0	0	12	0	0	35	24	5	0	0	7	8	12
Private	40	61	10	20	0	15	5	5	0	5	0	5	9	22	5	25
Region																
Caprivi	4	29	0	0	0	0	0	0	0	50	50	0	0	0	0	1
Erongo	11	67	8	0	8	8	0	0	8	15	0	39	0	8	8	7
Hardap	13	76	0	0	0	0	0	0	0	9	0	19	9	63	0	10
Karas	10	76	0	0	0	0	0	14	0	0	44	0	0	42	0	8
Kavango	13	359	0	5	0	10	15	3	30	23	4	3	0	8	0	48
Khomas	34	109	16	16	0	10	0	10	12	7	0	13	6	3	7	37
Kunene	7	99	0	0	0	0	0	0	0	74	13	13	0	0	0	6
Ohangwena	4	120	0	0	0	13	0	0	20	27	13	27	0	0	0	5
Omaheke	6	112	0	0	0	0	23	54	0	23	0	0	0	0	0	7
Omusati	8	276	0	0	0	10	6	0	6	18	6	0	6	48	0	21
Oshana	15	61	0	32	0	23	0	0	0	11	0	0	0	23	11	9
Oshikoto	8	69	20	0	0	20	0	0	10	20	20	10	0	0	0	5
Otjozondjupa	9	90	7	20	14	7	0	0	7	9	0	9	27	0	0	8
Total	11	1,544	5	7	1	9	6	6	13	17	6	8	4	16	2	174

Table A-4.23 Educational characteristics of caretakers of observed sick children

Percent distribution of interviewed caretakers of sick children by educational level, and percentage of caretakers with primary, informal or no education who are literate by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of interviewed caretakers who have:					Number of interviewed caretakers of sick children	Percentage of interviewed caretakers with primary, informal or no education who:				Number of interviewed caretakers with primary, informal or no education
	No education	Informal	Primary (1-3)/ Upper primary (4-7)	Secondary	Tertiary/ University		Cannot read or write	Can read, cannot write	Can read and write[1]	Missing	
Type of facility											
Hospital	11	0	30	57	1	108	34	1	65	0	45
Health centre	10	1	35	53	1	288	30	4	56	10	133
Clinic	13	1	30	55	1	1,148	34	6	49	11	508
Managing authority											
MoHSS	13	1	32	54	1	1,352	33	5	52	10	609
Mission/NGO	11	2	36	50	1	131	34	8	48	11	64
Private	13	0	8	64	15	61	53	0	41	6	13
Region											
Caprivi	10	0	29	61	0	29	48	0	32	21	11
Erongo	5	0	25	70	0	67	17	8	64	11	20
Hardap	7	0	31	62	0	76	28	0	63	9	29
Karas	0	1	16	80	2	76	8	0	75	16	13
Kavango	13	1	42	43	1	359	38	4	48	10	200
Khomas	2	0	16	74	7	109	7	6	81	6	20
Kunene	43	2	24	31	0	99	56	6	32	6	68
Ohangwena	7	3	30	60	1	120	17	5	65	12	48
Omaheke	22	0	31	46	0	112	42	0	43	16	60
Omusati	11	1	36	52	1	276	24	8	59	9	130
Oshana	1	0	15	83	1	61	8	0	68	24	10
Oshikoto	12	1	26	61	0	69	33	6	45	16	27
Otjozondjupa	20	2	33	44	2	90	40	11	47	3	49
Total	12	1	31	54	1	1,544	33	5	52	10	686

[1] Clients who completed 7th grade of upper primary are automatically categorised as able to read and write.

Chapter 5

Table A-5.1 Methods of family planning offered

Among facilities offering family planning (FP) services, percentage that provide, prescribe or counsel clients on specific FP methods, by type of facility, Namibia HFC 2009

Methods offered	Type of facility				Total percentage
	Hospital	Health centre	Clinic	Sick bay	
Combined oral contraceptive	83	96	99	67	97
Progestin-only oral pill	83	98	95	33	94
Progestin-only injectable (three monthly)	87	100	98	100	98
Progestin-only injectable (two monthly)	87	100	99	100	99
Progestin-only injectable (2 or 3 monthly)	87	100	99	100	99
Combined injectable (one monthly)	4	7	3	0	4
Male condom	96	98	99	100	99
Female condom	87	89	85	67	86
Intrauterine contraceptive device (IUCD)	52	24	24	0	25
Implant	0	4	7	0	6
Spermicide	0	4	4	0	4
Diaphragm	9	4	6	0	6
Counselling on natural (rhythm) method	65	49	46	0	47
Moon beads for SDM	9	9	7	0	8
Female sterilisation	22	18	16	0	17
Male sterilisation	87	27	35	0	37
At least two of any temporary modern methods[1]	96	100	100	100	100
At least four of any temporary modern methods[1]	87	100	99	67	98
Emergency contraceptive pill	57	42	33	0	36
Number of facilities offering TFP or permanent methods	23	45	288	3	359

[1] Includes contraceptive pills (combined or progestin-only), injectables (combined or progestin-only), implants, intrauterine contraceptive devices (IUCD), condoms (male or female), spermicides, or diaphragm. Permanent methods (sterilisation), natural methods (rhythm) or emergency contraceptive pills are not included.

Table A-5.2 Methods of family planning provided

Among facilities *offering* family planning (FP) services, percentage that *provide* clients specific FP methods, by type of facility, Namibia HFC 2009

Methods provided	Type of facility				Total percentage
	Hospital	Health centre	Clinic	Sick bay	
Combined oral contraceptive	65	96	97	67	94
Progestin-only oral pill	65	98	92	33	91
Progestin-only injectable (three monthly)	78	100	98	100	97
Progestin-only injectable (two monthly)	78	100	99	100	98
Progestin-only injectable (2 or 3 monthly)	78	100	99	100	98
Combined injectable (one monthly)	4	4	1	0	1
Male condom	96	98	99	100	99
Female condom	83	89	82	67	82
Intrauterine contraceptive device	35	4	3	0	6
Implant	0	0	1	0	1
Spermicide	0	0	0	0	0
Diaphragm	4	0	0	0	1
Moon beads for SDM	4	4	2	0	3
Female sterilisation	4	2	2	0	2
Male sterilisation	52	2	4	0	7
At least two of any temporary modern methods[1]	96	100	100	100	100
At least four of any temporary modern methods[1]	78	100	98	67	97
Emergency contraceptive pill	48	36	27	0	29
Number of facilities offering TFP or permanent methods	23	45	288	3	359

[1] Includes contraceptive pills (combined or progestin-only), injectables (combined or progestin-only), implants, intrauterine contraceptive devices (IUCD), condoms (male or female), spermicides, or diaphragm. Permanent methods (sterilisation), natural methods (rhythm) or emergency contraceptive pills are not included.

Table A-5.3 Availability of family planning methods by type of facility

Among facilities that provide clients the indicated family planning method, percentage where the method was available on the day of the survey, by type of facility, Namibia HFC 2009

Methods	Type of facility				Total percentage
	Hospital	Health centre	Clinic	Sick bay	
Combined oral contraceptive	93	98	97	50	97
Progestin-only oral pill	93	98	91	100	92
Progestin-only injectable (three monthly)	89	98	94	100	95
Progestin-only injectable (two monthly)	89	98	96	100	96
Progestin-only injectable (2 or 3 monthly)	89	98	99	100	98
Male condom	86	98	97	100	96
Female condom	68	95	86	50	85
Intrauterine contraceptive device	25	0	30	-	25
Diaphragm	100	-	0	-	50
Emergency contraceptive pill	55	100	77	-	78
Each method provided by a facility was available the day of the survey	50	82	69	67	69

Table A-5.4 Availability of family planning methods by region

Among facilities that provide clients the indicated family planning method percentage where the method was available on the day of the survey, by region, Namibia HFC 2009

Methods	Region													Total percentage
	Caprivi	Erongo	Hardap	Karas	Kavango	Khomas	Kunene	Ohangwena	Omaheke	Omusati	Oshana	Oshikoto	Otjozondjupa	
Combined oral contraceptive	100	81	94	95	100	100	100	100	100	93	100	100	96	97
Progestin-only oral pill	100	79	94	90	92	95	82	93	93	91	94	94	96	92
Progestin-only injectable (three monthly)	100	88	95	95	93	96	85	100	100	89	100	100	100	95
Progestin-only injectable (two monthly)	96	89	95	96	94	100	92	93	100	98	100	95	100	96
Progestin-only injectable (2 or 3 monthly)	100	93	95	96	98	100	96	100	100	98	100	100	100	98
Male condom	100	97	100	91	96	100	93	97	93	93	100	95	96	96
Female condom	100	81	81	85	75	100	75	79	93	89	88	90	79	85
Intrauterine contraceptive device	-	0	0	33	50	40	0	-	-	-	0	0	-	25
Diaphragm	-	-	-	100	-	-	-	-	-	0	-	-	-	50
Emergency contraceptive pill	100	57	0	83	67	40	100	0	100	100	54	67	0	78
Each method provided by a facility was available the day of the survey	96	52	63	65	71	76	59	72	73	74	53	70	68	69

Table A-5.5 Availability of infrastructure, resources, and systems for quality family planning services

Percentage of facilities offering family planning (FP) services where items to support good counselling, infection control and physical examinations were observed to be available, by type of facility, Namibia HFC 2009

Item	Type of facility				Total percentage
	Hospital	Health centre	Clinic	Sick bay	
Items to support quality counselling					
Visual and auditory privacy	91	96	95	100	95
Visual privacy only	9	0	1	0	1
No privacy	0	0	1	0	1
Individual client health cards	59	84	83	33	81
Written FP guidelines	9	53	52	0	49
Written STI guidelines	50	76	85	67	82
Visual aids for health education on FP	68	89	86	67	85
Visual aids for health education on sexually transmitted infections (STIs including HIV/AIDS)	64	84	82	67	81
All items to support quality counselling[1]	0	38	39	0	36
All items to support quality counselling for FP and for STI services and client education[2]	0	27	34	0	31
Items for infection control					
Soap	82	73	84	100	82
Running water	91	96	83	100	85
Soap and running water	82	73	75	100	75
Hand disinfectant	77	62	59	33	60
Soap and running water or else hand disinfectant	91	87	88	100	88
Clean latex gloves	86	87	91	100	90
Disposable non-latex gloves	5	7	5	0	5
Disinfecting solution	64	76	79	67	77
Sharps box	100	100	99	100	99
All items for infection control[3]	50	62	67	67	65
Waste receptacle[4]	36	40	36	33	37
All items plus waste receptacle for infection control	14	22	24	0	23
Table cloth/plastic on any surface	14	11	13	100	14
Items for pelvic examination					
Visual and auditory privacy	82	98	94	100	94
Visual privacy only	9	0	1	0	2
Auditory privacy only	0	0	0	0	0
Examination bed or couch[5]	91	100	94	100	95
Examination light[6]	64	44	33	0	36
Vaginal speculum	27	2	2	0	4
All furnishings and equipment for pelvic examination[7]	14	2	2	0	3
All items for both infection control and pelvic examination[8]	0	2	1	0	1
Number of facilities offering TFP	22	45	288	3	358

[1] Either private room or visual barrier, individual client health cards, written guidelines for FP, and any visual aids for FP
[2] All items to support quality counselling, written STI guidelines and visual aids for health education on STIs (including HIV/AIDS).
[3] Soap and running water or else hand disinfectant, disposable latex gloves, disinfecting solution, and sharps box.
[4] Pedal bin with plastic liner. While important for infection control, this is not an item that has been commonly introduced so was not included in the aggregate for infection control.
[5] Any bed where a woman can lie down flat.
[6] Examination light, flashlight, or other spotlight source.
[7] Visual and auditory privacy, examination bed or couch, examination light, and vaginal speculum.
[8] Soap and running water or else hand disinfectant, disposable latex gloves, disinfecting solution, and sharps box; and visual and auditory privacy, examination bed, examination light, and vaginal speculum.

Table A-5.6 Availability of observed teaching and visual aids

Percentage of facilities offering family planning (FP) services where specific teaching tool and visual aids were observed to be available, by type of facility, Namibia HFC 2009

Item	Type of facility				Total percentage
	Hospital	Health centre	Clinic	Sick bay	
Visual aids or teaching materials					
Samples of different methods	50	67	63	67	63
Other visual aids for teaching about FP	27	38	25	33	27
Posters for general promotion of FP	18	33	22	33	23
Visual aids about STIs	45	64	63	33	62
Visual aids about HIV/AIDS	36	60	53	67	53
Posters for general awareness of STIs or HIV/AIDS	41	60	59	67	58
Model for demonstrating how to use male condom	23	62	58	67	56
Model for demonstrating female condom	5	11	3	0	4
Information for client to take home					
On family planning	9	11	12	0	11
On sexually transmitted infections	9	42	32	0	32
On HIV/AIDS	23	56	42	67	43
Service guidelines					
Any family planning guidelines	9	53	52	0	49
WHO guidelines for syndromic approach	45	69	79	33	75
Other guidelines for diagnosis and treatment of STIs	5	47	53	33	49
Number of facilities offering TFP	22	45	288	3	358

Table A-5.7 Availability of teaching and visual aids in facilities that offer family planning and STI services

Percentage of facilities offering family planning (FP) services where FP providers routinely treat STIs, percentage where the specific teaching materials and visual aids were observed to be available, by type of facility, Namibia HFC 2009

Item	Type of facility				Total percentage
	Hospital	Health centre	Clinic	Sick bay	
Visual aids or teaching materials					
Samples of different methods	50	61	63	100	63
Other visual aids for teaching about FP	38	25	23	50	24
Posters for general promotion of FP	13	32	21	50	22
Visual aids about sexually transmitted infections	38	64	64	50	63
Visual aids about HIV/AIDS	13	54	56	100	55
Posters for general awareness of STIs or HIV/AIDS	50	61	60	100	60
Model for demonstrating how to use male condom	13	75	60	100	60
Model for demonstrating female condom	13	11	3	0	4
Information for client to take home					
On family planning	0	11	11	0	10
On sexually transmitted infections	13	39	30	0	30
On HIV/AIDS	0	46	41	100	41
Service guidelines					
Any family planning guidelines	13	50	53	0	51
WHO guidelines for syndromic approach	38	71	81	0	78
Other guidelines for diagnosis and treatment of STIs	13	57	56	50	55
Number of facilities offering TFP & FP providers routinely treat STIs	8	28	252	2	290

Table A-5.8 Availability of medicines for treating sexually transmitted infections

Percentage of facilities offering temporary family planning (FP) methods where FP providers routinely treat sexually transmitted infections (STIs), and among these, percentage with specific medicines available, and percentage with at least one treatment for each of the four common STIs, by type of facility, Namibia HFC 2009

Item (illness treated)	Type of facility				Total percentage
	Hospital	Health centre	Clinic	Sick bay	
FP providers routinely treat STIs	36	62	88	67	81
Number of facilities offering TFP	22	45	288	3	358
Metronidazole oral tabs/capsules (trichomoniasis)	100	100	89	100	91
Ceftriaxone (gonorrhea)	100	75	80	50	80
Ciprofloxin (gonorrhea)	100	96	87	50	88
Amoxicillin caps or injection (chlamydia)	100	86	87	100	87
Augmentin tabs (chlamydia)	13	0	2	0	2
Norfloxacin (chlamydia, gonorrhea)	13	0	1	0	1
Doxycycline (chlamydia, syphilis)	100	82	87	100	87
Tetracycline (chlamydia, syphilis)	0	0	2	0	1
Erythromycin tabs (chlamydia, syphilis)	100	89	80	100	82
Any injectable or oral Penicillin (syphilis)	100	100	96	100	97
Nystatin oral or vaginal suppositories (candidiasis)	100	57	50	50	52
Miconazole cream or suppository (candidiasis)	13	0	1	0	1
Clotrimazole cream or suppository (candidiasis)	100	100	86	100	88
At least one medication for each of the following:					
Trichomoniasis	100	100	89	100	91
Gonorrhea	100	96	95	50	95
Chlamydia	100	100	98	100	99
Syphilis	100	100	99	100	99
All four STIs assessed[1]	100	96	85	50	87
Number of facilities offering TFP & FP providers routinely treat STIs	8	28	252	2	290

[1] At least one medicine each for treating trichomoniasis, gonorrhea, chlamydia, and syphilis

Table A-5.9 Availability of equipment and infrastructure for providing specific methods of contraception

Among facilities offering contraceptive methods containing oestrogen and among facilities providing injectable methods or intrauterine contraceptive devices (IUCDs), percentage with the equipment and infrastructure required to provide the method safely, by type of facility, Namibia HFC 2009

	Oestrogen containing method		Injectables		IUCD	
Type of facility	Percentage with blood pressure apparatus[1]	Number of facilities offering method with oestrogen	Percentage with sterile needle and syringe	Number of facilities providing injectable method	Percentage with basic items for IUCD insertion[2]	Number of facilities providing IUCD
Hospital	95	19	94	18	13	8
Health centre	88	43	96	45	0	2
Clinic	94	286	96	285	10	10
Sick bay	100	2	67	3	-	0
Total	94	350	96	351	10	20

[1] Sphygmomanometer and a stethoscope, or an automatic blood pressure apparatus, such as Datex.
[2] Clean latex gloves, iodine antiseptic, speculum, forceps for holding gauze to clean cervix, tenacula and uterine sound (or IUCD kit that includes a tenacula and uterine sound).

Table A-5.10 Availability of items for providing the intrauterine contraceptive device

Among facilities that provide the intrauterine contraceptive device (IUCD), percentage that have specific supplies and equipment to support insertion and/or removal of IUCD, by type of facility, Namibia HFC 2009

Item	Type of facility			Total percentage
	Hospital	Health centre	Clinic	
Clean or sterile latex gloves	100	100	100	100
Antiseptic solution	100	50	90	90
Sponge holding forceps	63	50	70	65
Speculum	75	50	70	70
Tenacula	50	0	10	25
Uterine sound	38	50	30	35
All basic items	13	0	10	10
IUCD method available	25	0	30	25
Number of facilities providing IUCD	8	2	10	20

Table A-5.11 Availability of items for pelvic examination of STI clients

Among facilities where FP providers routinely treat sexually transmitted infections (STIs), percentage that have specific supplies and equipment to support quality pelvic examination, by type of facility, Namibia HFC 2009

Item	Type of facility				Total percentage
	Hospital	Health centre	Clinic	Sick bay	
Visual and auditory privacy	63	100	94	100	94
Examination bed or couch	88	100	94	100	95
Examination light	63	54	33	0	35
Speculum	13	0	2	0	2
Protocol for STI diagnosis and treatment	50	82	87	50	85
Number of facilities where FP providers routinely treat STIs	8	28	252	2	290

Table A-5.12 Facility utilisation statistics for family planning clients

Median number of family planning consultations per month, by background characteristics, Namibia HFC 2009

Background characteristics	Median number of FP consultations[1]	Number of facilities providing data on FP consultation
Type of facility		
Hospital	75	13
Health centre	117	40
Clinic	43	250
Sick bay	-	3
Managing authority		
MoHSS	49	255
Mission/NGO	64	27
Private	17	20
MoD/POLICE	-	4
Region		
Caprivi	53	26
Erongo	38	23
Hardap	37	16
Karas	43	19
Kavango	46	50
Khomas	80	18
Kunene	22	24
Ohangwena	58	29
Omaheke	50	14
Omusati	33	36
Oshana	80	16
Oshikoto	80	20
Otjozondjupa	48	15
Total	46	306

[1] Data are from health information system monthly reports or registers available at the facility on the day of the survey. Data were requested for the 12 months complete months preceding the visit, but frequently some months were missing. Information from the months for which data were available was summed and an average monthly number of clients calculated for each facility. This number was then used to calculate the median number of clients per month.

Table A-5.13 Information on user fees for family planning services

Percentage of facilities offering family planning (FP) services that report charging user fees for specific items, and among facilities with any FP user fees, percentage that offer discounts and publicly post fees, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities charging for the indicated item:						Number of facilities offering TFP	Discount/ exemption for some clients	Percentage where fees are posted in public view			Number of facilities with any user fees for FP services
	Client passport	Consult fee	Method	Tests	Registration	No charges/ Don't know			All fees posted	Some fees posted	No fees posted	
Type of facility												
Hospital	0	9	5	9	9	77	22	20	60	0	40	5
Health centre	0	2	2	2	2	98	45	0	0	0	100	1
Clinic	3	6	5	4	2	93	288	43	33	14	52	21
Sick bay	0	0	0	0	0	100	3	-	-	-	-	0
Managing authority												
MoHSS	1	1	0	1	1	98	293	43	71	0	29	7
Mission/NGO	0	0	0	0	0	100	27	-	-	-	-	0
Private	15	56	50	35	21	41	34	35	25	15	60	20
MoD/POLICE	0	0	0	0	0	100	4	-	-	-	-	0
Region												
Caprivi	0	0	0	0	0	100	26	-	-	-	-	0
Erongo	0	10	6	6	0	90	31	0	33	33	33	3
Hardap	11	16	16	11	5	74	19	80	60	0	40	5
Karas	4	13	9	17	4	74	23	33	33	0	67	6
Kavango	0	4	4	2	4	95	55	0	33	0	67	3
Khomas	16	36	28	16	16	64	25	33	33	22	44	9
Kunene	0	0	0	0	0	100	27	-	-	-	-	0
Ohangwena	0	0	0	0	0	100	29	-	-	-	-	0
Omaheke	0	0	0	0	0	100	15	-	-	-	-	0
Omusati	2	2	2	2	2	98	46	100	0	0	100	1
Oshana	0	0	0	0	0	100	17	-	-	-	-	0
Oshikoto	0	0	0	0	0	100	20	-	-	-	-	0
Otjozondjupa	0	0	0	0	0	100	25	-	-	-	-	0
Total	2	6	5	4	3	92	358	37	37	11	52	27

Table A-5.14 Out-of-pocket payments for family planning services

Among observed and interviewed female FP clients, percentage who reported paying any out-of-pocket fees for FP services on the day of the survey and, among these, median amount (Namibia dollars) paid on the day of the survey, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of interviewed FP clients paying any out-of-pocket fees	Number of interviewed FP clients	Median out-of-pocket payment (N$) by FP clients who paid anything for FP services the day of survey[1]	Number of interviewed FP clients providing valid responses for out-of-pocket payments
Type of facility				
Hospital	3	112	-	0
Health centre	4	199	8	6
Clinic	2	672	5	15
Managing authority				
MoHSS	3	844	5	17
Mission/NGO	0	115	-	0
Private	16	24	26	4
Region				
Caprivi	0	18	-	0
Erongo	3	106	5	3
Hardap	5	57	-	3
Karas	5	101	-	4
Kavango	3	211	5	5
Khomas	4	171	26	4
Kunene	0	84	-	0
Ohangwena	2	31	-	0
Omaheke	0	16	-	0
Omusati	1	56	-	1
Oshana	0	57	-	0
Oshikoto	1	35	-	0
Otjozondjupa	1	39	-	1
Total	3	983	5	21

[1] Includes any amount paid out-of-pocket, including consultation, laboratory test, medicines, or other fees

Table A-5.15 Out-of-pocket payments for specific family planning procedures

Among observed and interviewed female FP clients who received injectable contraceptive or a pelvic exam without another procedure, percentage who paid any out-of-pocket fees on the day of the survey, and among these, median amount paid (Namibia dollars) on the day of the survey, by the main procedure received, Namibia HFC 2009

Procedure	Percentage of clients who paid out-of-pocket fee	Total number of clients receiving procedure	Median out-of-pocket fee (N$) paid by client receiving indicated procedure[1]	Number of clients who paid out-of-pocket fee
Injectable contraceptive	3	808	8	18
Pelvic exam	0	3	-	0

[1] Includes any amount paid out-of-pocket, including consultation, laboratory test, medicines, or other fees.

Table A-5.16 Supportive management for providers of family planning services

Among interviewed family planning (FP) service providers, percentage who received training related to their work and personal supervision during specific time periods, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of interviewed service providers who received:				Number of interviewed FP service providers[2]
	Training related to FP during the 12 months preceding the survey[1]	Personal supervision during the 6 months preceding the survey	Training related to FP during the 12 months and personal supervision during the 6 months preceding the survey	Most recent training in the 13-35 months preceding the survey	
Type of facility					
Hospital	14	64	7	19	189
Health centre	13	77	11	17	182
Clinic	8	69	5	11	409
Sick bay	0	63	0	20	8
Managing authority					
MoHSS	10	71	7	15	616
Mission/NGO	13	80	9	18	105
Private	16	39	3	7	57
MoD/POLICE	0	64	0	22	10
Region					
Caprivi	8	72	8	15	24
Erongo	10	59	7	12	66
Hardap	2	77	2	1	63
Karas	17	69	3	12	61
Kavango	6	78	5	20	95
Khomas	17	61	8	12	86
Kunene	10	68	8	7	34
Ohangwena	8	75	6	11	53
Omaheke	5	91	3	14	23
Omusati	5	83	3	15	89
Oshana	14	68	12	37	69
Oshikoto	21	68	13	13	73
Otjozondjupa	10	45	6	12	52
Total	11	70	7	15	788

[1] This refers to structured sessions and does not include individual instructions received during routine supervision.
[2] Includes only providers of family planning services in facilities offering FP services.

Table A-5.17 Training for family planning service providers on specific topics

Among interviewed family planning (FP) service providers, percentage who received pre- or in-service training on specific topics during the 12 months or 13-35 months preceding the survey, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of interviewed family planning providers who received pre- or in-service training[1] on:										Number of interviewed FP service providers[2]
	Counselling on FP		FP-related clinical issues		Update on symptoms/ symptom management of methods		FP topics for HIV+ women		Any other FP topics		
	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	
Type of facility											
Hospital	11	12	12	19	12	19	11	13	4	4	189
Health centre	11	18	12	18	12	17	10	15	1	3	182
Clinic	6	11	7	11	7	11	7	8	1	2	409
Sick bay	0	20	0	10	0	10	0	0	0	0	8
Managing authority											
MoHSS	8	13	8	15	8	15	8	10	1	2	616
Mission/NGO	13	18	13	16	13	16	13	16	4	9	105
Private	8	7	15	6	15	7	7	7	1	1	57
MoD/POLICE	0	22	0	14	0	14	0	6	0	0	10
Region											
Caprivi	8	15	8	13	8	15	8	15	0	3	24
Erongo	8	14	8	13	6	14	7	7	3	0	66
Hardap	1	2	1	2	1	2	2	1	0	0	63
Karas	10	12	15	12	15	12	12	7	0	1	61
Kavango	5	21	5	20	5	20	5	18	0	4	95
Khomas	11	8	16	11	15	11	11	12	1	2	86
Kunene	4	5	4	7	6	7	8	7	2	0	34
Ohangwena	6	13	6	11	8	9	5	6	3	0	53
Omaheke	5	14	5	14	5	14	5	14	0	3	23
Omusati	3	16	3	14	3	14	5	12	0	2	89
Oshana	13	20	14	37	14	36	11	16	6	3	69
Oshikoto	21	12	21	13	21	13	19	12	6	10	73
Otjozondjupa	10	12	9	11	9	11	8	7	1	3	52
Total	8	13	9	14	9	14	8	11	2	3	788

[1] Includes structured training sessions only; does not include individual instructions received during routine supervision
[2] Includes only providers of FP services in facilities offering FP services

Table A-5.18 Supportive supervision for family planning service providers

Among interviewed family planning (FP) service providers who were personally supervised in the 6 months preceding the survey, median number of times they were supervised, and percentage who report specific activities of the supervisor during the last visit, by background characteristics, Namibia HFC 2009

Background characteristics	Median number of times staff were supervised in the 6 months preceding the survey	Percentage of providers reporting that during the last supervisory visit, the supervisor:						Number of FP service providers who were supervised in the 6 months preceding the survey[1]
		Checked records	Observed work	Provided feedback	Provided updates	Discussed problems	Delivered supplies	
Type of facility								
Hospital	3	94	82	89	70	83	38	122
Health centre	4	94	82	88	74	85	32	141
Clinic	3	93	69	84	70	87	36	283
Sick bay	6	100	88	100	88	84	17	5
Managing authority								
MoHSS	3	92	72	85	70	85	36	439
Mission/NGO	3	98	86	93	71	84	33	84
Private	3	96	100	100	87	100	30	22
MoD/POLICE	6	100	91	100	91	87	24	7
Region								
Caprivi	2	93	50	68	57	75	39	17
Erongo	4	98	79	89	74	86	31	39
Hardap	3	94	77	90	70	82	24	48
Karas	4	98	90	94	72	94	35	42
Kavango	3	92	82	83	59	73	39	74
Khomas	4	81	71	82	69	85	41	53
Kunene	2	82	72	77	58	81	51	23
Ohangwena	3	97	58	87	71	87	35	40
Omaheke	3	100	91	94	85	94	40	21
Omusati	3	98	74	89	76	89	21	74
Oshana	6	97	78	91	91	92	45	47
Oshikoto	3	94	77	85	68	90	39	50
Otjozondjupa	3	89	70	85	77	86	37	23
Total	3	94	76	87	71	86	35	551

[1] Includes only providers of FP services in facilities offering FP services.

Table A-5.19 Description of observed female family planning clients

Among observed female family planning (FP) clients, percentage for whom this was the first or follow-up visit for family planning at this facility, and percentage who reported no prior pregnancy, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of observed FP clients			Number of observed female family planning clients
	First visit	Follow-up visit	Never pregnant	
Type of facility				
Hospital	53	47	17	112
Health centre	10	90	7	199
Clinic	12	88	13	672
Managing authority				
MoHSS	16	84	11	844
Mission/NGO	19	81	18	115
Private	8	92	32	24
Region				
Caprivi	3	97	24	18
Erongo	16	84	15	106
Hardap	10	90	9	57
Karas	7	93	6	101
Kavango	13	87	16	211
Khomas	36	64	16	171
Kunene	14	86	8	84
Ohangwena	17	83	4	31
Omaheke	12	88	21	16
Omusati	15	85	1	56
Oshana	11	89	3	57
Oshikoto	20	80	5	35
Otjozondjupa	4	96	23	39
Total	16	84	12	983

Table A-5.20 User status and principal reason for visit for observed family planning clients

Among observed female family planning (FP) clients, percent distribution by user status and principal reason for seeking family planning service the day of the survey, and user status, Namibia HFC 2009

Principal reason for visit	Percentage of observed female family planning clients with indicated status
Current user at clinic for:	
Re-supply current method/routine visit	76
Elective method change	2
Discuss problem with current method	1
Discuss non-FP health problem	0
Other/missing reason for user's visit	2
Non-user	
Used method in past	8
Never used method	11
Not determined reason for visit	0
Number of observed female family planning clients	983

Table A-5.21 Method of choice for observed female family planning clients

Among observed and interviewed female family planning (FP) clients, percentage who received, were prescribed, or continued using specific FP methods at the end of the visit, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of FP clients who received, were prescribed, or continued to use as their main method:							Number of observed and interviewed female family planning clients
	Combined oral contraceptive (COC) or type unknown	Progestin only pill (POP)	Progestin injectable (2 or 3 monthly) (PIN)	Combined injectable (1 monthly) (CIN)	Condom	Other[1]	No method	
Type of facility								
Hospital	4	10	84	0	9	0	3	112
Health centre	14	10	76	0	10	0	1	199
Clinic	10	3	84	0	10	1	1	672
Managing authority								
MoHSS	10	5	81	0	11	0	1	844
Mission/NGO	3	6	90	0	4	0	0	115
Private	30	2	68	0	5	0	0	24
Region								
Caprivi	15	0	82	0	3	0	3	18
Erongo	6	0	94	0	13	1	0	106
Hardap	15	12	71	0	9	0	1	57
Karas	13	4	77	1	7	1	1	101
Kavango	4	7	86	1	2	0	1	211
Khomas	11	10	75	0	17	0	2	171
Kunene	4	2	94	0	17	0	0	84
Ohangwena	20	0	78	0	4	0	0	31
Omaheke	12	12	70	0	9	0	0	16
Omusati	18	0	75	0	8	0	0	56
Oshana	14	6	80	0	26	0	0	57
Oshikoto	12	8	78	0	0	3	1	35
Otjozondjupa	11	0	89	0	4	0	0	39
Total	10	5	82	0	10	0	1	983

[1] Other may include spermicides, diaphragm, emergency contraception, counselling on rhythm or female sterilisation.

Table A-5.22 Components of counselling among observed female family planning clients

Among observed female family planning clients, percentage whose consultations included components that contribute to quality counselling, by type of facility, Namibia HFC 2009

Components of consultation	Type of facility			Total percentage
	Hospital	Health centre	Clinic	
Visual privacy assured	100	85	94	93
Auditory privacy assured	85	82	94	90
Client was assured of confidentiality	26	42	48	44
Client was asked about concerns of methods discussed or used	49	62	63	61
All counselling conditions met[1]	10	31	36	32
Individual client card reviewed during consultation	81	81	85	84
Individual client card written on after consultation	97	100	99	99
Visual aids were used during consultation	49	10	16	18
Return visit was discussed	93	97	94	94
Number of observed female family planning clients	112	199	672	983

[1] Visual and auditory privacy, confidentiality assured and client was asked about concerns of methods discussed or currently used

Table A-5.23 General assessments, examinations, and interventions for observed first-visit female family planning clients

Percentage of observed first-visit family planning clients whose consultations included specific assessments and examinations, by type of facility, Namibia HFC 2009

Components of consultation	Type of facility			Total percentage
	Hospital	Health centre	Clinic	
Client history				
Age	88	48	72	75
Any history of pregnancy	99	80	74	84
Current pregnancy status	65	48	37	49
Desired timing for next child or desire for another child	29	8	29	26
Breastfeeding status (if ever pregnancy)	74	13	22	43
Regularity of menstrual cycle	59	77	62	63
All elements of reproductive history[1]	11	0	12	10
Client medical history				
Asked about smoking	2	9	7	5
Asked about symptoms of sexually transmitted infections (STIs)	36	39	24	30
Asked about any chronic illnesses	48	27	20	31
All risk-history[2]	1	9	6	5
Client examination				
Measure blood pressure	100	67	98	95
Measure weight	100	64	89	90
Client examination (Specific exam information)				
Measure blood pressure (according to client)	99	67	90	91
Measure blood pressure (according to facility standard)	22	47	65	47
Measure weight (according to client)	100	64	78	85
Measure weight (according to facility standard)	22	33	61	43
Number of first-visit FP clients who have had previous pregnancy	60	19	61	139
Number of first-visit FP clients	60	19	82	161

[1] Asked about age, any history of pregnancy, current pregnancy status, desired timing for next child or desire for another child and regularity of menstrual cycle
[2] Asked about smoking, symptoms of STIs and any chronic illness

Table A-5.24 General assessments, examinations, and interventions for observed first-visit female family planning clients

Percentage of observed first-visit family planning clients whose consultations included specific assessments and examinations, by type of facility, Namibia HFC 2009

Components of consultation	Type of facility			Total percentage
	Hospital	Health centre	Clinic	
Discussion related to partner				
Partner attitude toward family planning	6	9	14	10
Partner status[1]	6	9	11	9
Either partner question	6	19	16	13
Discussion related to STIs and condoms				
Use of condoms to prevent STIs	65	23	41	48
Use of condoms as dual method[2]	71	33	40	50
Any discussion related to STIs[3]	71	33	46	53
Individual client card reviewed during consultation	94	83	91	91
Individual client card written on after consultation	94	100	100	98
Visual aids were used during consultation	69	25	30	44
Client was assured of confidentiality	33	25	47	39
Number of first-visit FP clients	60	19	82	161

[1] Asked about other partners for self or partner, and about absence of partner
[2] Both to prevent pregnancy and STIs
[3] Discussed risks of STIs, using condoms to prevent STIs, or using condoms as dual method

Table A-5.25 Assessments of client who received contraceptives containing oestrogen

Among observed family planning (FP) clients who received a contraceptive containing oestrogen (either combined oral pills or combined injectable), percentage who had their blood pressure and weight measured, by type of facility, Namibia HFC 2009

Components of consultation	Type of facility			Total percentage
	Hospital	Health centre	Clinic	
Examination specific to oestrogen-based contraceptive				
Blood pressure measured	100	91	98	96
Weight measured	100	70	85	82
Number of clients receiving oestrogen-based contraceptive	4	27	69	100

Table A-5.26 Counselling and client knowledge related to injectable and oral contraceptives

Among observed and interviewed female family planning clients who received oral contraceptive pills or injectable, percentage who were observed being told essential information about the method, percentage who reported that the provider explained their method to them, and percentage who knew the correct response to an exit interview question on their method, by type of facility, Namibia HFC 2009

Components of consultation	Type of facility			Total percentage
	Hospital	Health centre	Clinic	
Provider was observed to explain the item to the client				
When to take	98	80	89	88
Menstrual changes (side-effects)	50	31	38	38
Non-menstrual side effects	47	18	25	26
Any side effects	56	35	40	41
What to do if she forgets	40	18	21	22
Mentioned follow-up visit	96	96	94	95
Client reported that the provider shared the indicated information				
Explained how to use the method	70	73	67	68
Explained about possible side effects	49	46	46	46
Explained what to do for problems	74	51	53	55
Mentioned follow-up visit	87	95	96	95
For all pill and injectable clients:				
Percentage who knew correct response for question asked about method	100	94	95	96
Number of observed and interviewed FP pill/injectable clients[1]	108	197	653	959

Table A-5.27 Counselling and client knowledge related to condoms, IUCDs, and implants

Among observed and interviewed clients who received or were prescribed condoms, IUCDs, or implants, percentage who were observed being told essential information about the method; percentage who correctly answered a key question about using their method during exit interview; and percentage who reported that a provider instructed them on their method Namibia HFC 2009

Components of consultation	Percentage observed and interviewed clients
Condom clients were observed being told:	
Cannot use if allergic to latex	6
Can be used one time only	11
Lubricants that can/cannot be used	4
Can use as a backup method	17
About dual protection	30
Interviewed client received condom and knows to use condom only once	62
Number of observed and interviewed clients receiving condom	98
Summary of interviewed client responses	
Client knew the correct response for the survey question about their method	62
Client reported provider explained tow to use the method	83
Client reported provider explained about possible side effects	57
Client reported provider explained what to do for problems	55
Client reported provider told about a follow-up visit	95
Number of observed and interviewed FP clients receiving condoms, IUCDs or implants or a prescription for them	98

Table A-5.28 Client feedback on services

Percentage of interviewed family planning (FP) clients who considered specific service issues to be a major problem on the day of the visit, by type of facility, Namibia HFC 2009

Client service issue	Type of facility			Total percentage
	Hospital	Health centre	Clinic	
Behaviour/attitude of provider	0	4	4	3
Ability to discuss problem	0	3	5	4
Insufficient explanation about method or problems	1	5	5	5
Waiting time to see provider	7	13	22	18
Quality of examination and treatment	0	3	4	3
Availability of methods or medicines	1	4	5	4
Days facility is open	6	7	4	5
Hours facility is open	4	7	4	5
Cleanliness of facility	9	6	5	6
Cost of services	0	1	1	1
Insufficient visual privacy	0	2	3	2
Insufficient auditory privacy	0	3	3	3
Number of interviewed FP clients	112	199	672	983

Table A-5.29 Client choice of facility

Among interviewed family planning (FP) clients, percentage who reported this was not the closest health facility to their home, and among these clients, the main reason they did not go to the nearest facility, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of interviewed FP clients who report this is not the closest facility to their home	Number of interviewed FP clients	Percentage of family planning (FP) clients mentioning the indicated item was a problem with the nearest facility													Number of interviewed FP clients for whom this was not the closest facility to their home
			Incon-venient operating hours	Bad reputation	Don't like personnel	No medicines	Prefer anonymity	More expensive	Was referred to this facility	Incon-venient for visit/work location	No/poor staff	Long wait	No/poor service	Other	Don't know/ missing	
Type of facility																
Hospital	36	112	0	0	0	0	1	0	33	5	9	0	1	42	8	40
Health centre	6	199	16	0	0	15	16	16	0	4	0	0	0	32	0	12
Clinic	10	672	12	3	4	2	6	5	2	43	1	1	0	19	1	65
Managing authority																
MoHSS	11	844	5	2	3	4	6	6	15	28	5	1	1	20	4	90
Mission/NGO	15	115	0	0	0	0	3	0	8	13	0	0	0	77	0	18
Private	38	24	57	0	0	0	0	0	0	29	0	0	0	14	0	9
Region																
Caprivi	13	18	0	0	0	0	0	0	0	75	0	0	0	25	0	2
Erongo	12	106	0	8	0	0	0	25	0	66	0	0	0	0	0	13
Hardap	2	57	0	0	0	0	0	0	0	0	0	0	0	100	0	1
Karas	12	101	11	0	11	0	0	0	0	23	0	0	0	54	0	12
Kavango	12	211	4	4	0	4	11	0	0	11	4	0	0	62	0	25
Khomas	26	171	16	0	3	0	4	4	32	12	7	0	0	13	7	45
Kunene	6	84	0	0	0	0	22	0	0	78	0	0	0	0	0	5
Ohangwena	12	31	0	0	0	17	0	0	0	50	0	17	0	17	0	4
Omaheke	3	16	0	0	0	0	0	0	0	0	0	0	0	0	100	0
Omusati	5	56	0	0	0	0	0	0	0	25	0	0	0	75	0	3
Oshana	3	57	0	0	0	100	0	0	0	0	0	0	0	0	0	2
Oshikoto	8	35	0	0	0	0	17	0	0	67	0	0	0	17	0	3
Otjozondjupa	5	39	0	0	0	0	0	0	0	53	24	0	24	0	0	2
Total	12	983	8	2	2	3	5	4	12	26	4	1	0	28	3	117

Table A-5.30 Educational characteristics of female family planning clients

Percent distribution of observed and interviewed female family planning clients according to educational level and percentage of clients with primary, informal, or no education who are literate, by background characteristics, Namibia HFC 2009

Background characteristics	Among interviewed FP clients, percentage with:					Number of interviewed FP clients	Percentage of interviewed FP clients with primary, informal or no education who:				Number of interviewed FP clients with primary, informal or no education
	No education	Informal	Primary (1-3) or upper primary (4-7)	Secondary	Tertiary/ University		Cannot read or write	Can read, cannot write	Can read and write[1]	Missing	
Type of facility											
Hospital	0	0	16	79	5	112	0	0	8	92	19
Health centre	6	0	24	69	1	199	25	4	19	51	59
Clinic	6	0	20	71	3	672	28	3	24	45	176
Managing authority											
MoHSS	5	0	20	73	2	844	24	3	24	49	214
Mission/NGO	6	0	28	66	0	115	29	2	9	60	39
Private	4	0	0	52	44	24	100	0	0	0	1
Region											
Caprivi	3	0	12	82	3	18	21	21	0	59	3
Erongo	4	0	8	85	3	106	13	9	0	79	12
Hardap	1	0	17	81	1	57	13	0	19	69	10
Karas	3	0	16	79	3	101	7	0	35	57	19
Kavango	7	0	37	55	0	211	28	3	16	53	94
Khomas	1	0	7	84	8	171	10	15	30	45	13
Kunene	24	0	21	54	1	84	58	0	17	25	37
Ohangwena	2	2	44	53	0	31	4	0	56	40	15
Omaheke	12	0	30	58	0	16	36	0	36	28	7
Omusati	3	0	24	73	0	56	13	4	28	55	15
Oshana	0	0	19	78	3	57	0	0	25	75	11
Oshikoto	3	0	16	80	1	35	14	0	29	57	7
Otjozondjupa	7	1	21	71	0	39	36	0	21	43	11
Total	5	0	20	72	3	983	25	3	22	50	254

[1] Clients who completed 7th grade of upper primary are automatically categorised as able to read and write.

Chapter 6

Table A-6.1 Availability of antenatal care and other family health services on the day of the survey

Among facilities offering antenatal care (ANC), percentage offering ANC, tetanus toxoid (TT) vaccine, family planning (FP), outpatient curative care for sick children (SC), and child immunisation (EPI) services on the day of the survey, by background characteristics, Namibia HFC 2009

	Percentage of facilities offering the indicated services the day of the survey						
Background characteristics	ANC	ANC and TT vaccine	ANC and FP	ANC and SC	ANC and FP and SC services	ANC and EPI	Number of facilities offering ANC
Type of facility							
Hospital	67	67	33	56	22	33	9
Health centre	60	58	60	60	60	58	43
Clinic	63	58	60	62	59	58	253
Managing authority							
MoHSS	63	59	60	62	59	58	265
Mission/NGO	46	46	42	46	42	35	26
Private	86	64	71	86	71	71	14
Region							
Caprivi	96	85	92	92	88	88	26
Erongo	53	42	47	47	47	42	19
Hardap	68	63	63	68	63	58	19
Karas	58	58	53	58	53	58	19
Kavango	49	49	40	47	38	45	53
Khomas	78	56	56	67	44	44	9
Kunene	68	60	68	68	68	64	25
Ohangwena	62	62	62	62	62	59	29
Omaheke	62	62	62	62	62	62	13
Omusati	61	59	61	61	61	59	41
Oshana	36	29	36	36	36	36	14
Oshikoto	70	70	70	70	70	60	20
Otjozondjupa	67	61	67	67	67	61	18
Total	63	58	59	61	58	57	305

Table A-6.2 Availability of antenatal care and tetanus vaccine services

Among facilities offering antenatal care (ANC), percentage offering ANC and tetanus toxoid vaccine (TT) the indicated number of days per week and percentage offering TT every day that ANC is offered, by background characteristics, Namibia HFC 2009

Background characteristics	ANC services offered the indicated number of days per week[1]			TT services offered the indicated number of days per week[1]				TT every day ANC is offered	Number of facilities offering ANC
	1-2 days	3-4 days	5+ days	Not offered/ less than once a week	1-2 days	3-4 days	5+ days		
Type of facility									
Hospital	56	11	22	22	22	11	44	67	9
Health centre	58	23	19	2	7	2	88	98	43
Clinic	66	8	22	3	8	1	87	96	253
Managing authority									
MoHSS	63	12	20	3	8	2	87	95	265
Mission/NGO	88	4	8	0	15	4	81	100	26
Private	36	0	64	21	0	0	79	79	14
Region									
Caprivi	23	4	54	0	4	15	81	100	26
Erongo	63	26	5	11	0	0	89	89	19
Hardap	26	11	53	16	0	0	84	84	19
Karas	58	5	32	5	5	0	89	95	19
Kavango	74	11	15	0	19	2	79	98	53
Khomas	56	11	33	11	22	0	67	78	9
Kunene	80	0	20	8	16	0	76	88	25
Ohangwena	69	17	10	0	10	0	90	100	29
Omaheke	77	8	15	0	0	0	100	100	13
Omusati	76	7	17	2	2	0	95	98	41
Oshana	79	21	0	0	14	0	86	93	14
Oshikoto	75	20	0	0	0	0	95	100	20
Otjozondjupa	61	0	33	6	0	0	89	94	18
Total	64	10	21	4	8	2	86	95	305

[1] Some facilities offer the services less than one day per week so total percentage may be less than 100%.

Table A-6.3 Availability of observed items to support quality antenatal care services

Percentage of facilities offering antenatal care (ANC) where supplies and equipment to support quality counselling, infection control, physical examinations, and basic ANC services were observed to be available in the ANC service area or adjacent to the consultation or examination room, by type of facility, Namibia HFC 2009

Item	Type of facility			Total percentage
	Hospital	Health centre	Clinic	
Items to support quality counselling				
Individual client health cards/ passport	89	93	92	92
ANC guidelines[1]	22	35	35	34
Visual aids for health education	67	58	47	49
All items to support quality counselling[2]	11	30	20	21
Items for infection control				
Soap	67	77	79	79
Running Water	78	95	81	83
Soap and water	56	77	72	72
Hand disinfectant	56	56	62	61
Soap and running water or else hand disinfectant	78	84	87	87
Clean latex gloves	100	86	91	90
Disinfecting solution	67	67	76	74
Sharps box	100	93	96	95
All items for infection control[3]	44	49	63	61
Covered waste receptacle with plastic liner[4]	67	37	35	36
All items for infection control plus waste receptacle	33	19	22	22
Table cloth/plastic on any surface	11	9	14	13
Items for physical examination				
Visual and auditory privacy	89	95	95	95
Visual privacy only	11	0	1	1
Auditory privacy only	0	2	0	1
Examination bed/couch[5]	89	95	95	95
Examination light[6]	44	49	32	35
All elements for physical examination[7]	44	44	30	32
All elements for physical examination and specific components for infection control present[8]	22	26	19	20
Essential supplies for basic ANC				
Blood pressure apparatus	89	95	94	94
Foetoscope (Pinard)	100	100	98	98
Iron tablets[9]	89	100	90	91
Folic acid tablets[9]	89	98	91	91
Tetanus toxoid vaccine	100	100	92	93
All basic ANC equipment and medicines[10]	89	93	74	77
Number of facilities offering ANC	9	43	253	305

[1] Any antenatal care guidelines or protocols, or any other maternal or neonatal health guidelines or protocols.
[2] Individual client health cards, written ANC guidelines, and visual aids for health education.
[3] Soap and running water or else hand disinfectant, gloves, disinfecting solution for decontaminating reusable items, and sharps box
[4] While important for infection control, a waste receptacle with plastic liner was not included in the aggregate for infection control.
[5] May be any type of bed or couch where a client can lie down flat.
[6] May be examination light, flashlight or other spotlight source
[7] Visual and auditory privacy, examination light, plus an examination bed/couch.
[8] Visual and auditory privacy, examination light, bed, and all infection control items, excluding sharps box.
[9] Iron and folic acid may be separate tablets, or one combined tablet.
[10] Blood pressure apparatus, foetoscope, iron and folic acid, tetanus toxoid vaccine.

Table A-6.4 Availability of specific medicines and guidelines for antenatal and postnatal services

Among facilities offering antenatal care (ANC), percentage with medicines for managing common complications during pregnancy, percentage that routinely provide the indicated medicine or test as a component of ANC, and percentage with items for postnatal care, by type of facility, Namibia HFC 2009

Item	Type of facility			Total percentage
	Hospital	Health centre	Clinic	
Medicines for managing common complications during pregnancy				
Antibiotic[1]	89	98	95	95
Albendazole (anthelminth)	78	93	85	86
Mebendazole (anthelminth)	11	9	8	8
Either Albendazole or Mebendazole	78	95	86	87
First line antimalarial[2]	89	84	74	76
Other antimalarial	89	91	82	83
Methyldopa (aldomet)	89	63	33	39
Medicines for STIs				
Metronidazole (trichomoniasis)	89	95	89	90
Ceftriaxone (gonorrhoea)	89	84	81	81
Ciprofloxacin (gonorrhoea)	78	95	89	89
Amoxicillin (chlamydia)	89	86	87	87
Augmentin (chlamydia)	67	2	3	5
Norfloxacin (chlamydia,gonorrhoea)	0	0	1	1
Doxycycline (chlamydia, syphilis)	89	88	86	87
Tetracycline (chlamydia, syphilis)	0	0	1	1
Erythromycin (chlamydia, syphilis)	89	91	81	83
Any injectable or oral penicillin (syphilis)	89	98	97	97
Nystatin suppository or oral (candidiasis)	89	49	51	52
Miconazole cream or suppository (candidiasis)	11	0	2	2
Clotrimazole cream or suppository (candidiasis)	89	100	87	89
At least one medication for:				
Trichomoniasis	89	95	89	90
Gonorrhoea	89	98	95	95
Chlamydia	89	100	97	97
Syphylis	89	100	98	98
All four STIs assessed[3]	89	93	86	87
All medicines for ANC complications[4]	78	44	20	25
ANC service components				
Routine preventive anti-malarial (IPTp)	33	72	71	70
ANC providers routinely treat STIs	56	81	94	91
Routine family planning counselling	67	86	91	90
Routine counselling about HIV/AIDS	89	100	95	96
Routine HIV testing	89	98	80	83
Routine HIV/AIDS counselling or HIV testing	89	100	96	96
Equipment related to postpartum care				
Thermometer	89	88	97	96
Infant scale	89	91	83	84
Guidelines for other ANC				
Any STI guidelines (including syndromic approach or diagnosis for STI)	22	77	83	81
Number of facilities offering ANC	9	43	253	305

[1] Amoxicillin or augmentin (amoxicillin + clavulanate) or cotrimoxazole
[2] First-line antimalarial in Namibia is Coartem.
[3] At least one medicine for treating trichomoniasis, gonorrhoea, chlamydia, and syphilis
[4] At least one broad-spectrum antibiotic (amoxicillin or augmentin or cotrimoxazole); either Albendazole or mebendazole; Methyldopa (aldomet); 1st line anitmalarial; and at least one medicine for treating each of the following STIs: trichomoniasis, gonorrhoea, chlamydia, syphilis and candidiasis

Table A-6.5 Capacity to provide anaemia screening with antenatal care

Among facilities offering antenatal care (ANC), percentage that have the capacity to test for anaemia and/or a standard to routinely screen ANC clients for anaemia, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities offering ANC services that have: Capacity to conduct anaemia test[1]	Standard to screen ANC clients for anaemia	Standard to screen ANC clients for anaemia and capacity to conduct anaemia test	Number of facilities offering ANC
Type of facility				
Hospital	89	89	89	9
Health centre	95	95	91	43
Clinic	94	90	87	253
Managing authority				
MoHSS	95	91	88	265
Mission/NGO	96	96	92	26
Private	71	79	71	14
Region				
Caprivi	100	100	100	26
Erongo	89	89	89	19
Hardap	89	89	89	19
Karas	58	100	58	19
Kavango	100	92	92	53
Khomas	67	67	67	9
Kunene	100	80	80	25
Ohangwena	100	97	97	29
Omaheke	100	100	100	13
Omusati	95	83	78	41
Oshana	100	93	93	14
Oshikoto	100	95	95	20
Otjozondjupa	100	89	89	18
Total	94	91	88	305

[1] Capacity to conduct an anaemia test using any of the following means: haemoglobinometer or calorimeter, HemoCue®, centrifuge and capillary tubes for hematocrit, or any of the blotting paper tests.

Table A-6.6 Capacity to test urine protein with antenatal care

Among facilities offering antenatal care (ANC), percentage that have the capacity to test urine for protein and/or a standard to routinely screen ANC clients for urine protein, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities offering ANC services that have: Capacity to conduct urine protein test[1]	Standard to screen ANC clients for urine protein	Standard to screen ANC clients for urine protein and capacity to conduct urine protein test	Number of facilities offering ANC
Type of facility				
Hospital	78	89	78	9
Health centre	100	95	95	43
Clinic	98	92	92	253
Managing authority				
MoHSS	98	92	92	265
Mission/NGO	100	100	100	26
Private	79	93	79	14
Region				
Caprivi	100	96	96	26
Erongo	95	89	89	19
Hardap	89	89	89	19
Karas	100	100	100	19
Kavango	100	94	94	53
Khomas	56	89	56	9
Kunene	100	100	100	25
Ohangwena	100	86	86	29
Omaheke	100	100	100	13
Omusati	100	78	78	41
Oshana	100	100	100	14
Oshikoto	100	100	100	20
Otjozondjupa	100	100	100	18
Total	98	93	92	305

[1] Dip sticks for urine protein, or acetic acid for checking urine albumin and flame for heating acetic acid

Table A-6.7 Capacity to test urine glucose with antenatal care

Among facilities offering antenatal care (ANC), percentage that have the capacity to test urine for glucose and/or a standard to routinely screen ANC clients for urine glucose, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities offering ANC services that have: Capacity to conduct urine glucose test[1]	Standard to screen ANC clients for urine glucose	Standard to screen ANC clients for urine glucose and capacity to conduct urine glucose test	Number of facilities offering ANC
Type of facility				
Hospital	78	89	78	9
Health centre	100	93	93	43
Clinic	98	91	90	253
Managing authority				
MoHSS	98	90	90	265
Mission/NGO	100	96	96	26
Private	79	93	79	14
Region				
Caprivi	100	92	92	26
Erongo	95	89	89	19
Hardap	89	89	89	19
Karas	100	95	95	19
Kavango	100	94	94	53
Khomas	56	89	56	9
Kunene	100	96	96	25
Ohangwena	100	86	86	29
Omaheke	100	100	100	13
Omusati	100	73	73	41
Oshana	100	93	93	14
Oshikoto	100	100	100	20
Otjozondjupa	100	100	100	18
Total	98	91	90	305

[1] Dip sticks for urine glucose or Benedict's solution for urine glucose testing with stove for boiling benedicts solution were assessed.

Table A-6.8 Capacity to provide blood grouping with Rh factor with antenatal care

Among facilities offering antenatal care (ANC), percentage that have the capacity to determine blood group and Rh factor and/or a standard to routinely offer blood grouping and Rh factor tests to ANC clients for anaemia, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities offering ANC services that have: Capacity to conduct blood grouping and Rh factor test	Standard to offer blood grouping and Rh factor test to ANC clients	Standard to offer blood group and Rh factor test for ANC clients and capacity to conduct blood grouping and Rh test	Number of facilities offering ANC
Type of facility				
Hospital	33	44	11	9
Health centre	56	35	9	43
Clinic	57	35	19	253
Managing authority				
MoHSS	55	34	16	265
Mission/NGO	65	31	12	26
Private	57	64	50	14
Region				
Caprivi	100	46	46	26
Erongo	26	37	16	19
Hardap	5	37	0	19
Karas	11	63	11	19
Kavango	68	23	9	53
Khomas	22	33	22	9
Kunene	60	36	16	25
Ohangwena	83	55	48	29
Omaheke	100	15	15	13
Omusati	68	17	5	41
Oshana	0	50	0	14
Oshikoto	80	55	35	20
Otjozondjupa	22	17	0	18
Total	56	35	17	305

[1] Anti-A, Anti-B, Anti-AB, and Anti-D reagents, plus an incubator, Coomb's reagent and glass slides all present.

Table A-6.9 Capacity to test for syphilis with antenatal care

Among facilities offering antenatal care (ANC), percentage that have the capacity to test for syphilis and/or a standard to routinely screen ANC clients for syphilis, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities offering ANC services that have:			Number of facilities offering ANC
	Capacity to conduct syphilis test[1]	Standard to screen ANC clients for syphilis	Standard to screen ANC clients for syphilis and capacity to conduct syphilis test	
Type of facility				
Hospital	89	89	89	9
Health centre	95	88	84	43
Clinic	92	80	76	253
Managing authority				
MoHSS	94	83	80	265
Mission/NGO	96	77	73	26
Private	64	64	50	14
Region				
Caprivi	100	100	100	26
Erongo	47	79	42	19
Hardap	89	79	79	19
Karas	95	100	95	19
Kavango	100	74	74	53
Khomas	67	67	67	9
Kunene	100	60	60	25
Ohangwena	100	86	86	29
Omaheke	100	100	100	13
Omusati	90	83	76	41
Oshana	100	100	100	14
Oshikoto	100	90	90	20
Otjozondjupa	83	50	50	18
Total	92	81	78	305

[1] Either VDRL or PCR with functioning rotator or shaker, or RPR test

Table A-6.10 Utilisation of antenatal care and postnatal care services

Median average monthly antenatal care (ANC) clients (including new and repeat clients) and postnatal care (PNC) clients for the 12 months preceding the survey, by type of facility, Namibia HFC 2009

Type of facility	Median monthly ANC visits[1]	Number of facilities reporting ANC data	Median monthly PNC visits[1]	Number of facilities reporting PNC data
Hospital	165	7	70	6
Health centre	68	41	11	33
Clinic	17	236	-	150
Total	20	284	-	189

[1] Data are from health information system monthly reports available at the facility on the day of the survey. Data were requested for the 12 months preceding the survey, but frequently some months were missing. Information from the months for which data were available was summed and an average monthly number of clients calculated for each facility. This number was then used to calculate the median number of clients per month.

Table A-6.11 User fees for antenatal care services

Percentage of facilities offering antenatal care (ANC) that charge user fees for specific items or offer prepayment systems and discounts, and percentage of facilities charging user fees that publicly post fees, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities charging for the indicated item:								Number of facilities offering ANC	Percentage where fees are posted in public view			Number of facilities with routine fees for ANC services
	Client passport	Consultation	Registration	Medicines	Laboratory tests	System to prepay for multiple visits	Discount/ exemption for some clients	No fees/ don't know		All fees are posted	Some fees are posted	No fees are posted	
Type of facility													
Hospital	0	11	22	11	11	11	11	78	9	0	0	100	2
Health centre	9	2	5	2	2	2	5	86	43	17	0	83	6
Clinic	5	5	3	4	4	1	8	89	253	29	14	57	28
Managing authority													
MoHSS	6	0	3	0	0	0	5	92	265	27	5	68	22
Mission/NGO	0	0	0	0	0	0	0	100	26	-	-	-	0
Private	7	100	21	93	79	29	79	0	14	21	21	57	14
Region													
Caprivi	0	0	0	0	0	0	0	100	26	-	-	-	0
Erongo	0	5	0	5	5	5	0	95	19	0	100	0	1
Hardap	26	16	37	16	11	5	47	32	19	23	8	69	13
Karas	11	16	5	16	16	5	21	74	19	0	0	100	5
Kavango	0	4	0	4	4	0	4	96	53	0	0	100	2
Khomas	11	56	11	44	33	11	44	44	9	20	40	40	5
Kunene	16	0	8	0	0	0	16	80	25	40	0	60	5
Ohangwena	3	0	0	0	0	0	0	97	29	100	0	0	1
Omaheke	23	8	0	0	0	0	8	69	13	50	0	50	4
Omusati	0	0	0	0	0	0	0	100	41	-	-	-	0
Oshana	0	0	0	0	0	0	0	100	14	-	-	-	0
Oshikoto	0	0	0	0	0	0	0	100	20	-	-	-	0
Otjozondjupa	0	0	0	0	0	0	0	100	18	-	-	-	0
Total	5	5	4	4	4	1	8	88	305	25	11	64	36

Table A-6.12.1 Out-of-pocket payments for antenatal care services: First-visit clients

Among first-visit ANC clients whose consultation was observed and who were interviewed, percentage who reported paying any out-of-pocket fees for ANC services on the day of the survey; among the clients who paid any fees for services, median amount (Namibia dollars) paid on the day of the survey, by type of facility, Namibia HFC 2009

Type of facility	Percentage of interviewed first-visit ANC clients paying any out-of-pocket fees	Number of interviewed first-visit ANC clients	Median out-of-pocket payment (N$) by first-visit ANC clients who paid anything for ANC services day of survey[1]	Number of interviewed first-visit ANC clients providing valid responses for out-of-pocket payments
Hospital	0	39	-	0
Health centre	7	90	82	6
Clinic	12	261	46	31
Total	10	390	47	37

[1] Includes any amount paid out-of-pocket, including consultation, laboratory test, medicines, or other.

Table A-6.12.2 Out-of-pocket payments for antenatal care services: Follow-up clients

Among follow-up ANC clients whose consultation was observed and who were interviewed, percentage who reported paying any out-of-pocket fees for ANC services on the day of the survey; among the clients who paid any fees for services, median amount (Namibia dollars) paid on the day of the survey, by type of facility, Namibia HFC 2009

Type of facility	Percentage of interviewed follow-up visit ANC clients paying any out-of-pocket fees	Number of interviewed follow-up visit ANC clients	Median out-of-pocket payment (N$) by follow-up visit ANC clients who paid anything for ANC services day of survey[1]	Number of interviewed follow-up visit ANC clients providing valid responses for out-of-pocket payments
Hospital	0	31	-	0
Health centre	3	122	-	0
Clinic	2	316	47	6
Total	2	469	47	7

[1] Includes any amount paid out-of-pocket, including consultation, laboratory test, medicines, or other.

Table A-6.13 Supportive management for providers of ANC

Among interviewed antenatal care (ANC) service providers, percentage who received work-related training and personal supervision during specific time periods, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of interviewed service providers who received:				Number of interviewed ANC providers[2]
	Training related to ANC during the 12 months preceding the survey[1]	Personal supervision during the 6 months preceding the survey	Training related to ANC during the 12 months and personal supervision during the 6 months preceding the survey	Most recent training in the 13-35 months preceding the survey	
Type of facility					
Hospital	53	68	41	13	87
Health centre	50	81	40	24	150
Clinic	47	70	34	24	321
Managing authority					
MoHSS	47	74	36	24	438
Mission/NGO	62	80	51	18	91
Private	29	30	4	9	30
Region					
Caprivi	49	72	41	26	24
Erongo	48	62	29	28	34
Hardap	21	80	18	14	45
Karas	49	62	29	12	37
Kavango	43	77	36	27	90
Khomas	28	59	19	23	33
Kunene	46	68	32	43	23
Ohangwena	36	74	31	27	48
Omaheke	51	85	46	29	13
Omusati	60	81	47	15	75
Oshana	75	82	60	22	45
Oshikoto	69	71	50	20	62
Otjozondjupa	42	52	22	18	28
Total	49	73	37	22	559

[1] This refers to structured pre- or in-service sessions, and does not include individual instructions received during routine supervision.
[2] Includes only providers of ANC services in facilities offering ANC services

Table A-6.14.1 Training for antenatal care service providers: (I)

Among interviewed antenatal care (ANC) service providers, percentage who received training1 on specific topics during the 12 months or 13-35 months preceding the survey, by background characteristics, Namibia HFC 2009

Background characteristics	ANC counselling		ANC screening		Complications of pregnancy		Management of risk pregnancies		Symptom management for pregnancy		Postnatal care		Number of interviewed ANC service providers
	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	
Type of facility													
Hospital	26	1	29	1	29	1	29	1	29	1	26	4	87
Health centre	12	22	12	22	11	19	12	19	12	20	12	20	150
Clinic	10	16	11	15	9	13	9	13	9	15	10	14	321
Managing authority													
MoHSS	10	17	11	16	9	15	9	14	10	16	10	16	438
Mission/NGO	27	11	28	10	27	7	27	8	28	10	26	11	91
Private	20	4	20	4	20	4	20	4	20	4	22	4	30
Region													
Caprivi	15	21	15	18	15	15	13	18	13	21	13	23	24
Erongo	6	16	10	12	6	10	2	12	4	10	6	10	34
Hardap	2	5	3	5	2	5	2	5	2	5	2	4	45
Karas	20	13	25	9	23	6	22	6	22	9	20	11	37
Kavango	13	15	16	16	16	14	14	14	16	16	15	16	90
Khomas	4	2	4	2	4	2	4	2	4	2	6	2	33
Kunene	11	15	8	12	5	12	8	12	8	9	11	12	23
Ohangwena	7	18	10	18	7	18	8	15	8	18	10	16	48
Omaheke	5	20	5	20	5	14	5	14	5	14	9	14	13
Omusati	10	18	8	18	6	15	7	16	7	19	6	18	75
Oshana	21	38	19	41	16	38	19	35	19	40	19	37	45
Oshikoto	31	9	33	6	33	7	33	7	33	7	29	9	62
Otjozondjupa	13	6	13	6	13	4	13	2	13	6	15	5	28
Total	13	15	14	14	13	13	13	13	13	14	13	14	559

[1] This refers to structured pre- or in-service training sessions, and does not include individual instructions received during routine supervision.
[2] Includes only providers of ANC services in facilities offering ANC services

Table A-6.14.2 Training for antenatal care service providers: (II)

Among interviewed antenatal care (ANC) service providers, percentage who received training[1] on specific topics during the 12 months or 13-35 months preceding the survey, by background characteristics, Namibia HFC 2009

Background characteristics	Family planning		Any diagnosis or treatment of STI		PMTCT[2]		Intermittent Preventive Treatment (IPT) of malaria for pregnant women		Nutritional counselling for HIV+ pregnant women		Nutritional assessment of pregnant women[3]		Number of interviewed ANC service providers[4]
	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	
Type of facility													
Hospital	21	13	11	10	32	5	28	12	20	0	10	11	87
Health centre	11	17	18	28	15	20	33	27	13	14	12	6	150
Clinic	8	13	22	20	17	14	26	22	14	10	9	5	321
Managing authority													
MoHSS	9	14	20	22	15	15	28	24	13	11	9	6	438
Mission/NGO	18	18	12	19	32	13	34	18	24	4	13	9	91
Private	22	6	16	6	27	4	10	4	13	2	13	2	30
Region													
Caprivi	8	15	3	23	20	18	33	33	10	18	13	8	24
Erongo	14	6	40	21	14	16	16	16	12	12	4	8	34
Hardap	3	2	5	2	5	3	13	16	5	2	6	4	45
Karas	16	22	16	14	26	13	16	14	10	6	7	4	37
Kavango	9	17	12	25	17	19	21	29	17	9	7	4	90
Khomas	6	7	19	7	11	14	15	9	8	0	8	12	33
Kunene	11	7	22	46	16	17	27	46	16	17	5	12	23
Ohangwena	8	11	14	21	11	15	26	18	10	12	7	8	48
Omaheke	9	5	14	14	28	11	46	18	23	11	9	0	13
Omusati	6	17	31	20	18	15	35	22	16	12	10	3	75
Oshana	16	26	33	36	30	30	57	22	19	23	22	9	45
Oshikoto	24	15	14	24	32	7	41	22	26	1	20	9	62
Otjozondjupa	8	18	18	13	13	5	18	19	13	5	4	2	28
Total	11	14	19	21	19	14	28	22	15	9	10	6	559

[1] This refers to structured pre- or in-service training sessions, and does not include individual instruction received during routine supervision.
[2] Training on any topic related to prevention of mother-to-child transmission (PMTCT) for HIV/AIDS, including counselling for PMTCT, guidelines to follow when dispensing and/or administering ARVs for PMTCT, nutritional counselling for the newborn of mothers with HIV, and record keeping or other management of ARVs for PMTCT.
[3] Any training covering nutritional assessment such as BMI calculation and Mid-upper Arm circumference measurement
[4] Includes only providers of ANC services in facilities offering ANC services

Table A-6.15 Supportive supervision for antenatal care service providers

Among interviewed antenatal care (ANC) service providers who were personally supervised during the 6 months preceding the survey,, median number of times providers were supervised, and percentage who report specific activities by the supervisor during the last visit, by background characteristics, Namibia HFC 2009

Background characteristics	Median number of times staff were supervised in the 6 months preceding the survey	Percentage of providers reporting that during the last supervisory visit, the supervisor:						Number of ANC service providers who were supervised in the 6 months preceding the survey[1]
		Checked records	Observed work	Provided feedback	Provided updates	Discussed problems	Delivered supplies	
Type of facility								
Hospital	3	93	79	93	61	82	37	60
Health centre	4	97	83	89	76	86	31	122
Clinic	3	93	67	84	69	87	36	225
Managing authority								
MoHSS	3	93	70	85	71	87	36	325
Mission/NGO	3	99	87	94	65	81	33	73
Private	3	100	100	100	91	100	15	9
Region								
Caprivi	2	93	50	68	57	75	39	17
Erongo	3	97	76	88	73	79	34	21
Hardap	3	91	72	87	74	92	27	36
Karas	3	100	91	97	70	97	44	23
Kavango	3	92	82	86	59	72	37	70
Khomas	3	78	63	78	66	89	37	20
Kunene	2	88	59	81	52	92	44	16
Ohangwena	3	96	59	87	72	89	35	36
Omaheke	3	100	95	95	95	100	35	11
Omusati	3	98	72	88	72	88	24	61
Oshana	6	98	78	90	90	92	31	37
Oshikoto	3	95	77	88	68	90	41	44
Otjozondjupa	2	91	71	83	75	83	42	14
Total	3	94	74	87	70	86	35	406

[1] Includes only providers of ANC services in facilities offering ANC services

Table A-6.16 Characteristics of observed antenatal care clients

Among antenatal care (ANC) clients whose consultation was observed, percentage making their first or follow-up ANC visit, percentage for whom this was their first pregnancy, and estimated gestational status, by background characteristics, Namibia HFC 2009

Background characteristics	Characteristics of observed ANC clients						Number of observed ANC clients
	First ANC visit for this pregnancy	Follow-up ANC visit	First pregnancy	Month of pregnancy			
				<5m	≥5m	≥8m	
Type of facility							
Hospital	56	44	30	13	51	36	70
Health centre	42	58	34	14	51	35	212
Clinic	45	55	38	15	53	33	577
Managing authority							
MoHSS	45	55	37	13	52	35	743
Mission/NGO	51	49	32	22	52	27	113
Private	34	66	0	0	71	29	3
Region							
Caprivi	20	80	25	3	43	54	14
Erongo	32	68	32	11	45	44	83
Hardap	34	66	35	13	32	55	37
Karas	34	66	38	17	36	47	32
Kavango	61	39	35	9	70	21	126
Khomas	48	52	30	9	53	37	85
Kunene	52	48	48	16	62	22	106
Ohangwena	64	36	33	24	50	26	76
Omaheke	43	57	38	16	73	11	16
Omusati	31	69	35	11	54	36	107
Oshana	25	75	40	15	31	54	82
Oshikoto	85	15	37	36	46	17	48
Otjozondjupa	33	67	34	13	56	31	47
Total	45	55	36	14	52	34	859

Table A-6.17 General assessments, examinations, and interventions for observed first-visit ANC clients

Among first-visit antenatal care (ANC) clients whose consultation was observed, percentage whose consultation included specific assessments, examinations, and interventions, and among ANC clients with prior pregnancies, percentage whose consultation included a discussion of prior complications, by type of facility, Namibia HFC 2009

Components of consultation	Type of facility			Total percentage
	Hospital	Health centre	Clinic	
Prior history and client characteristics				
Client age	94	99	93	94
Date of last menstrual period	99	99	96	97
Any aspects related to prior pregnancy[1]	99	100	97	98
Any aspects of complications during prior pregnancy (if had prior pregnancy)	62	66	58	60
Medications client currently taking	64	72	82	78
All relevant elements for client history[2]	64	70	78	75
Laboratory tests and examinations				
Measure blood pressure	100	100	98	98
Weigh client	100	100	92	95
Urine test (protein)	100	100	94	96
Blood test (anaemia)	100	100	91	94
Preventive interventions				
Give or prescribe iron or folic acid tablets or both	94	95	90	92
Give or prescribe tetanus toxoid vaccine	39	60	49	51
Number of first-visit ANC clients	39	90	261	390
Among women with prior pregnancies, specific prior complications discussed:				
Stillbirth	75	73	72	72
Infant mortality first one week after birth	47	71	64	64
Heavy bleeding during labour or postpartum	40	24	40	36
Assisted delivery	71	56	83	74
Previous abortion	78	71	85	81
Number of observed first-visit ANC clients with prior pregnancy	29	72	158	258

[1] This includes any questions that would indicate whether the client had a prior pregnancy, such as number of prior pregnancies, complications during any previous pregnancies.
[2] Client age, last menstrual period, medicines, any prior pregnancies, and, if there was a prior pregnancy, any questions related to complications during prior pregnancies.

Table A-6.18 Assessment of current health status of observed antenatal care clients

Among antenatal care (ANC) clients whose consultation was observed, percentage whose consultation included specific examinations, examinations, and interventions, by type of facility, Namibia HFC 2009

Components of consultation	Type of facility			Total percentage
	Hospital	Health centre	Clinic	
Client questioned regarding				
Vaginal bleeding	24	23	29	27
Foetal movement (at least 5m pregnant)	75	50	66	63
Any other problems[1]	69	65	74	71
Basic physical examination				
Measured blood pressure	100	100	97	98
Urine test (protein)	100	95	91	93
Check foetal position (at least 8m pregnant)	100	99	98	98
Listened for foetal heart (at least 5m pregnant)	95	99	97	97
All questions and basic examination[2]	23	22	25	24
Other examinations				
Weigh client	100	100	94	96
Check uterine/fundal height[3]	100	100	98	99
Blood test (anaemia)	99	58	70	70
Preventive interventions				
Provider gave or prescribed iron or folic acid tablets	86	66	77	75
Provider explained purpose of iron or folic acid tablets	50	45	55	52
Provider explained how to take tablets	78	56	66	64
Provider gave or prescribed tetanus toxoid vaccine	33	32	29	30
Provider explained purpose of TT vaccine	25	24	22	23
Number of observed ANC clients at least 5 months pregnant	61	182	493	736
Number of observed ANC clients at least 8 months pregnant	25	74	189	288
Number of observed ANC clients	70	212	577	859

[1] Other problems include fever, headache or blurred vision, swollen face or hands, tiredness or breathlessness.
[2] Questions regarding vaginal bleeding and foetal movement (if at least 5 months pregnant), blood pressure measured, foetal position palpated or ultrasound performed (if at least 8 months pregnant), and provider listened for foetal heart (if at least 5 months pregnant).
[3] Either by palpating the abdomen or using an ultrasound device to assess gestational age of the foetus.

Table A-6.19.1 Health education for antenatal care clients: Insecticide-treated bed nets

Among first and follow-up visit antenatal care (ANC) clients whose consultations were observed, percentage who were counselled on insecticide-treated nets (ITNs), given ITNs free of charge, or who purchased an ITN from a provider, by region, Namibia HFC 2009

	Region													Total
Counselling topic	Caprivi	Erongo	Hardap	Karas	Kavango	Khomas	Kunene	Ohangwena	Omaheke	Omusati	Oshana	Oshikoto	Otjozondjupa	percentage
First-visit ANC client														
Importance of using ITN explained	84	0	0	0	14	0	12	64	0	0	11	27	0	16
Given ITN free of charge	84	4	0	0	0	0	4	34	0	0	11	33	0	10
Client purchased ITN	0	0	0	0	0	0	0	0	26	0	0	1	0	1
Number of first-visit ANC clients	3	26	13	11	76	41	55	49	7	33	21	41	16	390
Follow-up visit ANC client														
Importance of using ITN explained	5	0	0	0	3	0	16	31	0	0	1	24	0	4
Given ITN free of charge	5	0	0	0	0	14	15	15	0	1	1	24	0	5
Client purchased ITN	0	0	0	3	0	0	3	0	5	0	0	0	0	1
Number of follow-up visit ANC clients	11	57	25	21	50	44	51	27	9	74	61	7	32	469

Table A-6.19.2 Health education for antenatal care clients: Intermittent prophylactic treatment (IPT) of malaria

Among first and follow-up visit antenatal care (ANC) clients, percentage observed to be counselled on intermittent prophylactic treatment (IPT) for malaria and observed to ingest dose of IPT in facility, by region, Namibia HFC 2009

	Region													Total
Counselling topic	Caprivi	Erongo	Hardap	Karas	Kavango	Khomas	Kunene	Ohangwena	Omaheke	Omusati	Oshana	Oshikoto	Otjozondjupa	percentage
First-visit ANC client														
Provider gave or prescribed IPT	0	0	0	0	17	0	18	15	0	24	3	16	5	12
Provider explained purpose of IPT	0	0	0	0	14	0	14	15	0	21	3	14	0	10
Provider explained how to take IPT	0	0	0	0	15	0	17	15	0	24	3	15	5	11
Provider explained possible side effects of IPT	0	0	0	0	0	0	1	4	0	3	0	2	0	1
Dose of IPT ingested in presence of provider	0	0	0	0	8	0	14	15	0	9	3	2	0	7
Importance of 2nd dose of IPT explained	0	0	0	0	4	0	9	4	0	9	3	1	0	4
Number of first-visit ANC clients	3	26	13	11	76	41	55	49	7	33	21	41	16	390
Follow-up visit ANC client														
Provider gave or prescribed IPT	17	0	0	0	33	0	20	46	0	23	14	29	16	16
Provider explained purpose of IPT	13	0	0	0	11	0	17	42	0	23	8	29	13	12
Provider explained how to take IPT	13	0	0	0	16	0	17	46	0	23	14	29	16	13
Provider explained possible side effects of IPT	0	0	0	0	0	0	9	0	0	0	0	0	7	2
Number of follow-up visit ANC clients	11	57	25	21	50	44	51	27	9	74	61	7	32	469

Table A-6.20.1 Observed content of ANC counselling by type of facility

Percentage of first and follow-up visit ANC clients who were observed to receive counselling on topics related to nutrition during pregnancy, risk symptoms, the progress of their pregnancy, delivery plans, exclusive breastfeeding, and family planning after birth, by type of facility, Namibia HFC 2009

Counselling topic	Type of facility			Total percentage
	Hospital	Health centre	Clinic	
First-visit ANC client				
Nutrition[1]	79	87	71	76
Progress of pregnancy	70	40	59	55
Any risk symptoms for seeking help	59	38	54	51
Specific risk: vaginal bleeding	54	31	43	41
Specific risk: fever	10	21	15	16
Specific risk: short breath; excess tiredness	21	8	19	16
Specific risk: swelling hands or face	47	24	37	35
Specific risk: headache or blurred vision	35	15	24	23
Delivery plans	67	89	85	84
Exclusive breastfeeding	94	58	71	70
Family planning after birth	30	53	38	41
Provider used any visual aids	61	25	38	38
Number of first-visit ANC clients	39	90	261	390
Follow-up visit ANC client				
Nutrition[1]	44	10	32	27
Progress of pregnancy	46	21	54	45
Any risk symptoms for seeking help	27	8	36	28
Specific risk: vaginal bleeding	27	5	25	20
Specific risk: fever	13	4	12	10
Specific risk: short breath; excess tired	14	2	9	7
Specific risk: swelling hands or face	25	5	26	21
Specific risk: headache or blurred vision	19	2	11	9
Delivery plans	38	14	42	35
Exclusive breastfeeding	38	9	12	13
Family planning after birth	19	19	14	16
Provider used any visual aids	19	3	9	8
Number of follow-up visit ANC clients	31	122	316	469
All observed ANC clients				
Nutrition[1]	64	42	49	49
Progress of pregnancy	59	29	56	50
Any risk symptoms for seeking help	45	21	44	38
Specific risk: vaginal bleeding	42	16	33	29
Specific risk: fever	11	11	13	12
Specific risk: short breath; excess tired	18	4	13	12
Specific risk: swelling hands or face	38	13	31	27
Specific risk: headache or blurred vision	28	8	17	15
Delivery plans	54	46	62	57
Exclusive breastfeeding	69	30	39	39
Family planning after birth	25	34	25	27
Provider used any visual aids	43	12	22	22
Number of all observed ANC clients	70	212	577	859

[1] Any discussion about the quantity and quality of food to eat during the pregnancy

Table A-6.20.2 Observed content of ANC counselling by region

Percentage of first and follow-up visit ANC clients who were observed to receive counselling on topics related to nutrition during pregnancy, risk symptoms, the progress of their pregnancy, delivery plans, exclusive breastfeeding, and family planning after birth, by region, Namibia HFC 2009

Counselling topic	Region													Total percentage
	Caprivi	Erongo	Hardap	Karas	Kavango	Khomas	Kunene	Ohangwena	Omaheke	Omusati	Oshana	Oshikoto	Otjozondjupa	
First-visit ANC client														
Nutrition[1]	65	61	47	62	81	81	71	81	75	88	100	63	71	76
Progress of pregnancy	16	48	32	55	67	76	58	74	81	38	8	41	43	55
Any risk symptoms for seeking help	0	50	42	34	51	62	43	74	44	55	0	54	54	51
Specific risk: vaginal bleeding	0	48	17	23	36	43	29	70	44	49	0	53	49	41
Specific risk: fever	0	7	11	0	29	9	9	30	0	11	0	12	27	16
Specific risk: short breath; excess tiredness	0	7	17	6	3	14	17	49	0	12	0	20	38	16
Specific risk: swelling hands or face	0	20	25	6	31	53	31	70	37	37	0	19	43	35
Specific risk: headache or blurred vision	0	4	28	6	9	24	27	42	0	37	0	33	38	23
Delivery plans	84	78	67	94	79	72	86	98	100	88	100	83	82	84
Exclusive breastfeeding	81	93	32	40	53	95	74	77	88	63	100	73	33	70
Family planning after birth	65	46	28	23	30	43	27	83	50	17	89	24	33	41
Provider used any visual aids	0	45	6	28	48	67	20	64	38	19	11	26	22	38
Number of first-visit ANC clients	3	26	13	11	76	41	55	49	7	33	21	41	16	390
Follow-up visit ANC client														
Nutrition[1]	31	16	15	37	10	86	57	19	81	14	2	35	8	27
Progress of pregnancy	36	54	35	48	42	100	45	69	76	25	20	41	36	45
Any risk symptoms for seeking help	14	29	12	60	8	87	48	54	57	6	1	53	9	28
Specific risk: vaginal bleeding	0	15	10	48	3	87	28	27	29	1	1	47	9	20
Specific risk: fever	0	7	5	23	2	50	9	19	10	0	0	6	4	10
Specific risk: short breath; excess tired	0	14	5	28	0	9	12	19	29	0	0	12	3	7
Specific risk: swelling hands or face	14	26	10	34	3	45	45	54	38	5	0	29	6	21
Specific risk: headache or blurred vision	0	15	8	23	3	13	18	19	29	0	0	41	3	9
Delivery plans	18	38	22	34	16	96	32	65	100	29	0	59	20	35
Exclusive breastfeeding	8	24	8	26	3	27	25	27	33	1	1	12	0	13
Family planning after birth	4	13	2	17	0	13	28	58	33	10	24	6	4	16
Provider used any visual aids	14	2	2	0	3	13	15	58	14	5	0	0	0	8
Number of follow-up visit ANC clients	11	57	25	21	50	44	51	27	9	74	61	7	32	469
All observed ANC clients														
Nutrition[1]	37	30	26	45	53	84	64	59	78	37	27	59	29	49
Progress of pregnancy	32	52	34	50	57	89	52	72	78	29	17	41	38	50
Any risk symptoms for seeking help	11	36	22	51	34	75	45	67	51	21	1	54	24	38
Specific risk: vaginal bleeding	0	26	12	40	23	65	28	55	35	16	1	52	22	29
Specific risk: fever	0	7	7	16	18	31	9	26	5	3	0	11	11	12
Specific risk: short breath; excess tired	0	12	9	20	2	11	15	38	16	4	0	19	14	12
Specific risk: swelling hands or face	11	24	15	25	20	49	38	64	38	15	0	21	19	27
Specific risk: headache or blurred vision	0	12	14	17	7	18	23	34	16	11	0	34	14	15
Delivery plans	31	51	37	55	54	84	60	86	100	48	25	79	40	57
Exclusive breastfeeding	23	46	16	31	33	60	50	59	57	20	26	64	11	39
Family planning after birth	16	23	11	19	18	28	27	74	41	12	40	21	13	27
Provider used any visual aids	11	15	3	9	30	39	18	61	25	9	3	22	7	22
Number of all observed ANC clients	14	83	37	32	126	85	106	76	16	107	82	48	47	859

[1] Any discussion about the quantity and quality of food to eat during the pregnancy

Table A-6.21 Reported health education received and knowledge related to warning signs during pregnancy by type of facility

Among interviewed antenatal care (ANC) clients, percentage who said provider counselled them on warning signs for pregnancy, percentage who named specific warning signs, and percentage who said provider told them what to do in case of warning signs and discussed breastfeeding, delivery plans and supplies and family planning during this visit or a previous visit, by type of facility, Namibia HFC 2009

Issue discussed during current/previous visit	Type of facility			Total percentage
	Hospital	Health centre	Clinic	
Provider counselled on:				
Any warning signs	55	55	45	48
Warning signs named by client				
Vaginal bleeding	50	41	32	36
Fever	1	1	4	3
Swollen face or hands	5	6	10	9
Tiredness or breathlessness	1	3	3	3
Headache or blurred vision	11	7	8	8
Convulsions	0	0	1	1
Reduced foetal movement	11	16	13	14
Early contractions/rupture of membrane	2	6	3	4
What client was told to do if warning sign occurs				
Seek care at facility	53	56	45	49
Decrease activity	0	2	2	2
Change diet	0	0	0	0
Client reported provider discussed				
Exclusive breastfeeding	84	82	65	71
Exclusive breastfeeding 4-6 months	53	59	46	50
Exclusive breastfeeding for 6 months	20	11	10	11
Delivery plans	73	82	74	76
Supplies to prepare for delivery	61	69	53	57
Using family planning after birth	39	52	41	43
Number of interviewed ANC clients	70	212	577	859

Table A-6.22 Reported health education received and knowledge related to warning signs during pregnancy by region

Among interviewed antenatal care (ANC) clients, percentage who said provider counselled them on warning signs for pregnancy, percentage who named specific warning signs, and percentage who said provider told them what to do in case of warning signs and discussed breastfeeding, delivery plans and supplies and family planning during this visit or a previous visit, by region, Namibia HFC 2009

Issue discussed during current/ previous visit	Region													Total percentage
	Caprivi	Erongo	Hardap	Karas	Kavango	Khomas	Kunene	Ohangwena	Omaheke	Omusati	Oshana	Oshikoto	Otjozondjupa	
Provider counselled on:														
Any warning signs	11	46	56	57	41	54	32	44	78	57	47	67	54	48
Warning signs named by client														
Vaginal bleeding	11	27	38	38	22	49	24	29	73	44	38	60	47	36
Fever	0	2	11	7	0	0	3	3	0	3	1	0	15	3
Swollen face or hands	0	13	19	17	2	0	12	8	24	5	4	21	18	9
Tiredness or breathlessness	0	2	9	2	5	0	0	5	0	1	1	7	2	3
Headache or blurred vision	4	11	14	2	6	5	7	9	22	3	5	29	11	8
Convulsions	0	1	0	0	1	0	4	1	0	1	0	0	0	1
Reduced foetal movement	7	8	27	21	15	23	15	3	30	12	9	15	9	14
Early contractions/rupture of membrane	0	0	2	4	0	7	2	1	0	5	4	19	2	4
What client was told to do if warning sign occurs														
Seek care at facility	11	44	54	53	40	59	35	43	78	57	53	68	51	49
Decrease activity	0	4	24	2	1	0	0	0	3	0	0	0	4	2
Change diet	0	1	0	0	1	0	0	0	0	1	0	0	0	0
Client reported provider discussed														
Exclusive breastfeeding	39	80	52	79	65	74	68	69	73	64	93	65	79	71
Exclusive breastfeeding 4-6 months	31	61	14	38	49	28	53	52	22	57	64	61	57	50
Exclusive breastfeeding for 6 months	0	10	17	7	9	37	8	10	35	0	13	2	9	11
Delivery plans	55	57	66	79	75	79	82	67	89	78	79	81	91	76
Supplies to prepare for delivery	22	64	40	47	46	58	54	54	62	62	84	55	67	57
Using family planning after birth	20	48	42	56	54	51	36	34	33	38	53	23	41	43
Number of interviewed ANC clients	14	83	37	32	126	85	106	76	16	107	82	48	47	859

Table A-6.23 Client plan for place of delivery

Among interviewed antenatal care (ANC) clients, percentage who reported planning for where they deliver, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of ANC clients who plan to deliver at:				Number of interviewed ANC clients
	This facility	Other facility	Private home	Don't know	
Type of facility					
Hospital	93	4	0	3	70
Health centre	46	53	1	1	212
Clinic	31	67	1	1	577
Managing authority					
MoHSS	36	62	1	2	743
Mission/NGO	66	34	0	0	113
Private	29	71	0	0	3
Region					
Caprivi	17	76	0	6	14
Erongo	13	85	1	1	83
Hardap	21	79	0	0	37
Karas	41	59	0	0	32
Kavango	54	44	0	2	126
Khomas	53	45	0	2	85
Kunene	68	29	2	1	106
Ohangwena	26	73	0	1	76
Omaheke	14	76	5	5	16
Omusati	44	55	0	2	107
Oshana	27	73	0	0	82
Oshikoto	17	83	0	0	48
Otjozondjupa	51	47	3	0	47
Total	40	58	1	1	859

Table A-6.24 Use of individual health passports

Among first and follow-up visit antenatal care (ANC) clients whose consultation was observed, percentage of consultations in which the provider looked at the client health passport during the consultation and wrote on the client health passport at the end of the visit, by background characteristics, Namibia HFC 2009

Background characteristics	Provider looked at client health passport during consultation		Provider wrote on client health passport at end of visit		Number of first-visit ANC clients	Number of follow-up visit ANC clients
	First visit	Follow-up visit	First visit	Follow-up visit		
Type of facility						
Hospital	100	100	100	100	39	31
Health centre	99	92	100	100	90	122
Clinic	97	93	99	99	261	316
Managing authority						
MoHSS	97	93	99	100	332	411
Mission/NGO	100	96	100	100	57	56
Private	42	22	100	22	1	2
Region						
Caprivi	100	95	100	100	3	11
Erongo	93	89	100	100	26	57
Hardap	76	85	100	100	13	25
Karas	100	88	100	97	11	21
Kavango	100	90	99	97	76	50
Khomas	100	100	100	100	41	44
Kunene	100	100	100	100	55	51
Ohangwena	100	88	100	100	49	27
Omaheke	100	100	100	100	7	9
Omusati	94	92	97	100	33	74
Oshana	100	93	100	99	21	61
Oshikoto	100	94	100	100	41	7
Otjozondjupa	84	97	100	100	16	32
Total	98	93	100	99	390	469

Table A-6.25 Outcome of observed consultations

Among antenatal care (ANC) clients whose consultations were observed, percentage who went home, were referred elsewhere in the same facility, were admitted to the facility, were referred outside the facility, and whose status was uncertain at the end of the consultation, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of ANC consultations where:				Number of observed ANC clients
	Client sent home	Client referred in same facility	Client referred to other facility	Don't know	
Type of facility					
Hospital	35	65	0	0	70
Health centre	91	8	1	1	212
Clinic	87	8	2	2	577
Managing authority					
MoHSS	82	14	2	2	743
Mission/NGO	98	0	1	0	113
Private	34	66	0	0	3
Region					
Caprivi	94	0	0	6	14
Erongo	91	7	0	2	83
Hardap	67	20	13	0	37
Karas	87	5	0	8	32
Kavango	89	10	1	0	126
Khomas	47	53	0	0	85
Kunene	73	22	3	2	106
Ohangwena	89	4	1	5	76
Omaheke	92	8	0	0	16
Omusati	93	4	1	2	107
Oshana	100	0	0	0	82
Oshikoto	87	11	1	1	48
Otjozondjupa	93	0	5	2	47
Total	84	13	2	2	859

Table A-6.26 Client feedback on service problems

Among interviewed ANC clients, percentage who said that they considered specific service issues to be a major problem on the day of the visit, by type of facility, Namibia HFC 2009

Client service issue	Type of facility			Total percentage
	Hospital	Health centre	Clinic	
Behaviour/attitude of provider	8	3	2	3
Ability to discuss problem	0	3	4	3
Insufficient explanation about pregnancy or problems	3	4	5	4
Waiting time to see provider	21	29	26	27
Quality of examination and treatment	0	0	2	1
Availability of medicines	3	2	3	3
Days facility is open	3	4	5	4
Hours facility is open	0	1	6	4
Cleanliness of facility	3	0	4	3
Cost of services	0	1	1	1
Insufficient visual privacy	3	0	0	1
Insufficient auditory privacy	3	0	1	1
Number of interviewed ANC clients	70	212	577	859

Table A-6.27 Client choice of facility

Among interviewed antenatal care (ANC) clients, percentage who reported this was not the closest health facility to their home, and among these, the main reason they did not go to the nearest facility, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of interviewed ANC clients who report this is not the closest facility to their home	Number of interviewed ANC clients	Percentage of ANC clients mentioning the indicated item was a problem with the nearest facility												Number of interviewed ANC clients for whom this was not the closest facility
			Inconve-nient operating hours	Bad reputation	Don't like personnel	No medicines	Prefer anonymity	More expensive	Was referred to this facility	Inconve-nient for visit/work location	No/poor staff	Long wait	No/poor service	Other	
Type of facility															
Hospital	6	70	0	0	0	0	0	0	0	0	10	0	45	45	4
Health centre	10	212	0	7	0	0	2	0	2	11	17	2	43	16	22
Clinic	9	577	12	2	2	2	9	2	4	22	7	8	20	10	50
Managing authority															
MoHSS	9	743	9	2	2	2	6	2	4	17	5	6	30	16	64
Mission/NGO	10	113	0	15	0	0	0	0	0	24	38	0	22	0	11
Private	45	3	0	0	0	0	56	0	0	0	0	44	0	0	1
Region															
Caprivi	7	14	0	0	0	0	0	0	0	50	0	0	0	50	1
Erongo	10	83	0	12	12	0	0	12	0	0	12	41	0	12	8
Hardap	22	37	0	0	0	0	0	0	0	8	0	7	84	0	8
Karas	4	32	0	0	0	0	0	0	0	0	0	50	0	50	1
Kavango	8	126	0	17	0	0	8	0	0	33	16	0	25	0	10
Khomas	12	85	61	0	0	0	0	0	0	0	0	0	20	20	10
Kunene	9	106	0	0	0	0	17	0	17	33	0	0	33	0	9
Ohangwena	5	76	0	0	0	26	0	0	0	52	0	0	0	22	4
Omaheke	0	16	-	-	-	-	-	-	-	-	-	-	-	-	0
Omusati	13	107	0	0	0	0	15	0	0	22	7	0	14	42	13
Oshana	4	82	0	0	0	0	0	0	0	0	100	0	0	0	4
Oshikoto	4	48	0	0	0	0	25	0	50	0	25	0	0	0	2
Otjozondjupa	13	47	0	0	0	0	0	0	0	14	0	0	86	0	6
Total	9	859	8	3	1	1	6	1	3	18	10	6	28	14	76

Table A-6.28 Educational characteristics of antenatal care clients

Percent distribution of observed and interviewed antenatal care (ANC) clients by educational level, and percentage of clients with primary, informal, or no education who are literate, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of all ANC clients:					Number of interviewed ANC clients	Percentage of ANC clients with primary, informal or no education who:			Number of interviewed ANC clients with primary, informal or no education
	No education	Informal	Primary (1-3 or 4-7)	Secondary	Tertiary/ university		Cannot read or write	Can read, cannot write	Can read and write[1]	
Type of facility										
Hospital	0	0	6	90	5	70	0	0	100	4
Health centre	5	0	35	60	1	212	21	2	74	83
Clinic	12	0	21	66	0	577	33	4	60	195
Managing authority										
MoHSS	10	0	22	67	0	743	31	3	63	243
Mission/NGO	2	0	33	63	2	113	13	4	78	39
Private	0	0	0	45	55	3	-	-	-	0
Region										
Caprivi	14	0	22	64	0	14	49	9	42	5
Erongo	0	0	13	87	0	83	0	0	96	11
Hardap	12	0	21	67	0	37	42	5	53	12
Karas	2	0	13	82	3	32	13	0	75	5
Kavango	8	1	51	38	2	126	24	5	68	75
Khomas	0	0	12	86	2	85	0	0	100	10
Kunene	34	0	16	50	0	106	59	3	32	53
Ohangwena	14	0	38	47	1	76	24	5	71	39
Omaheke	22	0	24	54	0	16	47	0	53	7
Omusati	5	0	22	73	0	107	9	3	87	29
Oshana	0	0	16	84	0	82	29	0	71	13
Oshikoto	6	0	19	74	1	48	11	4	86	12
Otjozondjupa	8	0	13	79	0	47	37	0	54	10
Total	9	0	23	66	1	859	29	4	65	282

[1] Clients who completed 7th grade of upper primary are automatically categorised as able to read and write.

Table A-6.29 Emergency maternity transportation systems

Among facilities that support transportation for obstetric emergencies, percentage with specific emergency transportation systems and median transportation time (in minutes) to referral facility, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage using the following emergency transportation systems				Median transportation time (minutes) to referral facility using most common mode of emergency transportation		Number of facilities supporting emergency transportation
	Ambulance or other facility based vehicle[1]	Vehicle at other facility[2]	Facility hires vehicle	Other arrangement to support cost[3]	Dry season	Wet season	
Type of facility							
Hospital	97	46	0	24	121	121	37
Health centre	61	78	7	24	60	61	41
Clinic	10	93	2	13	46	61	239
Managing authority							
MoHSS	22	88	2	13	60	90	268
Mission/NGO	38	81	8	31	45	60	26
Private	74	65	4	30	16	21	23
Region							
Caprivi	7	93	0	4	60	90	27
Erongo	30	87	4	22	51	61	23
Hardap	45	95	0	15	60	90	20
Karas	54	63	0	8	61	61	24
Kavango	17	88	4	35	41	51	52
Khomas	14	86	0	21	30	30	14
Kunene	21	83	0	13	121	240	24
Ohangwena	23	87	0	10	41	51	30
Omaheke	50	93	14	29	121	181	14
Omusati	19	92	0	8	31	60	36
Oshana	33	89	11	22	31	60	9
Oshikoto	29	90	10	14	61	120	21
Otjozondjupa	39	70	0	4	61	121	23
Total	27	86	3	16	60	61	317

[1] Ambulance or other vehicle that stays at the facility
[2] Facility calls for dedicated ambulance or other vehicle from other facility to collect emergency patient.
[3] This may include facility or community financial support, such as funds set aside for emergencies, community insurance scheme, a revolving fund system, or some other system to help provide transport during time of need.

Table A-6.30 Availability of equipment, infrastructure, and staff for quality delivery services

Percentage of facilities offering delivery services that were observed to have equipment, supplies, infrastructure, and staff for infection control and delivery services in the delivery service area, by type of facility, Namibia HFC 2009

Background characteristics	Type of facility			Total percentage
	Hospital	Health centre	Clinic	
Infection control				
Soap	79	82	78	79
Running Water	93	95	81	85
Soap and running water	79	79	70	73
Hand disinfectant	72	39	54	55
Soap and water or else hand disinfectant	86	82	82	82
Clean latex gloves	95	92	93	93
Disinfecting solution	84	79	77	78
Sharps box	100	95	89	92
All items for infection control[1]	74	66	62	65
Covered waste receptacle with plastic liner[2]	33	29	27	29
All items for infection control plus waste receptacle	23	21	18	19
Table cloth/plastic on any surface	12	16	20	18
Infrastructure for delivery				
Visual privacy and auditory privacy	98	100	95	96
Visual privacy only	0	0	2	2
Delivery bed[3]	79	71	87	84
Examination light[4]	88	66	33	47
All elements of infrastructure[5]	72	45	29	38
Other items to support quality services				
Blank Partograph	91	68	36	50
Essential maternal & neonatal care clinical Guidelines for Namibia	5	11	3	4
Other guidelines for normal delivery	16	16	5	8
Guidelines for emergency obstetric care	9	16	4	7
Qualified delivery provider on site 24 hours[6]	95	58	14	34
Qualified delivery provider on call 24 hours[6]	0	5	2	2
All other items to support quality services[7]	21	13	1	6
Number of facilities offering delivery services	43	38	175	256

[1] Soap & running water or else hand disinfectant, clean latex gloves, disinfecting solution for decontaminating reusable items, and sharps box
[2] While important for infection control, this is not an item that has been commonly introduced and so was not included in the aggregate for infection control.
[3] Any type of bed or couch where a client can lie down and deliver a baby
[4] Examination light, flashlight, or other spotlight source
[5] Both visual and auditory privacy, examination bed, and examination light
[6] A duty schedule must be observed.
[7] Guidelines, partograph, and delivery staff available 24 hours per day with duty schedule observed

Table A-6.31 Locations where delivery equipment is sterilised or disinfected

Among facilities that offer delivery services, percentage that process delivery equipment for reuse by sterilisation or high-level disinfection (HLD) in the indicated locations, by background characteristics, Namibia HFC 2009

Background characteristic	Percentage of facilities where delivery service equipment is processed in the indicated area				Number of facilities offering delivery services
	Delivery service area	Main facility area	Outside facility	No processing of delivery equipment	
Type of facility					
Hospital	14	79	7	0	43
Health centre	5	13	71	11	38
Clinic	0	3	94	3	175
Managing authority					
MoHSS	2	12	82	4	218
Mission/NGO	8	28	64	0	25
Private	8	85	8	0	13
Region					
Caprivi	0	4	96	0	23
Erongo	0	46	54	0	13
Hardap	8	23	69	0	13
Karas	0	41	53	6	17
Kavango	0	14	80	7	44
Khomas	0	38	63	0	8
Kunene	4	4	92	0	25
Ohangwena	10	5	85	0	20
Omaheke	0	19	81	0	16
Omusati	3	6	81	10	31
Oshana	8	23	69	0	13
Oshikoto	14	14	64	7	14
Otjozondjupa	0	32	63	5	19
Total	3	17	76	4	256

[1] Main facility area and delivery processing area may be the same location in small facilities.

Table A-6.32 Sterilisation and disinfecting capacity for delivery service equipment in facilities that report equipment processing

Among facilities offering delivery services, percentage where facility has all items to support quality sterilisation or high-level disinfection (HLD) processes, and percentage with written guidelines at the site where delivery equipment is processed for reuse, by background characteristics, Namibia HFC 2009

Background characteristic	Percentage of facilities where the indicated procedure is the highest level for which all conditions for quality sterilisation/HLD of delivery equipment was available			Percentage of facilities with written guidelines for sterilisation or HLD procedures at processing site	Number of facilities offering delivery services and report processing equipment in facility
	Dry heat or autoclave[1]	Boil/steam or chemical HLD[1]	Report sterilisation, but missing equipment or knowledge[2]		
Type of facility					
Hospital	65	5	30	40	40
Health centre	29	0	71	29	7
Clinic	20	0	80	20	5
Managing authority					
MoHSS	61	3	35	29	31
Mission/NGO	33	0	67	44	9
Private	58	8	33	50	12
Region					
Caprivi	100	0	0	0	1
Erongo	83	0	17	50	6
Hardap	0	0	100	75	4
Karas	86	0	14	14	7
Kavango	50	0	50	33	6
Khomas	67	0	33	100	3
Kunene	50	0	50	50	2
Ohangwena	33	0	67	0	3
Omaheke	67	0	33	0	3
Omusati	67	0	33	0	3
Oshana	25	0	75	75	4
Oshikoto	0	50	50	50	4
Otjozondjupa	83	0	17	17	6
Total	56	4	40	37	52

[1] Functioning equipment, appropriate knowledge of temperature and time for method used, and an automatic timer are all present.
[2] Either equipment or knowledge was lacking.

Table A-6.33.1 Storage conditions for sterilised or high-level delivery equipment: Facilities where items are present anywhere in facility

Percentage of facilities with stored, sterilised or high-level disinfected (HLD) delivery instruments present and among these, percentage that meet standards for good storage, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities with stored sterilised/HLD delivery items present anywhere in facility	Number of facilities offering delivery services	Sterile/HLD status storage conditions[1]	Clean, but not sterile, storage conditions[2]	Processing dates observed on processed and stored items	Sterile/HLD status storage conditions and processing dates on sterilised items	Number of facilities with stored sterilised HLD delivery items
Type of facility							
Hospital	100	43	88	0	95	86	43
Health centre	92	38	91	0	89	86	35
Clinic	95	175	75	4	78	67	167
Managing authority							
MoHSS	95	218	78	3	83	73	207
Mission/NGO	100	25	84	0	76	68	25
Private	100	13	92	8	85	85	13
Region							
Caprivi	96	23	73	5	77	73	22
Erongo	100	13	85	0	92	85	13
Hardap	100	13	100	0	85	85	13
Karas	88	17	87	0	87	73	15
Kavango	98	44	67	2	70	58	43
Khomas	100	8	88	0	100	88	8
Kunene	96	25	63	0	92	63	24
Ohangwena	100	20	95	0	90	90	20
Omaheke	100	16	88	6	88	81	16
Omusati	84	31	85	4	81	77	26
Oshana	100	13	69	23	46	38	13
Oshikoto	100	14	79	0	93	79	14
Otjozondjupa	95	19	89	0	94	89	18
Total	96	256	80	3	82	73	245

[1] Items are wrapped is sterile paper, sealed with tape, or stored in a sterile container with a lid that clasps shut, or stored under other sterile conditions, and the storage area is dry and clean.
[2] Items may be wrapped but not sealed, unwrapped on a tray under a cloth, unwrapped on a tray in the steriliser or autoclave, or sitting in disinfecting solution.

Table A-6.33.2 Storage conditions for sterilised or high-level delivery equipment: Facilities where items are present in delivery service area

Percentage of facilities with stored, sterilised or high-level disinfected (HLD) delivery instruments present in the delivery service area, and among these, percentage that meet standards for good storage, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities with stored sterilised/HLD delivery items present in the delivery area	Number of facilities offering delivery services	Sterile/HLD status storage conditions[1]	Clean, but not sterile, storage conditions[2]	Processing dates observed on processed and stored items	Sterile/HLD status storage conditions and processing dates on sterilised items	Number of facilities with stored sterilised HLD delivery items in the delivery area
Type of facility							
Hospital	51	43	82	0	95	82	22
Health centre	18	38	100	0	100	100	7
Clinic	18	175	88	3	75	72	32
Managing authority							
MoHSS	23	218	84	2	84	76	50
Mission/NGO	28	25	100	0	86	86	7
Private	31	13	100	0	100	100	4
Region							
Caprivi	9	23	100	0	100	100	2
Erongo	31	13	75	0	100	75	4
Hardap	23	13	100	0	67	67	3
Karas	41	17	86	0	71	57	7
Kavango	25	44	73	9	64	64	11
Khomas	38	8	67	0	100	67	3
Kunene	8	25	50	0	50	50	2
Ohangwena	45	20	100	0	89	89	9
Omaheke	25	16	100	0	100	100	4
Omusati	10	31	67	0	100	67	3
Oshana	8	13	100	0	100	100	1
Oshikoto	29	14	100	0	100	100	4
Otjozondjupa	42	19	100	0	100	100	8
Total	24	256	87	2	85	79	61

[1] Items are wrapped is sterile paper, sealed with tape, or stored in a sterile container with a lid that clasps shut, or stored under other sterile conditions, and the storage area is dry and clean.
[2] Items may be wrapped but not sealed, unwrapped on a tray under a cloth, unwrapped on a tray in the steriliser or autoclave, or sitting in disinfecting solution.

Table A-6.34 Delivery service providers

Among facilities offering delivery services, percentage where a qualified, trained delivery provider is available onsite on or call 24 hours a day to conduct deliveries, with or without an observed duty schedule, and percentage where the provider on duty at night is most commonly a doctor, a registered nurse/midwife, an enrolled nurse/midwife, or other staff member, by background characteristics, Namibia HFC 2009

Background characteristics	Qualified, trained delivery provider available 24 hours, with observed duty schedule		Qualified, trained delivery provider available 24 hours, with no observed duty schedule		Percentage of facilities where provider commonly on duty to conduct delivery at night is[1]					Number of facilities offering delivery services
	On site	On call	On site	On call	Doctor[2]	Registered nurse/ midwife[3]	Enrolled nurse/ midwife[4]	Nursing assistant	Other/don't know	
Type of facility										
Hospital	95	0	0	0	28	91	65	2	0	43
Health centre	58	5	3	3	5	47	63	3	3	38
Clinic	14	2	17	17	0	25	41	0	1	175
Managing authority										
MoHSS	31	2	13	13	3	38	48	0	1	218
Mission/NGO	44	0	12	12	0	32	60	4	0	25
Private	69	0	0	0	54	69	31	8	0	13
Region										
Caprivi	4	0	17	9	4	22	13	0	0	23
Erongo	62	0	0	8	8	62	38	8	0	13
Hardap	62	8	0	8	0	62	69	0	8	13
Karas	35	6	12	12	6	53	65	0	6	17
Kavango	27	0	18	36	2	23	73	2	0	44
Khomas	63	0	0	13	13	75	13	0	0	8
Kunene	12	4	48	8	4	12	72	0	0	25
Ohangwena	20	0	0	0	10	20	15	0	0	20
Omaheke	63	0	13	13	6	75	81	0	0	16
Omusati	23	0	6	0	0	23	23	0	0	31
Oshana	23	0	8	8	8	31	15	0	0	13
Oshikoto	43	0	0	0	7	43	36	0	0	14
Otjozondjupa	74	11	0	16	16	95	79	0	5	19
Total	34	2	12	12	5	39	48	1	1	256

[1] There may be more than one type of staff who routinely conducts night deliveries at the same facility.
[2] Include gynaecologists and medical officers
[3] Includes all registered nurse midwives, registered nurses, and registered midwives
[4] Includes enrolled nurses and enrolled midwives

Table A-6.35 Availability of medicines and supplies for quality delivery services

Percentage of facilities offering delivery services where specific medicines and supplies are observed to be in the delivery room (DR) and/or pharmacy, by type of facility, Namibia HFC 2009

Item	Type of facility			Total percentage
	Hospital	Health centre	Clinic	
Basic medicines and supplies for delivery				
Scissor or blade	100	97	94	95
Cord clamp or tie	95	87	86	88
Suction apparatus (bulb or machine)	100	92	55	68
Suction bulb	28	11	10	13
Suction machine	100	92	53	67
Antibiotic eye ointment for newborn (delivery room)	77	71	61	65
Antibiotic eye ointment for newborn (pharmacy or delivery room)	93	76	67	73
Skin disinfectant for perineum	95	74	79	81
All basic supplies for delivery[1]	84	45	29	40
Additional medicines and supplies for managing common complications of delivery				
Syringes and needles in DR	100	97	99	99
Syringes and needles in facility	100	100	99	100
Intravenous solution[2] and perfusion set in DR	95	76	84	85
Intravenous solution[2] and perfusion set in facility	100	100	97	98
Oral antibiotic[3] in facility	100	97	95	96
Injectable oxytocic medication in DR	95	47	33	45
Injectable oxytocic medication in facility	98	63	39	53
Suture material in DR	98	100	95	96
Needle holder in DR	100	92	88	91
All basic treatment interventions[4]	88	37	29	40
Additional medicines and supplies for managing serious complications				
Valium or magnesium sulfate in DR	91	58	70	71
Valium or magnesium sulfate in facility	100	89	81	86
Injectable amoxicillin or ampicillin in DR	49	26	7	17
Injectable amoxicillin or ampicillin in facility	95	37	7	26
Injectable procaine penicillin in DR	40	58	58	55
Injectable procaine penicillin in facility	77	74	69	71
Injectable gentamicin in DR	49	29	23	29
Injectable gentamicin in facility	100	45	29	43
All other medicines for complications[5]	91	37	25	38
Injectable hydralazine in DR	79	24	22	32
Injectable ergometrine/methergine in DR	81	55	31	43
Number of facilities offering delivery services	43	38	175	256

[1] Scissor or blade, cord clamp, suction apparatus, antibiotic eye ointment for newborn, and skin disinfectant for perineum

[2] Accepted Intravenous solutions were 0.9% normal saline, Dextrose 5% and normal saline (5%D/NS), Ringers lactate and plasma expanders.

[3] Oral amoxicillin, augmentin (amoxicillin-clavulanate), ampicillin, or co-trimoxazole

[4] Needles and syringes, intravenous solution with infusion set, injectable oxytocic, and suture material and needle holder all located in delivery room area, oral antibiotic (cotrimoxazole or amoxicillin or ampicillin) located in pharmacy or delivery room area

[5] Injectable anticonvulsant (Valium or magnesium sulfate) in delivery room area, an injectable antibiotic (penicillin and ampicillin, or gentamicin) in delivery room area or pharmacy

Table A-6.36 Availability of services, equipment, and supplies for complications of labour and delivery: All facilities

Percentage of all facilities offering delivery services where specific services, equipment and supplies are available for certain complications of labour and delivery, by background characteristics, Namibia HFC 2009

Background characteristics	Assist labour	Remove retained products		Blood transfusion services	Caesarean section	Emergency support for newborn		Number of facilities offering delivery services
	Vacuum extractor	Vacuum aspirator	D&C kit[1]			Newborn respiratory support[2]	External heat source[3]	
Type of facility								
Hospital	63	44	53	95	81	95	98	43
Health centre	0	0	0	3	3	82	47	38
Clinic	0	0	0	1	0	50	4	175
Managing authority								
MoHSS	6	4	7	12	10	61	22	218
Mission/NGO	16	16	12	20	20	60	36	25
Private	69	54	31	85	77	92	85	13
Region								
Caprivi	4	4	0	4	4	26	4	23
Erongo	23	23	23	46	31	54	54	13
Hardap	8	8	8	15	15	77	31	13
Karas	18	6	18	29	24	82	41	17
Kavango	7	5	5	9	7	30	18	44
Khomas	50	25	0	50	50	75	75	8
Kunene	4	4	12	12	12	72	12	25
Ohangwena	5	5	10	10	5	80	20	20
Omaheke	0	0	0	13	13	75	19	16
Omusati	3	6	10	10	6	61	13	31
Oshana	8	0	8	15	15	69	23	13
Oshikoto	14	14	14	21	21	86	50	14
Otjozondjupa	32	16	16	32	26	89	53	19
Total	11	7	9	17	14	62	26	256

[1] Dilation and curettage kit
[2] Infant sized Ambu bag or equivalent
[3] Most often an incubator, although heat light would be sufficient.

Table A-6.37 Capacity to conduct caesarean section

Among facilities that offer caesarean section, percentage where basic items and staff were observed to be available, by background characteristics, Namibia HFC 2009

Background characteristics	Basic item					Additional components		Provider for conducting caesarean section on duty 24-hours[3]	Number of facilities offering caesarean section
	Operating table	Operating light	Scrub area adjacent to OR	Sterilised instruments	All basic items observed[1]	Anaesthetist[2]	Anaesthesia-giving set		
Type of facility									
Hospital	94	94	97	86	86	54	91	69	35
Health centre	100	100	100	100	100	0	100	0	1
Managing authority									
MoHSS	95	95	95	86	86	57	90	67	21
Mission/NGO	80	80	100	60	60	40	80	100	5
Private	100	100	100	100	100	50	100	50	10
Region									
Caprivi	100	100	100	100	100	100	100	100	1
Erongo	100	100	100	100	100	0	100	0	4
Hardap	50	50	100	50	50	0	50	100	2
Karas	100	100	100	75	75	75	100	75	4
Kavango	100	100	100	67	67	33	100	67	3
Khomas	100	100	100	100	100	75	75	75	4
Kunene	100	100	100	100	100	100	100	100	3
Ohangwena	100	100	100	100	100	0	100	100	1
Omaheke	100	100	100	100	100	0	100	0	2
Omusati	100	100	100	100	100	50	100	50	2
Oshana	50	50	50	50	50	50	50	100	2
Oshikoto	100	100	100	67	67	67	100	33	3
Otjozondjupa	100	100	100	100	100	80	100	100	5
Total	94	94	97	86	86	53	92	67	36

[1] Operating table, operating light, scrub area, and sterilised instruments
[2] An anaesthetist is present and duty schedule observed, or reported as on call and a duty roster is observed.
[3] A provider skilled in conducting a CS present and duty schedule observed, or reported on call and duty schedule observed.

Table A-6.38 Newborn care practices

Percentage of facilities that report the indicated practice is a routine component of newborn care, by type of facility, Namibia HFC 2009

Background characteristics	Type of facility			Total percentage
	Hospital	Health centre	Clinic	
Routine newborn care practices				
Routine suction with catheter	65	63	35	45
Full immersion bath within 24 hours after birth	86	47	29	41
Weigh newborn	100	97	86	90
Infant scale available	98	97	69	78
Provide vitamin A to mother	79	97	84	85
Vitamin A in delivery area	72	82	86	83
Vitamin A in pharmacy or delivery area	81	97	98	95
Provide OPV to newborn	98	95	89	91
Provide BCG to newborn	98	95	89	91
Provide prelacteal liquids to newborn	16	3	4	6
Practices rooming-in[1]	98	95	82	87
Number of facilities offering delivery services	43	38	175	256

[1] Newborn stays with mother in the same room, either at all times, or part of the time when woman is in the health facility until she is discharged.

Table A-6.39.1 Emergency obstetric practices: All facilities offering delivery services

Among all facilities offering delivery services, percentage that ever provide specific interventions and percentage that report providing the intervention during the three months preceding the survey, by background characteristics, Namibia HFC 2009

Background characteristics	Assisted delivery[1]		Removal of retained products[2]		Parenteral antibiotics		Parenteral oxytocic drugs		Parental anticonvulsants		Manual removal of placenta		Blood transfusion		Caesarian section		Number of facilities offering delivery services
	Ever	Within past 3 months	Ever	Within past 3 months	Ever	Within past 3 months	Ever	Within past 3 months	Ever	Within past 3 months	Ever	Within past 3 months	Ever	Within past 3 months	Ever	Within past 3 months	
Type of facility																	
Hospital	72	30	86	35	79	72	93	93	63	42	60	33	95	47	81	70	43
Health centre	0	0	5	0	21	18	32	21	18	5	21	11	3	0	3	3	38
Clinic	0	0	1	0	11	3	13	7	15	2	15	6	1	0	0	0	175
Managing authority																	
MoHSS	8	3	12	4	21	15	28	21	23	10	23	11	12	7	10	8	218
Mission/NGO	16	8	20	8	36	24	28	28	24	12	20	8	20	8	20	20	25
Private	69	38	62	31	54	38	62	62	31	0	38	15	85	15	77	69	13
Region																	
Caprivi	4	0	4	0	9	9	30	13	13	9	17	9	4	4	4	4	23
Erongo	31	8	31	15	54	31	54	46	54	8	62	38	46	23	31	31	13
Hardap	8	0	23	15	38	23	54	46	38	23	38	31	15	8	15	15	13
Karas	24	6	24	12	35	24	41	35	47	12	29	6	29	6	24	18	17
Kavango	7	2	14	2	16	11	25	18	11	9	32	14	9	5	7	5	44
Khomas	50	13	50	25	38	38	50	50	25	25	38	13	50	38	50	50	8
Kunene	4	0	12	4	16	12	20	16	4	0	8	0	12	4	12	12	25
Ohangwena	5	0	10	5	35	15	20	20	60	10	70	25	10	5	5	0	20
Omaheke	6	0	6	0	25	19	31	19	13	6	13	13	13	0	13	13	16
Omusati	3	3	13	0	13	10	19	19	26	6	3	0	10	3	6	6	31
Oshana	15	8	15	0	8	8	15	15	8	8	0	0	15	8	15	15	13
Oshikoto	14	14	21	21	29	21	29	21	21	7	0	0	21	14	21	14	14
Otjozondjupa	32	26	16	5	42	32	32	32	21	16	16	16	32	16	26	21	19
Total	12	5	16	6	24	17	29	24	24	9	24	11	17	8	14	12	256

[1] Use of forceps or Ventous (vacuum extractor)
[2] Manual vacuum aspiration or dilatation and curettage

Table A-6.39.2 Emergency obstetric practices: Hospitals and health centres offering delivery services

Among hospitals and Health Centres offering delivery services, percentage that ever provide specific interventions and percentage that report providing the intervention during the three months preceding the survey, by background characteristics, Namibia HFC 2009

Background characteristics	Assisted delivery[1]		Removal of retained products[2]		Parenteral antibiotics		Parenteral oxytocic drugs		Parental anticonvulsants		Manual removal of placenta		Blood transfusion		Caesarian section		Number of hospitals and health centres offering delivery services
	Ever	Within past 3 months	Ever	Within past 3 months	Ever	Within past 3 months	Ever	Within past 3 months	Ever	Within past 3 months	Ever	Within past 3 months	Ever	Within past 3 months	Ever	Within past 3 months	
Type of facility																	
Hospital	72	30	86	35	79	72	93	93	63	42	60	33	95	47	81	70	43
Health centre	0	0	5	0	21	18	32	21	18	5	21	11	3	0	3	3	38
Managing authority																	
MoHSS	30	10	43	15	46	44	64	57	41	28	41	25	44	26	34	28	61
Mission/NGO	40	20	50	20	80	60	60	60	50	30	40	10	50	20	50	50	10
Private	90	50	80	40	60	50	70	70	40	0	50	20	100	20	100	90	10
Region																	
Caprivi	25	0	25	0	25	25	75	50	50	50	50	25	25	25	25	25	4
Erongo	67	17	67	33	83	67	83	83	67	17	100	67	100	50	67	67	6
Hardap	25	0	75	50	75	75	100	100	75	75	50	25	50	25	50	50	4
Karas	57	14	57	29	57	57	57	57	86	29	57	14	57	14	57	43	7
Kavango	25	8	42	8	50	33	58	50	33	25	50	17	33	17	25	17	12
Khomas	100	25	100	50	75	75	100	100	50	50	75	25	100	75	100	100	4
Kunene	17	0	50	17	67	50	83	67	17	0	33	0	50	17	50	50	6
Ohangwena	20	0	40	20	60	60	80	80	40	0	60	60	40	20	20	0	5
Omaheke	33	0	33	0	67	67	33	33	33	33	67	67	67	0	67	67	3
Omusati	11	11	44	0	33	33	56	56	44	22	11	0	33	11	22	22	9
Oshana	33	17	33	0	17	17	33	33	17	17	0	0	33	17	33	33	6
Oshikoto	33	33	50	50	50	50	67	50	33	17	0	0	50	33	50	33	6
Otjozondjupa	67	56	33	11	44	44	44	44	22	22	33	33	67	33	56	44	9
Total	38	16	48	19	52	47	64	59	42	25	42	22	52	25	44	38	81

[1] Use of forceps or Ventous (vacuum extractor)
[2] Manual vacuum aspiration or dilatation and curettage

Table A-6.40 Utilisation of delivery services

Median average monthly number of vaginal deliveries and caesarean sections among facilities with data available on the day of the survey, by type of facility, Namibia HFC 2009

Background characteristic	Median monthly vaginal deliveries	Number of facilities reporting vaginal delivery data	Median monthly caesarean sections	Number of facilities reporting caesarean section data
Type of facility				
Hospital	47	43	10	32
Health centre	6	34	na	1
Clinic	na	88	na	0
Managing authority				
MoHSS	2	136	9	19
Mission/NGO	5	18	16	5
Private	6	11	10	9
Region				
Caprivi	na	21	na	1
Erongo	6	11	11	4
Hardap	3	12	11	2
Karas	3	16	4	3
Kavango	2	26	4	2
Khomas	38	6	48	4
Kunene	na	15	1	3
Ohangwena	47	6	na	1
Omaheke	2	14	9	2
Omusati	10	10	3	2
Oshana	22	3	10	2
Oshikoto	na	11	5	2
Otjozondjupa	4	14	4	5
Total	2	165	10	33

[1] Data are from health information system monthly reports or registers available at the facility the day of the survey. Data were collected for the 12 months preceding the survey; however, frequently some months were missing. Information from the number of months for which data were available was summed and an average monthly number of clients calculated for each facility. This number was then used to calculate the median number of clients per month.
na= Not applicable

Table A-6.41 User fees for delivery services

Percentage of facilities offering delivery services that charge user fees of various kinds, and among these, percentage that offer discounts or exemptions and that publicly post fees, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities charging for indicated item:						Number of facilities offering delivery services	Percentage where fees are posted in public view			Number of facilities having any routine charges for delivery services
	Normal delivery	Fixed fee for ANC plus delivery	Medicines	Tests	Discount/ exemption	No charges or don't know		All fees are posted	Some fees are posted	No fees are posted	
Type of facility											
Hospital	56	14	28	21	33	19	43	37	6	57	35
Health centre	45	3	11	3	32	37	38	33	0	67	24
Clinic	30	1	3	0	31	51	175	18	0	82	85
Managing authority											
MoHSS	33	1	3	0	31	46	218	22	1	77	117
Mission/NGO	44	4	12	4	40	40	25	33	0	67	15
Private	77	38	85	69	31	8	13	42	8	50	12
Region											
Caprivi	35	0	0	0	26	61	23	67	0	33	9
Erongo	15	15	23	15	38	31	13	11	11	78	9
Hardap	46	0	8	0	46	23	13	30	0	70	10
Karas	65	18	12	6	41	24	17	31	0	69	13
Kavango	39	2	9	2	34	48	44	22	0	78	23
Khomas	75	0	25	25	25	25	8	33	17	50	6
Kunene	16	0	0	0	20	68	25	0	0	100	8
Ohangwena	15	0	0	0	70	10	20	11	0	89	18
Omaheke	50	6	13	6	38	19	16	31	0	69	13
Omusati	23	0	3	0	26	58	31	0	0	100	13
Oshana	31	0	8	8	15	69	13	25	0	75	4
Oshikoto	43	7	7	7	36	57	14	33	0	67	6
Otjozondjupa	58	0	21	5	0	37	19	50	0	50	12
Total	36	3	8	4	32	44	256	25	1	74	144

Table A-6.42 Supportive management for providers of delivery services

Among interviewed delivery service providers, percentage who received work-related training and personal supervision during specific time periods, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of interviewed service providers who received:				Number of interviewed delivery service providers[2]
	Training related to delivery services during the 12 months preceding the survey[1]	Personal supervision during the 6 months preceding the survey	Training related to delivery services during the 12 months and personal supervision during the 6 months preceding the survey	Most recent training in the 13-35 months preceding the survey	
Type of facility					
Hospital	47	73	32	17	288
Health centre	32	85	27	38	110
Clinic	37	74	27	27	145
Managing authority					
MoHSS	44	75	32	24	418
Mission/NGO	30	77	24	28	91
Private	36	83	19	8	35
Region					
Caprivi	47	71	32	36	18
Erongo	35	75	31	19	25
Hardap	21	84	20	29	43
Karas	60	72	32	15	38
Kavango	35	73	26	26	85
Khomas	14	93	11	3	20
Kunene	42	63	28	37	26
Ohangwena	44	81	40	31	43
Omaheke	36	93	32	20	19
Omusati	51	86	40	22	74
Oshana	45	69	17	36	47
Oshikoto	50	72	37	20	64
Otjozondjupa	39	59	24	11	42
Total	41	76	30	24	543

[1] This refers to structured pre- or in-service training sessions, and does not include individual instruction received during routine supervision
[2] Includes only providers of delivery services in facilities offering delivery service

Table A-6.43.1 Training for delivery service providers: Topics related to delivery and newborn care

Among interviewed delivery service providers, percentage who received pre- or in-service training on topics related to delivery during the 12 months or 13-59 months preceding the survey, by background characteristics, Namibia HFC 2009

Background characteristics	Delivery care		Use of partograph		Essential obstetric care/ life-saving skills		Post-abortion care		Exclusive breastfeeding		Number of interviewed delivery service providers
	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	
Type of facility											
Hospital	24	16	24	15	23	16	17	7	19	18	288
Health centre	18	15	19	14	15	16	11	11	14	21	110
Clinic	11	16	11	17	11	13	5	8	11	13	145
Managing authority											
MoHSS	18	17	19	16	17	16	12	8	16	18	418
Mission/NGO	18	16	17	16	18	15	15	9	12	14	91
Private	32	6	32	6	32	6	20	6	24	11	35
Region											
Caprivi	32	25	32	25	25	25	4	7	25	21	18
Erongo	16	11	16	7	16	11	13	4	19	7	25
Hardap	12	7	10	9	11	5	4	3	4	9	43
Karas	36	14	36	15	36	14	27	8	33	12	38
Kavango	20	20	20	20	20	18	16	11	19	16	85
Khomas	11	0	11	0	11	0	0	11	11	3	20
Kunene	18	7	18	7	18	7	9	7	17	16	26
Ohangwena	12	14	12	14	8	12	9	7	20	12	43
Omaheke	10	9	10	13	7	9	7	9	16	13	19
Omusati	17	17	21	13	19	15	17	5	16	22	74
Oshana	13	38	11	38	13	38	7	9	2	45	47
Oshikoto	27	20	27	19	27	20	22	14	19	19	64
Otjozondjupa	21	2	21	2	14	5	8	5	9	7	42
Total	19	16	19	15	18	15	13	8	16	17	543

Table A-6.43.2 Training for delivery service providers: Topics related to HIV/AIDS

Among interviewed delivery service providers, percentage who received pre- or in-service training on topics related to HIV/AIDS during the 12 months or 13-59 months preceding the survey, by background characteristics, Namibia HFC 2009

Background characteristics	Care of normal newborn		Neonatal resuscitation		PMTCT[1]		Nutrition counselling for mothers with HIV/AIDS		Modified obstetric practices for HIV/AIDS		Number of interviewed delivery service providers
	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	
Type of facility											
Hospital	17	18	18	13	33	24	25	20	32	16	288
Health centre	14	18	12	16	28	37	22	31	27	31	110
Clinic	7	15	7	13	31	26	23	23	28	24	145
Managing authority											
MoHSS	14	18	14	15	32	30	24	26	30	23	418
Mission/NGO	12	15	12	12	28	24	21	16	27	17	91
Private	18	8	18	10	35	6	30	6	30	8	35
Region											
Caprivi	29	21	25	18	43	36	29	32	43	32	18
Erongo	12	7	10	17	26	21	22	16	23	21	25
Hardap	4	7	4	7	16	25	9	17	16	9	43
Karas	30	18	21	18	54	15	46	15	47	22	38
Kavango	17	16	18	14	29	24	23	17	27	24	85
Khomas	11	3	11	3	14	0	14	0	11	3	20
Kunene	8	16	8	13	40	37	30	42	30	39	26
Ohangwena	18	15	16	15	35	41	29	28	26	28	43
Omaheke	10	13	10	10	32	20	26	16	23	13	19
Omusati	13	21	8	16	40	24	29	29	31	22	74
Oshana	0	41	24	12	21	59	15	58	45	28	47
Oshikoto	19	19	17	19	32	28	19	16	28	21	64
Otjozondjupa	10	9	7	10	28	13	25	10	28	7	42
Total	14	17	14	14	32	27	24	23	29	21	543

[1] Any training on Prevention of mother-to-child transmission of HIV

Table A-6.44 Supportive supervision for delivery service providers

Among interviewed delivery service providers who received a supervisory visit during the 6 months preceding the survey, median number of times providers were supervised, and percentage who report specific activities of the supervisor during the last visit, by background characteristics, Namibia HFC 2009

Background characteristics	Median number of times staff were supervised in the 6 months preceding the survey	Percentage of providers reporting that during the last supervisory visit, the supervisor:						Number of delivery service providers who were supervised in past 6 months[1]
		Checked records	Observed work	Provided feedback	Provided updates	Discussed problems	Delivered supplies	
Type of facility								
Hospital	5	94	85	90	75	81	27	210
Health centre	10	95	80	87	73	83	34	94
Clinic	1	93	61	84	78	91	41	108
Managing authority								
MoHSS	4	93	76	85	76	84	35	312
Mission/NGO	15	98	84	94	66	80	28	70
Private	9	98	85	100	95	100	13	29
Region								
Caprivi	-	95	35	60	60	80	35	12
Erongo	9	100	84	96	77	89	42	19
Hardap	10	95	74	96	74	82	26	36
Karas	12	100	95	94	72	94	36	27
Kavango	5	92	87	87	65	76	41	62
Khomas	-	100	73	88	76	88	15	19
Kunene	1	78	72	78	71	81	49	16
Ohangwena	2	95	77	96	90	84	21	35
Omaheke	3	100	96	97	89	89	40	18
Omusati	-	98	73	87	74	82	18	63
Oshana	20	91	76	84	91	93	46	33
Oshikoto	4	93	68	80	71	85	34	46
Otjozondjupa	4	86	84	88	74	85	38	25
Total	5	94	78	88	75	84	32	411

[1] Includes only providers of delivery services in facilities offering delivery services

Table A-6.45 Use of partograph by delivery service providers

Among interviewed delivery service providers, percent distribution of reported partograph use, by background characteristics, Namibia HFC 2009

Background characteristics	Partograph use						Total	Number of interviewed delivery service providers
	During past 1 week	During past 2-4 weeks	During past 2-6 months	Over 6 months ago	Never	Don't know/ missing		
Type of facility								
Hospital	45	15	10	27	2	0	100	288
Health centre	27	28	11	28	5	1	100	110
Clinic	5	12	9	58	11	5	100	145
Managing authority								
MoHSS	30	17	10	36	5	1	100	418
Mission/NGO	25	15	10	41	6	4	100	91
Private	62	20	8	10	0	0	100	35
Region								
Caprivi	21	14	7	36	18	4	100	18
Erongo	28	16	18	32	5	0	100	25
Hardap	32	22	15	27	2	2	100	43
Karas	33	21	14	27	2	4	100	38
Kavango	26	13	11	41	8	2	100	85
Khomas	56	14	0	29	0	0	100	20
Kunene	37	17	7	35	5	0	100	26
Ohangwena	49	8	8	31	5	0	100	43
Omaheke	24	21	16	26	10	3	100	19
Omusati	36	10	4	46	2	2	100	74
Oshana	18	33	0	46	3	0	100	47
Oshikoto	27	14	18	36	2	2	100	64
Otjozondjupa	25	27	13	23	12	0	100	42
Total	31	17	10	35	5	2	100	543

Chapter 7

Table A-7.1 Availability of services for sexually transmitted infections (STIs) in facilities reporting no primary STI services

Among facilities reporting they do not offer primary services for sexually transmitted infections (STIs), percentage where service providers for antenatal care and family planning report that they offer STI diagnosis and treatment to their clients, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities where providers report STI services are offered to clients attending the indicated service		Number of facilities reporting no STI services
	Family planning services	Antenatal care services	
Type of facility			
Hospital	0	8	13
Health centre	0	0	1
Clinic	0	0	10
Sick bay	50	0	2
Managing authority			
MoHSS	0	25	4
Private	0	0	20
MoD/POLICE	50	0	2
Region			
Caprivi	0	0	1
Erongo	0	0	3
Karas	0	0	3
Khomas	9	9	11
Omaheke	0	0	1
Omusati	0	0	2
Oshana	0	0	2
Oshikoto	0	0	1
Otjozondjupa	0	0	2
Total	4	4	26

Table A-7.2 Availability of systems, infrastructure, and resources to support quality services for sexually transmitted infections

Among facilities offering services for sexually transmitted infections (STIs), percentage where the indicated systems and items to support utilisation of STI services, quality counselling, infection control, and physical examination were observed to be available, by type of facility, Namibia HFC 2009

Item	Type of facility				Total percentage
	Hospital	Health centre	Clinic	Sick bay	
Items to support utilisation of STI services					
Active partner follow-up system	28	28	27	0	26
Passive partner follow-up system	91	100	97	57	96
No follow-up system for partners	9	0	3	43	4
Items to support quality counselling					
Individual client record/chart	81	76	87	71	85
Visual and auditory privacy	84	93	92	71	91
Visual privacy only	3	0	1	0	1
No privacy	13	7	7	29	8
Any guidelines for STIs	81	96	92	71	91
Guidelines for syndromic approach to STIs	81	93	89	71	89
Any visual aids or educational materials for STIs (including HIV/AIDS)	69	98	91	100	90
Educational materials specific for HIV/AIDS	59	85	74	86	74
Male condoms at service delivery site	72	87	90	71	88
Female condoms at service delivery site	44	70	68	43	66
Male condoms anywhere in facility	100	100	99	86	99
Female condoms anywhere in facility	97	89	79	71	82
All items to support quality counselling[1]	38	63	67	14	63
Items for infection control					
Soap	94	87	84	86	85
Running water	100	98	84	100	87
Soap and running water	94	85	76	86	79
Hand disinfectant	66	54	58	29	58
Soap and running water or else hand disinfectant	97	93	89	86	91
Clean latex gloves	94	100	91	71	92
Disinfecting solution	69	76	74	57	74
Sharps box	97	98	97	71	97
All items for control of infection[2]	66	67	65	57	65
Waste receptacle[3]	38	41	34	14	35
All items for control of infection plus waste receptacle	28	28	25	0	25
Tablecloth or plastic on any surface	9	4	14	57	13
Items for physical examination					
Visual and auditory privacy	88	100	94	100	94
Visual privacy	3	0	1	0	1
No privacy	9	0	5	0	5
Examination bed/ couch[4]	91	96	95	71	94
Examination light[5]	69	48	32	0	37
All items for examination	50	48	30	0	34
All conditions to provide quality physical examination[6]	44	28	20	0	23
Number of facilities offering STI services	32	46	285	7	370

[1] Private room assuring visual and auditory privacy, any guidelines for STI diagnosis and/or treatment, any visual aids or educational materials, individual client chart, and male or female condoms in STI service area
[2] Soap and running water or else hand disinfectant, latex gloves, disinfecting solution, and sharps box
[3] While important for infection control, a waste receptacle with plastic liner was not included in the aggregate for infection control.
[4] Any type of couch or bed where a woman can lie down flat
[5] Examination light, flashlight or other spotlight source
[6] 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

Table A-7.3 Availability of specific tests for diagnosis and medicines for treatment of sexually transmitted infections

Percentage of facilities offering services for sexually transmitted infections (STIs) that have equipment and tests for etiological diagnosis of STIs and medicines for treating STIs, by type of facility, Namibia HFC 2009

Item	Type of facility				Total percentage
	Hospital	Health centre	Clinic	Sick bay	
Items for etiologic examination					
Vaginal speculum	75	70	43	0	48
Swab stick for specimen	50	50	23	0	28
Syphilis test capacity[1]	91	96	89	57	89
Gonorrhoea test capacity[2]	81	96	89	57	89
Chlamydia test capacity[3]	19	17	24	14	23
Wet mounting test capacity[4]	91	98	93	57	92
HIV/AIDS testing capacity[5]	72	89	78	86	79
All five laboratory tests	19	17	24	14	23
Medicines for treatment					
Metronidazole (trichomoniasis)	100	96	89	86	91
Ceftriaxone (gonorrhoea)	97	85	78	57	80
Ciprofloxin (gonorrhoea)	91	96	86	100	88
Amoxicillin (Chlamydia)	100	87	87	86	88
Augmentin (Chlamydia)	38	2	3	0	6
Norfloxacin (Chlamydia, gonorrhoea)	3	0	1	0	1
Doxycycline (Chlamydia, syphilis)	94	89	86	57	86
Tetracycline (Chlamydia, syphilis)	0	0	2	0	1
Erythromycin (Chlamydia, syphilis)	97	89	79	100	82
Any injectable or oral Penicillin (syphilis)	100	98	95	71	95
Nystatin oral or vaginal suppositories (candidiasis)	100	50	51	29	54
Miconazole cream or suppositories (candidiasis)	6	0	2	0	2
Clotrimazole cream or suppositories (candidiasis)	100	100	86	57	88
At least one medicine for:					
Trichomoniasis	100	96	89	86	91
Gonorrhoea	100	98	94	100	95
Chlamydia	100	100	97	100	98
Syphilis	100	100	98	100	98
Each of the four STIs assessed[6]	100	93	85	86	88
Number of facilities offering STI services	32	46	285	7	370

[1] Either VDRL or PCR with functioning rotator or shaker, or RPR test
[2] Gram stain reagents and functioning microscope and glass slides, or culture capacity, i.e., culture medium plus incubator
[3] Giemsa stain for Chlamydia and functioning microscope and glass slides, or PCR for Chlamydia testing
[4] Functioning microscope and glass slides
[5] ELISA, Western Blot, HIV rapid test or any other HIV testing capacity available in the facility
[6] At least one medicine for treating trichomoniasis, gonorrhoea, Chlamydia, and syphilis available in the facility

Table A-7.4 Information on user fees for services for sexually transmitted infections

Percentage of facilities with user fees for STI services and among those with user fees, percentage where each of the indicated fee systems is utilised, and percentage publicly posting fees by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities charging for the indicated item:						Number of facilities offering STI services	Percentage where fees are posted in public view			Number of facilities having any user fees for STI services
	Health passport	Consultation	Medicines	Tests	Registration	No charges or don't know		All fees are posted	Some fees are posted	No fees are posted	
Type of facility											
Hospital	22	41	13	3	25	6	32	50	13	37	30
Health centre	26	46	20	4	33	4	46	25	2	73	44
Clinic	18	51	23	4	24	5	285	24	2	74	272
Sick bay	0	0	0	0	0	100	7	-	-	-	0
Managing authority											
MoHSS	19	49	17	1	27	2	302	27	2	72	296
Mission/NGO	25	39	32	0	18	0	28	21	7	71	28
Private	14	72	59	38	17	24	29	27	18	55	22
MoD/POLICE	0	0	0	0	0	100	11	-	-	-	0
Region											
Caprivi	0	85	0	0	15	0	27	41	0	59	27
Erongo	21	33	9	6	15	36	33	33	14	52	21
Hardap	24	62	33	10	29	10	21	32	11	58	19
Karas	23	55	32	14	23	0	22	36	14	50	22
Kavango	14	39	40	5	21	2	57	18	0	82	56
Khomas	32	68	32	18	41	9	22	35	10	55	20
Kunene	57	39	7	0	43	4	28	26	0	74	27
Ohangwena	6	50	9	0	34	0	32	38	0	63	32
Omaheke	20	60	20	0	13	0	15	27	0	73	15
Omusati	4	40	28	2	32	2	47	7	0	93	46
Oshana	0	61	11	0	11	11	18	13	0	88	16
Oshikoto	43	48	0	0	19	0	21	24	5	71	21
Otjozondjupa	19	30	30	0	15	11	27	38	0	63	24
Total	19	49	21	4	25	6	370	26	3	71	346

Table A-7.5 Supportive management of service providers for sexually transmitted infections

Among interviewed providers of services for sexually transmitted infections (STIs), percentage who received work-related training and personal supervision, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of interviewed service providers who received:				Number of interviewed providers of STI services[3]
	Training related to STIs during the 12 months preceding the survey[1]	Personal supervision during the 6 months preceding the survey[2]	Training related to STIs during the 12 months and personal supervision during the 6 months preceding the survey	Most recent training in the 13-35 months preceding the survey	
Type of facility					
Hospital	55	73	39	19	314
Health centre	60	77	45	24	194
Clinic	56	69	39	23	403
Sick bay	23	59	9	27	19
Managing authority					
MoHSS	59	73	43	22	746
Mission/NGO	50	80	41	24	108
Private	34	36	9	23	44
MoD/POLICE	36	66	20	24	31
Region					
Caprivi	73	72	59	14	27
Erongo	51	64	36	24	76
Hardap	27	76	23	22	75
Karas	65	74	43	17	59
Kavango	50	75	34	21	124
Khomas	61	63	33	15	96
Kunene	54	68	41	34	42
Ohangwena	54	79	43	34	84
Omaheke	55	92	50	30	25
Omusati	63	82	50	26	102
Oshana	74	79	60	24	55
Oshikoto	58	69	40	23	99
Otjozondjupa	61	50	33	10	67
Total	56	72	40	22	930

[1] Training here refers to structured pre- or in-service sessions anytime during the 12 months preceding the survey and does not include instructions that they may have received during supervision.
[2] Providers were personally supervised any time during the 6 months preceding the survey.
[3] Includes only providers of STI services in facilities where STI services are offered in any assessed service site or location.

Table A-7.6 Training for providers of services for sexually transmitted infections

Among interviewed providers of services for sexually transmitted infections (STIs), percentage who received pre- or in-service training on specific topics during the 12 months or 13-35 months preceding the survey, by background characteristics, Namibia HFC 2009

Background characteristics	Any diagnosis and treatment for STIs		Syndromic approach for diagnosing and treating STIs		Any course related to HIV/AIDS		Specific course related to PMTCT[1]		Number of interviewed STI service providers[2]
	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	
Type of facility									
Hospital	19	18	15	18	37	19	37	17	314
Health centre	26	21	23	22	45	21	26	31	194
Clinic	23	20	22	18	39	23	29	22	403
Sick bay	4	21	4	12	23	12	0	12	19
Managing authority									
MoHSS	25	20	21	20	41	21	31	24	746
Mission/NGO	12	21	12	20	35	24	37	14	108
Private	18	11	18	8	27	15	24	13	44
MoD/POLICE	7	15	3	9	36	15	0	7	31
Region									
Caprivi	15	23	8	26	57	14	33	26	27
Erongo	30	20	27	18	34	23	20	23	76
Hardap	4	2	3	2	27	17	10	18	75
Karas	21	11	21	9	47	20	49	10	59
Kavango	10	22	10	21	37	19	30	20	124
Khomas	42	10	32	16	37	14	17	13	96
Kunene	24	44	19	33	38	30	26	43	42
Ohangwena	18	18	17	15	45	24	34	27	84
Omaheke	7	10	5	7	44	24	35	21	25
Omusati	33	21	32	22	28	36	36	28	102
Oshana	43	28	42	28	63	16	40	40	55
Oshikoto	12	37	9	36	37	19	39	22	99
Otjozondjupa	24	9	22	8	43	7	34	11	67
Total	22	20	20	19	39	21	30	22	930

[1] Prevention of mother-to-child transmission of HIV/AIDS
[2] Includes only providers of STI services in facilities where STI services are offered in any assessed service site or location

Table A-7.7 Supportive supervision for providers of services for sexually transmitted infections

Among interviewed providers of services for sexually transmitted infections (STIs) who were personally supervised in the 6 months preceding the survey, median number of times they were supervised, and percentage who report specific activities by the supervisor during the last visit, by background characteristics, Namibia HFC 2009

Background characteristics	Median number of times staff were supervised in the 6 months preceding the survey	Percentage of providers reporting that during the last supervisory visit, the supervisor:						Number of STI service providers who received supervision in the 6 months preceding the survey[1]
		Checked records	Observed work	Provided feedback	Provided updates	Discussed problems	Delivered supplies	
Type of facility								
Hospital	5	96	84	84	78	84	28	228
Health centre	4	93	82	86	76	85	32	149
Clinic	3	93	69	84	71	88	36	280
Sick bay	6	89	76	76	68	83	19	11
Managing authority								
MoHSS	4	94	75	84	75	86	32	545
Mission/NGO	3	97	89	90	70	83	32	87
Private	3	92	92	92	83	92	29	16
MoD/POLICE	4	84	72	68	77	91	19	21
Region								
Caprivi	3	87	55	64	65	84	44	19
Erongo	4	99	79	88	75	89	24	49
Hardap	4	91	76	90	71	83	24	57
Karas	5	97	88	92	73	92	33	44
Kavango	4	93	85	84	68	76	37	94
Khomas	4	88	75	60	76	90	34	60
Kunene	3	94	75	89	63	93	42	29
Ohangwena	4	96	60	90	78	79	28	66
Omaheke	3	100	89	94	86	91	36	23
Omusati	4	98	78	91	79	91	23	83
Oshana	7	97	80	89	89	90	36	43
Oshikoto	3	92	76	81	70	89	35	68
Otjozondjupa	4	88	79	85	79	83	37	33
Total	4	94	77	84	75	86	32	669

[1] Includes only providers of STI services in facilities where STI services are offered in any assessed service site or location.

Table A-7.8 Utilisation of services for sexually transmitted infections and sources of data on sexually transmitted infections

Median average monthly number of clients for sexually transmitted infections (STIs) by background characteristics, Namibia HFC 2009

Background characteristics	Median average number of STI clients per month[1]	Number of facilities reporting statistics
Type of facility		
Hospital	21	26
Health centre	15	42
Clinic	5	259
Sick bay	2	6
Managing authority		
MoHSS	6	283
Mission/NGO	10	28
Private	7	13
MoD/POLICE	3	9
Region		
Caprivi	4	27
Erongo	7	29
Hardap	4	18
Karas	2	9
Kavango	6	54
Khomas	12	14
Kunene	6	28
Ohangwena	9	32
Omaheke	16	15
Omusati	3	42
Oshana	9	17
Oshikoto	11	21
Otjozondjupa	7	27
Total	6	333

[1] Median value for the average of the number of months out of the past 12 months for which data were available. Data are from health information system monthly reports available at the facility on the day of the survey. Data were requested for the 12 months preceding the survey, but frequently some months were missing. Information from the months for which data were available was summed and an average monthly number of clients calculated for each facility. This number was then used to calculate the median number of clients per month.

Table A-7.9 Lab capacity to provide services for tuberculosis

Among facilities providing any tuberculosis (TB) services, percentage that have the capacity to test for TB and medicines for treating TB, by type of facility, Namibia HFC 2009

Item	Type of facility				Total percentage
	Hospital	Health centre	Clinic	Sick bay	
Capacity to stain sputum for TB diagnosis[1]	28	31	28	60	29
Capacity to conduct microscopic sputum exam[2]	89	98	94	80	94
Capacity to stain and conduct microscopic sputum exam[3]	28	31	28	60	29
Capacity to culture[4]	17	18	21	60	21
Availability of medicines					
Ethambutol tabs	89	31	24	0	32
Isoniazid (INH) tabs	89	64	65	20	67
Pyrazinamide tabs	78	29	13	0	22
Rifampin tabs	92	31	11	0	22
Streptomycin injection	89	64	37	40	46
Rifina (rifampin & INH)	94	96	83	40	85
RHZ, Rifater (Isoniazid + rifampin+pyrazinamide)	81	69	58	20	61
EH (Isoniazid + ethambutol)	25	16	13	0	14
4FDC (INH, Ethambutol, Pyrazinamide, rifampin)	94	91	79	40	82
Amikacin	61	7	2	0	8
Capreomycin injection	42	0	0	0	5
Cycloserin tabs	61	2	2	0	8
Etionamide tabs	83	24	9	0	19
Levofloxacine	67	2	3	0	10
Para-amino salicylic acid	44	2	1	0	6
Pre-packed DOTS TB drugs	42	24	28	20	29
All first-line TB medicines available[5]	89	67	51	60	57
Number of facilities providing TB diagnostic, treatment and/or follow-up services	36	45	259	5	345

[1] Glass slides plus all stains for AFB or Ziehl-Neelson
[2] Functioning microscope
[3] Functioning microscope and glass slides plus all stains for AFB or Ziehl-Neelson
[4] Culture medium (e.g., MGIT 960) and a functioning incubator
[5] Any combination of Pyrazinamide, rifampicin, ethambutol, Isoniazid and streptomycin. If medicines provided are pre-packaged for individual DOTS clients, medicines had to be available for all DOTS clients currently on treatment from this facility.

Table A-7.10.1 Supportive management of TB services: Laboratory diagnostic services

Among interviewed providers of laboratory TB diagnostic services, percentage who received work-related training and personal supervision during specific time periods, by background characteristics, Namibia HFC 2009

	Percentage of interviewed providers of TB diagnostic services who:				
Background characteristics	Received pre- or in-service training during the past 12 months[1]	Were personally supervised in the past 6 months	Both received pre- or in-service training during the past 12 months and were personally supervised during the past 6 months	Most recent pre- or in-service training was 13-35 months preceding the survey	Number of interviewed providers of lab TB diagnostic services[3]
Type of facility					
Hospital	20	89	20	44	37
Health centre	0	89	0	7	9
Clinic	0	51	0	0	12
Managing authority					
MoHSS	8	80	8	25	41
Mission/NGO	30	100	30	49	14
Total	13	81	13	29	58

[1] This refers to structured pre- or in-service training sessions, and does not include individual instructions received during routine supervision.
[2] Includes only providers of lab TB services in facilities where TB services are offered in any assessed service site or location
[3] Total number includes 2 providers in private and 1 provider in MOD/POLICE-managed facilities.

Table A-7.10.2 Supportive management of TB services: Clinical services

Among interviewed clinical providers of TB services, percentage who received work-related training and personal supervision during specific time periods, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of interviewed clinical providers of TB services who: Received pre- or in-service training during the past 12 months[1]	Were personally supervised in the past 6 months	Both received pre- or in-service training during the past 12 months and were personally supervised during the past 6 months	Most recent pre- or in-service training was 13-35 months preceding the survey	Number of interviewed clinical providers of TB services[2]
Type of facility					
Hospital	31	68	23	18	247
Health centre	41	77	30	24	181
Clinic	38	73	31	31	380
Sick bay	37	69	31	31	10
Managing authority					
MoHSS	37	72	29	27	655
Mission/NGO	37	86	33	21	110
Private	25	30	6	17	32
MoD/POLICE	35	72	25	20	21
Region					
Caprivi	43	67	37	25	25
Erongo	30	69	25	26	78
Hardap	31	83	29	19	75
Karas	39	70	27	21	53
Kavango	39	78	33	22	114
Khomas	48	57	28	12	66
Kunene	24	73	13	49	28
Ohangwena	43	78	34	24	69
Omaheke	38	91	38	19	22
Omusati	30	78	25	37	93
Oshana	40	70	31	26	77
Oshikoto	38	80	33	24	60
Otjozondjupa	32	44	17	33	56
Total	37	72	28	25	817

[1] This refers to structured pre- or in-service training sessions, and does not include individual instructions received during routine supervision.
[2] Includes only clinical providers of TB services in facilities where TB services are offered in any assessed service site or location. Excludes providers of laboratory TB diagnostic services only.

Table A-7.11 Tuberculosis treatment and/or follow-up using DOTS strategy

Percentage of facilities following direct observed treatment short-course (DOTS) strategy, and among these, percentage having the indicated components, by background characteristics, Namibia HFC 2009

	Percent of facilities offering:			Among facilities following DOTS strategy for TB treatment, percentage:					
Background characteristics	Any TB services	DOTS strategy for TB	Number of facilities	Reporting they are part of national DOTS programme	With observed up-to-date client register for DOTS	With observed TB treatment protocol at any site offering TB treatment following the DOTS strategy[1]	With all first-line TB medicines available[2]	With all items for TB indicator[3]	Number of facilities following DOTS strategy for TB treatment
Type of facility									
Hospital	80	44	45	95	90	100	95	85	20
Health centre	96	57	47	89	81	96	81	67	27
Clinic	88	51	295	88	81	97	66	57	150
Sick bay	56	44	9	100	50	100	75	50	4
Managing authority									
MoHSS	93	55	306	92	83	98	73	63	169
Mission/NGO	93	54	28	73	87	100	60	53	15
Private	51	18	49	56	44	78	44	33	9
MoD/POLICE	69	62	13	100	63	100	75	63	8
Region									
Caprivi	96	29	28	50	63	100	50	25	8
Erongo	94	61	36	95	82	95	68	64	22
Hardap	90	57	21	100	100	100	100	100	12
Karas	88	76	25	84	68	95	68	53	19
Kavango	93	58	57	85	73	100	67	52	33
Khomas	55	36	33	92	92	100	100	92	12
Kunene	71	25	28	100	71	100	57	57	7
Ohangwena	94	66	32	100	90	95	57	48	21
Omaheke	88	81	16	100	92	100	85	85	13
Omusati	94	27	49	92	92	92	54	38	13
Oshana	95	35	20	100	86	86	86	57	7
Oshikoto	91	68	22	53	80	100	60	53	15
Otjozondjupa	79	66	29	100	74	100	84	74	19
Total	87	51	396	89	81	98	71	61	201

[1] National guideline for the management of TB, Manual of the national TB and leprosy programme, or any other guideline on the management of TB
[2] Any combination of Pyrazinamide, rifampicin, ethambutol, Isoniazid and streptomycin. If medicines provided are prepackaged for individual DOT clients, medicines had to be available for all DOT clients currently on treatment from this facility.
[3] Observed up-to-date client records or register for DOTS, observed TB treatment guidelines or protocols, plus all first-line TB medicines available in facility.

Table A-7.12 Items to support management of tuberculosis

Among facilities offering any tuberculosis treatment and/or follow-up services, percentage with observed up-to-date client register at any site offering TB treatment, with observed treatment protocols at any site offering TB treatment, and with all first-line medicines, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities offering TB treatment services: Observed up-to-date client record or register at any site offering TB treatment	Observed TB treatment protocol at any site offering TB treatment[1]	All first-line TB medicines available[2]	All items for TB indicator[3]	Number of facilities offering TB treatment and/or follow-up services
Type of facility					
Hospital	66	94	89	63	35
Health centre	73	96	67	56	45
Clinic	67	96	54	40	247
Sick bay	40	100	60	40	5
Managing authority					
MoHSS	69	97	61	45	279
Mission/NGO	85	100	58	54	26
Private	22	67	39	17	18
MoD/POLICE	56	100	67	56	9
Region					
Caprivi	31	100	31	8	26
Erongo	61	87	65	45	31
Hardap	89	100	89	83	18
Karas	64	95	64	50	22
Kavango	67	96	62	40	52
Khomas	80	87	93	80	15
Kunene	32	100	42	26	19
Ohangwena	86	97	66	52	29
Omaheke	86	100	86	79	14
Omusati	69	93	27	18	45
Oshana	79	95	74	53	19
Oshikoto	80	100	50	45	20
Otjozondjupa	64	100	82	64	22
Total	67	96	59	44	332

[1] National guideline for the management of TB, Manual of the national TB and leprosy programme, or any other guideline on the management of TB

[2] Any combination of Isoniazid (INH), rifampicin, ethambutol, Pyrazinamide and streptomycin. If medicines provided are pre-packaged for individual DOTS clients, medicines had to be available for all DOTS clients.

[3] Observed client register for DOTS at any TB treatment site, observed TB treatment protocols at any TB treatment sites, and all first-line TB medicines available in facility.

Table A-7.13 Resources and supplies for diagnosing tuberculosis

Percentage of facilities offering specific TB diagnostic methods, and among those using sputum and X-rays, percentage with capacity for diagnostic activities, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities with indicated TB diagnostic activities				Total number of facilities	Among facilities using sputum test[3] to diagnose TB, percentage with:					Number of facilities diagnosing TB using sputum test	Among facilities using X-ray to diagnose TB, percentage with X-ray capacity[5]	Number of facilities diagnosing TB using X-ray
	Any TB diagnostic services[1]	Sputum[2]	X-ray	Clinical symptoms		All items for conducting sputum test for TB[3]	Documented system for sending sputum elsewhere for TB diagnosis	Observed record of sputum test results	All items for indicator[4]	Staff trained in sputum TB test in 36 months preceding survey			
Type of facility													
Hospital	80	78	27	2	45	49	49	69	69	37	35	58	12
Health centre	91	89	9	2	47	48	52	93	93	2	42	75	4
Clinic	82	76	3	2	295	48	52	83	83	0	223	40	10
Sick bay	44	44	0	0	9	75	25	100	100	0	4	-	0
Managing authority													
MoHSS	88	84	5	1	306	46	53	86	86	3	257	50	14
Mission/NGO	89	82	11	4	28	48	52	87	87	26	23	100	3
Private	43	33	16	4	49	63	31	25	25	0	16	38	8
MoD/POLICE	62	62	8	0	13	88	13	88	88	0	8	100	1
Region													
Caprivi	96	96	0	0	28	100	0	100	100	0	27	-	0
Erongo	86	69	17	8	36	92	8	60	60	8	25	67	6
Hardap	90	90	14	0	21	5	95	95	95	11	19	67	3
Karas	84	84	24	0	25	10	90	90	90	0	21	50	6
Kavango	89	77	4	5	57	48	52	61	61	9	44	100	2
Khomas	55	55	15	0	33	83	11	67	67	0	18	20	5
Kunene	43	36	0	0	28	10	90	100	100	10	10	-	0
Ohangwena	94	94	6	0	32	0	100	93	93	3	30	0	2
Omaheke	88	88	0	0	16	100	0	100	100	0	14	-	0
Omusati	84	80	2	2	49	21	79	100	100	5	39	100	1
Oshana	95	95	0	0	20	5	95	47	47	5	19	-	0
Oshikoto	91	77	5	0	22	100	0	100	100	6	17	100	1
Otjozondjupa	72	72	0	0	29	76	14	76	76	0	21	-	0
Total	82	77	7	2	396	48	51	83	83	5	304	54	26

[1] Includes diagnosing TB using sputum smears, or using x-ray, or by clinical symptoms, or using any combination of the indicated methods.
[2] Includes diagnosing TB using sputum microscopy, sputum culture, or any TB rapid test using sputum.
[3] All stains required for AFB or Ziehl-Neelson test are available, plus a functioning microscope and glass slides with covers, or agar plates for culture and a functioning incubator or any rapid TB diagnostic test kit.
[4] All items for conducting test or reported system for sending sputum elsewhere, and record of TB test results
[5] Functioning x-ray machine with films

Table A-7.14 Tuberculosis and HIV services

Among facilities offering any TB services, percentage that refer TB clients for HIV testing, percentage with records on HIV testing and status of TB clients, and percentage with service providers trained on TB, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities where newly diagnosed TB clients are referred for HIV testing		Percentage of facilities with observed records/register of:		TB service provider received TB-related training in:		Number of facilities offering any TB services
	All cases routinely referred[1]	Only suspect cases referred[2]	Newly diagnosed TB clients referred for HIV testing	Current TB clients who are also HIV positive	The 12 months preceding the survey	The 13-35 months preceding the survey	
Type of facility							
Hospital	89	6	56	69	69	14	36
Health centre	93	4	80	93	78	13	45
Clinic	82	5	68	74	51	31	259
Sick bay	80	20	20	40	80	0	5
Managing authority							
MoHSS	87	4	71	80	58	27	285
Mission/NGO	96	4	88	92	54	31	26
Private	36	16	16	16	36	16	25
MoD/POLICE	89	11	44	56	67	11	9
Region							
Caprivi	85	7	7	81	41	30	27
Erongo	74	3	41	59	56	21	34
Hardap	89	0	79	89	74	21	19
Karas	95	5	77	82	77	18	22
Kavango	77	8	75	77	55	25	53
Khomas	61	17	50	67	67	6	18
Kunene	55	5	55	40	20	50	20
Ohangwena	97	0	90	73	73	20	30
Omaheke	100	0	100	93	50	36	14
Omusati	93	2	78	78	39	41	46
Oshana	89	11	84	84	68	16	19
Oshikoto	90	5	80	90	60	25	20
Otjozondjupa	87	4	74	74	74	22	23
Total	84	5	68	75	57	26	345

[1] All newly diagnosed TB clients are routinely referred for HIV testing regardless of whether they show any signs of HIV infection.
[2] Only those newly diagnosed TB clients who are suspected to be infected with HIV are referred for HIV testing.

Table A-7.15 Tuberculosis infection control plans

Among facilities offering any tuberculosis treatment and/or follow-up services, percentage having TB infection control plans, by background characteristics, Namibia HFC 2009

Background characteristics	TB Infection Control					TB Infection control plan	Facility applies SOP for management of cough patients in waiting area	N95 respirator		Number of facilities offering TB diagnostic treatment and/or follow-up services
	TB IC focal person	TB IC committee	Both TB IC focal person and IC committee	Either TB IC focal person or IC committee	Neither			Facility uses N95 respirator, observed	Facility uses N95 respirator, reported not seen	
Type of facility										
Hospital	66	3	0	69	31	51	63	60	6	35
Health centre	40	2	7	49	51	29	33	13	0	45
Clinic	33	3	2	38	60	23	38	6	2	247
Sick bay	60	0	0	60	40	20	20	0	0	5
Managing authority										
MoHSS	35	3	3	41	57	27	42	12	2	279
Mission/NGO	50	0	0	50	50	31	42	23	4	26
Private	44	6	0	50	50	22	22	11	0	18
MoD/POLICE	67	0	0	67	33	22	22	11	11	9
Region										
Caprivi	12	0	0	12	88	4	50	4	0	26
Erongo	35	16	0	52	48	29	35	10	3	31
Hardap	28	11	33	72	17	56	22	17	0	18
Karas	36	0	0	36	64	27	50	9	5	22
Kavango	40	2	0	42	56	19	29	12	2	52
Khomas	60	0	0	60	33	33	53	27	0	15
Kunene	16	0	0	16	84	16	21	11	0	19
Ohangwena	86	0	3	90	10	69	79	14	3	29
Omaheke	36	7	0	43	57	43	71	21	7	14
Omusati	20	0	0	20	80	4	31	13	2	45
Oshana	63	0	0	63	37	32	21	11	0	19
Oshikoto	50	0	0	50	45	30	50	15	5	20
Otjozondjupa	18	0	9	27	73	18	27	18	0	22
Total	38	3	3	43	55	27	40	13	2	332

Chapter 8

Table A-8.1 Pre- and post-test counselling for HIV: Components in any testing site

Among facilities that have a system for HIV testing, percentage with program components to support counselling and testing (CT) services, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities with observed written policy for routine provision of pre- and post-test counselling for HIV testing[1]	Percentage of facilities with at least one counsellor trained in pre- and post-test counselling who is assigned to a HIV testing site	Percentage of facilities where any HIV testing site has:					Percentage of facilities with all items for counselling[3]	Number of facilities with HIV testing system[4]
			Observed guidelines for content of pre- and post-test counselling[2]	Observed guidelines or policy on confidentiality for HIV test results	Observed up-to-date record for clients receiving pre- and post-test counselling	Observed system linking test results with pre- and post-test counselling	Visual and auditory privacy possible in counselling areas		
Type of facility									
Hospital	69	89	69	80	60	80	73	49	45
Health centre	85	96	85	98	91	96	94	81	47
Clinic	79	80	79	88	70	74	78	59	289
Free standing VCT	93	100	93	79	86	93	93	57	14
Sick bay	57	71	57	71	0	29	71	0	7
Managing authority									
MoHSS	86	85	86	89	79	82	82	67	306
Mission/NGO	86	90	86	83	86	90	83	69	42
Private	26	60	26	84	12	30	58	5	43
MoD/POLICE	64	82	55	82	9	55	82	9	11
Region									
Caprivi	79	96	79	100	93	93	86	64	28
Erongo	69	81	67	86	56	64	81	47	36
Hardap	83	83	83	91	70	78	87	65	23
Karas	80	96	80	84	72	92	84	52	25
Kavango	69	78	69	79	72	76	76	55	58
Khomas	61	77	61	94	42	61	71	29	31
Kunene	83	66	83	62	59	59	62	45	29
Ohangwena	97	97	97	94	91	94	94	82	33
Omaheke	81	88	75	100	88	88	88	75	16
Omusati	86	76	86	86	68	74	76	66	50
Oshana	90	90	90	95	67	76	81	62	21
Oshikoto	95	95	95	95	95	95	91	91	22
Otjozondjupa	67	77	67	90	63	67	73	53	30
Total	79	83	78	88	71	77	80	59	402

[1] Presence of Namibia National Guideline for voluntary HIV counselling and testing, or any other guideline that specifically mentions that all clients receiving HIV test must be offered pre-test counselling or information, and post- test counselling for both positive and negative test results in any relevant HIV counselling and testing service site.
[2] Pre-test counselling may consist of general education for groups or individual client counselling. Availability of the Namibia National guidelines for voluntary HIV counselling and testing, or any other guideline that specifies pre-test counselling or information sharing, and post-test counselling counts.
[3] Facility has written policy for provision of pre-test and post-test counselling for HIV testing, at least one trained counsellor assigned to counselling and testing site, observed guidelines for content of counselling, policy on confidentiality, records of clients receiving pre-test and post-test counselling, observed system linking test results with pre-/post-test counselling, and visual and auditory privacy in counselling areas.
[4] Facility either conducts the test, or has an affiliated external laboratory, or has an agreement with a testing site where the test results are expected to be returned to the facility.

Table A-8.2 Tuberculosis treatment at HIV service sites using DOTS

Percentage of facilities offering HIV/AIDS care and support services (CSS), and among these, percentage with different tuberculosis (TB) activities; and among facilities offering HIV/AIDS CSS and TB treatment following the direct observation of therapy (DOTS), percentage with program components that support TB treatment, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities offering HIV/AIDS CSS[1]	Number of facilities	Among facilities offering HIV/AIDS CSS, percentage with indicated TB activities			Number of facilities offering HIV/AIDS CSS	Among facilities offering HIV/AIDS CSS and following DOTS treatment strategy, percentage with				Number of facilities offering HIV/AIDS CSS and following DOTS treatment strategy
			Any TB diagnostic or treatment services[2]	Report they are part of national DOTS program	Follow DOTS treatment strategy[3]		Observed client register for DOTS	Observed TB treatment protocol	All first-line TB medicines available[4]	All items for TB indicator[5]	
Type of facility											
Hospital	98	45	82	66	45	44	65	100	95	60	20
Health centre	98	47	98	76	59	46	74	96	81	63	27
Clinic	88	295	90	63	52	259	64	98	66	54	134
Sick bay	67	9	67	67	67	6	50	100	75	50	4
Managing authority											
MoHSS	92	306	94	70	55	281	68	99	74	58	155
Mission/NGO	89	28	100	72	56	25	64	100	64	50	14
Private	80	49	59	18	21	39	38	75	38	25	8
MoD/POLICE	77	13	80	80	80	10	50	100	75	50	8
Region											
Caprivi	96	28	100	19	30	27	0	100	50	0	8
Erongo	89	36	97	81	66	32	67	95	67	57	21
Hardap	100	21	90	81	57	21	100	100	100	100	12
Karas	88	25	91	73	77	22	59	94	71	47	17
Kavango	77	57	95	70	57	44	68	100	64	52	25
Khomas	85	33	61	39	39	28	91	100	100	91	11
Kunene	89	28	80	52	28	25	29	100	57	29	7
Ohangwena	97	32	94	90	68	31	71	95	57	43	21
Omaheke	94	16	93	93	87	15	92	100	85	85	13
Omusati	86	49	93	57	21	42	67	100	67	44	9
Oshana	100	20	95	80	35	20	71	86	86	57	7
Oshikoto	100	22	91	36	68	22	40	100	60	40	15
Otjozondjupa	90	29	85	81	73	26	63	100	84	63	19
Total	90	396	90	65	52	355	65	98	72	56	185

[1] Providers assigned to this facility provide treatment for any opportunistic infections or symptoms related to HIV/AIDS (such as treatment for topical fungal infections, cryptococcal meningitis or Kaposi sarcoma), or provide (or prescribe) palliative care for patients (such as symptom or pain management, or nursing care for the terminally ill) , or provide nutritional rehabilitation services, including the prescription or provision of fortified protein supplements, or provide care for paediatric HIV/AIDS patients.
[2] Facility conducts TB tests for TB diagnosis (sputum or x-ray or both), or these tests are done externally and there is record of test results, or providers diagnose TB based on clinical symptoms, or providers prescribe initial therapy or provide follow-up treatment services for TB patients.
[3] Treatment strategy followed is either direct-observe 2 months with 4 months follow-up, or direct-observe 6 months.
[4] Any combination of Isoniazid (INH), rifampicin, ethambutol, and Pyrazinamide and streptomycin. If medicines provided are prepackaged for individual DOTS clients, medicines had to be available for all DOTS clients.
[5] Observed client records or register for DOTS and observed TB treatment protocols and all first-line TB medicines available in facility.

Table A-8.3 Treatment and/or follow-up for tuberculosis using any treatment strategy

Among facilities offering HIV/AIDS care and support services (CSS) and any tuberculosis treatment services, percentage having the indicated components for management of tuberculosis (TB), by background characteristics, Namibia HFC 2009

Background characteristics	Percent of facilities offering TB treatment services	Number of facilities offering HIV/AIDS CSS	Among facilities offering HIV/AIDS CSS and offering any TB treatment services, percentage reporting they follow indicated treatment strategy			Among facilities offering HIV/AIDS CSS and offering any TB treatment services, percentage with				Number of facilities offering HIV/AIDS CSS and offering any TB treatment services
			DOTS[1]	Follow-up treatment only[2]	Other strategies[3]	Observed up-to-date client register at any site	Observed TB treatment protocol at any site	All first-line TB medicines available[4]	All items for TB indicator[5]	
Type of facility										
Hospital	80	44	57	3	40	66	94	89	63	35
Health centre	98	46	60	20	20	73	96	67	56	45
Clinic	86	259	60	22	18	67	97	54	41	222
Sick bay	67	6	100	0	0	50	100	75	50	4
Managing authority										
MoHSS	91	281	60	21	18	69	98	61	46	257
Mission/NGO	100	25	56	16	28	84	100	60	56	25
Private	41	39	50	0	50	19	69	38	13	16
MoD/POLICE	80	10	100	0	0	63	100	75	63	8
Region										
Caprivi	96	27	31	0	69	31	100	31	8	26
Erongo	88	32	75	7	18	64	89	64	46	28
Hardap	86	21	67	17	17	89	100	89	83	18
Karas	91	22	85	5	10	60	95	65	50	20
Kavango	93	44	61	7	32	68	98	61	41	41
Khomas	50	28	79	7	14	79	86	93	79	14
Kunene	76	25	37	63	0	32	100	42	26	19
Ohangwena	90	31	75	21	4	86	96	64	50	28
Omaheke	93	15	93	7	0	86	100	86	79	14
Omusati	90	42	24	63	13	68	95	29	21	38
Oshana	95	20	37	26	37	79	95	74	53	19
Oshikoto	91	22	75	5	20	80	100	50	45	20
Otjozondjupa	81	26	90	0	10	67	100	86	67	21
Total	86	355	60	19	20	67	96	60	45	306

[1] Treatment strategy followed is either direct observe 2 months with 4 months follow-up, or direct observe 6 months.
[2] Facility provides follow-up for TB clients only after clients have received intensive direct observation of therapy elsewhere.
[3] Facility does not provide direct observed treatment for TB patients, or patients are treated only while inpatient but discharged to a different facility for follow-up treatment services.
[4] Any combination of Isoniazid (INH), rifampicin, ethambutol, Pyrazinamide and streptomycin. If medicines provided are prepackaged for individual DOTS clients, medicines had to be available for all DOTS clients.
[5] Observed client register for DOT and observed TB treatment protocols and all first-line TB medicines available in facility.

Table A-8.4 Resources and supplies for diagnosing tuberculosis

Among facilities offering HIV/AIDS care and support services (CSS), percentage diagnosing tuberculosis (TB), and percentage with the indicated diagnostic elements, by background characteristics, Namibia HFC 2009

Background characteristics	Among facilities offering HIV/AIDS CSS, percentage with indicated TB diagnostic activities				Number of facilities offering HIV/AIDS CSS	Among facilities offering HIV/AIDS CSS and diagnosing TB using sputum[2] percentage with:				Number of facilities offering HIV/AIDS CSS and diagnosing TB using sputum test	Percentage with x-ray capacity[4]	Number of facilities offering HIV/AIDS CSS and diagnosing TB using x-ray
	Any TB diagnostic services[1]	Use sputum for TB diagnosis[2]	Use X-ray for TB diagnosis	Use clinical symptoms		All items for conducting sputum test for TB	Reported system for sending sputum elsewhere for TB diagnosis	Observed record of sputum test results	All items for indicator[3]			
Type of facility												
Hospital	82	80	27	2	44	49	89	69	69	35	58	12
Health centre	93	91	9	2	46	48	98	93	93	42	75	4
Clinic	85	79	4	2	259	48	97	81	81	204	40	10
Sick bay	67	67	0	0	6	75	100	100	100	4	-	0
Managing authority												
MoHSS	89	85	5	1	281	46	96	85	85	239	50	14
Mission/NGO	96	92	12	4	25	48	100	87	87	23	100	3
Private	51	38	21	5	39	67	87	27	27	15	38	8
MoD/POLICE	80	80	10	0	10	88	88	88	88	8	100	1
Region												
Caprivi	100	100	0	0	27	100	100	100	100	27	-	0
Erongo	94	75	19	9	32	96	67	63	63	24	67	6
Hardap	90	90	14	0	21	5	100	95	95	19	67	3
Karas	86	86	27	0	22	11	100	89	89	19	50	6
Kavango	93	84	5	7	44	38	100	54	54	37	100	2
Khomas	61	61	18	0	28	82	88	65	65	17	20	5
Kunene	48	40	0	0	25	10	100	100	100	10	-	0
Ohangwena	94	94	6	0	31	0	100	93	93	29	0	2
Omaheke	93	93	0	0	15	100	100	100	100	14	-	0
Omusati	81	76	2	2	42	22	100	100	100	32	100	1
Oshana	95	95	0	0	20	5	100	47	47	19	-	0
Oshikoto	91	77	5	0	22	100	100	100	100	17	100	1
Otjozondjupa	81	81	0	0	26	76	90	76	76	21	-	0
Total	85	80	7	2	355	48	96	82	82	285	54	26

[1] Facility conducts TB tests for TB diagnosis (sputum or x-ray or both), or these tests are done externally and there is record of test results, or providers diagnose TB based on clinical symptoms.
[2] Includes sputum microscopy, culture, or rapid test.
[3] All items for conducting test or documented system for sending sputum elsewhere, and record of test results
[4] Functioning x-ray machine with films

Table A-8.5 Malaria diagnosis and treatment

Among facilities offering HIV/AIDS care and support services (CSS), percentage offering malaria treatment, and among those, percentage having the indicated components for supporting services for malaria, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities that offer malaria treatment services	Percentage of facilities with lab diagnostic capacity for malaria[1]	Number of facilities offering HIV/AIDS CSS	Among facilities offering HIV/AIDS CSS and malaria treatment services, percentage with			Number of facilities offering HIV/AIDS CSS and offering malaria treatment services
				Observed malaria treatment protocol in any relevant site	Coartem available in facility	Treatment protocol in any relevant site and Coartem in facility	
Type of facility							
Hospital	82	98	44	64	94	61	36
Health centre	100	100	46	93	85	83	46
Clinic	89	97	259	90	77	73	230
Sick bay	67	50	6	50	75	50	4
Managing authority							
MoHSS	95	99	281	93	82	77	266
Mission/NGO	100	96	25	96	88	84	25
Private	49	85	39	5	47	5	19
MoD/POLICE	60	70	10	50	83	50	6
Region							
Caprivi	100	100	27	93	96	89	27
Erongo	53	97	32	76	76	53	17
Hardap	81	95	21	65	53	41	17
Karas	77	91	22	76	71	59	17
Kavango	100	93	44	89	95	89	44
Khomas	57	89	28	50	69	44	16
Kunene	100	100	25	100	72	72	25
Ohangwena	100	100	31	97	90	87	31
Omaheke	93	100	15	100	86	86	14
Omusati	98	98	42	90	76	68	41
Oshana	100	95	20	85	60	50	20
Oshikoto	100	100	22	100	95	95	22
Otjozondjupa	96	100	26	88	76	68	25
Total	89	97	355	87	80	72	316

[1] Microscopy or malaria rapid diagnostic test (RDT) available either in the facility or in an affiliated external laboratory.

Table A-8.6 Diagnosis and treatment of sexually transmitted infections at HIV service sites: Treatment protocols

Percentage of facilities offering HIV/AIDS care and support services (CSS) that treat sexually transmitted infections (STIs), and among these, percentage having the indicated components to support STI services (including treatment protocols at any service sites), by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities that offer STI treatment services	Number of facilities offering HIV/AIDS CSS	Percentage of facilities offering HIV/AIDS CSS and STI services, with					Number of facilities offering HIV/AIDS CSS and STI treatment services
			Observed STI treatment guideline in any relevant site	Medications for treating each major STI[1]	Male condoms in any service area or pharmacy	Female condoms in any service area or pharmacy	All items for STI services[2]	
Type of facility								
Hospital	91	44	80	98	75	60	65	40
Health centre	100	46	98	93	98	89	93	46
Clinic	99	259	92	84	98	79	80	257
Sick bay	100	6	67	83	83	50	33	6
Managing authority								
MoHSS	100	281	98	91	98	81	87	281
Mission/NGO	100	25	100	84	100	84	84	25
Private	85	39	39	55	82	55	24	33
MoD/POLICE	100	10	60	80	70	40	40	10
Region								
Caprivi	100	27	96	100	100	93	96	27
Erongo	100	32	81	81	91	81	69	32
Hardap	100	21	76	90	100	76	76	21
Karas	100	22	77	86	91	77	64	22
Kavango	100	44	95	82	98	50	77	44
Khomas	82	28	78	78	96	70	74	23
Kunene	100	25	100	88	96	80	84	25
Ohangwena	100	31	100	97	100	81	97	31
Omaheke	100	15	87	87	100	100	80	15
Omusati	100	42	100	81	93	88	76	42
Oshana	100	20	95	85	90	85	75	20
Oshikoto	100	22	95	95	95	91	91	22
Otjozondjupa	96	26	88	84	92	64	72	25
Total	98	355	91	87	95	78	79	349

[1] At least one medicine for treating syphilis (Doxycycline, erythromycin, penicillin, or tetracycline), at least one medicine for treating gonorrhoea (Ceftriaxone, ciprofloxacin, or Norfloxacin), at least one medicine for treating Chlamydia (amoxicillin, Doxycycline, erythromycin, Norfloxacin, or tetracycline), and at least one medicine for treating trichomoniasis (Metronidazole , tinidazole, or Miconazole vaginal suppository)

[2] Observed treatment protocols in any relevant STI service site, STI medicines available, and condoms in any service area or pharmacy.

Table A-8.7 Supportive management practices for providers of TB, malaria, or STI treatment

Among facilities offering HIV/AIDS care and support services (CSS), percentage with management practices that support treatment of TB, malaria and STIs, including protocols at any relevant sites, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities offering HIV/AIDS CSS	Number of facilities	Percentage of facilities offering HIV/AIDS CSS with: Training for providers of TB, malaria or STI services[1]	Supervision for providers of TB, malaria or STI services[2]	All items for TB, malaria and STI services, including guidelines or protocols at any relevant service sites[3]	Number of facilities offering HIV/AIDS CSS
Type of facility						
Hospital	98	45	57	68	23	44
Health centre	98	47	87	87	30	46
Clinic	88	295	85	71	17	259
Sick bay	67	9	67	50	0	6
Managing authority						
MoHSS	92	306	90	80	22	281
Mission/NGO	89	28	88	92	28	25
Private	80	49	15	13	0	39
MoD/POLICE	77	13	70	60	0	10
Region						
Caprivi	96	28	96	74	7	27
Erongo	89	36	69	63	16	32
Hardap	100	21	71	86	24	21
Karas	88	25	68	68	14	22
Kavango	77	57	89	73	20	44
Khomas	85	33	46	43	18	28
Kunene	89	28	100	72	12	25
Ohangwena	97	32	84	84	32	31
Omaheke	94	16	80	93	47	15
Omusati	86	49	86	81	7	42
Oshana	100	20	90	80	25	20
Oshikoto	100	22	95	91	27	22
Otjozondjupa	90	29	81	50	23	26
Total	90	396	81	73	19	355

[1] At least half of the interviewed providers of TB, malaria, or STI services reported they received pre- or in-service training related to one of these topics during the 3 years preceding the survey.
[2] At least half of the interviewed providers of TB, malaria, or STI services reported they were personally supervised at least once during the 3 months preceding the survey.
[3] All records, guidelines, medicines, and trained and supervised staff for offering tuberculosis, malaria, and STI services

Table A-8.8 Isoniazid for preventing tuberculosis in HIV/AIDS clients

Among facilities offering HIV/AIDS care and support services (CSS), percentage offering Isoniazid preventive treatment (IPT) for tuberculosis (TB) to HIV/AIDS clients, and among these, percentage with program components supporting preventive treatment for TB (including treatment protocols at any service site), by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities offering Isoniazid preventative treatment for TB to HIV/AIDS clients			Number of facilities offering HIV/AIDS CSS	Among facilities offering Isoniazid preventative treatment for TB, percentage with			Number of facilities offering HIV/AIDS CSS and reporting they offer Isoniazid preventative treatment for TB
	Offers routinely[1]	Offers selectively[2]	Routinely refers clients elsewhere[3]		Observed guideline or protocol for Isoniazid preventative treatment for TB in any relevant service site	Isoniazid available in facility	At least one provider of Isoniazid preventative treatment trained during the 3 years preceding the survey	
Type of facility								
Hospital	57	14	7	44	13	87	42	31
Health centre	57	13	13	46	6	69	41	32
Clinic	44	18	13	259	4	73	17	162
Sick bay	0	0	0	6	-	-	-	0
Managing authority								
MoHSS	52	16	12	281	6	78	24	192
Mission/NGO	52	28	4	25	0	75	30	20
Private	15	18	13	39	0	23	8	13
MoD/POLICE	0	0	30	10	-	-	-	0
Region								
Caprivi	59	4	4	27	0	76	12	17
Erongo	34	19	13	32	0	65	12	17
Hardap	76	5	10	21	0	82	59	17
Karas	50	18	14	22	13	60	47	15
Kavango	43	11	9	44	4	42	17	24
Khomas	36	18	14	28	13	73	20	15
Kunene	24	12	28	25	11	67	33	9
Ohangwena	77	6	0	31	4	96	8	26
Omaheke	80	7	7	15	23	92	15	13
Omusati	29	50	14	42	3	76	24	33
Oshana	35	15	10	20	0	70	20	10
Oshikoto	59	27	5	22	5	84	26	19
Otjozondjupa	35	4	27	26	0	90	40	10
Total	47	17	12	355	5	75	24	225

[1] At least one site in facility routinely offers Isoniazid preventive treatment to HIV/AIDS clients.
[2] At least one site in facility selectively offers Isoniazid preventive treatment to HIV/AIDS clients, and no other site routinely offers or refers clients for the service.
[3] At least one site in facility routine refers HIV/AIDS clients elsewhere for Isoniazid preventive treatment, and no other site routinely or selectively offers the service.

Table A-8.9 Primary preventive treatment (Cotrimoxazole preventive treatment) for preventing opportunistic infections in HIV/AIDS clients

Percentage of facilities offering HIV/AIDS care and support services (CSS) that offer primary preventive treatment (such as Cotrimoxazole preventive therapy (CPT)) for preventing opportunistic infections to HIV/AIDS clients, and among these, percentage with program components supporting CPT by background characteristics, Namibia HFC 2009

	Percentage of facilities offering primary preventive treatment (such as CPT) to HIVAIDS clients				Among facilities ever offering CPT, percentage with:			
Background characteristics	Offers routinely[1]	Offers selectively[2]	Routinely refers clients elsewhere[3]	Number of facilities offering HIV/AIDS CSS	Observed protocol for CPT in any service sites	Cotrimoxazole available	At least one provider of CPT trained during the 3 years preceding the survey	Number of facilities offering HIV/AIDS CSS and reporting they ever offer primary preventive treatment (such as CPT)
Type of facility								
Hospital	64	14	5	44	12	97	44	34
Health centre	83	9	7	46	7	86	45	42
Clinic	57	20	8	259	4	88	17	199
Sick bay	33	0	0	6	0	100	0	2
Managing authority								
MoHSS	64	16	8	281	6	89	25	225
Mission/NGO	60	32	0	25	4	100	30	23
Private	46	18	3	39	0	80	8	25
MoD/POLICE	40	0	20	10	0	100	25	4
Region								
Caprivi	63	4	7	27	0	83	6	18
Erongo	78	16	6	32	0	97	30	30
Hardap	86	0	5	21	0	94	44	18
Karas	64	23	5	22	16	74	47	19
Kavango	52	9	11	44	7	89	22	27
Khomas	50	14	7	28	11	83	28	18
Kunene	36	28	12	25	13	94	31	16
Ohangwena	87	6	0	31	7	93	7	29
Omaheke	87	0	7	15	23	92	15	13
Omusati	29	60	10	42	0	95	19	37
Oshana	65	5	5	20	0	93	29	14
Oshikoto	59	32	9	22	5	95	20	20
Otjozondjupa	69	0	8	26	0	67	28	18
Total	61	17	7	355	5	89	24	277

[1] At least one site in facility routinely offers CPT to HIV/AIDS clients.
[2] At least one site in facility selectively offers CPT to HIV/AIDS clients, and no other site routinely offers CPT or refers clients for CPT.
[3] At least one site in facility routinely refers HIV/AIDS clients elsewhere for CPT, and no other site routinely or selectively offers CPT.

Table A-8.10 Availability of trained providers to support advanced services for HIV/AIDS

Among facilities offering HIV/AIDS care and support services (CSS), percentage with trained and supervised providers to offer each of the indicated services, by background characteristics, Namibia HFC 2009

	Among facilities offering HIV/AIDS CSS, percentage with at least one trained provider for:[1]						Percentage of facilities offering HIV/AIDS CSS that have:		
Background characteristics	Psychosocial counselling	Treatment of opportunistic infections	Palliative care	HIV/AIDS-related neurological disorders	AIDS in children	Nutritional rehabilitation for HIV/AIDS clients	Supervised providers of CSS for PLHA[2]	Trained and supervised staff available for all key services	Number of facilities offering HIV/AIDS CSS
Type of facility									
Hospital	75	52	27	20	57	32	64	9	44
Health centre	93	61	28	17	54	43	80	11	46
Clinic	69	15	7	4	13	8	65	2	259
Sick bay	50	0	0	0	0	0	50	0	6
Managing authority									
MoHSS	81	28	13	8	26	17	74	5	281
Mission/NGO	88	36	16	8	36	16	76	4	25
Private	5	3	3	3	3	3	13	3	39
MoD/POLICE	50	10	10	10	0	10	60	0	10
Region									
Caprivi	85	15	7	4	7	7	81	4	27
Erongo	56	31	13	6	31	13	56	0	32
Hardap	81	43	38	19	33	29	81	10	21
Karas	73	36	18	18	36	27	77	9	22
Kavango	73	30	18	11	20	18	68	9	44
Khomas	39	14	7	7	11	7	32	0	28
Kunene	80	24	8	0	16	16	56	0	25
Ohangwena	94	23	10	6	29	10	74	6	31
Omaheke	93	27	7	7	33	7	93	7	15
Omusati	57	19	7	2	14	10	71	2	42
Oshana	90	30	5	5	40	35	80	5	20
Oshikoto	86	32	14	9	36	18	59	0	22
Otjozondjupa	62	15	8	8	15	12	54	4	26
Total	72	25	12	8	23	15	67	4	355

[1] At least one provider of indicated HIV/AIDS service trained any time during the 3 years preceding the survey on a topic related to the indicated service
[2] At least half of interviewed providers of care and support services for people living with HIV/AIDS (PLHA) reported receiving personal supervision during the 3 months preceding the survey.

Table A-8.11 Protocols and guidelines to support advanced services for HIV/AIDS

Among facilities offering HIV/AIDS care and support services (CSS), percentage having guidelines or protocols for specific services in any CSS service site, by background characteristics, Namibia HFC 2009

Background characteristics	Among facilities offering HIV/AIDS CSS, percentage with observed guidelines and protocols for the following services in any CSS site:					Number of facilities offering HIV/AIDS CSS
	Opportunistic infections[1]	Symptomatic/ palliative care[2]	Clinical management of HIV/AIDS in children[3]	Clinical management of HIV/AIDS in adults[4]	Confidentiality guideline in any eligible service site[5]	
Type of facility						
Hospital	9	18	73	75	70	44
Health centre	20	28	85	87	85	46
Clinic	8	15	49	52	80	259
Sick bay	0	33	50	50	50	6
Managing authority						
MoHSS	11	19	59	62	86	281
Mission/NGO	16	16	76	80	88	25
Private	3	8	26	28	26	39
MoD/POLICE	0	20	60	60	60	10
Region						
Caprivi	4	15	48	48	78	27
Erongo	0	3	69	69	66	32
Hardap	24	33	24	43	81	21
Karas	9	36	77	77	77	22
Kavango	30	25	52	52	66	44
Khomas	7	36	50	50	54	28
Kunene	0	4	68	68	92	25
Ohangwena	6	13	58	65	97	31
Omaheke	33	27	80	80	87	15
Omusati	2	14	36	38	86	42
Oshana	10	10	90	90	90	20
Oshikoto	9	18	82	86	95	22
Otjozondjupa	0	4	38	38	73	26
Total	10	18	57	59	79	355

[1] Any guideline or protocol that covers the management of opportunistic infections
[2] Guidelines for home based care services or any guideline/protocol on provision of symptomatic or palliative care
[3] National ART guideline or any other protocol/guideline on the clinical management of HIV/AIDS in children
[4] National ART guideline or any other protocol/guideline on the clinical management of HIV/AIDS in adults
[5] The national VCT guideline or any other guideline on counselling for HIV testing or any written policy document or statement on confidentiality and disclosure of HIV test results or HIV/AIDS status.

Table A-8.12 Availability of advanced care and support services for HIV/AIDS

Among facilities offering HIV/AIDS care and support services (CSS), percentage that report providing treatment for opportunistic diseases, antiretroviral therapy (ART), post-exposure prophylaxis (PEP), and all advanced CSS services in the facility, by background characteristics, Namibia HFC 2009

	Treatment for opportunistic infections								
Background characteristics	Systemic IV treatment for specific fungal infections (e.g., for cryptococcal infections)	Treatment for Kaposi's sarcoma	Palliative care such as symptom or pain management, or nursing care for the terminally ill (hospice care)	Nutritional rehabilitation[1]	Any psychosocial support services[2]	Prescribe ART and/or provide medical follow-up services	Post-exposure prophylaxis (PEP) for staff[3]	All advanced CSS[4]	Number of facilities offering HIV/AIDS CSS
Type of facility									
Hospital	91	73	89	80	91	70	95	43	44
Health centre	22	17	30	85	100	37	93	4	46
Clinic	8	9	19	81	98	8	78	1	259
Sick bay	0	17	33	83	100	0	100	0	6
Managing authority									
MoHSS	17	15	27	83	99	19	83	6	281
Mission/NGO	32	16	32	88	100	24	84	12	25
Private	41	41	46	64	85	26	72	8	39
MoD/POLICE	10	20	30	90	100	10	90	10	10
Region									
Caprivi	11	22	56	96	100	19	33	4	27
Erongo	16	13	34	88	97	41	88	6	32
Hardap	43	33	52	76	100	29	86	14	21
Karas	41	32	55	59	86	32	100	9	22
Kavango	18	9	25	70	100	16	91	7	44
Khomas	29	36	21	68	93	21	71	7	28
Kunene	12	0	20	100	100	16	80	0	25
Ohangwena	23	26	23	90	97	16	77	10	31
Omaheke	27	27	40	87	100	7	80	7	15
Omusati	7	5	7	93	98	10	100	0	42
Oshana	10	20	20	85	100	10	95	5	20
Oshikoto	18	14	23	86	100	18	64	5	22
Otjozondjupa	27	23	31	54	100	23	92	19	26
Total	20	18	29	81	98	20	82	7	355

[1] Client education and provision of nutritional supplements
[2] These are support services that are commonly needed by people living with HIV/AIDS, such as support groups, emotional/spiritual support, support for orphans or other vulnerable children, legal services and social support such as food, materials and income generating project. The facility reports that they offer the service, either in the facility or as an outreach service, or the facility reports that they refer clients to specific referral locations.
[3] Post-exposure prophylaxis is available to staff either in the facility or in another facility.
[4] All palliative care, ART, inpatient care, and post-exposure prophylaxis

Table A-8.13 Availability of treatments for opportunistic infections and conditions

Among facilities offering HIV/AIDS care and support services (CSS), percentage with medicines to treat or manage opportunistic infections and other conditions, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities offering HIV/AIDS CSS and having at least one medicine for managing the indicated conditions or with the indicated item:								Number of facilities offering HIV/AIDS CSS
	Topical fungal infection[1]	Bacterial infections including pneumonia[2]	Vitamin supplementation[3]	Management of chronic diarrhoea[4]	Basic management of pain[5]	Anthelminths[6]	Intravenous fluid with infusion set for rehydration[7]	Oral rehydration salts	
Type of facility									
Hospital	100	100	91	100	100	93	98	100	44
Health centre	33	100	91	100	100	96	98	100	46
Clinic	17	98	66	98	97	84	91	95	259
Sick bay	50	100	17	100	100	100	100	100	6
Managing authority									
MoHSS	23	100	77	99	99	89	96	99	281
Mission/NGO	28	100	84	100	100	88	100	100	25
Private	72	87	33	90	87	69	69	72	39
MoD/POLICE	60	100	30	100	100	100	90	100	10
Region									
Caprivi	11	100	89	100	100	100	100	100	27
Erongo	41	100	69	100	100	88	84	91	32
Hardap	57	100	71	100	95	62	95	100	21
Karas	41	95	82	100	100	77	100	95	22
Kavango	20	100	80	100	100	93	100	95	44
Khomas	64	86	54	86	82	68	79	79	28
Kunene	32	100	52	100	100	100	96	96	25
Ohangwena	23	97	84	97	97	97	90	100	31
Omaheke	20	100	80	100	100	93	100	100	15
Omusati	19	100	64	98	100	95	88	98	42
Oshana	15	100	70	100	100	95	90	100	20
Oshikoto	23	100	68	100	100	86	100	100	22
Otjozondjupa	35	100	69	100	100	62	92	100	26
Total	30	98	72	98	98	87	93	96	355

[1] Clotrimazole or Fluconazole or Ketoconazole or Nystatin
[2] Amoxicillin or Augmentin or ampicillin or chloramphenicol or Tetracycline or Nalidixic acid or Cotrimoxazole or erythromycin or penicillin
[3] Iron or iron with folate and any multivitamin, and B6 or other B vitamins
[4] Loperamide or Diphenoylate or oral codeine
[5] Paracetamol or aspirin or ibuprofen or Indomethacin
[6] Albendazole or mebendazole
[7] Normal saline or 5%D/NS or ringers lactate or plasma expanders or 5%D/W, and infusion sets

Table A-8.14 Availability of medicines for advanced care of people living with HIV/AIDS

Among facilities offering HIV/AIDS care and support services (CSS), percentage with medicines to manage opportunistic infections and provide palliative care for the advanced care of people living with HIV/AIDS, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities providing systemic IV treatment for fungal infections	Among facilities offering HIV/AIDS CSS, percentage with at least two medicines to treat or manage:									Percentage of facilities with fortified protein supplement	Number of facilities offering HIV/AIDS CSS
		Crypto-coccus fungal[1]	Bacterial respiratory infection[2]	Other bacterial infections[3]	Herpes[4] (both medica-tions)	Herpes (only 1 medication)	Parasitic infection[5]	Herpes ophthalmic infection[6]	AIDS dementia complex[7]	Pain[8]		
Type of facility												
Hospital	91	61	100	100	2	86	100	89	100	100	64	44
Health centre	22	4	98	100	0	9	100	9	96	52	20	46
Clinic	8	1	93	97	0	3	95	5	90	26	14	259
Sick bay	0	0	83	100	0	17	83	17	50	50	17	6
Managing authority												
MoHSS	17	6	99	100	0	12	99	12	96	36	21	281
Mission/NGO	32	8	100	100	0	20	100	20	96	32	32	25
Private	41	26	67	82	3	28	74	38	67	59	18	39
MoD/POLICE	10	20	80	100	0	20	80	20	50	60	10	10
Region												
Caprivi	11	0	100	100	0	4	100	4	93	70	19	27
Erongo	16	13	88	97	3	22	94	28	84	38	22	32
Hardap	43	10	95	100	0	14	95	14	100	62	24	21
Karas	41	18	91	95	0	27	91	32	91	68	9	22
Kavango	18	2	98	98	0	11	95	14	95	23	5	44
Khomas	29	18	79	86	0	32	82	32	71	46	11	28
Kunene	12	4	96	100	0	16	100	16	100	56	28	25
Ohangwena	23	10	94	97	0	10	97	10	90	16	26	31
Omaheke	27	0	100	100	0	7	100	7	100	60	0	15
Omusati	7	7	98	100	0	10	100	10	90	14	29	42
Oshana	10	10	100	100	0	10	100	10	95	20	55	20
Oshikoto	18	9	100	100	0	9	100	9	91	18	32	22
Otjozondjupa	27	15	96	100	0	19	92	19	92	54	23	26
Total	20	9	95	98	0	15	96	16	91	39	21	355

[1] Amphotericin B, Fluconazole, Itraconazole, and Ketoconazole
[2] Acyclovir, Ceftriaxone, ciprofloxacin, gentamycine, Cotrimoxazole, and dapsone
[3] Tetracycline, Nalidixic acid, Cotrimoxazole, erythromycin, penicillin, Doxycycline, clindamycin, Norfloxacin, cloxacillin oral, cloxacillin inj., amoxicillin oral, Augmentin oral, amoxicillin inj., oral ampicillin., ampicillin inj., chloramphenicol oral, chloramphenicol inj., clarithromycin oral, kanamycin inj., Metronidazole i.v., spectinomycin inj., nitrofurantoin, cefalexine, cefotaxime and sulfadiazine cream/ointment
[4] Acyclovir and gancyclovir
[5] Metronidazole, tinidazole, Nalidixic acid, and Cotrimoxazole
[6] One of: Acyclovir ophthalmic or acyclovir oral
[7] Cotrimoxazole, Phenobarbital, Fansidar, and dexamethasone
[8] One from each group: Group 1 (Diazepam, dapsone, Indomethacin, prednisolone). Group 2 (oral codeine, inj. diclofenac, inj. dipyrone, oral morphine)

Table A-8.15 Laboratory testing capacity for monitoring HIV/AIDS clients

Among facilities offering HIV/AIDS care and support services (CSS), percentage with laboratory testing capacity to conduct various tests or a system for receiving results when test is conducted outside the facility, by background characteristics, Namibia HFC 2009

	Percentage of facilities with laboratory capacity[1] to conduct the following tests OR a documented system for sending blood and receiving results for the test:											
Background characteristics	Culture media[2] and incubator	Haemo-globin or haemato-crit[3]	White cell count	Platelet count	BUN and serum creatinine[4]	Liver function test[4]	Serum glucose[4]	Indian ink test[5]	Gram stain[6]	Enzyme-linked immuno-sorbent assay (ELISA) for HIV	All lab available * excludes spinal tap	Number of facilities offering HIV/AIDS CSS
Type of facility												
Hospital	82	91	80	80	91	91	91	82	80	64	41	44
Health centre	98	96	80	80	98	98	98	96	72	87	52	46
Clinic	88	94	83	83	93	92	93	88	80	75	53	259
Sick bay	50	33	17	17	50	50	50	50	17	67	17	6
Managing authority												
MoHSS	90	95	83	83	95	95	95	90	79	75	50	281
Mission/NGO	88	96	88	88	88	88	88	88	88	84	52	25
Private	74	85	79	79	82	82	82	77	74	72	64	39
MoD/POLICE	60	50	30	30	60	60	60	50	30	70	20	10
Region												
Caprivi	100	100	100	100	100	100	100	100	100	100	100	27
Erongo	66	81	34	34	69	66	69	66	34	72	34	32
Hardap	95	100	95	95	95	95	95	95	43	100	43	21
Karas	59	59	36	36	91	91	91	68	91	59	5	22
Kavango	82	100	75	75	82	82	82	80	73	86	34	44
Khomas	82	89	89	89	89	89	89	79	79	89	79	28
Kunene	100	100	100	100	100	100	100	100	100	32	32	25
Ohangwena	100	100	100	100	100	100	100	100	100	81	81	31
Omaheke	100	100	100	100	100	100	100	100	100	40	40	15
Omusati	98	88	81	81	98	98	98	98	98	74	57	42
Oshana	90	95	90	90	90	90	90	90	5	90	5	20
Oshikoto	100	100	100	100	100	100	100	100	100	91	91	22
Otjozondjupa	73	92	73	73	100	100	100	69	73	46	42	26
Total	88	93	81	81	92	92	92	87	77	75	51	355

[1] Laboratory either in the facility or an external affiliated laboratory has all equipment and reagents to conduct the test available on the day of the survey.
[2] Chocolate agar or Thayer-Martin or modified Thayer-Martin or Vancomycin-free selective medium (VFSM) or culture medium for TB (e.g., MGIT 960).
[3] The lab either has a Haematology analyzer capable of doing a total lymphocyte count, full blood count, platelet count, etc., or a haemoglobinometer/HemoCue, a calorimeter or spectroscope and Drabkin's solution, or a centrifuge for haematocrit and capillary tubes for haematocrit, or litmus paper for haemoglobin test with a valid expiration date, or any other anaemia test.
[4] The lab either has a functioning blood chemistry analyzer capable of providing serum creatinine, serum glucose and liver function tests on the day of the survey, or observed records of these tests conducted in an external lab.
[5] The lab either has Indian ink with a functioning microscope, or observed record of test conducted in an external lab.
[6] Crystal or Gentian violet and Lugol's iodine and Acetone (or acetone alcohol) and Neutral red (or carbol fuchsin or other counter stain) available in the lab on the day of the survey, or observed records of these tests conducted in an external lab.

Table A-8.16 Facilities with links to home or community-based care for HIV/AIDS clients

Among facilities offering HIV/AIDS care and support services (CSS), percentage with components supporting home and community-based care (HC), by background characteristics, Namibia HFC 2009

	Percentage of facilities offering HIV/AIDS CSS with:					
Background characteristics	HBC in facility or through outreach	HBC through referral and written document naming a referral site[1]	HBC through referral, no written document, but can name a HC referral site[2]	Observed written form for client referral[3]	At least one trained provider for community home-based care for HIV/AIDS clients	Number of facilities offering HIV/AIDS CSS
Type of facility						
Hospital	25	9	34	39	34	44
Health centre	37	17	35	24	35	46
Clinic	22	5	40	10	16	259
Sick bay	17	0	17	17	17	6
Managing authority						
MoHSS	24	7	43	15	22	281
Mission/NGO	40	8	44	24	28	25
Private	18	5	10	15	3	39
MoD/POLICE	20	0	10	10	20	10
Region						
Caprivi	41	4	52	7	26	27
Erongo	19	3	44	16	25	32
Hardap	19	0	67	24	38	21
Karas	32	5	14	27	23	22
Kavango	32	7	41	11	20	44
Khomas	11	7	11	4	11	28
Kunene	40	0	8	24	16	25
Ohangwena	3	13	71	10	26	31
Omaheke	47	7	20	27	20	15
Omusati	21	19	38	17	21	42
Oshana	15	5	30	0	30	20
Oshikoto	36	9	36	23	9	22
Otjozondjupa	15	4	50	19	4	26
Total	25	7	38	15	21	355

[1] The facility offers HBC through referrals, and at least one service site in the facility has a written document that names a referral site.
[2] The facility offers HBC through referrals but no service site in the facility is able to show a document that names a referral site. However, at least one site in the facility is able to verbally name a referral site.
[3] The facility offers HBC, either in the facility, outreach or through referrals and at least one site in the facility has an observed referral form for client HC services.

Table A-8.17.1 Youth-friendly services for HIV/AIDS (Facilities with HIV testing system)

Percentage of facilities with an HIV testing system that offer youth-friendly services (YFS) for counselling and testing for HIV/AIDS, and among these, percentage with components supporting YFS, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities offering youth-friendly HIV testing services	Number of facilities with an HIV testing system	Percentage of facilities with:			Number of facilities offering youth friendly HIV testing services
			Observed policy/ guidelines for YFS	At least one trained provider for YFS[1]	All items for YFS[2]	
Type of facility						
Hospital	7	45	0	67	0	3
Health centre	45	47	48	81	43	21
Clinic	19	289	39	55	29	56
Free standing VCT	21	14	0	0	0	3
Sick bay	0	7	-	-	-	0
Managing authority						
MoHSS	24	306	41	62	33	73
Mission/NGO	21	42	22	44	11	9
Private	2	43	0	100	0	1
MoD/POLICE	0	11	-	-	-	0
Region						
Caprivi	21	28	33	33	17	6
Erongo	14	36	40	20	20	5
Hardap	13	23	33	67	33	3
Karas	16	25	0	75	0	4
Kavango	22	58	15	62	15	13
Khomas	13	31	0	75	0	4
Kunene	7	29	50	50	50	2
Ohangwena	18	33	33	50	17	6
Omaheke	63	16	80	70	60	10
Omusati	18	50	67	89	56	9
Oshana	19	21	75	100	75	4
Oshikoto	45	22	10	30	10	10
Otjozondjupa	23	30	57	71	43	7
Total	21	402	39	60	30	83

[1] Provider reports having received training related to youth-specific services during the 3 years preceding the survey, or facility in-charge reports there is a trained provider, but the provider was not present the day of the visit.
[2] Facility offers youth-friendly HIV testing services, has observed policy or guidelines for YFS, and has at least one provider trained in YFS.

Table A-8.17.2 Youth-friendly services for HIV/AIDS (All facilities, without free-standing VCT facilities)

Percentage of all facilities that offer youth-friendly services (YFS) for counselling and testing for HIV/AIDS, and among these, percentage with components supporting YFS, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities offering youth friendly HIV testing services	Number of facilities	Percentage of facilities with:			Number of facilities offering youth friendly HIV testing services
			Observed policy/ guidelines for YFS	At least one trained provider for YFS[1]	All items for YFS[2]	
Type of facility						
Hospital	7	45	0	67	0	3
Health centre	45	47	48	81	43	21
Clinic	19	295	39	55	29	56
Sick bay	0	9	-	-	-	0
Managing authority						
MoHSS	24	306	41	62	33	73
Mission/NGO	21	28	33	67	17	6
Private	2	49	0	100	0	1
MoD/POLICE	0	13	-	-	-	0
Region						
Caprivi	21	28	33	33	17	6
Erongo	11	36	50	25	25	4
Hardap	10	21	50	100	50	2
Karas	16	25	0	75	0	4
Kavango	23	57	15	62	15	13
Khomas	12	33	0	75	0	4
Kunene	4	28	100	100	100	1
Ohangwena	19	32	33	50	17	6
Omaheke	63	16	80	70	60	10
Omusati	18	49	67	89	56	9
Oshana	20	20	75	100	75	4
Oshikoto	45	22	10	30	10	10
Otjozondjupa	24	29	57	71	43	7
Total	20	396	40	63	31	80

[1] Provider reports having received training related to youth-specific services during the 3 years preceding the survey, or facility in-charge reports there is a trained provider, but the provider was not present the day of the survey.
[2] Facility offers youth-friendly HIV testing services, has observed policy or guidelines for YFS, and has at least one provider trained in YFS.

Table A-8.18.1 Components supporting antiretroviral therapy services: Record-keeping and staff

Among all facilities, percentage prescribing antiretroviral therapy (ART) and/or providing medical follow-up services, and among these, percentage with indicated program components, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities prescribing ART and/or providing medical follow-up services	Number of facilities	Percentage of facilities prescribing antiretroviral therapy (ART) and/or providing medical follow-up services and:			Percentage of facilities prescribing ART and/or providing medical follow-up services and having trained provider of indicated services[1]			Percentage of facilities prescribing antiretroviral therapy (ART) and/or providing medical follow-up services and having supervised providers[2]	Number of facilities prescribing ART and/or providing medical follow-up services
			Having observed record system for individual client appoint-ments for ART clients	Having individual client record/ chart for ART clients	Having observed up-to-date register/ client cards where number of current ART clients can be calculated	ART prescription or clinical services	ART adherence counselling	Nutritional rehabilitation related to HIV/AIDS		
Type of facility										
Hospital	69	45	97	97	84	58	42	55	77	31
Health centre	36	47	71	100	88	41	41	24	71	17
Clinic	8	295	57	61	61	48	52	48	74	23
Sick bay	0	9	-	-	-	-	-	-	-	0
Managing authority										
MoHSS	17	306	81	87	85	55	47	45	77	53
Mission/NGO	21	28	100	100	83	50	33	50	83	6
Private	22	49	45	73	36	36	45	36	55	11
MoD/POLICE	8	13	100	100	100	0	0	100	100	1
Region										
Caprivi	18	28	100	100	100	20	60	20	60	5
Erongo	39	36	50	50	64	43	43	29	71	14
Hardap	29	21	67	100	67	67	33	33	100	6
Karas	28	25	57	86	86	71	57	86	100	7
Kavango	12	57	86	100	86	71	43	29	86	7
Khomas	18	33	83	83	33	50	83	50	33	6
Kunene	14	28	100	100	100	50	50	50	75	4
Ohangwena	16	32	100	100	100	40	40	40	80	5
Omaheke	6	16	100	100	0	100	0	0	100	1
Omusati	8	49	100	100	100	50	25	75	100	4
Oshana	10	20	50	100	100	50	0	50	100	2
Oshikoto	18	22	75	75	75	25	50	50	50	4
Otjozondjupa	21	29	100	100	83	50	33	67	50	6
Total	18	396	77	86	77	51	45	45	75	71

[1] At least one interviewed provider of indicated service has related training in the past 12 months.
[2] At least half of interviewed providers of ART, adherence counselling, or nutritional rehabilitation for ART clients were personally supervised during past 3 months.

Table A-8.18.2 Components supporting antiretroviral therapy services: Medicines and lab capacity

Among all facilities, percentage prescribing antiretroviral therapy (ART) and/or providing medical follow-up services, and among these, percentage with indicated program components, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities prescribing ART and/or providing medical follow-up services	Number of facilities	ART medicines		Up-to-date pharmacy stock cards for ARVs	ARVs storage			Lab capacity for monitoring ART[3]	ART monitoring tests conducted outside, observed record for results	Number of facilities prescribing ART and/or providing medical follow-up services[4]
			Adult first-line ART regimen available[1]	No stock-outs for any normally stocked first-line ARVs during past 6 months		Stored separate from other medicines[2]	Locked/ limited access	Separate from other medicines and locked/ limited access			
Type of facility											
Hospital	69	45	97	97	94	74	97	74	81	16	31
Health centre	36	47	94	94	71	65	100	65	94	0	17
Clinic	8	295	78	70	61	17	78	17	70	17	23
Sick bay	0	9	-	-	-	-	-	-	-	-	0
Managing authority											
MoHSS	17	306	96	94	87	60	96	60	77	17	53
Mission/NGO	21	28	83	83	83	50	83	50	100	0	6
Private	22	49	64	55	27	18	73	18	82	0	11
MoD/POLICE	8	13									
Region											
Caprivi	18	28	100	100	60	40	100	40	100	0	5
Erongo	39	36	93	86	86	36	86	36	64	36	14
Hardap	29	21	100	100	67	33	100	33	100	0	6
Karas	28	25	71	57	43	43	86	43	29	14	7
Kavango	12	57	86	86	86	57	86	57	86	14	7
Khomas	18	33	67	67	67	67	83	67	83	0	6
Kunene	14	28	100	100	100	100	100	100	100	0	4
Ohangwena	16	32	100	100	100	60	100	60	100	0	5
Omaheke	6	16	100	100	100	100	100	100	100	0	1
Omusati	8	49	75	75	75	25	75	25	75	25	4
Oshana	10	20	100	100	100	100	100	100	100	0	2
Oshikoto	18	22	100	100	75	75	100	75	100	0	4
Otjozondjupa	21	29	100	100	83	67	100	67	83	17	6
Total	18	396	90	87	77	54	92	54	80	13	71

[1] Any of the following combination of ARVs: 1) Stavudine, Lamivudine and Nevirapine as separate ARVs or as combination drugs; 2) Stavudine, Lamivudine and Efavirenz; 3) Zidovudine, Lamivudine and Nevirapine or Combivir (AZT/3TC) and Nevirapine; 4) Zidovudine, Lamivudine and Efavirenz or Combivir (AZT/3TC) and Efavirenz.
[2] ARVs stored in a separate location or in main pharmacy but separate from non-ARVs.
[3] Lab in facility can either conduct CD4, viral load, or total lymphocyte count (TLC).
[4] Totals include 1 MoD facility.

Table A-8.19 Protocols and guidelines for antiretroviral combination therapy services

Among all facilities, percentage prescribing antiretroviral therapy (ART) and/or providing medical follow-up services, and among these, percentage with the indicated items, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities prescribing ART and/or providing medical follow-up services	Number of facilities	Observed guidelines/protocols in ART site: National Guidelines for Antiretroviral Therapy	Guideline for management of HIV/AIDS for workplace programs	Protocol for adherence counselling	Other treatment guidelines[1]	All guidelines for indicator	Number of facilities prescribing ART and/or providing medical follow-up services
Type of facility								
Hospital	69	45	90	26	23	52	22	31
Health centre	36	47	88	18	18	53	11	17
Clinic	8	295	78	9	4	35	9	23
Sick bay	0	9	-	-	-	-	0	0
Managing authority								
MoHSS	17	306	94	21	19	53	36	53
Mission/NGO	21	28	83	17	17	67	4	6
Private	22	49	45	0	0	9	1	11
MoD/POLICE	8	13	100	100	0	0	1	1
Region								
Caprivi	18	28	80	40	20	40	3	5
Erongo	39	36	71	7	7	43	7	14
Hardap	29	21	67	33	33	83	4	6
Karas	28	25	100	0	14	43	3	7
Kavango	12	57	86	14	29	71	5	7
Khomas	18	33	83	17	0	33	3	6
Kunene	14	28	100	0	25	25	2	4
Ohangwena	16	32	100	40	40	40	4	5
Omaheke	6	16	100	0	0	0	0	1
Omusati	8	49	100	25	0	25	2	4
Oshana	10	20	100	0	50	50	2	2
Oshikoto	18	22	100	0	0	100	4	4
Otjozondjupa	21	29	83	50	0	17	3	6
Total	18	396	86	18	15	46	42	71

[1] Other guidelines for the clinical management of HIV/AIDS infection in adults and in children, or other guidelines for the management of opportunistic infections, or guidelines on provision of symptomatic or palliative care.

Table A-8.20 Post-exposure prophylaxis (PEP)

Among all facilities, percentage where staff have access to PEP, and among these, percentage where the indicated elements are present, by background characteristics. Namibia HFC 2009

Background characteristic	Percentage of facilities where staff have access to PEP	Number of facilities	Percentage of facilities offering PEP and having:				Percentage of facilities offering PEP with indicated PEP ARV storage conditions			Number of facilities where staff have access to PEP
			Observed PEP guidelines[2]	Any record/ register of staff receiving PEP services	Any observed record for monitoring full compliance for PEP regime	Observed antiretroviral (ARV) for PEP[3]	Separate from other medications[4]	Locked[5]	Separate and locked	
Type of facility										
Hospital	96	45	93	53	5	84	58	81	56	43
Health centre	91	47	100	14	0	37	21	35	19	43
Clinic	77	295	97	5	0	18	7	18	6	228
Free standing VCT	80	15	92	0	0	0	0	0	0	12
Sick bay	89	9	63	0	0	0	0	0	0	8
Managing authority										
MoHSS	84	306	99	13	1	29	15	27	14	257
Mission/NGO	83	42	97	9	3	20	14	20	14	35
Private	63	49	81	6	0	35	16	42	16	31
MOD	79	14	73	9	0	9	9	9	9	11
Region										
Caprivi	34	29	100	20	0	60	30	60	30	10
Erongo	84	38	97	22	0	41	13	41	13	32
Hardap	87	23	95	25	0	30	15	30	15	20
Karas	92	26	100	13	0	42	29	46	29	24
Kavango	93	58	98	4	0	9	7	9	7	54
Khomas	67	36	92	17	0	50	25	54	25	24
Kunene	83	29	92	21	8	21	17	21	17	24
Ohangwena	73	33	100	21	0	21	13	21	13	24
Omaheke	75	16	100	8	0	83	33	75	33	12
Omusati	98	50	96	4	2	8	8	8	8	49
Oshana	95	21	100	5	0	10	0	5	0	20
Oshikoto	64	22	93	7	0	29	14	29	14	14
Otjozondjupa	90	30	89	7	0	44	19	33	7	27
Total	81	411	96	12	1	28	15	27	14	334

[1] The facility provides PEP to staff, or there is a system to refer staff elsewhere for PEP.
[2] Either the national guideline for Anti-retroviral Therapy or the guideline for PEP for healthcare workers or any other guideline that specifically mentions PEP and the regimen to follow is available at the site where PEP is prescribed, or any of these guidelines is available anywhere in the facility, or the wall chart on PEP is available in a visible place somewhere in the facility.
[3] The recommended PEP regimen includes the following ARVs in various combinations and the assessment looked for the availability of any of these ARVs: Zidovudine, Lamivudine, Tenofovir, Efavirenz, Lopinavir, Indinavir and Nelfinavir. Any other ARV which is reported as used for PEP and available on the day of the survey is also captured.
[4] Stored alone and separate from other meds, including other ARVs
[5] Locked apart from other medicines and other ARVs

Table A-8.21.1 Availability of service records for PMTCT services

Among all facilities, percentage offering minimum package PMTCT services, and among these, percentage with the indicated documentation observed and up-to-date, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities offering minimum package PMTCT services	Total number of facilities	Percentage of facilities offering minimum package PMTCT services and having indicated documentation:						Number of facilities offering minimum package PMTCT services
			Observed record of women attending ANC and who accepted HIV testing	Observed record of women who received HIV test results	Observed record of woman who received post-test counselling	Observed record of HIV+ pregnant women who were offered a complete ARV course for PMTCT	All records and results	PMTCT guidelines available in any PMTCT site	
Type of facility									
Hospital	53	45	29	29	29	58	21	100	24
Health centre	68	47	91	91	91	84	75	100	32
Clinic	32	295	88	86	88	68	59	97	95
Sick bay	0	9	-	-	-	-	-	-	0
Managing authority									
MoHSS	43	306	80	78	80	70	55	98	132
Mission/NGO	57	28	94	94	94	81	75	100	16
Private	6	49	0	0	0	0	0	100	3
MoD/POLICE	0	13	-	-	-	-	-	-	0
Region									
Caprivi	14	28	100	100	100	50	50	100	4
Erongo	28	36	60	60	60	60	30	100	10
Hardap	38	21	63	63	63	100	63	88	8
Karas	48	25	58	58	58	58	42	100	12
Kavango	16	57	89	89	89	89	78	100	9
Khomas	9	33	67	67	67	33	33	100	3
Kunene	21	28	83	83	83	100	83	100	6
Ohangwena	72	32	91	91	91	87	78	100	23
Omaheke	75	16	100	100	100	75	75	100	12
Omusati	57	49	86	86	86	57	50	96	28
Oshana	55	20	73	55	73	73	27	100	11
Oshikoto	55	22	100	100	100	83	83	100	12
Otjozondjupa	45	29	46	46	46	38	23	92	13
Total	38	396	79	78	79	70	56	98	151

Table A-8.21.2 Availability of service records for PMTCT services facilities providing ANC

Percentage of facilities offering minimum package PMTCT services, and among these, percentage with the indicated documentation observed and up-to-date, by background characteristics. Namibia HFC 2009

Background characteristics	Percentage of facilities offering minimum package PMTCT services	Total number of facilities offering ANC services*	Percentage of facilities offering minimum package PMTCT services and having indicated documentation						Number of facilities offering ANC and minimum package PMTCT services
			Observed record of women attending ANC and who accepted HIV testing	Observed record of women who received HIV test results	Observed record of woman who received post-test counselling	Observed record of HIV+ pregnant women who were offered a complete ARV course for PMTCT	All records and results	PMTCT guidelines available in any PMTCT site	
Type of facility									
Hospital	89	9	63	63	63	50	38	100	8
Health centre	74	43	91	91	91	84	75	100	32
Clinic	37	254	88	86	88	68	59	97	95
Managing authority									
MoHSS	44	265	88	86	88	72	61	97	117
Mission/NGO	58	26	100	100	100	80	80	100	15
Private	21	14	0	0	0	0	0	100	3
Region									
Caprivi	15	26	100	100	100	50	50	100	4
Erongo	35	20	86	86	86	43	43	100	7
Hardap	37	19	71	71	71	100	71	86	7
Karas	58	19	64	64	64	64	45	100	11
Kavango	17	53	89	89	89	89	78	100	9
Khomas	33	9	67	67	67	33	33	100	3
Kunene	16	25	100	100	100	100	100	100	4
Ohangwena	76	29	95	95	95	86	82	100	22
Omaheke	85	13	100	100	100	73	73	100	11
Omusati	63	41	92	92	92	62	54	96	26
Oshana	71	14	80	60	80	70	30	100	10
Oshikoto	60	20	100	100	100	83	83	100	12
Otjozondjupa	50	18	67	67	67	44	33	89	9
Total	44	306	87	86	87	71	61	98	135

* Total includes 1 MoD/Police facility that did not offer the minimum package of PMTCT services.

Table A-8.22.1 Availability of service records for PMTCT+ services

Among all facilities, percentage offering PMTCT+ service, and among these, percentage with the indicated up-to-date documentation, by background characteristics, Namibia HFC 2009

Background characteristics	Percentage of facilities offering PMTCT+ services	Total number of facilities	Percentage of facilities: Observed record of HIV+ pregnant women put on ART	Percentage of facilities: All elements and records PMTCT+[1]	Number of facilities offering PMTCT+ services[2]
Type of facility					
Hospital	11	45	80	40	5
Health centre	15	47	86	71	7
Clinic	1	295	33	33	3
Sick bay	0	9	-	-	0
Managing authority					
MoHSS	4	306	73	55	11
Mission/NGO	11	28	100	67	3
Private	2	49	0	0	1
MoD/POLICE	0	13	-	-	0
Region					
Caprivi	7	28	-	-	-
Erongo	6	36	-	-	-
Hardap	14	21	-	-	-
Karas	8	25	-	-	-
Kavango	0	57	-	-	-
Khomas	3	33	-	-	-
Kunene	0	28	-	-	-
Ohangwena	3	32	-	-	-
Omaheke	6	16	-	-	-
Omusati	2	49	-	-	-
Oshana	5	20	-	-	-
Oshikoto	5	22	-	-	-
Otjozondjupa	0	29	-	-	-
Total	4	396	73	53	15

[1] All elements and records for PMTCT+ services are: HIV counselling and testing services, ARV prophylaxis for HIV-infected mother and her newborn, counselling on infant feeding and family planning for HIV positive women, ARV treatment for HIV positive women and her HIV-infected newborn and other family members, HIV counselling and testing records for ANC clients, records on ARV prophylaxis offered to HIV-infected ANC client, and records on therapeutic ARV for women receiving PMTCT services.
[2] Regional level data suppressed because of small number of cases.

Table A-8.22.2 Availability of service records for PMTCT+ services in facilities with ANC

Percentage of facilities offering PMTCT+ service, and among these, percentage with the indicated up-to-date documentation, by background characteristics. Namibia HFC 2009

Background characteristics	Percentage of facilities offering PMTCT+ services	Total number of facilities[1]	Percentage of facilities with: Observed record of HIV+ pregnant women put on ART	Percentage of facilities with: All elements and records PMTCT+[2]	Number of facilities offering PMTCT+ services[3]
Type of facility					
Hospital	33	9	100	67	3
Health centre	16	43	86	71	7
Clinic	1	254	33	33	3
Managing authority					
MoHSS	4	265	80	60	10
Mission/NGO	8	26	100	100	2
Private	7	14	0	0	1
Region					
Caprivi	8	26	-	-	-
Erongo	5	20	-	-	-
Hardap	11	19	-	-	-
Karas	11	19	-	-	-
Kavango	0	53	-	-	-
Khomas	11	9	-	-	-
Kunene	0	25	-	-	-
Ohangwena	3	29	-	-	-
Omaheke	8	13	-	-	-
Omusati	2	41	-	-	-
Oshana	7	14	-	-	-
Oshikoto	5	20	-	-	-
Otjozondjupa	0	18	-	-	-
Total	4	306	77	62	13

[1] Includes 1 MoD/POLICE facility which does not offer PMTCT+ services.
[2] All elements and records for PMTCT+ services are: HIV counselling and testing services, ARV prophylaxis for HIV-infected mother and her newborn, counselling on infant feeding and family planning for HIV positive women, ARV treatment for HIV-infected women and her HIV-infected newborn and other family members, HIV counselling and testing records for ANC clients, records on ARV prophylaxis offered to HIV-infected ANC clients, and records on therapeutic ARV for women receiving PMTCT services
[3] Regional level data suppressed because of small number of cases.

Table A-8.23 Facilities with record-keeping and reporting systems for monitoring HIV/AIDS treatment, care, and support

Among all facilities offering the indicated HIV/AIDS-related care and support service, percentage with records of services received by clients and percentage submitting any reports on specified services, by background characteristics, Namibia HFC 2009

Background characteristics	Among facilities with HIV testing system, percentage		Number of facilities with an HIV testing system	Among facilities prescribing ART and/or providing medical follow-up services, percentage		Number of facilities prescribing ART and/or providing medical follow-up services	Among facilities offering HIV/AIDS care and support services (CSS), percentage		Number of facilities offering HIV/AIDS CSS	With records of HIV/AIDS services offered and that routinely submit reports on these services	Number of facilities with an HIV testing system, prescribing ART and/or providing medical follow-up services, and offering HIV/AIDS care and support services (CSS)
	With records indicating clients receiving pre- and post-test counselling and received test results	Submitting any reports for HIV testing services		With records indicating number of clients receiving ARV treatment	Submitting any reports for ART services		With records documenting clients treated for HIV/AIDS related illnesses	Submitting any reports for HIV/AIDS related illnesses treated			
Type of facility											
Hospital	36	69	45	84	97	31	75	86	44	45	31
Health centre	47	96	47	88	59	17	59	89	46	18	17
Clinic	36	69	289	61	48	23	59	85	259	14	22
Free standing VCT	0	100	14	-	-	-	-	-	-	-	-
Sick bay	29	57	7	-	-	0	67	67	6	-	0
Managing authority											
MoHSS	40	78	306	85	79	53	64	91	281	28	53
Mission/NGO	40	86	42	83	100	6	76	96	25	67	6
Private	7	23	43	36	18	11	28	36	39	0	10
MoD/POLICE	27	73	11	100	100	1	60	80	10	100	1
Region											
Caprivi	0	93	28	100	80	5	4	93	27	0	5
Erongo	28	69	36	64	50	14	44	78	32	15	13
Hardap	48	78	23	67	67	6	81	81	21	33	6
Karas	4	76	25	86	71	7	14	73	22	0	7
Kavango	40	64	58	86	71	7	73	86	44	43	7
Khomas	19	52	31	33	50	6	43	50	28	0	6
Kunene	62	55	29	100	100	4	100	96	25	100	4
Ohangwena	45	88	33	100	80	5	77	97	31	20	5
Omaheke	13	88	16	0	100	1	13	93	15	0	1
Omusati	28	70	50	100	100	4	50	81	42	50	4
Oshana	62	81	21	100	50	2	100	100	20	0	2
Oshikoto	86	95	22	75	100	4	100	95	22	50	4
Otjozondjupa	43	63	30	83	83	6	88	92	26	67	6
Total	36	73	402	77	72	71	61	85	355	29	70

SURVEY PERSONNEL

Appendix **B**

Survey Director
Anna Jonas

Project Technical Coordinator
Efraim Dumeni

Finance and Administrator
Taimi Mwapopi

National Supervisors
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Efraim Dumeni
Todd Kopenhaver
Uche Nwokenna
Wilhelmina Kafita

Head of Processing
Pancho Mulongeni

Data Entry Clerks
Ms. V.M. Mukena
Ms. C. Murangi
Ms. K. Kapolo
Ms. L. Ihemba

Trainers
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Efraim Dumeni
Paulina Mutabani
Aina Kuutondokwa
Justine Amadhila
Elise Shikongo
Joyce Namuhuija
Anna Jonas

Technical Working Group
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Efraim Dumeni
Sadhna Patel
Tamsin Bowra
Uche Nwokenna
Martin Odiit
Desta Tiruneh
Todd Koppenhaver

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Caprivi (1)
Florence Libita (Manga)
Idah Mendai
Patrick Mbala
Ammon Aron
Mr. V. Sekelo (driver)

Erongo(2)
Aina Kuutondokwa
France Tweufiilwa
Sylivia Horases
Selma Gau-Goes
Mr. B. Mwetudhana (driver)

Hardap (3)
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Cavin Kulatau
Anna Isaaks
Martha Mweuhanga
Mr. M. !Nowaseb (driver)

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Herman Ucham
Maria Belchem
Helena Nakalenga
Patemoshela Hamunyela
Mr. M. Dausab (driver)

Kavango (5)
Titus Shilongo
Paulina Mutabani
Agustinus Kastherody
Igna Simataa
Mr. T. Nangolo (driver)

Kunene (6)
Frans Kaluhoni
Elise Shikongo
Toini Amadhila
Vicky Heita
Mr. H. Inkono (driver)

Ohangwena (7)
Joyce Namuhuja
Lidwina Kornelius
Abner Shigwedha
Josua Nghipangelwa
Mr. M. Haufiku (driver)

Omaheke (8)
Naem Nghitewapo
Alice Ngaringombe
Selma Nekwaya
Simeon Iyambo
Mr. H. Karuhumba (driver)

Omusati (9)
Jutina Amadhila
Asteria Evard
Amalia Taapopi
Paulus Shaanika
Mrs. E. Haipinge (driver)

Oshana (10)
Vaino Tauya
Adelheid Hamutenya
Fabian Sisamu
Fernand Hamukwaya
Mr. Eliphas Tomas (driver)

Oshikoto (11)
Elina Asino
Lioba Iininga
Claudia Kambonde
Michael Hamukoto
Mr. S. Shifula (driver)

Otjozondjupa (12)
Emgard Kaune
Linez Hans
Rector Maketo
Hileni Absalom
Mr. S. Karongee (driver)

Khomas
Done by combined teams

Reserves
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Pancho Mulongeni
Willhelmme Mbuudu
Agness Otto
Elina Nghilondo

ICF Macro
Paul Ametepi
Jeanne Cushing
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Michelle Busangu
Erica Nybro
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Jura Editorial Services SARL
Ward Rinehart
Sarah Johnson

INSTRUMENTS

Appendix C

AUDIT

2009 NAMIBIA HEALTH FACILITY CENSUS
COVER SHEET

1. Facility Identification

001 NAME OF FACILITY _____

002 LOCATION OF FACILITY (TOWN/CITY/VILLAGE) _____

003 REGION . . . . . [ ][ ]

004 DISTRICT . . . . . [ ][ ]

005 FACILITY NUMBER . . . . . [ ][ ][ ]

006 TYPE OF FACILITY

HOSPITAL	1
HEALTH CENTRE	2
CLINIC	3
FREE STANDING VCT	4
SICK BAY	5

007 MANAGING AUTHORITY (OWNERSHIP)

PUBLIC-MoHSS	1
PUBLIC-MISSION/NGO	2
PRIVATE	3
MOD/POLICE	4

008 ADJACENT FACILITY

YES	1
NO	2

008A OPD/IPD

OPD PRESENT	1
IPD ONLY	2

2. Information about Interview

009 DATE: . . . . . .

DAY . . . . . [ ][ ]

MONTH . . . . . [ ][ ]

YEAR . . . . [2][0][0][9]

010 Name of the interviewer _____

INTERVIEWER CODE . . . . . [ ][ ]

011 INTERVIEWER VISITS:

	Visit 1	Visit 2	Visit 3
DATE:	_____	_____	_____

RESULT CODES (LAST VISIT):
1 = COMPLETED
2 = RESPONDENT NOT AVAILABLE
3 = REFUSED
4 = PARTIALLY COMPLETED
6 = OTHER _____ (SPECIFY)

RESULT CODE . . . . . [ ]

012 CHECKED BY TEAM LEADER: NAME _____

SIGNATURE _____ DATE _____

Checked = 1
Unchecked = 2 [ ]

013 CHECKED BY CENTRAL EDITOR: NAME _____

SIGNATURE _____ DATE _____

Checked = 1
Unchecked = 2 [ ]

GPS READING

1 Turn GPS machine on and wait until satellite page changes to "position'

2 Write Altitude

3 Press "MARK"

4 Highlight "AVERAGE" and press "ENTER"

5 Highlight "WAYPOINT NUMBER" and press "ENTER"

6 Enter 3-digit facility number

7 Wait 5 minutes

8 Highlight "SAVE" and press "ENTER"

9 Page to main menu, highlight "WAYPOINT LIST" and press "ENTER"

10. Highlight your waypoint

11. Copy information from waypoint list page- this is the average of all the satellite readings

12. Be sure to copy the waypoint name from the waypoint list page to verify that you are entering the correc waypoint information on the data form.

013	WAYPOINT NAME (FACILITY NUMBER)	NAME . . . . .
014	ELEVATION	ELEVATION . . . . .
015	LATITUDE	N/S . . . . . a S DEGREES/DECIM b c
016	LONGITUDE	E/W . . . . . a E DEGREES/DECIM b c

CHECKLIST FOR QUESTIONNAIRES

TEAM LEADER:
USE THIS CHECKLIST TO ORGANISE YOUR DATA COLLECTION IN THE FACILITY.

REMEMBER, EVEN IF A SPECIFIC SERVICE IS NOT OFFERED AT A FACILITY, STILL A QUESTIONNAIRE (WITH THE APPROPRIATE "NO SERVICES" CODE CIRCLED) NEEDS TO BE RUTURNED TO YOU.

	SECTION NUMBER	DESCRIPTION OFSERVICE	CHECK (√) FOR EVERY QRE COMPLETED
01	1	OPD - GENERAL INFORMATION + HIV/AIDS	
02	2a	VACCINE LOGISTICS	
03	2b	CHILD HEALTH SERVICES	
04	3a	FAMILY PLANNING (FP) SERVICES	
05	3b	CONTRACEPTIVE SUPPLIES	
06	4	ANTENATAL-POSTNATAL CARE (ANC-PNC)	
07	5	DELIVERY - NEWBORN CARE	
08	6	SEXUALLY TRANSMITTED INFECTIONS (STI)	
09	14	HEALTH INFORMATION SYSTEM (HIS)	
10	15	LABORATORY AND OTHER DIAGNOSTICS (LAB)	
11	16	MEDICATION AND SUPPLIES (MEDS)	
12	17	TUBERCULOSIS DIAGNOSIS AND TREATMENT (TB)	
13	18	COUNSELLING AND TESTING (CT)	
14	19	ANTIRETROVIRAL THERAPY (ART)	
15	20	PREVENTION OF MOTHER-TO-CHILD TRANSMISSION (PMTCT)	

IN THIS SECTION, PLEASE PUT THE TOTAL NUMBER OF OBSERVATIONS (OBS) AND CLIENT EXIT INTERVIEW (CEI) QUESTIONNAIRES COMPLETED FOR EACH OF THE THREE AREAS (SC, FP, ANC) AND THE TOTAL NUMBER OF HEALTH WORKER INTERVIEWS (HWI)

Number of questionnaires completed:

		Questionnaire Type: OBS	Questionnaire Type: CEI
Sick Child Observations & Client Exit Interviews	CHILD OBS & CEI		
FP Observations & Client Exit Interviews	FP OBS & CEI		
ANC Observations & Client Exit Interviews	ANC OBS & CEI		
Health Worker Interviews	HWI		

STAFF LISTING FORM

FACILITY NUMBER [ ][ ][ ]

INTERVIEWER CODE [ ][ ]

LIST ALL PROVIDERS WHO ARE PRESENT TODAY IN THIS FACILITY. FOR SMALL HEALTH FACILITIES (e.g., CLINICS), ALL STAFF SHOULD BE LISTED. WRITE THE NUMBER THAT CORRESPONDS TO THE PROVIDER QUALIFICATION, AND CHECK THE SERVICES THE PROVIDER OFFERS.
CHECK IF PROVIDER INTERVIEWED FOR FACILTY INFORMATION AND/OR INDIVIDUAL INTERVIEW

				SERVICE PROVIDED							INTERVIEWED	
PROV SL NUM	Provider first name or initials	Qual-ification Code		ART	Any HIV counselling testing, VCT	Treatment HIV/AIDS related illnesses	Treatment Malaria STI TB	ANC FP Delivery PMTCT	Other client services (Child Hlth)	Conduct lab tests	Check if staff interview conducted YES facility	Check if staff interview conducted Yes individual
01												
02												
03												
04												
05												
06												
07												
08												
09												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20												
21												
22												

01 SPECIALIST
02 MEDICAL OFFICER / PHYSICIAN
03 MEDICAL ASSISTANT
04 REGISTERED NURSE/MIDWIFE
05 ENROLLED NURSE/MDWIFE
06 NURSE ASSISTANT/AUXILIARY
07 H.INSPECTOR/ENV.H.OFFICER
08 ENVIRONMENTAL HEALTH ASSISTANT
09 SOCIAL WORKER
10 PHARMACIST
11 PHARMACIST ASSISTANT
12 OCCUPATIONAL THERAPIST
13 PHYSIOTHERAPIST
14 OTHER:_____
15 MED. REHAB. O / INSTRUCTOR/WORKEF
16 NUTRITIONIST
21 LAB SCIENTIST
22 LAB TECHNOLOGIST
23 LABORATORY TECHNICIAN/ASSISTANT
31 COMMUNITY HIV COUNSELLOR
32 COMMUNITY HEALTH WORKER / HOME-BASED CARE GIVER / CBRP
33 LIFESTYLE AMBASSADOR (TB/HIV)
34 FIELD PROMOTERS (TB/HIV)

STAFF LISTING FORM

FACILITY NUMBER [ ][ ][ ]

INTERVIEWER CODE [ ][ ]

LIST ALL PROVIDERS WHO ARE PRESENT TODAY IN THIS FACILITY. FOR SMALL HEALTH FACILITIES (e.g., CLINICS), ALL STAFF SHOULD BE LISTED. WRITE THE NUMBER THAT CORRESPONDS TO THE PROVIDER QUALIFICATION, AND CHECK THE SERVICES THE PROVIDER OFFERS.

CHECK IF PROVIDER INTERVIEWED FOR FACILTY INFORMATION AND/OR INDIVIDUAL INTERVIEW

				SERVICE PROVIDED							INTERVIEWED	
PROV SL NUM.	Provider first name or initials	Qual-ification Code		ART	Any HIV counselling testing, VCT	Treatment HIV/AIDS related illnesses	Treatment Malaria STI TB	ANC FP Delivery PMTCT	Other client services (Child Hlth)	Conduct lab tests	Check if staff interview conducted YES facility	Check if staff interview conducted Yes individual
24												
25												
26												
27												
28												
29												
30												
31												
32												
33												
34												
35												
36												
37												
38												
39												
40												
41												
42												
43												
44												
45												

01 SPECIALIST
02 MEDICAL OFFICER / PHYSICIAN
03 MEDICAL ASSISTANT
04 REGISTERED NURSE/MIDWIFE
05 ENROLLED NURSE/MDWIFE
06 NURSE ASSISTANT/AUXILIARY
07 H.INSPECTOR/ENV.H.OFFICER
08 ENVIRONMENTAL HEALTH ASSISTANT
09 SOCIAL WORKER
10 PHARMACIST
11 PHARMACIST ASSISTANT
12 OCCUPATIONAL THERAPIST
13 PHYSIOTHERAPIST
14 OTHER:_____
15 MED. REHAB. O / INSTRUCTOR/WORKEF
16 NUTRITIONIST
21 LAB SCIENTIST
22 LAB TECHNOLOGIST
23 LABORATORY TECHNICIAN/ASSISTANT
31 COMMUNITY HIV COUNSELLOR
32 COMMUNITY HEALTH WORKER / HOME-BASED CARE GIVER / CBRP
33 LIFESTYLE AMBASSADOR (TB/HIV)
34 FIELD PROMOTERS (TB/HIV)

STAFF LISTING FORM

FACILITY NUMBER [ ][ ][ ]

INTERVIEWER CODE [ ][ ]

LIST ALL PROVIDERS WHO ARE PRESENT TODAY IN THIS FACILITY. FOR SMALL HEALTH FACILITIES (e.g., CLINICS), ALL STAFF SHOULD BE LISTED. WRITE THE NUMBER THAT CORRESPONDS TO THE PROVIDER QUALIFICATION, AND CHECK THE SERVICES THE PROVIDER OFFERS.
CHECK IF PROVIDER INTERVIEWED FOR FACILTY INFORMATION AND/OR INDIVIDUAL INTERVIEW

				SERVICE PROVIDED							INTERVIEWED	
PROV SL. NUMB	Provider first name or initials	Qual-ification Code		ART	Any HIV counselling testing, VCT	Treatment HIV/AIDS related illnesses	Treatment Malaria STI TB	ANC FP Delivery PMTCT	Other client services (Child Hlth)	Conduct lab tests	Check if staff interview conducted YES facility	Check if staff interview conducted Yes individual
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01 SPECIALIST
02 MEDICAL OFFICER / PHYSICIAN
03 MEDICAL ASSISTANT
04 REGISTERED NURSE/MIDWIFE
05 ENROLLED NURSE/MDWIFE
06 NURSE ASSISTANT/AUXILIARY
07 H.INSPECTOR/ENV.H.OFFICER
08 ENVIRONMENTAL HEALTH ASSISTANT
09 SOCIAL WORKER
10 PHARMACIST
11 PHARMACIST ASSISTANT
12 OCCUPATIONAL THERAPIST
13 PHYSIOTHERAPIST
14 OTHER:_____
15 MED. REHAB. O / INSTRUCTOR/WORKEF
16 NUTRITIONIST
21 LAB SCIENTIST
22 LAB TECHNOLOGIST
23 LABORATORY TECHNICIAN/ASSISTANT
31 COMMUNITY HIV COUNSELLOR
32 COMMUNITY HEALTH WORKER / HOME-BASED CARE GIVER / CBRP
33 LIFESTYLE AMBASSADOR (TB/HIV)
34 FIELD PROMOTERS (TB/HIV)

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SECTION 1: GENERAL INFORMATION

FACILITY NUMBER [ ][ ][ ] **INTERVIEWER CODE** [ ][ ]

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER RESPONSIBLE FOR OUTPATIENT SERVICES WHO IS PRESENT AT THE FACILITY. READ THE FOLLOWING GREETING:

Good day! My name is _____. We are here on behalf of the Ministry of Health and Social Services (MOHSS) conducting a study to assist the government in knowing more about health services in Namibia. Now I will read a statement explaining the study.

ALL facilities in the country are participating in this study. We will be asking you questions about various health services and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility may be used by the MOHSS, organizations supporting services in your facility, and researchers, for planning service improvement or for conducting further studies of health services.

Neither your name nor that of any other health worker respondents participating in this study will be included in the dataset or in any report; however, there is a small chance that any of these respondents may be identified later. Still, we are asking for your help to ensure that the information we collect is accurate.

You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will answer the questions, which will benefit the services you provide and the nation.

If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate if you introduce us to that person to help us collect that information.

At this point, do you have any questions about the study? Do I have your agreement to proceed?

_____ [ ][ ] [ ][ ] 2 0 0 9

Interviewer's signature DAY MONTH YEAR
(Indicates respondent's willingness to participate)

100	May I begin the interview?	YES . 1 NO . 2	→ STOP

2. Information About Services

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
101	How many days each week is the facility routinely open for outpatient curative services?	NUMBER OF DAYS . . . . . [ ] DON'T KNOW 8	
102	Does a trained health provider live on the facility premises?	YES . . . . . 1 NO 2	
103	Is there a health care worker assigned to and present at the facility at all times (24 hours a day) for emergencies? IF YES, ASK: Is there a duty schedule/call list for 24-hour staff coverage? IF YES, ASK TO SEE THIS.	YES, DUTY SCHEDULE OBSERVED . . . . . 1 YES, 24-HR ONSITE STAFF NO DUTY SCHEDULE SEEN . . . . 2 NO 24-HOUR ONSITE STAFF 3	→ 105
104	Is there a health care worker available away from the facility but officially on call, at all times (24 hours a day) for emergencies? IF YES, ASK: Is there a duty schedule/call list for 24-hour staff coverage? IF YES, ASK TO SEE THIS.	YES, DUTY SCHEDULE OBSERVED . . . . . 1 YES, 24-HR ONCALL STAFF NO DUTY SCHEDULE SEE . . . . . 2 NO 24-HOUR ONCALL STAFF 3	

105	Now I have some questions about staffing for this facility. Please tell me how many staff with each qualification should be in this facility by establishment, the number that are currently assigned to or employed by this facility, and and how many are actually present today. We want to know the highest technical qualification that any staff may hold (such as nurse or doctor) regardless of the person's actual assignment or specialist studies.			
	QUALIFICATION	(a) STAFF PER ESTABLISHMENT	(b) STAFF ASSIGNED OR EMPLOYED	(c) STAFF PRESENT TODAY
01	SPECIALIST (INCLUDING PATHOLOGIST)			
02	MEDICAL OFFICER/PHYSICIAN			
03	MEDICAL ASSISTANT			
04	REGISTERED NURSE/MIDWIFE			
05	ENROLLED NURSE/MIDWIFE			
06	NURSE ASSSISTANT/AUXILIARY			
07	HEALTH INSTPECTOR/ENV-TAL HEALTH OFFICER			
08	ENVIRONMENTAL HEALTH ASSISTANT			
09	SOCIAL WORKER			
10	PHARMACIST			
11	PHARMACIST ASSISTANT			
12	OCCUPATIONAL THERAPIST			
13	PHYSIOTHERAPIST			
14	OTHER:_____ (SPECIFY)			
15	MEDICAL REHAB OFFICER/INSTRUCTOR/WORKER			
16	NUTRITIONIST			
17	SUM THE NUMBER OF STAFF REPORTED IN EACH COLUMN			
	You have told me that there are (TOTAL STAFF) who are assigned to or employed by this facility. Is this correct? IF NOT CORRECT, PROBE AND CHANGE ITEM 105 (01-16) AS NECESSARY.			
106	In addition to the previously mentioned staff who are assigned to or employed by the facility, does this facility have any people who are **seconded,** that is they are not officially employed but are sent from other organizations, projects or volunteers (e.g., VSO), and who work routinely (either full or part time) and provide client services?	YES . . . . . 1 NO 2		→ 110

107	Please tell me how many staff with each of the following qualification or category are currently **seconded** to this facility, the number who work specifically with HIV/AIDS related services, and the number present today.			
	QUALIFICATION	(a) # OF STAFF SECONDED	(b) # WORKING WITH HIV SERVICES	(c) # OF SECONDED STAFF PRESENT TODAY
01	(01) SPECIALIST (INCLUDING PATHOLOGIST)			
02	(02) MEDICAL OFFICER/PHYSICIAN			
03	(04) REGISTERED NURSE/MIDWIFE			
04	(10) PHARMACIST			
05	(31) COMMUNITY HIV COUNSELLOR			
06	(32) COMMUNITY HEALTH WORKER/ HOME-BASED CARE GIVER / CBRP			
07	(33) LIFESTYLE AMBASSADOR (TB/HIV)			
08	(34) FIELD PROMOTER (TB/HIV)			
09	(96) OTHER:_____			
108	SUM THE NUMBER OF SECONDED STAFF IN Q107 WHO WORK WITH THE FACILITY.			

109	How many of the seconded staff that you have identified are foreigners?	NUMBER OF FOREIGN SECONDED STAFF . . DON'T KNOW 98	
110	Do you have an estimate of the size of the catchment population that this facility serves, i.e., the target or total population living in the area served by this facility? IF YES: How many people is that?	CATCHMENT POPULATION - NO CATCHMENT AREA . . . . 9999995 - DON'T KNOW SIZE OF CATCHMENT POPULATION . . 9999998	
111	Does this facility routinely provide inpatient care?	YES . . . . . 1 NO 2	→ 113
112	Does this facility have beds for overnight observation?	YES . . . . . 1 NO 2	→ 114
113	How many overnight or inpatient beds does this facility have?	NUMBER OF BEDS	
114	Does this facility have routine meetings for reviewing managerial or administrative matters? By this I mean any management meeting.	YES . . . . . 1 NO . . . . 2 DON'T KNOW 8	 → 117 → 117
115	How often do meetings to discuss the facility managerial and administrative matters take place?	MONTHLY OR MORE OFTEN . . . . 1 EVERY 2-3 MONTHS . . . . . 2 EVERY 4-6 MONTHS . . . . . 3 LESS THAN EVERY 6 MONTHS OR IRREGULARLY 4	 → 117

116	Is an official record of management meetings maintained? IF YES, ASK TO SEE SOME RECORD (MINUTES OR NOTES) FROM THE MOST RECENT MEETING.	YES, RECORD OBSERVED .... 1 YES, REPORTED, NOT SEEN .... 2 NO RECORD MAINTAINED 3	
117	Are there any *routine* meetings about facility activities or management issues that include both facility staff and community members?	YES ..... 1 NO ..... 2 DON'T KNOW 8	 → 120 → 120
118	How often are routine meetings held with both facility staff and community members?	MONTHLY OR MORE OFTEN ..... 1 EVERY 2-3 MONTHS ..... 2 EVERY 4-6 MONTHS ..... 3 LESS THAN EVERY 6 MONTHS OR IRREGULARLY 4	 → 120
119	Is an official record of the meetings with both facility staff and community members maintained? IF YES, ASK TO SEE SOME RECORD (MINUTES OR NOTES) FROM THE MOST RECENT MEETING.	YES, RECORD OBSERVED .... 1 YES, REPORTED, NOT SEEN .... 2 NO RECORD MAINTAINED 3	
120	Does this facility have any system for determining clients' opinions about the health facility or its services? IF YES, ASK: What systems do you use? CIRCLE ALL METHODS THAT ARE USED FOR ELICITING CLIENTS' OPINIONS. PROBE FOR ALL METHODS USED.	SUGGESTION BOX ..... A CLIENT INTERVIEW/SURVEY FORM B CLIENT HELP DESK ..... C OFFICIAL MEETING WITH COMMUNITY LEADERS ..... D INFORMAL DISCUSSIONS WITH CLIENT OR COMMUNITY ..... E OTHER _____ . X (SPECIFY) NO CLIENT FEEDBACK ..... Y DON'T KNOW ..... Z	 → 122 → 122
121	Is there a procedure for reviewing or reporting on clients' opinions? IF YES, ASK TO SEE A REPORT OR FORM ON WHICH DATA ARE COMPILED OR DISCUSSION IS REPORTED.	YES, REPORT SEEN ..... 1 YES, REPORT NOT SEEN ..... 2 NO 3	
122	Does this facility routinely carry out quality assurance activities? By this I mean some formal review system or comparison of work or system to a standard? An example may be ***facility-wide review of mortality***	YES ..... 1 NO ..... 2 DON'T KNOW 8	 → 124 → 124
123	Is there an official record of any quality assurance activities carried out during the past year? A REPORT OR MINUTES OF A QA MEETING, A SUPERVISORY CHECKLIST, A MORTALITY REVIEW, AN AUDIT OF RECORDS OR REGISTERS ARE ALL ACCEPTABLE.	YES, RECORD OBSERVED ..... 1 YES, REPORTED, NOT SEEN ..... 2 NO RECORD MAINTAINED 3	
124	When was the last time a supervisor from outside this facility came here to visit?	WITHIN THE PAST 6 MONTHS .... 1 MORE THAN 6 MONTHS AGO ..... 2 NEVER SUPERVISED FROM OUTSIDE FACILITY 3	 → 126 → 126

125	The most recent time during the past 6 months that a supervisor from outside the facility visited, did he or she…		YES	NO	DON'T KNOW	
01	Check some registers or books?	CHECKED REGISTERS	1	2	8	
02	Discuss problems?	DISCUSSED PROBLEMS	1	2	8	
03	Discuss policy or administrative matters?	DISCUSSED POLICY	1	2	8	
04	Discuss technical protocols or issues in service delivery practices?	DISCUSSED TECH. MATTERS	1	2	8	
05	Hold an official staff meeting?	STAFF MEETING	1	2	8	
06	Observe individual staff providing services?	SERVICE OBSERVED	1	2	8	
126	When you refer a client **to another facility** for services, do you use a preprinted form or other written form (e.g. note), or a verbal report that specifies information about the client that should be shared to the referring place? IF YES, ASK: Which, and may I see a copy of any written form?	YES, PREPRINTED FORM SEEN . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 PATIENT SENT WITH MEDICAL RECORDS/FILE/CARD . . . . . 3 WRITE NOTE ON PRESCRIPTION FORM, LETTERHEAD OR OR BLANK PAPER . . . . . 4 VERBAL REPORT OR ACCOMPANIES CLIENT . . . . . 5 OTHER _____ (SPECIFY) 6 NEVER REFER OUTSIDE FACILITY . . 7 DON'T KNOW 8				
127	Does this facility have a program for routine maintenance and repair of **infrastructure?**	YES, ROUTINE MAINTENANCE . . . . 1 NO ROUTINE MAINTENANCE 2				→ 128
127A	Is the person(s) responsible for maintenance and repair of infrastructure assigned to and based in the facility or from outside the facility?	ONSITE STAFF . . . . . 1 OUTSIDE SUPPORT . . . . . 2 BOTH ONSITE AND OUTSIDE STAFF . . . . . 3 DON'T KNOW 8				
128	Does this facility have a program for routine preventive maintenance for **major equipment** such as a generator, refrigerator, and sterilization equipment? This means the equipment is checked periodically even if there is no problem.	YES, ROUTINE MAINTENANCE . . . . 1 NO ROUTINE MAINTENANCE 2				→ 129
128A	Is the person(s) responsible for routine preventive maintenance for major equipment assigned to the facility or from outside the facility?	ONSITE STAFF . . . . . 1 OUTSIDE SUPPORT . . . . . 2 BOTH ONSITE AND OUTSIDE STAFF . . . . . 3 DON'T KNOW 8				
129	What is the system used for repairing or replacing small equipment (such as blood pressure cuffs or stethoscopes)? PROBE AND CIRCLE ALL THAT APPLY.	ONSITE MAINTENANCE . . . . . A PETTY CASH FOR PURCHASE REPLACEMENT OR REPAIR . . . . B SEND ELSEWHERE FOR REPAIR . . . . . C OTHER _____ (SPECIFY) X NO SYSTEM . . . . . Y DON'T KNOW . . . . . Z				

AT THIS POINT FIND THE PERSON MOST KNOWLEDGEABLE ABOUT THE FINANCES OF THE FACILITY. IT MAY BE THE PERSON YOU ARE INTERVIEWING OR YOU MAY NEED TO BE INTRODUCED TO SUCH PERSON TO ACCURATELY ANSWER QUESTIONS 130 TO 130E

		IF RESPONSE IS "YES" BUT AMOUNT IS NOT KNOWN WRITE "999999998" IN THE BOXES			
130	Now, I would like to ask about the sources of revenue or funding for this facility. Tell me if the facility received any revenue or funding from any of the listed resources during the 2008/09 financial year and the amount.	YES	AMOUNT IN N$	NO	DK
01	MINISTRY OF HEALTH AND SOCIAL SERVICES	1		2	8
02	OTHER PUBLIC MINISTRIES	1		2	8
03	MEDICAL SCHEMES (INSURANCE)	1		2	8
04	SOCIAL SECURITY FUND	1		2	8
05	REIMBURSEMENT BY EMPLOYER	1		2	8
06	GOVT. CONTRIBUTION TO PRIVATE (NFP)	1		2	8
07	USER FEES / OUT-OF-POCKET (DIRECT CHARGES)	1		2	8
08	DONOR AGENCIES/NGOs (SECULAR)	1		2	8
09	FAITH-BASED (E.G. MISSIONS, CHURCHES)	1		2	8
10	COMMUNITY PROGRAMS	1		2	8
11	MINISTRY OF DEFENCE	1		2	8
12	OTHER _____ (SPECIFY)	1		2	8

130C	Did you receive any ***in-kind*** contributions (such as equipment, commodities, vehicles, bed nets, training, etc.) from any sources during the 2008/09 financial year?	YES . . . . . 1 NO 2	→ 130E
130D	Now, I would like to ask about the sources of the ***in-kind*** contributions. Tell me if the facility received any of the contributions from any of the listed resources and the specific items received.	MEDICINES, PHARMACEUTICALS . . A EQUIPMENT . . . . . B COMMODITIES (E.G., CONTRACEPTIVES) . C VEHICLES . . . . . D BEDNETS . . . . . E TRAINING . . . . . F ANY OTHER CONTRIBUTIONS . . . . X NONE . . . . . Y DON'T KNOW . . . . . Z	
01	MINISTRY OF HEALTH AND SOCIAL SERVICES	A B C D E F X Y Z	
02	OTHER PUBLIC MINISTRIES	A B C D E F X Y Z	
03	PRIVATE INSURANCE COMPANIES/BANKS	A B C D E F X Y Z	
04	PUBLIC INSURANCE COMPANIES	A B C D E F X Y Z	
05	PRIVATE COMPANIES	A B C D E F X Y Z	
06	PARASTATALS (e.g., NAMPOWER, NAMWATER)	A B C D E F X Y Z	
07	INDIVIDUAL DONATIONS	A B C D E F X Y Z	
08	DONOR AGENCIES/NGOs (SECULAR)	A B C D E F X Y Z	
09	FAITH-BASED (E.G. MISSIONS, CHURCHES)	A B C D E F X Y Z	
10	COMMUNITY PROGRAMS	A B C D E F X Y Z	
11	MINISTRY OF DEFENCE	A B C D E F X Y Z	
12	OTHER SOURCE: _____ (SPECIFY)	A B C D E F X Y Z	

130E	How does the overall budget and external funding of this facility meet the expenses, including expansion plans of this facility? Does the budget and external funding allow for: 1) meeting expenses comfortably, allowing for investments (e.g., expansion, new furniture, more medicines, etc.) 2) meeting expenses comfortably, not enough for investments 3) barely meeting expenses, or economic difficulties	**MEET EXPENSES:** COMFORTABLY, INVESTMENTS MADE . . . . 1 COMFORTABLEY BUT WITHOUT INVESTMENTS . . . . . 2 BARELY OR DIFFICULTIES . . . . . 3 OTHER _____ 6 (SPECIFY) DON'T KNOW 8	
131	Does this facility have any routine user-fees or charges for any services for sick adults? This includes any fees, including those for registration, health card/passport, medicines, or laboratory investigations?	YES . . . . . 1 NO, CLIENTS HAVE NO OUT-OF-POCKET CHARGES OR USER-FEES 2	→ 134
132	Please tell me if any of the following user-fee or charging practices are ever applied by this facility for sick adults:	YES / NO / DON'T KNOW	
01	Is there a fee for the client health card/health passport?	CLIENT CARD 1 2 8	
02	Is there a fee for each consultation?	CONSULTATION 1 2 8	
03	Does the user fee vary depending on the diagnosis?	FEE VARIES BY DIAGNOSIS 1 2 8	
04	Are there fees for medications?	MEDICINE 1 2 8	
05	Are there fees for laboratory tests?	TESTS 1 2 8	
06	Is there a fee for registration?	REGISTRATION 1 2 8	
07	Are discounts or exemptions from fees allowed for some clients?	DISCOUNT/ EXEMPTIONS 1 2 8	
08	Is there a system for clients to pre-pay for multiple visits for curative care?	PRE-PAY FOR MULTIPLE 1 2 8	
133	Are the official fees posted or displayed so that the client can easily see them? IF YES, VERIFY BY ASKING TO SEE WHERE FEES ARE POSTED	YES, ALL FEES POSTED . . . . . 1 YES, SOME, NOT ALL FEES POSTED . . . . . 2 NO POSTED FEES 3	
134	Please tell me the common means of transport used by patients who are referred from other facilities to this facility for emergency services.	AMBULANCE . . . . . A PRIVATE CAR/BUS . . . . . B PUBLIC CAR/BUS . . . . . C MOTORCYCLE . . . . . D BICYCLE . . . . . E PEOPLE CARRY/PUSH OR PULL PATIENT . . . . . F ANIMALS CARRY/PULL PATIENTS . . . . . G OTHER _____ . X (SPECIFY) NEVER RECEIVE REFERRALS . . . Y DON'T KNOW . . . . . Z	
135	Does this facility have a functional ambulance or other vehicle for emergency transportation for clients? IF YES, ASK TO SEE THE AMBULANCE OR VEHICLE.	YES, OBSERVED . . . . . 1 YES, REPORTED NOT SEEN . . . . . 2 NO . . . . . 3 DON'T KNOW 8	 → 138 → 138
136	Is fuel available today? ACCEPT REPORTED RESPONSE FROM KNOWLEDGEABLE RESPONDENT.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

137	ASK RESPONDENT TO TAKE YOU TO SEE THE AMBULANCE OR OTHER VEHICLE. CHECK THE ODOMETER; IF NECESSARY, SWITCH ON THE IGNITION KEY AND READ THE KILOMETERS IN THE PANEL (IF MORE THAN ONE AMBULANCE, CHECK THE NEWEST)	KMS [ ][ ][ ][ ][ ][ ] VEHICLE NOT AT POST . . . . 999995 KEY NOT AVAILABLE 999996	
138	Does this facility have a generator for electricity? This may be a back-up or stand-by generator. IF YES, ASK TO SEE THE GENERATOR	YES, OBSERVED . . . . . 1 YES, REPORTED NOT SEEN 2 NO . . . . . 3 DON'T KNOW 8	 → 140 → 140
139	Is the generator functional and is there fuel today? ACCEPT REPORTED RESPONSE FROM KNOWLEDGEABLE RESPONDENT.	YES, FUNCTIONAL WITH FUEL . . . . 1 YES, FUNCTIONAL, NO FUEL . . . . . 2 NOT FUNCTIONAL . . . . . 3 DON'T KNOW 8	
140	Does this facility ever obtain electricity from a source other than a generator? PROBE FOR THE RIGHT ANSWER	YES, CENTRAL SUPPLY . . . . . 1 YES, SOLAR OR OTHER SOURCE . . . . . 2 YES, BOTH CENTRAL SUPPLY AND SOLAR . . . . . 3 NO 4	 → 141A
141	Is the electricity (not including any backup generator) always available during the times when the facility is providing services, or is it sometimes interrupted?	ALWAYS AVAILABLE . . . . . 1 SOMETIMES INTERRUPTED 2	
141A	Is there a fire extinguisher within reach? IF YES, ASK TO SEE IT AND STATE ITS CONDITION	YES, CHECKED TO DATE . . . . . 1 YES, CHECK OUTDATED . . . . . 2 NO 3	
141B	OBSERVE THE FLOOR IN THE MAIN AREAS AND INDICATE WHAT IT IS MADE OF	CEMENT . . . . . 1 TERRAZO . . . . . 2 PVC . . . . . 3 STONE . . . . . 4 WOOD . . . . . 5 MARBLE . . . . . 6 CERAMIC 7	
142	What is the *most commonly used* source of water for the facility *at this time?*	PIPED FROM PROTECTED SOURCE . . . . . 01 PIPED FROM UNPROTECTED SOURCE . . . . . 02 PIPED FROM UNKNOWN SOURCE . . . . . 03 NON-PIPED PROTECTED (E.G., PROTECTED WELL) . 04 NON-PIPED UNPROTECTED (E.G., UNPROTECTED WELL, RAIN . . . 05 RIVER OR LAKE OR POND . . . 06 OTHER _____ 96 (SPECIFY) DON'T KNOW . . . . . 98 NO WATER SOURCE 00	 → 145
143	Is water outlet from this source available onsite (that is, within 500m of the facility?) REPORTED RESPONSE IS ACCEPTABLE	YES, ONSITE . . . . . 1 NO 2	
144	Is there routinely a time of year when the facility has a severe shortage or lack of water?	YES . . . . . 1 NO 2	

145	Does this facility have a working phone or shortwave radio to call outside, that is available at all times client services are offered? CLARIFY THAT IF 24-HOUR EMERGENCY SERVICES ARE OFFERED, THIS REFERS TO 24-HOUR AVAILABILITY. CIRCLE ALL AVAILABLE.	YES, LANDLINE . . . . . A YES, CELL PHONE . . . . . B YES, PAY PHONE OR PERSONAL CELL PHONE ONLY . . . . . C YES, RADIO . . . . . D NO . . . . . Y	147
146	Is there a phone or shortwave radio within 5 minutes' distance from the facility that staff can use in an emergency? IF YES, ASK: Is that phone or shortwave radio available at all times services are offered?	YES, AVAILABLE ALL TIMES . . . . . 1 YES, NOT AVAILABLE ALL TIMES . . . . . 2 NO, NONE WITHIN 5 MINUTES 3	
147	Does the facility have a computer? IF YES, ASK: Is the computer functioning today? REPORTED RESPONSE IS ACCEPTABLE	YES, FUNCTIONING . . 1 YES, NOT FUNCTIONING . . . . . 2 NO 3	→ **HIV OPD**
148	Is there ever access to email/internet within the facility? REPORTED RESPONSE IS ACCEPTABLE	YES . . . . . 1 NO 2	

GENERAL INFORMATION (HIV OPD)

AT THIS POINT, FIND THE MANAGER OR MOST SENIOR HEALTH WORKER RESPONSIBLE FOR, OR MOST KNOWLEDGEABLE ABOUT CLINICAL SERVICES, PARTICULARLY HIV/AIDS SERVICES IN THE FACILITY.

IF THE PROVIDER IS DIFFERENT FROM THE PREVIOUS RESPONDENT, INTRODUCE YOURSELF AND EXPLAIN THE PURPOSE OF YOUR VISIT, AND ASK IF HE/SHE WOULD BE WILLING TO ANSWER A FEW QUESTIONS ABOUT HIV/AIDS-RELATED SERVICES IN THE FACILITY. IF IN AGREEMENT, READ THE INTRODUCTORY CONSENT STATEMENT BELOW.

IF THE RESPONDENT HAS ALREADY BEEN INTERVIEWED FOR A PREVIOUS SECTION, OR IS THE SAME PERSON YOU HAVE BEEN SPEAKING WITH, SIMPLY CIRCLE "1" IN Q149 AND PROCEED.

Good day! My name is _____. We are here on behalf of the Ministry of Health and Social Services (MOHSS) conducting a study to assist the government in knowing more about health services in Namibia.
Now I will read a statement explaining the study.

ALL facilities in the country are participating in this study. We will be asking you questions about various health services and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility may be used by the MOHSS, organizations supporting services in your facility, and researchers, for planning service improvement or for conducting further studies of health services.

Neither your name nor that of any other health worker respondents participating in this study will be included in the dataset or in any report; however, there is a small chance that any of these respondents may be identified later. Still, we are asking for your help to ensure that the information we collect is accurate.

You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will answer the questions, which will benefit the services you provide and the nation.

If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate if you introduce us to that person to help us collect that information.

At this point, do you have any questions about the study? Do I have your agreement to proceed?

_____ Interviewer's signature

				2	0	0	9
DAY		MONTH		YEAR			

SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.

NO.	QUESTIONS	CODING CATEGORIES	GO TO
149	Do I have your agreement to participate? Thank you. Let's begin now.	YES . . . . . 1 NO 2	 →STOP
150	First, I would like to identify clinical staff (such as nurses or doctors) or other staff (such as counsellors, social workers, and laboratory technicians) who provide services related to HIV/AIDS, TB, malaria, or STIs, who are assigned to this unit who are present today. Please give me the names and main service responsibility of this staff assigned to this unit, and present today, who provide any HIV/AIDS care and support services or services for TB, malaria, or STIs. COMPLETE THE STAFF LIST FOR THIS UNIT. DO NOT DUPLICATE SERVICE PROVIDERS WHO ARE LISTED FOR A SERVICE AREA THAT WAS PREVIOUSLY ASSESSED		
	RESPONDENT MUST BE INTERVIEWED FOR TRAINING AND EXPERIENCE.	STAFF LIST COMPLETED YES . . . . . 1 NO 2	

		SERVICE OFFERED IN THIS FACILITY		NO SERVICE THIS FACILITY	
151	Now I want to know about any services for diagnosis and treatment. For each service I will mention, please tell me if providers assigned to this unit ever provide the service, refer clients for the service, or never offer the service at all.	PROVIDE SERVICE THIS UNIT	SERVICE BY PROVIDERS FROM OTHER UNIT IN THIS FACILITY	REFER CLIENTS OUTSIDE FACILITY	NO SERVICE OR REFERRAL
01	Do providers assigned to this unit prescribe treatment for malaria?	1	2	3	4
02	Do providers assigned to this unit prescribe treatment for sexually transmitted infections (STI)?	1	2	3	4 → 153

NO.	QUESTIONS	CODING CATEGORIES	GO TO
152	Are all STI clients referred for HIV testing? IF YES, ASK: Are all of them routinely referred for the HIV testing?	YES, ROUTINELY . . . . . 1 ONLY IF CLIENT SUSPECTED TO BE HIV +VE . . . . . 2 NO HIV TESTING REFERRAL FOR STI CLIENTS . . . . . 3 DON'T KNOW 8	
153	Are there any guidelines or protocols/policy for providers working in this unit? Guidelines that are posted on the wall are acceptable. IF YES, ASK: May I see **all** the guidelines and protocols that are available here?	YES, GUIDELINES/PROTOCOLS AVAILABLE . . . . . 1 NO GUIDELINES OR PROTOCOLS . 2	→157

154	First I would like to ask about national guidelines. ASK ABOUT EACH GUIDELINE/PROTOCOL Do you have [NAME OF GUIDELINE]?	(a) OBSERVED	(a) REPORTED AVAIL. NOT SEEN	(a) NOT AVAIL.	(b) YEAR OF PUBLICATION
01	National Guidelines for Antiretroviral Therapy	1 → b	2 → 02	3 → 02	
02	National Infection Prevention and control guidelines for health care services	1 → b	2 → 03	3 → 03	
03	National Guidelines for Voluntary Counselling and Testing	1 → b	2 → 04	3 → 04	
04	National Guidelines for Syndromic Management of STIs	1 → b	2 → 05	3 → 05	
05	National guidelines for prevention of mother-to-child transmission of HIV(PMTCT)	1 → b	2 → 06	3 → 06	
06	Guidelines for Home Based Care Services	1 → b	2 → 07	3 → 07	
07	National Malaria Policy	1 → b	2 → 08	3 → 08	
08	Guidelines and Standards for Counselling and Supervision	1 → b	2 → 09	3 → 09	
09	National Guidelines for the Management of Tuberculosis	1 → b	2 → 10	3 → 10	
10	National HIV Policy	1 → b	2 → 11	3 → 11	
11	National Guidelines for Outreach VCT	1 → b	2 → 12	3 → 12	
12	HIV Rapid Testing Standard Operating Procedures (including infection control)	1 → b	2 → 13	3 → 13	
13	National Guidelines on Post Exposure Prophylaxis (PEP)	1 → b	2 → 14	3 → 14	
14	Nutrition Information Management	1 → b	2 → 15	3 → 15	
15	Cholera Control Guideline	1 → b	2 → 16	3 → 16	
16	National Community-Based Care and Rehabilitation Guideline	1 → b	2 → 17	3 → 17	
17	National Policy on Infant and young Child feeding	1 → b	2 → 18	3 → 18	
18	Food and Nutrition Policy for Namibia	1 → b	2 → 19	3 → 19	
19	Wall chart on PEP in a visible place	1 → b	2 → 20	3 → 20	
20	Biohazard sign up in visible place (red over white background)	1 → b	2 → 155	3 → 155	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
155	**Other than the previously mentioned national** guidelines, are there any other protocols or guidelines available?	YES, OTHER PROTOCOLS/ GUIDELINES . . . . . 1 NO OTHER PROTOCOLS/GUIDELINES . . . 2	→ 157

156	ASK ABOUT ANY GUIDELINES OTHER THAN THOSE PREVIOUSLY RECORDED, THAT COVER THE FOLLOWING TOPICS:	(a) OBSERVED	(a) REPORTED AVAIL. NOT SEEN	(a) NOT AVAIL.	(b) YEAR OF PUBLICATION
01	Other protocols/guidelines for infection control?	1 → b	2 → 02	3 → 02	
02	Other protocols/guidelines for diagnosis or treatment of sexually transmitted infections?	1 → b	2 → 03	3 → 03	
03	Other protocols/guidelines on syndromic management of STIs?	1 → b	2 → 04	3 → 04	
04	Other protocols/guidelines for diagnosis or treatment of malaria?	1 → b	2 → 05	3 → 05	
05	Protocols/guidelines for intermittent preventive treatment (IPT) for malaria, during pregnancy?	1 → b	2 → 06	3 → 05	
06	Protocols/guidelines for routinely offering HIV tests to all STI clients?	1 → b	2 → 07	3 → 07	
07	Any guidelines for post-exposure prophylaxis (PEP)?	1 → b	2 → '157	3 → 157	

157 Now I would like to know whether providers assigned to this facility ever provide any **curative** care for illnesses that may be HIV/AIDS-related (such as opportunistic infections), or provide or refer the clients for **counselling** or **social support** services for help in living with HIV/AIDS.

	For each service I will mention, please tell me if providers in this unit personally provide the service, refer clients for the service either within this facility or outside, or do not offer the service at all. Do providers in this unit personally: [READ EACH TOPIC BELOW]	SERVICE OFFERED IN THIS FACILITY: PROVIDE SERVICE THIS UNIT	REFER TO OTHER UNIT	INPATIENT SERVICE ONLY	REFER CLIENTS OUTSIDE FACILITY	NO SERVICE OR REFERRAL
01	Prescribe treatment for any opportunistic infections or symptoms related to HIV/AIDS? This includes treating topical fungal infections.	1	2	3	4	5
02	Provide systemic intravenous treatment of specific fungal infections such as cryptococcal meningitis?	1	2	3	4	5
03	Provide treatment for Kaposi's sarcoma?	1	2	3	4	5
04	Provide or prescribe palliative care for patients, such as symptom or pain management, or nursing care for the terminally ill or severely debilitated client? [HOSPICE CARE]	1	2	3	4	5
05	Provide nutritional rehabilitation services? By this I mean providing client education and providing nutritional supplements?	1	2	3	4	5
06	Prescribe or provide fortified protein supplementation (FPS)?	1	2	3	4	5
07	Care for paediatric HIV/AIDS patients?	1	2	3	4	5

NO.	QUESTIONS	CODING CATEGORIES				GO TO
158	Next I want to ask about **preventive** services that are sometimes provided to people with HIV/AIDS. For each service I mention, tell me if every HIV +ve client - is offered the service regardless of their condition (i.e., routinely offered) - is offered the service based on their condition (i.e., sometimes or selectively) - is never offered the service IF OFFERED, ASK: Is the preventive service offered in this unit, or is the client referred elsewhere to receive the service?	PROVIDE THE SERVICE IN THIS UNIT		REFER CLIENTS FOR THE SERVICE		NEVER OFFER SERVICE
		ROUTINELY, FOR ALL HIV/AIDS CLIENTS	SOMETIMES/ SELECTIVELY	ROUTINELY, FOR ALL HIV/AIDS CLIENTS	SOMETIMES/ SELECTIVELY	
01	Testing or screening for tuberculosis?	1	2	3	4	5
02	Preventive treatment for TB (INH + Pyridoxine)	1	2	3	4	5
03	Primary preventive treatment for opportunistic infections such as Cotrimoxazole preventive treatment (CPT)	1	2	3	4	5
04	Provide or prescribe micronutrient supplementation such as vitamins or iron?	1	2	3	4	5
05	Advise clients about using family planning services for health reasons related to HIV/AIDS?	1	2	3	4	5
06	Screening for other STIs	1	2	3	4	5
07	Provide condoms for preventing further transmission of HIV/AIDS?	1	2	3	4	5
159	CHECK 158.03: IS "1" OR "2" OR "3" OR "4" CIRCLED FOR PREVENTIVE TREATMENT FOR OIs? YES ☐ NO ☐ →					160A
160	Is there any records of clients receiving CPT? IF YES, ASK TO SEE THE RECORDS AND INDICATE IF CLIENT SEX IS RECORDED	YES, OBSERVED, SEX RECORDED . . . . . 01 YES, OBSERVED, SEX NOT RECORDED . . . . . 02 RECORD REPORTED, NOT SEEN . . . . . 03 ONLY RECORDED IN INDIVIDUAL CLIENT CHART 04 INFORMATION NOT RECORDED 05				
160A	CHECK 158.02: IS "1" OR "2" OR "3" OR "4" CIRCLED FOR PREVENTIVE TREATMENT FOR TB? YES ☐ NO ☐ →					162
161	Is there any records of clients receiving Isoniazid (INH) for TB preventive Treatment? IF YES, ASK TO SEE THE RECORDS AND INDICATE IF CLIENT SEX IS RECORDED	YES, OBSERVED, SEX RECORDED . . . . . 01 YES, OBSERVED, SEX NOT RECORDED . . . . . 02 RECORD REPORTED, NOT SEEN . . . . . 03 ONLY RECORDED IN INDIVIDUAL CLIENT CHART 04 INFORMATION NOT RECORDED 05				
162	Other than the protocols and guidelines we have already seen, do you have any other written materials specific to HIV/AIDS services?	YES . . . . . 1 NO 2				→ 164
163	IF YES, ASK TO SEE THE MATERIALS AND CHECK TO SEE IF ANY OF THE TOPICS BELOW ARE INCLUDED IN THESE OTHER PROTOCOLS/GUIDELINES	(a)			(b)	
		OBSERVED	REPORTED AVAIL. NOT SEEN	NOT AVAIL.	YEAR OF PUBLICATION	
01	Other protocols/guidelines for the clinical management of HIV/AIDS infection in adults	1 → b	2 → 02	3 → 02	☐☐☐☐	
02	Other protocols/guidelines for management of opportunistic infections in adults.	1 → b	2 → 03	3 → 03	☐☐☐☐	
03	Other protocols/guidelines for the clinical management of HIV/AIDS infection in children	1 → b	2 → 04	3 → 04	☐☐☐☐	
04	Protocols/guidelines on micronutrient supplementation	1 → b	2 → 05	3 → 05	☐☐☐☐	
05	Protocols/guidelines on advanced nutritional support, such as fortified protein supplement to treat or prevent severe malnutrition?	1 → b	2 → 06	3 → 06	☐☐☐☐	
06	Protocols/guidelines on provision of symptomatic or palliative care?	1 → b	2 → 07	3 → 07	☐☐☐☐	
07	Protocols/guidelines on preventive therapy other than TB, such as cotrimoxazole to prevent pneumonia?	1 → b	2 → 08	3 → 08	☐☐☐☐	
08	Protocols/guidelines on preventive therapy for tuberculosis (INH/Pyridoxine)	1 → b	2 → 09	3 → 09	☐☐☐☐	
09	Other protocols/guidelines on community or home-based care for HIV/AIDS clients	1 → b	2 → 164	3 → 164	☐☐☐☐	

NO.	QUESTIONS	CODING CATEGORIES				GO TO
164	I want to ask about various support services that are commonly needed by people with HIV/AIDS. For each service I ask about, please tell me if providers in this unit ever provide the service themselves, or if they refer clients for the service. IF YES FOR REFERRAL, PROBE FOR WHETHER THERE IS A WRITTEN DOCUMENT LISTING THE REFERRAL SITE, OR IF THE PROVIDER CAN NAME A SPECIFIC REFERRAL SITE FOR THE SERVICE IN QUESTION.	YES, SERVICE IS AVAILABLE IN FACILITY OR THROUGH OUTREACH BY THIS FACILITY	YES, SERVICE PROVIDED THROUGH REFERRAL			NO SERVICE OR REFERRAL
			REFERRAL SITE OBSERVED ON WRITTEN LIST	REFERRAL LIST NOT SEEN. PROVIDER: CAN NAME SPECIFIC REFERRAL SITE FOR SERVICE	REFERRAL LIST NOT SEEN. PROVIDER: CANNOT NAME SITE	
01	Home-based care services for people living with HIV/AIDS, and their families?	1	2	3	4	5
02	Support group for people living with HIV/AIDS (PLWHA)?	1	2	3	4	5
03	Emotional/spiritual support for clients and/or family?	1	2	3	4	5
04	Support for orphans or other vulnerable children?	1	2	3	4	5
05	Social support, such as food, material, income generating projects and fee exemption for PLWHA and their families?	1	2	3	4	5
06	Legal services?	1	2	3	4	5
07	Counselling or health education for prevention of transmission of HIV/AIDS?	1	2	3	4	5
08	Education on HIV care for patients and their families?	1	2	3	4	5
09	Involve or refer to other services such as herbalist, acupuncture, traditional	1	2	3	4	5
10	Provide or refer providers of HIV/AIDS services for emotional/spiritual support?	1	2	3	4	5

165	Is there a record maintained of client referrals outside this unit? IF YES, ASK TO SEE DOCUMENTS WHERE REFERRALS ARE RECORDED.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 RECORDED ON CLIENT CHART ONLY 3 NO . . . . . 4 NO, NEVER REFER IN OR OUTSIDE FACILITY 5	→ 169
166	When you refer a client **to another unit** within this facility, do you use a pre-printed form, a note or a verbal report that specifies information about the client that should be shared? IF PREPRINTED, ASK: May I see a copy of the form?	YES, PREPRINTED FORM SEEN ..... 1 YES, REPORTED, NOT SEEN . . . . . 2 PATIENT SENT WITH MEDICAL RECORDS/FILE/CARD . . . . . 3 WRITE NOTE ON PRESCRIPTION FORM, LETTERHEAD OR BLANK PAPER . . . . . 4 VERBAL REPORT OR ACCOMPANIES CLIENT . . . . . 5 OTHER _____ . 6 (SPECIFY) NEVER REFER WITHIN FACILITY . . . . 7 DON'T KNOW 8	
167	When you refer a client **to another facility** (outside this facility), do you use a pre-printed form, a note or a verbal report that specifies information about the client that should be shared? IF PREPRINTED, ASK: May I see a copy of the form?	YES, PREPRINTED FORM SEEN ..... 1 YES, REPORTED, NOT SEEN . . . . . 2 PATIENT SENT WITH MEDICAL RECORDS/FILE/CARD . . . . . 3 WRITE NOTE ON PRESCRIPTION FORM, LETTERHEAD OR BLANK PAPER . . . . . 4 VERBAL REPORT OR ACCOMPANIES CLIENT . . . . . 5 OTHER _____ 6 (SPECIFY) NEVER REFER OUTSIDE FACILITY . . . . 7 DON'T KNOW 8	→ 169

NO.	QUESTIONS	CODING CATEGORIES	GO TO
168	Is there any system for providing or receiving feedback for referrals made by or received by this facility? PROBE TO DETERMINE IF FEEDBACK IS EVER RECEIVED OR PROVIDED. ASK TO SEE DOCUMENTATION THAT SHOWS FEEDBACK HAS BEEN PROVIDED OR RECEIVED. CIRCLE ALL THAT APPLY.	YES, RECEIVE FEEDBACK, DOCUMENTATION OBSERVED ..... A YES, PROVIDE FEEDBACK DOCUMENTATION OBSERVED ..... B REPORTED SYSTEM, BUT NO DOCUMENTATION OBSERVED ..... C PROVIDE FEEDBACK ONLY IF REQUESTED BY PROVIDER D NO FEEDBACK FOR REFERRALS ..... Y	
169	Do you have a system for making individual client appointments for HIV/AIDS clients? IF YES, ASK TO SEE ANY EVIDENCE THAT THE SYSTEM FUNCTIONS	YES, OBSERVED ..... 1 YES, REPORTED, NOT SEEN ..... 2 NO 3	
170	CHECK Q157 AND RECORD IF ANY RESPONSES ARE '1' OR '2' OR '3' INDICATING FACILITY PROVIDES CLINICAL SERVICES FOR HIV/AIDS.	YES ..... 1 NO 2	→179
171	Where can we find information on the numbers of clients seen in this unit or facility who received services for HIV/AIDS related diagnoses, such as opportunistic infections? PROBE TO DETERMINE THE SYSTEM USED. YOU MAY NEED TO ASK FOR THE DATA CLERK. INFORMATION MAY BE COLLECTED FROM A CENTRAL LOCATION. EVEN IF REPORTS DO NOT CAPTURE HIV/AIDS DIAGNOSES, REVIEW THE CLINIC/UNIT REGISTER AS INSTRUCTED BELOW.	UNIT REGISTER/RECORDS OR COMPUTER ..... 1 CENTRAL FACILITY LOCATION OR HIS (RECORDS OR COMPUTERIZED) ..... 2 NO RECORD MAINTAINED 3	 → 176 → 179

172 EXPLAIN: I want to review the record/register to count the number of client visits for HIV/AIDS related illnesses in this unit or facility during the past year. If the diagnoses/conditions I am looking for are compiled for reports, I can use those reports, otherwise, I need to review the unit or facility records.

START WITH ENTRIES FROM THE LAST DAY OF THE MOST RECENT COMPLETED MONTH, AND REVIEW LISTED DIAGNOSES/SYMPTOMS FOR 12 FULL MONTHS OR FOR 1000 CLIENT VISITS, WHICHEVER IS THE LEAST NUMBER OF VISITS.
IF LESS THAN 12 MONTHS, PLACE IN THE NEXT QUESTION THE MONTHS DATA REFER TO.
IF MORE THAN ONE REGISTER IS USED, BE CERTAIN TO SCAN ALL REGISTERS WHERE ELIGIBLE CLIENTS MAY HAVE BEEN RECORDED FOR THE TIME PERIOD BEING REVIEWED.
IF THERE ARE MORE THAN ONE OF THE BELOW LISTED DIAGNOSES/SYMPTOMS FOR ONE CLIENT, CHOOSE THE SYMPTOM OR DIAGNOSIS MOST SPECIFIC FOR HIV/AIDS.
FOR THE SAME CLIENT VISIT RECORD ONLY ONE OF THE BELOW LISTED DIAGNOSES/SYMPTOMS (i.e., DO NOT "DOUBLE COUNT"). ALSO, DO NOT INCLUDE DATA FROM THE OUTREACH CLINIC

			NUMBER OF VISITS
01	ORAL CANDIDIASIS/MOUTH SORES	.....	
02	CRYPTOCOCCAL MENINGITIS	.....	
03	TOXOPLASMOSIS	.....	
04	KAPOSI'S SARCOMA	.....	
05	AIDS-RELATED COMPLEX (ARC)	.....	
06	HERPES ZOSTER/SIMPLEX	.....	
07	PCP (PNEUMOCYSTIS CARINII PNEUMONIA)	.....	
08	IMMUNOSUPPRESSION/ HIV/AIDS OR RVD	.....	
09	WASTING SYNDROME FAILURE TO THRIVE (FTT)	.....	
10	CHRONIC DIARRHEA (MUST SPECIFY CHRONIC)	.....	
11	TUBERCULOSIS	.....	
12	OTHER NON-SPECIFIC DIAGNOSIS COMMON TO HIV/AIDS ILLNESSES, e.g., PYREXIA/FEVER UNKNOWN ORIGIN (PUO/FUO) LYMPHADENOPATHY, etc.	.....	
13	OTHER DIAGNOSIS INDICATING CLIENT HAD HIV/AIDS RELATED ILLNESS_____	.....	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
173	RECORD THE NUMBER OF MONTHS OF DATA THAT IS REPRESENTED IN PREVIOUS Qs.	NUMBER OF FULL MONTHS OF DATA . . . . . [ ][ ]	
174	RECORD THE TOTAL NUMBER OF VISITS FROM WHICH DIAGNOSTIC INFORMATION WAS COLLECTED	TOTAL NUMBER OF VISITS. . . [ ][ ][ ][ ][ ]	
175	WHAT IS THE MOST RECENT DATE THAT ANY HIV/AIDS OR NON-HIV/AIDS CLIENT DIAGNOSES ARE RECORDED?	WITHIN PAST 30 DAYS . . . . . 1 MORE THAN 30 DAYS AGO . . . . . 2 REGISTER NOT SEEN 3	
176	Are reports regularly compiled on the number of client visits to this unit or facility seeking treatment?	YES . . . . . 1 NO 2	→179
177	How frequently are the compiled reports submitted to someone outside of this unit or facility?	MONTHLY OR MORE OFTEN . . . . . 1 EVERY 2-3 MONTHS . . . . . 2 EVERY 4-6 MONTHS . . . . . 3 LESS OFTEN THAN EVERY 6 MONTHS 4 NEVER 5	→179
178	To whom are the reports sent? CIRCLE ALL THAT APPLY.	RECORDS CLERK . . . . . A FACILITY DIRECTOR/SUPERVISOR . . . . . B DISTRICT LEVEL (MOHSS/DSP/HIS) . . . C REGIONAL LEVEL (MOHSS/DSP/MIS) . . . D NATIONAL LEVEL (MOHSS/DSP/MIS) . . . E DONOR AGENCY . . . . . F OTHER _____ X (SPECIFY)	
179	Now I want to ask you about post-exposure prophylaxis (PEP) for people who may have been exposed to HIV/AIDS. Is PEP available to staff in this facility? IF YES, ASK: Do providers in this unit prescribe the PEP or refer staff for PEP?	YES, PEP PRESCRIBED/STAFF REFERRED BY THIS UNIT . . . . . 1 YES, PEP PRESCRIBED/REFERRED IN OTHER UNIT THIS FACILITY . . . . . 2 YES, PEP PRESCRIBED/REFERRED IN THIS AND OTHER UNIT IN FACILITY 3 YES, STAFF CAN RECEIVE PEP FROM OTHER FACILITY IF DESIRED 4 NO ACCESS TO PEP 5	 →186A →186A
180	Is there a register or record maintained in this facility for workers who have been prescribed PEP or have been referred for PEP? IF YES, ASK: May I see the register/record? IF REGISTER IS AVAILABLE ONLY IN ANOTHER LOCATION, GO TO THAT LOCATION AND CHECK THE REGISTER TO SEE WHICH INFORMATION IS AVAILABLE. CIRCLE THE CORRECT LETTER FOR EACH PIECE OF INFORMATION THAT IS RECORDED.	YES, REFERRED FOR PEP . . . . . A YES, RECEIVED PRE-PEP HIV TEST . . B YES, RECEIVED PEP ARV DRUGS . . C YES, RECEIVED POST-PEP HIV TEST D NO, INFORMATION RECORDED IN INDIVIDUAL HEALTH RECORD ONLY E NO RECORD FOR PEP . . . . . Y	
181	Are there any written protocols/guidelines for post-exposure prophylaxis available in this site? IF YES, ASK TO SEE THE PROTOCOLS/ GUIDELINES	YES, OBSERVED . . . . . 1 YES, REPORTED NOT SEEN . . . . 2 NO 3	
182	What is the PEP regimen that is most commonly prescribed by providers in this facility?	ZDV + 3TC . . .. 1 TDF + 3TC (FOR NO TOLERANCE OF AZT) 2 ZDV + 3TC ***plus*** EFAVIRENZ ***or*** LOPINAVIR . . . 3 ZDV + 3TC ***plus*** INDINAVIR ***or*** NELFINAVIR . . . 4 OTHER _____ 6 (SPECIFY)	
183	Are any PEP medicines stored in this unit or any other location in facility? IF YES, ASK TO SEE THE PEP MEDICINES	YES, THIS UNIT . . . . . 1 YES, OTHER LOCATION IN FACILITY 2 NO 3	 →186A
184	RECORD WHICH MEDICINES ARE PRESENT FOR PEP	ZIDOVUDINE (AZT) . . . . . A LAMIVUDINE (3TC) . . . . . B TENOFOVIR (TDF) . . . . . C EFAVIRENZ (EFV) . . . . . D LOPINAVIR (LPV) . . . . . E INDINAVIR (IDV) . . . . . F NELVINAVIR (NFV) . . . . . G OTHER(S) _____ H (SPECIFY) NONE . . . . . Y	 →186A

NO.	QUESTIONS	CODING CATEGORIES	GO TO
185	DESCRIBE THE STORAGE OF THE PEP MEDICINES. ARE THE PEP MEDICINES STORED SEPARATE FROM OTHER MEDICINES OR SUPPLIES?	STORED ALONE . . . . . 1 STORED WITH OTHER ARVS/APART FROM OTHER MEDICINES . . . . . 2 STORED WITH NON-ARV MEDS . . . . . 3 OTHER_____ . . . . . 6 (SPECIFY)	
186	DESCRIBE THE SECURITY FOR THE PEP MEDICINES.	LOCKED APART FROM OTHER MEDS AND ARVS . . . . . 1 LOCKED, LIMITED ACCESS SITE . . 2 UNLOCKED OR NO LIMITED ACCESS . . 3	
186A	**ASK TO SEE THE AREA(S) IN THIS UNIT WHERE MOST CLIENTS ARE EXAMINED OR A PROCEDURE IS CARRIED OUT. OBSERVE THE CONDITIONS UNDER WHICH CLIENT EXAMINATION TAKES PLACE. IF THERE ARE SEVERAL ROOMS FOR THE SAME PURPOSE, RANDOMLY PICK ONE TO ASSESS.**		
	IF THE SAME EXAMINATION AREA/ROOM HAS ALREADY BEEN OBSERVED FOR ITEMS IN Q187, INDICATE WHICH SECTION THE DATA ARE RECORDED	CHILD HEALTH [Q256] . . . . . 12 FAMILY PLANNING [Q322] . . . . . 13 ANTENATAL CARE [Q429] . . . . . 14 DELIVERY [Q530] . . . . . 15 STI [Q626] . . . . . 16 SECTION 17-TB [Q1719] . . . . . 17 SECTION 18-CT [Q1830] . . . . . 18 NOT PREVIOUSLY SEEN 19	188

187	INDICATE IF THE ITEMS LISTED BELOW ARE AVAILABLE IN THE ROOM OR IN AN IMMEDIATELY ADJACENT AREA	AVAILABILITY		
		OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED)	1 → 04	2	3
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 → 04	2	3
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3
04	HAND-WASHING SOAP/LIQUID SOAP	1	2	3
05	HAND DISINFECTANT	1	2	3
06	SINGLE-USE HAND DRYING TOWELS	1	2	3
07	WASTE RECEPTACLE WITH LID (PEDAL BIN) AND PLASTIC LINER	1 → 10	2	3
08	OTHER WASTE RECEPTACLE (NOT PEDAL BIN) WITH PLASTIC LINER	1 → 10	2	3
09	WASTE RECEPTACLE WITH LID (PEDAL BIN) WITHOUT PLASTIC LINER	1	2	3
10	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
11	DISPOSABLE LATEX GLOVES	1 → 13	2	3
12	DISPOSABLE NON-LATEX GLOVES	1	2	3
13	DISINFECTANT [E.G., HIBITANE, ALCOHOL]	1	2	3
14	DISPOSABLE NEEDLES	1	2	3
15	AUTO-DISABLE SYRINGES (3 OR 5 ml)	1	2	3
16	DISPOSABLE SYRINGES (3 OR 5 ml)	1	2	3
17	AUDITORY PRIVACY	1	2	3
18	VISUAL PRIVACY	1	2	3
19	TABLE CLOTH/PLASTIC ON ANY SURFACE	1	2	3

NO.	QUESTIONS	CODING CATEGORIES	GO TO
188	ASK THE RESPONDENT TO TAKE YOU TO THE MAIN AREA WHERE EQUIPMENT IS CLEANED AND STERILIZED OR DISINFECTED [CSSD]. ASK TO SPEAK WITH THE PERSON MOST KNOWLEDGEABLE ABOUT THE PROCESSES USED. What procedure is used for **decontaminating** and **cleaning** equipment before its final processing for reuse? PROBE, IF NECESSARY, TO DETERMINE CORRECT RESPONSE.	SOAKED IN DISINFECTANT SOLUTION AND THEN BRUSH SCRUBBED WITH SOAP AND WATER . . . . . 01 BRUSH SCRUBBED WITH SOAP AND WATER AND THEN SOAKED IN DISINFECTANT . . . . . 02 BRUSH SCRUBBED WITH SOAP AND WATER ONLY . . . . . 03 SOAKED IN DISINFECTANT, NOT BRUSH SCRUBBED . . . . . 04 CLEAN WITH SOAP AND WATER, NOT BRUSH SCRUBBED . . . . . 05 OTHER _____ 96 (SPECIFY) NO EQUIPMENT EVER REUSED . . . . . 07 DON'T DECONTAMINATE IN FACILITY 95	 → 194 → 190
189	Are there written guidelines for how to decontaminate equipment? IF YES, ASK: May I see them?	YES, OBSERVED . 1 YES, REPORTED, NOT SEEN 2 NO . 3	
190	What is the ***final method*** most commonly used for disinfecting or sterilizing medical equipment (such as surgical instruments) before they are reused? IF DIFFERENT METHODS ARE USED FOR DIFFERENT TYPES OF EQUIPMENT, INDICATE THE METHOD(S) USED FOR METAL EQUIPMENT SUCH AS SPECULUMS OR FORCEPS.	DRY-HEAT STERILIZATION . . . . . A AUTOCLAVING . . . . . B BOILING . . . . . C STEAM STERILIZATION . . . . . D CHEMICAL METHOD . . . . . E PROCESSED OUTSIDE FACILITY . . . . . F NONE . . . . . Y	 → 192(6) → 192(6)

191 ASK IF EACH OF THE INDICATED ITEMS BELOW IS AVAILABLE, AND IF SO, ASK TO SEE IT AND IF IT IS **FUNCTIONING OR NOT (IF RELEVANT)**

	ITEM	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Electric autoclave (PRESSURE AND WET HEAT)	1 → b	2 → b	3 → 02	8 → 02	1	2	8
02	Non-electric autoclave (PRESSURE/WET HEAT)	1 → b	2 → b	3 → 03	8 → 03	1	2	8
03	Electric dry heat sterilizer	1 → b	2 → b	3 → 04	8 → 04	1	2	8
04	Electric boiler or steamer (no pressure)	1 → b	2 → b	3 → 05	8 → 05	1	2	8
05	Non-electric pot with cover (FOR STEAM/ BOIL)	1	2	3	8			
06	Heat source for non-electric equipment (STOVE OR COOKER)	1 → b	2 → b	3 → 07	8 → 07	1	2	8
07	Automatic timer (MAY BE ON EQUIPMENT)	1 → b	2 → b	3 → 08	8 → 08	1	2	8
08	TST Indicator strips or other item that indicates when sterilization is complete.	1	2	3	8			
09	Written protocols or guidelines for sterilization of disinfection	1	2	3	8			

192	FOR EACH OF THE FOLLOWING METHODS FOR STERILIZATION/ DISINFECTION USED IN THE FACILITY, INDICATE THE PROCESSING DETAILS INCLUDING TIME PROCESSED AFTER THE REQUIRED TEMPERATURE/ PRESSURE/ BOILING IS REACHED						
		(1) Dry heat sterilization	**(2)** Autoclave (steam with pressure)	**(3)** Boil	**(4)** Steam without pressure	**(5)** Chemical High Level Disinfectant (HLD)	**(6)** Initial decontamination
A	Method	USED . . . . . 1 NOT USED . . 2 → 2	USED . . . . . 1 NOT USED . . 2 → 3	USED . 1 NOT USED 2 → 4	USED . . . . . 1 NOT USED . . 2 → 5	USED . . . . . 1 NOT USED . . 2 → 6	USED . . . . . 1 NOT USED . . 2 → 193
B	Temperature (centigrade)	TEMPERATURE AUTOMATIC . . . . 666 DON'T KNOW . . . 998	TEMPERATURE AUTOMATIC . . . . 666 DON'T KNOW . . . 998				
C	Pressure		PRESS-URE AUTOMATIC 666 → 2E DON'T KNOW 998 → 2E				
D	Units of pressure		UNITS OF PRESSURE: KG/SQ CM . . 1 ATM PRESSURE . . 2 KILOPASCAL . . . 3 MILLIMETER HG . . 4				
E	Minutes-when equipment is not wrapped in cloth	MINUTES AUTOMATIC . . . . 666 DON'T KNOW . . . 998	MINUTES AUTOMATIC . . . . . 666 DON'T KNOW 998	MINUTES DON'T KNOW . . . 998	MINUTES DON'T KNOW . . . 998	MINUTES DON'T KNOW . . . 998	MINUTES DON'T KNOW . . . 998
F	Minutes when equipment is wrapped		MINUTES WRAPPED AUTOMATIC . . . . 666 DON'T KNOW . . . 998				
G	Chemical disinfectant used					CHLORINE 1 CIDEX . . . . . 2 BETADINE . . . . . 3 ALCOHOL . . . . . 4 HYDROCHLORITES 5 H202 . . . . . 6 FORMALDEHYDE 7 DON'T KNOW 8	CHLORINE 1 CIDEX . . . . . 2 BETADINE . . . . . 3 ALCOHOL . . . . . 4 HYDROCHLORITES 5 H202 . . . . . 6 FORMALDEHYDE 7 DON'T KNOW 8
H	Percent solution before dilution					PERCENT DON'T KNOW . . 998	PERCENT DON'T KNOW . . 998
I	Mixture, parts solution and water					MIXTURE PARTS a) DISINFECTANT b) WATER DK 998	MIXTURE PARTS a) DISINFECTANT b) WATER DK 998

NO.	QUESTIONS	CODING CATEGORIES				GO TO
193	ASK TO SEE WHERE PROCESSED EQUIPMENT SUCH AS SPECULUMS AND FORCEPS ARE STORED PRIOR TO REUSE. INDICATE FOR EACH OF THE BELOW IF THIS STORAGE PRACTICE WAS OBSERVED OR REPORTED.	STORAGE CONDITIONS				
		OBSERVED PRESENT	REPORTED AVAILABLE	NOT AVAILABLE	DON'T KNOW	
01	Wrapped in sterile paper, sealed with tape	1	2	3	8	
02	Stored in sterile container with lid that clasps shut	1	2	3	8	
03	Stored unwrapped inside an autoclave or dry-heat sterilizer	1	2	3	8	
04	On tray, covered with cloth or wrapped without sealing tape	1	2	3	8	
05	In container with disinfectant or antiseptic	1	2	3	8	
06	Other sterile storage	1	2	3	8	
07	Other Non-sterile S	1	2	3	8	
08	Date of sterilization written on packet or container with processed items	1	2	3	8	
193A	IS THE STORAGE AREA DRY AND CLEAN?	YES . . . . . 1 NO 2				
194	Now I would like to ask you a few questions about the waste disposal practices for sharps waste, such as needles or blades. How does this facility ***finally*** dispose of sharps waste, or, what is the final disposal process for filled sharps boxes in this facility?	**BURN IN INCINERATOR:** 2-CHAMBER INDUSTRIAL (800-1000+°C). 02 1-CHAMBER DRUM/BRICK . . . . . 03 **OPEN BURNING** FLAT GROUND-NO PROTECTION . . . . . 04 PIT OR PROTECTED GROUND . . . . . 05 **DUMP WITHOUT BURNING** FLAT GROUND-NO PROTECTION . . . . . 06 COVERED PIT OR PIT LATRINE . . . . . .07 OPEN PIT-NO PROTECTION . . . . . 08 PROTECTED GROUND OR PIT . . . . . .09 **REMOVE OFFSITE** STORED IN COVERED CONTAINER . . . . 10 STORED IN OTHER PROTECTED ENVIRONMENT . . . . . 11 STORED UNPROTECTED . . . . . 12 **OTHER** _____ 96 (SPECIFY) NEVER HAVE SHARPS WASTE 95				→ 195
194A	ASK TO SEE THE PLACE USED BY THIS FACILITY FOR DISPOSAL OF SHARPS WASTE AND INDICATE THE CONDITION OBSERVED. IF SHARPS WASTE IS DISPOSED OFF-SITE, OBSERVE THE SITE WHERE WASTE IS STORED PRIOR TO COLLECTION FOR OFF-SITE DISPOSAL. IF NOT APPLICABLE, CIRCLE '8'.	WASTE VISIBLE, ***NOT*** PROTECTED . . . . . 1 WASTE VISIBLE, BUT PROTECTED . . . . . 2 NO WASTE VISIBLE . . . . . 3 WASTE SITE NOT INSPECTED 8				
194B	CHECK **Q194:** IS **10** OR **11** OR **12** CIRCLED (ANY SHARPS WASTE REMOVED OFFSITE FOR DISPOSAL?) YES ☐ NO ☐					→ 195
194C	How is the sharps waste that is collected and removed offsite finally disposed?	INCINERATED . . . . . 1 **TAKEN TO LOCAL DUMP:** BURNED . . . . . 2 BURNED BUT NOT BURRIED . . . 3 BURIED UNBURNED . . . . . 4 OTHER _____ 6 (SPECIFY) DON'T KNOW 8				

NO.	QUESTIONS	CODING CATEGORIES	GO TO
195	Now I would like to ask you a few questions about the waste disposal practices for medical waste other than sharps, such as used bandages How does this facility ***finally*** dispose of medical waste other than sharps boxes?	SAME AS FOR SHARP ITEMS . . . . . .01 **BURN IN INCINERATOR:** 2-CHAMBER INDUSTRIAL (800-1000+°C) 02 1-CHAMBER DRUM/BRICK . . . . . 03 **OPEN BURNING** FLAT GROUND-NO PROTECTION . . . . . 04 PIT OR PROTECTED GROUND . . . . . 05 **DUMP WITHOUT BURNING** FLAT GROUND-NO PROTECTION . . . . . 06 COVERED PIT OR PIT LATRINE . . . . . .07 OPEN PIT-NO PROTECTION . . . . . 08 PROTECTED GROUND OR PIT . . . . . .09 **REMOVE OFFSITE** STORED IN COVERED CONTAINER . . . . 10 STORED IN OTHER PROTECTED ENVIRONMENT . . . . . 11 STORED UNPROTECTED . . . . . 12 **OTHER** _____ 96 (SPECIFY) NEVER HAVE OTHER MEDICAL WAST 95	→196 → 196
195A	ASK TO SEE THE PLACE USED BY THIS FACILITY FOR DISPOSAL OF MEDICAL WASTE AND INDICATE THE CONDITION OBSERVED. IF WASTE IS DISPOSED OFF-SITE, OBSERVE THE SITE WHERE WASTE IS STORED PRIOR TO COLLECTION FOR OFF-SITE DISPOSAL. IF NOT APPLICABLE, CIRCLE '8'.	WASTE VISIBLE, ***NOT*** PROTECTED . . . . . 1 WASTE VISIBLE, BUT PROTECTED . . . . . 2 NO WASTE VISIBLE . . . . . 3 WASTE SITE NOT INSPECTED 8	
195B	CHECK **Q195:** IS **10** OR **11** OR **12** CIRCLED (ANY MEDICAL WASTE REMOVED OFFSITE FOR DISPOSAL?) YES ☐ NO ☐		→ 196
195C	How is the medical waste that is collected and removed offsite finally disposed?	INCINERATED . . . . . 1 **TAKEN TO LOCAL DUMP:** BURNED . . . . . 2 BURNED BUT NOT BURRIED . . . 3 BURIED UNBURNED . . . . . 4 OTHER _____ 6 (SPECIFY) DON'T KNOW 8	

196	ASSESS GENERAL CLEANLINESS OF FACILITY	YES	NO
01	**FLOOR:** SWEPT, NO OBVIOUS DIRT OR WASTE	1	2
02	**COUNTERS/TABLES/CHAIRS:** WIPED CLEAN-NO OBVIOUS DUST OR WASTE	1	2
03	BROKEN EQUIPMENT, PAPERS, BOXES AROUND MAKING AREA CLUTTERED AND DIRTY	1	2
04	**WALLS:** REASONABLY CLEAN	1	2
05	**DOORS:** NO (OR MINOR) DAMAGE	1	2
06	**WALLS:** NO (OR MINOR) DAMAGE	1	2
07	**ROOF:** NO (OR MINOR) DAMAGE	1	2
08	**CEILING:** NO (OR LITTLE) WATER STAINS/DAMAGE	1	2
09	NEEDLES, SHARPS OUTSIDE SHARPS BOX	1	2
10	SHARPS BOX OVERFLOWING OR TORN/PIERCED	1	2
11	BANDAGES/INFECTIOUS WASTE LYING UNCOVERED	1	2

THANK YOUR RESPONDENT AND MOVE TO THE NEXT DATA COLLECTION POINT

2a. Vaccine Logistical System

Facility number: [ ][ ][ ] **Interviewer Code** [ ][ ]

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
200	Now I would like to find out about immunisation services provided to children or women (including pregnant women) either by or at your facility. Are any immunisation services provided, either as outreach or at the facility itself? IF YES: ASK: Do you provide immunisations for children only, for women only, or for both children and women?	YES, CHILDREN ONLY . . . . . 1 YES, WOMEN ONLY. . . . . 2 BOTH CHILDREN AND WOMEN. . . . . 3 NO IMMUNISATION SERVICES. 4	 → **END**

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN MANAGEMENT OF IMMUNISATION SERVICES. IF THIS IS A NEW RESPONDENT, OBTAIN INFORMED CONSENT BELOW. IF THE PERSON IS NOT A NEW RESPONDENT, CONTINUE WITH Q201.
READ THE FOLLOWING TO NEW RESPONDENTS:

Good day! My name is _____. We are here on behalf of the Ministry of Health and Social Services (MOHSS) conducting a study to assist the government in knowing more about health services in Namibia.
Now I will read a statement explaining the study.

ALL facilities in the country are participating in this study. We will be asking you questions about various health services and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility may be used by the MOHSS, organizations supporting services in your facility, and researchers, for planning service improvement or for conducting further studies of health services.

Neither your name nor that of any other health worker respondents participating in this study will be included in the dataset or in any report; however, there is a small chance that any of these respondents may be identified later. Still, we are asking for your help to ensure that the information we collect is accurate.

You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will answer the questions, which will benefit the services you provide and the nation.

If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate if you introduce us to that person to help us collect that information.

At this point, do you have any questions about the study? Do I have your agreement to proceed?

_____ [ ][ ] [ ][ ] **2 0 0 9**
Interviewer's signature — DAY — MONTH — YEAR
(Indicates respondent's willingness to participate)

201	May I begin the interview now?	YES . . . . . 1 NO 2	 → **STOP**
202	Does this facility routinely store *any* vaccines, or are all its vaccines either picked up from another facility or delivered when services are being provided?	YES, STORES VACCINES. . . . . 1 STORES NO VACCINES. 2	 → 215
203	ASK TO GO WHERE VACCINES ARE STORED, AND EXPLAIN: I want to find out about your system for keeping vaccines. What type of equipment do you usually use to store your vaccines? CIRCLE ALL THAT APPLY	ELECTRIC REFRIGERATOR . . A KEROSENE REFRIGERATOR . . B GAS REFRIGERATOR . . . . . C SOLAR REFRIGERATOR . . . . . D OTHER_____ X (SPECIFY)	
204	ASK TO SEE THE REFRIGERATOR OR STORAGE EQUIPMENT AND TO BE ALLOWED TO READ THE TEMPERATURE INSIDE THE EQUIPMENT INDICATE THE TEMPERATURE INSIDE THE REFRIGERATOR OR EQUIPMENT.	TEMPERATURE IN CENTIGRADE . . . . . [ ][ ] NOT OBSERVED . . . . . 94 THERMOMETER NOT FUNCTIONING . . . . . 95 NO THERMOMETER 96	 → 206 → 206 → 206

205	INDICATE WHETHER TEMPERATURE INSIDE COOLING UNIT IS ABOVE OR BELOW 0 (ZERO) DEGREES CENTIGRADE. FOR 0 DEGREES, CIRCLE 1.	POSITIVE (+) . . . . . 1 NEGATIVE (-) 2	
206	Do you have a cold-chain temperature-monitoring chart? IF YES, ASK: May I see it?:	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . 2 NO 3	 → 208 → 208
207	CHECK WHETHER THE TEMPERATURE RECORD WAS COMPLETED TWICE DAILY FOR EACH OF THE PAST 30 DAYS.	YES, COMPLETED . . . . . 1 NO, NOT COMPLETED 2	
208	INDICATE WHETHER THE REFRIGERATOR OR STORAGE EQUIPMENT IS PROTECTED FROM DIRECT SUNLIGHT.	YES . . . . . 1 NO 2	

209 VALIDATION OF VACCINE

	GO TO THE MAIN AREA WHERE VACCINES ARE STORED. ASK IF THE ITEMS LISTED ARE STOCKED/CARRIED IN THE FACILITY. IF YES, THEN PROCEED TO COLLECT INFORMATION ON EACH ITEM IN COLUMNS B-F.	A IS PRODUCT NORMALLY CARRIED OR STOCKED IN FACILITY	B UNIT OF MEASURE	C STOCK CARD AVAILABLE	D VALID EXPIRATION DATE ON ALL UNITS PRESENT TODAY	E ITEMS STORED BY DATE OF EXPIRATION	F ITEMS ARRANGED BY VVM
	PRODUCT	1=YES 2=NO **IF NO, SKIP TO NEXT ITEM**	1=TAB/CAPS 2=VIALS 3=AMPOULES 4=PACKS	1=YES 2=NO	1=YES 2=NO	1=YES 2=NO	1=YES 2=NO
01	Tetanus Toxoid						
02	BCG and diluent						
03	Oral Polio Virus (OPV)						
04	DPT/Pentavalent						
05	Measles vaccine and Diluent						
06	Vitamin A (NOT A FRIDGE ITEM)						

210	When was the last time that you received a scheduled supply of vaccines? (i.e., from the main order and not interim order)	WITHIN PRIOR 4 FULL WEEKS 1 BETWEEN 4-12 WEEKS . . . . . 2 MORE THAN 12 WEEKS AGO . . 3 NO ROUTINE SUPPLY SYSTEM ... 4 DON'T KNOW 8	

211	Does this facility determine the quantity of vaccines required and order that, or is the quantity that you receive determined elsewhere?	DETERMINES OWN NEED AND ORDERS . . . . . 1 NEED DETERMINED ELSEWHERE . . . . . 2 BOTH (DIFFER BY VACCINE) 3 DON'T KNOW 8	→213 →213
212	Routinely, when you order vaccines, which best describes the system you use to determine ***how much*** of each to order? Do you: - **Review** the amount of each vaccine remaining, and order to bring the stock amount to a pre-determined (fixed) amount (max stock level)? - **Order** exactly the same quantity each time, regardless of the existing stock? - **Review** the amount of each vaccine used since the previous order, and plan based on prior consumption and expected future consumption? - **Other** _____ (SPECIFY) - Don't know	ORDER TO MAINTAIN FIXED STOCK . . . . . 1 ORDER SAME AMOUNT . . . . . 2 ORDER BASED ON UTILIZATION . . . . . 3 OTHER . . . . . 6 DON'T KNOW 8	
213	How many vaccine carriers do you have available?	ONE . . . . . 1 TWO OR MORE . . . . . 2 NONE 3	→215
214	Are there ice packs for the vaccine carriers (four or five per carrier)? NOTE: 4-5 ICE PACKS=1 SET FOR A VACCINE CARRIER.	YES, ONE SET . . . . . 1 YES, TWO OR MORE SETS. . . . . 2 NO, USE PURCHASED ICE. . . . . 3 NO 4	
215	What type of *injection equipment* (i.e., syringes and needles) is used during routine immunization sessions at this facility?	DISPOSABLE NEEDLES AND SYRINGES, NOT AUTO-DESTRUCT. . . A DISPOSABLE NEEDLES AND SYRINGES, AUTO-DESTRUCT. . . . . B RE-USEABLE GLASS + METAL. . . . . C OTHER _____ (SPECIFY) X	

2b. Child Health Services

Facility number: [ ][ ][ ] **Interviewer Code:** [ ][ ]

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
230	Does this facility provide any services for children below 5 years of age, either at the facility or on an outreach basis?	YES . . . . . 1 NO 2	→ **END**

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN MANAGEMENT OF CURATIVE CHILD HEALTH SERVICES. IF THIS IS A NEW RESPONDENT, OBTAIN INFORMED CONSENT BELOW. IF THE PERSON IS NOT A NEW RESPONDENT, CONTINUE WITH Q231.
READ THE FOLLOWING TO NEW RESPONDENTS:

Good day! My name is _____. We are here on behalf of the Ministry of Health and Social Services (MOHSS) conducting a study to assist the government in knowing more about health services in Namibia.
Now I will read a statement explaining the study.

ALL facilities in the country are participating in this study. We will be asking you questions about various health services and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility may be used by the MOHSS, organizations supporting services in your facility, and researchers, for planning service improvement or for conducting further studies of health services.

Neither your name nor that of any other health worker respondents participating in this study will be included in the dataset or in any report; however, there is a small chance that any of these respondents may be identified later. Still, we are asking for your help to ensure that the information we collect is accurate.

You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will answer the questions, which will benefit the services you provide and the nation.

If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate if you introduce us to that person to help us collect that information.

At this point, do you have any questions about the study? Do I have your agreement to proceed?

_____ [ ][ ] [ ][ ] **2 0 0 9**
Interviewer's signature — DAY | MONTH | YEAR
(Indicates respondent's willingness to participate)

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
231	May I begin the interview?	YES . . . . . 1 NO 2	→ **STOP**

232 Now I would like to ask you specifically about child health services. For each of the following services, please tell me whether the service is offered by your facility, and if so, how many days per month the service is provided *at the facility, and how many days per month outreach services are provided (if any).*

	CHILD HEALTH SERVICE (USE A 4-WEEK MONTH TO CALCULATE # OF DAYS)	(a) # OF DAYS PER MONTH SERVICE IS PROVIDED AT FACILITY	(b) # OF DAYS PER MONTH SERVICE IS THROUGH OUTREACH (VILLAGE LEVEL) ACTIVITIES
01	Routine series of immunisations for children (DPT/Pentavalent, polio, measles)	# OF DAYS 00=NO SERVICE [ ][ ]	# OF DAYS 00=NO SERVICE [ ][ ]
02	BCG immunisations	# OF DAYS 00=NO SERVICE [ ][ ]	# OF DAYS 00=NO SERVICE [ ][ ]
03	Consultation or curative services for a sick child	# OF DAYS 00=NO SERVICE [ ][ ]	# OF DAYS 00=NO SERVICE [ ][ ]
04	Growth monitoring or growth promotion (where a *healthy child* is routinely weighed, has the weight charted on a growth chart, and feeding advice is given.)	# OF DAYS 00=NO SERVICE [ ][ ]	# OF DAYS 00=NO SERVICE [ ][ ]

233	CHECK 232 (01a) AND INDICATE WHETHER ROUTINE CHILD IMMUNISATIONS ARE EVER PROVIDED AT THE FACILITY YES ☐ NO ☐ →		245
234	Are routine immunisations for children available at the facility today?	YES . . . . . 1 NO 2	
235	Are immunisations offered in the facility on every day that sick child consultations are provided? IF YES, ASK: Are all vaccines offered?	YES, ALL VACCINES . . . . . 1 YES, SOME VACCINES, NOT ALL . . . . . 2 NO . . . . . 3 DON'T KNOW 8	
236	Does this facility have any routine user-fees or charges for any child immunisation services? This includes any fees, including those for registration, client health card/passport, or vaccines?	YES . . . . . 1 NO, CLIENTS HAVE NO OUT-OF-POCKET CHARGES OR USER-FEES . . 2	→ 239
237	Please tell me if any of the following user-fee or charging practices are ever applied by this facility for child immunisation services:	YES / NO / DON'T KNOW	
01	Is there a fee for the child immunisation chart or health card/passport?	IMMUNISATION CHART/RECORD 1 2 8	
02	Is there a fee for syringes provided by the facility?	SYRINGES 1 2 8	
03	Is there a fee for immunisation services?	IMMUNISATION SERVICE 1 2 8	
04	Is there a fee for any vaccines?	VACCINE 1 2 8	
05	Are there any other elements for which user-fees or charges are routinely asked for immunisation services? IF YES, SPECIFY _____	OTHER 1 2 8	
238	Are the official fees posted or displayed so that the client can easily see them? IF YES, VERIFY BY ASKING TO SEE WHERE FEES ARE POSTED OR DISPLAYED	YES, ALL FEES POSTED . . . . . 1 YES, SOME, NOT ALL FEES POSTED . . . . . 2 NO POSTED FEES 3	
238A	What is the procedure if a child is unable to pay for any of the fees associated with child immunization services that are indicated above?	FEE EXEMPTED/DISCOUNTED, NO PAYMENT EXPECTED. . . . . A FEE EXEMPTED/DISCOUNTED, PAYMENT EXPECTED LATER. . B SERVICE NOT PROVIDED, ASKED TO COME BACK WHEN ABLE TO PAY. . . . . C PAYMENT IN-KIND. . . . . D OTHER _____ X SPECIFY	
239	ITEMS REQUIRED FOR IMMUNISATION SERVICES	OBSERVED / REPORTED, NOT SEEN / NOT AVAILABLE / DON'T KNOW	
01	National guidelines for immunisation or circular	1 2 3 8	
02	Blank, individual child immunisation cards/passport	1 2 3 8	
03	Tally sheets	1 2 3 8	
04	Summary forms	1 2 3 8	
05	Permanent register for recording immunisations	1 2 → 241 3 → 241 8 → 241	
240	ASK WHEN IMMUNISATIONS WERE MOST RECENTLY PROVIDED IN THE FACILITY AND VERIFY THAT THE REGISTER IS UP-TO-DATE.	UP-TO-DATE . . . . . 1 NOT UP TO DATE 2	
241	What is the current estimate for your DPT (or PENTAVALENT) dropout rate?	DPT DROPOUT RATE (%) . . . . . ☐☐☐ DON'T KNOW 998	

242	Do you have an estimate of the target population for child immunisations in the facility catchment area, that is, children under 1 year of age? IF YES: How many children is that?	TARGET POPULATION [ ][ ][ ][ ][ ] NO CATCHMENT AREA . 99995 DON'T KNOW 99998	 → 245 → 245
243	What is the current estimate for your facility's measles coverage. THIS IS AN ANNUALIZED RATE	MEASLES COVERAGE (%) . . [ ][ ][ ] DON'T KNOW 998	
244	RECORD THE SOURCE(S) OF INFORMATION FOR % COVERAGE AND DROPOUT RATE ESTIMATES.	WRITTEN REPORT . . . . . A GRAPH/CHART. . . . . B OTHER _____ X (SPECIFY) NO COVERAGE RATES . . . . . Y SOURCE NOT KNOWN . . . . . Z	
245	CHECK Q232(03a): DOES FACILITY PROVIDE SICK-CHILD CONSULTATIONS? YES [ ] NO [ ] →		**END**
246	Do providers routinely provide care following the IMCI guidelines?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
247	Does this facility have any routine user-fees or charges for any services related to curative care for children? This includes any fees, including those for registration or for client health records.	YES . . . . . 1 NO, CLIENTS HAVE NO OUT-OF-POCKET CHARGES OR USER-FEES . . 2	→ 250
248	Please tell me if any of the following user-fee or charging practices are ever applied by this facility for curative care for children:	YES / NO / DON'T KNOW	
01	Is there a fee for the child health chart or record?	CLIENT HEALTH CARD/PASSPORT 1 2 8	
02	Is there a fee for the consultation service?	FEE FOR CONSULT 1 2 8	
03	Is there a fee for overnight stay?	FEE FOR OVERNIGHT STAY 1 2 8	
04	Is there a different fee depending on the child's diagnosis?	VARY BY DIAGNOSIS 1 2 8	
05	Are there fees for medications?	MEDICINES 1 2 8	
06	Are there fees for laboratory tests?	TESTS 1 2 8	
07	Is there a fee for registration?	REGISTRATION 1 2 8	
08	Are discounts or exemptions from fees allowed for some clients?	DISCOUNT/ EXEMPTIONS 1 2 8	
09	Is there a system for clients to pre-pay for multiple visits for curative care?	PREPAY FOR MULTIPLE 1 2 8	
249	Are the official fees posted or displayed so that the client can easily see them? IF YES, VERIFY BY ASKING TO SEE WHERE FEES ARE POSTED OR DISPLAYED	YES, ALL FEES POSTED . . . . . 1 YES, SOME, NOT ALL FEES POSTED . . . . . 2 NO POSTED FEES 3	

249A	What is the procedure if a child is unable to pay for any of the fees associated with curative care that are indicated above?	FEE EXEMPTED/DISCOUNTED, NO PAYMENT EXPECTED. . . . . A FEE EXEMPTED/DISCOUNTED, PAYMENT EXPECTED LATER. . B NO SERVICE, ASKED TO COME BACK WHEN ABLE TO PAY. . . . . C PAYMENT IN-KIND. . . . . D OTHER _____ X SPECIFY	
250	Does this facility have a system whereby certain observations and parameters are routinely carried out on sick children before the consultation for the presenting illness? IF YES, ASK TO SEE THE PLACE WHERE SICK CHILDREN ARE SEEN BEFORE THE CONSULTATION .	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	 → 252 → 252

251	OBSERVE IF THE BELOW ACTIVITIES ARE BEING CONDUCTED ROUTINELY. IF NOT SEEN ASK: Is [READ ACTIVITY YOU DO NOT SEE] routinely conducted for all sick children?	OBSERVED ACTIVITY	ACTIVITY REPORTED, NOT SEEN	ACTIVITY NOT ROUTINELY CONDUCTED	DON'T KNOW
01	Weighing the child	1	2	3	8
02	Plotting child's weight on graph	1	2	3	8
03	Taking child's temperature	1	2	3	8
04	Assessing child's immunisation status	1	2	3	8
05	Providing group health education	1	2	3	8
06	Administering paracetamol and/or sponge for fever	1	2	3	8

252	Is there an ORT corner at the facility? IF YES, ASK TO SEE WHERE THE ORT IS PROVIDED.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO ORT CORNER . . . . . 3 DON'T KNOW 8	
253	Is there a routine system for a health worker other than the one who examines the child to give him or her the first dose of **prescribed** oral medication? IF YES, ASK TO SEE WHERE THE FIRST DOSE IS PROVIDED.	YES, OBSERVED CHILD RECEIVING DOSE . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO ROUTINE SYSTEM . . . . . 3 DON'T KNOW 8	
254	Does this facility use blood tests to verify the diagnosis of malaria? IF YES, ASK: Is this done always or only sometimes?	ALWAYS . . . . . 1 SOMETIME . . . . . 2 NEVER . . . . . 3 DON'T KNOW 8	

255	ASK TO GO TO THE PLACE WHERE EXAMINATIONS OF SICK CHILDREN ARE CARRIED OUT. CHECK WHETHER EACH OF THE ITEMS BELOW IS EITHER IN THE ROOM WHERE THE SERVICE IS GIVEN OR IN AN ADJACENT ROOM.		
	IF THE *SAME EXAMINATION ROOM* HAS ALREADY BEEN OBSERVED, INDICATE WHICH SECTION THE DATA ARE RECORDED IN.	OPD [Q187] . . . . . 11 FAMILY PLANNING [Q322] . . . 13 ANTENATAL [Q429] 14 DELIVERY [Q530] . . . . . 15 STI [Q626] . . . . . 16 SECTION 17-TB [Q1719] . . . . . 17 SECTION 18-CT [Q1830] 18 NOT PREVIOUSLY SEEN 19	257

		(a) AVAILABILITY			
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	
01	RUNNING WATER (PIPED)	1 → 04	2	3	
02	OTHER RUNNING WATER BUCKET WITH TAP OR POUR PITCHER)	1 → 04	2	3	
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	
04	HAND-WASHING SOAP/LIQUID SOAP	1	2	3	
05	HAND DISINFECTANT	1	2	3	
06	SINGLE-USE HAND DRYING TOWELS	1	2	3	
07	WASTE RECEPTACLE WITH LID (PEDAL BIN) AND PLASTIC LINER	1 → 10	2	3	
08	OTHER WASTE RECEPTACLE (NOT PEDAL BIN) WITH PLASTIC LINER	1 → 10	2	3	
09	WASTE RECEPTACLE WITH LID (PEDAL BIN) WITHOUT PLASTIC LINER	1	2	3	
10	SHARPS CONTAINER ("SAFETY BOX")	1	2	3	
11	DISPOSABLE LATEX GLOVES	1 → 13	2	3	
12	DISPOSABLE NON-LATEX GLOVES	1	2	3	
13	DISINFECTANT [E.G., HIBITANE, ALCOHOL]	1	2	3	
14	DISPOSABLE NEEDLES	1	2	3	
15	AUTO-DISABLE SYRINGES (3 OR 5 ml)	1	2	3	
16	DISPOSABLE SYRINGES (3 OR 5 ml)	1	2	3	
17	AUDITORY PRIVACY	1	2	3	
18	VISUAL PRIVACY	1	2	3	
19	TABLE CLOTH OR PLASTIC COVERING ANY SURFACE	1	2	3	

257		(a) AVAILABILITY				(b) FUNCTIONING		
	ITEMS FOR SICK CHILD CONSULTATIONS	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Infant scale	1→b	2→b	3 → 02	8 → 02	1	2	8
02	Child scale	1→b	2→b	3 → 03	8 → 03	1	2	8
03	Thermometer	1→b	2→b	3 → 04	8 → 04	1	2	8
04	Timer or watch with second hand	1→b	2→b	3 → 05	8 → 05	1	2	8
05	Staff has watch with second hand	1	2	3	8			
06	Butterfly or scalp vein 21-23g, or branula (intercath) 22-24g	1	2	3	8			
07	Intravenous fluid (5%D/NS, NS, ringers lactate (½DD or full strength Hartman's) or 5%D/W	1	2	3	8			
08	Perfusion or IV administration set	1	2	3	8			
09	Jar/pitcher/container for oral rehydration solution (ORS)	1	2	3	8			
10	Cup and spoon	1	2	3	8			
11	ORS PACKETS OR SACHETS	1	2	3	8			
12	Examination Table	1	2	3	8			
258	ASK TO SEE THE FOLLOWING MATERIALS	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW			
01	Medical protocols or clinical guidelines for children's illnesses	1	2	3	8			
02	IMCI chart booklet	1	2	3	8			
03	IMCI counselling cards for provider to use	1	2	3	8			
04	IMCI mother's cards (to give to caretaker)	1	2	3	8			
05	Guideline/protocol on Management of Malaria	1	2	3	8			
06	Other visual aids for teaching caretakers	1	2	3	8			

259	Is there a patient register where information on the diagnosis for each child is written? IF YES, ASK TO SEE THE REGISTER. TO BE VALID, THE REGISTER MUST INDICATE THAT THE CHILD IS BELOW 5 YEARS OF AGE AND THE DIAGNOSIS OR MAJOR SYMPTOM.	OBSERVED, SEPARATE <5 REGISTER . . . . . 1 OBSERVED, SEPARATE <13 REGISTER . . . . . 2 OBSERVED COMBINED ADULT AND <5 REGISTER . . . . . 3 YES, REPORTED, NOT SEEN . . 4 NO REGISTER 5	 → 263 → 263
260	HOW RECENT IS THE DATE OF THE MOST RECENT ENTRY?	WITHIN THE PAST 7 DAYS . . . 1 MORE THAN 7 DAYS OLD . . . 2	
261	RECORD THE NUMBER OF SICK CHILDREN, BELOW 5 YEARS OF AGE, WHO RECEIVED CONSULTATION SERVICES DURING THE PAST 12 COMPLETED MONTHS.	NUMBER [ ][ ][ ][ ][ ][ ] DON'T KNOW 999998	 → 263
262	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA . . . . . [ ][ ] DON'T KNOW 98	
263	Are individual health records or charts maintained for sick children, i.e., child growth card or health passport? IF YES, ASK TO SEE A BLANK COPY.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN .... 2 NO 3	
264	Are curative child health services available at the facility today?	YES . . . . . 1 NO 2	
265	If a sick child today is noticed to need an immunisation, can it be provided today? IF YES, CLARIFY THE SYSTEM FOR PROVIDING THE IMMUNISATION	YES, SEND TO ROUTINE IMMUNISATION SERVICE . . . 1 YES, SPECIAL SYSTEM FOR IMMUNISATION FOR SICK CHILDREN . . . . . 2 NO 3	
	THANK YOUR RESPONDENT AND MOVE TO NEXT DATA COLLECTION POINT.		

3a. Family Planning Services

Facility number: [ ][ ][ ] **Interviewer Code:** [ ][ ]

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
300	Does this facility offer any family planning services—including clinical methods, counselling on natural family planning or surgical sterilisation?	YES . . . . . 1 NO 2	→ **END**

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN MANAGEMENT OF FAMILY PLANNING SERVICES. IF THIS IS A NEW RESPONDENT, OBTAIN INFORMED CONSENT BELOW. IF THE PERSON IS NOT A NEW RESPONDENT, CONTINUE WITH Q302.
READ THE FOLLOWING TO NEW RESPONDENTS:

Good day! My name is _____. We are here on behalf of the Ministry of Health and Social Services (MOHSS) conducting a study to assist the government in knowing more about health services in Namibia.
Now I will read a statement explaining the study.

ALL facilities in the country are participating in this study. We will be asking you questions about various health services and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility may be used by the MOHSS, organizations supporting services in your facility, and researchers, for planning service improvement or for conducting further studies of health services.

Neither your name nor that of any other health worker respondents participating in this study will be included in the dataset or in any report; however, there is a small chance that any of these respondents may be identified later. Still, we are asking for your help to ensure that the information we collect is accurate.

You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will answer the questions, which will benefit the services you provide and the nation.

If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate if you introduce us to that person to help us collect that information.

At this point, do you have any questions about the study? Do I have your agreement to proceed?

_____ [ ][ ] [ ][ ] 2 0 0 9
Interviewer's signature — DAY MONTH YEAR
(Indicates respondent's willingness to participate)

301	May I begin the interview now?	YES . . . . . 1 NO 2	→ **STOP**
302	How many days in a month are family planning services offered at this facility? USE A 4-WEEK MONTH TO CALCULATE # OF DAYS	NUMBER OF DAYS [ ][ ] DON'T KNOW 98	
303	Are family planning services being offered at this facility today?	YES . . . . . 1 NO 2	

304	Which of the following contraceptive methods do you provide, prescribe, or counsel about in this facility?	PROVIDED	PRESCRIBED/ COUNSELLED	NOT OFF-ERED	
01	Combined oral pills	1	2	3	
02	Progestin-only pills	1	2	3	
03	Combined Injectable (1 monthly)	1	2	3	
04	Progestin-only Injectable (2 monthly)	1	2	3	
05	Progestin-only Injectable (3 monthly)	1	2	3	
06	Male condom	1	2	3	
07	Female condom (e.g., FERMIDOM)	1	2	3	
08	Intrauterine Contraceptive Device (IUCD)	1	2	3	
09	Implant	1	2	3	
10	Spermicides	1	2	3	
11	Diaphragm	1	2	3	
12	Emergency contraceptive pill	1	2	3	
13	Counselling on natural methods	1	2	3	
14	Beads for the Standard Days Method (SDM)	1	2	3	
15	Male sterilisation (Vasectomy)	1	2	3	
16	Female sterilisation (Tubal ligation)	1	2	3	
17	Others _____ (SPECIFY)	1	2	3	
305	Does this facility have any routine user-fees or charges for any services related to family planning? This includes any fees, including those for registration, client health card/passport, lab investigations, or contraceptive methods?	YES . . . . . 1 NO, CLIENTS HAVE NO OUT-OF-POCKET CHARGES OR USER-FEES . 2			→ 308
306	Please tell me if any of the following user-fee or charging practices are ever applied by this facility for family planning services:		YES	NO	DON'T KNOW
01	Is there a fee for the client family planning client card/passport?	FP CARD/PASSPORT	1	2	8
02	Is there a fee for the consultation service? EITHER FIRST OF FOLLOW-UP VISIT	FEE FOR CONSULT	1	2	8
03	Is there any fee or charge for the method provided?	VARY BY METHOD	1	2 → 05	8 → 05
04	Is there a different fee depending on the method provided?	METHOD	1	2	8
05	Are there any fees or charges for laboratory tests?	LAB TESTS	1	2	8
06	Is there a fee for registration?	REGISTRATION	1	2	8
07	Are discounts or exemptions from fees allowed for some clients?	DISCOUNT/ EXEMPTION	1	2	8
307	Are the official fees posted or displayed so that the client can easily see them? IF YES, VERIFY BY ASKING TO SEE WHERE FEES ARE POSTED	YES, ALL FEES POSTED . . . . . 1 YES, SOME, NOT ALL FEES POSTED . . . . . 2 NO POSTED FEES 3			

308	Does this facility have a system in which observations or parameters for family planning are routinely carried out before the consultation or client examination takes place?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8			→ 310 → 310
309	ASK TO SEE THE PLACE WHERE FAMILY PLANNING CLIENTS ARE SEEN BEFORE THEY HAVE THEIR MEDICAL CONSULTATION AND INDICATE WHICH OF THE FOLLOWING ACTIVITIES ARE ROUTINELY CARRIED OUT THERE.				
	OBSERVE IF THE BELOW ACTIVITIES ARE BEING CONDUCTED ROUTINELY. IF NOT SEEN ASK: Is [READ ACTIVITY YOU DO NOT SEE] routinely conducted for all family planning clients?	OBSERVED ACTIVITY	ACTIVITY REPORTED, NOT SEEN	ACTIVITY NOT ROUTINELY CONDUCTED	DON'T KNOW
01	Weighing clients	1	2	3	8
02	Taking blood pressure	1	2	3	8
03	Conducting group health education sessions	1	2	3	8
04	Other_____ (SPECIFY)	1	2	3	8
310	ASK TO SEE WHERE COUNSELLING FOR FAMILY PLANNING IS PROVIDED AND INDICATE THE SETTING.	PRIVATE ROOM WITH VISUAL AND AUDITORY PRIVACY . 1 NON-PRIVATE ROOM WITH AUDITORY AND VISUAL PRIVACY . . . . . 2 VISUAL PRIVACY ONLY . . . 3 NO PRIVACY 4			
311	Are any of the following visual aids for teaching available in the counselling room or the examination room?	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW
01	Samples of various family planning methods	1	2	3	8
02	Other visual aids for teaching about family planning or specific contraceptive methods (e.g., leaflets)	1	2	3	8
03	Visual aids for teaching about STIs	1	2	3	8
04	Visual aids for teaching about HIV/AIDS	1	2	3	8
05	Model for demonstrating how to use male condoms	1	2	3	8
06	Model for demonstrating how to use female condoms	1	2	3	8
07	Posters for general promotion of family planning	1	2	3	8
08	Posters for general awareness of STIs or HIV/AIDS	1	2	3	8
312	Are any of the following types of information booklets or pamphlets for clients to take home available in the counselling or the examination room?				
01	Printed material about family planning	1	2	3	8
02	Printed material about STIs	1	2	3	8
03	Printed material about HIV/AIDS	1	2	3	8
313	Are any of the following guidelines or protocols for delivery of services available in the counselling room or the examination room?				
01	Guidelines or protocols on family planning	1	2	3	8
02	Syndromic diagnosis and treatment of STIs (based on WHO guidelines)	1	2	3	8
03	Other guidelines for STI diagnosis or treatment	1	2	3	8

314	Is there a register where family planning consultation information is recorded? IF YES, ASK TO SEE THE REGISTER. FOR THE REGISTER TO BE VALID, IT MUST SHOW THE CHOSEN METHOD AND STATUS (NEW OR CONTINUING) FOR EACH CLIENT.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN 2 NO 3	 → 318 → 318
315	HOW RECENT IS THE DATE OF THE MOST RECENT ENTRY?	WITHIN THE PAST 7 DAYS . . . 1 MORE THAN 7 DAYS OLD . . . 2	
316	RECORD THE **TOTAL** NUMBER OF FAMILY PLANNING **VISITS (NEW AND CONTINUING)** DURING THE PAST 12 COMPLETED MONTHS.	TOTAL FP VISITS [ ][ ][ ][ ][ ][ ] DON'T KNOW 999998	 → 318
317	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN Q316.	MONTHS OF DATA . . . . . [ ][ ] DON'T KNOW 98	
318	Are individual records or charts maintained for family planning clients? IF YES, ASK TO SEE A BLANK RECORD OR CHART.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN 2 NO 3	
319	Does the family planning provider routinely treat STIs, or are clients referred to another provider or location for STI treatment?	ROUTINELY TREATS STIs . . . 1 REFERS TO OTHER PROVIDER OR LOCATION . . . . . 2 NO TREATMENT PROVIDED . . 3	
320	ASK TO SEE THE ROOM WHERE EXAMINATIONS FOR FAMILY PLANNING ARE CONDUCTED.		
	IF THE *SAME EXAMINATION ROOM* HAS ALREADY BEEN OBSERVED FOR ITEMS IN 321, INDICATE WHICH SECTION THE DATA ARE RECORDED IN.	ANTENATAL [Q428] . . . . . 14 DELIVERY [Q530A] . . . . . 15 STI [Q626B] . . . . . 16 NOT PREVIOUSLY SEEN 19	} 321A

321 FOR EACH OF THE FOLLOWING ITEMS, CHECK TO SEE WHETHER ITEM IS EITHER IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN ADJACENT ROOM.

	ITEMS	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Spotlight for pelvic exam (flashlight/torch or exam light acceptable)	1→ b	2→ b	3 ↲ 02	8 ↲ 02	1	2	8
02	Manual BP apparatus	1→ b	2→ b	3 ↲ 03	8 ↲ 03	1	2	8
03	Stethoscope	1→ b	2→ b	3 ↲ 04	8 ↲ 04	1	2	8
04	Automatic BP apparatus (Datex)	1→ b	2→ b	3 ↲ 05	8 ↲ 05	1	2	8
05	Examination couch	1	2	3	8			

321A	ASK TO SEE THE AREA(S) IN THIS CLINIC/UNIT WHERE MOST CLIENTS ARE EXAMINED OR A PROCEDURE IS CARRIED OUT. OBSERVE THE CONDITIONS UNDER WHICH CLIENT EXAMINATION TAKES PLACE. IF THERE ARE SEVERAL ROOMS FOR IT, RANDOMLY PICK ONE TO ASSESS.		
	IF THE SAME EXAMINATION AREA/ROOM HAS ALREADY BEEN OBSERVED FOR ITEMS IN Q322, INDICATE WHICH SECTION THE DATA ARE RECORDED	OPD [Q187] . . . . . 11 CHILD HEALTH [Q256] . . . . . 12 ANTENATAL CARE [Q429] . . . . . 14 DELIVERY [Q530] . . . . . 15 STI [Q626] . . . . . 16 SECTION 17-TB [Q1719] . . . . . 17 SECTION 18-CT [Q1830] . . . . . 18 NOT PREVIOUSLY SEEN 19	323

322	FOR EACH OF THE FOLLOWING ITEMS, CHECK TO SEE WHETHER ITEM IS EITHER IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN ADJACENT ROOM.			
	ITEMS FOR INFECTION CONTROL AND CONDITIONS FOR EXAMINATION	(a) AVAILABILITY		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED)	1 → 04	2	3
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 → 04	2	3
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3
04	HAND-WASHING SOAP/LIQUID SOAP	1	2	3
05	HAND DISINFECTANT	1	2	3
06	SINGLE-USE HAND DRYING TOWELS	1	2	3
07	WASTE RECEPTACLE WITH LID (PEDAL BIN) AND PLASTIC LINER	1 → 10	2	3
08	OTHER WASTE RECEPTACLE (NOT PEDAL BIN) WITH PLASTIC LINER	1 → 10	2	3
09	WASTE RECEPTACLE WITH LID (PEDAL BIN) WITHOUT PLASTIC LINER	1	2	3
10	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
11	DISPOSABLE LATEX GLOVES	1 → 13	2	3
12	DISPOSABLE NON-LATEX GLOVES	1	2	3
13	DISINFECTANT [E.G., HIBITANE, ALCOHOL]	1	2	3
14	DISPOSABLE NEEDLES	1	2	3
15	AUTO-DISABLE SYRINGES (3 OR 5 ml)	1	2	3
16	DISPOSABLE SYRINGES (3 OR 5 ml)	1	2	3
17	AUDITORY PRIVACY	1	2	3
18	VISUAL PRIVACY	1	2	3
19	TABLE CLOTH/PLASTIC ON ANY SURFACE	1	2	3

323	CHECK Q304(08) and (09): IS "1" CIRCLED IN EITHER QUESTION TO INDICATE THAT THE FACILITY PROVIDES IUCD OR IMPLANT? YES ☐ NO ☐ →				**END**
324	OBSERVE THE AVAILABILITY OF COMMON SUPPLIES FOR IUCD OR IMPLANT SERVICES.	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW
01	Sterile gloves	1	2	3	8
02	Antiseptic solution (such as iodine)	1	2	3	8
03	Sponge holding forceps	1	2	3	8
04	Gauze pad or cotton wool	1	2	3	8
325	CHECK Q304(08): IS "1" CIRCLED TO INDICATE THAT THE FACILITY PROVIDES IUCD? YES ☐ NO ☐ →				**END**
326	OBSERVE THE AVAILABILITY OF MATERIALS FOR THE INSERTION OF IUCD	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW
01	Vaginal speculum - small	1	2	3	8
02	Vaginal speculum - medium	1	2	3	8
03	Vaginal speculum - large	1	2	3	8
04	Tenacula (Volsellum forceps)	1	2	3	8
05	Uterine sound	1	2	3	8
327	CHECK Q304(09): IS "1" CIRCLED TO INDICATE THAT THE FACILITY PROVIDES IMPLANT? YES ☐ NO ☐ →				**END**
328	NOTE THE AVAILABILITY OF THE FOLLOWING ITEMS:	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW
01	Local anaesthetic (such as lignocaine)	1	2	3	8
02	Sterile syringe and needle	1	2	3	8
03	Canula and trochar for inserting Implant	1	2	3	8
04	Sealed implant pack	1	2	3	8
05	Scalpel with blade	1	2	3	8
06	Minor surgery kit (e.g., artery forceps, haemostat)	1	2	3	8
	THANK YOUR RESPONDENT AND MOVE TO THE NEXT DATA COLLECTION POINT.				

3b. Availability of Contraceptive Supplies

Facility number: [ ][ ][ ]

Interviewer: Code [ ][ ]

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
350	Are any contraceptive methods ever stored in this facility?	YES, IN FAMILY PLANNING SERVICE AREA . . . . . 1 YES, IN PHARMACY OR OTHER SITE NOT FP SERVICE AREA . 2 YES, AREA LOCKED, NO ACCESS . . . . . 3 NO 4	 → **STOP** → **END**

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN MANAGEMENT OF FAMILY PLANNING COMMODITIES. IF THIS IS A NEW RESPONDENT, OBTAIN CONSENT CONSENT BELOW. IF THE PERSON IS NOT A NEW RESPONDENT, CONTINUE WITH 351.
READ THE FOLLOWING TO NEW RESPONDENTS:

Good day! My name is _____. We are here on behalf of the Ministry of Health and Social Services (MOHSS) conducting a study to assist the government in knowing more about health services in Namibia.
Now I will read a statement explaining the study.

ALL facilities in the country are participating in this study. We will be asking you questions about various health services and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility may be used by the MOHSS, organizations supporting services in your facility, and researchers, for planning service improvement or for conducting further studies of health services.

Neither your name nor that of any other health worker respondents participating in this study will be included in the dataset or in any report; however, there is a small chance that any of these respondents may be identified later. Still, we are asking for your help to ensure that the information we collect is accurate.

You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will answer the questions, which will benefit the services you provide and the nation.

If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate if you introduce us to that person to help us collect that information.

At this point, do you have any questions about the study? Do I have your agreement to proceed?

_____ [ ][ ] [ ][ ] **2 0 0 9**

Interviewer's signature
(Indicates respondent's willingness to participate)

DAY MONTH YEAR

351	May I begin the interview now?	YES . . . . . 1 NO 2	 → **STOP**

352	VALIDATION OF CONTRACEPTIVES					
	GO TO THE MAIN AREA WHERE CONTRACEPTIVES ARE STORED AND COLLECT INFORMATION ON VALIDATION OF THE LISTED CONTRACEPTIVES.	A PRODUCT NORMALLY CARRIED OR STOCKED IN FACILITY	B UNIT OF MEASURE	C STOCK CARD AVAILABLE	D VALID EXPIRATION DATE ON ALL UNITS PRESENT TODAY	E ITEMS STORED BY DATE OF EXPIRATION
	PRODUCT	1=YES 2=NO **IF NO, SKIP TO NEXT ITEM**	1=TAB/CAPS 2=VIALS 3=AMPOULES 4=PACKS	1=YES 2=NO	1=YES 2=NO	1=YES 2=NO
01	COMBINED ORAL PILLS					
02	PROGESTIN-ONLY PILLS					
03	COMBINED INJECTABLE (1 MONTHLY)					
04	PROGESTIN-ONLY INJECTABLE (2 MONTHLY)					
05	PROGESTIN-ONLY INJECTABLE (3 MONTHLY)					
06	CONDOM (MALE)					
07	CONDOM (FEMALE)					
08	INTRAUTERINE DEVICE (IUCD)					
09	IMPLANT					
10	SPERMICIDE					
11	DIAPHRAGM					
12	EMERGENCY CONTRACEPTIVE PILLS					

353	Are contraceptive supplies stored in the same location as other medicines?	YES 1 NO 2	
354	OBSERVE THE PLACE WHERE CONTRACEPTIVE SUPPLIES ARE STORED AND INDICATE THE PRESENCE (OR ABSENCE) OR EACH OF THE FOLLOWING CONDITIONS.		
01	ARE THE METHODS OFF THE FLOOR	YES . . . . . 1 NO 2	
02	ARE THE METHODS PROTECTED FROM WATER?	YES . . . . . 1 NO 2	
03	ARE THE METHODS PROTECTED FROM THE SUN?	YES . . . . . 1 NO 2	
04	IS THE ROOM CLEAN OF EVIDENCE OF RODENTS (BATS, RATS) OR PESTS (ROACHES, ETC.).	YES . . . . . 1 NO 2	
355	When was the last time that you received a scheduled supply of contraceptive methods? (i.e. from the main order & not interim order)	WITHIN PRIOR 4 FULL WEEKS 1 BETWEEN 4-12 WEEKS . . . . . 2 MORE THAN 12 WEEKS AGO . 3 NO ROUTINE SUPPLY SYSTEM 4 DON'T KNOW 8	
356	Does this facility determine the quantity of each contraceptive method required and order that, or is the quantity that you receive determined elsewhere?	DETERMINES OWN NEED AND ORDERS . . . . . 1 NEED DETERMINED ELSEWHERE . . . . . 2 BOTH (DIFFER BY METHOD) 3 DON'T KNOW 8	→ END → END
357	Routinely, when you order contraceptive methods, which best describes the system you use to determine how much of each to order? Do you: - **Review** the amount of each method remaining, and order to bring the stock amount to a pre-determined (fixed) amount (max stock level)? - **Order** exactly the same quantity each time, regardless of the existing stock? - **Review** the amount of each method used since the previous order, and plan based on prior consumption and expected future consumption? - **Other** _____ (SPECIFY) - DON'T KNOW	ORDER TO MAINTAIN FIXED STOCK . . . . . 1 ORDER SAME AMOUNT . . . . . 2 ORDER BASED ON UTILIZATION . . . . . 3 OTHER . . . . . 6 DON'T KNOW 8	

4. Antenatal and Postnatal Care

Facility Number: [ ][ ][ ] **Interviewer Code:** [ ][ ]

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
400	Does this facility offer antenatal (ANC) services , postnatal (PNC) services, or both? INDICATE THE SERVICES OFFERED.	YES, ANTENATAL ONLY . . . . . 1 YES, POSTNATAL ONLY . . . . . 2 YES, BOTH ANTENATAL AND POSTNATAL . . . . . 3 NO, NEITHER SERVICE 4	 → 418E → 432

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN MANAGEMENT OF ANTENATAL CARE SERVICES. IF THIS IS A NEW RESPONDENT, OBTAIN INFORMED CONSENT BELOW. IF THE PERSON IS NOT A NEW RESPONDENT, CONTINUE WITH Q401.
READ THE FOLLOWING TO NEW RESPONDENTS:

Good day! My name is _____. We are here on behalf of the Ministry of Health and Social Services (MOHSS) conducting a study to assist the government in knowing more about health services in Namibia.
Now I will read a statement explaining the study.

ALL facilities in the country are participating in this study. We will be asking you questions about various health services and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility may be used by the MOHSS, organizations supporting services in your facility, and researchers, for planning service improvement or for conducting further studies of health services.

Neither your name nor that of any other health worker respondents participating in this study will be included in the dataset or in any report; however, there is a small chance that any of these respondents may be identified later. Still, we are asking for your help to ensure that the information we collect is accurate.

You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will answer the questions, which will benefit the services you provide and the nation.

If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate if you introduce us to that person to help us collect that information.

At this point, do you have any questions about the study? Do I have your agreement to proceed?

[ ][ ] [ ][ ] 2 0 0 9

Interviewer's signature DAY MONTH YEAR
(Indicates respondent's willingness to participate)

401	May I begin the interview now?	YES . . . . . 1 NO 2	 → **STOP**
402	How many days of the month are antenatal-care services provided at the facility? USE A 4-WEEK MONTH TO CALCULATE NUMBER OF DAYS	NUMBER OF DAYS [ ][ ] DON'T KNOW 98	
403	Are antenatal-care services being provided at the facility today?	YES . . . . . 1 NO 2	
404	Does this facility have any routine user-fees or charges for any services related to antenatal care services? This includes any fees, including those for registration, client health card/passport, medicines or laboratory investigations?	YES . . . . . 1 NO, CLIENTS HAVE NO OUT-OF-POCKET CHARGES OR USER-FEES . . 2	 → 407

405	Please tell me if any of the following user-fee or charging practices are ever applied by this facility for antenatal care services:		YES	NO	DON'T KNOW	
01	Is there a fee for the client health card?	ANC CARD/RECORD	1	2	8	
02	Is there a fee for each consultation?	FEE FOR CONSULT	1	2	8	
03	Are there fees for medications?	MEDICINE	1	2	8	
04	Are there fees for laboratory tests?	TESTS	1	2	8	
05	Is there a fee for registration?	REGISTRATION	1	2	8	
06	Are discounts or exemptions from fees allowed for some clients?	DISCOUNT/ EXEMPTIONS	1	2	8	
07	Is there a system for clients to pre-pay for multiple visits for care during pregnancy?	PRE-PAY FOR MULTIPLE	1	2	8	
406	Are the official fees posted or displayed so that the client can easily see them? IF YES, VERIFY BY ASKING TO SEE WHERE FEES ARE POSTED	YES, ALL FEES POSTED . . . . . 1 YES, SOME, NOT ALL FEES POSTED . . . . . 2 NO POSTED FEES 3				
407	Does this facility have a system whereby observation or parameters for ANC clients are routinely carried out before the consultation?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8				 → 409 → 409

408	ASK TO SEE THE PLACE WHERE ANTENATAL CLIENTS ARE SEEN BEFORE THEY HAVE THEIR MEDICAL CONSULTATION AND INDICATE WHICH OF THE FOLLOWING ACTIVITIES ARE ROUTINELY CARRIED OUT THERE.				
	OBSERVE IF THE BELOW ACTIVITIES ARE BEING CONDUCTED ROUTINELY. IF NOT SEEN ASK: Is [READ ACTIVITY YOU DO NOT SEE] routinely conducted for all antenatal care clients?	OBSERVED ACTIVITY	ACTIVITY REPORTED, NOT SEEN	ACTIVITY NOT ROUTINELY CONDUCTED	DON'T KNOW
01	Weighing clients	1	2	3	8
02	Taking blood pressure	1	2	3	8
03	Urine test for protein	1	2	3	8
04	Blood test for anaemia	1	2	3	8
05	Group health education sessions	1	2	3	8
06	Other_____ (SPECIFY)	1	2	3	8

		(a) ROUTINE TESTING			(b) ITEMS FOR TEST AVAILABLE IN ANC UNIT TODAY		
409	Which of the following activities are performed as part of routine services, that is, each client has this test at least once? FOR EACH TEST THAT IS ROUTINELY CONDUCTED, ASK TO SEE IF ALL ITEMS NEEDED FOR THE TEST ARE AVAILABLE IN THE ANC AREA, OR THE TESTS ARE DONE IN THE LAB.	YES	NO	DON'T KNOW	YES	NO	TEST IN LAB
01	Blood test for anaemia	1→ b	2 → 02	8 → 02	1	2	3
02	Blood test for syphilis	1→ b	2 → 03	8 → 03	1	2	3
03	Blood group	1→ b	2 → 04	8 → 04	1	2	3
04	Test for RH factor	1→ b	2 → 05	8 → 05	1	2	3
05	Urine test for protein	1→ b	2 → 06	8 → 06	1	2	3
06	Urine test for glucose	1→ b	2 → 410	8 → 410	1	2	3

		ROUTINE SERVICE			
410	Which of the following types of treatment and services are routinely offered to antenatal clients?	YES	NO	DON'T KNOW	
01	Preventive antimalarial medication (IPT)	1	2	8	
02	Counselling about family planning	1	2	8	
03	Counselling about HIV/AIDS/PMTCT	1	2	8	
04	Testing for HIV/AIDS	1	2	8	
05	Making preparations for delivery (e.g., transport)	1	2	8	
411	Is tetanus toxoid vaccination available on all days antenatal care services are offered?	YES . . . . . 1 NOT ALL ANC DAYS . . . . . 2 TT NEVER OFFERED 3			→ 414
412	How many days each week are tetanus toxoid vaccinations offered at this facility?	DAYS PER WEEK . . . . . [ ] LESS OFTEN THAN ONCE/WEEK 0 DON'T KNOW 8			
413	Is tetanus toxoid immunization available today?	YES . . . . . 1 NO 2			
414	Do antenatal care providers here routinely treat STIs, or are clients referred to another provider or location for STI treatment?	ROUTINELY TREATS STIs . . . . 1 REFERS . . . . . 2 NO TREATMENT PROVIDED . . 3			
415	Is there a register where information on antenatal care clients' visits is recorded? IF YES, ASK TO SEE THE REGISTER. FOR THE REGISTER TO BE VALID IT MUST SHOW CLIENTS' STATUS (NEW OR CONTINUING).	YES, REGISTER SEEN . . . . . 1 YES, REGISTER NOT SEEN . . 2 NO REGISTER KEPT 3			 → 418A → 418A
416	HOW RECENT IS THE DATE OF THE MOST RECENT ENTRY?	WITHIN THE PAST 7 DAYS . . . . 1 MORE THAN 7 DAYS OLD 2			
417	RECORD THE NUMBER OF ANTENATAL VISITS, **(1st AND FOLLOW-UP)** DURING PAST 12 COMPLETED MONTHS	NUMBER OF ANC VISITS [ ][ ][ ][ ][ ][ ]			
418	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA . . . . . [ ][ ]			

418A	Does this facility distribute insecticide treated bed nets (ITNs) to ANC clients? IF YES, ASK: Are the ITNs routinely distributed to ANC clients or only sometimes?	YES, ROUTINELY . . . . . 1 YES, ONLY SOMETIMES . . . . . 2 NO DISTRIBUTION OF ITNs 3	→ 418E
418B	Do you maintain a register or record on the number of ITNs distributed to ANC clients? IF YES, ASK: May I see a register or record on the number of ITNs distributed?	YES, OBSERVED . . . . . 1 YES, REGISTER NOT SEEN . . . . . 2 NO REGISTER KEPT 3	→ 418E → 418E
418C	REVIEW THE RECORD. INDICATE THE NUMBER OF ITNS DISTRIBUTED IN THE PREVIOUS 12 COMPLETED MONTHS.	NUMBER OF ITNs GIVEN TO ANC CLIENTS [ ][ ][ ][ ][ ][ ]	
418D	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA . . . . . [ ][ ]	
418E	CHECK 400: IS EITHER "2" OR "3" CIRCLED? YES [ ] NO [ ]		→ 423
419	Is there a register where client information from postnatal care (PNC) visits is recorded? IF YES, ASK TO SEE REGISTER. FOR THE REGISTER TO BE VALID, IT MUST SHOW THE NUMBER OF DAYS POSTNATAL AND INDICATE WHETHER OR NOT THERE ARE COMPLICATIONS.	YES, REGISTER SEEN . . . . . 1 YES, REGISTER NOT SEEN . . 2 NO REGISTER KEPT 3	→ 423 → 423
420	HOW RECENT IS THE DATE OF THE MOST RECENT ENTRY?	WITHIN THE PAST 7 DAYS . . . . 1 MORE THAN 7 DAYS OLD 2	
421	HOW MANY POSTNATAL VISITS TOOK PLACE DURING THE PREVIOUS 12 COMPLETED MONTHS?	NUMBER OF PNC VISITS [ ][ ][ ][ ][ ][ ] DON'T KNOW 999998	→ 423
422	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA . . . . . [ ][ ] DON'T KNOW 98	
423	Do you have an estimate of the annual number of deliveries (births) in the facility's catchment areas?	NUMBER OF BIRTHS . . . [ ][ ][ ][ ][ ][ ] NO CATCHMENT AREA . . . 999995 DON'T KNOW 999998	→ 426 → 426
424	What is the estimated annual rate of antenatal-care coverage for this facility?	ANC % COVERAGE . . . . . [ ][ ][ ] DON'T KNOW 998	→ 426
425	RECORD THE SOURCE OF INFORMATION FOR ESTIMATED PERCENT OF ANTENATAL CARE COVERAGE.	WRITTEN REPORT . . . . . A GRAPH/CHART . . . . . B OTHER _____ X (SPECIFY) SOURCE NOT KNOWN . . . . . Z	
426	Are individual client cards/charts/records maintained for antenatal care clients? IF YES, AS TO SEE A BLANK RECORD OR CHART.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO 3	
427	ASK TO SEE THE ROOM WHERE EXAMINATIONS FOR ANTENATAL OR POSTPARTUM CLIENTS ARE CONDUCTED.		
	IF THE *SAME EXAMINATION ROOM* HAS ALREADY BEEN OBSERVED FOR ITEMS IN 428, INDICATE WHICH SECTION THE DATA ARE RECORDED IN.	FAMILY PLANNING [Q321] 13 DELIVERY [Q530A] . . . . . 15 STI [Q626B] . . . . . 16 NOT PREVIOUSLY SEEN 19	428A

428	FOR EACH OF THE FOLLOWING ITEMS, CHECK TO SEE WHETHER ITEM IS EITHER IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN ADJACENT ROOM.							
	ITEMS	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Spotlight for pelvic exam (flashlight/torch or exam light acceptable)	1→ b	2→ b	3 → 02	8 → 02	1	2	8
02	Manual BP apparatus	1→ b	2→ b	3 → 03	8 → 03	1	2	8
03	Stethoscope	1→ b	2→ b	3 → 04	8 → 04	1	2	8
04	Automatic BP apparatus	1→ b	2→ b	3 → 05	8 → 05	1	2	8
05	Examination couch	1	2	3	8			

428A	ASK TO SEE THE AREA(S) IN THIS CLINIC/UNIT WHERE MOST CLIENTS ARE EXAMINED OR A PROCEDURE IS CARRIED OUT. OBSERVE THE CONDITIONS UNDER WHICH CLIENT EXAMINATION TAKES PLACE. IF THERE ARE SEVERAL ROOMS FOR IT, RANDOMLY PICK ONE TO ASSESS.		
	IF THE SAME EXAMINATION AREA/ROOM HAS ALREADY BEEN OBSERVED FOR ITEMS IN Q187, INDICATE WHICH SECTION THE DATA ARE RECORDED	OPD [Q187] . . . . . 11 CHILD HEALTH [Q256] . . . . . 12 FAMILY PLANNING [Q322] . . . . . 13 DELIVERY [Q530] . . . . . 15 STI [Q626] . . . . . 16 SECTION 17-TB [Q1719] . . . . . 17 SECTION 18-CT [Q1830] . . . . . 18 NOT PREVIOUSLY SEEN 19	430

429	FOR EACH OF THE FOLLOWING ITEMS, CHECK TO SEE WHETHER ITEM IS EITHER IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN ADJACENT ROOM.			
	ITEMS FOR INFECTION CONTROL AND CONDITIONS FOR EXAMINATION	(a) AVAILABILITY		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED)	1 → 04	2	3
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 → 04	2	3
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3
04	HAND-WASHING SOAP/LIQUID SOAP	1	2	3
05	HAND DISINFECTANT	1	2	3
06	SINGLE-USE HAND DRYING TOWELS	1	2	3
07	WASTE RECEPTACLE WITH LID (PEDAL BIN) AND PLASTIC LINER	1 → 10	2	3
08	OTHER WASTE RECEPTACLE (NOT PEDAL BIN) WITH PLASTIC LINER	1 → 10	2	3
09	WASTE RECEPTACLE WITH LID (PEDAL BIN) WITHOUT PLASTIC LINER	1	2	3
10	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
11	DISPOSABLE LATEX GLOVES	1 → 13	2	3
12	DISPOSABLE NON-LATEX GLOVES	1	2	3
13	DISINFECTANT [E.G., HIBITANE, ALCOHOL]	1	2	3
14	DISPOSABLE NEEDLES	1	2	3
15	AUTO-DISABLE SYRINGES (3 OR 5 ml)	1	2	3
16	DISPOSABLE SYRINGES (3 OR 5 ml)	1	2	3
17	AUDITORY PRIVACY	1	2	3
18	VISUAL PRIVACY	1	2	3
19	TABLE CLOTH/PLASTIC ON ANY SURFACE	1	2	3

430	EQUIPMENT AND SUPPLIES	(A) AVAILABILITY: OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	(B) FUNCTIONING: YES	NO	DON'T KNOW
	NOTE THE AVAILABILITY AND CONDITION OF OTHER EQUIPMENT. EQUIPMENT MAY BE IN EXAMINATION ROOM, AN ADJACENT ROOM, OR ROOM WHERE MEASURE IS TAKEN.							
01	Foetal stethoscope (Pinard)	1→ b	2→ b	3 → 02	8 → 02	1	2	8
02	Adult weighing scale	1→ b	2→ b	3 → 03	8 → 03	1	2	8
03	Vaginal speculum (s)	1	2	3	8			
04	Vaginal speculum (m)	1	2	3	8			
05	Vaginal speculum (l)	1	2	3	8			
06	Thermometer	1→ b	2→ b	3 → 07	8 → 07	1	2	8
07	Infant scale	1→ b	2→ b	3 → 08	8 → 08	1	2	8
08	Facility provided minute timer	1→ b	2→ b	3 → 09	8 → 09	1	2	8
09	Personal watch with second hand	1→ b	2→ b	3 → 10	8 → 10	1	2	8
10	Individual chart/record for infant	1	2	3	8			
11	Vitamin K	1	2	3	8			
12	Vitamin A	1	2	3	8			

431	NOTE THE AVAILIBILITY OF PROTOCOLS AND TEACHING MATERIALS.	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW
01	Guidelines or protocols for antenatal care	1	2	3	8
02	Guidelines for Syndromic Approach or Dx for STIs	1	2	3	8
03	Other guidelines and protocols for reproductive health (e.g., maternal, neonatal health)	1	2	3	8
04	Visual aids for client education on subjects related to pregnancy or antenatal care	1	2	3	8

432	Does this facility have a formal relationship with traditional birth attendants (TBAs) in which they receive training or other types of support?	YES . . . . . 1 NO 2	→ 437
433	Is there any documentation on activities with TBAs (such as lists of affiliated TBAs or records of their training)?	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . 2 NO 3	
434	Please tell me how many TBAs report to this facility? ENTER "00" FOR "NONE"	# OF TBAs REPORTING . . . . . [ ][ ] DON'T KNOW 98	
435	Does anyone from this facility supervise the activities of the TBAs?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
437	Do (the) TBAs refer women to this facility?	YES . . . . . 1 NO 2	
438	Does the facility or the ANC unit have safe delivery kits for sale or to provide free of charge to women for home births? IF YES, ASK TO SEE ONE	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . 2 NO 3	

439	What are the *most common* means of transport used by women coming from their homes to this facility for help during obstetric emergencies? IF THERE IS MORE THAN ONE MOST COMMON MEANS, CIRCLE THE LETTER FOR ALL THAT APPLY.	AMBULANCE . . . . . A PRIVATE CAR/BUS . . . . . B PUBLIC CAR/BUS . . . . . C MOTORCYCLE . . . . . D BICYCLE . . . . . E PEOPLE CARRY/PUSH OR PULL PATIENT . . . . . F ANIMALS CARRY/PULL PATIENTS . . . . . G OTHER_____ . . X (SPECIFY) NEVER RECEIVE EMERGENCY Y DON'T KNOW . . . . . Z	
440	Does this **facility** ever refer a woman to another facility for emergency obstetric care?	YES . . . . . 1 NO 2	→ END
441	Does this **facility** have a functional ambulance or other vehicle for emergency obstetric transportation? ACCEPT REPORTED RESPONSE.	YES . . . . . 1 NO 2	→ 443
442	Is fuel available today? ACCEPT REPORTED RESPONSE.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
443	What is the *most common* means by which women or sick neonates are transported from this **facility** to the nearest referral facility to receive help during an obstetric/sick newborn emergency?	AMBULANCE . . . . . 01 PRIVATE CAR/BUS . . . . . 02 PUBLIC CAR/BUS . . . . . 03 MOTORCYCLE . . . . . 04 BICYCLE . . . . . 05 PEOPLE CARRY/PUSH OR PULL PATIENT . . . . . 06 ANIMALS CARRY/PULL PATIENTS . . . . . 07 OTHER_____ . . 96 (SPECIFY)	
444	How long does it take, using this form of transportation, to get to the nearest referral facility? ASK THE TIME FOR DRY AND WET SEASON. IF CALL ELSEWHERE MUST BE MADE TO OBTAIN A VEHICLE, RECORD AVERAGE TIME FROM THE CALL TO THE PATIENT'S ARRIVAL AT THE REFERRAL FACILITY.	**01) DRY SEASON** MINUTES [ ][ ][ ] DON'T KNOW . . . . . 998 **02) WET SEASON** MINUTES . . . . [ ][ ][ ] DON'T KNOW 998	

445	Please tell me if this facility has any of the following systems to support emergency obstetric referrals.		YES	NO	DON'T KNOW	
01	Are there any funds set aside to help clients with emergency transportation?	PROVIDE FUNDS	1	2	8	
02	Does the facility hire a vehicle locally to provide emergency obstetric transportation?	HIRE VEHICLE	1	2	8	
03	Is there a community health insurance scheme that provides support for emergency obstetric referrals?	COMMUNITY SUPPORT	1	2	8	
04	Is fuel set aside for emergency obstetric referrals?	FUEL SET ASIDE	1	2	8	
05	Is there a revolving fund system for transportation for emergency obstetric referrals?	REVOLVING FUND	1	2	8	
06	Does the facility radio or phone another facility to send transportation for emergency obstetric referrals?	PHONE FOR TRANSPORT	1	2	8	
07	Is there any other system? IF YES, SPECIFY _____	OTHER	1	2	8	
	THANK YOUR RESPONDENT AND MOVE TO THE NEXT DATA COLLECTION POINT.					

5. Delivery and Newborn Care

Facility Number: [ ][ ][ ] **Interviewer Code:** [ ][ ]

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
500	Does this facility offer delivery services, including normal deliveries and other related services?	YES . . . . . 1 NO 2	→ 550

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN MANAGEMENT OF DELIVERY SERVICES. IF THIS IS A NEW RESPONDENT, OBTAIN INFORMED CONSENT BELOW. IF THE PERSON IS NOT A NEW RESPONDENT, CONTINUE WITH Q501.
READ THE FOLLOWING TO NEW RESPONDENTS:

Good day! My name is _____. We are here on behalf of the Ministry of Health and Social Services (MOHSS) conducting a study to assist the government in knowing more about health services in Namibia.
Now I will read a statement explaining the study.

ALL facilities in the country are participating in this study. We will be asking you questions about various health services and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility may be used by the MOHSS, organizations supporting services in your facility, and researchers, for planning service improvement or for conducting further studies of health services.

Neither your name nor that of any other health worker respondents participating in this study will be included in the dataset or in any report; however, there is a small chance that any of these respondents may be identified later. Still, we are asking for your help to ensure that the information we collect is accurate.

You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will answer the questions, which will benefit the services you provide and the nation.

If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate if you introduce us to that person to help us collect that information.

At this point, do you have any questions about the study? Do I have your agreement to proceed?

_____ [ ][ ] [ ][ ] 2 0 0 9
Interviewer's signature DAY MONTH YEAR
(Indicates respondent's willingness to participate)

501	May I begin the interview now?	YES . . . . . 1 NO 2	→ STOP
502	Do skilled attendants/midwives routinely provide home deliveries or attend home delivery emergencies as a part of the facility's services?	YES, ROUTINELY . . . . . 1 YES, EMERGENCY ONLY . . . 2 NO 3	→ 505
503	Is there a home delivery bag or kit for use by skilled attendants? IF YES, ASK TO SEE THE BAG/KIT.	YES, BAG SEEN . . . . . 1 YES, BAG NOT SEEN . . . . . 2 NO 3	
504	Do midwives/providers routinely provide home-based post-natal care (PNC) as part of their facility services?	YES, ROUTINELY . . . . . 1 YES, EMERGENCY ONLY . . . 2 NO 3	
505	Does the facility provide 24 hour coverage for delivery services?	YES . . . . . 1 NO 2	→ 508
506	Is a person skilled in conducting deliveries present at the facility or on call 24 hours a day, including weekends, to provide delivery care? IF YES, ASK TO SEE A SCHEDULE FOR 24-HOUR STAFF ASSIGNMENT.	YES, PRESENT, SCHEDULE OBSERVED . . . . . 1 YES, PRESENT, SCHEDULE REPORTED, NOT SEEN . . . 2 YES, ON-CALL SCHEDULE OBSERVED . . . . . 3 YES, ON-CALL, SCHEDULE REPORTED, NOT SEEN . . . 4 NO 5	→ 508

507	At night, what level of provider is most commonly on duty to conduct deliveries? IF DIFFERENT LEVELS ARE COMMONLY AVAILABLE, CIRCLE ALL RELEVANT LEVELS.	OBSTETRICIAN/ GYNECOLOGIST ..... A MEDICAL OFFICER B MEDICAL ASSISTANT ..... C R. NURSE/MIDWIFE ..... D R. NURSE E R. MIDWIFE ..... F E. NURSE/MIDWIFE ..... G E. NURSE H NURSING ASSISTANT ... K OTHER _____ X (SPECIFY) DON'T KNOW ..... Z	
508	During normal working hours, what level of provider is most commonly available to conduct complicated deliveries?	OBSTETRICIAN/ GYNECOLOGIST ..... A MEDICAL OFFICER B MEDICAL ASSISTANT ..... C R. NURSE/MIDWIFE ..... D R. NURSE E R. MIDWIFE ..... F E. NURSE/MIDWIFE ..... G E. NURSE H NURSING ASSISTANT ... K OTHER _____ X (SPECIFY) DON'T KNOW ..... Z	
509	Does this facility have any routine user-fees or charges for delivery services? This includes any fees, including those for registration, health card/passport, medicines, or laboratory investigations?	YES ..... 1 NO, CLIENTS HAVE NO OUT-OF-POCKET CHARGES OR USER-FEES 2	→ 512
510	Please tell me if any of the following user-fee or charging practices are ever applied by this facility for delivery services:	YES / NO / DON'T KNOW	
01	Is there a fee for normal delivery?	FEE FOR DELIVERY 1 2 8	
02	Is there a fee for the package of ANC and delivery services?	FIXED ANC PLUS DELIVERY FEE 1 2 8	
03	Are there any fees or charges for medicines?	MEDICINES 1 2 8	
04	Are there fees for laboratory or other diagnostic tests?	TESTS 1 2 8	
05	Are discounts or exemptions from fees allowed for some clients?	DISCOUNT/ EXEMPTIONS 1 2 8	
511	Are the official fees posted or displayed so that the client can easily see them? IF YES, VERIFY BY ASKING TO SEE WHERE FEES ARE POSTED	YES, ALL FEES POSTED ..... 1 YES, SOME, NOT ALL FEES POSTED ..... 2 NO POSTED FEES 3	
512	Is there a register where client information from attended births is recorded, i.e., a delivery register? IF YES, ASK TO SEE THE REGISTER.	YES, OBSERVED ..... 1 YES, REPORTED, NOT SEEN 2 NO 3	 → 519 → 519

513	SCAN THE REGISTER FOR THE PAST 3 MONTHS AND CIRCLE THE RESPONSE FOR EACH TYPE OF INFORMATION ROUTINELY RECORDED FOR DELIVERIES. SEARCH ALL APPLICABLE REGISTERS/RECORDS MAINTAINED ROUTINELY.	BIRTH OUTCOME FOR INFANT. . . . A MATERNAL OUTCOME . . . . . B TYPE OF DELIVERY . . . . . C MOTHER AGE . . . . . D GESTATIONAL AGE . . . . . E IF ANC RECEIVED . . . . . F HIV STATUS OF MOTHER . . G NEWBORN WEIGHT . . . . . H IF PARTOGRAPH USED . . . . I NONE OF ABOVE . . . . . Y	
514	WHAT IS THE DATE OF THE MOST RECENT BIRTH ATTENDED BY FACILITY STAFF?	DAY [ ][ ] MONTH [ ][ ] DK 98 DK 98	
515	HOW MANY WOMEN DELIVERED IN THIS FACILITY DURING THE PREVIOUS 12 COMPLETED MONTHS? (EXCLUDE C-SECTION IF POSSIBLE)	NUMBER OF DELIVERIES [ ][ ][ ][ ][ ] DON'T KNOW 99998	→ 517
516	INDICATE THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA . . . . . [ ][ ] DON'T KNOW 98	
517	How many emergency home-deliveries were assisted by staff from this facility during the previous 12 complete months?	NUMBER OF DELIVERIES [ ][ ][ ][ ][ ] DON'T KNOW . . . . . 99998 NO HOME DELIVERIES 99995	→ 519 → 519
518	INDICATE THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA . . . . . [ ][ ] DON'T KNOW 98	
519	What percentage of deliveries in your catchment area are conducted by this facility (what is your estimated annual coverage rate?)	% COVERAGE . . . . [ ][ ][ ] NO CATCHMENT AREA . . . 995 DON'T KNOW 998	→ 521 → 521
520	RECORD THE SOURCE OF INFORMATION FOR THE ESTIMATED DELIVERY COVERAGE.	WRITTEN REPORT . . . . . A GRAPH/CHART . . . . . B OTHER _____ X (SPECIFY) SOURCE NOT KNOWN . . . . . Z	
521	Are there ever any meetings where service statistics for delivery services are discussed with staff from this clinic/unit, such as looking at changes in patterns or other items relevant to client services?	YES . . . . . 1 NO 2	→ 524
522	Is there any evidence of looking at service data for evaluating or monitoring data? IF YES, ASK TO SEE ANY REPORTS, WALL GRAPHS OR CHARTS THAT SHOW SERVICE DATA HAS BEEN REVIEWED. CIRCLE ALL RELEVANT TYPE OF REPORTS OBSERVED.	OBSERVED WALL CHART/GRAPH . . . . . A WRITTEN REPORT/MINUTES . B OTHER _____ . X (SPECIFY) NO OBSERVED EVIDENCE . . . Y	→ 524
523	ASSESS THE MOST RECENT DATE WHERE THERE IS EVIDENCE OF DATA BEING REVIEWED.	WITHIN THE PAST 3 MONTHS . . . 1 MORE THAN 3 MONTHS AGO . . . 2 DON'T KNOW 8	
524	Does the facility participate in regular reviews of maternal or newborn deaths or "near-misses"?	YES, FOR MOTHERS . . . . . 1 YES, FOR NEWBORNS . . . . . 2 YES, FOR BOTH . . . . . 3 NO, DOES NOT PARTICIPATE . . 4	→ 526
525	How often are reviews of maternal and/or infant deaths and/or near misses carried out?	- EVERY [ ][ ] WEEKS - WHEN CASE OCCURS . . . . . 53 - DON'T KNOW 98	
526	Please tell me the ***total number of beds*** in the *maternity ward/unit in this facility*	1) # OF BEDS IN MATERNITY [ ][ ][ ] NO SPECIFIC MATERNITY BEDS 000	

527	Please tell me the *total number of delivery beds* available for delivery in this facility	2) # DELIVERY BEDS [ ][ ][ ]	
528	ASK TO SEE THE ROOM(S) WHERE WOMEN IN LABOUR STAY UNTIL TIME FOR DELIVERY AND INDICATE THE SITUATION FOR PRIVACY	PRIVATE ROOM WITH VISUAL AND AUDITORY PRIVACY . . 1 NON-PRIVATE ROOM WITH AUDITORY AND VISUAL PRIVACY . . . . . 2 VISUAL PRIVACY ONLY . . . 3 NO PRIVACY . . . . . 4 NO SEPARATE LABOR ROOM 5	
529	ASK TO SEE THE ROOM(S) WHERE DELIVERIES TAKE PLACE. IF THE SAME *ROOM* HAS ALREADY BEEN OBSERVED FOR ITEMS IN Q530, INDICATE WHICH SECTION THE DATA ARE RECORDED IN.	OPD [Q187] . . . . . 11 CHILD HEALTH [Q256] . . . . . 12 FAMILY PLANNING [Q322] . . . . . 13 ANTENATAL CARE [Q429] . . . . . 14 STI [Q626] . . . . . .16 SECTION 17-TB [Q1719] . . . . . .17 SECTION 18 - CT [Q1830] . . . . . .18 NOT PREVIOUSLY SEEN 19	530A

530 FOR EACH OF THE FOLLOWING ITEMS, CHECK TO SEE WHETHER ITEM IS EITHER IN THE ROOM WHERE THE DELIVERY TAKES PLACE OR IN AN ADJACENT ROOM.

	ITEMS FOR INFECTION CONTROL AND CONDITIONS FOR DELIVERY	(a) AVAILABILITY			
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	
01	RUNNING WATER (PIPED)	1 → 04	2	3	
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 → 04	2	3	
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	
04	HAND-WASHING SOAP/LIQUID SOAP	1	2	3	
05	HAND DISINFECTANT	1	2	3	
06	SINGLE-USE HAND DRYING TOWELS	1	2	3	
07	WASTE RECEPTACLE WITH LID (PEDAL BIN) AND PLASTIC LINER	1 → 10	2	3	
08	OTHER WASTE RECEPTACLE (NOT PEDAL BIN) WITH PLASTIC LINER	1 → 10	2	3	
09	WASTE RECEPTACLE WITH LID (PEDAL BIN) WITHOUT PLASTIC LINER	1	2	3	
10	SHARPS CONTAINER ("SAFETY BOX")	1	2	3	
11	DISPOSABLE LATEX GLOVES	1 → 13	2	3	
12	DISPOSABLE NON-LATEX GLOVES	1	2	3	
13	DISINFECTANT [E.G., HIBITANE, ALCOHOL]	1	2	3	
14	DISPOSABLE NEEDLES	1	2	3	
15	AUTO-DISABLE SYRINGES (3 OR 5 ml)	1	2	3	
16	DISPOSABLE SYRINGES (3 OR 5 ml)	1	2	3	
17	AUDITORY PRIVACY	1	2	3	
18	VISUAL PRIVACY	1	2	3	
19	TABLE CLOTH/PLASTIC ON ANY SURFACE	1	2	3	

530A	SUPPLIES AND EQUIPMENT	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Spotlight for pelvic exam flashlight/torch or exam light acceptable)	1→b	2→b	3 → 02	8 → 02	1	2	8
02	Manual BP apparatus	1→b	2→b	3 → 03	8 → 03	1	2	8
03	Stethoscope	1→b	2→b	3 → 04	8 → 04	1	2	8
04	Automatic BP apparatus	1→b	2→b	3 → 05	8 → 05	1	2	8
05	Examination couch	1	2	3	8			
531	OTHER SUPPLIES AND EQUIPMENT	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Infant scale	1→b	2→b	3 → 02	8 → 02	1	2	8
02	24-hr functioning light source (lantern acceptable)	1→b	2→b	3 → 03	8 → 03	1	2	8
03	Foetal stethoscope (Pinard)	1→b	2→b	3 → 04	8 → 04	1	2	8
04	Electronic foetal stethoscope	1→b	2→b	3 → 05	8 → 05	1	2	8
05	Skin antiseptic (e.g., Chlorhexidine, Povidine-Iodine (Betadine))	1	2	3	8			
06	Intravenous infusion set	1	2	3	8			
07	Syringes and needles	1	2	3	8			
08	Delivery pack	1 → 17	2	3	8			
09	Episiotomy scissors	1→b	2→b	3 → 10	8 → 10	1	2	8
10	Baby scissors	1→b	2→b	3 → 11	8 → 11	1	2	8
11	Blade (to cut cord)	1	2	3	8			
12	Swab holder	1	2	3	8			
13	Needle holder	1	2	3	8			
15	Forceps (large)	1	2	3	8			
16	Forceps (medium)	1	2	3	8			
17	Cord ties/clamp	1	2	3	8			
18	Suture material with needle	1	2	3	8			
19	Sterile gloves	1	2	3	8			
20	Thermometer	1	2	3	8			

532	**MEDICATIONS IN DELIVERY SERVICE AREA**	(a) AVAILABILITY				(b) AT LEAST ONE VALID		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Intravenous solutions: either Ringers lactate, 5%D/NS, or NS infusion	1→ b	2 02	3 02	8 02	1	2	8
02	Injectable ergometrine/ methergine	1→ b	2 03	3 03	8 02	1	2	8
03	Injectable oxytocic/ (e.g. Syntometrin)	1→ b	2 04	3 04	8 04	1	2	8
04	Injectable diazepam (e.g. Valium)	1→ b	2 05	3 05	8 05	1	2	8
05	Injectable magnesium sulphate	1→ b	2 06	3 06	8 06	1	2	8
06	Hydralazine/apresoline Nifedipine	1→ b	2 07	3 07	8 07	1	2	8
07	Injectable ampicillin	1→ b	2 08	3 08	8 08	1	2	8
08	Injectable gentamicin	1→ b	2 09	3 09	8 09	1	2	8
09	Antibiotic eye drops or ointment (Ceforexin?)	1→ b	2 10	3 10	8 10	1	2	8
10	Vitamin A 200,000 IU (oral)	1→ b	2 11	3 11	8 11	1	2	8
11	Benzyl penicillin injection	1→ b	2 12	3 12	8 12	1	2	8
12	Vitamin K Injection	1→ b	2 13	3 13	8 13	1	2	8
13	AZT+3TC+NVP Combined Tabs	1→ b	2 14	3 14	8 14	1	2	8
14	AZT+3TC Combined Tabs	1→ b	2 15	3 15	8 15	1	2	8
15	NVP Tabs	1→ b	2 16	3 16	8 16	1	2	8
16	AZT syrup	1→ b	2 17	3 17	8 17	1	2	8
17	3TC syrup	1→ b	2 18	3 18	8 18	1	2	8
18	NVP syrup	1→ b	2 533	3 533	8 533	1	2	8

533	**EQUIPMENT AND SUPPLIES FOR NEWBORN CARE**	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Bag and mask or tube and mask (infant size) for resuscitation	1→ b	2→ b	3 02	8 02	1	2	8
02	Incubator	1→ b	2→ b	3 03	8 03	1	2	8
03	Other source of heat for premature infant	1→ b	2→ b	3 04	8 04	1	2	8
04	Infant scale	1→ b	2→ b	3 05	8 05	1	2	8
05	Suction bulb for mucus extraction	1→ b	2→ b	3 06	8 06	1	2	8
06	Suction apparatus for use with catheter	1→ b	2→ b	3 07	8 07	1	2	8
07	Resuscitation table for baby with heat source	1	2	3	8			
08	Disposable cord ties or clamps	1	2	3	8			
09	Towel to wipe baby	1	2	3	8			
10	Blanket to wrap baby	1	2	3	8			

534	GUIDELINES/ PROTOCOLS	(a) AVAILABILITY			
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW
01	Essential maternal & Neonatal care clinical Guidelines for Namibia	1	2	3	8
02	Other guidelines for normal delivery	1	2	3	8
03	Guidelines for emergency obstetric care	1	2	3	8
04	Blank partographs ANY PARTOGRAPH REGARDLESS OF WHETHER IT IS SEPARATE PAPERS OR ON THE MOTHER'S CARD	1	2	3	8

535	CHECK Q533(02) IF INCUBATOR IS AVAILABLE IN UNIT YES, OBSERVED OR REPORTED ☐ NO ☐		→ 537
536	Is there someone in the unit who has received technical training to operate the incubator?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
537	Now I will ask you a few questions about the management of 3rd stage of labour. For each of the following practices for managing 3rd stage of labour, please tell me if this is: **i)** a routine practice, or **ii)** selectively done (depending on the condition of the client or the provider conducting the delivery), or **iii)** it is never carried out.		
01	Do you administer Uterotonic medicine (e.g., Syntometrin)?	YES, ROUTINELY . . . . . 1 YES, SELECTIVELY . . . . . 2 NEVER 3	 → 03 → 03
02	How many minutes after birth is the medicine usually administered?	IMMEDIATELY/WITHIN 1 MINUTE 1 WITHIN 5 MINUTES . . . . . 2 NO SPECIFIC PRACTICE . . . . . 3 OTHER _____ 6 (SPECIFY)	
03	Do you apply controlled cord traction?	YES, ROUTINELY . . . . . 1 YES, SELECTIVELY . . . . . 2 NEVER 3	 → 05 → 05
04	Can you describe the technique used when applying cord traction? DOES THE PROVIDER INDICATE THAT COUNTER TRACTION IS APPLIED TO THE UTERUS? **DO NOT PROMPT.**	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
05	Do you massage fundus through the abdomen?	YES, ROUTINELY . . . . . 1 YES, SELECTIVELY . . . . . 2 NEVER 3	
538	Now I want to ask you about routine practices related to the newborn at this facility. I am using the word "routine" to indicate that the activity is conducted for essentially all newborns or their mothers.		
01	Is rooming-in the normal practice in this facility? That is, does the newborn stay in the same room with the mother?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
02	Does this facility routinely provide vitamin A to mothers before their discharge?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

		YES	NO	DON'T KNOW	
539	Does this facility routinely observe any of the following practices postpartum or related to newborns?				
01	Suction the newborn by means of catheter	1	2	8	
02	Suction the newborn by means of bulb	1	2	8	
03	Weigh the newborn	1	2	8	
04	Give full bath (immerse newborn in water) within 24 hours of birth	1	2	8	
05	Give the newborn prelacteal liquids	1	2	8	
06	Give the newborn OPV prior to discharge	1	2	8	
07	Give the newborn BCG prior to discharge	1	2	8	

540	How is the umbilical cord treated? ASK FOR EACH ITEM IF IT IS APPLIED AND CIRCLE ALL PRACTICES THAT ARE ROUTINELY USED	APPLY SPIRIT/ALCOHOL . . . . . A APPLY OTHER ANTISEPTIC . . . . B APPLY NOTHING TO CORD . . . . C WRAP WITH DRY DRESSING . . D OTHER _____ X (SPECIFY)	
541	How is the newly delivered placenta kept prior to final disposal? ASK TO SEE ANY CONTAINER THAT IS USED. CIRCLE ALL TYPES OF CONTAINERS REPORTED AND OBSERVED FOR IMMEDIATE PLACEMENT OF PLACENTA	**PUT IN CONTAINER** COVERED LEAKPROOF . . . . . A UNCOVERED LEAKPROOF . . . B DOUBLE PLASTIC BAGS . . . . . C NOT LEAKPROOF . . . . . D OTHER _____ X (SPECIFY)	
542	What are the most common methods used for final disposal of the placenta? …any others? CIRCLE ALL THAT APPLY.	GIVE TO FAMILY . . . . . A DISPOSE WITH OTHER INFECTIOUS WASTE OF FACILITY . . . . . B DISPOSE SEPARATE FROM OTHER WASTE BURN . . . . . C BURY . . . . . D OTHER _____ . X (SPECIFY)	
543	Does this facility handle assisted deliveries—that is, use forceps or Ventous (vacuum extractor)? IF YES, ASK TO SEE THE EQUIPMENT USED.	YES . . . . . 1 NO 2	→ 546

544 CHECK WHETHER THE EQUIPMENT IS IN THE DELIVERY ROOM OR AN ADJACENT ROOM.

		(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Ventous (vacuum extractor)	1 → b	2 → b	3 → 545	8 → 545	1	2	8

545	Has an assisted delivery been conducted in this facility within the past 3 months?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
546	Is this facility able to extract retained products of conception when necessary? IF YES, ASK TO SEE THE EQUIPMENT USED.	YES . . . . . 1 NO 2	→ 549

547	CHECK WHETHER THE EQUIPMENT IS IN THE DELIVERY ROOM OR AN ADJACENT ROOM.							
	EQUIPMENT	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Vacuum aspirator	1 → b	2 → b	3 → 02	8 → 02	1	2	8
02	Dilatation and curettage (D&C) kit	1	2	3	8			
03	Other_____	1 → b	2 → b	3 → 548	8 → 548	1	2	8

548	Has vacuum aspiration or D & C been used to remove retained products of conception by this facility during the past 3 months?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

549	Now I am going to ask you about other medical interventions for management of complications during labour or delivery. For each intervention, please tell me if this is ever provided at this facility, and if yes, if it has been conducted in this facility within the past 3 months?						
	INTERVENTION	(a) EVER PROVIDE			(b) PROVIDED IN PAST 3 MONTHS		
		YES	NO	DK	YES	NO	DK
01	Parenteral antibiotics (i.e., IV or IM)	1 → b	2 → 02	8 → 02	1	2	8
02	Parenteral oxytocic medicine (i.e., IV or IM)	1 → b	2 → 03	8 → 03	1	2	8
03	Parenteral anti-convulsants for pregnancy-induced hypertension (i.e., IV or IM)	1 → b	2 → 04	8 → 04	1	2	8
04	Manual removal of placenta	1 → b	2 → 550	8 → 550	1	2	8

550	Does this facility provide blood transfusions? IF YES: Is there a blood bank or are there transfusion services only?	YES, TRANSFUSION, YES, BLOOD BANK . . . . . 1 YES, TRANSFUSION, NO BLOOD BANK . . . . . 2 NO BLOOD TRANSFUSION . . . 3	→ 552
551	Has blood transfusion been performed for maternity care by this facility during the past 3 months?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
552	Does this facility ever perform caesarean sections?	YES . . . . . 1 NO 2	→ 561

553	Is there a routine fee for admissions (e.g., to perform Caesarean sections) for: IF YES: Please tell me the amount of the fee	YES	AMOUNT IN N$ **[99998 IF FEE NOT KNOWN]**	NO	DK
01	STATE PATIENTS	1		2	8
02	PRIVATE NAMIBIAN PATIENTS	1		2	8
03	PRIVATE FOREIGNERS	1		2	8

554	ASK TO SEE THE ROOM WHERE CAESAREAN SECTIONS ARE PERFORMED. CHECK IF THE FOLLOWING EQUIPMENT AND SUPPLIES ARE AVAILABLE IN THE ROOM OR IN AN ADJACENT ROOM.							
	EQUIPMENT AND SUPPLIES FOR CAESAREAN SECTION	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Operating table	1 → b	2 → b	3 → 02	8 → 02	1	2	8
02	Operating light	1 → b	2 → b	3 → 03	8 → 03	1	2	8
03	Anaesthesia giving set	1 → b	2 → b	3 → 04	8 → 04	1	2	8
04	Scrub area adjacent to or in the operating room	1	2	3	8			
05	Tray, drum, or package with sterilized instruments ready for use	1	2	3	8			
06	Emergency source of light	1 → b	2 → b	3 → 07	8 → 07	1	2	8
07	Suction machine	1 → b	2 → b	3 → 555	8 → 555	1	2	8

555	Does this facility have a health worker who can perform a Caesarean section present in the facility or on call 24 hours a day (including weekends)? IF YES, ASK TO SEE A SCHEDULE FOR 24-HOUR STAFF ASSIGNMENT.	YES, PRESENT, SCHEDULE OBSERVED . . . . . 1 YES, PRESENT, SCHEDULE REPORTED, NOT SEEN . . . 2 YES, ON-CALL SCHEDULE OBSERVED . . . . . 3 YES, ON-CALL, SCHEDULE REPORTED, NOT SEEN . . . 4 NO 5	
556	Does this facility have an anaesthetist present in the facility or on call 24 hours a day (including weekends)? IF YES, ASK TO SEE A SCHEDULE FOR 24-HOUR STAFF ASSIGNMENT.	YES, PRESENT, SCHEDULE OBSERVED . . . . . 1 YES, PRESENT, SCHEDULE REPORTED, NOT SEEN . . . 2 YES, ON-CALL SCHEDULE OBSERVED . . . . . 3 YES, ON-CALL, SCHEDULE REPORTED, NOT SEEN . . . 4 NO 5	
557	Is there a register where Caesarean section data is recorded? IF YES, ASK: May I see the register please?	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN 2 NO 3	 → 561 → 561
558	RECORD THE NUMBER OF CAESAREAN SECTIONS CONDUCTED AT THIS FACILITY DURING THE PAST 12 COMPLETED MONTHS.	NUMBER OF CAESAREAN . [ ][ ][ ][ ] DON'T KNOW 9998	 → 561
559	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA . . . . . [ ][ ] DON'T KNOW 98	
560	MONTH AND YEAR OF LAST CAESAREAN SECTION? TAKE THE DATE FROM THE REGISTER OR REPORT FORM.	MONTH [ ][ ] YEAR [ ][ ][ ][ ] DK . . . . 98 DK 9998	
561	Does this facility have a health worker who can repair obstetric fistulae?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	 → 565 → 565

562	Is there a register where fistula repair data is recorded? IF YES, ASK: May I see the register please?	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN 2 NO 3	 → 565 → 565
563	RECORD THE NUMBER OF FISTULAE REPAIRED AT THIS FACILITY DURING THE PAST 12 COMPLETED MONTHS.	NUMBER OF FISTULAE . . . [ ][ ][ ][ ] DON'T KNOW 9998	 → 565
564	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA . . . . . [ ][ ] DON'T KNOW 98	
	MALE CIRCUMCISION		
565	Does this facility ever perform male circumcision? **IF YES, ASK:** Is the circumcision done for children only, adults only, or for both children and adults?	YES, CHILDREN ONLY. . . . . 1 YES, ADULTS ONLY. . . . . 2 YES, BOTH CHILDREN AND ADULTS. . 3 NO MALE CIRCUMCISION. . . . . 4 DON'T KNOW. 8	 → 570 → 570
565A	Is there a fee for male circumcision? IF YES, ASK: Please tell me the amount of the fee. If the fee varies for infant and adult circumcision, please tell me the fee for ***adult*** male circumcision.	YES: 1 AMOUNT IN N$ **[99998 IF FEE NOT KNOWN]**: [ ][ ][ ][ ][ ] NO: 2 DK: 8	
565B	Does this facility have a health worker who can perform male circumcision present in the facility or on call 24 hours a day? IF YES, ASK TO SEE A SCHEDULE	YES, PRESENT, SCHEDULE OBSERVED . . . . . 1 YES, PRESENT, SCHEDULE REPORTED NOT SEEN . . . . . 2 YES, ON CALL, SCHEDULE OBSERVED . . . . . 3 YES, ON CALL, SCHEDULE REPORTED NOT SEEN . . . . . 4 NO 5	
566	Is there a register where male circumcision data is recorded? IF YES, ASK: May I see the register please?	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN 2 NO 3	 → 570 → 570
567	RECORD THE NUMBER OF <u>CHILD</u> MALE CIRCUMCISIONS AT THIS FACILITY DURING THE PAST 12 COMPLETED MONTHS.	NUMBER OF CIRCUMSISIONS [ ][ ][ ][ ] DON'T KNOW 9998	
568	RECORD THE NUMBER OF <u>ADULT</u> MALE CIRCUMCISIONS AT THIS FACILITY DURING THE PAST 12 COMPLETED MONTHS.	NUMBER OF CIRCUMSISIONS [ ][ ][ ][ ] DON'T KNOW 9998	 → 570
569	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN Q568 FOR <u>ADULT</u> MALE CIRCUMCISION.	MONTHS OF DATA . . . . . [ ][ ] DON'T KNOW 98	
	CERVICAL SCREENING		
570	Does this facility offer any services for screening changes ("wounds") in the woman's cervix, to detect precancerous lesions? IF YES, WHICH SERVICES? PROBE: Anything else?	YES, PAP SCREENING . . . . . A YES, VISUAL INSPECTION . . . . . B YES, HPV TEST . . . . . C OTHER _____ X (SPECIFY) NO . . . . . Y DON'T KNOW . . . . . Z	 → 572
571	If a woman is identified with a cervical pre-cancer, how is she commonly managed? Is she treated at, this facility, referred elsewhere, or both?	TREATED AT THIS FACILITY A REFERRED WITHIN DISTRICT B REFERRED OUTSIDE DISTRICT C OTHER _____ X (SPECIFY) DON'T KNOW. . . . . Z	
572	AT THIS POINT, CHECK IF EITHER Q500 OR Q552 IS "1" [FACILITY OFFERS DELIVERY OR C-SECTION SERVICES]	YES . . . . . 1 NO 2	 → **END**

	PROCESSING OF EQUIPMENT FOR REUSE		
573	After completing a delivery, what procedures does this service follow for initial handling of contaminated equipment (such as speculums, scalpel handles, etc.) that will be reused another time? IF THE UNIT PROCESSES SOME EQUIPMENT AND SENDS OTHER EQUIPMENT ELSEWHERE, INDICATE THE PROCEDURE FOR EQUIPMENT PROCESSED IN THIS SERVICE DELIVERY UNIT **IF VAGINAL DELIVERIES ARE CONDUCTED IN A DIFFERENT ROOM THAN CAESAREAN SECTION DELIVERIES, ASSESS THE PROCESSING EQUIPMENT FOR VAGINAL DELIVERIES.**	SOAKED IN DISINFECTANT SOLUTION AND THEN BRUSH SCRUBBED WITH SOAP AND WATER . . . . . 01 BRUSH SCRUBBED WITH SOAP AND WATER AND THEN SOAK IN DISINFECTANT . . . . . 02 BRUSH SCRUBBED WITH SOAP AND WATER ONLY . . . . . 03 SOAKED IN DISINFECTANT, NOT BRUSH SCRUBBED . 04 CLEAN WITH SOAP AND WATER, NOT BRUSH SCRUBBED . 05 OTHER _____ . 06 (SPECIFY) NO EQUIPMENT EVER REUSED 07 DON'T DECONTAMINATE HERE . . 95	 → 581 → 575
574	Are there written guidelines for how to decontaminate equipment? IF YES, ASK: May I see them?	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN 2 NO . 3	
575	Where is this equipment then ***finally*** processed prior to reuse? IF THE SYSTEM AT THAT LOCATION HAS ALREADY BEEN SEEN, INDICATE WHICH SECTION THE INFORMATION IS IN. IF NOT YET SEEN, CIRCLE "2 " AND CONTINUE.	SECTION 1 [Q190-192] . . . . . 1 NOT PREVIOUSLY SEEN . . . . . 2 PROCESS OUTSIDE FACILITY 3 NO EQUIPMENT PROCESSED 4	→578(6) →578(6) →578(6)
576	What is the ***final method*** most commonly used for disinfecting or sterilizing medical equipment (such as surgical instruments) before they are reused? IF DIFFERENT METHODS ARE USED FOR DIFFERENT TYPES OF EQUIPMENT, INDICATE THE METHOD(S) USED FOR METAL EQUIPMENT SUCH AS SPECULUMS OR FORCEPS.	DRY-HEAT STERILIZATION . . . A AUTOCLAVING . . . . . B BOILING . . . . . C STEAM STERILIZATION D CHEMICAL METHOD . . . . . E PROCESSED OUTSIDE FACILITY F	 → 578(6)

577	ITEM	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Electric autoclave (PRESSURE AND WET HEAT)	1→ b	2→ b	3 02	8 02	1	2	8
02	Non-electric autoclave (PRESSURE/WET H)	1 →b	2 →b	3 03	8 03	1	2	8
03	Electric dry heat sterilizer	1→ b	2 → b	3 04	8 04	1	2	8
04	Electric boiler or steamer (no pressure)	1→ b	2→ b	3 05	8 05	1	2	8
05	Non-electric pot with cover (FOR STEAM/ BOIL)	1	2	3	8			
06	Heat source for non-electric equipment	1→ b	2→ b	3 07	8 07	1	2	8
07	Automatic timer (MAY BE ON EQUIPMENT)	1 →b	2 →b	3 08	8 08	1	2	8
08	TST Indicator strips or other item that indicates when sterilization is complete.	1	2	3	8			
09	Written protocols or guidelines for sterilization of disinfection	1	2	3	8			

578 FOR EACH OF THE FOLLOWING METHODS FOR STERILIZATION/ DISINFECTION USED IN THE FACILITY, INDICATE THE PROCESSING DETAILS INCLUDING TIME PROCESSED AFTER THE REQUIRED TEMPERATURE/ PRESSURE/ BOILING IS REACHED

		(1) Dry heat sterilization	(2) Autoclave (steam with pressure)	(3) Boil	(4) Steam without pressure	(5) Chemical High Level Disinfectant (HLD)	(6) Initial decontamination
A	Method	USED . . . . . 1 NOT USED. . 2 → 2	USED . . . . . 1 NOT USED. . 2 → 3	USED . 1 NOT USED 2 → 4	USED . . . . 1 NOT USED . . 2 → 5	USED . . . . . 1 NOT USED . . 2 → 6	USED . . . . 1 NOT USED . . 2 → 579
B	Temperature (centigrade)	TEMPERATURE [ ][ ][ ] AUTOMATIC . . . . 666 DON'T KNOW . . . 998	TEMPERATURE [ ][ ][ ] AUTOMATIC . . . . 666 DON'T KNOW. . . . 998				
C	Pressure		PRESS-URE [ ][ ][ ] AUTOMATIC 666 → 2E DON'T KNOW 998 → 2E				
D	Units of pressure		UNITS OF PRESSURE: KG/SQ CM . . 1 ATM PRESSURE . . 2 KILOPASCAL . . . 3 MILLIMETER HG . . 4				
E	Minutes-when equipment is not wrapped in cloth	MINUTES [ ][ ][ ] AUTOMATIC . . 666 DON'T KNOW . 998	MINUTES [ ][ ][ ] AUTOMATIC . . . . 666 DON'T KNOW 998	MINUTES [ ][ ][ ] DON'T KNOW . 998	MINUTES [ ][ ][ ] DON'T KNOW . . . 998	MINUTES [ ][ ][ ] DON'T KNOW . 998	MINUTES [ ][ ][ ] DON'T KNOW . 998
F	Minutes when equipment is wrapped		MINUTES WRAPPED [ ][ ][ ] AUTOMATIC . . . . 666 DON'T KNOW . . . 998				
G	Chemical disinfectant used					CHLORINE 1 CIDEX . . . 2 BETADINE . . . . 3 ALCOHOL 4 HYDROCHLORITES 5 H202 6 FORMALDEHYDE 7 DON'T KNOW 8	CHLORINE 1 CIDEX . . 2 BETADINE . . . . 3 ALCOHOL 4 HYDROCHLORITE 5 H202 6 FORMALDEHYDE 7 DON'T KNOW 8
H	Percent solution before dilution					PERCENT [ ][ ][ ] DON'T KNOW 998	PERCENT [ ][ ][ ] DON'T KNOW 998
I	Mixture, parts solution and water					MIXTURE PARTS a) DISINFECTANT [ ] b) WATER [ ][ ] DK 998	MIXTURE PARTS a) DISINFECTANT [ ] b) WATER [ ][ ] DK 998

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
579	INDICATE ALL STORAGE CONDITIONS IN THIS SERVICE DELIVERY AREA FOR PROCESSED EQUIPMENT (SUCH AS SPECULUM , FORC-EPS) READY FOR REUSE. IF LOCATION HAS ALREADY BEEN ASSESSED, INDICATE WHICH SECTION THE INFORMATION IS IN. IF NOT PREVIOUSLY ASSESSED, CIRCLE "2" AND CONTINUE.	SECTION 1 [Q193] . . . . . 1 NOT PREVIOUSLY SEEN 2				→ **END**
580	INDICATE STORAGE CONDITIONS FOR PROCESSED EQUIPMENT USED FOR THIS SERVICE DELIVERY AREA.	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	
01	Wrapped in sterile paper, sealed with tape	1	2	3	8	
02	Stored in sterile container with lid that clasps shut	1	2	3	8	
03	Stored unwrapped inside an autoclave or dry-heat sterilizer	1	2	3	8	
04	On tray, covered with cloth or wrapped without sealing tape	1	2	3	8	
05	In container with disinfectant or antiseptic	1	2	3	8	
06	Other Sterile Storage	1	2	3	8	
07	Other Non-sterile Storage	1	2	3	8	
08	Date of sterilization written on packet or container with processed items	1	2	3	8	
580A	IS THE STORAGE LOCATION DRY AND CLEAN?	YES . . . . . 1 NO 2				
581	ASSESS CONDITION OF DELIVERY SERVICE AREA	YES	NO			
01	**FLOOR:** SWEPT, NO OBVIOUS DIRT OR WASTE	1	2			
02	**COUNTERS/TABLES/CHAIRS:** WIPED CLEAN-NO OBVIOUS DUST OR WASTE	1	2			
03	BROKEN EQUIPMENT, PAPERS, BOXES AROUND MAKING AREA CLUTTERED AND DIRTY	1	2			
04	**WALLS:** REASONABLY CLEAN					
05	**DOORS:** NO (OR MINOR) DAMAGE	1	2			
06	**WALLS:** NO (OR MINOR) DAMAGE	1	2			
07	**ROOF:** NO (OR MINOR) DAMAGE	1	2			
08	**CEILING:** NO (OR LITTLE) WATER STAINS/DAMAGE	1	2			
09	NEEDLES, SHARPS OUTSIDE SHARPS BOX	1	2			
10	SHARPS BOX OVERFLOWING OR TORN/PIERCED	1	2			
11	BANDAGES/INFECTIOUS WASTE LYING UNCOVERED	1	2			

6. Services for Reproductive Tract and Sexually Transmitted Infections

Facility Number: [ ][ ][ ] **Interviewer Code:** [ ][ ]

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
600	Does this facility offer any services for diagnosis or treatment of STIs? That is, if a client comes with symptoms that may be an STI, will he or she receive any services for the diagnosis or treatment of the STI?	YES . . . . . 1 NO 2	→ **END**

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN MANAGEMENT OF SERVICES FOR STIs. IF THIS IS A NEW RESPONDENT, OBTAIN INFORMED CONSENT BELOW. IF THE PERSON IS NOT A NEW RESPONDENT, CONTINUE WITH Q601.
READ THE FOLLOWING TO NEW RESPONDENTS:

Good day! My name is _____. We are here on behalf of the Ministry of Health and Social Services (MOHSS) conducting a study to assist the government in knowing more about health services in Namibia.
Now I will read a statement explaining the study.

ALL facilities in the country are participating in this study. We will be asking you questions about various health services and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility may be used by the MOHSS, organizations supporting services in your facility, and researchers, for planning service improvement or for conducting further studies of health services.

Neither your name nor that of any other health worker respondents participating in this study will be included in the dataset or in any report; however, there is a small chance that any of these respondents may be identified later. Still, we are asking for your help to ensure that the information we collect is accurate.

You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will answer the questions, which will benefit the services you provide and the nation.

If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate if you introduce us to that person to help us collect that information.

At this point, do you have any questions about the study? Do I have your agreement to proceed?

	DAY	MONTH	YEAR
Interviewer's signature (Indicates respondent's willingness to participate)	[ ][ ]	[ ][ ]	2 0 0 9

601	May I begin the interview now?	YES . . . . . 1 NO 2	→ STOP
602	Are services for STI clients being offered at this facility today?	YES . . . . . 1 NO 2	
603	Are STI services primarily offered in a special STI clinic or through general outpatient services?	SPECIAL STI CLINIC . . . . . 1 GENERAL OUTPATIENT 2	
604	How many days in the month are STI services available in either the special/the general clinic? USE A 4-WEEK MONTH TO CALCULATE DAYS	NUMBER OF DAYS [ ][ ]	
604a	Does this facility have any routine user-fees or charges for any STI related services? This includes any fees, including those for registration, health card/passport, medicines or lab investigations?	YES . . . . . 1 NO, CLIENTS HAVE NO OUT-OF-POCKET CHARGES OR USER-FEES 2	→ 605

			YES	NO	DON'T KNOW
604b	Please tell me if any of the following user-fee or charging practices are ever applied by this facility for STI services				
01	Is there a fee for the health card/passport?	HEALTH CARD	1	2	8
02	Is there a fee for the consultation?	CONSULTATION	1	2	8
03	Is there a fee for lab tests?	LAB TESTS	1	2	8
04	Is there a fee for medicines?	MEDICINES	1	2	8
05	Is there a fee for registration?	REGISTRATION	1	2	8

604c	Are the official fees posted or displayed so that the client can easily see them? IF YES, VERIFY BY ASKING TO SEE WHERE FEES ARE POSTED	YES, ALL FEES POSTED . . . . . 1 YES, SOME, NOT ALL FEES POSTED . . . . . 2 NO POSTED FEES 3	

605	How are diagnoses of STIs made in this facility? CIRCLE ALL THAT APPLY.	SYNDROMIC APPROACH . . . . . A ETIOLOGIC (LAB) . . . . . B CLINICAL JUDGMENT C	

606 FOR EACH OF THE FOLLOWING LABORATORY TESTS, ASK:
Does this service (or facility) use any laboratory test for diagnosing [THE INDICATED ILLNESS]?
IF YES, ASK:
Do you: 1) conduct the test in this facility, or, 2) collect the specimen and send it elsewhere for the test, or, 3) does the client have to go somewhere else for the test?

	FOR EACH TEST CONDUCTED AT FACILITY ASSESS AVAILABILITY OF EQUIPMENT AND SUPPLIES USING LABORATORY QRE.	CONDUCT TEST	COLLECT SPECI-MEN	SEND CLIENT ELSEWHERE	TEST NOT UTILISED	DON'T KNOW
01	Syphilis	1	2	3	4	8
02	Gonorrhea	1	2	3	4	8
03	HIV	1	2	3	4	8
04	Chlamydia	1	2	3	4	8

607	Does this facility have a protocol or guideline regarding confidentiality for STI clients? IF YES, ASK TO SEE A COPY.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO . . . . . 3 DON'T KNOW 8	
608	Does the facility normally perform partner notification or follow-up? IF YES: Is the follow-up ever active (where the facility makes contact with the partner) or is it only passive (where the facility asks the clients to inform or bring their partners)?	YES, SOMETIMES ACTIVE . . . . . 1 YES, ONLY PASSIVE . . . . . 2 NO 3	→ 610 → 610
609	Do you have a form–a referral form or a register where records are kept about clients for active follow-up? IF YES, ASK TO SEE A COPY.	YES, FORM OBSERVED . . . . . 1 YES, REGISTER OBSERVED ..... 2 YES, FORM/REGISTER REPORTED, NOT SEEN . . . . . 3 NO 4	
610	Is there a register where information is recorded on STI consultations? IF YES, ASK TO SEE THE REGISTER. MAY BE GENERAL OPD REGISTERS.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 NO 3	→ 616 → 616
611	SKIM THE REGISTER FOR THE PAST 3 MONTHS AND CIRCLE IF THE INDICATED INFORMATION IS ROUTINELY RECORDED FOR CLIENTS RECEIVING SERVICES THIS CLINIC/UNIT	CLIENT NAME . . . . . A CLIENT AGE . . . . . B CLIENT SEX . . . . . C DIAGNOSIS/MAIN SYMPTOM . . . . . D NONE OF THE ABOVE Y	
612	WERE THERE ANY DIAGNOSES NOTED THAT INDICATED A CLIENT HAD AN STI OR A REPRODUCTIVE TRACT INFECTION? IF YES, CIRCLE WHICH OF THE INDICATED INFORMATION WAS OBSERVED FOR ANY CLIENTS	SYMPTOM (DISCHARGE/PAIN) A GENERAL DIAGNOSIS (STI/RTI) B SPECIFIC TYPE OF STI/RTI C OTHER INDICATION OF RTI/STI _____ X (SPECIFY)(SPECIFY)(SPECIFY) NONE OF THE ABOVE Y	→ 616
613	HOW RECENT IS THE DATE OF THE MOST RECENT ENTRY FOR A PROBABLE STI OR RTI?	WITHIN THE PAST 7 DAYS . . . . . 1 MORE THAN 7 DAYS OLD 2	
614	RECORD THE NUMBER OF CLIENTS WHO RECEIVED STI SERVICES DURING THE PAST 12 COMPLETED MONTHS.	NUMBER OF STI CLIENTS [ ][ ][ ][ ][ ]	
615	INDICATE THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA . . . . . [ ][ ]	

616	Is there any evidence of looking at service data for evaluating or monitoring services? IF YES, ASK TO SEE ANY REPORTS, WALL GRAPHS OR CHARTS THAT SHOW SERVICE DATA HAS BEEN REVIEWED. CIRCLE ALL RELEVANT TYPE OF REPORTS OBSERVED.	OBSERVED WALL CHART/GRAPH . . . . . A WRITTEN REPORT/MINUTES . . . B OTHER _____ . . . X (SPECIFY) NO OBSERVED EVIDENCE . . . . . Y	
617	Do you submit an official report externally (usually to the MOHSS or a public-health agency responsible for communicable diseases) that specifically identifies numbers of cases of STI syndromes, or specific STIs such as syphilis or HIV/AIDS seen by the facility services?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
618	ASK TO SEE WHERE COUNSELLING FOR CLIENTS WITH SYMPTOMS OF STI IS PROVIDED. DESCRIBE THE SETTING.	PRIVATE ROOM WITH VISUAL AND AUDITORY PRIVACY . . . 1 NON-PRIVATE ROOM WITH AUDITORY AND VISUAL PRIVACY . . . . . 2 VISUAL PRIVACY ONLY . . . . . 3 NO PRIVACY 4	

ASK TO SEE EACH OF THE FOLLOWING ITEMS, AND ASSESS IF THE ITEM IS IN THE ROOM (OR AN ADJACENT ROOM) WHERE COUNSELLING OR EXAMINATION OF STI CLIENTS TAKES PLACE.

619	**VISUAL AIDS FOR TEACHING CLIENT:**	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW
01	About STIs	1	2	3	8
02	About HIV/AIDS	1	2	3	8
03	Posters on STIs (MAY INCLUDE HIV/AIDS)	1	2	3	8
04	Posters on HIV/AIDS	1	2	3	8
05	Model to demonstrate use of male condom	1	2	3	8
06	Model to demonstrate use of female condom	1	2	3	8
	INFORMATION FOR CLIENT TO TAKE HOME				
07	About STIs	1	2	3	8
08	About HIV/AIDS	1	2	3	8
09	Male condoms that can be given to the client	1	2	3	8
10	Female condoms (e.g., Femidom) that can be given to the client	1	2	3	8
620	**SERVICE DELIVERY STANDARDS/PROTOCOLS**				
01	Guidelines for the syndromic management of Sexually Transmitted Diseases	1	2	3	8
02	Etiologic (laboratory) diagnosis of STIs	1	2	3	8
03	Any other Treatment protocols for STIs	1	2	3	8
04	Syndromic approach treatment flowchart	1	2	3	8
05	Guidelines for diagnosing HIV/AIDS	1	2	3	8
621	Is there a policy (or guideline) that all STI clients should be offered an HIV test? IF YES, ASK TO SEE THE POLICY/GUIDELINE	1	2	3	8

622	Are all STI clients routinely referred for HIV testing?	YES . . . . . 1 ONLY IF CLIENT SUSPECTED TO BE HIV+ . . 2 NO 3	

623	Where are the clients sent for HIV testing? PROBE FOR A SPECIFIC UNIT WITHIN FACILITY, OR SPECIFIC LOCATION OUTSIDE FACILITY TO BE NAMED	LOCATION NAMED INSIDE FACILITY . . . . . 1 OUTSIDE FACILITY . . . . . 2 DON'T KNOW SPECIFIC LOCATION 3	
624	Are individual client health records or charts used? IF YES, ASK TO SEE EITHER A USED OR NEW CLIENT HEALTH CARD/CHARD/RECORD.	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3	
625	ASK TO SEE THE ROOM WHERE EXAMINATIONS FOR STIs ARE CONDUCTED.		
	IF THE *SAME EXAMINATION ROOM* HAS ALREADY BEEN OBSERVED FOR ITEMS IN 626, INDICATE WHICH SECTION THE DATA ARE RECORDED IN.	OPD [Q187] . . . . . 11 CHILD HEALTH [Q256] . . . . . 12 FAMILY PLANNING [Q322] . . . . . 13 ANTENATAL CARE [Q429] . . . . . 14 DELIVERY [Q530] . . . . . 15 SECTION 17 - TB [Q1719] . . . . . 17 SECTION 18 - CT [1830] . . . . . 18 NOT PREVIOUSLY SEEN 19	626A

626 FOR EACH OF THE FOLLOWING ITEMS, CHECK TO SEE WHETHER ITEM IS EITHER IN THE ROOM WHERE CLIENTS ARE EXAMINED OR IN AN ADJACENT ROOM.

	ITEMS FOR INFECTION CONTROL AND CONDITIONS FOR EXAMINATION	(a) AVAILABILITY			
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	
01	RUNNING WATER (PIPED)	1 → 04	2	3	
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 → 04	2	3	
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	
04	HAND-WASHING SOAP/LIQUID SOAP	1	2	3	
05	HAND DISINFECTANT	1	2	3	
06	SINGLE-USE HAND DRYING TOWELS	1	2	3	
07	WASTE RECEPTACLE WITH LID (PEDAL BIN) AND PLASTIC LINER	1 → 10	2	3	
08	OTHER WASTE RECEPTACLE (NOT PEDAL BIN) WITH PLASTIC LINER	1 → 10	2	3	
09	WASTE RECEPTACLE WITH LID (PEDAL BIN) WITHOUT PLASTIC LINER	1	2	3	
10	SHARPS CONTAINER ("SAFETY BOX")	1	2	3	
11	DISPOSABLE LATEX GLOVES	1 → 13	2	3	
12	DISPOSABLE NON-LATEX GLOVES	1	2	3	
13	DISINFECTANT [E.G., HIBITANE, ALCOHOL]	1	2	3	
14	DISPOSABLE NEEDLES	1	2	3	
15	AUTO-DISABLE SYRINGES (3 OR 5 ml)	1	2	3	
16	DISPOSABLE SYRINGES (3 OR 5 ml)	1	2	3	
17	AUDITORY PRIVACY	1	2	3	
18	VISUAL PRIVACY	1	2	3	
19	TABLE CLOTH/PLASTIC ON ANY SURFACE	1	2	3	

626A	IF THE *SAME EXAMINATION ROOM* HAS ALREADY BEEN OBSERVED FOR ITEMS IN 626B, INDICATE WHICH SECTION THE DATA ARE RECORDED IN.	FAMILY PLANNING [Q321] ..... 13 ANTENATAL CARE [Q428] ..... 14 DELIVERY [Q530A] ..... 15 NOT PREVIOUSLY SEEN 19	→ 627

626B	SUPPLIES AND EQUIPMENT REQUIRED FOR EXAMINATION	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED PRESENT	REPORTED AVAILABLE	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Spotlight for pelvic exam (flashlight/torch or exam light acceptable)	1→b	2→b	3 → 02	8 → 02	1	2	8
02	Manual BP Apparatus	1→b	2→b	3 → 03	8 → 03	1	2	8
03	Stethoscope	1→b	2→b	3 → 04	8 → 04	1	2	8
04	Automatic BP Apparatus	1→b	2→b	3 → 05	8 → 05	1	2	8
05	Examination couch	1	2	3	8			

627	OTHER SUPPLIES AND EQUIPMENT REQUIRED FOR EXAMINATION	(a) AVAILABILITY			
		OBSERVED PRESENT	REPORTED AVAILABLE	NOT AVAILABLE	DON'T KNOW
01	Vaginal speculum (s)	1	2	3	8
02	Vaginal speculum (m)	1	2	3	8
03	Vaginal speculum (l)	1	2	3	8
04	Swab sticks for taking specimen	1	2	3	8

627A	ASSESS CONDITION OF SERVICE AREA. IF THIS LOCATION HAS ALREADY BEEN ASSESSED IN Q196, CIRCLE "1" AND END THE INTERVIEW. IF NOT PROCEED AND ASSESS THE AREA	ASSESSED IN SECTION 1 [Q196] . . . 1 ASSESSED IN SECTION 5 [Q581] . . . 2 NOT PREVIOUSLY SEEN 3	→ **END** → **END**

628	ASSESS CONDITION OF SERVICE AREA.	YES	NO
01	**FLOOR:** SWEPT, NO OBVIOUS DIRT OR WASTE	1	2
02	**COUNTERS/TABLES/CHAIRS:** WIPED CLEAN-NO OBVIOUS DUST OR WASTE	1	2
03	BROKEN EQUIPMENT, PAPERS, BOXES AROUND MAKING AREA CLUTTERED AND DIRTY	1	2
04	**WALLS:** REASONABLY CLEAN	1	2
05	**DOORS:** NO (OR MINOR) DAMAGE	1	2
06	**WALLS:** NO (OR MINOR) DAMAGE	1	2
07	**ROOF:** NO (OR MINOR) DAMAGE	1	2
08	**CEILING:** NO (OR LITTLE) WATER STAINS/DAMAGE	1	2
09	NEEDLES, SHARPS OUTSIDE SHARPS BOX	1	2
10	SHARPS BOX OVERFLOWING OR TORN/PIERCED	1	2
11	BANDAGES/INFECTIOUS WASTE LYING UNCOVERED	1	2

SECTION 14. HEALTH INFORMATION SYSTEM

Facility Number: [ ][ ][ ]

QRE TYPE **14**

Interviewer Code: [ ][ ]

1400	INDICATE WHICH UNITS THIS DATA REPRESENTS	OUTPATIENT ONLY . . . . . 1 INPATIENT ONLY . . . . . 2 BOTH IN AND OUTPATIENT . . . . . 3 NO HIS IN FACILITY 4	→**END**

FIND THE PERSON IN CHARGE OF THE HIS REPORTS. IF HE/SHE IS NOT PRESENT, ASK TO SEE THE PROVIDER MOST KNOWLEDGEABLE ABOUT OR WHO WRITES HIV/AIDS HIS REPORTS IN THIS FACILITY.

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER RESPONSIBLE FOR THE CLINIC/UNIT WHO IS PRESENT TODAY. READ THE FOLLOWING GREETING:

Good day! My name is _____. We are here on behalf of the Ministry of Health and Social Services (MOHSS) conducting a study to assist the government in knowing more about health services in Namibia. Now I will read a statement explaining the study.

ALL facilities in the country are participating in this study. We will be asking you questions about various health services and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility may be used by the MOHSS, organizations supporting services in your facility, and researchers, for planning service improvement or for conducting further studies of health services.

Neither your name nor that of any other health worker respondents participating in this study will be included in the dataset or in any report; however, there is a small chance that any of these respondents may be identified later. Still, we are asking for your help to ensure that the information we collect is accurate.

You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will answer the questions, which will benefit the services you provide and the nation.

If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate if you introduce us to that person to help us collect that information.

At this point, do you have any questions about the study? Do I have your agreement to proceed?

_____ [ ][ ] [ ][ ] **2 0 0 9**

Interviewer's signature — DAY | MONTH | YEAR

SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.

1403	May I begin the interview now?	YES . . . . . 1 NO 2	→**STOP**

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1404	What is your technical background for completing the HIS reports? PROBE IF NECESSARY	DATA CLERK/ACCOUNTANT . . . . . A HEALTH STATISTICS/MED RECORDS . . B PROFESSIONAL PROVIDER (e.g. R.NURSE) C SUB-PROFESSIONAL PROV.(e.g. E.NURSE). . D NON-CLINICAL PROV.(e.g. SOC.WORKER) E LABORATORY WORKER . . . . . F OTHER _____ X (SPECIFY)	
1405	Did you have special training in recording systems or reports for health information, such as training in the HIS? IF YES, ASK: Was the training formal or informal? IF BOTH, RECORD FORMAL.	YES, FORMAL . . . . . 1 YES, INFORMAL . . . . . 2 NO 3	→ 1407
1406	When was your most recent training in HIS or reporting on health statistics?	IN PAST 12 MONTHS . . . . . 1 IN PAST 1-3 YEARS . . . . . 2 MORE THAN 3 YEARS AGO 3	
1407	How many years have you been responsible for HIS records/reports in this facility? RECORD '00' FOR LESS THAN ONE YEAR	YEARS . . . . . [ ][ ]	
1408	Do you conduct training of staff in HIS, for example, recording, compiling, and reporting data? IF YES, ASK: Do you provide formal or informal training? IF BOTH, RECORD 'FORMAL'.	YES, FORMAL . . . . . 1 YES, INFORMAL . . . . . 2 NO 3	→ 1410
1409	Who do you train in HIS? PROBE TO ARRIVE AT CORRECT RESPONSE	STAFF IN HIS UNIT . . . . . A STAFF IN SERVICE UNITS . . . . . B STAFF IN HIS AND SERVICE UNITS . . C STAFF IN OTHER FACILITIES D	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1410	Have you or other staff in this unit ever had any training in Strategic Information, such as monitoring and evaluation, or surveillance for HIV/AIDS?	YES . . . . . 1 NO 2	→ 1412
1411	Was the training on strategic information for HIV/AIDS, formal or informal? IF BOTH, RECORD 'FORMAL'.	FORMAL . . . . . 1 INFORMAL 2	

1412	Do you have any of the following guidelines? IF YES, ASK: May I see the guidelines please?	(a) OBSERVED	(a) REPORTED, NOT SEEN	(a) NOT AVAILABLE	(b) YEAR OF PUBLICATION
01	HIS reporting guidelines	1 → b	2 → 02	3 → 02	
02	HIV/AIDS surveillance reporting guidelines	1 → b	2 → 03	3 → 03	
03	National technical guidelines for integrated disease surveillance and response	1 → b	2 → 04	3 → 04	
04	National HIV/AIDS reporting guidelines	1 → b	2 → 1413	3 → 1413	

1413	Do you receive or compile reports of services for confirmed or suspected HIV/AIDS cases from the following units? IF YES, ASK TO SEE A REPORT.	YES OBSERVED	YES, REPORTED NOT SEEN	NO REPORT	NOT APPLICABLE
01	Outpatient services	1	2	3	4
02	Inpatient services	1	2	3	4
03	Laboratory services	1	2	3	4
04	Tuberculosis services	1	2	3	4
05	HIV counselling and testing services	1	2	3	4
06	Antiretroviral treatment services	1	2	3	4
07	Prevention of mother-to-child transmission services	1	2	3	4
08	Sources based outside facility (community health workers, traditional birth attendants, etc.)	1	2	3	4

1414	Do you receive or compile reports of deaths in the facility attributed to HIV/AIDS? IF YES, ASK TO SEE A REPORT	YES OBSERVED	YES REPORTED NOT SEEN	NO REPORT	NOT APPLIC.
		1	2 → 1417	3 → 1419	4 → 1419

1415	RECORD THE NUMBER OF DEATHS ATTRIBUTED TO HIV/AIDS REPORTED FOR PAST 12 MONTHS	NUMBER OF DEATHS . . . . . [ ][ ][ ][ ]	
1416	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION	MONTHS OF DATA . . . . . [ ][ ]	
1417	How frequently are reports on deaths submitted to someone outside of this facility?	MONTHLY OR MORE OFTEN . . . . . 1 EVERY 2-3 MONTHS . . . . . 2 EVERY 4-6 MONTHS . . . . . 3 LESS OFTEN THAN EVERY 6 MONTHS . . . . . 4 NEVER 5	→ 1419
1418	To whom are the reports sent? CIRCLE ALL THAT APPLY.	DISTRICT LEVEL (MOHSS/DSP/HIS) . . . . C REGIONAL LEVEL (MOHSS/DSP/HIS) . . . . D NATIONAL LEVEL (MOHSS/DSP/HIS) . . . E DONOR AGENCY . . . . . F OTHER _____ X (SPECIFY)	

1419	Do you receive or compile reports of newly diagnosed HIV cases in the facility? IF YES, ASK TO SEE A REPORT	YES OBSERVED	YES REPORTED NOT SEEN	NO REPORT	NOT APPLIC.
		1	2 → 1422	3 → 1424	4 → 1424

1420	RECORD THE NUMBER OF NEWLY DIAGNOSED HIV CASES DURING THE PAST 12 MONTHS	NEW HIV/AIDS CASES . . . . . [ ][ ][ ][ ]	
1421	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION	MONTHS OF DATA . . . . . [ ][ ]	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1422	How frequently are reports on newly diagnosed HIV cases submitted to someone outside of this facility?	MONTHLY OR MORE OFTEN . . . . . 1 EVERY 2-3 MONTHS . . . . . 2 EVERY 4-6 MONTHS . . . . . 3 LESS OFTEN THAN EVERY 6 MONTHS . . . . . 4 NEVER 5	→ 1424
1423	To whom are the reports sent? CIRCLE ALL THAT APPLY.	DISTRICT LEVEL (MOHSS/DSP/HIS) . . . . C REGIONAL LEVEL (MOHSS/DSP/HIS) . . . . . D NATIONAL LEVEL (MOHSS/DSP/HIS) . . E DONOR AGENCY . . . . . F OTHER _____ X (SPECIFY)	
1424	Do you receive or compile reports on client diagnoses for inpatient admissions/discharges and/or outpatient visits? IF YES, ASK TO SEE A REPORT. RECORD THE NUMBER OF PATIENTS WITH THE FOLLOWING DIAGNOSES- USE EITHER THE COMPILED REPORT, THE COMPUTER SYSTEM, OR UNIT RECORDS SUBMITTED TO THE HIS, WHICHEVER TYPE OF REPORT INCLUDES THE DIAGNOSES REQUESTED BELOW.	INFORMATION AVAILABLE, DATA NOT YET RECORDED . . . . . 1 INFORMATION AVAILABLE, DATA ALREADY RECORDED IN SECTION 1 . . . . . 2 INFORMATION REPORTED AVAILABLE, BUT NOT SEEN . . . . . 3 INFORMATION NOT AVAILABLE 4	 → 1428 → **END** → **END**
1425	INDICATE CLIENT INFORMATION FOR WHICH THE FOLLOWING QUESTION IS COMPLETED.	OUTPATIENT CLIENTS ONLY 1 INPATIENT CLIENTS ONLY 2 BOTH OUTPATIENT AND INPATIENT 3	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1426	RECORD THE NUMBER OF CLIENTS WITH THE ADMISSION/DISCHARGE/VISIT DIAGNOSES BELOW, FOR THE PAST 12 MONTHS. ENSURE DATA INCLUDES PEDIATRICS AND ADULTS. IF MORE THAN ONE DIAGNOSIS IS INDICATED FOR A CLIENT, CHOOSE THE ONE MOST INDICATIVE OF HIV/AIDS RELATED ILLNESS.		
		NUMBER (A) OUTPATIENT VISITS / (B) INPATIENT ADMISSIONS/DISCHARGES	
1	ORAL CANDIDIASIS/MOUTH SORES		
2	CRYPTOCOCCAL MENINGITIS		
3	TOXOPLASMOSIS		
4	KAPOSI'S SARCOMA		
5	AIDS-RELATED COMPLEX (ARC)		
6	HERPES ZOSTER/SIMPLEX		
7	PCP (PNEUMOCYSTIS CARINII PNEUMONIA)		
8	IMMUNOSUPPRESSION/ HIV/AIDS OR RVD		
9	WASTING SYNDROME FAILURE TO THRIVE (FTT)		
10	CHRONIC DIARRHEA (MUST SPECIFY CHRONIC)		
11	TUBERCULOSIS		
12	OTHER NON-SPECIFIC DIAGNOSIS COMMON TO HIV/AIDS ILLNESSES PYREXIA/FEVER UNKNOWN ORIGIN (PUO/FUO) LYMPHADENOPATHY		
13	OTHER DIAGNOSIS INDICATING CLIENT HAD HIV/AIDS RELATED ILLNESS (SPECIFY)		
1427	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN THE PREVIOUS QUESTION		
1428	RECORD THE NUMBER OF MALARIA CASES IN THE GROUPS INDICATED BELOW FOR THE PAST 12 COMPLETED MONTHS. FOR EACH GROUP, INDICATE IN COLUMN "A" THE TOTAL NUMBER OF REPORTED CASES SEEN AND IN COLUMN "B" THE NUMBER OF CONFIRMED CASES.		
		(A) TOTAL NUMBER OF CASES / (B) NUMBER OF CONFIRMED CASES	
	1 CHILDREN UNDER 5 YEARS		
	2 PREGNANT WOMEN		
	3 ALL ADULTS (NOT PREGNANT)		
1429	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN THE PREVIOUS QUESTION	NUMBER OF MONTHS	
1430	RECORD THE TOTAL NUMBER OF OUTPATIENT VISITS AND INPATIENT ADMISSIONS/ DISCHARGES FOR ALL HIV AND NON-HIV DIAGNOSES, FOR THE TIME PERIOD INDICATED IN Q.1426	TOTAL OPD VISITS / TOTAL IPD ADMISSIONS/DISCHARGES	
	THANK YOUR RESPONDENT FOR THE TIME AND HELP PROVIDED AND PROCEED TO THE NEXT DATA COLLECTION SITE		

SECTION 15: LABORATORY AND OTHER DIAGNOSTICS

Facility Number: [ ][ ][ ]

QRE TYPE **15**

Interviewer Code: [ ][ ]

1500	INDICATE SETTING FOR LAB	LAB IN FACILITY . . . . . 1 AFFILIATED EXTERNAL LAB . . . 2 AREA LOCKED/NO ACCESS . . . 3 FACILITY HAS NO LAB 4	→ **END**
1501	Does this lab provide services for both outpatients and inpatients, or does it provide services for outpatients only, or inpatients only?	OUTPATIENT ONLY . . . . . 1 INPATIENT ONLY . . . . . 2 BOTH OUT- AND INPATIENTS . . 3	
1503	CHECK QUESTION Q1500. IS THE RESPONSE '3', NO ACCESS?	YES . . . . . 1 NO 2	→ **STOP**

START DATA COLLECTION IN THE MAIN LABORATORY.
FOR EACH OF THE LABORATORY PROCEDURES OF INTEREST, GO TO THE MAIN LOCATION IN THE FACILITY WHERE THE TEST/INFORMATION IS LOCATED. IF A TEST/INFORMATION IS NOT IN THAT LOCATION, ASK IF IT IS ANYWHERE ELSE IN THE FACILITY AND GO THERE TO COMPLETE THE QUESTIONNAIRE.

IF THE PROVIDER IS DIFFERENT FROM ANY OF THE PREVIOUS RESPONDENTS, INTRODUCE YOURSELF. BRIEFLY EXPLAIN THE PURPOSE OF YOUR VISIT, AND ASK IF HE/SHE IS WILLING TO ANSWER A FEW QUESTIONS ABOUT LABORATORY SERVICES. IF IN AGREEMENT, READ THE INTRODUCTORY CONSENT FORM BELOW.

IF THE RESPONDENT HAS ALREADY BEEN INTERVIEWED FOR A PREVIOUS SECTION, CIRCLE NUMBER 1' (YES) IN Q1504 BELOW AND GO ON TO Q1505.

Good day! My name is _____. We are here on behalf of the Ministry of Health and Social Services (MOHSS) conducting a study to assist the government in knowing more about health services in Namibia.
Now I will read a statement explaining the study.

ALL facilities in the country are participating in this study. We will be asking you questions about various health services and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility may be used by the MOHSS, organizations supporting services in your facility, and researchers, for planning service improvement or for conducting further studies of health services.

Neither your name nor that of any other health worker respondents participating in this study will be included in the dataset or in any report; however, there is a small chance that any of these respondents may be identified later. Still, we are asking for your help to ensure that the information we collect is accurate.

You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will answer the questions, which will benefit the services you provide and the nation.

If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate if you introduce us to that person to help us collect that information.

At this point, do you have any questions about the study? Do I have your agreement to proceed?

_____
Interviewer's signature

[ ][ ] [ ][ ] **2 0 0 9**
DAY MONTH YEAR

SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.

1504	May I begin the interview now?	YES . . . . . 1 NO 2	→ **STOP**

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1505	How many days in a week is the lab open to serve clients?	NUMBER OF DAYS OPEN	
1506	Now I have some questions about staffing for this LAB. Please tell me how many staff with each qualification should be in this LAB by establishment, the number that are currently assigned to or employed by this LAB, and how many are actually present today.		

	QUALIFICATION	(a) STAFF PER ESTABLISHMENT	(b) STAFF ASSIGNED OR EMPLOYED	(c) STAFF PRESENT TODAY
01	(01) SPECIALIST			
02	(21) LAB. SCIENTIST			
03	(22) LAB.TECHNOLOGIST			
04	(23) LAB. TECHNICIAN/ASSISTANT			
05	SUM THE NUMBER OF LAB STAFF REPORTED IN EACH COLUMN			

1507	FILTER: ONLY DO THIS IF THE STAFF LIST HAS NOT BEEN COMPLETED. IF COMPLETED CIRCLE "1" AND SKIP TO Q1508, OTHERWISE, PROCEED: Now I would like to identify laboratory staff (such as lab technicians, lab technologists) or other staff (such as doctors, nurses, and counsellors) who are assigned to this LAB who are present today Please give me the names and main service responsibility of the staff assigned to this LAB and present today. COMPLETE THE STAFF LIST FOR THIS LAB. DO NOT DUPLICATE SERVICE PROVIDERS WHO ARE LISTED FOR A SERVICE AREA THAT WAS PREVIOUSLY ASSESSED.		
	RESPONDENT MUST BE INTERVIEWED FOR TRAINING AND EXPERIENCE.	STAFF LIST COMPLETED YES . . . . . 1 NO 2	
1508	Now I would like to know about guidelines and protocols that are available in this laboratory area.		

	please tell me if you have any of the following guidelines/protocols in the laboratory area. IF YES, ASK: May I see the guidelines please?	(a) OBSERVED	(a) REPORTED AVAIL. NOT SEEN	(a) NOT AVAIL.	(b) YEAR OR PUBLICATION
01	Laboratory Safety Guidelines	1 → b	2 → 02	3 → 02	
02	National Infection Prevention and control guidelines for health care services in Namibia, MOHSS	1 → b	2 → 03	3 → 03	
03	Other guidelines for blood safety	1 → b	2 → 04	3 → 04	
04	Other universal /standard precautions for healthcare workers	1 → b	2 → 05	3 → 05	
05	Other infection prevention guidelines	1 → b	2 → 06	3 → 06	
06	Guidelines for post-exposure (HIV/AIDS) prophylaxis (PEP) for healthcare workers	1 → b	2 → 07	3 → 07	
07	Manual for laboratory technicians for TB screening	1 → b	2 → 08	3 → 08	
08	Any standard operating procedures (SOPs)	1 → b	2 → 1509	3 → 1509	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
	HIV TESTING		
1509	Does this laboratory conduct any tests for HIV? IF YES, ASK: Are the tests done to determine a persons HIV status, or to screening blood for transfusion, or for some other reason? PROBE AND CIRCLE ALL THAT APPLY.	FOR CLIENT HIV STATUS ..... A BLOOD SCREENING FOR TRANSFUSION ..... B MANDATORY (FOR EMPLOYMENT /VISA/WORK PERMIT) ..... C NO .... Y	→ 1524

1510	Are there any guidelines related to any of the topics I will ask in the laboratory area? IF YES, ASK: May I see the guideline please.	(a) OBSERVED	(a) REPORTED AVAILABLE NOT SEEN	(a) NOT AVAILABLE	(b) YEAR OF PUBLICATION
01	Protocols/guidelines for HIV testing procedures (who to test, which test to use)	1 → b	2 → 02	3 → 02	
02	Any written guidelines on how to conduct HIV test (may be manufacturers instructions)	1 → b	2 → 03	3 → 03	
03	Written guidelines on confidentiality and disclosure of HIV test results	1 → b	2 → 04	3 → 04	
04	Other guidelines relevant to HIV/AIDS or related services _____ (SPECIFY)	1 → b	2 → 1511	3 → 1511	

1511	Now I would like to see the equipment and the reagents necessary to conduct various tests.								
	For each of the following tests or equipment, I would like to know if it is used, if it is functioning today, and, if relevant, if all items to conduct the test are available today.	(a) TEST CONDUCTED		(b) ARE ALL ITEMS FOR TEST AVAILABLE?			(c) IS THE ITEM IN WORKING ORDER?		
		Yes	No	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	ELISA/EIA scanner/reader and all items for test	1 → b	2 → 02	1 → c	2 → c	3 → 02	1	2	8
02	CD4 Count machine, and all items for test	1 → b	2 → 03	1 → c	2 → c	3 → 03	1	2	8
03	Dynabeads with vortex mixer	1 → b	2 → 04	1 → c	2 → c	3 → 04	1	2	8
04	Rapid test for HIV	1 → b	2 → 05	1	2	3 → 05			
05	Western Blot test	1 → b	2 → 06	1	2	3 → 06			
06	PCR for viral load	1 → b	2 → 07	1	2	3 → 07			
07	PCR for DNA-EID	1 → b	2 → 08	1	2	3 → 08			
08	Other HIV test _____ (SPECIFY)	1 → b	2 → 1512	1	2	3 → 1512			

1512	Do you have any record of HIV test results for tests conducted in this laboratory? IF YES, ASK TO SEE THE RECORDS FOR THE PAST 12 MONTHS.	YES ..... 1 NO 2	→ 1514

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1513	INDICATE IF THE SPECIFIED INFORMATION IS AVAILABLE AND IF SO, RECORD THE INDICATED CLIENT NUMBERS FOR THE PAST 12 MONTHS.	(a) RECORD AVAILABLE AND OBSERVED: YES / REPORTED NOT SEEN / NO RECORD (b) NUMBERS FROM OBSERVED RECORDS: NUMBER OF CLIENTS / MONTHS OF DATA	
01	TOTAL CLIENTS HAVING HIV TEST DONE	1 → b; 2 → 02; 3 → 02	
02	TOTAL RESULTS GIVEN TO PROVIDERS & CLIENTS	1 → b; 2 → 03; 3 → 03	
03	TOTAL POSITIVE RESULTS GIVEN TO PROVIDERS	1 → b; 2 → 04; 3 → 04	
04	TOTAL POSITIVE RESULTS GIVEN TO CLIENTS ONLY (e.g. SELF REQUESTED)	1 → b; 2 → 1514; 3 → 1514	
1514	Is there an established system for **external** quality control for the HIV tests conducted by this laboratory? IF YES, PROBE FOR SYSTEM USED. CIRCLE ALL THAT APPLY	YES, PROFICIENCY PANEL . . . A YES, EXTERNAL INSPECTION/ OBSERVATION OF TECHNIQUE B SEND BLOOD FOR RETESTING C NOT ROUTINE, BUT SOMETIMES D NO EXTERNAL QUALITY CONTROL Y	→ 1517 → 1517 → 1517 → 1520
1515	CHECK PREVIOUS QUESTION. IS C CIRCLED? IF YES ASK: How do you determine ***when*** to send a blood sample for retesting?	SEND EVERY FIXED NUMBER OF TESTS . . . . . 1 SEND PERCENT OF TESTS . . . 2 SEND, BUT NO FIXED NUMBER . . 3 DO NOT SEND BLOOD ELSEWHERE 4	 → 1517 → 1520
1516	Please tell me the specific number or percentage for when you send the blood sample for retesting.	RECORD % OR NUMBER FOR 1 OR 2 IN Q1515 [ ][ ][ ]	
1517	Is there a record of the results from the external quality check? IF YES, ASK TO SEE THE RECORD OR REPORT WHERE THE RESULTS ARE RECORDED.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 NO 3	 → 1520 → 1520
1518	What is the most recent date for an external quality check test result or error rate?	WITHIN PAST ONE MONTH . . . . . 1 WITHIN PAST 2-6 MONTHS . . . . . 2 MORE THAN 6 MONTHS 3	
1519	What is the most recent error rate that is recorded by external quality control?	PERCENT ERROR RATE . . . . . [ ][ ] DON'T KNOW 98	
1520	Other than external Quality Control, is there any other system used for quality control of laboratory tests for HIV/AIDS?	INTERNAL QUALITY CONTROL . . 1 OTHER _____ 2 DESCRIBE NO 3	 → 1522
1521	Is there a record of the results from the internal/ other quality check? IF YES, ASK TO SEE THE RECORD OR REPORT WHERE THE RESULTS ARE RECORDED.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 NO 3	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1522	Are there any fees assessed for any services or items related to HIV/AIDS tests?	YES . . . . . 1 NO 2	→ 1524
1523	For each of the following items, indicate if there is any routine fee, and if yes, the amount of the fee	(a) FEE: YES / NO / NA (b) AMOUNT IN N$	
01	HIV RAPID TEST	1 → b; 2 → 02; 3 → 02	
02	ELISA TEST	1 → b; 2 → 03; 3 → 03	
03	TEST FOR CD4 COUNT	1 → b; 2 → 04; 3 → 04	
04	FULL BLOOD COUNT	1 → b; 2 → 1524; 3 → 1524	
1524	Do you send blood outside the facility for HIV diagnostic testing?	YES . . . . . 1 NO 2	→ 1529
1525	For which HIV test do you send blood outside?	ELISA/EIA . . . . . A WESTERN BLOT . . . . . B PCR . . . . . C OTHER _____ X SPECIFY	
1526	Do you have a record with the result of the HIV/AIDS tests conducted elsewhere? IF YES, ASK TO SEE THE REGISTER	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 NO 3	→ 1528
1527	Does the register indicate if the client or the provider has received the results?	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 NO 3	
1528	After receiving the results, how are the results provided to the client? PROBE TO ARRIVE AT THE RIGHT RESPONSES.	LAB PROVIDES WRITTEN COPY OF RESULTS TO CLIENT . . . A LAB TELLS CLIENT VERBALLY . . . . B LAB PROVIDES RESULTS TO HEALTH WORKER/UNIT AND THEY TELL CLIENT . . . . . C OTHER _____ X (SPECIFY) DON'T KNOW . . . . . Z	
1529	Is any HIV pre- or post-test counselling ever provided to clients in the laboratory area?	YES . . . . . 1 NO 2	
1530	Do you send blood outside the facility for CD4 count, total lymphocyte count or viral load testing?	YES, CD4 . . . . . A YES, TCL . . . . . B YES, VIRAL LOAD . . . . . C NONE OF THE ABOVE . . . . . Y	→ 1533
1531	Do you have a record with results of the tests conducted elsewhere? IF YES, ASK TO SEE THE REGISTER	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 NO 3	
1532	After receiving the results, how are the results provided to the client?	LAB PROVIDES WRITTEN COPY OF RESULTS TO CLIENT . . . . A LAB TELLS CLIENT VERBALLY . . B LAB PROVIDES RESULTS TO HEALTHWORKER WHO TELLS CLIENT . . . . . C OTHER _____ X (SPECIFY) DON'T KNOW . . . . . Z	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1533	Does this laboratory or unit regularly compile reports of newly diagnosed HIV cases?	YES . . . . . 1 NO 2	→ 1538
1534	How frequently are the compiled reports submitted to someone outside of this laboratory (or unit)?	MONTHLY OR MORE OFTEN . . . . . 1 EVERY 2-3 MONTHS . . . . . 2 EVERY 4-6 MONTHS . . . . . 3 LESS OFTEN THAN EVERY 6 MONTHS . . . . . 4 NEVER 5	→ 1536
1535	To whom are the reports sent? CIRCLE ALL THAT APPLY	RECORDS CLERK . . . . . A FACILITY DIRECTOR/SUPERVISOR. . . B DISTRICT LEVEL (MOH/DSP/HIS). . . . . C REGIONAL LEVEL (MOHSS/DSP/HIS). D NATIONAL LEVEL (MOHSS/DSP/HIS). . E DONOR AGENCY . . . . . F OTHER _____ X (SPECIFY)	
1536	ASK TO SEE THE REPORT FOR NEWLY DIAGNOSED HIV CASES DURING THE PAST 12 MONTHS AND RECORD THE NUMBER OF CASES.	NEW HIV CASES [ ][ ][ ][ ][ ] REPORT NOT SEEN 99996	→ 1538
1537	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION	MONTHS OF DATA [ ][ ]	
1538	Do you record results by the unit ordering the HIV test or test results? IF YES, ASK TO SEE THE REGISTER AND INDICATE FROM WHICH UNITS RESULTS FOR TESTS ARE RECORDED.	YES . . . . . 1 NO 2	→ 1540

1539	HIV RESULTS ARE RECORDED SEPARATELY FOR:	YES	NO	NOT APPLICABLE
01	VCT UNIT	1	2	3
02	PMTCT UNIT	1	2	3
03	Surveillance	1	2	3
04	Blood bank or blood for transfusion	1	2	3
05	General or specialty outpatient units (other than VCT or PMTCT UNITS)	1	2	3
06	In-patient units, either by separate units or as total inpatient units	1	2	3
07	By sero-status, irrespective of source	1	2	3

NO.	QUESTIONS	CODING CATEGORIES			GO TO
1540	INDICATE IF THE ITEMS LISTED BELOW ARE AVAILABLE IN THE MAIN LABORATORY OR IN AN IMMEDIATELY ADJACENT AREA	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	
01	RUNNING WATER (PIPED)	1 → 04	2	3	
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 → 04	2	3	
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	
04	HAND-WASHING SOAP/LIQUID SOAP	1	2	3	
05	HAND DISINFECTANT	1	2	3	
06	SINGLE-USE HAND DRYING TOWELS	1	2	3	
07	WASTE RECEPTACLE WITH LID (PEDAL BIN) AND PLASTIC LINER	1 → 10	2	3	
08	OTHER WASTE RECEPTACLE (NOT PEDAL BIN) WITH PLASTIC LINER	1 → 10	2	3	
09	WASTE RECEPTACLE WITH LID (PEDAL BIN) WITHOUT PLASTIC LINER	1	2	3	
10	SHARPS CONTAINER ("SAFETY BOX")	1	2	3	
11	DISPOSABLE LATEX GLOVES	1 → 13	2	3	
12	DISPOSABLE NON-LATEX GLOVES	1	2	3	
13	DISINFECTANT [E.G., HIBITANE, ALCOHOL]	1	2	3	
14	DISPOSABLE NEEDLES	1	2	3	
15	AUTO-DISABLE SYRINGES (3 OR 5 ml)	1	2	3	
16	DISPOSABLE SYRINGES (3 OR 5 ml)	1	2	3	
17	AUDITORY PRIVACY	1	2	3	
18	VISUAL PRIVACY	1	2	3	
19	TABLE CLOTH/PLASTIC ON ANY SURFACE	1	2	3	
1541	ARE ALL SURFACE AREAS IN THE LAB AREA CLEAN OF BLOOD OR OTHER BODY FLUIDS?	YES . . . . . 1 NO 2			
1543	Is there a functioning autoclave in this laboratory or an immediately adjacent area?	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 YES, NOT FUNCTIONING . . . . . 3 NO 4			
1544	Do you decontaminate hazardous waste prior to disposal? IF YES, ASK WHAT PROCEDURE IS USED FOR DECONTAMINATION.	AUTOCLAVE . . . . . A DECONTAMINATE IN CHLORINE-BASED SOLUTION . . B OTHER _____ . X (SPECIFY) NO . . . . . Y			

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1545	What is the final procedure for disposing of hazardous laboratory waste? PROBE TO ARRIVE AT THE USUAL PRACTICE FOR THE LAB	**BURN IN INCINERATOR:** 2-CHAMBER INDUSTRIAL (800-1000+° C). . . . . 02 1-CHAMBER DRUM/BRICK . . . . . 03 **OPEN BURNING** FLAT GROUND-NO PROTECTION . . . . . 04 PIT OR PROTECTED GROUND . . . . . 05 **DUMP WITHOUT BURNING** FLAT GROUND-NO PROTECTION . . . . . 06 COVERED PIT OR PIT LATRINE . . . . . 07 OPEN PIT-NO PROTECTION . . . . . 08 PROTECTED GROUND OR PIT . . . . . 09 **REMOVE OFFSITE** STORED IN COVERED CONTAINER . . . . . 10 STORED IN OTHER PROTECTED ENVIRONMENT . . . . . 11 STORED UNPROTECTED . . . . . 12 **OTHER** _____ 96 (SPECIFY) NEVER HAVE HARZARDOUS WASTE 95	
1546	Is there a program for routine preventive maintenance for the laboratory equipment? This means the equipment is checked periodically even if there is no problem. IF YES, ASK: Is the person responsible for this maintenance assigned to the facility or from outside the facility?	YES, ONSITE STAFF . . . . . 1 YES, OUTSIDE SUPPORT . . . . . 2 YES, BOTH ONSITE AND OUTSIDE 3 NO ROUTINE MAINTENANCE . . . . 4 DON'T KNOW 8	
1547	Does this facility determine the quantity of each test kit or reagent that it needs and order that, or is the quantity that you receive determined elsewhere?	DETERMINES NEEDS AND ORDERS 1 NEEDS DETERMINED ELSEWHERE 2 BOTH (DEPENDS ON KIT/REAGENT) 3 DON'T KNOW 8	

1548	Now I would like to see specific tests, or equipment necessary for these tests. Are the following tests or equipment available and functioning today?	(a) TEST CONDUCTED		(b) EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?			(c) IS THE ITEM IN WORKING ORDER?		
		Yes	No	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	ANY HEMATOLOGY TESTS	1	2 → 1549						
02	Haematology analyzer (for total lymphocyte count, full blood count, platelet count, etc.)	1 → b	2 → 03	1 → c	2 → c	3 → 03	1 → 1549	2	8
03	Hemoglobinometer/HemoCue	1 → b	2 → 04	1 → c	2 → c	3 → 04	1	2	8
04	Colorimeter or spectroscope	1 → b	2 → 06	1 → c	2 → c	3 → 06	1	2	8
05	Drabkin's solution (for colorimeter)			1	2	3			
06	Centrifuge for hematocrit	1 → b	2 → 08	1 → c	2 → c	3 → 08	1	2	8
07	Capillary tubes for hematocrit			1	2	3			
08	Litmus paper for haemoglobin test (with valid expiration date)	1 → b	2 → 09	1	2	3			
09	Other anaemia test_____ (SPECIFY)	1 → b	2 → 1549	1	2	3			

NO.	QUESTIONS	CODING CATEGORIES						GO TO
1549	Are the following tests or equipment available and functioning today?	(a) TEST CONDUCTED		(b) EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?			(c) IS THE ITEM IN WORKING ORDER?		
		Yes	No	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	SYPHILIS TESTS	1	2 → 1550						
02	VDRL	1 → b	2 → 03	1	2	3			
03	PCR for STIs (CTN)	1 → b	2 → 04	1	2	3			
04	Rotator or shaker			1 → c	2 → c	3 → 05	1	2	8
05	Rapid plasma reagin test (RPR)	1 → b	2 → 1550	1	2	3			

BLOOD TRANSFUSION AND SCREENING (MAY NEED TO GO TO OTHER UNIT)

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1550	Does this facility ever conduct blood typing? IF YES, ASK TO SEE THE REAGENTS BELOW.	YES . . . . . 1 NO 2	→ 1552
1551		OBSERVED / REPORTED NOT SEEN / NOT AVAILABLE	
01	Anti-A Reagent (with valid expiration date)	1 / 2 / 3	
02	Anti-B Reagent (with valid expiration date)	1 / 2 / 3	
03	Anti-AB Reagent (with valid expiration date)	1 / 2 / 3	
04	Anti-D Reagent (with valid expiration date)	1 / 2 / 3	
05	Incubator (37 degrees Celsius)	1 / 2 / 3	
06	Coomb's reagent	1 / 2 / 3	
1552	Is blood ever transfused in this facility?	YES . . . . . 1 NO 2	→ 1558
1553	Is blood ever stored anywhere in the facility prior to transfusion? IF YES, ASK TO SEE THE FRIDGE THAT IS USED AND INDICATE THE STORAGE CONDITIONS	BLOOD/PLASMA STORED ALONE . . 1 BLOOD STORED W/MEDS/VACCINES 2 BLOOD STORED W/LAB REAGENTS 3 NO BLOOD EVER STORED . . . . . 4 UNABLE TO OBSERVE/DK 8	
1554	Does any place in this facility do blood screening for infectious diseases prior to transfusion? IF THE FACILITY RECEIVES BLOOD THAT IS ALREADY SCREENED, RESPONSE "2" APPLIES.	YES . . . . . 1 BLOOD SCREENED OUTSIDE FACILITY . . . . . 2 NO SCREENING TESTS DONE 3	→ 1558
1555	Is blood that is transfused in this facility screened for any of the following diseases? IF YES, ASK: Is the blood "always", "most of the time", rarely" or "never" screened for:	ALWAYS / MOST OF THE TIME / RARELY / NEVER	
01	Syphilis	1 / 2 / 3 / 4	
02	Hepatitis B	1 / 2 / 3 / 4	
03	Hepatitis C	1 / 2 / 3 / 4	
04	HIV	1 / 2 / 3 / 4	
1556	Do you ever send blood outside for screening for any of the 4 tests mentioned in the previous question?	YES . . . . . 1 NO 2	→ 1558
1557	INDICATE IF THERE IS AN OBSERVED RECORD OF RESULTS FOR TESTS CONDUCTED OUTSIDE.	(a) SEND SPECIMEN OUTSIDE FOR TEST: YES / NO (b) RECORD OF TEST RESULTS OBSERVED: YES / NO	
01	Syphilis	1 → b / 2 ↓ / 1 / 2	
02	Hepatitis B	1 → b / 2 ↓ / 1 / 2	
03	Hepatitis C	1 → b / 2 ↓ / 1 / 2	
04	HIV	1 → b / 2 ↓ / 1 / 2	

NO.	QUESTIONS	CODING CATEGORIES						GO TO
	BIOCHEMISTRY							
1558	Are items for the indicated tests available today? Is the equipment functioning?	(a) TEST CONDUCTED		(b) EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?			(c) IS THE ITEM IN WORKING ORDER?	
		Yes	No	OBSERVED	REPORTED NOT SEEN	NORMALLY AVAILABLE NOT TODAY	YES	NO / DON'T KNOW
01	Blood chemistry analyzer that provides serum creatinine, glucose, liver function tests)	1 → b	2 → 02	1 → c	2 → c	3 → 02	1 → 1559	2 / 8
02	Other means for serum glucose	1 → b	2 → 1559	1 → c	2 → c	3 → 1559	1	2 / 8
1559 01	URINE TESTS	1	2 → 1560					
02	Any dip sticks for urine protein (with valid expiration date)	1 → b	2 → 03	1	2	3		
03	Any dip sticks for urine glucose (with valid expiration date)	1 → b	2 → 04	1	2	3		
04	Acetic acid for checking urine albumin	1 → b	2 → 06	1	2	3		
05	Flame for heating acetic acid			1 → c	2 → c	3 → 06	1	2 / 8
06	Benedict's solution (for glucose testing)	1 → b	2 → 08	1	2	3		
07	Stove for boiling Benedict's solution			1 → c	2 → c	3 → 08	1	2 / 8
08	Centrifuge for urine testing	1 → b	2 → 1560	1 → c	2 → c	3 → 1560	1	2 / 8
1560	Pregnancy test	1 → b	2 → 1561	1	2	3		
1561	Do you ever send ***blood or urine*** outside the facility for blood chemistries, LFTs, urinalysis or pregnancy tests?	YES . . . . . 1 NO 2						→ 1563

1562	INDICATE IF THERE IS AN OBSERVED RECORD OF RESULTS FOR TESTS CONDUCTED OUTSIDE.	(a) SEND SPECIMEN OUTSIDE FOR TEST		(b) RECORD OF TEST RESULTS OBSERVED	
		YES	NO	YES	NO
01	Blood chemistries (serum creatinine and glucose)	1 → b	2 ↓	1	2
02	Liver Function Test (LFT)	1 → b	2 ↓	1	2
03	Urinalysis	1 → b	2 ↓	1	2
04	Pregnancy test	1 → b	2 ↓	1	2

NO.	QUESTIONS	CODING CATEGORIES						GO TO
	MICROBIOLOGY							
1563	Now I want to ask you about different laboratory equipment and tests. For each item I mention, please tell me if the item/test is available, if all items to conduct the test are present, and if equipment is functioning today,	(a) EQUIPMENT/ TEST USED		(b) EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?			(c) IS THE ITEM IN WORKING ORDER?		
		Yes	No	OBSERVED	REPORTED NOT SEEN	NORMALLY AVAILABLE NOT TODAY	YES	NO	DON'T KNOW
01	Microscope	1→b	2 → 02	1 → c	2 → c	3 → 02	1	2	8
02	Refrigerator	1→b	2 → 03	1 → c	2 → c	3 → 03	1	2	8
03	Incubator	1→b	2 → 04	1 → c	2 → c	3 → 04	1	2	8
04	Test tubes	1→b	2 → 05	1	2	3			
05	Centrifuge for CSF microscopy	1→b	2 → 06	1 → c	2 → c	3 → 06	1	2	8
06	Glass slides and covers	1→b	2 → 1564	1	2	3			
1564 01	**MALARIA TESTS**	1	2 → 1565						
02	Giemsa stain	1→b	2 → 03	1	2	3			
03	Field stain	1→b	2 → 04	1	2	3			
04	Rapid test (test strips, ICT, Paracheck, etc)	1→b	2 → 05	1	2	3			
05	Acridine Orange (AO microscope, and Acridine orange stain)	1→b	2 → 06	1	2	3			
06	Other test for malaria_____ (SPECIFY)	1→b	2 → 1564C	1	2	3			
1564C	Is there an established system for quality control for the reading of malaria slide are prepared and read by this laboratory?	YES, INTERNAL QC . . . . . 1 YES, EXTERNAL QC . . . . . 2 YES, BOTH INTERNAL AND EXTERNAL QUALITY CONTROL . . 3 NO QUALITY CONTROL SYSTEM . . 4 DON'T PREPARE SLIDES 5 DON'T KNOW 8						

NO.	QUESTIONS	CODING CATEGORIES							GO TO
1565	OTHER MICROBIOLOGY TESTS	(a) TEST CONDUCTED		(b) EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?			(c) IS THE ITEM IN WORKING ORDER?		
		Yes	No	OBSERVED	REPORTED, NOT SEEN	NORMALLY AVAILABLE NOT TODAY	YES	NO	DON'T KNOW
01	Indian ink stain	1→b	2 → 1566	1	2	3			
1566 01	**GONORRHEA TESTS**	1	2 → 1567						
02	Chocolate agar (culture medium)	1→b	2 → 03	1	2	3			
03	Oxidase Reagent	1→b	2 → 04	1	2	3			
04	Thayer-Martin or Modified TM or Vancomycin-free selective medium (VFSM)	1→b	2 → 1567	1	2	3			
1567 01	**GRAM STAIN**	1	2 → 1568						
02	Crystal violet or Gentian violet			1	2	3			
03	Lugol's iodine			1	2	3			
04	Acetone or Acetone alcohol			1	2	3			
05	Neutral red, carbol fuchsin, or other counter stain			1	2	3			
1568 01	**CHLAMYDIA TEST**	1	2 → 1569						
02	Giemsa stain	1→b	2 → 03	1	2	3			
03	PCR	1→b	2 → 04	1	2	3			
04	Other test for chlamydia_____ (SPECIFY)	1	2 → 1569	1	2	3			
1569	Urine microscopy	1→b	2 → 1570	1	2	3			
1570 01	**TUBERCULOSIS TEST**	1	2 → 1570C						
02	Ziehl-Neelson test for AFB	1	2 → 06						
03	Carbol-Fuchsin	1→b	2 → 04	1	2	3			
04	20% Sulphuric Acid	1→b	2 → 05	1	2	3			
05	Methylene Blue	1→b	2 → 06	1	2	3			
06	Fluorescence Microscope (FM)	1→b	2 → 07	1	2	3 → 07	1	2	8
07	New rapid test for TB	1→b	2 → 08	1	2	3			
08	Culture medium (e.g., MGIT 960)	1→b	2 → 09	1	2	3			
09	All items for other tests for TB SPECIFY_____	1→b	2 → 1570C	1	2	3			

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1570C	Does this laboratory send TB specimens outside for testing (e.g., to another facility either in Namibia or to South Africa?)	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
1571	Is there a system for internal or external quality control for the TB sputum smears assessed in this laboratory?	YES, INTERNAL QUALITY CONTROL . . . . . 1 YES, EXTERNAL INSPECTION/OBSERVATION. . . . . 2 YES, BOTH INTERNAL AND EXTERNAL Q.C. . . . . 3 SEND SLIDE FOR RE-READING. . . . 4 OTHER _____ 6 (SPECIFY) NO QUALITY CONTROL . . . . . 5 DON'T KNOW 8	→ 1573
1572	Are there records of the results from the internal or external quality control procedures?	YES, RECORDS FOR IQC ONLY . . 1 YES, RECORDS FOR EQC ONLY . . 2 YES, RECORDS FOR BOTH QC PROCEDURES . . . . . 3 DON'T KNOW 8	
1573	Does this laboratory conduct sensitivity testing for TB drugs? IF YES, ASK IF ALL COMPONENTS ARE AVAILABLE TODAY	YES, ALL COMPONENTS PRESENT. 1 YES, BUT NOT ALL COMPONENTS PRESENT TODAY . . . . . 2 NO SENSITIVITY TESTING 3	
1574	Does this laboratory have a record of TB test results? IF YES: May I please see the register?	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 NO 3	 → 1576 → 1576
1575	WHEN WAS THE LAST ENTRY IN THE REGISTER FOR TB TEST RESULTS?	WITHIN 30 DAYS . . . . . 1 MORE THAN 30 DAYS AGO 2	
1576	Do you ever send any specimen outside for Gram staining, Indian Ink staining, malaria testing or for culture?	YES . . . . . 1 NO 2	 → 1578

1577	INDICATE IF THERE IS AN OBSERVED RECORD OF RESULTS FOR TESTS CONDUCTED OUTSIDE.	(a) SEND SPECIMEN OUTSIDE FOR TEST		(b) RECORD OF TEST RESULTS OBSERVED	
		YES	NO	YES	NO
01	Gram stain	1 → b	2 ↓	1	2
02	Indian ink stain	1 → b	2 ↓	1	2
03	Malaria	1 → b	2 ↓	1	2
04	Specimen for culture	1 → b	2 ↓	1	2

NO.	QUESTIONS	CODING CATEGORIES	GO TO
	PATHOLOGY		
1578	Does this facility have a pathology department or other location where PAP smears or histology exams are carried out? IF YES, ASK TO SPEAK WITH THE PERSON MOST FAMILIAR WITH THE TESTS	YES . . . . . 1 NO 2	→ 1580

1579	Do you have all items today, for performing:	**ARE ALL ITEMS FOR TEST AVAILABLE?**				
		AVAILABLE TODAY		NORMALLY AVAILABLE NOT TODAY	NO TEST THIS FACILITY	DON'T KNOW
		OBSERVED	REPORTED, NOT SEEN			
01	PAP smears?	1	2	3	4	8
02	Histology?	1	2	3	4	8

	X-RAY/IMAGING		
1580	Does this facility perform diagnostic X-rays, ultrasound, or computerized tomography? IF YES, ASK TO GO TO WHERE THE EQUIPMENT IS LOCATED.	YES . . . . . 1 NO 2	→ **END**

1581	ASK TO SEE THE FOLLOWING EQUIPMENT. IF YOU ARE UNABLE TO SEE AN ITEM, ASK IF IT IS AVAILABLE. FOR EACH ITEM, CIRCLE THE APPROPRIATE CODE:	(b) **EQUIPMENT/ITEMS AVAILABLE?**			(c) **ITEM IN WORKING ORDER?**		
		OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	X-RAY MACHINE	1 → c	2 → c	3 → 02	1	2	8
02	FILM FOR X-RAYS	1	2	3			
03	ULTRASOUND EQUIPMENT	1 → c	2 → c	3 → 04	1	2	8
04	CT SCAN	1 → c	2 → c	3 → **END**	1	2	8

THANK YOUR RESPONDENT FOR THE TIME AND HELP PROVIDED AND PROCEED TO THE NEXT DATA COLLECTION SITE

SECTION 16: MEDICATION AND SUPPLIES

Facility Number: [ ][ ][ ] **Interviewer Code** [ ][ ] QRE TYPE **16**

1600	INDICATE WHICH CLIENTS HAVE ACCESS TO MEDICINES REPORTED IN THIS QRE.	OUTPATIENT ONLY . . . . . 1 INPATIENT ONLY . . . . . 2 BOTH IN AND OUTPATIENT . . . . . 3 AREA LOCKED/NO ACCESS . . . . . 4 NO MEDICINES STORED IN FACILITY 5	 →**STOP** →**END**

FIND THE PERSON IN CHARGE OF MEDICINES. IF HE/SHE IS NOT PRESENT, ASK TO SEE THE PROVIDER MOST KNOWLEDGEABLE ABOUT PHARMACEUTICAL PROCEDURES.

IF THE PROVIDER IS DIFFERENT FROM THE PREVIOUS RESPONDENT, INTRODUCE YOURSELF, BRIEFLY. EXPLAIN THE PURPOSE OF YOUR VISIT, AND ASK IF HE/SHE WOULD BE WILLING TO ANSWER A FEW QUESTIONS ABOUT PHARMACEUTICAL SUPPLIES FOR THE FACILITY. IF IN AGREEMENT, READ THE INTRODUCTORY CONSENT FORM BELOW.
IF THE RESPONDENT HAS ALREADY BEEN INTERVIEWED FOR A PREVIOUS SECTION, CIRCLE NUMBER 1 (YES) IN Q1604 BELOW AND GO ON TO Q1605.

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER RESPONSIBLE FOR THE PHARMACEUTICALS WHO IS PRESENT TODAY. READ THE FOLLOWING GREETING:

Good day! My name is _____. We are here on behalf of the Ministry of Health and Social Services (MOHSS) conducting a study to assist the government in knowing more about health services in Namibia. Now I will read a statement explaining the study.

ALL facilities in the country are participating in this study. We will be asking you questions about various health services and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility may be used by the MOHSS, organizations supporting services in your facility, and researchers, for planning service improvement or for conducting further studies of health services.

Neither your name nor that of any other health worker respondents participating in this study will be included in the dataset or in any report; however, there is a small chance that any of these respondents may be identified later. Still, we are asking for your help to ensure that the information we collect is accurate.

You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will answer the questions, which will benefit the services you provide and the nation.

If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate if you introduce us to that person to help us collect that information.

At this point, do you have any questions about the study? Do I have your agreement to proceed?

_____ [ ][ ] [ ][ ] **2 0 0 9**
Interviewer's signature — DAY | MONTH | YEAR
SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.

1604	May I begin the interview now?	YES . . . . . 1 NO 2	 → STOP

NO	MEDICATION/SUPPLY ITEM	CODING CATEGORIES	
1605	Is counselling related to HIV/AIDS ever provided by staff from this medicine storage area? By counselling I mean providing information and support other than telling clients how to take the medicines you provide.	YES, GENERAL COUNSELLING RELATED TO HIV/AIDS . . . . . A YES, ADHERENCE COUNSELLING FOR ART . . . . . B NO COUNSELLING . . . . . Y	
1606	Is there a register or stock cards where the amount of each medicine received, the amount issued and the stock on hand today is recorded? IF YES, ASK: May I see the records?	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3	 → 1609
1607	On average, how often do you update or reconcile your inventory/stock records? CIRCLE THE CLOSEST DESCRIPTION	DAILY . . . . . 01 WEEKLY . . . . . 02 MONTHLY . . . . . 03 EVERY 6 WEEKS . . . . . 04 EVERY 6 MONTHS . . . . . 05 WHENEVER I RECEIVE OR ISSUE STOCK . . . . . 06 NEVER 07	

1608	Is the stock maintenance system computerized? IF YES, ASK: Is it computerized for all medicines or only for ARVs?	YES, ALL MEDICINES . . . . . 1 YES, ARVs ONLY . . . . . 2 NO COMPUTERIZED SYSTEM 3	→ 1609
1608A	CIRCLE THE RESPONSE THAT BEST DESCRIBES THE SYSTEM IN PREVIOUS QUESTION, FOR THE NON-COMPUTERIZED SYSTEM	STOCK RECORDS UPDATED DAY ITEM DISBURSED . . . . . 1 STOCK RECORDS NOT ALWAYS UPDATED WHEN ITEM DISBURSED, BUT REGISTER OF DISTRIBUTED ITEMS OBSERVED . . 2 OTHER _____ 6 (SPECIFY)	

ASK TO SEE THE FOLLOWING MEDICATIONS AND SUPPLIES. IF THE ITEM IS LOCATED IN A DIFFERENT PART OF THE FACILITY, GO THERE TO OBSERVE IT. IF YOU ARE UNABLE TO SEE AN ITEM, ASK IF IT IS AVAILABLE. FOR EACH ITEM, CIRCLE THE APPROPRIATE CODE: FOR ALL ITEMS THAT ARE OBSERVED, ASK IF THERE HAS BEEN ANY STOCK OUT (NONE OF THE MEDICINE AVAILABLE) DURING THE LAST SIX MONTHS.

1609	GENERAL MEDICINES CHECK INVENTORY	(a) AVAILABILITY OF MEDICINES OBSERVED AVAILABLE			NOT OBSERVED			(b) OUT OF STOCK IN LAST SIX MONTHS		
		ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE	YES	NO	DK
01	Acetaminophen/ paracetamol (oral tabs)		2 → b	3 02	4 02	5 02	6 02	1	2	8
02	paracetamol (oral suspension)		2 → b	3 03	4 03	5 03	6 03	1	2	8
03	Acetylsalicylic acid/ aspirin (oral tabs)		2 → b	3 04	4 04	5 04	6 04	1	2	8
04	Acyclovir (ophthalmic)		2 → b	3 05	4 05	5 05	6 05	1	2	8
05	Acyclovir (oral)		2 → b	3 06	4 06	5 06	6 06	1	2	8
06	Albendazole (oral tabs)		2 → b	3 07	4 07	5 07	6 07	1	2	8
07	Amoxicillin (oral caps)	1 → b	2 → b	3 08	4 08	5 08	6 08	1	2	8
08	Amoxicillin (Oral suspension)	1 → b	2 → b	3 09	4 09	5 09	6 09	1	2	8
09	Amoxicillin/clavulanate (Augmentin) (oral tabs)		2 → b	3 10	4 10	5 10	6 10	1	2	8
10	Amoxicillin/clavulanate (Augmentin) (oral suspension)		2 → b	3 11	4 11	5 11	6 11	1	2	8
11	Amoxicillin (inj)	1 → b	2 → b	3 12	4 12	5 12	6 12	1	2	8
12	Ampicillin (inj)	1 → b	2 → b	3 13	4 13	5 13	6 13	1	2	8
13	Ampicillin (oral caps)	1 → b	2 → b	3 14	4 14	5 14	6 14	1	2	8
14	Ampicillin (Oral suspension)	1 → b	2 → b	3 15	4 15	5 15	6 15	1	2	8
15	Amphotericin B (inj)		2 → b	3 16	4 16	5 16	6 16	1	2	8
16	Bleomycin (Inj)		2 → b	3 17	4 17	5 17	6 17	1	2	8
17	Cefalexin (oral caps/tabs)		2 → b	3 18	4 18	5 18	6 18	1	2	8

	GENERAL MEDICINES CHECK INVENTORY	(a) AVAILABILITY OF MEDICINES OBSERVED AVAILABLE			NOT OBSERVED			(b) OUT OF STOCK IN LAST SIX MONTHS		
		ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAIL-ABLE TODAY/DK	NEVER AVAIL-ABLE	YES	NO	DK
18	Cefalexin (oral suspension)		2 → b	3 19	4 19	5 19	6 19	1	2	8
19	Cefotaxime (Inj)		2 → b	3 20	4 20	5 20	6 20	1	2	8
20	Ceftriaxone (Rocephin) (inj)	1 → b	2 → b	3 21	4 21	5 21	6 21	1	2	8
21	Chloramphenicol (oral caps)	1 → b	2 → b	3 22	4 22	5 22	6 22	1	2	8
22	Chloramphenicol (oral suspension)	1 → b	2 → b	3 23	4 23	5 23	6 23	1	2	8
23	Chloramphenicol (inj)	1 → b	2 → b	3 24	4 24	5 24	6 24	1	2	8
24	Cidofovir (injection)		2 → b	3 25	4 25	5 25	6 25	1	2	8

	GENERAL MEDICINES CHECK INVENTORY	(a) AVAILABILITY OF MEDICINES OBSERVED AVAILABLE ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	NOT OBSERVED REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE	(b) OUT OF STOCK IN LAST SIX MONTHS YES	NO	DK
25	Ciprofloxacin (oral tabs)		2 → b	3 → 26	4 → 26	5 → 26	6 → 26	1	2	8
26	Clarithromycin (Biaxin) (oral tabs)		2 → b	3 → 27	4 → 27	5 → 27	6 → 27	1	2	8
27	Clarithromycin (oral suspension)		2 → b	3 → 28	4 → 28	5 → 28	6 → 28	1	2	8
28	Clindamycin (oral or inj)		2 → b	3 → 29	4 → 29	5 → 29	6 → 29	1	2	8
29	Clotrimazole (topical cream/ointment)		2 → b	3 → 30	4 → 30	5 → 30	6 → 30	1	2	8
30	Clotrimazole (vaginal supp)		2 → b	3 → 31	4 → 31	5 → 31	6 → 31	1	2	8
31	Codeine (oral tabs)		2 → b	3 → 32	4 → 32	5 → 32	6 → 32	1	2	8
32	Co-trimoxazole (oral tabs)		2 → b	3 → 33	4 → 33	5 → 33	6 → 33	1	2	8
33	Co-trimoxazole (oral suspension)		2 → b	3 → 34	4 → 34	5 → 34	6 → 34	1	2	8
34	Cloxacillin (oral caps)		2 → b	3 → 35	4 → 35	5 → 35	6 → 35	1	2	8
35	Cloxacillin (oral suspension)		2 → b	3 → 36	4 → 36	5 → 36	6 → 36	1	2	8
36	Cloxacillin (inj)		2 → b	3 → 37	4 → 37	5 → 37	6 → 37	1	2	8
37	Dapsone (oral tabs)		2 → b	3 → 38	4 → 38	5 → 38	6 → 38	1	2	8
38	Dexamethasone (oral tabs)		2 → b	3 → 39	4 → 39	5 → 39	6 → 39	1	2	8
39	Dexamethasone (inj)		2 → b	3 → 40	4 → 40	5 → 40	6 → 40	1	2	8
40	Diazepam (oral tabs)		2 → b	3 → 41	4 → 41	5 → 41	6 → 41	1	2	8
41	Diazepam (inj) (Valium)		2 → b	3 → 42	4 → 42	5 → 42	6 → 42	1	2	8
42	Diclofenac (oral or inj)		2 → b	3 → 43	4 → 43	5 → 43	6 → 43	1	2	8
43	Dipyrone (inj) (Novalgin)		2 → b	3 → 44	4 → 44	5 → 44	6 → 44	1	2	8
44	Diphenoxylate (lomotil) (oral tabs/caps)		2 → b	3 → 45	4 → 45	5 → 45	6 → 45	1	2	8
45	Doxycycline (oral caps)	1 → b	2 → b	3 → 46	4 → 46	5 → 46	6 → 46	1	2	8
46	Ergometrine (or methergine Oral tabs)		2 → b	3 → 47	4 → 47	5 → 47	6 → 47	1	2	8
47	Syntocin or oxytocin (inj)		2 → b	3 → 48	4 → 48	5 → 48	6 → 48	1	2	8
48	Erythromycin (oral tabs)	1 → b	2 → b	3 → 49	4 → 49	5 → 49	6 → 49	1	2	8
49	Erythromycin (oral suspension)	1 → b	2 → b	3 → 50	4 → 50	5 → 50	6 → 50	1	2	8
50	Famciclovir (oral tabs)		2 → b	3 → 51	4 → 51	5 → 51	6 → 51	1	2	8
51	Fluconazole (oral or inj)		2 → b	3 → 52	4 → 52	5 → 52	6 → 52	1	2	8

	GENERAL MEDICINES CHECK INVENTORY	(a) AVAILABILITY OF MEDICINES OBSERVED AVAILABLE ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	NOT OBSERVED REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE	(b) OUT OF STOCK IN LAST SIX MONTHS YES	NO	DK
52	Folic Acid (oral tabs)		2 → b	3 53	4 53	5 53	6 53	1	2	8
53	Ganciclovir (oral or inj)		2 → b	3 54	4 54	5 54	6 54	1	2	8
54	Gentamicin (inj)		2 → b	3 55	4 55	5 55	6 55	1	2	8
55	Gentian Violet (GV paint)		2 → b	3 56	4 56	5 56	6 56	1	2	8
56	Ibuprofen (oral tabs)		2 → b	3 57	4 57	5 57	6 57	1	2	8
57	Ibuprofen (oral syrup)		2 → b	3 58	4 58	5 58	6 58	1	2	8
58	Indomethacin (suppository)		2 → b	3 59	4 59	5 59	6 59	1	2	8
59	Iron tabs (oral)		2 → b	3 60	4 60	5 60	6 60	1	2	8
60	Iron tabs with folic		2 → b	3 61	4 61	5 61	6 61	1	2	8
61	Itraconazole (oral tabs/caps)		2 → b	3 62	4 62	5 62	6 62	1	2	8
62	Kanamycin (inj)	1 → b	2 → b	3 63	4 63	5 63	6 63	1	2	8
63	Ketoconazole (oral or topical)	1 → b	2 → b	3 64	4 64	5 64	6 64	1	2	8
64	Loperamide (Imodium) (oral tabs/caps)	1 → b	2 → b	3 65	4 65	5 65	6 65	1	2	8
65	Magnesium sulphate (inj)		2 → b	3 66	4 66	5 66	6 66	1	2	8
66	Mebendazole (oral tabs)		2 → b	3 67	4 67	5 67	6 67	1	2	8
67	Methyldopa (aldomet) (oral tabs)		2 → b	3 68	4 68	5 68	6 68	1	2	8
68	Metronidazole intravenous		2 → b	3 69	4 69	5 69	6 69	1	2	8
69	Metronidazole (oral tabs/caps)		2 → b	3 70	4 70	5 70	6 70	1	2	8
70	Metronidazole (oral suspension)		2 → b	3 71	4 71	5 71	6 71	1	2	8
71	Miconazole (vaginal supp)	1 → b	2 → b	3 72	4 72	5 72	6 72	1	2	8
72	Miconazole cream		2 → b	3 73	4 73	5 73	6 73	1	2	8
73	Morphine (oral powder for suspension)		2 → b	3 74	4 74	5 74	6 74	1	2	8
74	Multivitamins (oral tabs)		2 → b	3 75	4 75	5 75	6 75	1	2	8
75	Nalidixic acid (oral tabs)		2 → b	3 76	4 76	5 76	6 76	1	2	8
76	Nitrofurantoin (oral tabs)		2 → b	3 77	4 77	5 77	6 77	1	2	8

	GENERAL MEDICINES	(a) AVAILABILITY OF MEDICINES						(b) OUT OF STOCK IN LAST SIX MONTHS		
		OBSERVED AVAILABLE			NOT OBSERVED					
	CHECK INVENTORY	ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAIL-ABLE TODAY/DK	NEVER AVAIL-ABLE	YES	NO	DK
77	Nitrofurazone (ointment)		2 → b	3 → 78	4 → 78	5 → 78	6 → 78	1	2	8
78	Norfloxacin (oral tabs)	1 → b	2 → b	3 → 79	4 → 79	5 → 79	6 → 79	1	2	8
79	Nystatin (oral suspension)	1 → b	2 → b	3 → 80	4 → 80	5 → 80	6 → 80	1	2	8
80	Nystatin (vaginal supp./cream)	1 → b	2 → b	3 → 81	4 → 81	5 → 81	6 → 81	1	2	8
81	Oral rehydration salts	1 → b	2 → b	3 → 82	4 → 82	5 → 82	6 → 82	1	2	8
82	Penicillin, Benzathine (Inj)		2 → b	3 → 83	4 → 83	5 → 83	6 → 83	1	2	8
83	Penicillin Benzyl (Inj)	1 → b	2 → b	3 → 84	4 → 84	5 → 84	6 → 84	1	2	8
84	Penicillin, procaine (Inj)	1 → b	2 → b	3 → 85	4 → 85	5 → 85	6 → 85	1	2	8
85	Penicillin-V (oral tabs/caps)	1 → b	2 → b	3 → 86	4 → 86	5 → 86	6 → 86	1	2	8
86	Penicillin-V (oral suspension)	1 → b	2 → b	3 → 87	4 → 87	5 → 87	6 → 87	1	2	8
87	Phenobarbital (oral or inj)	1 → b	2 → b	3 → 88	4 → 88	5 → 88	6 → 88	1	2	8
88	Prednisolone (or other steroid) (oral)		2 → b	3 → 89	4 → 89	5 → 89	6 → 89	1	2	8
89	Silver nitrate eye drop		2 → b	3 → 90	4 → 90	5 → 90	6 → 90	1	2	8
90	Spectinomycin, inj		2 → b	3 → 91	4 → 91	5 → 91	6 → 91	1	2	8
91	Sulfadiazine (cream/ointment)	1 → b	2 → b	3 → 92	4 → 92	5 → 92	6 → 92	1	2	8
92	Tetracycline (oral caps)		2 → b	3 → 93	4 → 93	5 → 93	6 → 93	1	2	8
93	Tetracycline eye ointment		2 → b	3 → 94	4 → 94	5 → 94	6 → 94	1	2	8
94	Tinidazole (oral tabs)		2 → b	3 → 95	4 → 95	5 → 95	6 → 95	1	2	8
95	Valganciclovir		2 → b	3 → 96	4 → 96	5 → 96	6 → 96	1	2	8
96	Vincristine (inj)		2 → b	3 → 97	4 → 97	5 → 97	6 → 97	1	2	8
97	Vitamin A (100,000 or 50,000 iu)		2 → b	3 → 98	4 → 98	5 → 98	6 → 98	1	2	8
98	Vitamin A (200,000iu)		2 → b	3 → 99	4 → 99	5 → 99	6 → 99	1	2	8
99	Vitamin B6 (pyridoxine) (oral tabs)		2 → b	3 → 100	4 → 100	5 → 100	6 → 100	1	2	8
100	Other B vitamins (oral)		2 → b	3 → 101	4 → 101	5 → 101	6 → 101	1	2	8
101	Xylocaine or lidocaine 1% or 2% (inj)		2 → b	3 → 102	4 → 102	5 → 102	6 → 102	1	2	8
102	Vitamin K (inj)		2 → b	3 → 1610	4 → 1610	5 → 1610	6 → 1610	1	2	8

1610	**ANTIMALARIALS**	(a) AVAILABILITY OF MEDICINES						(b) OUT OF STOCK IN LAST SIX MONTHS		
		OBSERVED AVAILABLE			NOT OBSERVED					
	CHECK INVENTORY	ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE	YES	NO	DK
01	Dihydroartemisinine (oral tabs) (Cotexin, Arinate, Artesunate)	1 → b	2 → b	3 02	4 02	5 02	6 02	1	2	8
02	Artermether-Lumefantrine (COARTEM)	1 → b	2 → b	3 03	4 03	5 03	6 03	1	2	8
03	Sulfadoxin+Pyrimethamine (Fansidar, Metakelfin, Orodar)	1 → b	2 → b	3 04	4 04	5 04	6 04	1	2	8
04	Quinine (oral tabs)	1 → b	2 → b	3 05	4 05	5 05	6 05	1	2	8
05	Quinine (inj)	1 → b	2 → b	3 06	4 06	5 06	6 06	1	2	8
06	Chloroquine (oral tabs)	1 → b	2 → b	3 07	4 07	5 07	6 07	1	2	8
07	Chloroquine (inj)	1 → b	2 → b	3 08	4 08	5 08	6 08	1	2	8
08	Amodiaquine (oral tabs)	1 → b	2 → b	3 09	4 09	5 09	6 09	1	2	8
09	Amodiaquine (oral syrup)	1 → b	2 → b	3 10	4 10	5 10	6 10	1	2	8
10	Mefloquine (oral tabs)	1 → b	2 → b	3 11	4 11	5 11	6 11	1	2	8
11	Other _____ (SPECIFY)	1 → b	2 → b	3 1611	4 1611	5 1611	6 1611	1	2	8
1611	**TUBERCULOSIS**									
01	Ethambutol (oral tabs)		2 → b	3 02	4 02	5 02	6 02	1	2	8
02	Isoniazid (oral tabs)		2 → b	3 03	4 03	5 03	6 03	1	2	8
03	Pyrazinamide (oral tabs)		2 → b	3 04	4 04	5 04	6 04	1	2	8
04	Rifampicin (oral tabs)		2 → b	3 05	4 05	5 05	6 05	1	2	8
05	Streptomycin (inj)		2 → b	3 06	4 06	5 06	6 06	1	2	8
06	Isoniazid + Rifampicin (Rifina) (oral)		2 → b	3 610	4 610	5 610	6 610	1	2	8
07	Isoniazid+Rifampicin+ Pyrazinamide (RHZ, Rifater)		2 → b	3 08	4 08	5 08	6 08	1	2	8
08	Isoniazid + Ethambutol (EH)		2 → b	3 09	4 09	5 09	6 09	1	2	8
09	4FDC (combination INH, Ethambutol, Pyrazinamide, Rifampicin)		2 → b	3 10	4 10	5 10	6 10	1	2	8
10	Amikacin inj		2 → b	3 11	4 11	5 11	6 11	1	2	8
11	Capreomycin inj		2 → b	3 12	4 12	5 12	6 12	1	2	8
12	Cycloserin (oral tabs)		2 → b	3 13	4 13	5 13	6 13	1	2	8
13	Ethionamide (oral tabs)		2 → b	3 14	4 14	5 14	6 14	1	2	8
14	Levofloxacine (oral tabs)		2 → b	3 15	4 15	5 15	6 15	1	2	8
15	Para-amino Salicylic Acid (Powder) (PAS)		2 → b	3 16	4 16	5 16	6 16	1	2	8
16	Other _____ (SPECIFY)		2 → b	3 1612	4 1612	5 1612	6 1612	1	2	8

1612	**INTRAVENOUS SOLUTION** CHECK INVENTORY	(a) AVAILABILITY OF MEDICINES OBSERVED AVAILABLE: ALL VALID	OBSERVED AVAILABLE: AT LEAST ONE VALID	OBSERVED AVAILABLE: AVAILABLE BUT NONE VALID	NOT OBSERVED: REPORTED AVAILABLE, NOT SEEN	NOT OBSERVED: NOT AVAILABLE TODAY/DK	NOT OBSERVED: NEVER AVAILABLE	(b) OUT OF STOCK IN LAST SIX MONTHS: YES	NO	DK
01	Normal Saline (0.9%NS)		2 → b	3 → 02	4 → 02	5 → 02	6 → 02	1	2	8
02	Dextrose and Normal Saline (5%D/NS)		2 → b	3 → 03	4 → 03	5 → 03	6 → 03	1	2	8
03	Ringers Lactate	1 → b	2 → b	3 → 04	4 → 04	5 → 04	6 → 04	1	2	8
04	Plasma Expander	1 → b	2 → b	3 → 1613	4 → 1613	5 → 1613	6 → 1613	1	2	8
1613	**OTHER**									
01	Infant formula		2 → b	3 → 02	4 → 02	5 → 02	6 → 02	1	2	8
02	Fortified protein supplement		2 → b	3 → 03	4 → 03	5 → 03	6 → 03	1	2	8
03	Male condom		2 → b	3 → 04	4 → 04	5 → 04	6 → 04	1	2	8
04	Female condom		2 → b	3 → 1614	4 → 1614	5 → 1614	6 → 1614	1	2	8

1614	WERE THE MEDICINES ORGANIZED ACCORDING TO DATE OF EXPIRATION ("first expire, first out") VERIFY WHEN CHECKING INDICATED MEDICINES FOR ALL BEING VALID	YES, VERIFIED . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
1615	OBSERVE THE PLACE WHERE MEDICINES ARE STORED AND INDICATE THE PRESENCE (OR ABSENCE) OF EACH OF THE FOLLOWING CONDITIONS:		
01	ARE ALL THE MEDICINES OFF THE FLOOR?	YES . . . . . 1 NO 2	
02	ARE ALL THE MEDICINES PROTECTED FROM WATER?	YES . . . . . 1 NO 2	
03	ARE ALL THE MEDICINES PROTECTED FROM THE SUN?	YES . . . . . 1 NO 2	
04	IS THE ROOM CLEAN OF EVIDENCE OF RODENTS (BATS, RATS) OR PESTS (ROACHES, ETC.)	YES . . . . . 1 NO 2	
1616	Is there a functioning refrigerator, separate from the one used for vaccines, used to store some medicines or reconstituted vials?	OBSERVED, FUNCTIONING . . 1 OBSERVED, NOT FUNCTIONING 2 REPORTED, NOT SEEN . . 3 SAME AS VACCINE FRIDGE . . 4 NO FRIDGE FOR MEDS . . 5	
1617	LOOK AT THE STORAGE AREA AND CIRCLE ALL THAT APPLY	AREA CAN BE LOCKED . . . . A LIMITED ACCESS . . . . B DOORS SOLID . . . . . C WINDOWS W/BARS/SHUTTERS . . D NONE OF THE ABOVE . . . . . Y	
1618	When was the last time that you received a scheduled supply of medicines ? (i.e. from the main order & not interim order)	WITHIN PRIOR 4 WEEKS . . . . 1 BETWEEN 4-12 WEEKS . . . . 2 MORE THAN 12 WEEKS AGO . . . . . 3 NO ROUTINE SUPPLY SYSTEM . . . . . 4 DON'T KNOW 8	
1619	Does this facility determine the quantity of each medicine required and order that, or is the quantity that you receive determined elsewhere?	DETERMINES OWN NEED AND ORDERS . . . . . 1 NEED DETERMINED ELSEWHERE . . . . . 2 BOTH (DIFFERS BY MEDICINE) 3 DON'T KNOW 8	→ 1621 → 1623

1620	Do you always receive a standard fixed supply or does the quantity you receive vary according to the activity level that you report?	QUANTITY BASED ON ACTIVITY LEVEL . . . . . 1 STANDARD FIXED SUPPLY . . 2 DON'T KNOW 8	
1620A	CHECK Q1619. IS "3" (BOTH) CIRCLED? YES ☐ NO ☐		→ 1623
1621	Routinely, when you order medicines, which best describes the system you use to determine ***how much*** of each to order? Do you: - **Review** the amount of each medicine remaining, and order to bring the stock amount to a pre-determined (fixed) amount (max stock level)? - **Order** exactly the same quantity each time, regardless of the existing stock? - **Review** the amount of each medicine used since the previous order, and plan based on prior consumption and expected future consumption? - **Other** _____ (SPECIFY) - Don't know	ORDER TO MAINTAIN FIXED STOCK . . . . . 1 ORDER SAME AMOUNT . . . . 2 ORDER BASED ON UTILIZATION . . . . . 3 OTHER . . . . . 6 DON'T KNOW 8	
1622	Which of the following best describes the routine system for deciding ***when*** to order medicines? Do you: - **Place** order whenever stock levels fall to a predetermined level (the minimum stock level)? - **Have** a fixed time that orders are submitted? - **Place** an order whenever there is believed to be a need, regardless of stock level? - **Other** _____ (SPECIFY) - Don't know	PREDETERMINED LEVEL . . 1 FIXED TIME . . . . . 2 ORDER WHEN NEEDED . . . . 3 OTHER . . . . . 6 DON'T KNOW 8	
1623	If there is a shortage of a specific medicine between routine orders, what is the most common procedure followed by this facility? - Submit special/interim order to normal supplier - Facility purchases from private market (buy-out) - Clients must purchase from outside the facility - Facility borrow from neighboring facility - Nothing	SPECIAL ORDER . . . . . A FACILITY PURCHASE . . . . . B CLIENT PURCHASE OUTSIDE . . C FACILITY BORROWS . . . . . D NONE OF THE ABOVE . . . . . Y	
1624	During the past 3 months, have you always, sometimes, or almost never received the amount of each medicine that you ordered (or that you are supposed to routinely receive)?	ALWAYS . . . . . 1 SOMETIMES . . . . . 2 ALMOST NEVER 3	
1625	Does this facility stock any antiretroviral medicines? IF YES, CLARIFY THE PURPOSE OF THE ANTIRETROVIRAL MEDICINES	YES, FOR HIV/AIDS TREATMENT . . A YES, FOR PEP ONLY . . . . . B YES, FOR PMTCT . . . . . C NO . . . . . Y	→ 1640
1626	What is the source of your antiretrovirals?	CENTRAL MEDICAL STORES . . . . . A REGIONAL MEDICAL STORES . . B DISTRICT HOSPITAL PHARMACY . . C PRIVATE WAREHOUSE . . . . . D PRIVATE PHARMACY . . . . . E NGO/DONORS . . . . . F OTHER _____ (SPECIFY) X	
1627	Is there a register or stock cards where the quantity of each antiretroviral medicine received, the amount issued and the stock on hand today is recorded? IF YES, ASK: May I see the records?	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN 2 NO 3	→ 1629

1628	CIRCLE THE RESPONSE THAT BEST DESCRIBES THE SYSTEM IN PREVIOUS QUESTION.	REGISTER/STOCK CARDS NOT UPDATED DAILY, BUT THERE IS DAILY RECORD OF DISTRIBUTED MEDICINES . 1 REGISTER/STOCK CARDS UPDATED DAILY . . . . . 2 OTHER _____ . . . 6 (SPECIFY)	

1629 ASK TO SEE THE FOLLOWING ANTIRETROVIRALS. IF THESE ARE LOCATED IN A DIFFERENT PART OF THE FACILITY, GO THERE TO OBSERVE IT. IF YOU ARE UNABLE TO SEE AN ITEM, ASK IF IT IS AVAILABLE. FOR EACH ITEM, CIRCLE THE APPROPRIATE CODE. FOR ALL ITEMS THAT ARE OBSERVED, ASK IF THERE HAS BEEN ANY STOCK OUT (NONE OF THE MEDICINE AVAILABLE) **ANYTIME DURING THE LAST SIX MONTHS.**

	ANTIRETROVIRAL MEDICINES	(a) AVAILABILITY OF MEDICINES						(b) OUT OF STOCK IN LAST SIX MONTHS		
		OBSERVED AVAILABLE			NOT OBSERVED					
	CHECK INVENTORY	ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE	YES	NO	DK
	NRTIs									
01	Zidovudine (ZDV,AZT) tabs	1 → b	2 → b	3 02	4 02	5 02	6 02	1	2	8
02	Zidovudine (ZDV,AZT) syrup	1 → b	2 → b	3 03	4 03	5 03	6 03	1	2	8
03	Abacavir/ABC tabs	1 → b	2 → b	3 04	4 04	5 04	6 04	1	2	8
04	Didanosine/ddI tabs	1 → b	2 → b	3 05	4 05	5 05	6 05	1	2	8
05	Lamivudine/3TC tabs	1 → b	2 → b	3 06	4 06	5 06	6 06	1	2	8
06	Lamivudine/3TC syrup	1 → b	2 → b	3 07	4 07	5 07	6 07	1	2	8
07	Stavudine 30 (D4T)	1 → b	2 → b	3 08	4 08	5 08	6 08	1	2	8
08	Stavudine syrup	1 → b	2 → b	3 09	4 09	5 09	6 09	1	2	8
09	Tenofovir (TDF) tabs	1 → b	2 → b	3 10	4 10	5 10	6 10	1	2	8
	NNRTIs									
10	Nevirapine (NVP) tabs	1 → b	2 → b	3 11	4 11	5 11	6 11	1	2	8
11	Nevirapine (NVP) syrup	1 → b	2 → b	3 12	4 12	5 12	6 12	1	2	8
12	Efavirenz (EFV) tabs/caps	1 → b	2 → b	3 13	4 13	5 13	6 13	1	2	8
13	Efavirenz (EFV) syrup	1 → b	2 → b	3 14	4 14	5 14	6 14	1	2	8
14	Delavirdine (DLV)	1 → b	2 → b	3 15	4 15	5 15	6 15	1	2	8

	ANTIRETROVIRAL MEDICINES CHECK INVENTORY	(a) AVAILABILITY OF MEDICINES OBSERVED AVAILABLE ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	NOT OBSERVED REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE	(b) OUT OF STOCK IN LAST SIX MONTHS YES	NO	DK
	PROTEASE INHIBITORS									
15	LOPINAVIR (LPV)	1 → b	2 → b	3 → 16	4 → 16	5 → 16	6 → 16	1	2	8
16	INDINAVIR (IDV)	1 → b	2 → b	3 → 17	4 → 17	5 → 17	6 → 17	1	2	8
17	NELFINAVIR (NFV)	1 → b	2 → b	3 → 18	4 → 18	5 → 18	6 → 18	1	2	8
18	SAQUINAVIR (SQV)	1 → b	2 → b	3 → 19	4 → 19	5 → 19	6 → 19	1	2	8
19	RITONAVIR (RTV)	1 → b	2 → b	3 → 20	4 → 20	5 → 20	6 → 20	1	2	8
20	ATAZANAVIR (ATV)	1 → b	2 → b	3 → 21	4 → 21	5 → 21	6 → 21	1	2	8
21	FOSAMPRENAVIR (FPV)	1 → b	2 → b	3 → 22	4 → 22	5 → 22	6 → 22	1	2	8
22	TIPRANAVIR (TPV)	1 → b	2 → b	3 → 23	4 → 23	5 → 23	6 → 23	1	2	8
23	DARUNAVIR (DRV)	1 → b	2 → b	3 → 24	4 → 24	5 → 24	6 → 24	1	2	8
24	LOPINAVIR-RITONAVIR tabs (LPV/r)	1 → b	2 → b	3 → 25	4 → 25	5 → 25	6 → 25	1	2	8
25	LOPINAVIR-RITONAVIR syrup (LPV/r)	1 → b	2 → b	3 → 26	4 → 26	5 → 26	6 → 26	1	2	8
	FUSION INHIBITORS									
26	Enfuvirtide (T-20)	1 → b	2 → b	3 → 27	4 → 27	5 → 27	6 → 27	1	2	8
	COMBINED-3DRUGS									
27	[3TC/d4T(30)/NVP]	1 → b	2 → b	3 → 28	4 → 28	5 → 28	6 → 28	1	2	8
28	[3TC/AZT/NVP]	1 → b	2 → b	3 → 29	4 → 29	5 → 29	6 → 29	1	2	8
	COMBINED-2DRUGS									
29	[AZT+3TC]	1 → b	2 → b	3 → 30	4 → 30	5 → 30	6 → 30	1	2	8
30	[D4T(30)+3TC]	1 → b	2 → b	3 → 31	4 → 31	5 → 31	6 → 31	1	2	8
31	[Tenofovir + 3TC]	1 → b	2 → b	3 → 32	4 → 32	5 → 32	6 → 32	1	2	8
32	OTHER: (SPECIFY)	1 → b	2 → b	3 → 1630	4 → 1630	5 → 1630	6 → 1630	1	2	8

1630	DESCRIBE THE STORAGE OF THE ANTIRETROVIRAL MEDICINES. ARE THE ANTIRETROVIRALS STORED IN A LOCKED STORAGE UNIT AND SEPARATE FROM OTHER MEDICINES OR SUPPLIES?	STORED ALONE . . . . . 1 STORED WITH NON-ARV MEDICINES . . . . . 2 OTHER _____ (SPECIFY) 6	
1631	OBSERVE THE PLACE WHERE THE ARVs ARE STORED AND INDICATE THE PRESENCE (OR ABSENCE) OF EACH OF THE FOLLOWING CONDITIONS:		
01	ARE ALL THE ARVs OFF THE FLOOR?	YES . . . . . 1 NO 2	
02	ARE ALL THE ARVs PROTECTED FROM WATER?	YES . . . . . 1 NO 2	
03	ARE ALL THE ARVs PROTECTED FROM THE SUN?	YES . . . . . 1 NO 2	
04	IS THE ROOM CLEAN OF EVIDENCE OF RODENTS (BATS, RATS) OR PESTS (ROACHES, ETC.)	YES . . . . . 1 NO 2	
1632	LOOK AT THE ARV STORAGE AREA AND CIRCLE ALL THAT APPLY	AREA CAN BE LOCKED . . . . A LIMITED ACCESS . . . . . B DOORS SOLID . . . . . C WINDOWS W/BARS/SHUTTERS D NONE OF THE ABOVE . . . . . Y	
1633	When was the last time that you received a scheduled supply of ARVs?	WITHIN PRIOR 4 WEEKS . . . . . 1 BETWEEN 4-12 WEEKS . . . . . 2 MORE THAN 12 WEEKS AGO . . . . . 3 NO ROUTINE SUPPLY SYSTEM 4 DON'T KNOW 8	
1634	Does this facility determine the quantity of ARVs required and order that, or is the quantity that you receive determined elsewhere?	DETERMINES OWN NEED AND ORDERS . . . . . 1 NEED DETERMINED ELSEWHERE . . . . . 2 BOTH (DEPENDS ON ARV) . . . . . 3 DON'T KNOW 8	→ 1636 → 1638
1635	Do you always receive a standard fixed supply of ARVs, or does the quantity you receive vary according to the activity level that you report?	QUANTITY BASED ON ACTIVITY LEVEL . . . . . 1 STANDARD FIXED SUPPLY . . 2 DON'T KNOW 8	
1635A	CHECK Q1634 AND INDICATE WHICH RESPONSE IS CIRCLED	"3" CIRCLED (BOTH, DEPENDS ON ARV) . . . 1 "2" CIRCLED (NEED DETERMINED ELSEWHERE) 2	→ 1638
1636	Routinely, when you order ARVs, which best describes the system you use to determine ***how much*** of each to order? Do you:		
	- **Review** the amount of each ARV remaining, and order to bring the stock amount to a pre-determined (fixed) amount?	ORDER TO MAINTAIN FIXED STOCK 1	
	- **Order** exactly the same quantity each time, regardless of the existing stock?	ORDER SAME AMOUNT 2	
	- **Review** the amount of each ARV used since the previous order, and plan based on prior consumption and expected future consumption?	ORDER BASED ON UTILIZATION 3	
	- **Other** _____ (SPECIFY)	OTHER 6	
	- Don't know	DON'T KNOW 8	

1637	Which of the following best describes the routine system (the main one) for deciding ***when*** to order ARVs? Do you: - **Place** order whenever stock levels fall to a predetermined level? - **Have** a fixed time that orders are submitted? - **Place** an order whenever there is believed to be a need, regardless of stock level? - **Other** _____ (SPECIFY) - Don't know	PREDETERMINED LEVEL .. 1 FIXED TIME ..... 2 ORDER WHEN NEEDED ..... 3 OTHER ..... 6 DON'T KNOW 8	
1638	If there is a shortage of a specific ARV between scheduled orders, what is the most common procedure followed by this facility? - Submit interim order to normal supplier - Facility purchases from private market - Clients must purchase from outside the facility - Facility borrow from neighbouring facility - Nothing	SPECIAL ORDER ..... A FACILITY PURCHASE ..... B CLIENT PURCHASE OUTSIDE .... C FACILITY BORROWS ..... D NONE OF THE ABOVE ..... Y	
1639	During the past 3 months, have you always, sometimes, or almost never received the amount of each medicine that you ordered (or that you are supposed to routinely receive)?	ALWAYS ..... 1 SOMETIMES ..... 2 ALMOST NEVER 3	
1640	Are antiretroviral medicines for PEP stored in the same area as ARVs for treatment? IF YES, ASK TO SEE THE PEP MEDICINES.	YES ..... 1 NO ..... 2 DON'T STOCK ARVS FOR PEP 3	 → 1642 → 1644
1641	RECORD WHICH MEDICINES ARE PRESENT FOR PEP	ZIDOVUDINE (AZT) ..... A LAMIVUDINE (3TC) ..... B TENOFOVIR (TDF) ..... C EFAVIRENZ (EFV) ..... D LOPINAVIR (LPV) ..... E INDINAVIR (IDV) ..... F NELVINAVIR (NFV) ..... G OTHER(S) _____ (SPECIFY) X NONE ..... Y	 → 1644
1642	DESCRIBE THE STORAGE OF THE PEP ARVs. ARE THE PEP MEDICINES STORED SEPARATE FROM OTHER MEDICINES OR SUPPLIES?	STORED ALONE ..... 1 STORED WITH OTHER ARVS APART FROM OTHER MEDS 2 STORED WITH NON-ARV MEDICINES ..... 3 OTHER _____ (SPECIFY) 6	
1643	DESCRIBE THE SECURITY FOR THE PEP MEDICINES.	LOCKED APART FROM OTHER MEDS AND ARVS ..... 1 LOCKED, LIMITED ACCESS SITE . 2 UNLOCKED OR NO LIMITED ACCESS 3	

1644	Finally, I would like to see supplies that you have in stock. Please show me the following stock supply items: (IF NECESSARY, GO TO **CLINICAL SUPPLIES**)	a			b		
		OBSERVED	REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE	OUT OF STOCK IN LAST SIX MONTHS		
					YES	NO	DK
01	Disposable needles (19 or 21 gauge)	1 → b	2 → 02	3 → 02	1	2	8
02	Disposable syringes (2,3, or 5 ml)	1 → b	2 → 03	3 → 03	1	2	8
03	Infusion sets for intravenous solution	1 → b	2 → 04	3 → 04	1	2	8
04	Canula for intravenous	1 → b	2 → 05	3 → 05	1	2	8
05	Clean non-latex, gloves	1 → b	2 → 06	3 → 06	1	2	8
06	Clean latex gloves	1 → b	2 → 07	3 → 07	1	2	8
07	Sterile latex gloves	1 → b	2 → 08	3 → 08	1	2	8
08	Spinal tap/lumbar puncture kits	1 → b	2 → 09	3 → 09	1	2	8
09	Disinfectant for cleaning surfaces (bleach or other cleaning solution such as chlorine or Chlorhexidine)	1 → b	2 → 10	3 → 10	1	2	8
10	Hand disinfectant	1 → b	2 → 11	3 → 11	1	2	8
11	Liquid soap	1 → b	2 → 12	3 → 12	1	2	8
12	Hand-washing soap	1 → b	2 → 13	3 → 13	1	2	8
13	Insecticide treated bed net	1 → b	2 → **End**	3 → **End**	1	2	8

THANK YOUR RESPONDENT FOR THE TIME AND HELP PROVIDED AND PROCEED TO THE NEXT DATA COLLECTION SITE

SECTION 17: TUBERCULOSIS DIAGNOSIS AND TREATMENT

Facility Number: [ ][ ][ ] **Interviewer Code:** [ ][ ] **QRE TYPE** **17**

1700	Does this facility offer services for Tuberculosis? By this I mean TB diagnosis or treatment or both.	YES, TB DIAGNOSIS . . . . . 1 YES, TB TREATMENT . . . . . 2 YES, BOTH TB DIAGNOSIS AND TREATMENT . . . . . 3 NO TB SERVICES 4	→ **END**

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN THE PROVISION OF TB SERVICES IN THIS FACILITY, AND IF RELEVANT, SPECIFICALLY TB SERVICES RELATED WITH HIV/AIDS SERVICES.

IF THIS IS A NEW RESPONDENT, INTRODUCE YOURSELF. BRIEFLY EXPLAIN THE PURPOSE OF YOUR VISIT AND ASK IF HE/SHE WOULD BE WILLING TO ANSWER A FEW QUESTIONS ABOUT TUBERCULOSIS SERVICES IN THE FACILITY. IF IN AGREEMENT, READ THE INTRODUCTORY CONSENT STATEMENT BELOW

IF THE RESPONDENT HAS ALREADY BEEN INTERVIEWED FOR A PREVIOUS SECTION, CIRCLE NUMBER 1 (YES) IN Q1701 BELOW AND GO ON TO Q1702.

Good day! My name is _____. We are here on behalf of the Ministry of Health and Social Services (MOHSS) conducting a study to assist the government in knowing more about health services in Namibia. Now I will read a statement explaining the study.

ALL facilities in the country are participating in this study. We will be asking you questions about various health services and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility may be used by the MOHSS, organizations supporting services in your facility, and researchers, for planning service improvement or for conducting further studies of health services.

Neither your name nor that of any other health worker respondents participating in this study will be included in the dataset or in any report; however, there is a small chance that any of these respondents may be identified later. Still, we are asking for your help to ensure that the information we collect is accurate.

You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will answer the questions, which will benefit the services you provide and the nation.

If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate if you introduce us to that person to help us collect that information.

At this point, do you have any questions about the study? Do I have your agreement to proceed?

_____ [ ][ ] [ ][ ] 2 0 0 9

Interviewer's signature — DAY | MONTH | YEAR

SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.

1701	May I begin the interview now?	YES . . . . . 1 NO 2	→ STOP

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1702	First, I would like to identify clinical staff (such as nurses or doctors) or other staff (such as counsellors, social workers, TB field promoters and laboratory technicians) who are assigned to this unit who are present today. Please give me the names and main service responsibility of the staff assigned to this unit and present today. COMPLETE THE STAFF LIST FOR THIS UNIT. DO NOT DUPLICATE SERVICE PROVIDERS WHO ARE LISTED FOR A SERVICE AREA THAT WAS PREVIOUSLY ASSESSED.		
	RESPONDENT MUST BE INTERVIEWED FOR TRAINING AND EXPERIENCE.	STAFF LIST COMPLETED YES . . . . . 1 NO 2	

1703	First, I would like to know about services for diagnosis and treatment of tuberculosis. For each service I will mention, please tell me if the service is offered in this facility and if providers assigned to this unit ever provide the service, refer clients for the service, or never offer the service at all.	SERVICE OFFERED IN THIS FACILITY		NO SERVICE OFFERED IN THIS FACILITY	
		PROVIDE SERVICE THIS UNIT	SERVICE BY PROVIDERS FROM OTHER UNIT THIS FACILITY	REFER CLIENTS OUTSIDE FACILITY	NO SERVICE OR REFERRAL
01	Do providers in this facility make diagnosis that a client has tuberculosis?	1	2	3	4
02	Do providers in this facility prescribe medicines for treatment of tuberculosis?	1	2	3	4
03	Do providers in this facility provide follow-up treatment for clients with tuberculosis?	1	2	3	4

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1704	Does this facility have a TB infection control focal person and/or a TB infection control committee?	YES, A TB I.C. FOCAL PERSON . . . . 1 YES, A TB I.C. COMMITTEE . . . . . 2 YES, BOTH A TB I.C. FOCAL PERSON AND A TB I.C. COMMITTEE . . . . . 3 NO, NEITHER . . . . . 4 DON'T KNOW 8	
1705	Does this facility have a TB infection control plan (administrative, environmental, personal)?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
1706	Does this facility apply Standard Operating Procedures (SOP) for management of coughing patients in waiting areas?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
1707	Does this facility use the N95 respirator (mask)? IF YES, ASK TO SEE RESPIRATOR	YES, OBSERVED . . . . . 1 YES, REPORTED NOT SEEN . . . . . 2 NO . . . . . 3 DON'T KNOW 8	
1708	Does this facility have sputum containers? IF YES, ASK TO SEE CONTAINERS	YES, OBSERVED . . . . . 1 REPORTED, NOT SEEN . . . . . 2 NO SPUTUM CONTAINER . . . . . 3 DON'T KNOW 8	
1709	What is the most common method used by providers in this facility for diagnosing TB?	SPUTUM SMEAR ONLY . . . . . 01 X-RAY ONLY . . . . . 02 EITHER SPUTUM OR X-RAY . . . 03 BOTH SPUTUM AND X-RAY . . . 04 CLINICAL SYMPTOMS ONLY . . . . 05 REFER WITHIN FACILITY . . . . 06 REFER TO OUTSIDE FACILITY . . . 07 NO TB DIAGNOSIS SERVICES . . . 08	→ 1713 → 1713 → 1713 → 1713 → 1713 → 1713 → 1713
1710	Does this facility have an agreement with a referral site for TB test results to be returned to the facility either directly or through the client?	YES . . . . . 1 NO 2	
1711	Is there a record of clients who are referred for TB diagnosis? IF YES, ASK TO SEE THE RECORD AND CHECK IF TB DIAGNOSTIC RESULTS ARE RECORDED	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 NO RECORD 3	
1712	When you refer a client **to another facility** (outside this facility), do you use a pre-printed form, a note or a verbal report that specifies information about the client that should be shared? IF PREPRINTED, ASK: May I see a copy of the form?	YES, PREPRINTED FORM SEEN . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 PATIENT SENT WITH MEDICAL RECORDS/FILE/CARD . . . . . 3 WRITE NOTE ON PRESCRIPTION FORM, LETTERHEAD OR BLANK PAPER . . . . . 4 VERBAL REPORT OR ACCOMPANIES CLIENT . . . . . 5 OTHER _____ 6 (SPECIFY) NEVER REFER OUTSIDE FACILITY . . 7 DON'T KNOW 8	
1713	Do you have any record or register of the number of newly diagnosed TB clients for this facility during the past twelve months?	YES, OBSERVED . . . . . 1 REPORTED NOT SEEN . . . . . 2 NO 3	 → 1716
1714	ASK TO SEE THE RECORDS AND RECORD THE NUMBER OF NEWLY DIAGNOSED TB CLIENTS FOR THE UNIT DURING THE PAST COMPLETED 12 MONTHS.	NUMBER OF CLIENTS [ ][ ][ ][ ]	
1715	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION	MONTHS OF DATA . . . . . [ ][ ]	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1716	Are there any TB-related guidelines or protocols for providers working in this unit? Guidelines or protocols that are posted on the wall are acceptable **IF YES, ASK:** May I see **all** the guidelines and protocols that are available here?	YES, GUIDELINES/PROTOCOLS AVAILABLE . . . . . 1 NO GUIDELINES/PROTOCOLS 2	→ 1718

1717	First I would like to ask about national guidelines. ASK ABOUT EACH GUIDELINE/PROTOCOL Do you have *[NAME OF GUIDELINE]*?	(a) OBSERVED	(a) REPORTED AVAILABLE NOT SEEN	(a) NOT AVAILABLE	(b) YEAR OF PUBLICATION
01	National Guidelines for the Management of Tuberculosis	1 → b	2 → 02	3 → 02	
02	Manual of the national Tuberculosis and Leprosy program	1 → b	2 → 03	3 → 03	
03	Biohazard sign up in visible place (red over white background)	1 → b	2 → 04	3 → 04	
04	Any other guideline on the management of TB	1 → b	2 → 1718	3 → 1718	

1718	ASK TO SEE THE AREA(S) WHERE MOST TB PATIENTS OR THOSE RECEIVING TB RELATED SERVICES ARE SEEN, EXAMINED OR A PROCEDURE IS CARRIED OUT. OBSERVE THE CONDITION UNDER WHICH MOST CLIENT EXAMINATION TAKE PLACE. IF THERE ARE SEVERAL ROOMS FOR THE SAME PROCEDURE, RANDOMLY PICK ONE TO ASSESS.		
	IF THE SAME EXAMINATION AREA/ROOM HAS ALREADY BEEN OBSERVED FOR ITEMS IN Q1719, INDICATE WHICH SECTION THE DATA ARE RECORDED	OPD [Q187] . . . . . 11 CHILD HEALTH [Q256] . . . . . 12 FAMILY PLANNING [Q322] . . . . . 13 ANTENATAL CARE [Q429] . . . . . 14 DELIVERY [Q530] 15 STI [Q626] . . . . . 16 SECTION 18 [Q1830] . . . . . 18 NOT PREVIOUSLY SEEN 19	1720

1719	INDICATE IF THE ITEMS LISTED BELOW ARE AVAILABLE IN THE ROOM OR IN AN ADJACENT AREA	(a) Availability OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED)	1 → 04	2	3
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 → 04	2	3
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3
04	HAND-WASHING SOAP/LIQUID SOAP	1	2	3
05	HAND DISINFECTANT	1	2	3
06	SINGLE-USE HAND DRYING TOWELS	1	2	3
07	WASTE RECEPTACLE WITH LID (PEDAL BIN) AND PLASTIC LINER	1 → 10	2	3
08	OTHER WASTE RECEPTACLE (NOT PEDAL BIN) WITH PLASTIC LINER	1 → 10	2	3
09	WASTE RECEPTACLE WITH LID (PEDAL BIN) WITHOUT PLASTIC LINER	1	2	3
10	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
11	DISPOSABLE LATEX GLOVES	1 → 13	2	3
12	DISPOSABLE NON-LATEX GLOVES	1	2	3
13	DISINFECTANT [E.G., HIBITANE, ALCOHOL]	1	2	3
14	DISPOSABLE NEEDLES	1	2	3
15	AUTO-DISABLE SYRINGES (3 OR 5 ml)	1	2	3
16	DISPOSABLE SYRINGES (3 OR 5 ml)	1	2	3
17	AUDITORY PRIVACY	1	2	3
18	VISUAL PRIVACY	1	2	3
19	TABLE CLOTH/PLASTIC ON ANY SURFACE	1	2	3

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1720	Is this facility included in the national DOTS program?	YES . . . . . 1 NO 2	
1721	What treatment strategy is followed by providers in this facility for TB treatment?	DIRECT OBSERVE 2M, FU 4M . . . 1 DIRECT OBSERVE 6M . . . . . 2 FOLLOW UP CLIENTS ONLY AFTER FIRST 2M DIRECT OBSERVATION ELSEWHERE . . . . . 3 DIAGNOSE AND TREAT WHILE INPATIENT. DISCHARGE TO OTHER UNIT FOR F/UP . 4 PROVIDE FULL TREATMENT, WITH NO ROUTINE DIRECT OBSERVATION PHASE . . . . 5 DIAGNOSE, PRESCRIBE/PROVIDE MEDICINES ONLY, NO F/UP . . . . 6 DIAGNOSE ONLY, NO TREATMENT OR PRESCRIPTION OF MEDICINE 7	 → 1725 → 1726 → 1725 → 1726 → **END**
1722	What is the strategy for the direct observed treatment during the first two months of treatment or until the client is sputum negative? CIRCLE ALL STRATEGIES USED BY THIS FACILITY FOR THE DOT.	CLIENT HOSPITALIZED . . . . . A CLIENT COMES TO FACILITY . . . B OUTREACH WORKER GOES TO CLIENT . . . . . C COMMUNITY WORKER OR FAMILY OBSERVES . . . . . D OTHER_____ X (SPECIFY)	
1723	Do you have a record or register that show the clients who are currently receiving DOTS? IF YES, ASK TO SEE THE REGISTER/RECORD	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 NO 3	 → 1725 → 1725
1724	IS THE RECORD/REGISTER UP-TO-DATE FOR THE PRIOR WEEK FOR ALL CLIENTS RECEIVING THEIR DOTS MEDICATIONS? ASK YOUR RESPONDENT IF INFORMATION IS NOT READILY AVAILABLE IN THE RECORDS.	YES . . . . . 1 NO 2	
1725	Does this facility provide routine follow-up for any clients who are placed on TB treatment? That is follow-up clients when they are at home, and after the initial 2 months of treatment?	YES . . . . . 1 NO 2	 → 1732
1726	Do you have individual client charts or records for clients receiving TB treatment? IF YES, ASK TO SEE A BLANK OR CURRENT CHART/RECORD.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 NO 3	
1727	Do you have a register or list of clients currently being followed by this facility for TB treatment, including those being treated on DOTS and no direct observation?	YES, REGISTER OR LIST OBSERVED . . . . . 1 ONLY HAVE DOTS CLIENTS 2 NO 3	 → 1731

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1728	ASK TO SEE THE REGISTER AND INDICATE THE DATE THE MOST RECENT CLIENT WAS ADMITTED TO TB TREATMENT.	WITHIN PAST 30 DAYS . . . . . 1 MORE THAN 30 DAYS AGO . . . . . 2 REGISTER NOT SEEN 3	→ 1731
1729	USING EITHER THE CARDS OR REGISTER, RECORD THE TOTAL NUMBER OF CLIENTS WHO ARE CURRENTLY ON TB TREATMENT AND WHO ARE FOLLOWED UP IN THIS UNIT.	TOTAL NUMBER OF CLIENTS ON TB TREATMENT [ ][ ][ ][ ]	
1730	RECORD THE NUMBER OF FEMALE CLIENTS CURRENTLY ON TB TREATMENT BY THIS UNIT.	NUMBER OF FEMALE CLIENTS [ ][ ][ ][ ] DON'T KNOW 9998	
1731	Do you have a register or record that shows the treatment outcome for clients who received TB treatment from this facility but are no longer under treatment? IF YES, ASK TO SEE THE REGISTER/RECORD	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 UNIT DOES NOT PROVIDE TB FOLLOW-UP SERVICES . . . 3 NO 4	
1732	Are newly diagnosed cases of TB (or cases followed up by this facility), referred for an HIV test or for counselling about HIV/AIDS?	YES, ALL REFERRED . . . . . 1 SUSPECT CASES ONLY REFERRED 2 NO . . . . . 3 DON'T KNOW 8	 → 1736 → 1736
1733	Do you have a register or list of new TB patients who were referred for an HIV test or for HIV test counselling? IF YES, ASK TO SEE THE REGISTER OR LIST.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 NO 3	 → 1736 → 1736
1734	How many new TB patients were referred for an HIV/AIDS test or counselling in the past twelve completed months?	NUMBER OF NEW TB CLIENTS REFERRED [ ][ ][ ][ ]	
1735	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION	MONTHS OF DATA . . . . . [ ][ ]	
1736	Do you have any record of clients currently under TB treatment who are also diagnosed as HIV positive or as having AIDS? YES, ASK TO SEE THE REGISTER/RECORD.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 NO 3	 → 1738
1737	How many patients currently under TB treatment in this facility are also diagnosed as HIV positive or as having AIDS?	NUMBER OF TB CLIENTS WITH HIV/AIDS [ ][ ][ ][ ] DON'T KNOW 9998	
1738	What is the original source of your TB medicines? IF MEDICINES ARE SUPPLIED FROM OTHER FACILITIES, CLARIFY IF THIS IS PART OF THE NATIONAL TB CONTROL PROGRAM OR NOT. CIRCLE ALL THAT APPLY	CENTRAL MEDICAL STORES . . . A NATIONAL TB CONTROL PROGRAM. B OTHER FACILITY (NOT PART OF NATIONAL TB PROGRAM) . . . C DIRECT PURCHASE . . . . . D DONATIONS FROM NGOS . . . . . E OTHER _____ X (SPECIFY)	
1739	Are any TB medicines that are individually packaged for clients kept in this unit? IF YES, ASK TO SEE THE MEDICINES AND INDICATE IF PREPACKAGED MEDICINES ARE AVAILABLE FOR ALL CLIENTS.	YES, AVAILABLE FOR ALL CLIENTS. . 1 YES, AVAILABLE FOR SOME, NOT ALL CLIENTS . . . . . 2 NO INDIVIDUALLY PACKAGED TB MEDICINES IN CLINIC/UNIT . . 3 NO TB MEDICINES STORED IN UNIT AREA 4	

THANK YOUR RESPONDENT FOR THE TIME AND HELP PROVIDED AND PROCEED TO THE NEXT DATA COLLECTION SITE

SECTION 18: COUNSELLING AND TESTING

Facility Number: [ ][ ][ ] **Interviewer Code:** [ ][ ] QRE TYPE **18**

1800	Does this facility offer any services related to HIV/AIDS counselling and testing? In other words, do providers in this facility ever prescribe HIV tests or refer clients to other facilities or to other units within this facility for HIV tests?	YES, HIV COUNSELING ONLY ..... 1 YES, HIV TESTING ONLY ..... 2 YES, BOTH HIV COUNSELING AND TESTING SERVICES ..... 3 NO HIV/AIDS COUNSELING OR TESTING SERVICES 4	→**END**

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN THE PROVISION OF HIV/AIDS COUNSELING AND TESTING IN THIS FACILITY

IF THIS IS A NEW RESPONDENT, INTRODUCE YOURSELF. BRIEFLY EXPLAIN THE PURPOSE OF YOUR VISIT AND ASK IF HE/SHE WOULD BE WILLING TO ANSWER A FEW QUESTIONS ABOUT HIV COUNSELING ANDTESTING SERVICES IN THE FACILITY. IF IN AGREEMENT, READ THE INTRODUCTORY CONSENT STATEMENT BELOW.

IF THE RESPONDENT HAS ALREADY BEEN INTERVIEWED FOR A PREVIOUS SECTION, CIRCLE NUMBER 1 (YES) IN Q1802 BELOW AND GO ON TO Q1803.

Good day! My name is _____. We are here on behalf of the Ministry of Health and Social Services (MOHSS) conducting a study to assist the government in knowing more about health services in Namibia.
Now I will read a statement explaining the study.

ALL facilities in the country are participating in this study. We will be asking you questions about various health services and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility may be used by the MOHSS, organizations supporting services in your facility, and researchers, for planning service improvement or for conducting further studies of health services.

Neither your name nor that of any other health worker respondents participating in this study will be included in the dataset or in any report; however, there is a small chance that any of these respondents may be identified later. Still, we are asking for your help to ensure that the information we collect is accurate.

You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will answer the questions, which will benefit the services you provide and the nation.

If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate if you introduce us to that person to help us collect that information.

At this point, do you have any questions about the study? Do I have your agreement to proceed?

_____ [ ][ ] [ ][ ] 2 0 0 9
Interviewer's signature DAY MONTH YEAR

SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.

1802	May I begin the interview now?	YES ..... 1 NO 2	→STOP

NO	QUESTIONS	CODING CATEGORIES	GO TO
1803	First, I would like to identify clinical staff (such as nurses or doctors) or other staff (such as counsellors, social workers, and laboratory technicians) who are assigned to this unit who are present today. Please give me the names and main service responsibility of the staff assigned to this unit and present today. COMPLETE THE STAFF LIST FOR THIS CLINIC/UNIT. DO NOT DUPLICATE SERVICE PROVIDERS WHO ARE LISTED FOR A SERVICE AREA THAT WAS PREVIOUSLY ASSESSED.		
	RESPONDENT MUST BE INTERVIEWED FOR TRAINING AND EXPERIENCE.	STAFF LIST COMPLETED YES ..... 1 NO 2	

NO	QUESTIONS	CODING CATEGORIES	GO TO
1804	How many days each week are counselling services for HIV/AIDS available in this facility? This means the counselling is conducted by staff in this facility.	DAYS PER WEEK . . . . . [ ] NO COUNSELLING SERVICES . . . 0	→1818
1805	How many months have counselling services been offered from this facility? IF EXACT MONTHS ARE UNCERTAIN, PROBE FOR AN ESTIMATE.	MONTHS . . . . . [ ][ ][ ]	
1806	Does this facility have a counsellor who has been trained for both pre-test and post-test counselling? IF YES, ASK IF THE PERSON IS PRESENT TODAY AND ENSURE THAT PERSON IS INTERVIEWED FOR THE HEALTH WORKER INTERVIEW	YES, PRESENT TODAY . . . . . 1 YES, NOT PRESENT TODAY . . . . . 2 NO 3	
1807	ASK TO SEE WHERE COUNSELING RELATED TO HIV/AIDS IS PROVIDED. DESCRIBE THE SETTING WHERE CLIENT COUNSELLING RELATED TO HIV/AIDS IS PROVIDED	PRIVATE ROOM WITH VISUAL AND AUDITORY PRIVACY . . . . . 1 OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY . . . . . 2 VISUAL PRIVACY ONLY . . . . . 3 NO PRIVACY 4	
1808	How is HIV counselling provided?	INDIVIDUAL ONLY . . . . . 1 COUPLES ONLY . . . . . 2 BOTH INDIVIDUAL AND COUPLES . . . . 3 INDIVIDUAL + COUPLE + GROUP SESSIONS 4	→1811
1809	Are there records of the couple and/or group HIV counselling/information sessions? IF YES, ASK TO SEE THE RECORDS FOR THE PAST 12 MONTHS AND RECORD THE NUMBER OF SESSIONS THAT HAVE BEEN HELD.	YES, ... NUMBER OF SESSIONS [ ][ ][ ] NO RECORDS ON GROUP INFORMATION 995	→1811
1810	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION	MONTHS OF DATA . . . . . [ ][ ]	
1811	Which staff most commonly provide HIV pre test counselling for clients in this facility? PROBE FOR RESPONSE THAT IS MOST ACCURATE.	COMMUNITY HIV COUNSELLORS. . . . . 01 VCT COUNSELLORS FROM OUTSIDE UNIT . . . . . 02 TRAINED STAFF FROM THIS UNIT. . . . . 03 TRAINED AND UNTRAINED STAFF FROM THIS UNIT DEPENDING ON TIME AND STAFF AVAILABILITY. . . . . 04 BOTH OUTSIDE STAFF AND TRAINIED STAFF FROM THIS UNIT PROVIDE COUNSELLING, DEPENDING ON TIME AND STAFF AVAILABILITY. . . . . 05 CLIENTS ALWAYS SENT TO ANOTHER UNIT FOR PRE-TEST COUNSELLING. 06	
1812	Which staff most commonly provide HIV post-test counselling for clients with negative test results in this facility? PROBE FOR RESPONSE THAT IS MOST ACCURATE.	COMMUNITY HIV COUNSELLORS. . . . . 01 VCT COUNSELORS FROM OUTSIDE UNIT . . . . . 02 TRAINED STAFF FROM THIS UNIT 03 TRAINED AND UNTRAINED STAFF FROM THIS UNIT DEPENDING ON TIME AND STAFF AVAILABILITY. . . . . 04 BOTH OUTSIDE STAFF AND TRAINIED STAFF FROM THIS UNIT PROVIDE COUNSELLING, DEPENDING ON TIME AND STAFF AVAILABILITY. . . . . 05 CLIENTS ALWAYS SENT TO ANOTHER UNIT FOR POST-TEST COUNSELLIN(. . . . . 06 NO POST TEST COUNSELLING FOR NEGATIVE RESULTS. 07	

NO	QUESTIONS	CODING CATEGORIES	GO TO
1813	Which staff most commonly provide HIV post-test counselling for clients with positive test results in this facility? PROBE FOR RESPONSE THAT IS MOST ACCURATE.	COMMUNITY HIV COUNSELLORS. . . . . 01 VCT COUNSELORS FROM OUTSIDE UNIT . . . . . 02 TRAINED STAFF FROM THIS UNIT 03 TRAINED AND UNTRAINED STAFF FROM THIS UNIT DEPENDING ON TIME AND STAFF AVAILABILITY. . . . . 04 BOTH OUTSIDE STAFF AND TRAINIED STAFF FROM THIS UNIT PROVIDE COUNSELLING, DEPENDING ON TIME AND STAFF AVAILABILITY. . . . . 05 CLIENTS ALWAYS SENT TO ANOTHER UNIT FOR POST-TEST COUNSELLIN(. . . . . 06 NO POST TEST COUNSELLING. 07	
1814	Are records kept for clients who receive any counselling or testing from this facility? IF YES, ASK TO SEE THE RECORDS AND INDICATE WHAT TYPE OF INFORMATION IS AVAILABLE.	RECORD AVAILABLE THIS UNIT . . 1 RECORD IN CLIENT INDIVIDUAL RECORD ONLY . . . . . 2 RECORDS MAINTAINED BY VCT/CT COUNSELORS FROM ANOTHER UNIT IN THE FACILITY. . . . . 3 NO RECORDS 4	→1818 →1818

1815	REVIEW THE COUNSELLING AND/OR TESTING RECORDS FOR THE FACILITY AND INDICATE WHICH INFORMATION IS AVAILABLE FOR THE PAST 12 COMPLETED MONTHS	(A) RECORD AVAILABILITY			(B) NUMBERS FROM OBSERVED RECORDS	
		OBSERVED	REPORTED, NOT SEEN	NO RECORD	NUMBER OF CLIENTS	MONTHS OF DATA
01	TOTAL CLIENTS RECEIVING INDIVIDUAL PRE-TEST COUNSELLING	1 → b	2 → 02	3 → 02		
02	TOTAL CLIENTS RECEIVING POST-TEST COUNSELLING	1 → b	2 → 03	3 → 03		
03	TOTAL CLIENTS WHO GOT HIV TEST	1 → b	2 → 04	3 → 04		
04	TOTAL FEMALE CLIENTS WHO GOT HIV TEST	1 → b	2 → 05	3 → 05		
05	TOTAL CLIENTS 15-24 YEARS WHO GOT HIV TEST	1 → b	2 → 06	3 → 06		
06	TOTAL CLIENTS WHO RECEIVED HIV TEST RESULTS	1 → b	2 → 07	3 → 07		
07	TOTAL CLIENTS WITH POSITIVE (+) HIV TEST RESULTS	1 → b	2 → 08	3 → 08		
08	TOTAL CLIENTS WITH POSITIVE (+) HIV TEST WHO RECEIVED RESULTS	1 → b	2 → 1816	3 → 1816		

1816	WHAT IS THE MOST RECENT DATE RECORDED FOR ANY COUNSELLING?	WITHIN PAST 30 DAYS . . . . . 1 MORE THAN 30 DAYS . . . . . 2 NO DATE RECORDED . . . . . 3 NO RECORD FOR COUNSELLING . 4	→ 1818
1817	Is there a client number or other identifier for clients receiving pre and post test counselling?	YES . . . . . 1 NO 2	
1818	How many days each week are testing services for HIV available in this facility? This means that a client can receive the HIV test or have their blood drawn for testing either inside or outside the facility	DAYS PER WEEK . . . . . [ ] NO HIV TESTING SERVICES 0	→ 1823
1819	How many months have HIV testing services been offered from this facility? IF EXACT MONTHS ARE UNCERTAIN, PROBE FOR AN ESTIMATE.	MONTHS . . . . . [ ][ ][ ]	
1819A	Do you do HIV rapid testing in this facility? IF YES, ASK: How many months have HIV **rapid** testing services been offered from this facility? IF EXACT MONTHS ARE UNCERTAIN, PROBE FOR AN ESTIMATE.	YES . . . . . 1 \# OF MONTHS [ ][ ][ ] . . . . . . NO HIV RAPID TESTING 2	→ 1820

NO	QUESTIONS	CODING CATEGORIES	GO TO
1819B	Which staff most commonly provide HIV rapid testing in this facility?	COMMUNITY COUNSELLORS . . . . . 1 NURSES . . . . . 2 LABORATORY STAFF . . . . . 3 OTHER (SPECIFY) _____ 6	
1820	DID YOU OBSERVE RECORDS FOR HIV TESTING AND TEST RESULTS? IF NO, ASK, Where are the records for HIV testing kept? RECORD THE CORRECT RESPONSE.	YES, OBSERVED . . . . . 1 RECORDS MAINTAINED ELSEWHERE IN FACILITY . . . . . 2 RECORDS IN LAB . . . . . 3 RECORDS IN STATISTICS/ MEDICAL RECORDS OFFICE . . . . 4 OTHER (SPECIFY) _____ 6 NO HIV TEST RECORDS . . . . . 7 DON'T KNOW 8	
1821	How many HIV tests were conducted by nurse testers, and how many were conducted by community counsellors in the last completed 1 month?	NURSE TESTER . . . . . [ ][ ][ ][ ] COMM. COUNSELLOR . . . [ ][ ][ ][ ] DON'T KNOW 9 9 9 8	
1822	Is there a system where you can link the HIV test result with the client who received pre and post test counselling? IF YES, ASK TO SEE HOW THE SYSTEM WORKS	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO 3	
1823	Are reports regularly compiled on the number of clients in this facility who receive testing or counselling services for HIV/AIDS? IF YES, ASK FOR EACH QUESTION AND CIRCLE LETTER FOR INFORMATION THAT IS COMPILED	YES, NEGATIVE TEST RESULTS . . . A YES, POSITIVE TEST RESULTS . . . . . B YES, COUNSELLING . . . . . C NO . . . . . Y	→ 1829
1824	How frequently are any of the compiled reports submitted to someone outside of this facility?	YES, MONTHLY OR MORE OFTEN . 1 YES, EVERY 2-3 MONTHS . . . . . 2 YES, EVERY 4-6 MONTHS . . . . . 3 YES LESS OFTEN THAN EVERY 6 MONTHS . . . . . 4 NEVER 5	→ 1829
1825	To whom are the reports sent? CIRCLE ALL THAT APPLY.	DISTRICT LEVEL (MOHSS/DSP/HIS). . . . C REGIONAL LEVEL(MOHSS/DSP/HIS). . . . D NATIONAL LEVEL(MOHSS/DSP/HIS). . . . E DONOR AGENCY. . . . . F OTHER (SPECIFY) _____ X	
1829	When a provider wants a client to receive an HIV test, or when a client agrees to an HIV test, what is the procedure that is followed? In other words, what are the possible options for the client to receive the test? AFTER RESPONSE IS PROVIDED, PROBE FOR ANY OTHER PROCEDURES USED FOR PROVIDING THE HIV TEST. CIRCLE ALL THAT APPLY	**TESTING IN THIS FACILITY** TEST IN THIS UNIT . . . . . A CLIENT SENT TO (V)CT UNIT . . . . . B CLIENT SENT TO PMTCT UNIT . . . . . C CLIENT REFERRED OTHER UNIT THIS FACILITY (NON-VCT/PMTCT) . . D BLOOD DRAWN IN THIS UNIT BY UNIT STAFF, TEST CONDUCTED ELSEWHERE . . . E BLOOD DRAWN IN THIS UNIT BY UNIT STAFF, AND SENT TO LAB . . . . . F BLOOD DRAWN IN THIS UNIT BY **EXTERNAL STAFF, TEST** CONDUCTED ELSEWHERE . . . G BLOOD DRAWN IN THIS UNIT BY **EXTERNAL STAFF, AND SENT** TO LAB . . . . . H CLIENT SENT TO LAB IN THIS FACILITY I **TESTING OUTSIDE FACILITY:** CLIENT SENT ELSEWHERE OUTSIDE THIS FACILITY . . . . . J BLOOD DRAWN IN THIS UNIT, SENT OUTSIDE FACILITY FOR TESTING . . K	

CHECK 1829: A OR E OR F OR G OR H OR K CIRCLED → ↓ | A OR E OR F OR G OR H OR K **NOT** CIRCLED **AND** B OR C OR D OR I CIRCLED → 1834 | ONLY J CIRCLED → 1832A

NO	QUESTIONS	CODING CATEGORIES			GO TO
1829A	ASK TO SEE WHERE BLOOD IS USUALLY DRAWN FOR HIV TESTING. IF THERE ARE SEVERAL ROOMS FOR THE SAME PROCEDURE, RANDOMLY PICK ONE TO ASSESS.				
	IF THE SAME EXAMINATION AREA/ROOM HAS ALREADY BEEN OBSERVED FOR ITEMS IN Q1830, INDICATE WHICH SECTION THE DATA ARE RECORDED	OPD [Q187] . . . . . 11 CHILD HEALTH [Q256] . . . . . 12 FAMILY PLANNING [Q322] . . . . . 13 ANTENATAL CARE [Q429] . . . . . 14 DELIVERY [Q530] 15 STI [Q626] . . . . . 16 SECTION 17 [Q1719] . . . . . 17 NOT PREVIOUSLY SEEN 19			1831
1830	INDICATE IF THE ITEMS LISTED BELOW ARE AVAILABLE IN THE ROOM OR IN AN ADJACENT AREA	(a) AVAILABILITY			
		OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	
01	RUNNING WATER (PIPED)	1 → 04	2	3	
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 → 04	2	3	
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	
04	HAND-WASHING SOAP/LIQUID SOAP	1	2	3	
05	HAND DISINFECTANT	1	2	3	
06	SINGLE-USE HAND DRYING TOWELS	1	2	3	
07	WASTE RECEPTACLE WITH LID (PEDAL BIN) AND PLASTIC LINER	1 → 10	2	3	
08	OTHER WASTE RECEPTACLE (NOT PEDAL BIN) WITH PLASTIC LINER	1 → 10	2	3	
09	WASTE RECEPTACLE WITH LID (PEDAL BIN) WITHOUT PLASTIC LINER	1	2	3	
10	SHARPS CONTAINER ("SAFETY BOX")	1	2	3	
11	DISPOSABLE LATEX GLOVES	1 → 13	2	3	
12	DISPOSABLE NON-LATEX GLOVES	1	2	3	
13	DISINFECTANT [E.G., HIBITANE, ALCOHOL]	1	2	3	
14	DISPOSABLE NEEDLES	1	2	3	
15	AUTO-DISABLE SYRINGES (3 OR 5 ml)	1	2	3	
16	DISPOSABLE SYRINGES (3 OR 5 ml)	1	2	3	
17	AUDITORY PRIVACY	1	2	3	
18	VISUAL PRIVACY	1	2	3	
19	TABLE CLOTH/PLASTIC ON ANY SURFACE	1	2	3	
1831	WERE ANY USED SHARPS OR BANDAGES OUTSIDE THEIR PROPER CONTAINERS, OR THE SHARPS CONTAINER OVERFLOWING/BROKEN?	YES . . . . . 1 NO 2			
1832	ARE ALL SURFACE AREAS IN THE BLOOD DRAWING AREA CLEAN OF BLOOD OR OTHER BODY FLUIDS?	YES . . . . . 1 NO 2			

NO	QUESTIONS	CODING CATEGORIES	GO TO
	CHECK Q1829: IS J OR K CIRCLED, IMPLYING EITHER CLIENT IS SENT ELSEWHERE OUTSIDE FACILITY, OR BLOOD IS DRAWN IN THE UNIT AND SENT TO AN EXTERNAL LAB FOR TESTING? YES, "J" OR "K" CIRCLED ☐ NEITHER "J" NOR "K" CIRCLED ☐ → 1834		
1832A	Does this facility have an agreement with the referral site for HIV tests that test results will be returned to the facility, usually directly or through the client?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
1832B	Is there a record maintained for clients who are referred for HIV tests or when blood is sent outside the facility for the HIV test? IF YES, ASK: May I see the record? MARK RESPONSE THAT BEST REFLECTS THE PRACTICE.	YES, RECORD OBSERVED WITH CLIENT TEST RESULTS . . . . 1 YES, RECORD MAINTAINED IN LAB . . 2 YES, RECORD REPORTED, BUT NOT SEEN . . . . . 3 NO RECORD MAINTAINED 4	
1833	When you refer a client **to another facility** for services, do you use a pre-printed form that specifies information about the client that should be shared, that is, an official referral form? IF YES, ASK: May I see a copy of the form?	YES, PREPRINTED FORM SEEN . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 PATIENT SENT WITH MEDICAL RECORDS/FILE/CARD . . . . . 3 WRITE NOTE ON PRESCRIPTION FORM, LETTERHEAD OR BLANK PAPER . . . . . 4 VERBAL REPORT OR ACCOMPANIES CLIENT . . . . . 5 OTHER _____ (SPECIFY) 6 NEVER REFER OUTSIDE FACILITY 7 DON'T KNOW 8	
1834	What is the normal practice for this unit if a person voluntarily asks for an HIV test? PROBE TO CLARIFY WHICH RESPONSE IS MOST ACCURATE.	PROVIDE SERVICE AT TIME OF VISIT THROUGH THIS UNIT . . 1 MAKE APPOINTMENT FOR TEST IN THIS FACILITY ANOTHER TIME . . 2 REFER/TELL TO RETURN LATER WITHOUT APPOINTMENT, FOR TEST WITHIN FACILITY . . . . 3 REFER TO SITE OUTSIDE FACILITY WITHOUT APPOINTMENT. . 4 DON'T PROVIDE SERVICE OR REFERRAL 5	
1835	Are there any CT-related guidelines/protocols for providers working in this unit? Guidelines that are posted on the wall are acceptable. IF YES, ASK: May I see all the guidelines and protocols that are available here?	YES, GUIDELINES/PROTOCOLS AVAILABLE . . . . . 1 NO GUIDELINES OR PROTOCOLS . 2	→ 1839

NO	QUESTIONS	CODING CATEGORIES				GO TO
1836	First I would like to ask about national guidelines. ASK ABOUT EACH GUIDELINE/PROTOCOL Do you have *[NAME OF GUIDELINE]*?	(a) OBSERVED	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE	(b) YEAR OF PUBLICATION	
01	National Guidelines for Voluntary Counselling and Testing	1 → b	2 → 02	3 → 02		
02	National Guidelines for Outreach VCT	1 → b	2 → 03	3 → 03		
03	HIV Rapid Testing Standard Operating Procedures (including infection control)	1 → b	2 → 04	3 → 04		
04	National Guidelines on Post Exposure Prophylaxis (PEP)	1 → b	2 → 05	3 → 05		
05	Wall chart on PEP in a visible place	1 → b	2 → 06	3 → 06		
06	Biohazard sign up in visible place (red over white background)	1 → b	2 → 1837	3 → 1837		
1837	**Other than the previously mentioned national** guidelines, are there any other protocols or guidelines for counselling and testing or other related topics?	YES, OTHER PROTOCOLS/ GUIDELINES . . . . . 1 NO OTHER PROTOCOLS/ GUIDELINES 2				→ 1839

NO	QUESTIONS	CODING CATEGORIES			GO TO
		(a)			(b)
1838	ASK ABOUT ANY GUIDELINES OTHER THAN THOSE PREVIOUSLY RECORDED, THAT COVER THE FOLLOWING TOPICS:	OBSERVED	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE	YEAR OR PUBLICATION
01	Other protocols/guidelines for pre-test counselling?	1 → b	2 → 02	3 → 02	
02	Other protocols/guidelines for post test counselling for both positive and negative test results?	1 → b	2 → 03	3 → 03	
03	Is there any written policy that all clients receiving HIV tests must be offered pre-test counselling or information, and post test counselling?	1 → b	2 → 04	3 → 04	
04	Is there any policy on HIV testing procedures, that is what test should be done, and when?	1 → b	2 → 05	3 → 05	
05	HIV Laboratory Manual for the Processing of samples, use of HIV test kits, and data management?	1 → b	2 → 06	3 → 06	
06	Is there a written informed consent document for the client to sign or keep?	1 → b	2 → 07	3 → 07	
07	Any other informed consent policy (e.g., verbal)?	1 → b	2 → 08	3 → 08	
08	Is there a written policy on confidentiality provided to the client, that specifies that no one will be told the HIV test result without the permission of the client?	1 → b	2 → 09	3 → 09	
09	Any other confidentiality policy reaffirming that no one will be told the results without the specific permission of the client?	1 → b	2 → 1839	2 → 1839	

1839	Is an individual client chart/record/card maintained for clients who receive services through this unit? (e.g., health passport) This refers to any system, where individual information about a client is recorded so that a record of all care and services is available in one document? IF YES, ASK TO SEE A BLANK OR CURRENT CHART/RECORD.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 YES, ONLY AVAILABLE IN OTHER FACILITY AREA . . . . . 3 YES, ONLY AVAILABLE WITH CENTRAL RECORDS/STATISTICS 4 OTHER _____ 6 (SPECIFY) NO INDIVIDUAL CLIENT CHART/RECORD 7	
	FAMILY PLANNING FOR HIV POSITIVE CLIENTS		
1840	Are family planning services routinely provided for all HIV positive clients?	YES, ALWAYS . . . . . 1 YES, SOMETIMES . . . . . 2 NO 3	→ 1844
1841	Who most often provides counselling about use and methods of family planning available?	PROVIDER, THIS UNIT . . . . . 1 PROVIDER, FP UNIT . . . . . 2 REFERRED OUTSIDE THIS FACILITY . . . 3	
1842	Who most often examines the client and provides or prescribes methods of family planning for HIV positive clients?	PROVIDER, THIS UNIT . . . . . 1 PROVIDER, FP UNIT . . . . . 2 REFERRED OUTSIDE THIS FACILITY. . . . 3	
1843	Please show me any guidelines or protocols on counselling and screening for appropriate family planning methods.	GUIDELINES OBSERVED . . . . . 1 GUIDELINES REPORTED, NOT SEEN . 2 NO GUIDELINES AVAILABLE 3	

NO	QUESTIONS	CODING CATEGORIES	GO TO
	YOUTH FRIENDLY SERVICES		
1844	Does this facility have any specific youth friendly services (YFS - Youth Friendly Corner)?	YES . . . . . 1 NO 2	→ 1848
1845	ASK TO SEE THE LOCATION WHERE YFS ARE PROVIDED. ASK TO SPEAK WITH THE PERSON MOST KNOWLEDGEABLE ABOUT THE YOUTH FRIENDLY SERVICES. Are there any written policies or guidelines for the youth friendly services? IF YES, ASK TO SEE THE POLICY/GUIDELINE.	YES, OBSERVED . . . . . 1 YES, REPORTED NOT SEEN . . . . . 2 NO 3	
1846	Do you have a staff member who has had specific training for providing youth friendly services? IF YES, ASK: Is the staff member present today?	YES, PRESENT TODAY . . . . . 1 YES, NOT PRESENT TODAY . . . . . 2 NO 3	
1847	What are the key components of the youth friendly services that are offered in this facility? In other words, what provisions are made in this facility to encourage the youth to utilize services that are geared towards them? DO NOT READ RESPONSES TO RESPONDENT! PROBE: Anything else?	DISCOUNT FEES . . . . . A NO FEES . . . . . B EDUCATION/COUNSELLING . . . . . C ADOLESCENT PARTICIPATION . . . . . D COMMUNITY SUPPORT AND PARTICIPATION. . . . . E ADOLESCENT FRIENDLY STAFF. . . . . F ADOLESCENT FRIENDLY ENVIRONMENT (E.G., SERVICE IS SEPARATE ROOM). G ADOLESCENT FRIENDLY PROCEDURES H NETWORKING AND COLLABORATION. . I OTHER _____ X (SPECIFY)	

NO	QUESTIONS	CODING CATEGORIES	GO TO
	COMMUNITY BASED SERVICES		
1848	Does this facility have links with community based health workers or volunteers for HIV/AIDS services? IF YES, ASK: What types of services do the community based workers provide? CIRCLE ALL THAT APPLY	YES, DISTRIBUTE ARVS . . . . . A YES, REFER FOR ART ELIGIBILITY . B YES, HOME CARE . . . . . C YES, CLIENT TREATMENT SUPPORT D YES, PRETEST COUNSELLING . . . . E YES, PREVENTIVE EDUCATION . . . . . F YES, ADHERENCE COUNSELLING . G YES, EMOTIONAL/SOCIAL SUPPORT H YES, DEFAULTER FOLLOW UP . . . . . I YES, NOT HIV/AIDS RELATED . . . . . J YES, OTHER HIV/AIDS RELATED _____ X (SPECIFY) NO . . . . . Y	→ **END**
1849	When clients are referred to community based health workers or volunteers, do you have a formal system for making the referral, such as a referral slip or other means? IF YES, ASK: What method do you use?	YES, REFERRAL SLIP OBSERVED . . . 01 YES, REFERRAL SLIP REPORTED, NOT SEEN . . . . . 02 PATIENT SENT WITH MEDICAL CHART/RECORD/CARD . . . . . 03 WRITE ON PRESCRIPTION FORM/ LETTERHEAD . . . . . 04 PROVIDER GIVES VERBAL REPORT TO SITE (MAY . . . . . ACCOMPANY CLIENT) . . . . . 05 WRITE NOTE/LETTER (UNSTRUCTURED) . . . . . 06 OTHER _____ 96 (SPECIFY) NO METHOD USED 95	
1850	When community based health workers refer clients to the facility, is there a formal system for making the referral such as a referral slip or other means? IF YES, ASK: What method do you use?	YES, REFERRAL SLIP OBSERVED . 01 YES, REFERRAL SLIP REPORTED, NOT SEEN . . . . . 02 PATIENT SENT WITH MEDICAL CHART/RECORD/CARD . . . . . 03 WRITE ON PRESCRIPTION FORM/ LETTERHEAD . . . . . 04 CHW GIVES VERBAL REPORT TO SITE (MAY ACCOMPANY CLIENT) . . . . . 05 WRITE NOTE/LETTER (UNSTRUCTURED) . . . . . 06 OTHER _____ . . . 96 (SPECIFY) NO METHOD USED 95	
1851	Do you have a reporting format that the community health worker completes, or that facility staff complete for the community work? IF YES, ASK TO SEE A COPY OF A RECENT REPORT	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO 3	
1852	Is there a system for periodic supervision of the community health worker? IF YES, ASK TO SEE EVIDENCE OF A SYSTEM SUCH AS A SUPERVISORY SCHEDULE/REPORT	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO 3	
1853	When was the most recent ***training session*** for community health workers who are linked with this facility?	WITHIN PAST 30 DAYS . . . . . 1 WITHIN PAST 2-6 MONTHS . . . . . 2 WITHIN PAST 7-12 MONTHS . . . . . 3 MORE THAN 12 MONTHS AGO . . . . . 4 NO TRAINING . . . . . 5 DON'T KNOW 8	
1854	When was the most recent ***meeting*** with community health workers who are linked with this facility?	WITHIN PAST 30 DAYS . . . . . 1 WITHIN PAST 2--6 MONTHS . . . . . 2 WITHIN PAST 7-12 MONTHS . . . . . 3 MORE THAN 12 MONTHS AGO . . . . . 4 NO MEETING . . . . . 5 DON'T KNOW 8	
	THANK YOUR RESPONDENT FOR THE TIME AND HELP PROVIDED AND PROCEED TO THE NEXT DATA COLLECTION SITE		

SECTION 19: ANTIRETROVIRAL THERAPY (ART)

Facility Number: [ ][ ][ ] **Interviewer Code:** [ ][ ] QRE TYPE **19**

1900	Does this facility offer any services related to antiretroviral therapy? IF YES, ASK: Do providers in this facility actually prescribe the treatment or provide follow-up services for persons receiving ART, including providing community community based services, or do providers from another facility use this place as an outreach site?	YES, PRECRIBE ART . . . . . 1 YES, PROVIDE FOLLOW-UP SERVICES . . . . . 2 YES, BOTH . . . . . 3 OUTREACH SITE FOR PROVIDERS FROM ANOTHER FACILITY. . . . . 4 NO ART SERVICES 5	 → **END** → **END**

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN THE PROVISION OF ART SERVICES IN THIS FACILITY

IF THIS IS A NEW RESPONDENT, INTRODUCE YOURSELF. BRIEFLY EXPLAIN THE PURPOSE OF YOUR VISIT AND ASK IF HE/SHE WOULD BE WILLING TO ANSWER A FEW QUESTIONS ABOUT ART SERVICES IN THE FACILITY. IF IN AGREEMENT, READ THE INTRODUCTORY CONSENT STATEMENT BELOW

IF THE RESPONDENT HAS ALREADY BEEN INTERVIEWED FOR A PREVIOUS SECTION, CIRCLE NUMBER 1 (YES) IN Q1902 BELOW AND GO ON TO Q1903.

Good day! My name is _____. We are here on behalf of the Ministry of Health and Social Services (MOHSS) conducting a study to assist the government in knowing more about health services in Namibia.
Now I will read a statement explaining the study.

ALL facilities in the country are participating in this study. We will be asking you questions about various health services and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility may be used by the MOHSS, organizations supporting services in your facility, and researchers, for planning service improvement or for conducting further studies of health services.

Neither your name nor that of any other health worker respondents participating in this study will be included in the dataset or in any report; however, there is a small chance that any of these respondents may be identified later. Still, we are asking for your help to ensure that the information we collect is accurate.

You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will answer the questions, which will benefit the services you provide and the nation.

If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate if you introduce us to that person to help us collect that information.

At this point, do you have any questions about the study? Do I have your agreement to proceed?

_____ [ ][ ] [ ][ ] **2 0 0 9**
Interviewer's signature DAY MONTH YEAR

SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.

1902	May I begin the interview now?	YES . . . . . 1 NO 2	 → STOP

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1903	First, I would like to identify clinical staff (such as nurses or doctors) or other staff (such as counsellors, social workers, and laboratory technicians) who are assigned to this unit who are present today. Please give me the names and main service responsibility of the staff assigned to this unit and present today COMPLETE THE STAFF LIST FOR THIS CLINIC/UNIT. DO NOT DUPLICATE SERVICE PROVIDERS WHO ARE LISTED FOR A SERVICE AREA THAT WAS PREVIOUSLY ASSESSED.		
	RESPONDENT MUST BE INTERVIEWED FOR TRAINING AND EXPERIENCE.	STAFF LIST COMPLETED YES . . . . . 1 NO 2	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1904	How many days each week are ART services available in this facility?	DAYS PER WEEK ..... [ ]	
1905	How many months have ART services been offered from this facility? IF EXACT MONTHS ARE UNCERTAIN, PROBE FOR AN ESTIMATE.	MONTHS ..... [ ][ ][ ]	
1906	Is there a person specifically in charge of ART in this facility?	YES ..... 1 NO ONE PERSON IN CHARGE OF ART 2	→ 1908
1907	What is the qualification of the person in charge of ART services in this facility?	SPECIALIST/CONSULTANT ..... 01 MEDICAL OFFICER/PHYSICIAN ..... 02 MEDICAL ASSISTANT ..... 03 REGISTERED NURSE ..... 04 ENROLLED NURSE ..... 05 OTHER (SPECIFY) _____ 96	
1908	Which ARV medicines are prescribed (or dispensed) in this facility? CIRCLE ALL THAT APPLY. AFTER THE RESPONSE, READ THE NAME OF EACH MEDICINE THAT IS NOT MENTIONED, TO VERIFY THAT THE MEDICINE IS NOT PRESCRIBED OR DISPENSED BY THIS UNIT IF A COMBINATION DRUG IS USED, CIRCLE THE COMPONENTS THAT ARE INDICATED IN LIST (E.G., FOR STAVUDINE40+LAMIVUDINE+ NEVIRAPINE, CIRCLE D, B, AND I)	**NRTIs** ZIDOVUDINE (ZDV, AZT) ..... A LAMIVUDINE (3TC) ..... B DIDANOSINE (ddI) ..... C STAVUDINE (d4T) OR D3T ..... D ABACAVIR (ABC) ..... E EMTRICITABINE (FTC) ..... F TENOFOVIR (TDF) ..... G AZT+3TC (COMBIVIR) ..... H **NNRTIs** NEVIRAPINE (NVP) ..... I EFAVIRENZ (EFZ) ..... J DELAVIRDINE (DLV) ..... K **PROTEASE INHIBITORS** LOPINAVIR (LPV) ..... L INDINAVIR (IDV) ..... M NELFINAVIR (NFV) ..... N SAQUINAVIR (SQV) ..... O RITONAVIR (RTV) ..... P ATAZANAVIR (ATV) ..... Q FOSAMPRENAVIR (FPV) ..... R TIPRANAVIR (TPV) ..... S DARUNAVIR (DRV) ..... T LOPINAVIR-RITONAVIR (LPV/r) U **FUSION INHIBITORS** ..... ENFUVIRTIDE (T-20) ..... V OTHER _____ X (SPECIFY)	
1909	What is the most commonly prescribed or dispensed first-line ART regimen in this facility?	STAVUDINE (d4T) + LAMIVUDINE (3TC) plus NEVIRAPINE (NVP) ..... 1 ZIDOVUDINE (AZT) + LAMIVUDINE (3TC) *plus* NEVIRAPINE (NVP) ..... 2 STAVUDINE (d4T) + LAMIVUDINE (3TC) *plus* EFAVIRENZ (EFV) ..... 3 ZIDOVUDINE (AZT) + LAMIVUDINE (3TC) *plus* EFAVIRENZ (EFV) ..... 4 NO ROUTINE FIRST-LINE REGIMEN .. 5	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1910	Now I want to know about eligibility criteria used for placing clients on ART. For each stage of AIDS that I will describe & each criteria I mention please indicate if a client at that stage is eligible for ART from this facility.		

	DISEASE STAGE & CRITERIA	ELIGIBILITY		
		YES	NO	DON'T KNOW
01	WHO stage 3 or 4, irrespective of CD4 cell count	1	2	8
02	CD4 cell counts ≤ 200 CELLS/CUBIC MM (≤ 250 FOR PREGNANT WOMEN) irrespective of WHO clinical stage	1	2	8
03	Client meets social eligibility criteria	1	2	8

1911	Are social or other criteria related to the client's personal situation considered prior to starting ART? IF YES, ASK: Which of the following criteria are considered prior to starting ART? READ EACH RESPONSE AND CIRCLE ALL THAT APPLY.	GEOGRAPHIC CRITERIA . . . . . A PROOF OF CAPACITY TO ATTEND CLINIC REGULARLY . . . . . B DISCLOSURE TO SIGNIFICANT OTHER/PARTNER (IF APPLICABLE) C **NO ART IF SOCIAL PROBLEM:** ALCOHOLIC . . . . . D DRUG ADDICT . . . . . E MENTAL ILLNESS . . . . . F HOMELESS . . . . . G ABILITY TO PAY . . . . . H OTHER _____ X (SPECIFY) NO SOCIAL CRITERIA APPLIED . . . . Y	
1912	Are adherence criteria considered prior to starting ART? IF YES, ASK: Which of the following eligibility criteria are considered prior to starting a client on ART? READ EACH RESPONSE AND CIRCLE ALL THAT APPLY.	CONSISTENT USE OF COTRIM OR TB TREATMENT . . . . . A REQUIRED PRE-ART CLINIC VISITS MADE ON TIME . . . . . B TREATMENT ASSISTANT OR SUPPORTER IDENTIFIED . . . . . C OTHER _____ X (SPECIFY) NO ADHERENCE CRITERIA APPLIED Y	
1913	Is a total lymphocyte count (TLC) always done prior to starting ART? IF YES, ASK: What is the most common practice for providing the test? i.e., where is the test conducted?	YES, CONDUCTED IN THIS FACILITY 1 YES, CLIENT GOES ELSEWHERE . . 2 YES, BLOOD SENT ELSEWHERE . . 3 NO 4	→ 1915

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1914	After the initial TLC test, do you retest for a follow up level? IF YES: Is retesting done only if it is indicated by the patient's condition, or is it done periodically? IF PERIODICALLY, ASK: How often is follow-up testing done?	ONLY IF INDICATED BY PATIENT CONDITION . . . . . 01 EVERY MONTH . . . . . 02 EVERY 2-3 MONTHS . . . . . 03 EVERY 4-6 MONTHS . . . . . 04 EVERY YEAR . . . . . 05 ONCE ONLY, WITHIN 1 MONTH . . . . . 06 OTHER _____ 96 (SPECIFY) NO FOLLOW-UP 95	
1915	Is a CD4 T Cell count always determined prior to starting ART? IF YES, ASK: What is the most common practice for providing the test? i.e., where is the test conducted?	YES, CONDUCTED IN THIS FACILITY 1 YES, CLIENT REFERRED OUTSIDE . . . 2 YES, BLOOD SENT OUTSIDE . . . . . 3 NO 4	→ 1917
1916	After the initial CD4 T cell count, do you retest for a follow up level? IF YES, ASK: Is retesting done only if it is indicated by the patient's condition, or is it done periodically? IF PERIODICALLY, ASK: How often is follow-up testing done?	ONLY IF INDICATED BY PATIENT CONDITION . . . . . 01 EVERY MONTH . . . . . 02 EVERY 2-3 MONTHS . . . . . 03 EVERY 4-6 MONTHS . . . . . 04 EVERY YEAR . . . . . 05 ONCE ONLY, WITHIN 1 MONTH 06 OTHER _____ 96 (SPECIFY) NO FOLLOW-UP 95	
1917	Is an HIV RNA Viral load level always done prior to starting ART? IF YES, ASK: What is the most common practice for providing the test? i.e., where is the test conducted?	YES, CONDUCTED IN THIS FACILITY . . . 1 YES, CLIENT REFERRED OUTSIDE . . . 2 YES, BLOOD SENT OUTSIDE . . . . 3 NO 4	→ 1919
1918	After the initial HIV RNA Viral load level, do you retest for a follow up level? IF YES ASK: Is retesting done only if it is indicated by the patient's condition, or is it done periodically? IF PERIODICALLY, ASK: How often is follow-up testing done?	ONLY IF INDICATED BY PATIENT CONDITION . . . . . 01 EVERY MONTH . . . . . 02 EVERY 2-3 MONTHS . . . . . 03 EVERY 4-6 MONTHS . . . . . 04 EVERY YEAR . . . . . 05 ONCE ONLY WITHIN 1 MONTH . . . . . 06 OTHER _____ 96 (SPECIFY) NO FOLLOW-UP 95	

1919 For each of the following tests, please tell me if the test is conducted routinely, selectively, or never, ***before starting*** a client on ART **(i.e., baseline test)**

	TEST	TEST CONDUCTED			
		ROUTINELY	SELECTIVELY	NO/NEVER	DK
01	Haemoglobin/hematocrit	1	2	3	8
02	Full blood count	1	2	3	8
03	Pregnancy test for women	1	2	3	8
04	Serum electrolytes (including serum creatinine and U&E)	1	2	3	8
05	Urinalysis	1	2	3	8
06	Liver function tests (Serum transaminases)	1	2	3	8
07	TB sputum test	1	2	3	8
08	Hepatitis B	1	2	3	8
09	Chest X-ray	1	2	3	8
10	Any other routine tests _____ (SPECIFY)	1	2	3	8

NO.	QUESTIONS	CODING CATEGORIES				GO TO
1919A	For each of the following tests, please tell me if the test is conducted routinely, selectively, or never ***while the client is on*** ART **(i.e., for monitoring)**.					
		TEST CONDUCTED				
	TEST	ROUTINELY	SELECTIVELY	NO/NEVER	DK	
01	Haemoglobin/hematocrit	1	2	3	8	
02	Full blood count	1	2	3	8	
03	Pregnancy test for women	1	2	3	8	
04	Serum electrolytes (including serum creatinine and U&E)	1	2	3	8	
05	Urinalysis	1	2	3	8	
06	Liver function tests (Serum transaminases)	1	2	3	8	
07	TB sputum test	1	2	3	8	
08	Hepatitis B	1	2	3	8	
09	Chest X-ray	1	2	3	8	
10	Any other routine tests _____ (SPECIFY)	1	2	3	8	
1920	When a client is started on ART, are any of the following types of counselling offered? IF YES, RECORD WHETHER THE COUNSELLING IS ALWAYS OR ONLY SOMETIMES OFFERED.	ALWAYS	SOMETIMES	NEVER	DON'T KNOW	
01	Pre-treatment medication counselling?	1	2	3	8	
02	Follow-up counselling to discuss adherence to ART medicines?	1	2	3	8	
03	Follow-up counselling to discuss adherence to medication plan in presence of significant others?	1	2	3	8	
04	Prevention counselling	1	2	3	8	
1921	CHECK Q1920 IF THERE IS ANY COUNSELLING RELATED TO ART? I.E., IS (01) OR (O2) OR (03) OR (04) = 1 (ALWAYS) OR 2 (SOMETIMES)?	YES ..... 1 NO 2				→ 1924
1922	Who provides the counselling for ART medicines? CIRCLE ALL THAT APPLY. IF NONE OF THE RESPONSES IN 1921 ARE CODED '1', CIRCLE 'Y', "NO COUNSELLING".	PRESCRIBING PHYSICIAN/MO/ OR MEDICAL ASSISTANT ..... A OTHER CONSULTANT/PHYSICIAN/ MEDICAL ASSISTANT ..... B REG. NURSE/NURSING OFFICER .. C N. MIDWIVE/PHN/TRAINED NURSE .. D TRAINED COUNSELOR ..... E PHARMACIST ..... F COMMUNITY/PLWHA WORKER OR "EXPERT PATIENT" ..... G OTHER _____ (SPECIFY) X				

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1923	Have all of the people you just mentioned who provide counselling for ART medicines been trained in counselling for adherence to ART?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
1924	Are there any fees assessed for any services or items related to ARV treatment?	YES . . . . . 1 NO 2	→ 1927

1925	For each of the following items, indicate if there is any routine fee, and if yes, the amount of the fee	(a) FEE YES	(a) FEE NO	(a) FEE NA	(b) AMOUNT IN N$
01	ART CLIENT CARD/CHART	1 → b	2 → 02	3 → 02	
02	CONSULTATION SERVICE	1 → b	2 → 03	3 → 03	
03	ARV MEDICINE	1 → b	2 → 04	3 → 04	
04	LAB TEST / CD4 COUNT	1 → b	2 → 1926	3 → 1926	

1926	Are the official fees posted or displayed so that the client can easily see them? IF YES, VERIFY BY ASKING TO SEE WHERE FEES ARE POSTED	YES, ALL FEES POSTED . . . . . 1 YES, SOME FEES POSTED ONLY . . . 2 NO POSTED FEES 3	
1927	Are there any **ART-related** guidelines or protocols for providers working in this unit? Guidelines that are posted on the wall are acceptable. IF YES, ASK: May I see <u>all</u> the guidelines and protocols that are available here?	YES, GUIDELINES/PROTOCOLS AVAILABLE . . . . . 1 NO GUIDELINES OR PROTOCOLS . 2	→1932

1929	First I would like to ask about national guidelines. ASK ABOUT EACH GUIDELINE/PROTOCOL Do you have *[NAME OF GUIDELINE]*?	(a) OBSERVED	(a) REPORTED AVAILABLE NOT SEEN	(a) NOT AVAIL.	(b) YEAR OF PUBLICATION
01	National Guidelines for Antiretroviral Therapy	1 → b	2 → 02	3 → 02	
02	Guidelines for management of HIV/AIDS for workplace program	1 → b	2 → 03	3 → 03	
03	Guidelines for Home Based Care Services	1 → b	2 → 04	3 → 04	
04	Protocol for Adherence Counselling	1 → b	2 → 05	3 → 05	
05	National Guidelines on Post Exposure Prophylaxis (PEP)	1 → b	2 → 06	3 → 06	
06	Nutrition Information Management	1 → b	2 → 07	3 → 07	
07	Wall chart on PEP in a visible place	1 → b	2 → 08	3 → 08	
08	Biohazard sign up in visible place (red over white background)	1 → b	2 → 1932	3 → 1932	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1932	Where is information for patients receiving ART through this facility recorded? CIRCLE ALL THAT APPLY. ASK TO SEE THE REGISTERS USED FOR FOLLOW-UP OF ART PROGRAM	GENERAL OPD REGISTER WITH HIV/ AIDS AND NON HIV/AIDS CLIENTS A SPECIFIC REGISTER FOR HIV/AIDS CLIENTS . . . . . B SPECIFIC REGISTER ONLY FOR CLIENTS RECEIVING ART . . . . . C INDIVIDUAL CLIENT CHART/ RECORD . . . . . D COMPUTER . . . . . E NO RECORD KEPT . . . . . Y	→ 1944
1933	SKIM THE REGISTER (OR COMPUTER) FOR ALL NEW ENTRIES FOR THE PAST ONE FULL MONTH AND INDICATE WHICH INFORMATION IS COMPLETED FOR ALL CLIENTS STARTED ON ART.	ELIGIBILITY CRITERIA . . . . . A DATE OF ELIGIBILITY . . . . . B NEITHER INFORMATION COMPLETED . . . . . Y	
1934	ASK TO SEE CLIENT INDIVIDUAL RECORDS. RANDOMLY SELECT 10 INDIVIDUAL CLIENT RECORDS/CHARTS/CARDS AND INDICATE WHICH INFORMATION IS PRESENT ON ALL 10 CARDS.	TREATMENT SUPPORTER . . . . . A DATE OF ENROLLMENT IN ART . . . . . B ELIGIBILITY CRITERIA . . . . . C ARV REGIME BEING USED . . . . . D NONE OF ABOVE ITEMS . . . . . Y	
1935	ASK TO SEE THE REGISTER/CLIENT CHART/ COMPUTER RECORDS, AND INDICATE THE DATE OF THE MOST RECENT TIME ART WAS PROVIDED.	WITHIN PAST 30 DAYS . . . . . 1 MORE THAN 30 DAYS AGO . . . . . 2 REGISTER/RECORDS NOT SEEN . . 3	→ 1944
1936	How many patients that are currently receiving ART through this facility are adults? **ADULTS: 14 YEARS AND OLDER**	TOTAL NUMBER OF ADULTS ON ART . . [ ][ ][ ][ ] NONE 0000	
1937	How many patients that are currently receiving ART through this facility are children? **CHILDREN: UNDER 14 YEARS**	TOTAL NUMBER OF CHILDREN ON ART . . . . . [ ][ ][ ][ ] NONE . . . . . 0000 DON'T KNOW 9998	
1938	How many children below 18 months of age are currently receiving ART through this facility?	TOTAL NUMBER OF < 18 MONTH CHILDREN ON ART [ ][ ][ ][ ] NONE . . . . . 0000 DON'T KNOW 9998	
1939	Since the beginning of the ART services, how many clients have been lost to follow-up or are defaulters? This is the number who began ART and no longer receive ART and you do not know their status (transferred or died).	NUMBER ART CLIENTS LOST TO FOLLOW-UP [ ][ ][ ][ ] NONE . . . . . 0000 DON'T KNOW 9998	
1940	During the past 12 full months, how many ART clients have died?	NUMBER OF CLIENBTS WHO DIED [ ][ ][ ][ ] NONE . . . . . 0000 DON'T KNOW 9998	→ 1942
1941	INDICATE MONTHS OF DATA IN PREVIOUS QUESTION.	MONTHS OF DATA . . . . . [ ][ ]	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1942	During the past 12 full months, how many ART clients have been lost to follow-up?	NUMBER OF CLIENTS LOST TO FOLLOW-UP [ ][ ][ ][ ] NONE ..... 0000 DON'T KNOW 9998	→ 1944
1943	INDICATE MONTHS OF DATA IN PREVIOUS QUESTION.	MONTHS OF DATA ..... [ ][ ]	
1944	Are reports regularly compiled on the numbers of clients receiving ART?	YES ..... 1 NO 2	→ 1947
1945	How frequently are the compiled reports submitted to someone outside of this facility?	YES, MONTHLY OR MORE OFTEN .. 1 YES, EVERY 2-3 MONTHS ..... 2 YES, EVERY 4-6 MONTHS ..... 3 YES LESS OFTEN THAN EVERY 6 MONTHS ..... 4 NEVER 5	→ 1947
1946	To whom do you send these reports? CIRCLE ALL THAT APPLY.	DISTRICT LEVEL (MOH/DSP/HIS) ... C REGIONAL LEVEL (MOHSS/DSP/HIS) ... D NATIONAL LEVEL (MOHSS/DSP/HIS) ... E DONOR AGENCY ..... F OTHER _____ X (SPECIFY)	
1947	Is an individual client chart/record/card where information on an individual client is recorded, and which provides information on previous visits of this client maintained? IF YES, ASK TO SEE A BLANK OR CURRENT CHART/RECORD.	YES, OBSERVED ..... 1 YES, REPORTED, NOT SEEN ..... 2 YES, CHART/RECORD AVAILABLE IN OTHER CLINIC/UNIT, THIS FACILITY ..... 3 NO 4	
1948	Do you have a system for making individual client appointments for follow-up? IF YES, ASK TO SEE ANY RECORD INDICATING THE SYSTEM FUNCTIONS	YES, OBSERVED ..... 1 YES, REPORTED, NOT SEEN ..... 2 NO 3	→ 1950
1949	Does the appointment system indicate if the client kept the appointment or not?	YES ..... 1 NO 2	
1950	Does this facility provide nutrition rehabilitation services for HIV/AIDS patients? NUTRITIONAL REHABILITATION REFERS TO EDUCATION ABOUT EATING WELL, EARLY IDENTIFICATION OF DEFICIENCIES, PROVIDING FORTIFIED PROTEIN SUPPLEMENT (FPS). IF YES, ASK: Which of the following are routine components of nutritional rehabilitation services? READ EACH RESPONSE AND CIRCLE ALL THAT APPLY.	NUTRITIONAL COUNSELLING ..... A TEACH EARLY IDENTIFICATION OF DEFICIENCIES ..... B PROVIDE VITAMINS ..... C PROVIDE FORTIFIED PROT. SUPP. D PROVIDE HIGH PROTEIN FOODS E PROVIDE OTHER DIET SUPPLEMENT _____ X (SPECIFY) NO SERVICES ..... Y	
	THANK YOUR RESPONDENT FOR THE TIME AND HELP PROVIDED AND PROCEED TO THE NEXT DATA COLLECTION SITE		

SECTION 20: PREVENTION OF MOTHER-TO-CHILD TRANSMISSION (PMTCT) SERVICES

Facility Number: [ ][ ][ ] **Interviewer Code:** [ ][ ] QRE TYPE **20**

2000	Does this facility provide any services related to preventing transmission of HIV/AIDS from mother to child (i.e., PMTCT)?	YES . . . . . 1 NO 2	→ **END**
2001	How are the PMTCT services in this facility organized and provided? PROBE TO CAPTURE ALL POSSIBLE WAYS THE FACILITY ORGANIZES PMTCT SERVICES AND CIRCLE ALL THAT APPLY.	SEPARATE PMTCT SERVICES . . . . . A PMTCT AND VCT SERVICES TOGETHER B PMTCT WITH ANC SERVICES . . . . . C PMTCT WITH ANC AND DELIVERY AS ONE SYSTEM . . . . . D PMTCT WITH DELIVERY . . . . . E	

CHECK 2001: IF MORE THAN ONE SYSTEM IS REPORTED, ASK FOR THE MAIN SYSTEM USED IN THE FACILITY. GO TO THAT LOCATION TO COLLECT THIS INFORMATION.

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN THE PROVISION OF PMTCT SERVICES IN THIS FACILITY.

IF THIS IS A NEW RESPONDENT, INTRODUCE YOURSELF. BRIEFLY EXPLAIN THE PURPOSE OF YOUR VISIT AND ASK IF HE/SHE WOULD BE WILLING TO ANSWER A FEW QUESTIONS ABOUT ART SERVICES IN THE FACILITY. IF IN AGREEMENT, READ THE INTRODUCTORY CONSENT STATEMENT BELOW

IF THE RESPONDENT HAS ALREADY BEEN INTERVIEWED FOR A PREVIOUS SECTION, CIRCLE NUMBER 1 (YES) IN Q2003 BELOW AND GO ON TO Q2004.

Good day! My name is _____. We are here on behalf of the Ministry of Health and Social Services (MOHSS) conducting a study to assist the government in knowing more about health services in Namibia. Now I will read a statement explaining the study.

ALL facilities in the country are participating in this study. We will be asking you questions about various health services and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility may be used by the MOHSS, organizations supporting services in your facility, and researchers, for planning service improvement or for conducting further studies of health services.

Neither your name nor that of any other health worker respondents participating in this study will be included in the dataset or in any report; however, there is a small chance that any of these respondents may be identified later. Still, we are asking for your help to ensure that the information we collect is accurate.

You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will answer the questions, which will benefit the services you provide and the nation.

If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate if you introduce us to that person to help us collect that information.

At this point, do you have any questions about the study? Do I have your agreement to proceed?

_____ [ ][ ] [ ][ ] **2 0 0 9**

Interviewer's signature — DAY | MONTH | YEAR

SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.

2003	May I begin the interview now?	YES . . . . . 1 NO 2	→ **STOP**

NO.	QUESTIONS	CODING CATEGORIES	GO TO
2004	First, I would like to identify clinical staff (such as nurses or doctors) or other staff (such as counsellors, social workers, and laboratory technicians) who are assigned to this unit who are present today. Please give me the names and main service responsibility of the staff assigned to this unit and present today COMPLETE THE STAFF LIST FOR THIS UNIT. DO NOT DUPLICATE SERVICE PROVIDERS WHO ARE LISTED FOR A SERVICE AREA THAT WAS PREVIOUSLY ASSESSED.		
	RESPONDENT MUST BE INTERVIEWED FOR TRAINING AND EXPERIENCE.	STAFF LIST COMPLETED YES . . . . . 1 NO 2	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
2005	How many months have PMTCT services been offered from this facility? IF EXACT MONTHS ARE UNCERTAIN, PROBE FOR AN ESTIMATE.	MONTHS . . . . . [ ][ ][ ]	

2006 For each service I will mention, please tell me if providers in this unit or facility offer the service or refer clients for the service, either in this facility or outside, for prevention of mother-to-child transmission of HIV

	SERVICE	SERVICE OFFERED IN THIS FACILITY: OUTPATIENT: OFFERED THIS UNIT	SERVICE OFFERED IN THIS FACILITY: OUTPATIENT: REFER TO OTHER UNIT THIS FACILITY	SERVICE OFFERED IN THIS FACILITY: INPATIENT SERVICE ONLY	REFER CLIENTS OUTSIDE FACILITY	NO SERVICE OR REFERRAL
01	Offer HIV testing	1	2	3	4	5
02	Offer group pre-test information or counselling	1	2	3	4	5
03	Offer individual HIV pre-test information or counselling	1	2	3	4	5
04	Offer individual HIV post-test counselling	1	2	3	4	5
05	Offer couple counselling for women who are HIV positive	1	2	3	4	5
06	Offer counselling on infant feeding to HIV positive women	1	2	3	4	5
07	Offer counselling on maternal nutrition to HIV positive women	1	2	3	4	5
08	Offer counselling on family planning	1	2	3	4	5
09	Offer family planning services	1	2	3	4	5
10	Offer counselling on condom use for dual protection	1	2	3	4	5
11	Distribute condoms to PMTCT clients	1	2	3	4	5
12	Offer ARV prophylaxis for pregnant women	1	2	3	4	5
13	Offer ARV prophylaxis for newborn	1	2	3	4	5
14	Provide breast-milk substitutes for newborns of HIV positive women	1	2	3	4	5
15	Offer follow up counselling for HIV positive women	1	2	3	4	5
16	Offer ARV therapy (long-term treatment) for HIV positive women	1	2	3	4	5
17	Offer ARV therapy for family members of HIV positive women	1	2	3	4	5
18	Offer women-to-women support groups	1	2	3	4	5
19	Offer PMTCT services with delivery services	1	2	3	4	5
20	Follow up services for PMTCT babies	1	2	3	4	5

2007	When the various services offered for PMTCT are provided, is this recorded anywhere so that you can see what services a pregnant woman has received? IF YES, ASK TO SEE WHERE THIS INFORMATION IS RECORDED AND ANSWER THE FOLLOWING QUESTIONS.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 RECORDED IN INDIVIDUAL CLIENT CHART/RECORD, NOT COMPILED FOR REPORTING . . . . . 3 NO 4	 → 2009 → 2009 → 2009

NO.	QUESTIONS	CODING CATEGORIES					GO TO
2008	RECORD THE FOLLOWING INFORMATION FOR ANC CLIENTS IT MAY BE NECESSARY TO REVIEW **ANC** AS WELL AS **PMTCT** RECORDS TO COLLECT THE INFORMATION.	(a) RECORD/REGISTER			(b) NUMBERS FROM OBSERVED RECORDS		
		OBSERVED	REPORTED NOT SEEN	NOT AVAIL	NUMBER OF CLIENTS	MONTHS OF DATA	
01	TOTAL ANC CLIENTS RECEIVING PRIMARY PREVENTIVE COUNSELLING (EITHER GROUP OR INDIVIDUAL) IN PAST 12 MONTHS	1 → b	2 → 02	3 → 02			
02	TOTAL HIV POSITIVE WOMEN RECEIVING SECONDARY PREVENTIVE COUNSELLING IN PAST 12 MONTHS	1 → b	2 → 03	3 → 03			
03	TOTAL HIV POSITIVE WOMEN RECEIVING COUNSELLING ON FAMILY PLANNING IN PAST 12 MOS.	1 → b	2 → 04	3 → 04			
04	TOTAL HIV POSITIVE WOMEN RECEIVING INFANT FEEDING COUNSELLING IN PAST 12 MONTHS	1 → b	2 → 05	3 → 05			
05	TOTAL HIV POSITIVE WOMEN RECEIVING COUPLES COUNSELLING IN PAST 12 MONTHS	1 → b	2 → 2009	3 → 2009			
2009	Are there any PMTCT-related guidelines/protocols for providers working in this unit? Guidelines that are posted on the wall are acceptable. IF YES, ASK: May I see all the guidelines and protocols that are available here?	YES, GUIDELINES/PROTOCOLS AVAILABLE . . . . . 1 NO GUIDELINES OR PROTOCOLS . 2					→ 2013
2010	First I would like to ask about national guidelines. ASK ABOUT EACH GUIDELINE/PROTOCOL Do you have *[NAME OF GUIDELINE]*?	(a)					
		OBSERVED	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE	YEAR OF PUBLICATION		
01	National guidelines for prevention of mother-to-child transmission of HIV (PMTCT)	1 → b	2 → 02	3 → 02			
02	National Guidelines for Voluntary Counselling and Testing	1 → b	2 → 03	3 → 03			
03	A Guideline for counsellors with special emphasis on HIV/AIDS/STDs counselling	1 → b	2 → 04	3 → 04			
04	Guidelines for management of HIV/AIDS for the workplace	1 → b	2 → 05	3 → 05			
05	Guidelines and Standards for Counselling and Supervision	1 → b	2 → 06	3 → 06			
06	National Guidelines for Outreach VCT	1 → b	2 → 07	3 → 07			
07	HIV Rapid Testing Standard Operating Procedures (including infection control)	1 → b	2 → 08	3 → 08			
08	National Guidelines on Post Exposure Prophylaxis (PEP)	1 → b	2 → 09	3 → 09			
09	Nutrition Management for PLWHA	1 → b	2 → 10	3 → 10			
10	Wall chart on PEP in a visible place	1 → b	2 → 11	3 → 11			
11	Biohazard sign up in visible place (red over white background)	1 → b	2 → 2011	3 → 2011			
2011	**Other than the previously mentioned national** guidelines, are there any other protocols or guidelines for counselling and testing or other related topics?	YES, OTHER PROTOCOLS/ GUIDELINES . . . . . 1 NO OTHER PROTOCOLS/ GUIDELINES 2					→ 2013

NO.	QUESTIONS	CODING CATEGORIES				GO TO
		(a)			(b)	
2012	ASK ABOUT ANY GUIDELINES OTHER THAN THOSE PREVIOUSLY RECORDED, THAT COVER THE FOLLOWING TOPICS:	OBSERVED	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE	YEAR OF PUBLICATION	
01	Other protocols/guidelines for pre-test counselling?	1 → b	2 → 02	3 → 02		
02	Other protocols/guidelines for post test counselling for both positive and negative test results?	1 → b	2 → 03	3 → 03		
03	Is there any written policy that all clients receiving HIV tests must be offered pre-test counselling or information, and post test counselling?	1 → b	2 → 04	3 → 04		
04	Is there any policy on HIV testing procedures, that is what test should be done, and when?	1 → b	2 → 05	3 → 05		
05	HIV Laboratory Manual for the Processing of samples, use of HIV test kits, and data management?	1 → b	2 → 06	3 → 06		
06	Is there a written informed consent document for the client to sign or keep?	1 → b	2 → 07	3 → 07		
07	Any other informed consent policy?	1 → b	2 → 08	3 → 08		
08	Is there a written policy on confidentiality provided to the client, that specifies that no one will be told the HIV test result without the client's permission?	1 → b	2 → 09	3 → 09		
09	Any other confidentiality policy reaffirming that no one will be told the results without the specific permission of the client?	1 → b	2 → 10	3 → 10		
10	Any other guidelines for PMTCT services?	1 → b	2 → 2013	3 → 2013		
2013	How many days each week is HIV testing available in this facility for pregnant women?	DAYS PER WEEK . . . . . [ ] DON'T KNOW 8				
2014	What is the most common procedure followed for offering HIV testing to pregnant women? RECORD THE RESPONSE THAT BEST REFLECTS THE PRACTICE. PROBE IF NECESSARY.	OFFERED WHEN VOLUNTARILY REQUESTED BY PREGNANT WOMAN. . . . . 1 OFFERED TO ALL ANC CLIENTS AT FIRST VISIT. . . . . 2 OFFERED SELECTIVELY TO ANC CLIENTS AT FIRST VISIT, BASED ON SOCIAL/MEDICAL HISTORY. . . . . 3 OTHER _____ 6 (SPECIFY)				
2015	Are all HIV positive women instructed to bring the child for an HIV test? IF YES, ASK WHETHER ALL ANC CLIENTS ARE INSTRUCTED OR ONLY THOSE DELIVERING AT THE FACILITY	YES, FOR ALL HIV POSITIVE WOMEN. . . . 1 YES, FOR FACILITY DELIVERIES ONLY. . . . . 2 NO. 3				→ 2022
2016	At what age are the women instructed to bring the child for HIV testing? INDICATE AGE IN WEEKS	AGE (IN WEEKS) INFANT TO BE BROUGHT FOR HIV TESTING [ ][ ] DON'T KNOW. 98				

NO.	QUESTIONS	CODING CATEGORIES	GO TO
2017	Do providers in this unit actually prescribe or provide the antiretroviral medicine to HIV positive pregnant women for PMTCT? IF YES, ASK: What is the ARV regime used? CIRCLE ALL THAT APPLY.	NEVIRAPINE ALONE . . . . . A ZIDOVUDINE ALONE . . . . . B ZIDOVUDINE AND LAMIVUDINE TOGETHER C ZIDOVUDINE AND LAMIVUDINE ***plus*** NEVIRAPINE TOGETHER. . . . . D ZIDOVUDINE AND NEVIRAPINE. . . . . E OTHER (SPECIFY)_____ X NO ARV AVAILABLE FROM THIS UNIT FOR PMTCT. . . . . Y	→ 2022
2018	What is the practice for providing the ARV prophylaxis to the HIV positive pregnant woman? PROBE TO ARRIVE AT CORRECT RESPONSES	PROVIDE TO WOMEN ATTENDING ANC SAME DAY HIV STATUS IS CONFIRMED FOR SELF ADMINISTRATION AT TIME OF LABOUR. . . . . A PROVIDE TO WOMEN WHO DELIVER IN FACILITY, AT TIME OF DELIVERY. . . . . B PROVIDE TO WOMEN ATTENDING ANC STARTING AT 28 WEEKS . . . . . C GIVEN TO CHW/TBA TO GIVE TO WOMAN AT HOME DURING LABOUR. . . . . D OTHER (SPECIFY)_____ X	
2020	Which ARV is used for the newborn for PMTCT?	NEVIRAPINE ONLY. . . . . A ZIDOVUDINE (or AZT) ONLY. . . . . B NEVIRAPINE ***plus*** ZIDOVUDINE AND LAMIVUDINE TOGETHER. . . . . C OTHER _____ X (SPECIFY) NO ARV PROPHYLAXIS FOR NEWBORN . . . . . Y	→ 2022
2021	What is the practice for providing the ARV prophylaxis to the newborn of the HIV positive woman?	GIVE TO ANC WOMAN FOR SELF ADMINISTRATION TO NEWBORN AFTER BIRTH. . . . . A INSTRUCT MOTHER TO BRING CHILD TO FACILITY FOR ARV WITHIN 72 HOURS AFTER BIRTH. . . . . B PROVIDE NVP TO NEWBORN AT TIME OF DELIVERY, FOLLOWED WITH AZT + 3TC FOR 7 DAYS. . . . . C OTHER_____ X (SPECIFY)	
2022	Now I would like to look at ANC records, including those that provide information on any PMTCT counselling and testing services		
	Do you have a record or register of the total number of first-visit ANC clients over the past 12 months? IF YES, ASK TO SEE THE RECORD/REGISTER.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO 3	 → 2025 → 2025
2023	RECORD THE TOTAL NUMBER OF FIRST VISIT ANC CLIENTS DURING THE PAST 12 MONTHS.	NUMBER OF FIRST VISIT ANC CLIENTS [ ][ ][ ][ ]	
2024	INDICATE NUMBER OF MONTHS OF DATA AVAILABLE IN PREVIOUS QUEST.	MONTHS OF DATA . . . . . [ ][ ]	
2025	Are there any records or registers that provide numbers of ANC clients receiving pre- or post-test counselling or HIV testing? GO TO WHERE PMTCT RECORDS ARE MAINTAINED FOR THE FOLLOWING INFORMATION. THE INFORMATION MAY BE KEPT IN ANC AND DELIVERY UNITS.	YES . . . . . 1 YES, IN VCT STATISTICS BUT NOT SPECIFIC FOR ANC . . . . . 2 NO 3	 → 2028 → 2028

NO.	QUESTIONS	CODING CATEGORIES					GO TO
2026	ASK TO SEE ANY RECORD OR REGISTER OF ANC CLIENTS WHO RECEIVED ANY HIV TEST OR COUNSELLING SERVICES DURING THE PAST 12 MONTHS, AND RECORD THE CORRECT RESPONSE	(a) RECORD/REGISTER			(b) NUMBERS FROM OBSERVED RECORDS		
		OBSERVED	REPORTED NOT SEEN	NOT AVAIL	NUMBER OF CLIENTS	MONTHS OF DATA	
01	TOTAL ANC CLIENTS RECEIVING INDIVIDUAL PRE-TEST COUNSELLING	1 → b	2 → 03	3 → 03			
02	TOTAL ANC CLIENTS RECEIVING POST-TEST COUNSELLING	1 → b	2 → 04	3 → 04			
03	TOTAL CLIENTS WHO OPTED OUT	1 → b	2 → 04	3 → 04			
04	TOTAL ANC CLIENTS WHO GOT AN HIV TEST	1 → b	2 → 05	3 → 05			
05	TOTAL ANC CLIENTS WHO RECEIVED HIV TEST RESULTS	1 → b	2 → 06	3 → 06			
06	TOTAL ANC CLIENTS WITH POSITIVE HIV TEST	1 → b	2 → 07	3 → 07			
07	TOTAL ANC CLIENTS WITH POSITIVE (+) HIV TEST WHO RECEIVED TEST RESULTS	1 → b	2 → 2027	3 → 2027			
2027	WHAT IS THE MOST RECENT DATE RECORDED FOR HIV TEST COUNSELLING?	WITHIN PAST 30 DAYS . . . . . 1 MORE THAN 30 DAYS . . . . . 2 NO DATE RECORDED . . . . . 3 NO COUNSELLING RECORDED 4					→ 2030
2028	Is there a system where you can link the HIV test result with the client who received pre- and post-test counselling? IF YES, ASK TO SEE HOW THE SYSTEM WORKS	YES, OBSERVED . . . . . 1 YES, REPORTED NOT SEEN . . . . . 2 NO . . . . . 3 SEROSTATUS NOT ASSESSED 4					→ 2033
2029	Is there a system for linking the counselling and test results with the receipt of ARV for the mother and the newborn? IF YES, ASK TO SEE THE RECORDS.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO RECORD 3					
2030	AMONG THE WOMEN FOR WHOM TESTING INFORMATION WAS AVAILABLE **(Q2026)** INDICATE IF INFORMATION ON RECEIVING ARV, AND ON THEIR NEWBORN IS AVAILABLE. IF INFORMATION ONLY AVAILABLE IN DELIVERY AREA, CIRCLE '2'.	(a) RECORD/REGISTER			(b) NUMBERS FROM OBSERVED RECORDS		
		OBSERVED	REPORTED NOT SEEN	NOT AVAIL	NUMBER OF CLIENTS	MONTHS OF DATA	
01	NUMBER OF HIV POSITIVE WOMEN WHO WERE PROVIDED ARV FOR PMTCT	1 → b	2 → 02	3 → 02			
02	NUMBER OF NEWBORNS OF HIV POSITIVE WOMEN WHO WERE PROVIDED ARV	1 → b	2 → 03	3 → 03			
03	NUMBER OF INFANTS BORN TO HIV POSITIVE WOMEN	1 → b	2 → 04	3 → 04			
04	NUMBER OF HIV POSITIVE INFANTS.	1 → b	2 → 05	3 → 05			
05	TOTAL NUMBER OF BIRTHS FOR ALL WOMEN	1 → b	2 → 2031	3 → 2031			

NO.	QUESTIONS	CODING CATEGORIES	GO TO
2031	Is there any record of HIV positive pregnant women who begin ARV treatment? IF YES, ASK TO SEE THE RECORD/REGISTER	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 WOMEN REFERRED TO ART OUTSIDE THIS UNIT. NO FURTHER FOLLOW-UP FROM THIS UNIT . . . . . 3 NO RECORDS . . . . . 4 ARV TREATMENT NOT AVAILABL 5	
2033	Do you compile and submit any statistics for pregnant women and infants receiving PMTCT services? IF YES, ASK: Which statistics do you compile & submit for pregnant women (and infants) receiving PMTCT services? CIRCLE ALL THAT APPLY	**NUMBER OF PREGNANT WOMEN** RECEIVING PRETEST COUNSELLING. . . A RECEIVING POSTTEST COUNSELLING. . B TESTED FOR HIV . . . . . C SERO POSITIVE FOR HIV . . . . . D RECEIVING ARV FOR PMTCT . . . . . E ON ART F **INFANTS OF HIV POSITIVE WOMEN** WHO ARE TESTED FOR HIV . . . . . G RECEIVING ARV FOR PMTCT . . . . . H NO STATISTICS COMPILED. . . . . Y	→ 2036
2034	How frequently are any of the compiled reports submitted to someone outside of this unit?	MONTHLY OR MORE OFTEN . . . . . 1 EVERY 2-3 MONTHS . . . . . 2 EVERY 4-6 MONTHS . . . . . 3 LESS OFTEN THAN EVERY 6 MONTHS . 4 NEVER SUBMIT REPORTS. 5	→ 2036
2035	To whom are the reports sent? CIRCLE ALL THAT APPLY.	DISTRICT LEVEL (MOH/DSP/HIS) . . . . . C REGIONAL LEVEL (MOHSS/DSP/HIS . . . . D NATIONAL LEVEL (MOHSS/DSP/HIS) . . . . E DONOR AGENCY . . . . . F OTHER _____ X (SPECIFY)	
2036	Are there any fees assessed for any services or items related to PMTCT services?	YES . . . . . 1 NO 2	→ 2038

2037	For each of the following items, indicate if there is any routine fee, and if yes, the amount of the fee	(a) FEE YES	(a) FEE NO	(a) FEE NA	(b) AMOUNT IN N$
01	Fee for HIV test	1→b	2 → 02	3 → 02	
02	Fee for antiretroviral prophylaxis for mother	1→b	2 → 03	3 → 03	
03	Fee for antiretroviral prophylaxis for newborn	1→b	2 → 2037A	3 → 2037A	

2037A	Are the official fees posted or displayed so that the client can easily see them? IF YES, VERIFY BY ASKING TO SEE WHERE FEES ARE POSTED	YES, ALL FEES POSTED . . . . . 1 YES, SOME FEES POSTED ONLY . . . 2 NO POSTED FEES 3	
2038	Is an individual client chart/record/card maintained for clients who receive services through this unit? This refers to any system, where individual information about a client is recorded so that a record of all care and services is available in one document? IF YES, ASK TO SEE A BLANK OR CURRENT CHART/RECORD.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 YES, ONLY AVAILABLE IN OTHER FACILITY AREA . . . . . 3 YES, ONLY AVAILABLE WITH CENTRAL RECORDS/STATISTICS . . . . 4 OTHER _____ 6 SPECIFY NO INDIVIDUAL CLIENT CHART/ RECORD 7	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
2039	Are there delivery services in this facility, where PMTCT clients can receive services? IF YES, ASK: Is there any system for linking the PMTCT clients from ANC to women who deliver in this facility and receive PMTCT? PROBE TO DECIDE IF PMTCT SERVICES IN THE DELIVERY UNIT ARE LINKED WITH PMTCT SERVICES FROM ANC, OR WHETHER THE DELIVERY UNIT PROVIDES PMTCT AS A SEPARATE PROGRAM.	YES, DELIVERY SERVICES LINKED WITH PMTCT FROM ANC . . . . . 1 DELIVERY SERVICES PROVIDE PMTCT SERVICES UNDER DIFFERENT SYSTEM. THIS QUESTIONNAIRE IS BEING ADMINISTERED IN DELIVERY . . . . . 2 NO DELIVERY SERVICES 3	→ GO TO DELIVERY UNIT & CONT. QRE → **END**
2040	Is the HIV serostatus routinely assessed for all women who deliver in the facility? IF YES, ASK: What methods do you use to assess the serostatus of these women? RECORD ALL ACCEPTED METHODS FOR ASSESSING SEROSTATUS	CLIENT HISTORY . . . . . A CLIENT ANC RECORD . . . . . B ROUTINE TESTING . . . . . C OFFERED TO ALL/TEST ONLY IF WOMAN GIVES CONSENT . . . . . D OFFER ONLY IF SUSPECT HIV . . . . . E OTHER _____ X SPECIFY SEROSTATUS NOT ROUTINELY ASSESSED . . . . . Y	
2041	Is pre-test counselling routinely offered to women in labour whose HIV status is unknown?	YES . . . . . 1 NO 2	→ 2044
2042	What is the most common practice for providing pre-test counselling for women in labour? CIRCLE ALL THAT APPLY	TRAINED PMTCT COUNSELLOR COMES TO UNIT . . . . . A TRAINED UNIT STAFF PROVIDE COUNSELLING . . . . . B NOT ALWAYS COUNSELLED BY TRAINED STAFF . . . . . C PRETEST COUNSELLING NOT ROUTINE D	
2043	What is the most common practice for providing post-test counselling to HIV positive women who were tested when admitted for delivery?	TRAINED PMTCT COUNSELLOR COMES TO UNIT . . . . . A TRAINED UNIT STAFF PROVIDE COUNSELLING . . . . . B NOT ALWAYS COUNSELLED BY TRAINED STAFF . . . . . C POST TEST COUNSELLING NOT ROUTIN D	
2044	Are there any guidelines for HIV test counselling in the delivery unit? IF YES, ASK TO SEE THE GUIDELINES AND INDICATE IF THEY SPECIFY BOTH PRE AND POST TEST COUNSELLING.	YES, NATIONAL PMTCT GUIDELINES OBSERVED . . . . . 1 YES, NATIONAL VCT GUIDELINES OBSERVED . . . . . 2 YES, OTHER GUIDELINES REPORTED NOT SEEN . . . . . 3 NO, GUIDELINES NOT AVAILABLE 4	
2045	Are records on HIV test counselling available in this unit? IF YES, ASK TO SEE RECORDS AND VERIFY IF BOTH PRETEST AND POST TEST ARE RECORDED.	YES, OBSERVED RECORD OF PRE AND POST TEST COUNSELLING . . . . . 1 REPORTED RECORDS KEPT WITH PMTCT/VCT CLINIC/UNIT . . . . . 2 RECORDED IN CLIENT INDIVIDUAL CHART/RECORD ONLY . . . . . 3 COUNSELLING NOT ROUTINELY RECORDED 4	
2046	Is there a written protocol/guideline for providing ARV prophylaxis for PMTCT to HIV positive women who deliver in this facility? IF YES, ASK TO SEE THE GUIDELINE	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO 3	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
2047	Is there a register or record where the HIV positive women who deliver in the facility and receive the ARV at the time of delivery are recorded? IF YES, ASK TO SEE THE REGISTER (THIS MAY BE THE SAME REGISTER KEPT FOR ANC PMTCT RECIPIENTS)	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO 3	 → 2049 → 2049

2048	ASK TO SEE RELEVANT RECORDS FOR THE DATA REQUESTED BELOW FOR THE PAST 12 MONTHS AND RECORD THE CORRECT RESPONSE.	(a) RECORD/REGISTER			(b) NUMBERS FROM OBSERVED RECORDS	
		OBSERVED	REPORTED NOT SEEN	NOT AVAIL	NUMBER OF CLIENTS	MONTHS OF DATA
01	TOTAL DELIVERIES IN THE FACILITY	1 → b	2 → 02	3 → 02		
02	TOTAL HIV POSITIVE WOMEN DELIVERING IN THE FACILITY	1 → b	2 → 03	3 → 03		
03	TOTAL HIV POSITIVE WOMEN DELIVERING IN THE FACILITY AND RECEIVING ARV PROPHYLAXIS	1 → b	2 → 2049	3 → 2049		

2049	Other than previously observed guidelines, do you have any guidelines or protocols for delivery to prevent mother to child transmission of HIV/AIDS? IF YES, ASK TO SEE THEM.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO 3	
2050	What delivery practices are implemented in this facility to decrease mother to child transmission of HIV/AIDS? DO NOT READ RESPONSES. PROMPT THE RESPONDENT BY ASKING: For example, have you changed any delivery practices because of the risk of HIV/AIDS? CIRCLE ALL THAT ARE MENTIONED.	NO ROUTINE EPISIOTOMY . . . . . A MINIMIZE INSTRUMENT DELIVERY . . . . B HIBITANE VAGINAL CLEANSING . . . . . C MINIMIZE VAGINAL EXAM . . . . . D MINIMIZE ARTIFICIAL RUPTURE MEMBRANES . . . . . E CAESAREAN SECTION . . . . . F ARV PROPHYLAXIS IF HIV POSITIVE . . G AVOID MILKING CORD/IMMEDIATE CLAMP CORD . . . . . H AVOID SUCTION . . . . . I ENCOURAGE EXCLUSIVE BREASTFEEDING . . . . . J OTHER _____ X (SPECIFY) NONE . . . . . Y DON'T KNOW . . . . . Z	

THANK YOUR RESPONDENT FOR THE TIME AND HELP PROVIDED AND PROCEED TO THE NEXT DATA COLLECTION SITE

OBSERVATION AND CLIENT EXIT INTERVIEWS

Sample List for Antenatal Care Client Observation

Date DAY MONTH YEAR

FACILITY #

IF THERE ARE MORE THAN 25 CLIENTS YOU MAY SIMPLY INDICATE THE TOTAL NUMBER OF FIRST VISIT AND TOTAL NUMBER OF FOLLOW-UP VISITS

	NAME	FIRST VISIT	FOLLOW-UP
01			
02			
03			
04			
05			
06			
07			
08			
09			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			

Observation of Antenatal-Care Consultation

1. Facility Identification

QTYPE | O | A | N |

Name of the facility: _____

Location of the facility: _____

FACILITY NUMBER . . . . . [ ][ ][ ]

2. Provider Information

Provider category:
- SPECIALIST. 01
- MEDICAL OFFICER/PHYSICIAN 02
- MEDICAL ASSISTANT 03
- REGISTERED NURSE/MIDWIFE 04
- ENROLLED NURSE/MIDWIFE 05
- NURSE ASSISTANT/AUXILIARY 06

PROVIDER CATEGORY [ ][ ]

SEX OF PROVIDER: (1=Male; 2=Female)

SEX OF PROVIDER . . . . . [ ]

PROVIDER SERIAL NUMBER [FROM STAFF LISTING FORM]

PROVIDER SL NUMBER . . . . . [ ][ ]

3. Information About Observation

Date: ➡

DAY . . . . . [ ][ ]

MONTH . . . . . [ ][ ]

YEAR . . . . . | 2 | 0 | 0 | 9 |

Name of the observer: _____

OBSERVER CODE . . . . . [ ][ ]

Client code: ➡

CLIENT CODE . . . . . [ ][ ]

4. Observation of Antenatal-Care Consultation

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	BEFORE OBSERVING THE CONSULTATION, OBTAIN PERMISSION FROM BOTH THE SERVICE PROVIDER AND THE CLIENT. MAKE SURE THAT THE PROVIDER KNOWS THAT YOU ARE NOT THERE TO EVALUATE HIM OR HER, AND THAT YOU ARE NOT AN "EXPERT" TO BE CONSULTED DURING THE SESSION. **READ TO PROVIDER:** Hello. I am [NAME OF OBSERVER]. I am representing the Ministry of Health and Social Services (MOHSS). We are conducting a study of all health facilities in Namibia with the goal of finding ways to improve the delivery of services. I would like to observe your consultation with this client in order to understand how ANC services are provided in this facility. Information from this observation is confidential. Neither your name nor that of the client will be recorded. The information acquired during this observation may be used by the MOHSS or other organizations to improve services, or for research on health services; however, neither your name nor the names of your clients will be entered in the database. Do you have any questions for me? If at any point you feel uncomfortable you can ask me to leave. However, we hope you won't mind our observing your consultation. Do I have your permission to be present at this consultation? _____ Interviewer's signature (Indicates respondent's willingness to participate) DAY | MONTH | 2009 YEAR		
100	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES . . . . . 1 NO 2	→ **END**
	READ TO CLIENT: Hello, I am_____. I am representing the Ministry of Health and Social Services (MOHSS). We are conducting a study of health services in health facilities in Namibia. I would like to be present while you are receiving services today, in order to better understand how health care is provided. We are not evaluating the [NURSE/DOCTOR/PROVIDER] or the facility. And although Information from this observation may be provided to researchers for analyses, neither your name nor the date of services will be provided on any shared data, so your identity and any information about you will remain completely confidential. Please know that whether you decide to allow me to observe your visit is completely voluntary and that whether you agree to participate or not will not affect the services you receive. If, at any point, you would prefer I leave please feel free to tell me. After the consultation, my colleague would like to talk with you about your experience here today. Do you have any questions for me? Do I have your permission to be present at this consultation? _____ Interviewer's signature (Indicates respondent's willingness to participate)		
101	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE CLIENT.	YES . . . . . 1 NO 2	→ **END**
102	RECORD THE TIME THE OBSERVATION STARTED	__ : __	
103	CLIENT STATUS. (OBSERVER TO COMPLETE)	YES NO DK	
01	RECORD WHETHER THIS IS CLIENT'S FIRST VISIT FOR ANTENATAL CARE **AT THIS FACILITY** FOR THIS PREGNANCY.	1 2 8	
02	RECORD WHETHER THIS IS THE CLIENT'S FIRST PREGNANCY.	1 2 8	

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
104	RECORD WHETHER THE PROVIDER ASKED ABOUT OR THE CLIENT MENTIONED ANY OF THE FOLLOWING FACTS:	YES	NO	DK	
01	Client's age	1	2	8	
02	Medications the client is taking	1	2	8	
03	Date client's last menstrual period began	1	2	8	
04	Number of prior pregnancies client has had	1	2	8	
105	RECORD WHETHER THE PROVIDER OR THE CLIENT DISCUSSED ANY OF THE FOLLOWING ASPECTS OF THE CLIENT'S PRIOR PREGNANCIES:				
01	Prior stillbirth(s)	1	2	8	
02	Infant(s) who died in the first week of life	1	2	8	
03	Heavy bleeding, during or after delivery	1	2	8	
04	Previous assisted delivery (caesarean section, ventouse, or forceps)	1	2	8	
05	Previous abortions	1	2	8	
106	RECORD WHETHER THE PROVIDER ASKED ABOUT OR THE CLIENT MENTIONED ANY OF THE FOLLOWING FOR CURRENT PREGNANCY:				
01	Bleeding	1	2	8	
02	Fever	1	2	8	
03	Headache or blurred vision	1	2	8	
04	Swollen face or hands	1	2	8	
05	Tiredness or breathlessness	1	2	8	
06	Whether the client has felt the baby move	1	2	8	
07	Whether there are any other symptoms or problems the client thinks might be related to this pregnancy	1	2	8	
107	RECORD WHETHER THE PROVIDER PERFORMED THE FOLLOWING PROCEDURES:	YES	NO	DK	
01	Take the client's blood pressure	1	2	8	
02	Weigh the client	1	2	8	
03	Examine conjunctiva/palms for anaemia	1	2	8	
04	Examine legs/feet/hands for edema	1	2	8	
05	Palpate the client's abdomen for fetal presentation (or conduct ultrasound)	1	2	8	
06	Palpate the client's abdomen for uterine height (or conduct ultrasound)	1	2	8	
07	Listen to the client's abdomen for fetal heartbeat	1	2	8	
08	Examine the client's breasts	1	2	8	
09	Conduct vaginal examination/exam of perineal area	1	2	8	
10	Perform or refer for anemia test	1	2	8	
11	Perform or refer for urine test	1	2	8	
12	Perform or refer the client for a syphilis test	1	2	8	
13	Perform or refer for HIV test	1	2	8	
14	Provide or refer for counselling related to HIV test	1	2	8	
15	Look at the client's health card/passport (either before beginning the consultation or while collecting information or examining the client)	1	2	8	

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
108	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING TREATMENTS OR COUNSELLING:	YES	NO	DK	
01	Prescribed or gave iron pills or folic acid (IFA) or both	1	2 → 05	8 → 05	
02	Explained the purpose of iron or folic acid	1	2	8	
03	Explained how to take iron or folic-acid pills	1	2	8	
04	Explained side effects of iron pills	1	2	8	
05	Prescribed or gave a tetanus toxoid (TT) injection	1	2 → 07	8 → 07	
06	Explained the purpose of the TT injection	1	2	8	
07	Prescribed or gave anti-malarial prophylaxis	1	2 → 13	8 → 13	
08	Explained the purpose of the preventive treatment with malaria medications	1	2	8	
09	Explained how to take the anti-malarial medications	1	2	8	
10	Explained possible side effects of malaria pills	1	2	8	
	DIRECT OBSERVATION:				
11	Observed that the 1st dose of IPT is given in the facility	1	2	8	
12	Importance of a second dose of IPT explained	1	2	8	
13	Importance of using ITN explained explicitly	1	2	8	
14	Given voucher for ITN/given ITN free of charge	1 → 109	2	8	
15	ITN purchased by the client	1	2	8	
109	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING ADVICE OR COUNSEL ABOUT PREPARATIONS:	YES	NO	DK	
01	Discussed quantity or quality of food to eat during pregnancy	1	2	8	
	Mentioned the following signs and symptoms as risk factors for which the woman should return to the facility:	YES	NO	DK	
02	Vaginal bleeding	1	2	8	
03	Fever	1	2	8	
04	Excessive tiredness or breathlessness	1	2	8	
05	Swollen hands and face	1	2	8	
06	Severe headache or blurred vision	1	2	8	
07	Informed the client about the progress of the pregnancy	1	2	8	

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
110	RECORD WHETHER THE PROVIDER ADVISED OR COUNSELED ABOUT DELIVERY IN ANY OF THE FOLLOWING WAYS:	YES	NO	DK	
01	Asked the client where she will deliver	1	2	8	
02	Advised the client to prepare for delivery (e.g. set aside money, arrange for emergency transportation)	1	2	8	
03	Advised the client to use a skilled health worker during delivery	1	2	8	
04	Discussed with client what items to have on hand at home for delivery (including for delivery at home), e.g., sterile blades	1	2	8	
05	Discussed importance of immunisation for the newborn	1	2	8	
111	RECORD WHETHER THE PROVIDER ADVISED EXCLUSIVELY BREASTFEEDING THE INFANT FOR UP TO 6 MONTHS.	1	2	8	
112	RECORD WHETHER THE PROVIDER DISCUSSED FAMILY PLANNING (OR BIRTH CONTROL) FOR USE AFTER DELIVERY.	1	2	8	
113	RECORD WHETHER THE PROVIDER ASKED WHETHER THE CLIENT HAD ANY QUESTIONS AND ENCOURAGED QUESTIONS.	1	2	8	
114	RECORD WHETHER THE PROVIDER USED ANY VISUAL AIDS FOR HEALTH EDUCATION OR COUNSELLING DURING THE CONSULTATION.	1	2	8	
115	RECORD WHETHER THE PROVIDER WROTE ON THE CLIENT'S HEALTH CARD/PASSPORT.	YES . . . . . 1 NO . . . . . 2 NO HEALTH CARD/ PASSPORT USED 3 DON'T KNOW 8			
116	ASK THE PROVIDER HOW MANY WEEKS PREGNANT THE CLIENT IS.	WEEK OF PREGNANCY . . . . . [ ][ ] DON'T KNOW 98			
117	RECORD THE OUTCOME OF THE CONSULTATION. [RECORD THE OUTCOME AT THE TIME THE OBSERVATION CONCLUDED]	CLIENT SENT HOME . . . . . 1 CLIENT REFERRED (TO LABORATORY OR OTHER PROVIDER) AT SAME FACILITY . . . . . 2 CLIENT ADMITTED TO SAME FACILITY . . . . . 3 CLIENT REFERRED TO OTHER FACILITY . . . . . 4 DON'T KNOW 8			
118	RECORD THE TIME THE OBSERVATION ENDED. . . . . [ ][ ] . [ ][ ]				
119	**Observer's comments:**				

MEASURE *DHS* SERVICE PROVISION ASSESSMENT

Exit Interview for Antenatal Care Client

1. Facility Identification

QTYPE | X | A | N |

Name of the facility: _____

Location of the facility: _____

FACILITY NUMBER . . . . . [ ][ ][ ]

2. Information About Interview

DATE: →	DAY . . . . . [ ][ ]
	MONTH . . . . . [ ][ ]
	YEAR 2 0 0 9
Name of the interviewer: _____	INTERVIEWER CODE . . . . . [ ][ ]
Client code: →	CLIENT CODE . . . . . [ ][ ]

3. Information About Visit

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	READ TO CLIENT: Hello, I am_____. As my colleague mentioned, we are representing the Ministry of Health and Social Services. We are conducting a study of health services in all health facilities in Namibia. In order to improve the services this facility offers, we would like to ask you some questions about your experience here today. Please know that whether you decide to allow this interview or not is completely voluntary and will not affect services you receive during any future visit. You may refuse to answer any question, and you may stop the interview at any time. Information from this interview may be provided to researchers for analyses, but neither your name nor the date of services will be on any shared information, so your identity will remain completely confidential. Do you have any questions for me? Do I have your permission to continue with the interview? _____ Interviewer's signature (Indicates respondent's willingness to participate)	DAY [ ][ ] MONTH [ ][ ] YEAR [2][0][0][9]	
100	May I begin the interview now?	CLIENT AGREES . . . . . 1 CLIENT REFUSES 2	→ **END**
101	RECORD THE TIME THE INTERVIEW STARTED.	. . . . . [ ][ ] : [ ][ ]	
102	Do you have an antenatal-care card/book, or an immunisation card with you today? IF YES: ASK TO SEE THE CARD/BOOK.	YES . . . . . 1 NO, CARD KEPT WITH FACILITY . . . . . 2 NO CARD/BOOK USED 3	 → 106 → 106
103	CHECK ANTENATAL-CARE CARD/BOOK, OR IMMUNISATION CARD. INDICATE WHETHER THERE IS ANY NOTE OR RECORD OF THE CLIENT HAVING RECEIVED TETANUS TOXOID.	YES, 1 TIME . . . . . 1 YES, 2 OR MORE TIMES . . . . 2 NO . . . . . 3 DON'T KNOW 8	
104	HOW MANY WEEKS PREGNANT IS THE CLIENT, ACCORDING TO THE ANC CARD?	WEEKS . . . . . [ ][ ] D.K. = 98	
105	DOES THE CARD INDICATE THE CLIENT HAS RECEIVED IPT? (IF NON MALARIOUS AREA, CIRCLE "NOT APPLICABLE")	YES, 1 DOSE ……. 1 YES, 2 DOSES ……. 2 NO ……. 3 NOT APPLICABLE …… 4 DON'T KNOW/UNCLEAR …. 8	
106	How many weeks pregnant do you think you are? IF RESPONSE IS IN MONTHS, CALCULATE WEEKS, USING 4 WEEKS PER MONTH.	WEEKS . . . . . [ ][ ] D.K. = 98	
107	Is this your first pregnancy?	YES . . . . . 1 NO 2	
108	Is this your first antenatal visit at this facility for this pregnancy?	YES . . . . . 1 NO 2	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
109	During this visit, or previous visits, did the provider give you iron pills, folic acid or iron with folic acid, or give you a prescription for them? SHOW THE CLIENT AN IRON PILL, A FOLIC-ACID PILL, OR A COMBINED PILL.	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	 → 111 → 114 → 114
110	ASK TO SEE THE CLIENT'S IRON/FOLIC ACID/IRON WITH FOLIC ACID PILLS.	SAW PILLS . . . . . 1 SAW PRESCRIPTION . . . . . 2 NO PILLS OR PRESCRIPTION SEEN 3	
111	During this visit or previous visits, has a provider explained to you how to take the iron pills?	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	
112	During this or previous visits, has a provider discussed with you the side effects of the iron pill?	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	
113	Please tell me any side effects of the iron pill that you know of.	NAUSEA . . . . . A BLACK STOOLS . . . . . B CONSTIPATION . . . . . C OTHER _____ X (SPECIFY) DON'T KNOW . . . . . Z	
114	During this or previous visits, has a provider given or prescribed any anti-malarial pills for you? SHOW THE CLIENT CAPSULES OF QUININE AND FANSIDAR.	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	 → 116 → 117 → 117
115	ASK TO SEE THE CLIENT'S ANTI-MALARIAL PILLS.	SAW PILLS . . . . . 1 SAW PRESCRIPTION . . . . . 2 NO PILLS OR PRESCRIPTION SEEN 3	
116	Did a provider explain to you how to take the anti-malarial pills?	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	
117	Do you own an ITN, that is a net that has been treated with an insecticide to protect you from mosquito bites?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
118	During this visit or a previous visit, did a provider offer you an ITN free of charge or offer to sell you one? IF THE CLIENT WILL PICK UP OR BUY THE ITN WITHIN THE FACILITY, THAT COUNTS AS PROVIDER OFFERING THE ITN.	YES, OFFERED FREE NOW 1 YES, OFFERED FREE IN PREVIOUS VISIT 2 YES, OFFERED FOR SALE NOW (THIS VISIT) 3 YES, OFFERED FOR SALE IN PREVIOUS VISIT 4 NO, NOT OFFERED 5	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
119	During this visit or previous visits, has a provider asked you whether you had ever received a tetanus toxoid (TT) injection?	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	
120	Have you ever received a tetanus toxoid (TT) injection, including one you may have received today? IF YES: Including any TT injection you received today, how many times in total during your lifetime have received a tetanus toxoid injection? (INJECTION MAY HAVE BEEN RECEIVED EITHER AT THIS FACILITY OR ELSEWHERE.)	NUMBER OF TETANUS INJECTIONS RECEIVED [ ][ ] NEVER . . . . . 96 DON'T KNOW 98	
121	During this visit or previous visits, has a provider discussed things you should have in preparation for your delivery? This may include planning in case of emergency, things you should bring to a facility, or things you should prepare at home for home delivery.	YES . . . . . 1 NO 2	
122	Please tell me any things you know of that you should have in preparation for your delivery. CIRCLE ALL RESPONSES YOU MAY PROBE WITHOUT USING SPECIFIC ANSWERS GIVEN ON RIGHT (E.G., "ANYTHING ELSE?")	EMERGENCY TRANSPORT . .A MONEY . . . . . B DISINFECTANT . . . . . C STERILE BLADE/SCISSORS TO CUT CORD . . . . . D OTHER _____ X (SPECIFY) DON'T KNOW . . . . . Z	
123	Do you have money set aside for the delivery? IF YES, PROBE	YES, ENOUGH . . . . . 1 YES, BUT NOT ENOUGH . . . . 2 NO 3	
124	During this visit or previous visits, has a provider talked with you about any signs of complications (danger signs) that should warn you of problems with the pregnancy?	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	 → 127 → 127
125	Please tell me any signs of complications (danger signs) that you know of. CIRCLE ALL RESPONSES YOU MAY PROBE WITHOUT USING SPECIFIC ANSWERS GIVEN ON RIGHT (E.G., "ANYTHING ELSE?")	ANY VAGINAL BLEEDING . . . A FEVER . . . . . B SWOLLEN FACE OR HAND . . . C TIREDNESS OR BREATHLESSNESS . . . . . D HEADACHE OR BLURRED VISION . . . . . E CONVULSIONS . . . . . F BABY STOPS MOVING OR REDUCED FETAL MOVEMENT . . . . . G OTHER _____ X (SPECIFY) DON'T KNOW . . . . . Z	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
126	What did the provider advise you to do if you experienced any of the warning signs? CIRCLE LETTER FOR ALL COURSES OF ACTION THE CLIENT MENTIONS. PROBE WITHOUT USING SPECIFIC ANSWERS.	SEEK CARE AT A FACILITY . . A DECREASE ACTIVITY . . . . . B CHANGE DIET . . . . . C OTHER _____ X (SPECIFY)	
127	Do you know any danger signs during/after delivery? IF YES: What danger signs do you know?	BLEEDING . . . . . A FEVER . . . . . B GENITAL INJURIES . . . . . C NO . . . . . Y	
128	During this visit or previous visits, has a provider talked to you about what you should eat during your pregnancy?	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	
129	During this visit or previous visits, has a provider given you advice on the importance of exclusively breastfeeding—that is, about giving your baby nothing apart from breast milk?	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	 → 131 → 131
130	For how many months did the provider recommend that you exclusively breastfeed, that is, that you do not give your baby liquid or food in addition to your breast milk?	4 TO 6 MONTHS. . . . . 1 6 MONTHS. . . . . 2 OTHER. . . . . 6 DON'T KNOW 8	
131	During this visit or previous visits, did the provider talk to you about where you plan to deliver your baby?	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	
132	Have you decided where you will go for the delivery of your baby? IF YES: PROBE FOR WHETHER THE PLAN IS TO DELIVER IN A FACILITY OR AT HOME.	AT THIS HEALTH FACILITY . . . 1 AT OTHER HEALTH FACILITY 2 IN A PRIVATE HOME . . . . . 3 OTHER _____ 6 (SPECIFY) DON'T KNOW 8	
133	During this or previous visits, did a provider talk with you about using family planning after the birth of your baby?	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	

4. Information About Client's Satisfaction

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	Now I am going to ask you some questions about the services you received today. I would like to have your honest opinion about the things that we will talk about. This information will help improve ANC services.		
201	How long did you wait between the time you arrived at this facility and the time you were able to see a provider for the consultation?	MINUTES . . . . . [ ][ ][ ] SAW PROVIDER IMMEDIATELY . . . . . 000 DON'T KNOW 998	
202	Now I am going to ask about some common problems clients have at health facilities. As I mention each one, please tell me whether any of these were problems for you today, and if so, whether they were **major** or **minor** problems for you.		

			MAJOR	MINOR	NO PROB-LEM	DK
01	Time you waited	WAITING TIME	1	2	3	8
02	Ability to discuss problems or concerns about your pregnancy with the provider	DISCUSS PROBLEMS	1	2	3	8
03	Amount of explanation you received about the problem or treatment	EXPLAIN PROB. OR TREATMENT	1	2	3	8
04	Quality of the examination and treatment provided	QUALITY	1	2	3	8
05	Privacy from having others see the examination	VISUAL PRIVACY	1	2	3	8
06	Privacy from having others hear your consultation discussion	AUDITORY PRIVACY	1	2	3	8
07	Availability of medicines at this facility	MEDICINES	1	2	3	8
08	The hours of service at this facility	HOURS OF SERVICE	1	2	3	8
09	The number of days services are available to you	DAYS OF SERVICE	1	2	3	8
10	The cleanliness of the facility	CLEAN	1	2	3	8
11	How the staff treated you	HOW TREATED	1	2	3	8
12	Cost for services or treatments	COST	1	2	3	8
13	Any problem you had today that I did not mention	_____ (SPECIFY)	1	2	3	8

203	Are you a part of any prepayment plan (such as medical aid, insurance or a similar program) or institutional arrangement that pays for some or all of the services you receive at this facility?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
204	Were you charged, or did you pay anything for any services provided today?	YES . . . . . 1 NO 2	→ 206

205	What is the total amount you paid for all services or treatments you received at this facility today?	TOTAL AMOUNT [ ][ ][ ][ ][ ][ ] PAID NO MONEY . . . . . 000000 DON'T KNOW 999998	 → 206 → 206
205A	Please tell me how much you paid for each of the following services you received today: RECORD AMOUNT AS "OTHER" IF RESPONDENT DOES NOT KNOW WHAT THE MONEY WAS PAID FOR. MUST ADD UP TO AMOUNT IN Q205	1) LAB [ ][ ][ ][ ][ ][ ] 2) MEDICINE [ ][ ][ ][ ][ ][ ] 3) CONSULT [ ][ ][ ][ ][ ][ ] 4) OTHER [ ][ ][ ][ ][ ][ ]	
206	Is this the closest health facility to your home?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 208 → 208
207	What was the main reason you did not go to the nearest facility? IF CARETAKER MENTIONS SEVERAL REASONS, PROBE FOR THE MOST IMPORTANT, OR MAIN REASON.	INCONVENIENT OPERATING HOURS . . . . . 01 BAD REPUTATION . . . . . 02 DON'T LIKE PERSONNEL . . .03 NO MEDICINE . . . . . .04 PREFERS TO REMAIN ANONYMOUS . . . . . 05 IT IS MORE EXPENSIVE . . . . 06 WAS REFERRED . . . . . .07 OTHER _____ 96 (SPECIFY) DON'T KNOW 98	
208	Have you ever visited this facility before (either as a patient or visiting or accompanying a patient)?	YES . . . . . 1 NO 2	
209	In general, which of the following statements describes best your opinion of the services given today at this facility: (READ ALL STATEMENTS; CHECK ONLY ONE) 01) I am **very satisfied** with the services given 02) I am **more or less satisfied** with the services given 03) I am not satisfied with the services given	 VERY SATISFIED. . . . . 01 MORE OR LESS SATISFIED 02 NOT SATISFIED. 03	
210	Will you recommend this health facility to a friend or family member? (CHECK ONLY ONE)	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

5. Personal Characteristics of Client

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	Now I am going to ask you some questions about yourself. I would like to have your honest responses as this information will help us to improve services.		
301	How old were you at your last birthday?	AGE IN YEARS . . . . . [ ][ ] DON'T KNOW. 98	
302	Have you ever attended school?	YES . . . . . 1 NO 2	 → 305
303	What is the highest level of school you attended?	INFORMAL (E.G. ADULT) ... 1 PRIMARY (1-3) ..... 2 UPPER PRIMARY (4-7) ..... 3 SECONDARY (8-12) ..... 4 TERTIARY 5	→ 305 → 306
304	What is the highest grade you completed at that level? (E.G., GRADE "9" OF SECONDARY)	GRADE . . . . . [ ][ ]	IF > 6TH GRADE ►306
305	Do you know how to read or how to write?	YES, READ AND WRITE . . . 1 YES, READ ONLY . . . . . 2 NO 3	
	Thank you very much for taking the time to answer my questions. Once again, any information you have given will be kept completely confidential. Have a good day!		
306	RECORD THE TIME THE INTERVIEW ENDED	[ ][ ] : [ ][ ]	
307	**Interviewer's comments:**		

Sample List for Family Planning Client Observation

Date DAY MONTH YEAR

FACILITY #

IF THERE ARE MORE THAN 25 CLIENTS YOU MAY SIMPLY INDICATE THE TOTAL NUMBER OF FIRST VISIT AND TOTAL NUMBER OF FOLLOW-UP VISITS

	NAME	FIRST VISIT	FOLLOW-UP
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			

Observation of Family Planning Consultation

1. Facility Identification

QTYPE | O | F | P |

Name of the facility: _____

Location of the facility: _____

FACILITY NUMBER . . . . . .

2. Provider Information

Provider category:
- SPECIALIST. 01
- MEDICAL OFFICER 09
- CLINICAL OFFICER 10
- REGISTERED NURSE 11
- REGISTERED MIDWIFE 12
- ENROLLED NURSE 13
- ENROLLED MIDWIFE 14
- NURSE AIDE 15

PROVIDER CATEGORY

SEX OF PROVIDER: (1=Male; 2=Female)

SEX OF PROVIDER . . . . . .

PROVIDER SERIAL NUMBER [FROM STAFF LISTING FORM]

PROVIDER SL NUMBER . . . . . .

3. Information About Observation

DATE →

DAY . . . . . .

MONTH . . . . . .

YEAR 2 0 0 9

Name of the observer: _____

OBSERVER CODE . . . . . .

Client code: →

CLIENT CODE . . . . . .

4. Observation of Family Planning Consultation

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	BEFORE OBSERVING THE CONSULTATION, OBTAIN PERMISSION FROM BOTH THE SERVICE PROVIDER AND THE CLIENT. MAKE SURE THAT THE PROVIDER KNOWS THAT YOU ARE NOT THERE TO EVALUATE HIM OR HER, AND THAT YOU ARE NOT AN "EXPERT" TO BE CONSULTED DURING THE SESSION. **READ TO PROVIDER:** Hello. I am [NAME OF OBSERVER]. I am representing the Ministry of Health and Social Services (MOHSS). We are conducting a study of all health facilities in Namibia with the goal of finding ways to improve the delivery of services. I would like to observe your consultation with this client in order to understand how family planning services are provided in this facility. Information from this observation is confidential. Neither your name nor that of the client will be recorded. The information acquired during this observation may be used by the MOHSS or other organizations to improve services, or for research on health services; however, neither your name nor the names of your clients will be entered in the database. Do you have any questions for me? If at any point you feel uncomfortable you can ask me to leave. However, we hope you won't mind our observing your consultation. Do I have your permission to be present at this consultation? Interviewer's signature (Indicates respondent's willingness to participate) — DAY ☐☐ MONTH ☐☐ YEAR 2009		
100	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES . . . . . 1 NO 2	→ **END**
	READ TO CLIENT: Hello, I am_____. I am representing the Ministry of Health and Social Services (MOHSS). We are conducting a study of health services in health facilities in Namibia. I would like to be present while you are receiving services today, in order to better understand how health care is provided. We are not evaluating the [NURSE/DOCTOR/PROVIDER] or the facility. And although Information from this observation may be provided to researchers for analyses, neither your name nor the date of services will be provided on any shared data, so your identity and any information about you will remain completely confidential. Please know that whether you decide to allow me to observe your visit is completely voluntary and that whether you agree to participate or not will not affect the services you receive. If, at any point, you would prefer I leave please feel free to tell me. After the consultation, my colleague would like to talk with you about your experience here today. Do you have any questions for me? Do I have your permission to be present at this consultation? Interviewer's signature (Indicates respondent's willingness to participate) — DAY ☐☐ MONTH ☐☐ YEAR 2009		
101	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE CLIENT.	YES . . . . . 1 NO 2	→ **END**
102	RECORD THE TIME THE OBSERVATION STARTED	☐☐ : ☐☐	

103	RECORD THE SEX OF CLIENT.	MALE . . . . . 1 FEMALE 2				
104	CLIENT STATUS. (OBSERVER TO COMPLETE)	YES	NO	DK	NA	
01	INDICATE WHETHER THE CLIENT HAS HAD ANY PREVIOUS CONTACT WITH A PROVIDER AT THIS FAMILY PLANNING UNIT.	1	2	8		
02	(IF FEMALE) INDICATE WHETHER THE CLIENT HAS EVER BEEN PREGNANT.	1	2	8	5	
105	CLIENT'S PERSONAL INFORMATION AND REPRODUCTIVE HISTORY. INDICATE BELOW WHETHER THE PROVIDER ASKED ABOUT OR THE CLIENT VOLUNTEERED INFORMATION ON THE FOLLOWING ITEMS:					
01	Age of client	1	2	8		
02	Number of living children	1	2	8		
03	Last delivery date or age of youngest child	1	2	8	5	
04	History of complications with pregnancy	1	2	8	5	
05	Current pregnancy status	1	2	8	5	
06	Desire for a child or more children	1	2	8		
07	Desired timing for birth of next child	1	2	8		
08	Breastfeeding status	1	2	8	5	
09	Regularity of menstrual cycle	1	2	8	5	
106	RECORD WHETHER THE PROVIDER PERFORMED ANY OF THE FOLLOWING PHYSICAL EXAMINATIONS OR ASKED ANY OF THE FOLLOWING HEALTH QUESTIONS.	YES	NO	DK		
01	Took the client's blood pressure	1	2	8		
02	Weighed the client	1	2	8		
03	Asked the client about smoking	1	2	8		
04	Asked the client about symptoms of STIs (e.g., abnormal discharge)	1	2	8		
05	Asked the client about chronic illnesses (heart disease, diabetes, hypertension, liver or jaundice problem, breast cancer)	1	2	8		
06	Looked at the client's health card (either before beginning the consultation or while collecting information or examining the client)	1	2	8		

107	RECORD WHETHER THE PROVIDER TOOK ANY OF THE FOLLOWING STEPS TO ASSURE THE CLIENT OF PRIVACY.	YES	NO	DK	
01	Ensured visual privacy	1	2	8	
02	Ensured auditory privacy	1	2	8	
03	Assured the client orally of confidentiality	1	2	8	
04	Asked the client about questions or concerns regarding methods currently used	1	2	8	
05	DID THE CLIENT SAY SHE HAD ANY CONCERNS, OR ASK ANY QUESTIONS ABOUT SIDE-EFFECTS OR ABOUT THE METHOD?	1	2	8	
108	RECORD WHETHER THE PROVIDER DISCUSSED ANY OF THESE ISSUES RELATED TO SEXUAL PARTNERS AND CHOICE OF FAMILY PLANNING METHOD.				
01	Partner's attitude toward family planning	1	2	8	
02	Partner status (number of partners for client or for client's partner; partner's absence)	1	2	8	
03	Risk of STIs	1	2	8	
04	Use of condoms to prevent STIs	1	2	8	
05	Using condoms as well as or along with another method (dual method) to attempt to prevent STIs	1	2	8	
109	INDICATE WHICH METHOD(S) WERE **PROVIDED OR PRESCRIBED** DURING THIS VISIT. IF CONDOMS WERE PRESCRIBED FOR USE ALONG WITH ANOTHER METHOD, CIRCLE BOTH METHODS. [IF CLIENT IS CONTINUING CLIENT WHO RECEIVED REFILLS FOR PILLS, REPEAT INJECTION, OR REPLACEMENT FOR IUD DURING THIS VISIT, CIRCLE THE METHOD THAT WAS REPLENISHED]	COMBINED PILL. . . . . A PROGESTIN-ONLY PILL. . . . . B PILL (TYPE UNSPECIFIED). . . . .C MALE CONDOM. . . . . D FEMALE CONDOM. . . . . E IUCD. . . . . F SPERMICIDE. . . . . G DIAPHRAGM. . . . . H PROGESTIN INJECTABLE. . . . . I MONTHLY INJECTABLE. . . . . J IMPLANT . . . . . K NATURAL METHODS (RHYTHM) . . . . . L LAM. . . . . M VASECTOMY . . . . . N FEMALE STERILISATION . . . O EMERGENCY CONTRACEPTION . . . . . P OTHER _____ X (SPECIFY) NO METHOD . . . . . Y			→ 111

110	FOR THE METHOD(S) IN QUESTION 109, INDICATE WHETHER THE RELEVANT INFORMATION INDICATED WAS ASSESSED OR DISCUSSED.	YES	NO	DK	NA
	PILLS OR INJECTIONS				5 → 05
01	When to take (pill daily; injection either every month or every 3 months)	1	2	8	
02	Changes that may occur with menstruation (decreased flow, spotting)	1	2	8	
03	Initial side effects that may occur (such as nausea, weight gain, and breast tenderness)	1	2	8	
04	What to do if forget pill or do not get injection on time	1	2	8	
	CONDOMS				5 → 10
05	Client cannot use if allergic to latex	1	2	8	
06	Can be used only one time	1	2	8	
07	Some lubricants may be used (male condom—water soluble only; female condom—any lubricant)	1	2	8	
08	Use as backup if client fears other method will fail	1	2	8	
09	Dual protection (from pregnancy and against STI)	1	2	8	
	IUCD				5 → 15
10	Good for up to 12 years	1	2	8	
11	Should return to the clinic 3-6 weeks post insertion or after first menses	1	2	8	
12	Common side effects that may occur (heavy bleeding for first few months post insertion, spotting, or mild abdominal cramps)	1	2	8	
13	Should return to clinic if side effects continue	1	2	8	
14	User should regularly check string after menstruation	1	2	8	
	SPERMICIDE/FOAM				5 → 17
15	May cause irritation	1	2	8	
16	Insert before each occurrence of intercourse	1	2	8	
	IMPLANT				5 → 21
17	Good for 3-5 years	1	2	8	
18	Changes that may occur with menstruation (irregular bleeding, decreased flow, spotting)	1	2	8	
19	Initial side effects that may occur (such as nausea, weight gain, and breast tenderness)	1	2	8	
20	Should return to clinic if side effects continue	1	2	8	
	RHYTHM METHOD or PERIODIC ABSTINENCE				5 → 23
21	How to identify a woman's fertile period	1	2	8	
22	No intercourse during woman's fertile period without alternative method (condom/spermicide)	1	2	8	

		YES	NO	DK	NA
	LACTATIONAL AMENORRHEA (LAM)				5 → 26
23	Slight risk of pregnancy during the time shortly before menstruation resumes	1	2	8	
24	Most effective with exclusive breastfeeding without menstruation	1	2	8	
25	Not effective after menstruation begins again	1	2	8	
	VASECTOMY				5 → 31
26	Partner is protected from pregnancy after 3 months	1	2	8	
27	Use of a back-up method for the next 3 months	1	2	8	
28	Procedure intended to be permanent; slight risk of failure	1	2	8	
29	Warning signs that may occur after surgery (severe pain, tenderness, bleeding)	1	2	8	
30	Should return to clinic if experience warning signs	1	2	8	
	FEMALE STERILIZATION				5 → 35
31	Protect from pregnancy immediately	1	2	8	
32	Procedure intended to be permanent, slight risk of failure	1	2	8	
33	Warning signs that may occur after surgery (severe pain, light-headedness, fever, bleeding, missed periods)	1	2	8	
34	Should return to clinic if experience warning sign	1	2	8	
	EMERGENCY CONTRACEPTION				5 → 111
35	If vomit within 2 hours, need another dose	1	2	8	
36	If next period is unusually light or fails to occur within 4 weeks, return for pregnancy check	1	2	8	
37	First dose to be taken within 72 hours of contact	1	2	8	
38	Second dose should be taken 12 hours after first dose	1	2	8	
39	Regimen not to be repeated/taken more than three times in any one month	1	2	8	
111	RECORD WHETHER THE PROVIDER WROTE ON THE CLIENT'S HEALTH CARD/ PASSPORT.	YES . . . . . 1 NO . . . . . 2 NO HEALTH CARD/ PASSPORT USED 3 DON'T KNOW 8			
112	RECORD WHETHER THE PROVIDER USED ANY VISUAL AIDS FOR HEALTH EDUCATION OR COUNSELLING ABOUT FAMILY PLANNING METHODS.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8			
113	RECORD WHETHER THE PROVIDER DISCUSSED A RETURN VISIT.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8			

5. Clinical Observation

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
201	INDICATE WHETHER ANY CLINICAL PROCEDURE WAS CONDUCTED DURING THIS VISIT. CLINICAL PROCEDURES INCLUDE PELVIC EXAMINATIONS, OR PROVIDING THE IUCD, INJECTABLE METHOD, OR IMPLANT.	YES . . . . . 1 NO 2	→ 301
202	INDICATE WHETHER CLINICAL PROVIDER IS PERSON WHO PROVIDED COUNSELLING.	YES . . . . . 1 NO 2	→ 206
	READ TO PROVIDER: Hello, I am representing the MOHSS. We are conducting a study of health facilities, with the goal of finding ways to improve the delivery of services. I would like to observe the procedure you will conduct with this client. [Mrs. ___] has agreed that she has no objection to my presence. Observing all components of the services provided to [Mrs. ___] will help us to better understand how health services are provided. Any information relating to this procedure will be completely confidential. If, at any point, you would prefer I leave, please feel free to tell me. Do you have any questions for me? Do I have your permission to be present during this procedure? _____ Interviewer's signature (Indicates respondent's willingness to participate) DAY [ ][ ] MONTH [ ][ ] YEAR [2][0][0][9]		
203	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES . . . . . 1 NO 2	→ **END**
204	RECORD THE TYPE OF PROVIDER PERFORMING MOST OF THE CLINICAL EXAMINATION.	SPECIALIST. . . . . 01 MEDICAL OFFICER/PHYSICIAN. . . . . 02 MEDICAL ASSISTANT. . . . . 03 REGISTERED NURSE/MIDWIFE. . . . 04 ENROLLED NURSE/MIDWIFE. . . . . 05 NURSE ASSISTANT/AUXILIARY. 06	
205	RECORD THE SEX OF THE PROVIDER CONDUCTING THE CLINICAL EXAMINATION.	MALE . . . . . 1 FEMALE 2	
206	INDICATE CLINICAL PROCEDURE (S) CONDUCTED DURING THIS VISIT.	PELVIC EXAM . . . . . A IUCD INSERTED/REMOVED . B INJECTABLE GIVEN . . . . . C IMPLANT INSERTED/ REMOVED . . . . . D	

6. Pelvic Examination

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
207A	CHECK Q206: WAS A PELVIC EXAMINATION CONDUCTED?	YES . . . . . 1 NO 2			→ 208A
207	RECORD WHETHER THE FOLLOWING OCCURRED DURING OR AFTER THE EXAMINATION		YES	NO	N.A.
01	ENSURED THAT CLIENT HAD VISUAL PRIVACY	VISUAL PRIVACY	1	2	
02	ENSURED THAT CLIENT HAD AUDITORY PRIVACY	AUDITORY PRIVACY	1	2	
03	EXPLAINED PROCEDURE BEFORE STARTING	EXPLAIN PROCEDURE BEFOREHAND	1	2	
04	PREPARED ALL INSTRUMENTS BEFORE STARTING PROCEDURE	PREPARED INSTRUMENTS	1	2	
05	USED STERILISED OR HIGH LEVEL DISINFECTED INSTRUMENTS	STERILISED/HLD INSTRUMENTS	1	2	
06	WASHED/DISINFECTED HIS/HER HANDS (INCL. SOAP) BEFORE STARTING PROCEDURE	WASHED/DISINF HANDS	1	2	
07	PUT ON NEW OR DISINFECTED LATEX GLOVES BEFORE STARTING PROCEDURE	PUT ON GLOVES	1	2	
08	ASKED THE CLIENT TO TAKE SLOW DEEP BREATHS AND RELAX MUSCLES	ASKED CLIENT TO RELAX MUSCLES	1	2	
09	INSPECTED THE EXTERNAL GENITALIA	INSPECTED GENITALIA	1	2	
10	EXPLAINED SPECULUM PROCEDURE (IF USED)	EXPLAINED SPECULUM	1	2	5
11	INSPECTED THE CERVIX AND VAGINAL MUCOSA (USED SPECULUM AND LIGHT)	INSPECTED CERVIX	1	2	5
12	PERFORMED A BIMANUAL EXAMINATION (TWO FINGERS IN VAGINA OTHER HAND PALPATING ABDOMEN)	PERFORMED BIMANUAL EXAM	1	2	
13	WASHED/DISINFECTED HANDS AFTER REMOVING GLOVES	WASHED/DISINF HANDS AFTER	1	2	
14	WIPED CONTAMINATED SURFACES WITH DISINFECTANT	DISINFECTED AREA	1	2	
15	PLACED REUSABLE GLOVES OR INSTRUMENTS IN CHLORINE SOLUTION IMMEDIATELY AFTER THE PROCEDURE.	DECONTAMINATED GLOVES OR INSTRUMENTS	1	2	

7. IUD Insertion and/or Removal

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
208A	CHECK 206: WAS AN IUCD EITHER INSERTED OR REMOVED?	YES . . . . . 1 NO 2				→ 210A
208	INDICATE PROCEDURE CONDUCTED.	IUCD INSERTION . . . . . A IUCD REMOVAL . . . . . B				
209	RECORD WHETHER THE FOLLOWING OCCURRED DURING OR AFTER THE EXAMINATION		YES	NO	N.A.	
01	ENSURED THAT CLIENT HAD VISUAL PRIVACY	VISUAL PRIVACY	1	2		
02	ENSURED THAT CLIENT HAD AUDITORY PRIVACY	AUDITORY PRIVACY	1	2		
03	EXPLAINED PROCEDURE BEFORE STARTING	EXPLAINED PROCEDURE BEFOREHAND	1	2		
04	(FOR NEW CLIENT) RECONFIRMED CLIENT CHOICE OF METHOD	RECONFIRMED CHOICE	1	2	5	
05	(FOR NEW CLIENT, CONFIRMED CLIENT NOT PREGNANT	CONFIRMED CLIENT NOT PREGNANT	1	2	5	
06	PREPARED ALL INSTRUMENTS BEFORE STARTING PROCEDURE	PREPARED INSTRUMENTS	1	2		
07	USED STERILISED OR HIGH LEVEL DISINFECTED INSTRUMENTS	STERILISED/HLD INSTRUMENTS	1	2		
08	WASHED/DISINFECTED HANDS BEFORE STARTING PROCEDURE	WASHED/DISINF HANDS	1	2		
09	PUT ON NEW OR DISINFECTED LATEX GLOVES BEFORE STARTING PROCEDURE	PUT ON GLOVES	1	2		
10	PERFORMED A SPECULUM EXAM (FOR RTI OR STI) BEFORE CONDUCTING BIMANUAL EXAMINATION	SPECULUM EXAM	1	2	5	
11	PERFORMED A BIMANUAL EXAMINATION (TWO FINGERS IN VAGINA OTHER HAND PALPATING ABDOMEN)	BIMANUAL EXAM	1	2	5	
12	INSPECTED THE CERVIX AND VAGINAL MUCOSA (USE SPECULUM AND LIGHT)	VISUALISED CERVIX	1	2	5	
13	USED A TENACULUM	USED TENACULUM	1	2	5	
14	SOUNDED THE UTERUS BEFORE INSERTING IUCD	SOUNDED UTERUS	1	2	5	
15	USED THE NO-TOUCH TECHNIQUE FOR INSERTION	NO-TOUCH TECHNIQUE	1	2	5	
16	WASHED/DISINF HANDS AFTER REMOVING GLOVES	WASHED/DISINF HANDS AFTER	1	2		
17	ASKED CLIENT TO WAIT AND REST FOR 15 MINS AFTER INSERTION OF IUCD	ASKED CLIENT TO WAIT 15 MINS	1	2		
18	WIPED CONTAMINATED SURFACES WITH DISINFECTANT	DISINFECTED AREA	1	2		

19	PLACED REUSABLE GLOVES OR INSTRUMENTS IN CHLORINE SOLUTION IMMEDIATELY AFTER THE PROCEDURE.	DECONTAMINATED GLOVES OR INSTRUMENTS	1	2	
20	WAS THE CLIENT TOLD THAT IUCD IS GOOD FOR UP TO 12 YEARS?	TOLD GOOD FOR UP TO 12 YEARS	1	2	5
21	WAS THE CLIENT INSTRUCTED TO RETURN TO THE CLINIC 3 TO 6 WEEKS POST INSERTION OR AFTER FIRST MENSES?	INSTRUCTED TO RETURN IN 3-6 WEEKS	1	2	5
22	WAS THE CLIENT INSTRUCTED TO REGULARLY CHECK THE STRINGS AFTER MENSTRUATION?	INSTRUCTED CHECK STRINGS	1	2	5
23	WAS THE CLIENT TOLD THAT SHE MAY EXPERIENCE SIDE EFFECTS (HEAVY BLEEDING FOR FIRST FEW MONTHS, SPOTTING, OR MILD ABDOMINAL CRAMPS)?	TOLD ABOUT SIDE EFFECTS	1	2	5
24	WAS THE CLIENT INSTRUCTED TO RETURN TO CLINIC IF SIDE EFFECETS CONTINUED?	INSTRUCTED TO RETURN TO CLINIC	1	2	5
25	WAS THE CLIENT PROVIDED WITH A CARD STATING THE DATE IUCD WAS INSERTED AND THE FOLLOW-UP DATE?	CARD PROVIDED	1	2	5

8. Injectable Contraceptive

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
210A	CHECK Q206: WAS A CONTRACEPTIVE INJECTION GIVEN?	YES . . . . . 1 NO 2				→ 212A
211	RECORD WHETHER THE PROVIDER DID THE FOLLOWING:		YES	NO	NA	
01	(With a **new client**) Reconfirmed the client's choice of method	RECONFIRMED CHOICE	1	2	5	
02	(With a **new client**) Verified that client was not pregnant	CONFIRMED CLIENT NOT PREGNANT	1	2	5	
03	(**Continuing client**) Checked the client's card to ensure giving injection at correct time	ENSURED CORRECT TIMING	1	2	5	
04	Washed/disinfected hands before giving the injection	WASHED/DISINF HANDS	1	2		
05	Prepared injection in area with clean table or tray to set items on	PREPARED IN CLEAN LOCATION	1	2		
06	(**If using reusables**) Used newly processed needle and syringe	USED NEW/CLEAN NEEDLE	1	2	5	
07	(**If using disposables**) Used new syringe and needle from a sterile sealed pack	USED NEW/CLEAN NEEDLE	1	2	5	
08	Saw the provider open the new packet with syringe and needle	SAW PROVIDER OPEN PACKET	1	2	5	
09	Removed needle from multiple dose vial each time	REMOVED NEEDLE	1	2	5	
10	Stirred or mixed the bottle *before* drawing dose (DEPO)	STIRRED BOTTLE	1	2	5	
11	Cleaned and air-dried the injection site *before* injection	CLEANED AND AIR-DRIED THE SITE	1	2		
12	Drew back plunger *before* giving injection	DREW BACK PLUNGER	1	2		
13	Allowed dose to self-disperse instead of massaging the site	NO MASSAGE	1	2		
14	Disposed of sharps in puncture-resistant container (not overflowing or pierced)	DISPOSED OF SHARPS	1	2		
211A	INDICATE WHETHER THE NEEDLE AND SYRINGE WERE PROVIDED BY THE FACILITY OR PROVIDED BY THE CLIENT.	PROVIDED BY FACILITY . . . . 1 PROVIDED BY CLIENT . . . . 2 DON'T KNOW 8				

9. Implant Insertion or Removal

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
212A	CHECK 206: WERE IMPLANTS EITHER INSERTED OR REMOVED?	YES . . . . . 1 NO 2				→ 301
212	INDICATE PROCEDURE CONDUCTED.	INSERTION . . . . . A REMOVAL . . . . . B				
213	RECORD WHETHER THE PROVIDER DID THE FOLLOWING:		YES	NO	N.A.	
01	Reconfirmed the client's choice of method	RECONFIRMED CHOICE	1	2	5	
02	Verified that client was not pregnant	CONFIRMED CLIENT NOT PREGNANT	1	2	5	
03	Ensured that the client had visual privacy	VISUAL PRIVACY	1	2		
04	Ensured that the client had auditory privacy	AUDITORY PRIVACY	1	2		
05	Explained the procedure before starting it	EXPLAINED PROCEDURE BEFOREHAND	1	2		
06	Prepared all instruments before the procedure	PREPARED INSTRUMENTS	1	2		
07	Used sterilised or high-level disinfected instruments	STERILISED/HLD INSTRUMENTS	1	2		
08	Washed/disinfected hands *before* the procedure	WASHED/DISINF HANDS	1	2		
09	Put on sterile gloves and maintain sterility during insertion	GLOVES AND STERILITY	1	2		
10	Cleaned skin where incision was made with antiseptic	USED ANTISEPTIC	1	2		
11	Used sterile towel to protect area	USED STERILE TOWEL	1	2		
12	Used new or sterilised needle and syringe for local anaesthetic	USED STERILE NEEDLE	1	2		
13	Allowed time for local anaesthetic to take effect prior to making incision	ALLOWED TIME FOR ANESTHETIC TO WORK	1	2		
14	Disposed of sharps in puncture-resistant containers	DISPOSED OF SHARPS	1	2		
15	Wiped contaminated surfaces with disinfectant	DISINFECTED AREA	1	2		
16	Placed reusable gloves and instruments in a chlorine solution immediately after completing the procedure	DECONTAMINATED GLOVES OR INSTRUMENTS	1	2		
17	Washed/disinfected hands *after* removing gloves	WASHED/DISINF HANDS AFTER	1	2		
18	Explained care of incision area and removal of the bandage	EXPLAINED INCISION CARE	1	2		

			YES	NO	NA
19	Discussed return visit to remove plaster	DISCUSSED RETURN	1	2	
20	Provided woman with card stating date implant was inserted and date when 5 years of implant would be completed	PROVIDED CARD	1	2	5
21	WAS THE CLIENT INSTRUCTED THAT THE IMPLANT IS GOOD FOR 3-5 YEARS?	TOLD IMPLANT GOOD 3-5 YEARS	1	2	5
22	WAS THE CLIENT TOLD ABOUT POSSIBLE MENSTRUAL CHANGES (SIDE EFFECTS)?	TOLD MENSTRUAL CHANGES	1	2	5
23	WAS THE CLIENT TOLD ABOUT OTHER (NON-MENSTRUAL) SIDE-EFFECTS SUCH AS NAUSEA, WEIGHT GAIN, OR BREAST TENDERNESS?	TOLD OTHER SIDE-EFFECTS	1	2	5
24	WAS THE CLIENT INSTRUCTED TO RETURN TO CLINIC IF SIDE EFFECTS PERSISTED?	RETURN TO CLINIC	1	2	5
214	Did the provider show each implant stick removed to the client and reassure her that all were removed?	SHOW REMOVED IMPLANT	1	2	5
215	INDICATE WHETHER THE NEEDLE AND SYRINGE WERE PROVIDED BY THE FACILITY OR PROVIDED BY THE CLIENT.	PROVIDED BY FACILITY . . . . 1 PROVIDED BY CLIENT . . . . . 2 DON'T KNOW 8			

10. Client's Family Planning Status			
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	AFTER THE CONSULTATION, COMPLETE THE FOLLOWING INFORMATION		
301	RECORD THE CLIENT'S FAMILY PLANNING STATUS AT THE BEGINNING OF THE CONSULTATION.	CURRENT USER . . . . . 1 NONUSER, USED IN PAST . . . 2 NONUSER, NO PAST USE . . . 3 NOT DETERMINED 8	 → 304 → 306 → 306
302	RECORD THE CLIENT'S PRINCIPAL REASON FOR THE VISIT.	RESUPPLY/ROUTINE FOLLOW-UP . . . . . 1 DISCUSS PROBLEM WITH METHOD . . . . . 2 DESIRE TO CHANGE METHOD (NO PROBLEM) 3 DESIRE TO DISCONTINUE FP (NO PROBLEM) 4 DISCUSS OTHER PHYSICAL PROBLEM 5	
303	RECORD THE OUTCOME OF THE VISIT. (FOR CURRENT USER)	CONTINUED WITH CURRENT METHOD . . . . . 1 SWITCHED METHOD . . . . . 2 PLANNED METHOD SWITCH, NOT RECEIVED TODAY, CONTINUED USE OF CURRENT METHOD . . . . . 3 PLANNED METHOD SWITCH, NOT RECEIVED TODAY, DISCONTINUED CURRENT METHOD . . . . . 4 DECIDED TO STOP USING FAMILY PLANNING 5	→ 307 → 307 → 307 → 307 → 308
304	RECORD THE CLIENT'S MOST RECENT USE OF CONTRACEPTION. (NON-USER, USED IN THE PAST)	WITHIN PAST 6 MONTHS . . . . 1 SIX OR MORE MONTHS AGO . . 2 NOT DETERMINED 8	
305	RECORD THE OUTCOME OF THE VISIT. (NON-USER, USED IN THE PAST)	RESTARTED PRIOR METHOD 1 ADOPTED DIFFERENT METHOD . . . . . 2 PLANNED DIFFERENT METHOD, NOT RECEIVED TODAY . . . 3 RECEIVED INFORMATION/ COUNSELLING ONLY . . . . . 4 NOT DETERMINED 8	→ 307 → 307 → 307 → 308 → 308
306	RECORD THE OUTCOME OF THE VISIT. (NON-USER, NO PAST USE)	ACCEPTED TO START METHOD . . . . . 1 DID NOT DECIDE ON METHOD 2	 → 308

307	DID CLIENT LEAVE FACILITY WITH METHOD? IF NO: RECORD THE REASON THE CLIENT DID NOT RECEIVE METHOD.	YES, LEFT WITH METHOD . . . 1 NO, METHOD NOT IN STOCK . . 2 NO, REQUIRES APPOINTMENT . . . . . 3 NO, DELAY RECEIVING DUE TO HEALTH PROBLEM . . . 4 NO, PREGNANCY STATUS UNCERTAIN . . . . . 5 OTHER _____ 6 (SPECIFY)	
308	INDICATE WHETHER THE PROVIDER WROTE IN OR ON AN INDIVIDUAL CLIENT'S CARD OR PASSPORT AFTER THE CONSULTATION.	YES . . . . . 1 NO . . . . . 2 NO INDIVIDUAL CARD USED . . 3 DON'T KNOW 8	
309	RECORD THE TIME THE OBSERVATION ENDED	. . . . . [ ][ ] : [ ][ ]	
310	**Observer's comments:**		

MEASURE *DHS* SERVICE PROVISION ASSESSMENT

Exit Interview for Family Planning Client

1. Facility Identification

QTYPE . . . . . | X | F | P |

Name of the facility: _____

Location of the facility: _____

FACILITY NUMBER . . . . . | | | |

2. Information About Interview

DATE →

Name of the interviewer: _____

Client code: →

DAY . . . . . | | |

MONTH . . . . . | | |

YEAR . . . . . | 2 | 0 | 0 | 9 |

INTERVIEWER CODE . . . . . | | |

CLIENT CODE: . . . . . | | |

3. Information About Visit

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	READ TO CLIENT: Hello, I am_____. As my colleague mentioned, we are representing the Ministry of Health and Social Services. We are conducting a study of health services in all health facilities in Namibia. In order to improve the services this facility offers, we would like to ask you some questions about your experience here today. Please know that whether you decide to allow this interview or not is completely voluntary and will not affect services you receive during any future visit. You may refuse to answer any question, and you may stop the interview at any time. Information from this interview may be provided to researchers for analyses, but neither your name nor the date of services will be on any shared information, so your identity will remain completely confidential. Do you have any questions for me? Do I have your permission to continue with the interview? _____ Interviewer's signature (Indicates respondent's willingness to participate) DAY [ ][ ] MONTH [ ][ ] YEAR [2][0][0][9]		
100	May I begin the interview?	CLIENT AGREES . . . . . 1 CLIENT REFUSES 2	→ **END**
101	RECORD THE TIME THE INTERVIEW STARTED	[ ][ ] : [ ][ ]	
102	Have you ever been to this clinic before for family planning services?	YES (FEMALE CLIENT) 1 NO (FEMALE CLIENT) 2 YES (MALE CLIENT) 3 NO (MALE CLIENT) 4	 → 104 → 104
103	Have you ever been pregnant?	YES . . . . . 1 NO 2	
104	Were you doing anything to prevent pregnancy when you came today?	YES . . . . . 1 NO 2	→ 106
105	Have you used a family planning method or taken any steps to prevent pregnancy at any time during the past 6 months?	YES . . . . . 1 NO 2	 → 112
106	What method were you (last) using? IF CONDOMS WERE PRESCRIBED FOR USE ALONG WITH ANOTHER METHOD, CIRCLE BOTH METHODS.	COMBINED PILL . . . . . A PROGESTIN-ONLY PILL . . . . . B PILL (TYPE UNSPECIFIED) . C MALE CONDOM . . . . . D FEMALE CONDOM . . . . . E IUD . . . . . F SPERMICIDE . . . . . G DIAPHRAGM . . . . . H PROGESTIN INJECTABLE (2-3M) I MONTHLY INJECTABLE . . . . . J IMPLANT . . . . . K NATURAL METHODS (RHYTHM/ PERIODIC ABSTINENCE) . L LAM . . . . . M VASECTOMY . . . . . N FEMALE STERILISATION . . . . . O EMERGENCY CONTRACEPTION . . . . . P OTHER _____ X (SPECIFY)	

107	Did the provider ask you today whether you were having (or had had) a problem with the method?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
108	Have you been having (did you have) a problem with the method?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	 → 111 → 111
109	Did the provider suggest any action(s) you should take to resolve the problem?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
110	What was the outcome of this visit—did you decide to continue (restart) the same method or to switch methods?	CONTINUE WITH OR RESTART SAME METHOD . . 1 SWITCH METHOD . . . . . 2 STOP USING METHOD (DUE TO PROBLEMS) . . . . . 3 STOP USING METHOD (ELECTIVE-NO PROBLEMS) 4	 → 201
111	Had you thought about switching methods, and which method to switch to, before you came here today?	YES . . . . . 1 NO 2	→ 113 → 115
112	Had you thought about what family planning method you wanted to use before you came here today?	YES . . . . . 1 NO 2	 → 115
113	What method was that? IF CLIENT MENTIONS CONDOMS ALONG WITH ANOTHER METHOD, CIRCLE BOTH METHODS.	COMBINED PILL . . . . . A PROGESTIN-ONLY PILL . . . . . B PILL (TYPE UNSPECIFIED) . C MALE CONDOM . . . . . D FEMALE CONDOM . . . . . E IUD . . . . . F SPERMICIDE . . . . . G DIAPHRAGM . . . . . H PROGESTIN INJECTABLE (2-3M) I INJECTABLE (1M) . . . . . J IMPLANT . . . . . K NATURAL METHODS (RHYTHM/ PERIODIC ABSTINENCE) . L LAM . . . . . M VASECTOMY . . . . . N FEMALE STERILISATION . . . . . O EMERGENCY CONTRACEPTION . . . . . P OTHER _____ X (SPECIFY)	
114	Did the provider talk to you about any of the method(s) you just mentioned?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

115	What (other) family planning methods did the provider talk with you about? CIRCLE ALL METHODS MENTIONED.	COMBINED PILL . . . . . A PROGESTIN-ONLY PILL . . . . . B PILL (TYPE UNSPECIFIED) . C MALE CONDOM . . . . . D FEMALE CONDOM . . . . . E IUD . . . . . F SPERMICIDE . . . . . G DIAPHRAGM . . . . . H PROGESTIN INJECTABLE (2-3M) I MONTHLY INJECTABLE . . . . . J IMPLANT . . . . . K NATURAL METHODS (RHYTHM/ PERIODIC ABSTINENCE) . L LAM . . . . . M VASECTOMY . . . . . N FEMALE STERILISATION . . . . . O EMERGENCY CONTRACEPTION P OTHER _____ X (SPECIFY) NONE . . . . . Y	
116	What family planning method did you either receive or get a prescription or referral for? CIRCLE ALL METHODS THE CLIENT HAS RECEIVED (REC) OR HAS A PRESCRIPTION OR A REFERRAL (PRES) FOR. IF THE CLIENT IS CONTINUING USING A PRIOR METHOD AND DID NOT RECEIVE ANY METHOD, PRESCRIPTION, OR REFERRAL ON THIS VISIT, CIRCLE Y. CHECK PACKET OR PRESCRIPTION TO CONFIRM TYPE OF PILL OR INJECTION	REC / PRES COMBINED PILL . . . . . A A PROGESTIN-ONLY PILL . . . . . B B PILL (TYPE UNSPECIFIED) . C C MALE CONDOM . . . . . D D FEMALE CONDOM . . . . . E E IUD . . . . . F F SPERMICIDE . . . . . G G DIAPHRAGM . . . . . H H PROGESTIN INJECTABLE (2-3M) I I MONTHLY INJECTABLE . . . . . J J IMPLANT . . . . . K K NATURAL METHODS (RHYTHM/ PERIODIC ABSTINENCE) . L L LAM . . . . . M M VASECTOMY . . . . . N N FEMALE STERILISATION . . . . . O O EMERGENCY CONTRACEPTION . . . . . P P CONTINUING WITH METHOD IN QUESTION 106 . . . . . Y Y OTHER _____ X X (SPECIFY) NO METHOD . . . . . Z → 201 Z → 201 ***[ONLY SKIP TO 201 IF BOTH "Z" ARE CIRCLED, IE, NO METHOD EITHER RECEIVED OR PRESCRIBED]. OTHEWISE CONTINUE TO Q117***	
117	Does your method protect against Sexually Transmitted Infections (STIs) and HIV/AIDS?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

118	During your consultation, did the provider		YES	NO	DK
01	Explain how to use the method?	HOW TO USE	1	2	8
02	Talk about possible side effects?	TELL SIDE EFFECTS . .	1	2	8
03	Tell you what to do if you have any problems?	TELL PROBLEMS	1	2	8
04	Tell you when to return for follow-up?	TELL WHEN RETURN . .	1	2	8

119	MARK BELOW THE METHOD THAT IS CIRCLED IN QUESTION 116. THEN, ASK THE CLIENT THE QUESTION RELATED TO THAT METHOD			
01	Pill (Any pill)	How often do you take the pill?	ONCE A DAY . . . . . 1 OTHER . . . . . 2 DON'T KNOW 8	
02	Condom (both male and female)	How many times can you use a condom?	ONCE . . . . . 1 OTHER . . . . . 2 DON'T KNOW 8	
03	Condom (female)	What type of lubricant can you use with the female condom?	ANY OIL OR LUBRICANT . . . . . 1 OTHER . . . . . 2 DON'T KNOW 8	
04	IUCD	What should you do to make sure that your IUD is in place?	CHECK STRING . . . . . 1 OTHER . . . . . 2 DON'T KNOW 8	
05	Spermicide	Approximately how long before intercourse should you insert the vaginal tablet?	BETWEEN 15 MINUTES AND 1 HOUR . . . . . 1 OTHER . . . . . 2 DON'T KNOW 8	
06	Diaphragm	Approximately how long after intercourse should the diaphragm remain in place?	AT LEAST 6 HOURS (BUT NO LONGER THAN 24 HOURS) . . 1 OTHER . . . . . 2 DON'T KNOW 8	
07	Injectable (e.g., Depo-Provera 2-3 months)	How long does the injection provide protection from pregnancy?	2-3 MONTHS . . . . . 1 OTHER . . . . . 2 DON'T KNOW 8	
08	Injectable (monthly)	How long does the Norigynon injection provide protection from pregnancy?	1 MONTH . . . . . 1 OTHER . . . . . 2 DON'T KNOW 8	
09	Implant	How long does your implant provide protection against pregnancy?	3-5 YEARS . . . . . 1 OTHER . . . . . 2 DON'T KNOW 8	
10	Natural method (RHYTHM)	How do you recognize the days on which you should not have sexual intercourse?	BODY TEMPERATURE RISES A MUCUS IN VAGINA . . . . . B DAYS 12–16 OF THE MENSTRUAL CYCLE . . . . . C OTHER . . . . . X DON'T KNOW . . . . . Z	
11	LAM	Can you use this method if your menstrual period has returned?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
12	Male sterilisation (Vasectomy)	After you have been sterilised (and after the first 3 months), can you make a woman pregnant again?	NO . . . . . 1 OTHER . . . . . 2 DON'T KNOW 8	
13	Female sterilisation	After you have been sterilised, could you ever become pregnant again?	NO . . . . . 1 OTHER . . . . . 2 DON'T KNOW 8	

4. Information About Client's Satisfaction

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	Now I am going to ask you some questions about the services you received today. I would like to have your honest opinion about the things that we will talk about. This information will help improve family planning services.		
201	How long did you wait between the time you arrived at this facility and the time you were able to see a provider for the consultation?	MINUTES . . . . . [ ][ ][ ] SAW PROVIDER IMMEDIATELY . . . . . 000 DON'T KNOW 998	
202	Now I am going to ask about some common problems clients have at health facilities. As I mention each one, please tell me whether any of these were problems for you today, and if so, whether they were **major** or **minor** problems for you.		

			MAJOR	MINOR	NO PROB-LEM	DK
01	Time you waited	WAITING TIME	1	2	3	8
02	Ability to discuss problems or concerns about your health with the provider	DISCUSS PROBLEMS	1	2	3	8
03	Amount of explanation you received about the problem or treatment	EXPLAIN PROB. OR TREATMENT	1	2	3	8
04	Quality of the examination and treatment provided	QUALITY	1	2	3	8
05	Privacy from having others see the examination	VISUAL PRIVACY	1	2	3	8
06	Privacy from having others hear your consultation discussion	AUDITORY PRIVACY	1	2	3	8
07	Availability of medicines/methods at this facility	MEDS/METHODS	1	2	3	8
08	The hours of service at this facility	HOURS OF SERVICE	1	2	3	8
09	The number of days services are available to you	DAYS OF SERVICE	1	2	3	8
10	The cleanliness of the facility	CLEAN	1	2	3	8
11	How the staff treated you	HOW TREATED	1	2	3	8
12	Cost for services or treatments	COST	1	2	3	8
13	Any problem you had today that I did not mention	_____ (SPECIFY)	1	2	3	8

203	Are you a part of any prepayment plan (such as medical aid, insurance or a similar program) or institutional arrangement that pays for some or all of the services you receive at this facility?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
204	Were you charged, or did you pay anything for any services provided today?	YES . . . . . 1 NO 2	→ 206

205	What is the total amount you paid for all services or treatments you received at this facility today?	TOTAL AMOUNT [ ][ ][ ][ ][ ][ ] PAID NO MONEY . . . . . 000000 DON'T KNOW 999998	 → 206 → 206
205A	Please tell me how much you paid for each of the following services you received today: RECORD AMOUNT AS "OTHER" IF RESPONDENT DOES NOT KNOW WHAT THE MONEY WAS PAID FOR. MUST ADD UP TO AMOUNT IN Q205	1) LAB [ ][ ][ ][ ][ ][ ] 2) MEDICINE [ ][ ][ ][ ][ ][ ] 3) CONSULT [ ][ ][ ][ ][ ][ ] 4) OTHER [ ][ ][ ][ ][ ][ ]	
206	Is this the closest health facility to your home?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 208 → 208
207	What was the main reason you did not go to the nearest facility? IF CARETAKER MENTIONS SEVERAL REASONS, PROBE FOR THE MOST IMPORTANT, OR MAIN REASON.	INCONVENIENT OPERATING HOURS . . . . . 01 BAD REPUTATION . . . . . 02 DON'T LIKE PERSONNEL . . .03 NO MEDICINE . . . . . .04 PREFERS TO REMAIN ANONYMOUS . . . . . 05 IT IS MORE EXPENSIVE . . . . 06 WAS REFERRED . . . . . .07 OTHER _____ 96 (SPECIFY) DON'T KNOW 98	
208	Have you ever visited this facility before (either as a patient or visiting or accompanying a patient)?	YES . . . . . 1 NO 2	
209	In general, which of the following statements describes best your opinion of the services given today at this facility: (READ ALL STATEMENTS; CHECK ONLY ONE) 01) I am **very satisfied** with the services given 02) I am **more or less satisfied** with the services given 03) I am not satisfied with the services given	 VERY SATISFIED. . . . . 01 MORE OR LESS SATISFIED 02 NOT SATISFIED. 03	
210	Will you recommend this health facility to a friend or family member? (CHECK ONLY ONE)	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

5. Personal Characteristics of Client

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	Now I am going to ask you some questions about yourself. I would like to have your honest responses as this information will help us to improve services.		
301	How old were you at your last birthday?	AGE IN YEARS . . . . . [ ][ ] DON'T KNOW. 98	
302	Have you ever attended school?	YES . . . . . 1 NO 2	 → 305
303	What is the highest level of school you attended?	INFORMAL (E.G. ADULT) ... 1 PRIMARY (1-3) ..... 2 UPPER PRIMARY (4-7) ..... 3 SECONDARY (8-12) ..... 4 TERTIARY 5	→ 305 → 306
304	What is the highest grade you completed at that level? (E.G., GRADE "9" OF SECONDARY)	GRADE . . . . . [ ][ ]	IF > 6TH GRADE ►306
305	Do you know how to read or how to write?	YES, READ AND WRITE . . . 1 YES, READ ONLY . . . . . 2 NO 3	
	Thank you very much for taking the time to answer my questions. Once again, any information you have given will be kept completely confidential. Have a good day!		
306	RECORD THE TIME THE INTERVIEW ENDED	[ ][ ] : [ ][ ]	
307	**Interviewer's comments:**		

Sample List for Sick Child Observation

Date | | | | | 2 | 0 | 0 | 9 |
DAY MONTH YEAR

| | | |
FACILITY #

IF THERE ARE MORE THAN 25 CHILDREN YOU MAY INDICATE THE TOTAL NUMBER HERE | | |

	INITIALS OF CHILD	AGE (MONTHS)	SYMPTOM	
			SICK	INJURY
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				

Observation of Sick Child Consultation

1. Facility Identification

QTYPE | O | S | C |

Name of the facility: _____

Location of the facility: _____

FACILITY NUMBER . . . . . | | | |

2. Provider Information

Provider category:
- SPECIALIST. 01
- MEDICAL OFFICER/PHYSICIAN 02
- MEDICAL ASSISTANT 03
- REGISTERED NURSE/MIDWIFE 04
- ENROLLED NURSE/MIDWIFE 05
- NURSE ASSISTANT/AUXILIARY 06

PROVIDER CATEGORY | | |

SEX OF PROVIDER: (1=Male; 2=Female)

SEX OF PROVIDER . . . . . | |

PROVIDER SERIAL NUMBER [FROM STAFF LISTING FORM]

PROVIDER SL NUMBER . . . . . | | |

3. Information About Observation

Date: ➡

DAY . . . . . | | |

MONTH . . . . . | | |

YEAR . . . . . | 2 | 0 | 0 | 9 |

Name of the observer: _____

OBSERVER CODE . . . . . | | |

Client code: ➡

CLIENT CODE . . . . . | | |

4. Observation of Sick-Child Consultation

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	BEFORE OBSERVING THE CONSULTATION, OBTAIN PERMISSION FROM BOTH THE SERVICE PROVIDER AND THE CLIENT. MAKE SURE THAT THE PROVIDER KNOWS THAT YOU ARE NOT THERE TO EVALUATE HIM OR HER, AND THAT YOU ARE NOT AN "EXPERT" TO BE CONSULTED DURING THE SESSION. **READ TO PROVIDER:** Hello. I am [NAME OF OBSERVER]. I am representing the Ministry of Health and Social Services (MOHSS). We are conducting a study of all health facilities in Namibia with the goal of finding ways to improve the delivery of services. I would like to observe your consultation with this client in order to understand how Sick Child services are provided in this facility. Information from this observation is confidential. Neither your name nor that of the client will be recorded. The information acquired during this observation may be used by the MOHSS or other organizations to improve services, or for research on health services; however, neither your name nor the names of your clients will be entered in the database. Do you have any questions for me? If at any point you feel uncomfortable you can ask me to leave. However, we hope you won't mind our observing your consultation. Do I have your permission to be present at this consultation? _____ DAY [ ][ ] MONTH [ ][ ] YEAR 2009 Interviewer's signature (Indicates respondent's willingness to participate)		
100	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES . . . . . 1 NO 2	→ **END**
	READ TO CLIENT: Hello, I am_____. I am representing the Ministry of Health and Social Services (MOHSS). We are conducting a study of health services in health facilities in Namibia. I would like to be present while you are receiving services today, in order to better understand how health care is provided. We are not evaluating the [NURSE/DOCTOR/PROVIDER] or the facility. And although information from this observation may be provided to researchers for analyses, neither your name nor the date of services will be provided on any shared data, so your identity and any information about you will remain completely confidential. Please know that whether you decide to allow me to observe your visit is completely voluntary and that whether you agree to participate or not will not affect the services you receive. If at any point you would prefer I leave please feel free to tell me. After the consultation, my colleague would like to talk with you about your experience here today. Do you have any questions for me? Do I have your permission to be present at this consultation? _____ DAY [ ][ ] MONTH [ ][ ] YEAR 2009 Interviewer's signature (Indicates respondent's willingness to participate)		
101	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE CARETAKER.	YES . . . . . 1 NO 2	→ **END**
102	RECORD THE TIME THE OBSERVATION STARTED . . . . . [ ][ ] : [ ][ ]		
103	RECORD SEX OF THE CHILD.	MALE . . . . . 1 FEMALE 2	
104	RECORD THE VISIT TYPE (THIS REFERS TO THIS SICKNESS).	FIRST VISIT . . . . . 1 FOLLOW-UP . . . . . 2 DON'T KNOW 8	

5. Provider's Interaction With Caretaker and Child

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
105	RECORD WHETHER A PROVIDER ASKED ABOUT OR WHETHER THE CARETAKER MENTIONED THAT THE CHILD HAD ANY OF THE FOLLOWING **MAJOR SYMPTOMS**.	YES	NO	DK	
01	Fever	1	2	8	
02	Cough or difficult breathing (e.g. fast breathing)	1	2	8	
03	Diarrhoea	1	2 → 05	8	
04	Blood in the stools	1	2	8	
05	Ear pain or discharge	1	2	8	
106	RECORD WHETHER A PROVIDER ASKED ABOUT OR WHETHER THE CARETAKER MENTIONED ANY OF THE FOLLOWING.				
01	Whether the child is unable to drink or breastfeed at all	1	2	8	
02	Whether the child vomits everything	1	2	8	
03	Whether the child has had convulsions with this sickness	1	2	8	
107	RECORD WHETHER A PROVIDER PERFORMED ANY OF THE FOLLOWING **PHYSICAL EXAMINATIONS**.				
01	Take child's temperature by thermometer	1	2	8	
02	Feel the child for fever or body hotness	1	2	8	
03	Count respiration (breaths)	1	2	8	
04	Auscultate child (listen to chest with stethoscope) or count pulse	1	2	8	
05	Check skin turgor for dehydration (pinch abdominal skin)	1	2	8	
06	Check for pallor by looking at palms	1	2	8	
07	Check for pallor by looking at conjunctiva or mouth	1	2	8	
08	Check mouth and throat	1	2	8	
09	Check for neck stiffness	1	2	8	
10	Look in child's ear	1	2	8	
11	Feel behind child's ear	1	2	8	
12	Undress child to examine (up to shoulders/ down to ankles)	1	2	8	
13	Press both feet to check for oedema	1	2	8	
14	Assessed for suspected symptomatic HIV infection	1	2	8	
15	Weigh the child IF YES:	1	2 → 108	8 → 108	
16	Plot weight on growth chart	1 → 108	2	8	
17	Compare child's weight to standard weight	1	2	8	

108	RECORD WHETHER A PROVIDER ASKED ABOUT OR PERFORMED OTHER ASSESSMENTS OF THE CHILD'S HEALTH **BY DOING ANY OF THE FOLLOWING.**	YES	NO	DK		
01	Offered the child something to drink or ask the mother to put the child to the breast (IF CHILD DRINKS OR FEEDS AT BREAST DURING VISIT, THIS COUNTS AS "YES")	1	2	8		
02	Asked about normal feeding practices when the child is not ill	1	2	8		
03	Asked about normal breastfeeding practices when the child is not ill	1	2	8		
04	Asked about feeding or breastfeeding practices for the child during this illness	1	2	8		
05	Mentioned the child's weight or growth to the caretaker, or discussed the growth chart with the caretaker	1	2	8		
06	Looked at the child's immunisation card or asked the caretaker about child's vaccination history	1	2	8		
07	Asked if child received Vitamin A	1	2	8		
08	Looked at the child's health card either before beginning the consultation, or while collecting information from the caretaker, or when examining the child (THIS ITEM MAY BE EITHER THE VACCINATION CARD OR ANOTHER HEALTH CARD).	1	2	8		
109	RECORD WHETHER A PROVIDER DID ANY OF THE FOLLOWING WHEN COUNSELLING THE CARETAKER.	YES	NO	DK	NA	
01	Provided general information about feeding or breast-feeding the child even when not sick	1	2	8		
02	Told the caretaker to give extra fluids to the child during this sickness	1	2	8		
03	Told the caretaker to continue feeding the child during this sickness	1	2	8		
04	Told the caretaker what illness(es) the child has	1	2	8		
05	Described signs and/or symptoms in the child for which the caretaker should immediately bring the child back	1	2	8		

110	RECORD WHETHER THE CHILD WAS REFERRED TO ANOTHER PROVIDER OR FOR A LABORATORY TEST	1	2 → 111	8 → 111		
01	WAS CHILD REFERRED TO ANOTHER PROVIDER?	1	2	8		
02	WAS CHILD REFERRED FOR A LABORATORY TEST?	1	2	8		
03	DID THE PROVIDER EXPLAIN THE REASON FOR THE REFERRAL?	1	2	8		
04	WAS A REFERRAL SLIP GIVEN?	1	2	8		
05	DID THE PROVIDER EXPLAIN WHERE/ WHOM TO GO?	1	2	8		
06	DID THE PROVIDER EXPLAIN WHEN TO GO FOR REFERRAL?	1	2	8		
111	THIS QUESTION REFERS TO MEDICINES THE CARETAKER WILL GIVE TO THE CHILD AT HOME, AND DOES NOT INCLUDE PARACETAMOL OR ORS PROVIDED FOR IMMEDIATE TREATMENT	YES	NO	DK		
01	Prescribed or provided oral medications during consultation	1	2 → 112	8 → 112		
02	Explained how to administer oral treatment(s)	1	2	8	5	
03	Asked the caretaker to repeat the instructions for the medications	1	2	8	5	
04	Gave the first dose of the oral treatment	1	2	8	5	
112	RECORD WHETHER A PROVIDER USED ANY VISUAL AIDS WHEN PROVIDING INDIVIDUAL HEALTH EDUCATION OR COUNSELLING TO THE CARETAKER ABOUT THE CHILD.	YES 1	NO 2	DK 8		
113	RECORD WHETHER THE MAIN PROVIDER REFERRED TO THE CHILD'S HEALTH CARD/ PASSPORT BEFORE OR DURING THE CONSULTATION.	YES . . . . . 1 NO . . . . . 2 NO HEALTH CARD/ PASSPORT USED . . . . . 3 DON'T KNOW 8				→ 115
114	RECORD WHETHER THE MAIN PROVIDER WROTE ON THE CHILD'S HEALTH CARD/ PASSPORT	YES . . . . . 1 NO . . . . . 2 NO HEALTH CARD/ PASSPORT USED . . . . . 3 DON'T KNOW 8				

115	RECORD WHETHER ANYONE DISCUSSED A FOLLOW-UP VISIT FOR THE CHILD	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
116	RECORD THE OUTCOME OF THE CONSULTATION. [THIS IS THE POINT WHEN THE OBSERVATION IS CONCLUDED]	CHILD SENT HOME . . . . . 1 CHILD REFERRED TO PROVIDER AT SAME FACILITY . . . . . 2 CHILD ADMITTED TO SAME FACILITY . . . . . 3 CHILD SENT TO LAB . . . . . 4 CHILD REFERRED TO OTHER FACILITY 5	
117	RECORD THE TIME WHEN THE CONSULTATION ENDED.	[ ][ ] : [ ][ ]	

6. Diagnosis, Severity and Treatment

ASK THE PROVIDER TO TELL YOU THE DIAGNOSIS FOR THE SICK CHILD. IF A DIAGNOSIS OF DEHYDRATION WAS MADE, ASK IF IT WAS SEVERE, MILD, OR MODERATE AND INDICATE ACCORDINGLY. FOR ANY OTHER DIAGNOSIS, SIMPLY INDICATE A YES OR NO. FINALLY, ASK ABOUT THE TREATMENT THAT WAS EITHER PRESCRIBED OR PROVIDED. IF NECESSARY, PROMPT.

DIAGNOSIS (OR MAIN SYMPTOM, IF NO DIAGNOSIS)						
201	**DEHYDRATION**	SEVERE	MOD-ERATE	MILD	NO	DON'T KNOW
	1) DEHYDRATION	1	2	3	4	8
202	**RESPIRATORY SYSTEM**	**YES**	**NO**	**DK**		
	1) PNEUMONIA	1	2	8		
	2) BRONCHO-PNEUMONIA	1	2			
	3) BRONCHIAL SPASM/ASTHMA	1	2	8		
	4) UPPER RESPIRATORY INFECTION (URI)	1	2	8		
	5) RESPIRATORY ILLNESS, DIAGNOSIS UNCERTAIN	1	2	8		
	6) COUGH, DIAGNOSIS UNCERTAIN	1	2	8		
203	**DIGESTIVE SYSTEM**					
	1) PERSISTENT DIARRHOEA	1	2	8		
	2) DIARRHOEA	1	2	8		
	3) DYSENTERY	1	2	8		
	4) AMEBIASIS	1	2	8		
	5) OTHER DIARRHOEA _____ (SPECIFY)	1	2	8		
204	**MALARIA**					
	1) MALARIA (CLINICAL DIAGNOSIS)	1	2	8		
	2) MALARIA (BLOOD SMEAR OR RAPID TEST)	1	2	8		
205	**FEVER/MEASLES**					
	1) FEVER	1	2	8		
	2) MEASLES	1	2	8		
	3) MEASLES WITH COMPLICATIONS	1	2	8		
206	**EAR**					
	1) MASTOIDITIS	1	2	8		
	2) ACUTE EAR INFECTION	1	2	8		
	3) CHRONIC EAR INFECTION	1	2	8		
	4) OTHER EAR INFECTION	1	2	8		
207	**THROAT**					
	1) STREPTOCOCCAL SORE THROAT	1	2	8		
	2) NON-STREPTOCOCCAL SORE THROAT	1	2	8		
	3) OTHER THROAT DX _____ (SPECIFY)	1	2	8		
208	**OTHER DIAGNOSIS**					
	1) OTHER DIAGNOSIS _____ (SPECIFY)	1	2	8		

209	CHECK RESPIRATORY ILLNESSES IN 202 ABOVE. IS CODE "1" CIRCLED FOR ANY OF THE RESPIRATORY ILLNESSES 01 - 06?	YES 1 NO 2	→ 210
209A	CLARIFY WITH THE PROVIDER IF THERE WAS WHEEZING ASSOCIATED WITH THE ILLNESS.	YES, WHEEZING . . . . . 1 NO WHEEZING . . . . . 2 NOT CERTAIN 8	
210	ASK ABOUT PRESCRIPTION, TREATMENT AND ACTIONS TAKEN FOR ILLNESS AND PROBE "ANYTHING ELSE?"		
	WAS TREATMENT PROVIDED	YES. . . . . 1 NO. 2	→ 217

	TREATMENT FOR VARIOUS ILLNESSES	YES	NO	DK	
211	**GENERAL**				
	1) BENZATHINE PENICILLIN INJECTION	1	2	8	
	2) OTHER ANTIBIOTIC INJECTION	1	2	8	
	3) OTHER INJECTION	1	2	8	
	4) CO-TRIMOXAZOLE TABLETS	1	2	8	
	5) CO-TRIMOXAZOLE SYRUP	1	2	8	
	6) AMOXICILLIN CAPSULES	1	2	8	
	7) AMOXICILLIN SYRUP	1	2	8	
	8) OTHER ANTIBIOTIC TABLET/SYRUP	1	2	8	
	9) PARACETAMOL	1	2	8	
	10) OTHER FEVER REDUCING MEDICINE	1	2	8	
	11) ZINC (for Diarrhoea) (SPECIFY DAILY DOSE in mg) [ ][ ][ ][ ]	1	2	8	
	12) VITAMINS (OTHER THAN VITAMIN A)	1	2	8	
	13) COUGH SYRUPS/OTHER MEDICATION FOR SYMPTOMATIC TREATMENT	1	2	8	
212	**RESPIRATORY**				
	1) NEBULISER OR INHALER	1	2	8	
	2) INJECTABLE BRONCHODILATOR (ADRENALINE)	1	2	8	
	3) ORAL BRONCHODILATOR	1	2	8	
	4) DRY EAR BY WICKING	1	2	8	
213	**MALARIA**				
	1) INJECTABLE QUININE	1	2	8	
	2) OTHER INJECTABLE ANTIMALARIAL (E.G., FANSIDAR, ARTEMETHER)	1	2	8	
	3) ORAL FANSIDAR (SP)	1	2	8	
	4) ORAL ARTEMISININ (INCL. ACT, E.G., COARTEM)	1	2	8	
	5) ORAL AMODIAQUINE	1	2	8	
	6) ORAL ARTEMETER	1	2	8	
	7) ORAL QUININE	1	2	8	
	8) OTHER ORAL ANTIMALARIAL _____ (SPECIFY)	1	2	8	

214	**DEHYDRATION**	YES	NO	DK	
	1) HOME ORT	1	2	8	
	2) INITIAL ORT IN FACILITY (4 HOURS)	1	2	8	
	3) INTRAVENOUS FLUIDS	1	2	8	
215	**OTHER TREATMENT & ADVICE**				
	1) VITAMIN A (MAY ALSO BE FOR IMMUNIZATION)	1	2	8	
	2) FEEDING SOLID FOODS	1	2	8	
	3) FEEDING EXTRA LIQUIDS	1	2	8	
	4) FEEDING BREAST MILK	1	2	8	
216	1) ANY OTHER TREATMENT _____ (SPECIFY)	1	2	8	
217	Did you give or refer the child for an immunisation other than VITAMIN A supplementation? IF NO: Why not?	YES, GAVE. . . . . 1 YES, REFERRED . . . . . 2 NOT DUE FOR IMMUNISATION/ COMPLETED IMMUNISATION. . . 3 VACCINE NOT AVAILABLE. . . . . 4 CHILD TOO SICK. . . . . 5 NOT DAY FOR IMMUNISATION. . . . . 6 DID NOT CHECK FOR IMMUNISATION 7			
218	RECORD THE TIME THE OBSERVATION ENDED.	[ ][ ] : [ ][ ]			

Observer's comments:

MEASURE *DHS* SERVICE PROVISION ASSESSMENT

Exit Interview for Caretaker of Sick Child

1. Facility Identification

QTYPE . . . . . | X | S | C |

Name of the facility: _____

Location of the facility: _____

FACILITY NUMBER . . . . . | | | |

2. Information About Interview

DATE: ➡	DAY . . . . .
	MONTH . . . . .
	YEAR 2 0 0 9
Name of the interviewer: _____	INTERVIEWER CODE . . . . .
Client code [USE SAME NUMBER FROM OBSERVATION]	CLIENT CODE: . . . . .
Sex of caretaker (1=Male; 2=Female) ➡	SEX OF CARETAKER . . . . .

3. Information About Visit

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	READ TO CARETAKER: Hello, I am_____. As my colleague mentioned, we are representing the Ministry of Health and Social Services. We are conducting a study of health services in all health facilities in Namibia. In order to improve the services this facility offers, we would like to ask you some questions about your experience here today. Please know that whether you decide to allow this interview or not is completely voluntary and will not affect services you receive during any future visit. You may refuse to answer any question, and you may stop the interview at any time. Information from this interview may be provided to researchers for analyses, but neither your name nor the date of services will be on any shared information, so your identity will remain completely confidential. Do you have any questions for me? Do I have your permission to continue with the interview? _____ [ ][ ] [ ][ ] 2 0 0 9 Interviewer's signature DAY MONTH YEAR (Indicates respondent's willingness to participate)		
100	May I begin the interview?	CLIENT AGREES . . . . . 1 CLIENT REFUSES 2	→ **END**
101	RECORD THE TIME THE INTERVIEW STARTED . . . . . [ ][ ] . [ ][ ]		
102	What is the name of the sick child?	NAME _____	
103	What month and year was [NAME] born?	MONTH . . . . . [ ][ ] DON'T KNOW MONTH . . . . . 98 YEAR . . . . . [ ][ ][ ][ ] DON'T KNOW YEAR 9998	
104	WERE YOU ABLE TO ASCERTAIN THE COMPLETE BIRTH DATE OF THE CHILD?	YES . . . . . 1 NO 2	
105	How old is [NAME] in completed months?	AGE IN MONTHS . . . . . [ ][ ] DON'T KNOW. 9 8	

106	Did you bring [NAME] to the facility today because he or she had any of the following problems?		YES	NO
01	Cough or difficult breathing	COUGH/DIFF. BREATH.	1	2
02	Diarrhea	DIARRHEA.	1	2
03	Fever/body hotness at home	FEVER/BODY HOTNESS	1	2
04	Vomiting everything	VOMITING EVERYTHING	1	2
05	Feeding problems	FEEDING PROBLEMS	1	2
06	Convulsions	CONVULSIONS	1	2
07	Excessive sleepiness	SLEEPINESS	1	2

107	For what other reason(s) did you bring [NAME] to this health facility today? CIRCLE ALL ITEMS THE RESPONDENT MENTIONS. PROBE: Anything else?	EYE PROBLEMS . . . . . A SKIN SORE/PROBLEMS B INJURY . . . . . C OTHER NON-SERIOUS W OTHER SERIOUS _____ X (SPECIFY) NO OTHER REASON . . . . . Y	
108	Has [NAME] been brought to this facility before for this same sickness?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	 → 110 → 110
109	IF YES: How long ago was that?	WITHIN THE PAST WEEK . . . 1 WITHIN THE PAST 2-4 WEEKS 2 MORE THAN 4 WEEKS AGO . 3 DON'T KNOW 8	
110	How many days ago did the illness for which you brought [NAME] here begin? IF LESS THAN 1 DAY, WRITE 00 IN THE BOXED CELLS.	DAYS AGO . . . . . [ ][ ] DON'T KNOW 98	
111	Did the provider tell you what illness [NAME] has?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
112	What will you do if [NAME] does not get completely better or becomes worse?	RETURN TO FACILITY . . . . . 1 GO TO OTHER FACILITY . . . 2 GO TO OTHER HEALTH WORKER/PHARMACY . . . . . 3 GO TO TRADITIONAL HEALER . . . . . 4 WAIT . . . . . 5 DON'T KNOW 8	
113	Did the provider tell you about any signs or symptoms you may see for which you must immediately bring the child back? IF YES, ASK: Can you tell me what these are? IF NECESSARY, PROBE: Were there any serious symptoms or danger signs for which you were told to bring [NAME] back immediately? CIRCLE THE SYMPTOM LISTED IF THE CARETAKER UNDERSTANDS THAT THE CHILD SHOULD BE BROUGHT BACK IF THE SYMPTOM EITHER FAILS TO GO AWAY OR BECOMES WORSE.	FEVER . . . . . A BREATHING PROBLEMS . . . . . B BECOMES SICKER . . . . . C BLOOD IN STOOL . . . . . D VOMITING . . . . . E POOR/NOT EATING . . . . . F POOR/NOT DRINKING . . . . . G OTHER _____ X (SPECIFY) NO, NONE . . . . . Y DON'T KNOW . . . . . Z	

114	Did the provider tell you anything about bringing [NAME] back to the health facility for follow-up or non-emergency reasons? IF YES: Why were you to return?	MORE MEDICINES . . . . . A IF SYMPTOMS INCREASE OR BECOME WORSE . . . . . B FOLLOW-UP APPOINTMENT C CHILD ADMITTED . . . . . D ROUTINE IMMUNISATION . . . . . E OTHER _____ X (SPECIFY) NO . . . . . Y DON'T KNOW . . . . . Z	
115	Did the provider give or prescribe any medicines for [NAME] to take at home?	YES, GAVE MEDS . . . . . 1 YES, GAVE PRESCRIPTION . 2 GAVE MEDS AND PRESCRIPTION . . . . . 3 NO 8	→ 120
116	ASK TO SEE ALL MEDICATIONS THAT THE CARETAKER RECEIVED AND ANY PRESCRIPTIONS THAT HAVE NOT YET BEEN FILLED. CIRCLE THE RESPONSE DESCRIBING THE MEDICATIONS AND PRESCRIPTIONS YOU SEE.	HAS ALL MEDS . . . . . 1 HAS SOME MEDS, SOME UNFILLED PRESCRIPTIONS 2 NO MEDICATIONS SEEN, HAS PRESCRIPTIONS ONLY . . . 3	
117	Did a provider at the facility explain to you how to give these medicines to [NAME] at home? IF "2" OR "8" SEND CLIENT BACK TO PROVIDER AT THE END OF THE QUESTIONNAIRE	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
118	Do you feel comfortable or confident that you know how much of each medication to give [NAME] each day and for how many days to give it? IF "2" OR "8" SEND CLIENT BACK TO PROVIDER AT THE END OF THE QUESTIONNAIRE	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
119	Has [NAME] been given a dose of any of these medications here at the facility already?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
120	Did [NAME] receive an injection for treating the sickness here at the facility today? IF NO, CHECK PRESCRIPTIONS AND RECORD IF THERE IS A PRESCRIPTION FOR AN INJECTION.	YES, RECEIVED INJ . . . . . 1 YES, RECEIVED PRESC. FOR INJ. . . . . 2 NO . . . . . 3 DON'T KNOW 8	
121	Did anyone at the health facility weigh [NAME] today?	YES . . . . . 1 NO 2	
122	Did anyone talk to you today about [NAME]'s weight and how [NAME] is growing?	YES . . . . . 1 NO 2	
123	Did any provider ask you today about the types of foods and amounts that you normally feed [NAME] when [NAME] is not sick?	YES . . . . . 1 NO . . . . . 2 CANNOT REMEMBER 8	

124	What did the provider tell you about feeding solid foods to [NAME] during this illness?	GIVE LESS THAN USUAL . . . . . 1 GIVE SAME AS USUAL . . . . . 2 GIVE MORE THAN USUAL . . . 3 GIVE NOTHING/DON'T FEED . . 4 DIDN'T DISCUSS . . . . . 6 NOT CERTAIN 8	
125	What did the provider tell you about giving fluids (or breast milk, if the child is breastfed) to [NAME] during this illness?	GIVE LESS THAN USUAL . . . . . 1 GIVE SAME AS USUAL . . . . . 2 GIVE MORE THAN USUAL . . . 3 GIVE NOTHING/DON'T FEED . . 4 DIDN'T DISCUSS . . . . . 6 DON'T KNOW 8	
126	Was [NAME] given a vaccination today? IF YES, ASK TO SEE THE HEALTH CARD OR PASSPORT TO VERIFY.	YES, OBSERVED. . . . . 1 REPORTED, NOT SEEN. . . . . 2 NO . . . . . 3 DON'T KNOW 8	
127	Did the provider instruct you to go to another facility, another provider, or for a laboratory test for further care for your child?	YES . . . . . 1 NO 2	→ 201

128		YES	NO	DK
01	Were you given any paper or record to take with you for the referral?	1	2	8
02	Were you told where to go for the referral?	1	2	8
03	Were you told who to see for the referral?	1	2	8
04	Were you told why you were to go for the referral?	1	2	8

129	Did you see another health provider or traditional healer before coming here? IF YES, ASK: Whom did you see? CIRCLE ALL THAT APPLY	YES, OTHER PROVIDER . . . . . A YES, TRADITIONAL HEALER . B NO . . . . . Y	

4. Information About Client's Satisfaction

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	Now I am going to ask you some questions about the services you received today. I would like to have your honest opinion about the things that we will talk about. This information will help improve child health services.		
201	How long did you wait between the time you arrived at this facility and the time you were able to see a provider for the consultation?	MINUTES . . . . . [ ][ ][ ] SAW PROVIDER IMMEDIATELY . . . . . 000 DON'T KNOW 998	
202	Now I am going to ask about some common problems clients have at health facilities. As I mention each one, please tell me whether any of these were problems for you today, and if so, whether they were **major** or **minor** problems for you.		

			MAJOR	MINOR	NO PROB-LEM	DK
01	Time you waited	WAITING TIME	1	2	3	8
02	Ability to discuss problems or concerns about your child's health with the provider	DISCUSS PROBLEMS	1	2	3	8
03	Amount of explanation you received about the problem or treatment	EXPLAIN PROB. OR TREATMENT	1	2	3	8
04	Quality of the examination and treatment provided	QUALITY	1	2	3	8
05	Privacy from having others see the examination	VISUAL PRIVACY	1	2	3	8
06	Privacy from having others hear your consultation discussion	AUDITORY PRIVACY	1	2	3	8
07	Availability of medicines at this facility	MEDICINES	1	2	3	8
08	The hours of service at this facility	HOURS OF SERVICE	1	2	3	8
09	The number of days services are available to you	DAYS OF SERVICE	1	2	3	8
10	The cleanliness of the facility	CLEAN	1	2	3	8
11	How the staff treated you	HOW TREATED	1	2	3	8
12	Cost for services or treatments	COST	1	2	3	8
13	Any problem you had today that I did not mention	_____ (SPECIFY)	1	2	3	8

203	Are you a part of any prepayment plan (such as medical aid, insurance or a similar program) or institutional arrangement that pays for some or all of the services you receive at this facility?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
204	Were you charged, or did you pay anything for any services provided today?	YES . . . . . 1 NO 2	→ 206

205	What is the total amount you paid for all services or treatments you received at this facility today?	TOTAL AMOUNT [ ][ ][ ][ ][ ][ ] PAID NO MONEY . . . . . 000000 DON'T KNOW 999998	 → 206 → 206
205A	Please tell me how much you paid for each of the following services you received today: RECORD AMOUNT AS "OTHER" IF RESPONDENT DOES NOT KNOW WHAT THE MONEY WAS PAID FOR. MUST ADD UP TO AMOUNT IN Q205	1) LAB [ ][ ][ ][ ][ ][ ] 2) MEDICINE [ ][ ][ ][ ][ ][ ] 3) CONSULT [ ][ ][ ][ ][ ][ ] 4) OTHER [ ][ ][ ][ ][ ][ ]	
206	Is this the closest health facility to your home?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 208 → 208
207	What was the main reason you did not go to the nearest facility? IF CARETAKER MENTIONS SEVERAL REASONS, PROBE FOR THE MOST IMPORTANT, OR MAIN REASON.	INCONVENIENT OPERATING HOURS . . . . . 01 BAD REPUTATION . . . . . 02 DON'T LIKE PERSONNEL . . .03 NO MEDICINE . . . . . .04 PREFERS TO REMAIN ANONYMOUS . . . . . 05 IT IS MORE EXPENSIVE . . . . 06 WAS REFERRED . . . . . .07 OTHER _____ 96 (SPECIFY) DON'T KNOW 98	
208	Have you ever visited this facility before (either as a patient or visiting or accompanying a patient)?	YES . . . . . 1 NO 2	
209	In general, which of the following statements describes best your opinion of the services given today at this facility: (READ ALL STATEMENTS; CHECK ONLY ONE) 01) I am **very satisfied** with the services given 02) I am **more or less satisfied** with the services given 03) I am not satisfied with the services given	 VERY SATISFIED 01 MORE OR LESS SATISFIED 02 NOT SATISFIED 03	
210	Will you recommend this health facility to a friend or family member? (CHECK ONLY ONE)	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

5. Personal Characteristics of Client

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	Now I am going to ask you some questions about yourself. I would like to have your honest responses as this information will help us to improve services.		
300	What is your relationship to [NAME]?	MOTHER . . . . . 1 FATHER . . . . . 2 SIBLING . . . . . 3 AUNT OR UNCLE . . . . . 4 GRAND MOM/GRAND DAD. . . . . 5 OTHER _____ 6 (SPECIFY)	
301	How old were you at your last birthday?	AGE IN YEARS . . . . . [ ][ ] DON'T KNOW. 98	
302	Have you ever attended school?	YES . . . . . 1 NO 2	 → 305
303	What is the highest level of school you attended?	INFORMAL (E.G. ADULT) ... 1 PRIMARY (1-3) …….. 2 UPPER PRIMARY (4-7) …….. 3 SECONDARY (8-12) …….. 4 TERTIARY …….. 5	→ 305 → 306
304	What is the highest grade you completed at that level? (E.G., GRADE "9" OF SECONDARY)	GRADE . . . . . [ ][ ]	IF > 6TH GRADE ►306
305	Do you know how to read or how to write?	YES, READ AND WRITE . . . 1 YES, READ ONLY . . . . . 2 NO 3	
	Thank you very much for taking the time to answer my questions. Once again, any information you have given will be kept completely confidential. Have a good day!		
306	RECORD THE TIME THE INTERVIEW ENDED	[ ][ ] : [ ][ ]	
307	**Interviewer's comments:**		

HEALTH WORKER INTERVIEW

HEALTH WORKER INTERVIEW

Facility Number: [ ][ ][ ] QRE **25**

Interviewer Code: [ ][ ]

Provider SERIAL Number: [ ][ ] **[FROM STAFF LISTING FORM]**

Provider Sex: (1=MALE; 2=FEMALE) [ ]

Provider Status (1=Assigned; 2=Seconded) [ ]

Number of ANC Observations Associated with Provider . . . . . [ ]

Number of FP Observations Associated with Provider . . . . . [ ]

Number of Sick Child Observations Associated with Provider . . . . . [ ]

INDICATE IF PROVIDER WAS PREVIOUSLY INTERVIEWED IN ANOTHER FACILITY. IF YES, RECORD NAME AND FACILITY NUMBER WHERE HE/SHE WAS INTERVIEWED

YES, PREVIOUSLY INTERVIEWED **1**

_____ NAME & NUMBER OF FACILITY [ ][ ][ ] → **STOP**

NO, NOT PREVIOUSLY INTERVIEWED **2**

READ THE FOLLOWING CONSENT FORM

Good day! My name is _____. We are here on behalf of the Ministry of Health and Social Services (MOHSS) conducting a study to assist the government in knowing more about health services in Namibia.
Now I will read a statement explaining the study.

ALL facilities are participating in this study. We will be asking you several questions about the types of services that you personally provide, as well as questions about training you have received.

The information you provide us may be used by the MOHSS, other organizations or researchers, for planning service improvements or further studies of services.

Neither your name nor that of any other health worker respondents participating in this study will be included in the dataset or in any report; however, there is a small chance that any of these respondents may be identified later. Still, we are asking for your help to ensure that the information we collect is accurate.

You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will collaborate with the survey. Do you have any questions about the study? Do I have your agreement to proceed?

_____ [ ][ ] [ ][ ] **2 0 0 9**

Interviewer's signature — DAY | MONTH | YEAR

SIGNATURE OF INTERVIEWER INDICATES INFORMED CONSENT WAS PROVIDED.

101	May I begin the interview now?	YES . . . . . 1 NO 2	→STOP

1. Education and Experience

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
102	I would like to ask you some questions about your educational background. How many years of education have you completed in total? This is starting from your primary, secondary and further education.	YEARS . . . . . [ ][ ]	
103	What is your current professional/technical/medical qualification?	SPECIALIST . . . . . 01 MEDICAL OFFICER/PHYSICIAN. . . . . 02 MEDICAL ASSISTANT . . . . . 03 REGISTERED NURSE/MIDWIFE . . . . . 04 ENROLLED NURSE/MIDWIFE . . . . . 05 NURSE ASSISTANT/AUXILIARY . . . . . .06 HEALTH INSPECTOR/ENVIRONMENTAL H. O . . .07 ENVIRONMENTAL HEALTH ASSISTANT . . . . . 08 SOCIAL WORKER . . . . . 09 PHARMACIST . . . . . .10 PHARMACIST ASSISTANT . . . . . 11 OCCUPATIONAL THERAPIST . . . . . 12 PHYSIOTHERAPIST . . . . . .13 OTHER (SPECIFY) _____ 14 MEDICAL REHAB OFFICER/INSTRUCTOR/WORK 15 NUTRITIONIST . . . . . 16 LABORATORY SCIENTIST . . . . . 21 LABORATORY TECHNOLOGIST . . . . . 22 LAB. TECHNICIAN/ASSISTANT . . . . . 23 COMMUNITY HIV COUNSELLOR . . . . . .31 COMMUNITY HEALTH WORKER/HOME-BASED CAREGIVER/CBRP . . . . . 32 LIFESTYLE AMBASSASOR (TB/HIV) . . . . . 33 FIELD PROMOTER (TB/HIV) 34	
104	What year did you graduate (or complete) with this qualification? IF NO TECHNICAL QUALIFICATION (31-34), ASK: What year did you complete any basic training for your current position?	YEAR [ ][ ][ ][ ]	
105	In what year did you start working in this facility?	YEAR [ ][ ][ ][ ]	
106	In what year did you start working in your ***current position*** in this facility? IF YEAR IS NOT KNOWN, PROBE AND MAKE THE BEST ESTIMATE	YEAR [ ][ ][ ][ ]	
107	What was your age at your last birthday?	AGE AT LAST BIRTHDAY (YRS) . [ ][ ]	

2. GENERAL TRAINING AND SERVICES PROVIDED IN CURRENT POSITION IN THIS FACILITY

		YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO TRAINING WITHIN PAST 3 YEARS
200	First I want to ask you about some general training courses. During the past 3 years, have you received any pre-service or in-service training on: [READ TOPIC]. IF YES, ASK: Was that training within the past 1 year? IF NOT WITHIN THE PAST 1 YEAR, ASK: Was that training within the past 3 years?			
01	Universal Precautions (of Infection Control)?	1	2	3
02	Waste management, that is, appropriate disposal of sharps and contaminated waste?	1	2	3
03	Any other training related to infection prevention?	1	2	3
04	Any training related to Injection safety?	1	2	3
05	Health Management Information Systems (HIS) or reporting requirements for any service?	1	2	3
06	Confidentiality and rights to non-discrimination practices for People Living with HIV/AIDS (PLWHA)?	1	2	3

201	As part of your services in this facility, have you received any dose of Hepatitis B vaccine? **IF YES, ASK:** How many doses have you received so far?	YES, ONE DOSE . . . . 1 YES, TWO DOSES . . . . 2 YES, THREE DOSES . . 3 NO 4	
202	Are you a manager or in-charge for any clinical services?	YES . . . . . 1 NO 2	
203	Do you provide any client/clinical services other than conducting laboratory tests or working as a community counsellor?	YES . . . . . 1 ONLY LAB TESTS . . . . 2 ONLY COMMUNITY COUNSELLOR 3 NO CLIENT SERVICES OR LAB TESTS AND NOT A COMMUNITY COUNSELLOR . . 4	→701 →601 →**END**

204	Now I want to ask you about services you personally provide. For each service I mention, tell me if you provide the service. I would then like to know if you have received any pre or in-service training related to those services that you provide, even if you don't currently provide the service. Please remember, I am asking about services you provide as a part of your current position for this facility.				
	Do you ever…….. [READ TOPIC]. IF INDICATED, ASK: How long have you provided this service, either in this facility or in another service setting? IF LESS THAN 1 YEAR WRITE '00'.	a YES	a NO	b DURATION IN YEARS	
01	Diagnose and/or treat STIs?	1→b	2 → 02		
02	Diagnose and/or treat malaria ?	1	2		
03	Diagnose, treat, or provide follow-up for tuberculosis? IF YES, ASK: How long have you provided TB services? THEN ASK: Do you [READ FOLLOWING LIST OF SERVICES]	1→b	2 → 09		
04	Diagnose tuberculosis based on clinical symptoms?	1	2		
05	Diagnose tuberculosis based on sputum tests or analysis?	1	2		
06	Prescribe treatment for tuberculosis?	1	2		
07	Provide follow-up treatment for tuberculosis?	1	2		
08	Participate in the Direct Observation Treatment Short-course (DOTS) strategy?	1	2		
09	Provide any services that are designed to be Youth Friendly, i.e., that have a specific aim to encourage adolescent utilization?	1	2		

205	Now I want to ask about any in-service or pre-service training you have received during the past 3 years on any of the topics I have just mentioned. During the past three years have you received any pre-service or in-service training on [READ TOPIC]? IF YES, ASK: Was this during the past 1 year?	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO TRAINING WITHIN PAST 3 YEARS
01	Diagnosing and treating sexually transmitted infections (STIs)?	1	2	3
02	The syndromic management for STIs?	1	2	3
03	Drug resistance to STI treatment medications	1	2	3
04	Any topic related to malaria? IF RESPONSE IS EITHER "1" OR "2", ASK: Did the training cover any of the following topics:	1	2	3 → 08
05	Diagnosis and treatment of malaria?	1	2	3
06	Specifically diagnosing and treating malaria in children?	1	2	3
07	Intermittent Preventive Treatment (IPT) of malaria for pregnant women?	1	2	3
08	Any topic related to tuberculosis? IF RESPONSE IS EITHER "1" OR "2", ASK: Did the training cover any of the following topics:	1	2	3 → 14
09	Diagnosing tuberculosis (TB) using sputum test?	1	2	3
10	Diagnosing TB using clinical symptoms?	1	2	3
11	Prescribing treatment for TB?	1	2	3
12	The DOTS (Direct observed treatment-short-course) strategy?	1	2	3
13	Follow-up treatment for TB clients?	1	2	3
14	Any topic specific to youth friendly services? This includes addressing psychological or health issues of particular relevance to adolescents?	1	2	3

3. Child Health Services

301	In your **current** position, and as a part of your work for this facility, do you ever personally provide any child health services?	YES . . . . . 1 NO 2	 →303
302	How many years in total have you provided such services (Service may have been in another facility)? IF LESS THAN 1 YEAR, WRITE 00 IN THE BOXED CELLS.	YEARS . . . . . [ ][ ]	
303	During the past three years have you received any pre-service or in-service training on subjects related to child health or childhood illness?	YES . . . . . 1 NO 2	 →401

304	Did you receive the training in any topic related to (READ SPECIFIC TOPIC)? IF YES, ASK: When was the most recent training?	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO TRAINING WITHIN PAST 3 YEARS
01	EPI/cold chain	1	2	3
02	Acute Respiratory Infection (ARI) treatment	1	2	3
03	Diarrhoea treatment	1	2	3
04	Malaria treatment for children	1	2	3
05	Nutrition/micronutrient deficiencies	1	2	3
06	Nutritional assessment (e.g., Body Mass Index calculation, Mid-Upper Arm Circumference measurement?)	1	2	3
07	Breast feeding (including exclusive breast-feeding)	1	2	3
08	Complementary feeding of infant	1	2	3
09	Integrated Management of Childhood Illnesses (IMCI)	1	2	3
10	Other training specific to child health: _____ (SPECIFY)	1	2	3

4. Family Planning

401	In your **current** position, and as a part of your work for this facility, do you ever personally provide any family planning services?	YES . . . . . 1 NO 2		→403
402	How many years in total have you provided such services (Service may have been in another facility)? IF LESS THAN 1 YEAR, WRITE 00 IN THE BOXED CELLS	YEARS	[ ][ ]	
403	During the past three years have you received any pre-service or in-service training on subjects related to family planning?	YES . . . . . 1 NO 2		→501

404	Did you receive the training in any topic related to (READ SPECIFIC TOPIC)? IF YES, ASK: When was the most recent training?	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO TRAINING WITHIN PAST 3 YEARS
01	General counselling for family planning?	1	2	3
02	Clinical issues related to providing family planning methods?	1	2	3
03	Symptom updates related to family planning methods	1	2	3
04	Symptom management for family planning methods	1	2	3
05	Topics specific for family planning for HIV infected women?	1	2	3
06	Other family planning topics? _____ (SPECIFY)	1	2	3

5. Maternal Health

501	Now I have a few questions about maternal and newborn health and HIV/AIDS. During the past three years have you received any pre-service or in-service training on subjects related to maternal or newborn health and HIV/AIDS?	YES . . . . . 1 NO 2	→503

		YES, IN PAST 1 YR	YES, IN PAST 2-3 YRS	NO TRAINING WITHIN PAST 3 YRS
502	Did you receive the training in any topic related to [READ TOPIC]? IF YES, ASK: When was the most recent training?			
01	Prevention of mother-to-child transmission of HIV/AIDS	1	2	3
02	Nutrition counselling for newborn of mother with HIV/AIDS	1	2	3
03	Modified obstetric practices as relates to HIV	1	2	3

503	In your **current** position, and as a part of your work for this facility, do you ever personally provide any **antenatal** or **postnatal care** services? IF YES, INDICATE WHICH SERVICE IS PROVIDED.	YES, ANTENATAL . . . . . 1 YES, POSTNATAL . . . . . 2 YES, BOTH . . . . . 3 NO, NEITHER 4	→505
504	How many years in total have you provided such services? Service may have been in another facility. IF LESS THAN 1 YEAR, WRITE "00" IN THE BOXES	YEARS . . . . . [ ][ ]	
505	Do you ***personally*** provide any **PMTCT** services? IF YES, ASK: Which specific services do you provide? INDICATE WHICH OF THE LISTED SERVICES ARE PROVIDED AND PROBE: Anything else?	PREVENTIVE COUNSELING . . A HIV TEST COUNSELING . . B CONDUCT HIV TEST . . . . . C PROVIDE ARV TO MOTHER . . . D PROVIDE ARV TO INFANT . E NO PMTCT SERVICES . . . . . Y	
506	During the past 3 years have you received any pre- or in-service training on subjects related to antenatal or postnatal care?	YES . . . . . 1 NO 2	→508

		YES, IN PAST 1 YR	YES, IN PAST 2-3 YRS	NO TRAINING WITHIN PAST 3 YRS
507	Did you receive the training in any topic related to [READ TOPIC]? IF YES, ASK: When was the most recent training?			
01	ANC counselling (preventive or symptomatic management)	1	2	3
02	ANC services or screening	1	2	3
03	Complications of pregnancy	1	2	3
04	Symptom management for pregnancy	1	2	3
05	Management of risk pregnancies	1	2	3
06	Postnatal care	1	2	3
07	Any topic related to pregnancy and HIV/AIDS or PMTCT?	1	2	3 → 14
08	Counselling for prevention of mother-to-child transmission of HIV?	1	2	3
09	Antiretroviral prophylactic treatment for prevention of mother to child transmission (PMTCT) of HIV?	1	2	3
10	Nutritional counselling for the newborn of mothers with HIV/AIDS?	1	2	3
11	Guidelines to follow when dispensing the preventive ARV to HIV positive women?	1	2	3
12	Record keeping, or other management of the ARVs for PMTCT?	1	2	3
13	Nutrition counselling for the pregnant woman with HIV/AIDS?	1	2	3
14	Nutritional assessment of the pregnant woman, such as Body Mass Index calculation and Mid-Upper Arm circumference measurement?	1	2	3

508	In your **current** position, and as a part of your work for this facility, do you ever personally provide **delivery services**? By that I mean conducting the actual delivery of newborns?	YES . . . . . 1 NO 2	→512
509	How many years in total have you provided such services? (Service may have been in another facility)? IF LESS THAN 1 YEAR, WRITE 00 IN THE BOXED CELLS	YEARS ..... [ ][ ]	
510	During the past 6 months, approximately how many deliveries have you conducted as the ***principal provider*** (include deliveries conducted for private practice and for facility)?	TOTAL DELIVERIES [ ][ ][ ][ ][ ]	
511	When was the last time you used a partograph?	NEVER . . . . . 0 WITHIN PAST WEEK . . . . . 1 WITHIN PAST MONTH . . . . . 2 WITHIN PAST 6 MONTHS . . . . . 3 OVER 6 MONTHS AGO . . . . . 4 DON'T KNOW 8	
512	During the past three years have you received any pre- or in-service training on subjects related to delivery care?	YES . . . . . 1 NO 2	→514

513	Did you receive the training in any topic related to [READ TOPIC]? IF YES, when was the most recent training?	YES, IN PAST 1 YR	YES, IN PAST 2-3 YRS	NO TRAINING WITHIN PAST 3 YRS
01	Care during labour or delivery	1	2	3
02	Use of partograph	1	2	3
03	Essential obstetric care/Life saving skills	1	2	3
04	Lifesaving skills/emergency complications	1	2	3
05	Post abortion care	1	2	3
06	Optimal delivery care for preventing mother-to-child transmission (PMTCT) of HIV/AIDS?	1	2	3
07	Other training related to delivery services _____ (SPECIFY)	1	2	3

514	In your **current** position, and as a part of your work for this facility, do you ever personally provide care for the newborn?	YES . . . . . 1 NO 2	→516
515	How many years in total have you provided such services? (Service may have been in another facility)? IF LESS THAN 1 YEAR, WRITE 00 IN THE BOXED CELLS	YEARS . . . . . [ ][ ]	
516	During the past three years have you received any pre- or in-service training on subjects related to newborn care?	YES . . . . . 1 NO 2	→601

517	Did you receive the training in any topic related to [READ TOPIC]? IF YES, when was the most recent training?	YES, IN PAST 1 YR	YES, IN PAST 2-3 YRS	NO TRAINING WITHIN PAST 3 YRS
01	Care of the normal newborn/neonatal care	1	2	3
02	Neonatal resuscitation	1	2	3
03	Exclusive breastfeeding	1	2	3
04	Nutrition for the newborn of the HIV infected woman	1	2	3
05	Other training related to newborn health: _____ (SPECIFY)	1	2	3

6. HIV/AIDS SERVICES

		(a) YES	(a) NO	(b) DURATION IN YEARS
601 01	Do you provide any counselling related to HIV testing? (Service may have been in another facility) IF YES, ASK: How long have you provided such services? IF LESS THAN 1 YEAR, WRITE "00" IN THE BOXES	1 → b	2 → 602	
	Now, do you provide:			
02	Pre-test counselling?	1	2	
03	Post-test counselling for HIV positive clients?	1	2	
04	Follow-up counselling for HIV, after the initial post-test counselling or emotional support?	1	2	
602 01	Do you provide education to patients and families on prevention of HIV/AIDS?	1	2	
02	Do you provide counselling on care and support of the HIV/AIDS infected person who is seriously ill?	1	2	
03	Do you assess HIV clients to determine the need for nutritional support?	1	2	
04	Do you provide nutrition counselling to HIV/AIDS infected clients?	1	2	
05	Do you yourself actually prescribe the HIV test for clients?	1	2	
603 01	Do you provide any services related to prevention of mother to child transmission of HIV/AIDS? IF YES: How long?	1 → b	2 → 604	
02	Do you provide nutrition counselling for the newborn of the HIV infected woman?	1	2	
03	Do you counsel HIV positive women about family planning?	1	2	
04	Do you ever provide or prescribe the preventive antiretroviral therapy for prevention of mother to child transmission (i.e., PMTCT)?	1	2	
604 01	Do you ever provide any follow-up services for HIV positive clients? This includes providing preventive treatments, treatment for opportunistic infections, ART, and palliative care, that is providing treatment for pain and symptoms of the seriously ill HIV/AIDS clients? IF YES, ASK: How long? Now, do you provide:	YES 1 → b	NO 2 → 605	DURATION IN YEARS
02	Clinical management of HIV/AIDS-related neurological disorders?	1	2	
03	Diagnosis and/or treatment of opportunistic infections?	1 → b	2 → 04	
04	Prescribe antiretroviral therapy (ART)?	1 → b	2 → 05	
05	Provide medical follow-up for clients on antiretroviral therapy?	1	2	
06	Provide adherence counselling for ART?	1	2	
07	Provide or prescribe preventive treatment for TB (INH)?	1	2	
08	Provide or prescribe preventive treatment for other opportunistic infections (OIs) such as Cotrimoxazole Preventive Therapy (CPT)?	1	2	
09	Prescribe, counsel, or provide nutritional rehabilitation for HIV/AIDS patients?	1	2	
10	Provide paediatric AIDS care?	1	2	
11	Provide nursing care, or train caregivers and patients in how to care for someone with HIV/AIDS? This includes providing palliative, or symptomatic care and support services?	1 → b	2 → 12	
12	Do you either provide home based care?	1	2	
13	Do you provide training or support for others who provide home-based care?	1	2	

605			
01	Do you ever provide counselling for post-exposure prophylaxis (PEP)?	1 2	
02	Do you ever prescribe medicines for post-exposure prophylaxis (PEP)?	1 2	
606	Do your clients who are HIV positive actively participate in the services that you provide or the services that they receive? IF YES, ASK: How do they actively participate? CIRCLE ALL THAT APPLY	SUPPORT GROUPS . . . . . A DELIVER MEDS FOR OTHER CLIENTS WHO ARE TOO SICK TO ATTEND CLINIC . . . . . B OTHER_____ X (SPECIFY) NO ACTIVE PARTICIPATIO . Y NO SERVICES TO HIV CLIENTS . . . . . Z	

		YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO TRAINING WITHIN PAST 3 YEARS
607	Now I want to know about pre-service or in-service training you have received during the past 3 years on any of the topics I will mention. First I want to know about specific trainings, then, I want to know if you received any other training on the topics I will mention. Did you receive [READ TRAINING COURSE] IF YES, ASK: Was this during the past 1 year?			
01	In-depth (or comprehensive) training for HIV/AIDS counsellors (3 weeks)	1	2	3
02	Refreshing training on HIV/AIDS counselling	1	2	3
03	Comprehensive Care and Treatment course	1	2	3
04	HIV/AIDS Training of trainers course (TOT)	1	2	3
05	Supervisors training course for counsellors at district and regional level (VCT)	1	2	3
06	Basic training for home based care providers	1	2	3
07	Health facility home based providers training	1	2	3
08	Community based home based care providers training course	1	2	3
09	Syndromic STI care management training	1	2	3
10	Syphilis screening training	1	2	3
11	Indent system training on STI commodities	1	2	3
12	Peer health education training	1	2	3
13	Youth friendly health service training (YFS)	1	2	3
14	HIS training	1	2	3
15	IMAI training	1	2	3
16	ART guideline training	1	2	3
17	OI training	1	2	3
18	ARV medicine adherence training	1	2	3
19	Paediatric ART training	1	2	3

608	Other than any previously mentioned trainings, during the past 3 years, have you received any training related to any aspect of HIV/AIDS prevention, counselling, or care and support?	YES . . . . . 1 NO 2	→610

609	IF YES, Ask: Did any other pre- or in-service education provide information about [READ TOPIC]? IF YES, ASK: was this during the past 1 year? MULTIPLE TOPICS MAY HAVE BEEN COVERED IN ONE TRAINING. IF THE RESPONDENT TELLS YOU THAT A TOPIC WAS COVERED AS PART OF A PREVIOUS TRAINING, CIRCLE RESPONSE "4".	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO TRAINING WITHIN PAST 3 YEARS	COVERED IN ANOTHER TRAINING PAST 1 YEAR	COVERED IN ANOTHER TRAINING PAST 2-3 YEARS
01	HIV pre-test and post-test counselling?	1	2	3	4	5
02	HIV testing procedures, that is, which tests to order, and when?	1	2	3	4	5
03	Follow-up counselling, after the initial post-test counselling or emotional support for HIV/AIDS clients?	1	2	3	4	5
04	Educational needs of patients and families about HIV/AIDS care?	1	2	3	4	5
05	General nutritional counselling for HIV/AIDS clients?	1	2	3	4	5
06	Primary prevention of HIV, such as behaviour change education, partner counselling, condom promotion and distribution?	1	2	3	4	5
07	Tuberculosis INH preventive therapy for HIV/AIDS clients?	1	2	3	4	5
08	Cotrimoxazole preventive therapy (CPT) for HIV/AIDS clients for pneumonia?	1	2	3	4	5
09	Clinical management of HIV/AIDS-related neurological disorders?	1	2	3	4	5
10	Diagnosis and treatment of opportunistic infections?	1	2	3	4	5
11	Prescribing antiretroviral therapy (ART)?	1	2	3	4	5
12	Ordering or prescribing laboratory tests for monitoring of ART?	1	2	3	4	5
13	Nutritional rehabilitation for HIV/AIDS patients?	1	2	3	4	5
14	Nutritional assessment, such as Body-Mass Index calculation and Mid-Upper Arm Circumference measurement?	1	2	3	4	5
15	Any topic specific to paediatric AIDS care?	1	2	3	4	5
16	Training on provision of palliative care, to manage symptoms of the seriously ill HIV/AIDS client?	1	2	3	4	5
17	Ordering or prescribing Post-exposure prophylaxis (PEP)?	1	2	3	4	5
18	Training on nursing care or training caregivers to provide care for HIV/AIDS patients? This might include training related to home-based care.	1	2	3	4	5

610	CHECK Q203. IS RESPONSE CODE "2" CIRCLED? YES, "2" CIRCLED ☐ ↓ "2" NOT CIRCLED ☐ → 701			
611	Have you attended an HIV conference in the last 3 months?	YES . . . . . 1 NO 2		
612	Have you been supervised on the technical aspects of your work in the last 1 month?	YES . . . . . 1 NO 2		
613	Have you been supervised on the administrative aspects of your work in the last 1 month?	YES . . . . . 1 NO 2		

7. Laboratory services

701	In your **current** position, and as a part of your work for this facility, do you ever personally actually conduct laboratory tests for tuberculosis or HIV/AIDS? CIRCLE 'NO' IF THE PROVIDER ONLY COLLECTS SPECIMENS.	YES . . . . . 1 NO 2	→800

702	Do you conduct any of the following laboratory tests?	a PROVIDES SERVICE YES	NO
01	Checking sputum for tuberculosis?	1	2
02	Any of the blood tests for HIV?	1	2
03	Any of the laboratory tests for monitoring antiretroviral therapy?	1	2

703	During the past three years have you received any pre-service or in-service training related to different laboratory tests for tuberculosis, HIV or for screening blood prior to transfusion?	YES . . . . . 1 NO 2	→800

704	Did you receive preservice or in-service training for [READ TOPIC] during the past 3 years? IF YES, ASK: Was this during the past 1 year?	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO TRAINING WITHIN PAST 3 YEARS
01	Microscopic examination of sputum for diagnosing tuberculosis?	1	2	3
02	HIV testing?	1	2	3
03	CD4 testing?	1	2	3
04	Blood screening for HIV prior to transfusion?	1	2	3
05	Blood screening for Hepatitis B prior to transfusion?	1	2	3
06	Tests for monitoring ART such as TLC and serum creatinine.	1	2	3

8. Working conditions in facility

800	Now I want to ask you a few more questions about your work in this facility. In an average week, how many hours do you work in this facility? IF WEEKS ARE NOT CONSISTENT, ASK THE RESPONDENT TO AVERAGE OUT HOW MANY HOURS PER MONTH AND THEN DIVIDE THIS BY 4.	AVERAGE HOURS PER WEEK WORKING IN THIS FACILITY [ ][ ]	
801	I want to know if you can estimate how much of your time each week is spent providing services or performing tasks related to HIV/AIDS. This includes such services as counselling, testing, providing clinical care and support, providing social support services, as well as record keeping and documentation related to HIV/AIDS. When you add up all the time you spend, on average, during a normal week either providing services or performing tasks related to HIV/AIDS, what percent of your time do you estimate this is? IF NO HIV/AIDS-RELATED SERVICES CODE "000"	AVERAGE WEEKLY PERCENTAGE OF WORK TIME . [ ][ ][ ] DON'T KNOW/NOT CERTAIN . . . 998	

802	During the past 12 months, if you add together all of the formal training you have received related to HIV/AIDS, how many days is this? By formal training I mean training where there was a structured session. This may have been conducted by this facility or external to the facility. I am interested in actual days of training. For example, a one week training usually entails 5 actual days of training, a four week training usually entails 20 days of training. IF THE TRAINING WAS LESS THAN ONE FULL DAY, ENTER 001. PROBE IF NECESSARY. IF NO DAYS OF TRAINING, ENTER 000	NUMBER OF DAYS OF HIV/AIDS RELATED TRAINING . . . . . [ ][ ][ ]	
803	Now I would like to ask you some questions about supervision you have personally received. This supervision may have been from a supervisor either in this facility, or from outside the facility. Do you receive technical support or supervision in your work? IF YES, ASK: When was the most recent time?	YES, IN THE PAST 3 MONTHS . . . . 1 YES, IN THE PAST 4-6 MONTHS . . . . 2 YES, IN THE PAST 7-12 MONTHS . . . . 3 YES, MORE THAN 12 MONTHS AGO . . 4 NO 5	→806 →806 →806
804	How many times in the past six months has your work been supervised?	NUMBER OF TIMES . . . . . [ ][ ]	
805	The last time you were personally supervised, did your supervisor do any of the following:	YES NO DK	
01	Deliver supplies?	DELIVERED SUPPLIES 1 2 8	
02	Check your records or reports?	CHECKED RECORD 1 2 8	
03	Observe your work?	OBSERVED 1 2 8	
04	Provide any feedback (either positive or negative) on your performance?	FEEDBACK 1 2 8 07	
05	Give you verbal feedback that you were doing your work well?	VERBAL PRAISE 1 2 8	
06	Provide any written comment that you were doing your work well?	WRITTEN PRAISE 1 2 8	
07	Provide updates on administrative or technical issues related to your work?	UPDATES 1 2 8	
08	Discuss problems you have encountered?	DISCUSS 1 2 8	
806	Do you have a written job description of your current job or position in this facility? IF YES, ASK: May I see it?	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . 2 NO 3	
807	Are there any opportunities for promotion in your current job?	YES . . . . . 1 NO . . . . . 2 UNCERTAIN/DON'T KNOW 8	
808	Do you personally receive any salary supplement, that is, money outside of your routine salary, that is related to your work in this facility?	YES . . . . . 1 NO 2	→810

809	Which type of salary supplement do you receive?	MONTHLY OR DAILY SALARY SUPPLEMENT. . . . . A PERDIEM WHEN ATTENDING TRAINING. . . . . B DUTY ALLOWANCE. . . . . C PAYMENT FOR EXTRA ACTIVITIES (NOT ROUTINELY PROVIDED). . . . . D OTHER _____ X (SPECIFY)	
810	In your current position, have you ever received any non-monetary incentives for the work you do? This might include such things as discounts for medicines or other items, uniforms or other clothing, food, training, or other things like this.	YES . . . . . 1 NO 2	→812
811	Describe any incentives that you have received. CIRCLE ALL THAT APPLY.	UNIFORMS, BACKPACKS, CAPS ETC. . . . . A DISCOUNT MEDICINES, FREE TICKETS FOR CARE, VOUCHERS, etc. . . . . B TRAINING . . . . . C FOOD RATION . . . . . D SUBSIDIZED HOUSING . . . . . E MONETARY BONUS (IRREGULAR) F OTHER _____ X (SPECIFY)	
812	Among the various things related to your working situation that you would like to see improved, can you tell me the three that you think would most improve your ability to provide care and support services for HIV/AIDS? CIRCLE ONLY THREE ITEMS. IF THE PROVIDER MENTIONS MORE THAN THREE ITEMS, ASK THE PROVIDER TO PRIORITIZE TO ONLY THREE. IF THE PROVIDER DOES NOT MENTION THREE ITEMS, PROBE FOR ANY OTHERS IN AN ATTEMPT TO HAVE THREE ANSWERS.	MORE SUPPORT FROM SUPERVISOR . . . . . A MORE KNOWLEDGE/ TRAINING . . . . . B MORE SUPPLIES/STOCK . . . . . C BETTER QUALITY EQUIPMENT/ SUPPLIES . . . . . D LESS WORKLOAD (i.e. MORE STAFF) . . . . . E BETTER WORKING HOURS . . . . F MORE INCENTIVES (SALARY, PROMOTION, HOLIDAYS) . . . . . G TRANSPORTATION FOR PATIENTS WHO ARE REFERRED . . . . . H PROVIDING ART . . . . . I INCREASED SECURITY . . . . . J BETTER FACILITY INFRASTRUCTURE . . . . . K MORE AUTONOMY /INDEPENDENCE . . . . . L EMOTIONAL SUPPORT FOR STAFF (COUNSELING/ GROUP SOCIAL ACTIVITIES) . . M OTHER _____ W (SPECIFY) OTHER _____ X (SPECIFY)	

9. Working with HIV/AIDS clients

900	Finally, I would like to ask you a few additional questions about HIV/AIDS and working with clients who may have HIV/AIDS. What should you do if you got a needle stick injury? PROBE: Anything else? CIRCLE ALL THAT ARE MENTIONED.	SQUEEZE FINGER . . . . . A WASH/SOAK IN DISINFECTANT (BLEACH, IODINE, ALCOHOL) . . B WASH WITH SOAP AND WATER . . C REPORT TO MANAGER . . . . . D LEARN PATIENT HIV STATUS . . . . E GET AN HIV TEST IMMEDIATELY . . F GET AN HIV TEST AFTER SOME TIME . . . . . G GET HIV TEST DEPENDING ON HIV STATUS OF PATIENT . . H GET ANTIRETROVIRAL OR REFERRAL FOR ARVs . . . . . I OTHER _____ X (SPECIFY) NOTHING . . . . . Y DON'T KNOW . . . . . Z	
901	Have you had any needle stick injuries in the last 6 months?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
902	Do you think that a health care worker who has HIV but is not sick, should be allowed to continue to work?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

903 In the past 12 months, have you seen or observed the following happen in this health care facility because a client was known or suspected of having HIV/AIDS? READ EACH SCENARIO BELOW

		YES	NO	NA	DK
01	Testing a client for HIV infection without their consent	1	2	5	8
02	Requiring some clients to be tested for HIV before scheduling surgery	1	2	5	8
03	Using latex gloves for performing non-invasive exams on clients suspected of HIV	1	2	5	8
04	Extra precautions been taken in the sterilisation of instruments used on HIV-positive patients	1	2	5	8
05	Health providers gossiping about a client's HIV status	1	2	5	8
06	Because a patient is HIV-positive a senior health provider pushing the client to a junior provider	1	2	5	8
07	An HIV-positive patient receiving less care/attention than other patients	1	2	5	8

904	Have you ever heard the word stigma?	YES . . . . . 1 NO 2	 →911
905	Does stigma occur **in** health facilities?	YES . . . . . 1 NO . . . . . 2 UNCERTAIN/DON'T KNOW 8	 → 907 → 907
906	Please give me some examples of stigma in the health facility PROBE BY ASKING: Any other examples?	USING LATEX GLOVES FOR NON-INVASIVE PROCEDURE ON SUSPECT/HIV+ CLIENTS . . A EXTRA PRECAUTION IN THE sterilisation OF EQUIP USED ON HIV+ CLIENTS . . . . . B PROVIDERS GOSSIPING ABOUT A CLIENT'S HIV STATUS . . . . . C LESS CARE/ ATTENTION GIVEN TO HIV+ CLIENTS . . . . D SENIOR STAFF PUSHING HIV+ CLIENT TO JUNIOR STAFF . . . . E STAFF UNWILLING TO SHAKE HANDS WITH HIV+ CLIENTS . . . . F OTHER _____ X (SPECIFY)	

907	Does stigma occur **outside** health facilities?	YES . . . . . 1 NO . . . . . 2 UNCERTAIN/DON'T KNOW 8	 → 911 → 911
908	Where have you observed or heard stigma occur? PROBE: Anything else?	HOUSEHOLD/FAMILY . . . . . A COMMUNITY . . . . . B WORKPLACE . . . . . C PLACES OF WORSHIP . . . . . D PLACES OF ENTERTAINMENT . . . . E OTHER _____ X (SPECIFY)	
909	Please give me some examples of stigma that occur **outside** health facility	SEPARATION/DIVORCE WHEN ONE PARTNER BECOMES HIV+ . . . . A NEIGHBORS/FAMILY GOSSIPING ABOUT CLIENT'S HIV STATUS . . B NOT BUYING FROM OR PATRONIZING HIV+ PERSON'S BUSINESS . . . . . C FAMILIES/NEIGHBORS RELUCTANT TO PROVIDE MONEY TOWARDS CARE FOR HIV+ PERSONS . . . . . D FAMILY MEMBERS UNWILLING TO SHARE BED/UTENSILS WITH HIV+ PERSONS . . . . . E OTHER _____ X (SPECIFY)	
910	If you ever saw any of the above types of stigma happening to a client because s/he is a PLWHA, would you be willing to report to higher authorities, if such a higher authority exists?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
911	I don't want to know the result, but have you ever had an HIV test?	YES . . . . . 1 NO 2	 → 913
912	The last time you had an HIV test, did you yourself ask for the test, were you encouraged to take it, was it offered to you and you accepted, or was it required?	ASK SELF . . . . . 1 ENCOURAGED TO TAKE IT ..... 2 WAS OFFERED . . . . . 3 WAS REQUIRED 4	
913	Finally, please tell me: In your opinion, how effective are condoms in preventing HIV infections when used correctly? Are they completely effective (100 percent) or not at all effective (0 percent) or somewhere between? HELP THE RESPONDENT TO ESTIMATE A PERCENTAGE.	CONDOM EFFECTIVENESS [ ][ ][ ] DON'T KNOW 998	
	Thank you for taking the time to talk with me and to answer these questions. As I mentioned at the beginning, all of your responses will remain confidential.		