



Republic of Namibia

National Policy on Sexual, Reproductive and Child Health



Republic of Namibia

National Policy on Sexual, Reproductive and Child Health

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Foreword

The Government of the Republic of Namibia has been engaged in developing and implementing evidence based policies and strategies to ensure that the people of Namibia are reached with quality health and social services to improve the quality of life and increase the productivity of the nation.

The implementation of the various health and social services policies and strategies has enabled Namibia to score remarkable achievements in stabilizing HIV/AIDS, ensuring access to sexual and reproductive health information and services and improving the quality of maternal, new-born, child and adolescent health and nutrition services in the country.

The Government of the Republic of Namibia is a signatory of the Millennium Declaration and has committed to implement the eight Millennium Development Goals (MDGs) out of which four are linked to this policy: MDG 1 seeks to improve the nutrition of both adults and children; The MDGs 4 and 5 focus on the reduction of child mortality and improving maternal health; and MDG 6 focuses on combating HIV/AIDS, Malaria and other diseases that underlie and threaten the nation's achievement of the other three goals.

The Ministry of Health and Social Services under the auspices of the Directorate of Primary Health Care Services constituted a task force comprising of various programmes, United Nations agencies and other partners to develop the Sexual, Reproductive, Child Health and Nutrition Policy. This policy will guide the delivery of quality health services to the Namibian population.

This policy will take Namibia forward towards the goal of universal access to comprehensive quality maternal, new-born, child and adolescent health care. It is based on principles of equity, affordability, access and responsiveness to the need of the population. The policy will guide the government, development partners, training institutions, and service providers, in supporting Government efforts towards the attainment of the MDGs related to maternal, new-born, child and adolescent health.

I urge every ministry, office and agency to collaborate in implementing this policy to contribute to the betterment of the quality of life of the Namibian population. My office as always is committed to mobilize human and financial resources for the effective implementation of this policy. I thank all those who, in diverse ways, helped to make the development of this policy possible.

.....
THE RIGHT HONOURABLE HAGE G. GEINGOB
PRIME MINISTER OF THE REPUBLIC OF NAMIBIA

Preface

At independence, Namibia inherited a highly inequitable health care delivery system that was biased in support of the wealthy and the few. The Government of the Republic of Namibia over the years has worked hard to balance service delivery within the context of two epidemiological profiles (rich and poor populations) to improve health outcomes for all Namibians. As part of the effort to improve sexual, reproductive and child health and nutrition services including maternal and newborn health care to the Namibian people, the Government with the support from various development partners has implemented cost effective and scientifically proven interventions in the areas of safe motherhood, integrated management of childhood illnesses, adolescent health services and sexual and reproductive health services.

In 2000 the Government of Namibia adopted the Millennium Development Goals (MDGs). The 1st, 4th and 5th MDGs focus on the reduction of malnutrition, child mortality rate by two thirds and the maternal mortality ratio by three quarters between 1990 and 2015 respectively (NPC, 2004). The Ministry of Health and Social Services under the auspices of the Directorate of Primary Health Care Services has embarked upon developing policies and strategies for delivering quality primary health care services to the population.

This policy is a continuation of the efforts to take Namibia forward towards the achievement of Vision 2030, National Development Plans (NDPs), the Millennium Development Goals related to maternal, child health, and improving the quality of reproductive health and nutrition services to the Namibian men, women and children.

This policy will guide the Ministry of Health & Social Services and its partners in delivering quality and evidence based Sexual, Reproductive and Child Health and Nutrition Services to the Namibian population. The Ministry of Health & Social Services officials and staff, line ministries, partners and stakeholders are therefore advised to consult this policy when designing and delivering interventions in the areas of Sexual, Reproductive and Child Health and Nutrition Services in the Republic of Namibia.

The Ministry of Health and Social Services wishes to recognize all valuable contributions made by many individuals, government directorates and partner agencies and organizations.

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**DR. RICHARD NCHABI KAMWI, MP,
MINISTER**

Abbreviations

AIDS	Acquired Immune-Deficiency Syndrome
AEFI	Adverse Events Following Immunization
AFHS	Adolescent Friendly Health Services
ANC	Antenatal Care
ART	Anti-Retroviral Therapy/Treatment
ARV	Anti Retroviral
BCC	Behavioural Change Communication
BCG	Bacillus Calmette Guerin
CBO	Community-Based Organization
CPR	Cardio-Pulmonary Resuscitation
CSOs	Civil Society Organizations
DHS	Demographic and Health Survey
DPT	Diphtheria, Pertussis and Tetanus
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and Neonatal Care
EPI	Expanded Program on Immunization
FBOs	Faith Based Organizations
GBV	Gender Based Violence
GDP	Gross Domestic Product
Hep-B	Hepatitis-B Virus
Hib	Hemophylis influenza type B
HIV	Human Immuno-deficiency Virus

HMIS	Health Management Information System
HPCN	Health Profession Councils of Namibia
ICPD	International Conference on Population and Development
ICN	International Conference on Nutrition
IEC	Information, Education & Communication
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illnesses
IMNCI	Integrated Management of Newborn and Childhood Illnesses
IMR	Infant Mortality Rate
ITN	Insecticide Treated Mosquito Nets
IYCF	Infant and Young Child Feeding practices
LSS	Life Saving Skills
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
M&E	Monitoring & Evaluation
MMR	Maternal Mortality Ratio
MNDN	Maternal and Neonatal Death Notification
MNH	Maternal and Newborn Health
MPNDR	Maternal Peri and Neonatal Death Review
MAWF	Ministry of Agriculture, Water and Forestry
MoD	Ministry of Defence
MoE	Ministry of Education
MoF	Ministry of Finance

MGECW	Ministry of Gender Equality and Child Welfare
MoHSS	Ministry of Health and Social Services
MICT	Ministry of Information and Communication Technology
MHAI	Ministry of Home Affairs and Immigration
MoJ	Ministry of Justice
MLSW	Ministry of Labour and Social Welfare
MRLGHRD	Ministry of Regional and Local Government, Housing and Rural Development
MWT	Ministry of Works and Transport
MYNSSC	Ministry of Youth, National Service, Sports and Culture
MVA	Manual Vacuum Aspirator
NANGOF	Namibia Non- Governmental Organization Foundation
NAPPA	Namibian Planned Parenthood Association
NCD	Non Communicable Diseases
NDF	Namibian Defence Force
NDP	National Development Plan
NGO	Non-Governmental Organization
NMR	Neonatal Mortality Rate
NPCS	National Planning Commission Secretariat
NYC	National Youth Council
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
OVC	Orphan and Vulnerable Children
PAC	Post Abortion Care

PEP	Post Exposure Prophylaxis
PLHIV	People Living With HIV
PMTCT	Prevention of Mother to Child Transmission
PNC	Postnatal Care
RED	Reach Every District
RUTF	Ready to Use Therapeutic Food
SADC	Southern African Development Community
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
U5MR	Under 5 Mortality Rate
UN	United Nations
UNICEF	United Nation Children’s Fund
VCT	Voluntary Counselling & Testing
WHO	World Health Organization

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CHAPTER 1: INTRODUCTION

1.1 Rationale

The Government of the Republic of Namibia, noting that:

- Maternal and Child Mortality in Namibia have increased over the past decades;
- The health and nutritional status of mothers and children are indicators of the economic development of a nation;
- The health and well-being of men, women, adolescents, and children are linked and interdependent;
- Women contribute significantly to the economic and social development of a nation

Recognizing that political, social and economic inequality negatively affect the health of women and children:

- Inequality along gender lines and roles cause women not to have the same levels of information, choices, rights and decision making powers as men concerning their sexual and reproductive health and the health of their children.
- Fifteen years after the international conference on population development (ICPD) Program of Action was adopted for the provision of universal education, and for ensuring universal healthcare, including family planning, assisted childbirth and prevention of sexually transmitted diseases, however, there is still a significant gap between sexual and reproductive health needs and access to services among young people in Namibia
- Instead of birth being a pleasant experience and a source of joy for the family, for some families' child birth brings grief and sorrow due to death of mothers or their children or both.
- Children and adolescents are the future of the nation: optimum care and support are required to have a healthy childhood and adolescence.
- Adolescents are challenged by their environment, peers and the biological, cognitive and emotional changes of puberty which sometimes lead them to engage in risky behaviours which predispose them to, unwanted pregnancies, STIs/HIV, alcohol and substance abuse, injuries and suicide.

Recognizing that the Convention on the Rights of the Child, ratified in 1989, calls to guarantee children's rights to the highest attainable standard of health.

- International treaties and conventions, including “A World Fit for Children” the UN Special Session on Children (2002) and the WHO/UNICEF Global Consultation on “Child and Adolescent Health and Development” held in Stockholm in 2002, emphasize the urgency to reduce child mortality for future prosperity.
- Malnutrition in Namibia is high among children under five years of age, which has a negative impact on the growth, development and survival of children of Namibia.
- The prevalence of stunting in children under five years of age is 29 percent. Stunting is an indicator of chronic malnutrition, poor infant feeding and care practices, food insecurity, poor hygiene and sanitation practices, and recurrence of infant and childhood illness.

Therefore; the Government of the Republic of Namibia developed this national policy to guide the Ministry of Health and Social Services, partners and stakeholders in health and development to deliver quality sexual reproductive, child health and nutrition services to the Namibian population.

1.2 Background

Namibia is considered an upper Middle Income country, ranked 120 out of 187 countries on the human development index in 2011. This classification is based on many indicators including the GINI coefficient used to assess the actual income/expenditure distribution inside a country. The Gini coefficient of 0.74 puts Namibia amongst countries with the highest income inequalities in the world.

After independence in 1990 provision of basic social services such as health and education, have improved through a government programme of rehabilitation and rapid expansion of health facilities and schools. Health facilities are now more equitably distributed throughout the country. As a result, access and quality of health services has increased.

Primary Health Care (PHC) is a guiding principle for the delivery of health services in Namibia. The PHC guideline was developed in 1992 as an instrument for the delivery of health services in Namibia. Various programme specific policies and strategies were also developed to complement the primary health care interventions in the country. The Ouagadougou declaration (2008) calls for Member States to develop a comprehensive National Health Policy and Strategy to guide Member States and partners to implement health priorities in countries.

This policy was developed to create an enabling environment and to give direction for the implementation of appropriate strategies for the reduction of maternal and child morbidities through the provision of quality reproductive and child health, nutrition information and services, including family planning with the purpose of making a significant

contribution to the achievement of the Millennium Development Goals (MDGs) 1, 4, 5 and 6 by 2015 and beyond.

The process of developing the policy was led by the Ministry of Health and Social Services in collaboration with key government ministries and implementing partners. The policy development steps included situation analysis through literature review, consensus building workshops, reviews of the draft policy by key stakeholders and approval by PMDRC.

CHAPTER 2: SITUATION ANALYSIS

The situation analysis was conducted through literature review both national and international to determine the status of sexual, reproductive and child health in Namibia, its challenges and current evidence based strategies and approaches that can make a difference.

Despite the population of Africa being 12% of the global population, it contributes to more than 40% of maternal mortality in the globe. The risk of a mother dying due to pregnancy, childbirth and its complications is 1:16, as compared to 1:4,200 in developed countries. Similar trends are observed in child health. More than 10 million children under-five years of age die each year, mainly due to preventable health conditions namely respiratory tract infections, diarrheal diseases, measles, malaria and malnutrition. Majority of these deaths happen in developing countries including in Sub-Saharan Africa. Sub-Saharan Africa continues to have the highest Maternal and Child mortality.

HIV/AIDS is an additional burden to the already compromised health system in developing countries including Africa. This dreadful epidemic increases the death toll of the most vulnerable segment of the population, women and children.

In Namibia, there is an increasing trend in maternal mortality ratio (MMR), according to the Demographic and Health Survey of 2006, 449/100,000 live births, from 271/100,000 in 2000, while the WHO/UNFPA/UNICEF, World Health estimation of 2010 MMR in Namibia is 200/100,000 Live Births (Trends in maternal mortality: 1990 to 2010: WHO, UNICEF, World Bank and UNFPA April 2012), which is still unacceptably high. The increase in 2006 could be explained by the impact of HIV/AIDS but with the introduction of ART, such an impact would be expected to have decreased. The major direct causes of maternal mortality are eclampsia (33%), haemorrhage (25%) and obstructed labour (25%) and HIV/AIDS is the leading indirect cause of maternal mortality (59.4%) accounting for a significant proportion of all deaths.

Newborn health is closely linked to maternal health. The outcome of a healthy newborn is directly dependent on improved maternal health care during pregnancy, delivery and postpartum. Therefore, reduction of newborn deaths should be addressed together with maternal mortality reduction. Up to 50% of neonatal deaths occur within the first 24 hours and 75% in the first week of life, thus newborn mortality is a sensitive indicator of the health status of pregnant women, the newborn and quality of health care provider during perinatal period especially delivery and immediate postnatal periods

Some of the challenges facing the Ministry of Health and Social Services include: limited access to basic and comprehensive emergency obstetric care services; shortage of skilled service providers, particularly midwives, doctors and anaesthetists; inadequate transport

and communication in some health facilities. Other challenges emanating from the community include poor male involvement in sexual, reproductive and child health; harmful socio-cultural beliefs and practices and poor socio-economic status. Despite the above challenges, remarkable achievements have been registered in other areas of health delivery. The ANC coverage is 95%, deliveries in health facilities is 81.4%, post natal coverage is 78%. Contraceptive Prevalence Rate (CPR) 47% and unmet need is 3%. The NDHS 2006 shows that teenage pregnancy rate has decreased from 18% in 2000 to 15% in 2006-7, but still remains high.

Access to Emergency Obstetric Care (EmOC) is unevenly distributed, 10 out of 13 regions in Namibia do not have facilities providing a Comprehensive EmOC services. The human resources for health at lower level of the health care delivery system are not adequately equipped with Life Saving Skills to handle emergency obstetric and neonatal services. Only 42% of health facilities have EmOC trained staff. In addition to the above mentioned constraints, access to health services because of distances to travel and vastness of the country is another challenge. About 21% of the population lives more than 10 km from a health facility and have to travel long distances to access basic and comprehensive EmOC services.

The HIV sero-prevalence among pregnant women attending Antenatal Care in 2010 was 18.8%. The total pregnant women in need of PMTCT services were 12,700. Namibia has adopted the 2010 WHO PMTCT guidelines and chose option A which recommends ARV prophylaxis with AZT to pregnant women as early as 14th week of gestation, continue throughout the pregnancy and put the breastfeeding infant on ARV prophylaxis with Nevirapine until 4 weeks after complete cessation of breastfeeding. Exclusive breastfeeding for the first six months of life is recommended for all infants regardless of HIV exposure or infection. Complementary feeding is recommended to start at 6 months. At one year of life, HIV exposed infants should wean from breastfeeding. HIV infected infants as well as infants born to HIV uninfected mothers should continue breastfeeding until 2 years and beyond. However Namibia is changing its PMTCT guidelines to option B+ in line with WHO 2012 update which recommends HAART for life for all HIV positive pregnant regardless of their clinical and immunological stage.

A total of 314 health facilities out of 340 are providing PMTCT services giving coverage of (92%). Out of the total 61,981 pregnant women who attended ANC in 2009, 58,882 (95%) received counselling and testing services. At labour and delivery, 85% of HIV positive women and 91% of exposed infants received ARV prophylaxis. The HIV positivity of exposed infants using DNA PCR technique has reduced from 13.4% in 2006/7 to 7.0% in 2008/9. Continued challenges exist with the quality of care, continued follow-up of HIV exposed infants, and reaching all women who need ARV prophylaxis and treatment for themselves. There are

also efforts to improve male involvement in PMTCT which has remained very low over the years.

Research indicates that widespread gender based violence (GBV) has implications for sexual reproductive and child health. According to the MoHSS records in 2009, 1039 of rape cases and 10,053 grievous bodily harm (GBH) cases were reported to the Women and Child Protection Units. Women and girls are mostly the victims, while the majority of perpetrators are males and are known to the victims, usually as family members, spouses and partners. Women and girls who are exposed to GBV are more likely to have less/ no control over their sexual and reproductive health. This results in unwanted pregnancies through rape, non-use of family planning, teenage pregnancy, poor maternal health, STIs including HIV, and death.

Globally, approximately 70% of childhood deaths are due to only five conditions, namely diarrhoea, pneumonia, measles, malnutrition and malaria. The situation is similar in Namibia whereby HIV/AIDS, pneumonia, diarrhoea, malaria and malnutrition are the main causes of mortality children under the age of 5. Under 5 Mortality Rate (U5MR) slightly increased from 62 per 1000 live births in 2000 to 69/1,000 live births. Infant mortality rates (IMR) also increased from 38 to 46 per 1000 live births over the same period. World health statistical estimates of 2012 showed that infant mortality rates decreased from 49/1000 in 2000 to 29/1000 in 2010 while under five mortality decreased from 74/1000 in 2000 to 40/1000 in 2010.

The major causes of child morbidity and mortality in Namibia are mainly preventable diseases such as malaria, acute respiratory infections (ARI), diarrhoea and malnutrition. To address this, the government has among other strategies adopted the Integrated Management of Newborn and Childhood Illnesses (IMNCI) strategy. The first phase of IMNCI implementation took place in 1997 with support from major partners, professional groups and other stakeholders in the country. National Immunization Days (NIDs) were introduced in 1996 to accelerate progress towards the eradication of preventable diseases such as polio and elimination of other childhood diseases. In 2006 DPT-3 coverage was 69% with inter-regional variations in the coverage of EPI. In 2008 the MOHSS introduced the "Reach Every District approach (RED)" to reach every child in every district for immunization. In 2009 Penta-valent vaccine (DPT-Hep-B-Hib-3) was introduced and the coverage for 2010 was 83%.

In Namibia, breast and cervical cancer are the commonest types of cancer of the reproductive system in women. IARC, Globocan 2008 estimates using incidence rates from the national cancer registry (1995-2006) applied to 2008 population showed crude cervical cancer incidence rate of 10.8 per 100,000 women per year and age-standardized rate of

15.8. The same report showed that breast cancer incidence rates of 14 per 100,000 women of all ages.

The Government of the Republic of Namibia is committed to the improvement of sexual, reproductive and child health of the Namibian population and to meeting the objectives of the Millennium Development Goals by 2015. The government also committed itself to the ICPD of 1994, and relevant human rights documents including the International Covenant on Economic, Social, and Cultural Rights; the Convention on the Elimination of all forms of Discrimination against Women; the Convention on the Rights of the Child; and other human rights documents related to sexual, reproductive and child health.

Nutritional problems remain to be a public health problem in Namibia. According to the DHS of 2006/7, 29% of children under-five years of age are stunted, 8% underweight and 2% severely malnourished. This situation has implication in the physical growth and mental development of children. Exclusive breastfeeding until six months of age is still very low at 24%.

The general pattern indicates that regions with high levels of poverty, low literacy rates, high HIV prevalence and with predominantly rural populations have the highest levels of stunting: ranging from 39% in Kavango to 22% in Erongo. Children born in the poorest and second poorest wealth quintile households have a threefold risk of being stunted compared to those born in the richest quintile.

Only half of all Namibian babies are exclusively breastfed within the first two months of life, and less than 25% of infants are exclusively breastfed for 4 months. In addition, immediately following birth, over 14% of Namibian newborn babies receive pre-lacteal feeds. Bottle feeding, non-breast milk feeds such as juices, plain water and complementary solid foods are introduced within the first 3 months of infants' lives. In Namibia, the number of bottle-fed babies exceeds the number of exclusively breastfed babies at three months.

During the International Conference on Nutrition (ICN) 1992, governments including Namibia pledged to make all efforts to eliminate or reduce substantially, starvation and famine; widespread chronic hunger; under nutrition, especially among children, women and the aged; micronutrient deficiencies, especially iron, iodine and vitamin A deficiencies; diet-related communicable and non-communicable diseases; impediments to optimal breastfeeding; and inadequate sanitation, poor hygiene and unsafe drinking-water before the next millennium.

Namibia adopted the Innocenti Declaration on Infant and Young Child Feeding at the WHO/UNICEF policymakers' meeting on "Breastfeeding" in 1990: The Innocenti meeting declared that as a global goal for optimal maternal and child health and nutrition, all women should be enabled to practise exclusive breastfeeding and all infants should be fed

exclusively on breast milk from birth to 6 months of age. Thereafter, children should continue to be breastfed, while receiving appropriate and adequate complementary foods, for up to two years of age or beyond. This child-feeding ideal is to be achieved by creating an appropriate environment of awareness and support so that women can breastfeed in this manner.

The Southern African Development Community (SADC) Health Protocol emphasizes that States Parties shall formulate coherent, comparable, harmonised and standardised policies, strategies, programmes and procedures for reproductive health. Concerning childhood and adolescent health the protocol states that States Parties shall: a) co-operate in improving the health status of children and adolescents b) develop and formulate coherent and standardized policies and set out targets with regard to child and adolescent health and c) encourage adolescents to delay engaging in early sexual activity which may result in unwanted teenage pregnancies.

The Abuja Declaration also emphasises that countries should allocate 15% of the Government budget to health. Namibia has made progress in this regard and is currently allocating 12% of its national budget to health. The World Health Assembly, the highest governing body of the WHO, has passed several resolutions in the areas of SRH, Child Health and Nutrition. These resolutions are complemented by the African Regional Committee resolutions to which this policy guideline will adhere.

The prevention of non-communicable diet-related diseases is high on Namibia's agenda. On 20 September 2011, The Head of State speaking at the UN General Assembly High Level meeting in New York on the Prevention and Control of non-communicable diseases (NCDs) called for acceleration actions to address the risk factors contributing to NCDs. There is an increasing trend of NCDs largely due to poor lifestyles such as unhealthy diets, smoking and physical inactivity. According to the 2006/07 NDHS, among women aged 15-49 years that gave birth in the previous five years, 28% were overweight or obese with a Body Mass Index (BMI) of >25. The obese proportion with a BMI index of >30 was 12.0%. In Namibia, diabetes and cardiovascular diseases rank among the top 10 diseases and among the top 15 causes of death among hospital in-patients.

CHAPTER 3: POLICY FRAMEWORK

3.1 Goal

The overall goal of this policy is to enhance the attainment of the highest possible standard of Sexual, Reproductive Health, Child Health and Nutrition for the Namibian population through provision of equitable, accessible and affordable health and nutrition information and services.

3.2 Guiding Principles

The Reproductive and Child Health Policy in Namibia is guided by, and based on the following principles:

- 3.2.1 Human Rights:** All Namibians have the right to enjoy good health through access to primary health care and referral health services according to their needs. Every citizen has a right to fair and reasonable access to public facilities and services in accordance with the law. Sexual, Reproductive and Child Health, and Nutrition are basic and fundamental human rights for every Namibian.
- 3.2.2 Equity and accessibility:** All Namibians (women, men and children) should have equal and equitable access to quality Sexual and Reproductive Health, and Nutrition services as well as information on these services whenever required.
- 3.2.3 Coordination and partnership:** Promoting partnership and collaboration among all stakeholders with clearly defined roles, recognizing their comparative advantages to offer the required quality Sexual and Reproductive Health, and Nutrition services while enhancing synergies and avoiding unnecessary duplication.
- 3.2.4 Non discrimination and gender equality:** No person should be discriminated against, nor denied any health services including Sexual, Reproductive and Child Health and Nutrition based on prejudice or biases related to age, sex, religion, ethnic origin, socioeconomic status and others.
- 3.2.5 Community involvement:** Actively involving beneficiaries in planning, implementation, monitoring and evaluation of Sexual, Reproductive and Child Health and Nutrition programs and activities to ensure ownership and service utilization.
- 3.2.6 Healthier lifestyles:** Promoting healthier lifestyles among Namibians to prevent lifestyle related Sexual, Reproductive and Child Health and Nutrition problems as well as Non Communicable Diseases (NCDs).
- 3.2.7 Leadership and commitment:** Ensuring MOHSS-driven leadership for evidence based and effective interventions for sexual, reproductive and child health and nutrition

services that are planned and implemented according to national priorities and the specific needs of the population.

3.3 Objectives

- To increase awareness and knowledge, and improve attitudes and practices related to sexual, reproductive and child health.
- To reduce maternal, neonatal/infant and child mortality in line with the NDPs and Millennium Development Goals.
- To reduce the level of malnutrition among infants, children and adults
- To reduce barriers to optimal infant and young child feeding practices and to improve support to women, their partners, caregivers of children, health workers and the community to comply with recommendations for IYCF.
- To reduce morbidity and mortality due to HIV in the country.
- To reduce morbidity and mortality due to non-communicable disease in the country.
- To virtually eliminate Parent to Child Transmission (zero transmission) of HIV.
- To provide quality maternal and child health care services at all levels of the health care delivery system.
- To provide quality neonatal/newborn services at all levels of the health care delivery system.
- To provide quality adolescent friendly health information and services at all levels of health care delivery system.
- To significantly reduce unintended pregnancy through provision of family planning information and services targeted to the needs of both men and women.
- To increase skilled care attendance during pregnancy, childbirth and post-natal period to all women in Namibia;
- To provide Integrated Management of Neonatal and Childhood Illnesses (IMNCI) at all levels of health care delivery in Namibia;
- To improve the quality and coverage of immunization services in the country.
- To increase awareness and knowledge, and improve attitudes and practices related to the prevention, promotion, treatment and rehabilitation of common conditions in order to improve the health and quality of life in households and communities

- To bring services closer to the community and ensure equitable distribution of community and household centered health care and social welfare services through health extension programme.

3.4 Strategies

To achieve these policy objectives, a combination of the following strategies have been identified: i) Advocacy; ii) Capacity Development; iii) Partnerships and Collaboration; iv) Resource Mobilisation; v) Health Promotion and Social Mobilization; vi) Enabling Environment; vii) Community involvement and participation; and viii) Research, Monitoring and Evaluation.

3.4.1 Advocacy

Concerted and sustained advocacy by all stakeholders is needed to promote sexual, reproductive, child health and nutrition as key priorities of Government's development agenda. Advocacy is needed to increase access to maternal and child health, construction and use of maternity waiting homes, ensuring the availability of ambulances for referral of mothers and newborns with complications, immunization services for all children and women, implementation of integrated management of newborn and childhood illnesses and promotion of all eight core indicators of Infant and Young Child Feeding (IYCF) including but not limited to early initiation of breastfeeding, exclusive breastfeeding, adequate, appropriate and safe complementary food from 6 months, and scaling up of community interventions for maternal and child health and adequate allocation of human and financial resources to provide quality health services including health promotion interventions.

3.4.2 Capacity Development

Developing capacity for all components of sexual and reproductive health, child health and nutrition, including routine and supplementary immunization, and school based health interventions is a key strategy to improving the management and provision of quality care. Capacity development is enhanced through pre-service and in-service training. The trained staff members need appropriate infrastructure and adequate equipment and supplies to enable them to provide quality services. A system of supportive supervision for health workers and professionals will be provided that supports on going skill development, clinical accountability and ensure improved quality of care to all Namibians. Continued medical education through on-the-job training, and using modern technologies such as video conferencing should be considered due to limited human resources in peripheral areas and distance. Using mobile phone technologies for standardized treatment and improving clinical skills could also be part of the capacity development.

3.4.3 Partnerships and Collaboration

Fostering partnerships in program design, implementation and monitoring, as well as advocating for increased commitment and resource mobilization for sexual and reproductive health and nutrition is of critical importance in establishing a solid and

sustainable program. The line ministries, UN Agencies, Bilateral and Multilateral agencies, local and international civil/NGOs, churches, private health sector, private organizations, the media and the community at large are major stakeholders in the development and implementation of the Policy guideline, under the leadership of the Ministry of Health and Social Services

3.4.4 Resource Mobilization

It is imperative to increase budget allocation for maternal, newborn and child health interventions and nutrition in order to reach the targets and goals of NDPs and MDGs. The target is to mobilize resources from internal and external sources in order to complement the Government's efforts towards reducing maternal, newborn and childhood deaths.

- Revision of laws, legislations and policies that hinder effective implementation of maternal, newborn and childcare.
- Strengthening implementation of exemption policies affecting reproductive and child health care.
- Improved employment/deployment and retention of skilled attendants at all levels

3.4.5 Health Promotion and Social Mobilization

Health Promotion aims at increasing awareness and demand for essential health services, with major focus on prevention of diseases and promotion of health. It will focus on the determinants of health (socio-economic factors that influence health), social mobilization, social and behavior change communication, community involvement and participation and enabling environments.

Primary prevention through increased public awareness and knowledge about sexual, reproductive, child health and nutritional issues such as the need for screening for reproductive tract cancers and voluntary testing for HIV will be promoted. Health promotion will create awareness and increase demand on the utilization of health facilities for maternal and newborn services.

Behaviour Change Communication (BCC) at all levels of the community will be used for bringing positive change with respect to sexual, reproductive and child health and nutrition across all segments of the population. The BCC will also extend to health workers to be more sympathetic and competent in addressing issues of sexual and reproductive health across all segments of the population. Media communication has a crucial role to play in awareness creation and better understanding by the general public on the need to minimize the consequences of sexual/domestic violence. BCC materials will be developed and disseminated to encourage and raise awareness about healthy lifestyles encompassing responsible dietary practices, encouraging physical activity and the reduction of alcohol and tobacco use.

Social mobilization is aimed at sensitizing and mobilizing the community and the general public to understand the importance of all the SRH and MCH and nutrition interventions as part of the household to hospital continuum of care, particularly the need for fathers, mothers and other family members to make the necessary preparations for delivery by skilled attendants.

Efforts must be made to integrate health messages into other sectors including education, agriculture, information and communications technology, gender and child welfare, labor and social welfare, youth, national service, sports and culture and religious affairs among others. Health professionals and their respective counterparts in other sectors are to work together towards a better health with synergy and complementarities to contribute to the pursuit of a better health and social advancement. Captive audiences including schools, women, youth and men's economic and social groups should be engaged as partners in the joint initiatives in this process of learning for transformation.

3.4.6 Enabling Environment

It is important to create conducive environment for healthcare workers at the same time an environment that supports communities utilizing affordable and accessible services. Staff accommodation and other support could boost the morale of healthcare staff at the same time out reach points, maternity waiting homes; etc. could create more access to services by people in the most remote areas. Strengthening the referral system could also improve equitable access to quality health services.

Concerned by the slow progress towards achievement of health MDGs 4 and 5 in Africa, delegates at a meeting of 20 sub-Saharan African countries in Senegal in March 2009 called on the strengthening and scaling up of high impact interventions for child survival. The delegates endorsed twice yearly Maternal, Child Health Days as an effective and sustainable strategy for the existing health system to deliver vitamin A and other high-impact interventions.

Maternal Child Health Days (MCHDs) are days of accelerated action to promote the health and well-being of children especially those that are difficult to reach. They are regular events organized to deliver an integrated package of preventive services and limited curative services where needed. When planned and implemented well they achieve high coverage and reduce inequities.

MCHDs could be an ideal for improving access to services of RCH to men and women using different platforms for delivering a package of interventions ranging from immunization, insecticide treated net (ITN) and ORS distribution, Vitamin A supplementation, deworming, growth monitoring, condom and other contraceptive distribution, antenatal care (ANC),

tetanus injection for pregnant women, health education and head count of number of children, etc.

3.4.7 Community Involvement and Participation

At community level, it is important to mobilize and support communities to protect and promote better health and safety for their own community members. All health workers should always create awareness and sensitize individuals and communities about the local health problems, their prevention and care. The aim is to promote a healthy life style and prevent diseases and create demand for health services.

The Ministry of Health and Social Services (MoHSS) in 2009 developed a strategy to strengthen community-based health system through recruitment of Health Extension Workers (HEWs) as public service employees to extend health care and social welfare services from the health facilities into the community and to state their role and responsibilities within the community. This strategy calls for better coordination of health care and social welfare services in the community to facilitate the implementation of health services through Health Extension Programme (HEP) within the Namibian context.

The establishment of HEWs in Namibia would accelerate the promotion of health awareness and build local community capacity for greater involvement and participation in primary health care interventions. Furthermore, the introduction of these new cadres will improve the number of health care providers available in the community.

3.4.8 Research, Monitoring and Evaluation

Research, monitoring and evaluation are imperative to effectively implement the policy. This requires capacity development in identifying research needs, conducting and utilizing the findings to improve the program. The evidence gathered through monitoring and conducting research should be used to improve the quality of sexual, reproductive, child health and nutrition services.

Monitoring and evaluation (M&E) are essential for assessing the performances of the Health and Nutrition Services and to make necessary adjustments to correct weaknesses and scale up best practices. M&E is also useful for adjustment of future programs and plans of action.

The Health Management Information System (HMIS) is a tool for monitoring the implementation and impact of RCH and Nutrition interventions at all levels of the health care delivery system. A periodic analysis of the routine HMIS reports and existing indicators need to be carried out to guide future plans and programs.

Periodic evaluation will be conducted through the existing systems such as Demographic and Health Survey (DHS), and other national, regional and local surveys as required. Thus it

is important to strengthen the data collection tools, and modify indicators as needed in RCH and Nutrition programs for periodic DHS.

The bulk of health problems and health systems challenges in developing countries lie at the marginalized and disadvantaged communities. The information gap at that level could be huge, therefore to guide the design and implementation of RCH and Nutrition programs, operational research at the community, and other levels of health care delivery system need to be promoted to guide policies and programs and design evidence based interventions.

The National Policy on Sexual, Reproductive and Child Health will complement and contribute to the implementation of the existing related policies and guidelines in the country.

3.5 Policy Statements

3.5.1 Sexual and Reproductive Health

Rationale

Sexual and Reproductive Health entails family planning on the part of both partners in a relationship, prevention and management of STIs, prevention and management of the reproductive system cancers, prevention and management of gender based violence, provision of post abortion care, safe motherhood, newborn care and PMTCT and management of menopause and andropause.

The assurance of quality sexual and reproductive health among the population contributes to the improvement of quality of life and is the key ingredient to the socio-economic development of the nation. The Government of the Republic of Namibia recognizes sexual and reproductive health as a fundamental human right as enshrined in the constitution of the country.

SRH Policy Statements

1. All Namibians shall be provided with quality Sexual and Reproductive Health Services irrespective of their creed, age, gender, sexual orientation, religion, political affiliation and socio-economic status.
2. All Namibians shall be provided with accurate information, education and counselling about sexual and reproductive health that is age-appropriate and sensitive to the needs of Namibian men and women.
3. All Namibians shall be protected from harmful practices which are detrimental to sexual, reproductive health.
4. All health facilities shall provide integrated SRH and HIV services.
5. All the skills acquired after basic training with certification shall be recognised as part of the nurse/ midwife's scope of practice.
6. All hospitals shall provide comprehensive emergency obstetric and neonatal care services, all health centres and clinics shall provide basic emergency obstetric and neonatal care services.
7. Antenatal Care (ANC), Maternity, Post Natal Care (PNC), newborn care, Family Planning (FP) information and services shall be available at all levels of the health care delivery system free of charge.

8. Taking into consideration the life-course approach and continuum of care, neonatal interventions that need to be scaled up should include access to skilled care during pregnancy, childbirth and the immediate postnatal period at community and facility level.
9. Capacity building of professional and non-professional staff should include optimal newborn care practices, newborn resuscitation, early and exclusive breastfeeding, warmth, hygienic cord and skin care as well as care of low- birth-weight infants
10. All health facilities (public and private) shall notify the ministry of all maternal and neonatal deaths in their facilities.
11. All facilities that do not have admission facilities or do not provide the required specialized services shall attend to and stabilize the patients before referral.
12. All nurses and doctors will receive clinical training on Emergency Triage, Assessment and Treatment (ETAT) of sick newborn care.
13. The Ministry of Health and Social Services shall promote the community initiatives on maternity waiting homes.
14. Health facilities shall provide screening, treatment and palliative services for cancer of the Reproductive system.
15. All health facilities shall provide screening, treatment and counselling for Sexually Transmitted Infections (STIs) including HIV/AIDS.
16. All health facilities shall provide a welcoming environment for partners, family members and caregivers who accompany a pregnant woman to the facility.
17. Insecticide-Treated mosquito Nets (ITN`s) shall be provided to all pregnant women and children under 5 years living in malaria endemic areas.
18. All health workers shall collaborate with traditional birth attendants (TBAs) to increase women`s, and their respective family members`, ability to recognise pregnancy related danger signs and newborn health danger signs and to seek timely referral to the health facility. TBAs shall be trained to recognise danger signs during pregnancy, labour, postpartum period and in newborns in order to refer clients to the health facilities early.
19. Women and men shall have the right to make their own decisions about their reproductive health and to make their own choice to involve their partner or family members if they so wish after receiving all the necessary information.

20. All persons who are sexually active, regardless of age or marital status, shall have the right to be fully informed about available family planning options and methods, and shall have the right to receive the family planning method of their choice.
21. Adolescents can access sexual and reproductive health services including family planning and STI services without parental consent after thorough counseling.
22. A written consent shall be obtained from an individual (man or woman) when requesting for any surgical procedure including vasectomy and tubal ligation after a thorough counselling.
23. Medical termination of pregnancy as per “Abortion and Sterilization Act (1975), as amended through Act 48 of 1982”, shall be provided when the pregnancy poses threat to the life of the mother, in cases of gross congenital malformations and, when the pregnancy is due to rape or is incest.
24. All health facilities shall provide information or services where possible for management of sexual dysfunctions, infertility, menopause and andropause.
25. All working pregnant women in both public and private sector shall be entitled to a maternity leave as per existing national labour laws.

3.5.2 Adolescent Health

Rationale

Adolescents constitute the segment of a population aged 10-19 years of age, and this definition is applied throughout this section and is applicable in all sections of this policy where the word “adolescent” is used. In Namibia, like in other countries, adolescents become sexually active at a very young age, while hardly using any protection against sexually transmitted infections (STIs) including HIV and pregnancies. Despite this known sexual activity, adolescents still face significant barriers to accessing SRH services. Unwelcoming attitudes of health service providers, lack of confidentiality and no privacy at health facilities often discourage adolescents from accessing needed services.

The assurance of the highest standard of adolescent health services is a fundamental right of adolescents and ensures the presence of healthy and productive youth that positively contribute to national development.

Adolescent Health Policy Statements

1. All health facilities in Namibia public and private shall have an adolescent health component in their service provision at all times and all staff should be trained in adolescent friendly service provision.
2. Health information and services to adolescents shall not be denied because of their inability to pay for services in the public sector.
3. Adolescents shall have access to Sexual and Reproductive Health Services without any need for parental consent (except for surgical procedures).
4. All girls aged 15 years and above shall be immunized against tetanus as per MOHSS EPI schedule.
5. Regarding HIV Counseling and Testing (HCT),
 - All children aged 16 years or above can give full informed consent for HCT.
 - For children below the age of 16 a parent or legal guardian's consent is required for testing unless the child is considered to be a mature minor. Young people under 16 years of age who are pregnant, parents, or engaged in behaviour that puts them at risk or have a STI should be considered "mature minors" who can give consent for HCT.
 - I. For older children from ten to sixteen years: The parent/guardian consents and ideally the child assents. The parent/guardian should be involved in the counselling and testing session even if the child assents.
 - II. For mature minors the minor gives verbal consent and the counsellor documents that they have assessed them to be a mature minor. The parent/guardian is usually not involved in the counselling session unless the minor specifically requests this.
6. Adolescents shall have the right to know their HIV status and to disclose to others out of their own free will after thorough counselling
7. Adolescents living with HIV shall have access to comprehensive care, treatment, and support services.
8. All sexually-active adolescents, regardless of age, shall have the right to confidential handling of all aspects of their personal health information, including testing behaviour, risk behaviour, and diagnoses.

3.5.3 Integrated Management of Neonatal and Childhood Illness (IMNCI)

Rationale

Substantial efforts to improve the health and nutritional status of children in developing countries have been made, but every year millions of children die before they reach their fifth birthday and many during the first year of life. Integrated Management of Neonatal and Childhood Illness (IMNCI) is a broad strategy, encompassing interventions at home and in the health system. It aims to reduce childhood death, illness and disability and to contribute to improved growth and development.

The presence of healthy children in a nation is ensuring the continuity of generations and existence of a country. In this respect, this policy addresses the integrated management of neonatal and childhood illnesses (IMNCI) to secure the above mentioned aspirations of the Government of the Republic of Namibia.

IMNCI Policy Statements

1. All health facilities shall implement the three components of IMNCI, namely capacity development for case management, strengthening the health system to support IMNCI and community component of IMNCI.
 - Empower families and communities, especially the poor and marginalized, to improve key child-care practices and ensure access to basic services available within the community through health extension workers
2. All medicines required for the implementation of IMNCI including pre-referral medications shall be available at all levels of the health care delivery system.
3. Insecticide-Treated mosquito's Nets (ITN's) shall be provided to all under five year-old children living in malaria endemic areas.

3.5.4 Expanded Program on Immunizations (EPI)

Rationale

Immunization is the basic right of a child and women of reproductive age. Vaccination of women and children is one of the most cost effective measures for reducing child morbidity, mortality, and improvement of maternal and child health which contributes to the economic development of the nation. This policy aims at ensuring access to quality immunization services for the attainment of the elimination and eradication of targeted diseases.

EPI Policy Statements

1. Immunization services shall be provided free of charge to all children and women of reproductive age at health facilities and outreach points according to the MoHSS schedule.
2. Any Adverse Events Following Immunization (AEFI) shall be reported and treated in the public health facilities free of charge.
3. All HIV positive children shall benefit from the vaccination program as per the MOHSS EPI guideline.
4. Availability of vaccines should be ensured at all times.
5. The MOHSS at all levels shall ensure availability of cold chain equipment including the maintenance and replenishment of cold chain equipment for effective immunization.
6. All private health facilities shall submit their immunization data on monthly basis through their respective regional health structures. The MOHSS shall provide all private health facilities with necessary reporting forms.
7. Immunization cards shall be requested at admission in all schools. Schools shall check prior to admission that every child's immunization status is up to date. Children with incomplete immunization schedule shall be provided support to receive the necessary vaccines.
8. Only WHO approved vaccines shall be used in the EPI programme.
9. Ensure EPI communication strategy rolled out nationwide with focus on low performing districts.

3.5.5 Nutrition

Rationale

Nearly one in three children under the age of five, in Namibia is stunted, which is a manifestation of chronic malnutrition. Children who are malnourished are at greater risk of infection, diseases and death. Approximately 15% of women of reproductive age are too thin for their height, which places mothers to be at a high risk of maternal morbidity and mortality. It is therefore important to design, implement, monitor and evaluate appropriate nutrition interventions to curb the high maternal and child morbidity and mortality associated with malnutrition.

Malnutrition not only negatively affects the health of the individual but also undermines school performance and subsequent economic productivity. Malnutrition in utero and early childhood has been proven to increase the risk of non-communicable diseases such as diabetes, heart diseases in adulthood. The prevalence of diet and lifestyle related diseases are of public health significance in Namibia. Namibia is experiencing the double burden of malnutrition which manifests as concurrent under and over nutrition in households and communities. The resultant morbidity and mortality has a negative bearing on the nation's development through increased burden on the health system and loss of productivity through the most economically productive sections of society. The ultimate result of malnutrition is the negative consequences on the country's economic productivity and competitiveness.

Nutrition Policy Statements

- All women of reproductive age and their partners, spouses, and families shall have access to health education and counselling on importance of maintaining adequate overall nutritional status prior to pregnancy and its impact on reproductive ability /outcomes.
- All mothers shall receive appropriate prophylactic micronutrient supplements during antenatal care, delivery and during lactation.
- All women, their partners, spouses, and families shall receive counselling and support on breastfeeding and maternal nutrition during ANC, delivery and during post-partum period.
- All health facilities shall provide Baby-Mother Friendly Initiative services through the implementation of the Ten Steps to Successful Breastfeeding as per the national nutrition guidelines.
- All mothers will be supported to initiate breastfeeding within the first half hour of birth and continue with exclusive breastfeeding up to 6 months.
- Every health facility shall have a breast feeding support group to help support, promote and protect breastfeeding. Whether health facility-based or community-based, the support group shall meet in publicly accessible venues, and shall invite participation of family, partners, and spouses in learning and building home-based support for breastfeeding.
- Marketing of all breast milk substitutes shall not be allowed in Namibia. The MoHSS will not market, recommend, or endorse substitutes for breast milk in Namibia

- Mothers, fathers, partners, family members, and infant caregivers shall be counselled to introduce adequate and appropriate complementary feeding to their infants at the age of 6 months with continued breastfeeding for the first 2 years of life or beyond.
- All mothers known to be HIV infected shall be encouraged to breastfeed their infants exclusively for the first six months of life, introduce appropriate complementary foods thereafter as per IYCF, PMTCT and ART guidelines.
- Growth monitoring, promotion of optimal infant and young child feeding practices, and nutrition intervention for the prevention and management of micronutrient deficiencies and malnutrition shall be provided to all children under-five years of age both in the health facilities and at outreach points.
- Micronutrient deficiency shall be prevented, identified and treated through routine health facility assessment, supplementation and campaigns.
- All infants should receive micronutrient supplements such as Vitamin A as per national nutrition guidelines.
- All children over the age of one through school years or up to 15 years of age shall receive deworming treatment twice a year through MOHSS and through the school system as appropriate.
- All cereal staple flours and products thereof shall be fortified with micronutrient/s.
- All salt for human and animal consumption will be fortified with iodine.

3.5.6 Emergency Situations

In case of emergencies and disasters such as flooding resulting in displacement of people, access to SRH services usually gets disrupted. Provision of SRH services as part of emergency response is critical to prevent and manage SRH related problems faced by displaced populations.

Policy statement on emergency situations

- Sexual, reproductive and child health, nutrition and psycho-social services shall be provided to all affected populations during disasters wherever they occur, including but not limited to emergency camps.

CHAPTER 4: INSTITUTIONAL FRAMEWORK FOR IMPLEMENTATION

4.1 Policy Coordination

The Minister of Health and Social Services will establish a National Steering Committee with membership from relevant Ministries, NGOs including youth, men's and women's organizations, Civil Society and relevant development partners. The Minister of Health and Social Services or his/her designated official chairs and convenes the Steering Committee meetings. The Directorate of Primary Health Care is the Secretary of the steering committee.

Responsibilities of the steering committee:

- 4.1.1 Coordination of all interventions related to sexual and reproductive health, Child health and Nutrition
- 4.1.2 Advocacy for increased commitment and resource allocation to strengthen the sexual and reproductive health, child health and nutrition, national level strategic planning, policy framework environment and service delivery systems.
- 4.1.3 Guidance for the development of programmes on sexual and reproductive health, child health and nutrition.
- 4.1.4 Policy review on sexual and reproductive health, child health and nutrition issues.
- 4.1.5 Establishment of a research agenda and development of guidelines for monitoring and evaluation of sexual and reproductive health, child health and nutrition programmes

The Minister of Health and Social Services has the authority to review and update the terms of reference of the Steering Committee as needed.

4.2 National Maternal, Child and Nutrition Technical Committee

The National Maternal, Child and Nutrition Technical Committee provide technical advise to make the policy document operational. The National Maternal, Child and Nutrition Technical Committee have sectoral representation from relevant Ministries, development partners, professional medical and health care associations, and youth and women's organizations. The Director of Primary Health Care Services or his/her designated official, chairs and convenes meetings of this technical committee. The Reproductive and Child health and Nutrition programme managers are the Secretariat for the technical committee.

Responsibilities of the National Maternal, Child and Nutrition Technical Committee:

- 4.2.1 Provide technical advice to the National Steering Committee;

- 4.2.2 Develop technical guidelines, standards and protocols for implementation of the sexual and reproductive, maternal and child health and nutrition policy;
- 4.2.3 Provide technical advice on the quality and impact of the implementation of sexual and reproductive, maternal and child health and nutrition programmes to Regional health management teams, implementing partners, Ministries, NGOs, youth and women's organizations, and civic society;
- 4.2.4 Conduct annual periodic assessment of the implementation of the policy and report to the Steering Committee;
- 4.2.5 Facilitate information sharing among the implementers of the sexual and reproductive health, maternal and child health and nutrition policy;
- 4.2.6 Identify gaps in human, financial and material resources for implementation of the policy, and make appropriate recommendations to the national steering committee;

The National Maternal, Child and Nutrition Technical Committee can form sub-committees for specific tasks as needed, such as Maternal, Infant and Young Child Nutrition (MIYCN) Technical Working Group which has the following roles and responsibilities:

- Advocate for the protection, promotion and support of IYCF practices
- Increase the evidence-base and knowledge of the barriers to optimal IYCF practices in Namibia
- Advocacy and social and resource mobilization for MIYCN
- Support monitoring and evaluation activities of MIYCN programmes
- Document and share experiences and evidence-based practices regarding MIYCN
- Provide a forum for the coordination of stakeholders and partners involved in MIYCN programming
- Provide technical input to National Micronutrient and nutrition assessment processes such as national nutrition and anthropometric surveys
- Support micronutrient supplementation at household level
- Through the Food Fortification Technical Working Group; Advocate for appropriate and relevant food fortification policy/s and guidelines
- Advocate for diversified food supply and intake at household, community and national level
- Provide a forum for the coordination of stakeholders and partners involved in food fortification programming, micronutrient supplementation programs and bio-engineering.
- Support investigation of barriers and enablers to an optimal dietary intake including food diversity and or foods fortified with micronutrients.

4.3 Regional Reproductive & Child Health Committee

The Regional Director creates a regional reproductive health committee to direct and monitor the development and implementation of the sexual and reproductive health, maternal and child health and nutrition services in the Region. The Regional Director or his/her designated official chairs and convenes the committee meetings. The reproductive health focal person is the secretary of the reproductive and child health committee.

The Regional Reproductive and Child Health Committee, through the Regional reproductive and child health focal person will coordinate data collection, analysis and production of quarterly regional reports. The quarterly reports will be used for program refinement within the region and copies will be sent to MOHSS.

4.4 Maternal, Peri/Neonatal Death Review Committee

The National Maternal, Peri/Neonatal Death Review Committee will continue with its mandate to investigate all maternal and newborn mortality in the country. The information will be submitted through Regional Maternal, Peri/Neonatal Death Review Committees.

4.5 Roles and Responsibility

This policy document will be effectively implemented with the involvement of all stakeholders in Sexual, Reproductive, Maternal and Child health and Nutrition services. Therefore, the Government of Namibia calls on all stakeholders to invest in the implementation, monitoring and evaluation of this policy document to ensure the attainment of Universal Access to Sexual and Reproductive Health, Maternal and Child Health and Nutrition, reduce morbidity and mortality among men and women and children to achieve the Millennium Development Goals related to hunger, HIV and maternal and child health.

Each stakeholder is requested to integrate maternal, neonatal and child health, sexual and reproductive health and nutrition issues into their employee wellness programs, and to implement this policy. Where applicable each stakeholder is also requested to avail to the Ministry of Health and Social Services reports on health related issues.

4.5.1 Office of the President: National Planning Commission Secretariat (NPCS)

The NPCS through the National Statistics Agency (NSA) will:

- Ensure that priority research topics as submitted by the National Steering Committee related to sexual, reproductive, maternal and child health and nutrition services are included in national surveys.

4.5.2 Office of the Prime Minister

The OPM as a public service coordinating body will:

- Ensure that policies are implemented and oversee staff recruitment for the various ministries.

- Provide timely and reliable data on emergency for programming purposes (planning, provision of services and monitoring).
- Coordinate resource mobilisation in case of emergencies.

The OPM chairs the **NAMIBIA ALLIANCE FOR IMPROVED NUTRITION (NAFIN)**.

NAFIN will:

- Create awareness of the high prevalence of malnutrition in the country;
- Advocate for increased resource allocation to nutrition interventions in Namibia
- Monitor household food security; monitor maternal health and support activities aimed at promoting improved nutrition for all Namibians.
- Convene and coordinate multisectoral responses to nutrition issues

4.5.3 Ministry of Health and Social Services (MoHSS)

The MoHSS is responsible for ensuring the implementation, monitoring, evaluation and overall coordination of the implementation of this policy. Through its national, regional and district structures, all sectors, including private health service providers, will collaborate with MoHSS in the implementation of this policy. The MOHSS will be responsible for the evaluation and review of the policy every five years.

4.5.4 Ministry of Information and Communication Technology (MICT)

MICT will:

- Inform and educate the public on Sexual, Reproductive and Maternal and Child health and Nutrition matters with the context of this national policy in collaboration with MoHSS. Messages will place emphasis on the need to seek sexual and reproductive, and maternal and child health and nutrition care at all levels of the community. Special emphasis will be given to maternal health including all stages of pregnancy, delivery, and infant and child care, including the importance of prevention of parent to child transmission of HIV. Adequate and appropriate IYCF and nutrition interventions and immunization of children will also be prioritised.
- Assist in the coordination of social mobilization including advocacy, community involvement (especially male involvement) and behaviour change communication.

4.5.5 Ministry of Gender Equality and Child Welfare (MGECW)

The MGECW will:

- Promote male/partner involvement in maternal and child health care.
- Promote immunization through early childhood development (ECD) centres.

- Train and educate women, men, and adolescents on their rights related to sexual and reproductive health.
- Train and educate women, girls, men, and boys on how gender impacts on sexual, reproductive and child health and nutritional status.
- Facilitate and promote the promulgation of the ILO Maternity Protection Convention and its recommendations in collaboration with the Ministry of Labour and Social Welfare.
- Educate the public on and reinforce existing policies related to maternity leave, the Rape Act and the Domestic Violence Act.
- Strengthen adoption policies and help reduce stigma associated with adoption.
- Educate the public on the existing policies related to maternal health, infant feeding and child welfare grants
- Establish a policy to address baby dumping.

4.5.6 Ministry of Justice (MOJ)

Ministry of Justice will:

- Promote sexual and reproductive health and child rights by ensuring justice for citizens on reproductive and child health issues that come before the courts particularly rape, gender based violence and abuse of the child.

4.5.7 Ministry of Finance (MOF)

Ministry of Finance will:

- Ensure adequate budget allocation and resource mobilization for the implementation of strategies derived from this policy that include sexual, reproductive and child Health and nutrition Strategies, maternal and child health care, under the auspices of the Ministry of Health and Social Services budget.

4.5.8 Ministry of Education (MOE)

Ministry of Education will:

- Provide education for boys, girls, men and women on the prevention of unwanted pregnancy, reproductive health, sexually transmitted infections (STIs) including HIV/AIDS, and Maternal, Newborn, Child Health and Nutrition.

- Strengthen the school-based health and nutrition programs.

4.5.9 Ministry of Defence (MOD)

The Ministry of Defence will:

- Ensure that all SRH, maternal and child health and nutrition services are provided to the Namibia Defence Force members and their families.
- Create awareness among the defence forces and their families by developing IEC materials on SRH and maternal and Child Health and Nutrition.
- Provide training and information as appropriate on male involvement and reproductive health.
- Collaborate with the Ministry of Health and Social Services to ensure that MoD health care providers are oriented towards provision of quality SRH, maternal and child health, and nutrition information and services.
- Provide logistics (**helicopters** etc) and personnel support during national immunization and Child Health Days and national emergencies.

4.5.10 Ministry of Labour and Social Welfare (MLSW)

Ministry of Labour and Social Welfare together with all relevant stakeholders will:

- Ensure that all elderly and disabled are entitled to quality SRH and nutrition information and services.
- Ensure children are protected from child labour and harmful traditional practices.
- Support the ratification and implementation of the new ILO Maternity Protection Convention No. 183 of June 2000 and its recommendations.
- Work towards ensuring fully-paid maternity leave for all employees including those in the private sector.

4.5.11 Ministry of Home Affairs and Immigration (MHAI)

The ministry will:

- Ensure that displaced women, children and their families are provided with information and services rendered by the ministry.
- Prioritize the processing of work permits for foreign nationals recruited for health services.
- Ensure that all births and deaths are registered.

4.5.12 Ministry of Regional and Local Government, Housing and Rural Development (MRLGHRD)

The ministry will:

- Mobilize civil society organizations in collaboration with the Namibia Non-Governmental Organization Foundation (NANGOF) to organize communities for the establishment of emergency transport schemes to support emergency referrals of mothers, caregivers and children to health facilities.
- Ensure that maternal and newborn deaths are notified by the community and reported to the Ministry of Health and Social Services.
- Mobilize resources and coordinate the establishment of maternity waiting homes.
- Identify traditional healers and regulate their practice.
- Traditional authorities will promote healthy cultural and traditional practices and behaviours.
- Promote healthy lifestyles in families. National Council will use constituency development funds to support community sexual, reproductive, maternal and child health and nutrition initiatives in their various constituencies.

4.5.13 Ministry of Works and Transport (MWT)

The ministry will:

- Construct, upgrade and maintain public health facilities in collaboration with the Ministry of Health and Social Services for the provision of sexual, reproductive, maternal and child health and nutrition care.
- Provide appropriate communication systems to enhance efficient referral systems.
- Prioritize maintenance of good roads in rural areas to facilitate easy transportation of pregnant women, their partners and/or other, caregivers and children.

4.5.14 Ministry of Youth, National Service, Sports and Culture (MYNSSC)

The ministry will:

- Provide youth with information and services on sexual and reproductive health as well as maternal and child health with a strong emphasis on preventing unwanted pregnancy and HIV/AIDS.

- Promote behaviour change among young people and communities, and in particular, by modifying negative cultural practices into safe practices.
- Promote Adolescent Friendly Health Services in collaboration with other stakeholders.
- Incorporate SRH, nutrition, maternal and child health issues into existing youth development programs

4.5.15 Ministry of Agriculture, Water and Forestry (MAWF)

The ministry will:

- Promote national, community and household food security
- Ensure availability of safe and adequate water supply, including promotion of water harvesting
- In collaboration with other stakeholders, promote nutrition education, food diversification and sustainable food production at national and household level.

4.5.16 Ministry of Safety and Security (MSS)

The ministry will:

- Ensure that inmates; women, men and children are provided with information and services on sexual, reproductive, HIV/AIDS, child health and nutrition.
- Enforcing of laws in relation to gender based violence.
- Through the Women and Protection Unit (WCPUs) ensure that survivors of Gender Based Violence (GBV) receive the necessary health services including SRH and HIV services.

4.5.17 Tertiary Education Institutions

The institutions will:

- Undertake priority health research identified by the Ministry of Health and Social Services.
- Collaborate with the Ministry of Health and Social Services to ensure that all student nurses and student medical doctors are trained in sexual and reproductive health, as well as maternal and child health and nutrition, including training on EmONC, EPI, IMNCI, IYCF and others.

- Ensure that the curricula are updated to include new developments and evidence based interventions in the areas of sexual, reproductive, maternal and child health and nutrition issues.
- Create a forum for sharing research findings.

4.5.18 Political Leaders

Parliament declared maternal and neonatal mortality reduction a national priority. Parliamentarians will:

- Support advocacy for adequate budgetary allocation to sexual and reproductive health for men and women, maternal and child health and nutrition.
- Support enactment of appropriate legislation with respect to sexual and reproductive health, maternal and child health and nutrition.

4.5.19 Health Professions Councils of Namibia (HPCNA)

Namibian Professional Council in collaboration with the Ministry of Health and Social Services will:

- Maintain universally accepted standards for sexual and reproductive health, maternal and child health and nutrition services.
- Investigate unprofessional conduct relating to sexual and reproductive health service, maternal and child health service delivery in the country.

4.5.20 National Youth Council (NYC)

NYC will:

- Use its regional structures to provide youth with information on sexual and reproductive health with a strong emphasis on preventing unwanted pregnancy, HIV/AIDS, and other STIs.
- Educate on the importance of timely seeking of sexual, reproductive and child health services.
- Create an enabling environment for open discussion of sexual and reproductive health by young men and women, as well as maternal and child health and nutrition issues.

4.5.21 Churches and Faith-Based Organizations (FBOs)

Churches and FBOs will:

- Promote maternal, adolescent, child health and nutrition care to all Namibians, with strong emphasis on male/partner involvement and adolescent counselling and guidance.
- Build capacity of congregations to mobilize the community to seek health care at all stages of pregnancy and child care, including IYCF and immunization.
- Serve as a referral system for people to access relevant services.
- Create an enabling environment for parenting, healthy family life, and open discussion on sexuality.
- Mobilize resources for the promotion of sexual, reproductive, maternal and child health and nutrition services.
- Assist Ministry of Health and Social Services in reporting deaths related to pregnancy and child birth occurring in their facilities.

4.5.22 Development partners (Multi-lateral and Bi-lateral agencies)

They will:

- Collaborate with the National Planning Commission to provide financial support for the promotion of sexual and reproductive health, maternal and child health and nutrition services.
- Provide technical support to MOHSS and other partners on sexual and reproductive health, maternal and child health and nutrition services.
- Support research on sexual and reproductive health, maternal and child health and nutrition services for evidence based decision making.

4.5.23 Private Health and Social Services Providers

They will:

- Contribute to quality sexual and reproductive, maternal and child health and nutrition, in line with set standards, protocol and guidelines.
- Private health sector will collaborate with MoHSS towards the development and implementation of strategies for their contribution towards training of health workers and support for emergency and specialized services.
- Collaborate and cooperate with the MOHSS in providing statistics related to immunization, neonatal and maternal deaths and malnutrition at private health facilities.

- Participate in health information dissemination related to SRH
- Join and participate in the regional Reproductive & Child Health Committee meetings.

4.5.24 Civil Society Organization (CSOs)/Non-Governmental Organizations (NGOs)

They will:

- Ensure that their programs integrate sexual and reproductive health services, maternal and child health and nutrition activities as prescribed under this policy.
- Collaborate with Ministry of Health and Social Services in availing their technical reports.
- All NGOs should educate their employees about sexual and reproductive health issues for men and women, as well as maternal and child health and nutrition issues, and make services available to their employees.
- Mobilize, in collaboration with the Ministry of Regional and Local Government, and Housing and Rural Development, civil society organizations to support communities for the establishment of emergency transport schemes for emergency referrals of pregnant women, their respective partners and children to health facilities.
- Mobilize resources for the promotion of sexual and reproductive , maternal and child health and nutrition services

4.5.25 Namibia Planned Parenthood Association (NAPPA)

NAPPA will:

- Educate men and women including youth and communities on sexual, reproductive and maternal and child health rights and available services.
- Complement the efforts of the MoHSS in providing comprehensive SRH to both sexes in addition to maternal and child health and nutrition services.
- Mobilize communities to organize support networks for men, women and children in the effort to promote a healthy and safe lifestyle.

CHAPTER 5: RESOURCE IMPLICATIONS

5.1 Financial Resources

The Government through the Ministry of Health and Social Services and its partners will mobilize adequate financial resources needed for the implementation of the Sexual Reproductive, Maternal and Child Health and Nutrition policy according to the specified roles.

The Ministry will also mobilize community support and resources as well as support from private organizations and donor agencies.

5.2 Human and Institutional Resources

Human and institutional resources will have to be mobilized from the key implementing ministries, the private sector, training institutions, professional bodies, social groups and from the beneficiaries of SRCH services such as youth groups, women's and men's groups to support service delivery, research and capacity building. Adequate financial resources shall be mobilized to provide knowledge and skills for personnel providing SRCH services as well as managers. Appropriate steps shall be taken to upgrade training institutions to enable them to meet the training needs of SRCH service providers through pre-service and in-service training.

5.3 Capacity building

All the personnel involved in sexual Reproductive, maternal and child and nutrition programmes will receive informal and formal training locally and abroad. This will enable them to provide services effectively and efficiently. The regions will be responsible for the training of regional personnel while National Level will provide support when needed.

For in-service training and post basic training that includes the private sector, the Ministry of Health and Social Services will review and assist in the development of a curriculum, train trainers, upgrade and maintain training. The Ministry will be represented in the accreditation boards to maintain professionalism and standard of care.

5.4 Infrastructural Resources

The Ministry of Health and Social Services and other line ministries shall in collaboration with other non-governmental organization endeavor to strengthen, consolidate and expand the provision of infrastructure needed for efficient Sexual and Reproductive health service, Maternal and Child Health and Nutrition service delivery to all target groups in urban as well as remote rural areas. The sexual, reproductive and maternal and child health services shall be provided through a hierarchy of facilities starting at the community level and increasing

in level of care through clinics, health centres district hospitals and ultimately referral hospitals. In providing SRCH Services, maximum efforts should be made to ensure priority at all times.

CHAPTER 6: MONITORING AND EVALUATION

Implementation of the Sexual, Reproductive, Maternal and Child Health and Nutrition Policy is a dynamic process, which is guided by regular supportive supervision and monitoring visits to health facilities and communities. Closely linked to monitoring activities is an agreed research agenda that responds to the needs of the national program. This implies that the national research capacity needs to be strengthened.

The National Quality Assurance Policy and the monitoring and evaluation strategies will guide the adherence to the policy and standards set by the National Sexual and Reproductive, Maternal and Child Health and Nutrition Policy. Monitoring and evaluation is imperative to the effective implementation of this policy.

The Ministry of Health and Social Services will take the responsibility in establishing consensus on the selection of appropriate indicators, within the Health Management Information System (HMIS), for all levels of the health care delivery system. The National Steering Committee, the National Technical Committee, the Regional Reproductive Health Committee, and their partners will integrate monitoring indicators into their Strategic and Annual Work Plans.

Periodic reviews and evaluations will be undertaken to ensure that activities are carried out as planned and objectives are achieved. This will be done through operational research, maternal death review reports, and community and health facility surveys, quarterly and annual reports, routine analysis of Health Management Information System data, Demographic Health Surveys, review of Supportive Supervisory Visits, and other Research/special studies. Maternal and neo-natal death audits will be used as diagnostic management tools in order to improve quality of care. Health Systems Research will be used to evaluate the quality of Reproductive Health Services and Community Based Approach.

The Ministry of Health and Social Services will disseminate a report on the status of sexual and reproductive health, maternal and child health and nutrition in Namibia, annually. An evaluation tool will be established through consultation of all stakeholders and evaluation of the health delivery system will be conducted every five years.

6.1 Key indicators for policy monitoring and evaluation

Indicators have been developed to monitor and evaluate the policy. Most of these indicators are included in the national Health Management Information System (HMIS). Greater emphasis will be placed on the routine collection and processing of data on process indicators for monitoring progress towards maternal and child mortality reduction.

The following indicators will be monitored regularly:

6.1.1 Impact indicators

- Maternal mortality ratio
- Perinatal mortality rate
- Neonatal Mortality Rate (disaggregated by sex)
- Infant Mortality Rate (disaggregated by sex)
- Under 5 Mortality Rate (disaggregated by sex)
- Stunting rate among under 5 children?

6.1.2 Outcomes indicators

- Proportion of 1 year-old children immunised against measles
- Contraceptive prevalence rate (disaggregated by age and sex)
- Met need for FP by age group (DHS)
- Teenage pregnancy rate
- Prevalence of HIV among pregnant women
- HIV prevalence among HIV exposed infants
- Prevalence of Malnutrition (wasting, stunting and underweight) disaggregated by age.
- Prevalence of NCDs
- New diagnoses of STIs (counts and proportions, disaggregated by sex and age)

6.1.3. Process Indicators

- Number of district hospitals that have a functional newborn resuscitation place in the delivery room
- Number of early neonatal deaths (deaths within the first seven days of life)
- Postnatal care attendance rate
- Contraceptive prevalence rate by method, by age group, sex, socio economic quintiles
- Antenatal care coverage (at least one visit and at least four visits)
- Proportion of ANC visits accompanied by male partner
- Proportion of births attended by skilled health personnel
- Proportion of births assisted by a skilled attendant
- Number of facilities offering Basic EmOC services
- Number of facilities offering Comprehensive EmOC services
- Proportion of deliveries taking place in a health facility
- Early initiation of breastfeeding: Proportion of children born in the last 24 months who were put to the breast within one hour of birth

- Exclusive breastfeeding”: Proportion of infants aged 0-6 months who are fed exclusively with breast milk.
- The new “minimum acceptable diet”: Proportion of children 6-23 months of age who had both minimum meal frequency and dietary diversity (in both BF and non-BF children).

CHAPTER 7: KEY IMPLEMENTATION PHASE

7.1 Cycle for Revision and Change

The policy covers the period of 2012 – 2022 and will be implemented through the road map and strategic plans. The road map and strategic plans shall be operationalized through the development of annual management plans. Guidelines will be developed or revised to guide the implementation of the policy. The policy will be reviewed every five years.

Definition of Terms

Adolescents: Adolescence is a phase of rapid growth and development during which physical, sexual and emotional changes occur (a transition period from childhood to adulthood). Persons between 10-19 years of age are categorized as adolescents

Child mortality or Under-five mortality: the death of infants and children under the age of five

Emergency Triage, Assessment and Treatment (ETAT): Triage is the process of rapidly examining all sick children when they first arrive in hospital in order to place them in one of the following categories: Those with EMERGENCY SIGNS who require immediate emergency treatment; those with PRIORITY SIGNS, indicating that they should be given priority in the queue, so that they can rapidly be assessed and treated without delay; and those who have no emergency or priority signs and therefore are NONURGENT cases who can wait their turn in the queue for assessment and treatment.

Emergency obstetric and neonatal care: refers to lifesaving services for emergency maternal and newborn conditions/complications being provided by a health facility or professional to include the following services categorized as 1) Basic Obstetric and Newborn Care (BEMONC): administration of parenteral oxytocic drugs, administration of loading dose of parenteral anticonvulsants, administration of initial dose of antibiotics, performance of assisted deliveries in imminent breech, removal of retained placental products, and manual removal of retained placenta. It also includes neonatal interventions which include at the minimum: newborn resuscitation, provision of warmth, and referral; 2) Comprehensive Emergency Obstetric and Newborn Care (CEMONC) - refers to lifesaving services for emergency maternal and newborn conditions/complications as in Basic Emergency Obstetric and Newborn Care plus the provision of surgical delivery (caesarean section) and blood bank services, and other highly specialized obstetric interventions. It also includes emergency neonatal care which includes at the minimum: newborn resuscitation, treatment of neonatal sepsis infection, oxygen support, and antenatal administration of (maternal) steroids for threatened premature delivery;

Family Planning - refers to a program which enables couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so, and to have access to a full range of safe, affordable, effective, and modern methods of preventing or timing pregnancy;

Food Fortification: the practice of deliberately increasing the content of an essential micronutrient, i.e. vitamins and minerals (including trace elements) in a food irrespective of whether the nutrients were originally in the food before processing or not, so as to improve the nutritional quality of the food supply and to provide a public health benefit with minimal risk to health

Infant Mortality: Deaths of babies under one year of age

Integrated Management of Neonatal and Childhood Illness (IMNCI): a systematic approach to children's health which focuses on the whole child; not only focusing on curative care but also on prevention of disease.

Maternal Health: refers to the health of women during pregnancy, childbirth and the postpartum period.

Maternal mortality: the deaths of women while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

Maternal, Peri/Neonatal Death Review: refers to qualitative, quantitative and in-depth study of the causes, trends and distribution of maternal and neonatal death with the primary purpose of preventing future deaths through changes or additions to programs, plans and policies.

Maternity Protection Convention: International Labour Organization Convention (2000) that addresses the following subjects: Health protection; Maternity leave; Leave in case of illness or complications; Benefits; Employment protection and non-discrimination; Breastfeeding mothers and Gender Based Violence (GBV).

Primary Health Care (PHC): Essential health care; based on practical, scientifically sound, and socially acceptable method and technology; universally accessible to all in the community through their full participation; at an affordable cost; and geared toward self-reliance and self-determination (WHO & UNICEF, 1978). Key components include: education for the identification and prevention / control of prevailing health challenges; proper food supplies and nutrition; adequate supply of safe water and basic sanitation; maternal and child care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases using appropriate technology; promotion of mental, emotional and spiritual health; provision of essential drugs.

Reproductive Health: “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the

reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.” Major elements of reproductive health include: The elements of reproductive health care include: 1) Maternal health and nutrition, including breastfeeding; 2) Family planning information and services; 3) Prevention of abortion and management of abortion complications; 4) Adolescent and youth reproductive health, guidance and counseling; 5) Prevention, treatment and management of reproductive tract infections, sexually transmittable infections, breast and reproductive tract cancers and other gynecological conditions and disorders; 6) Elimination of violence against women and children and other forms of sexual and gender-based violence; 7) Education and counseling on sexual health; 8) Male responsibility and involvement and men's reproductive health; and 9) Prevention and treatment of infertility and sexual dysfunction.

Sexual Health: Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

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