FOREWARD

Reproductive health, Reproductive Rights and Sexual Rights are important factors of quality of life, human as well as national development. Reproductive Health is a new concept, which includes men and women’s health. It embraces all the critical phases of life from conception, birth, childhood, adolescence, and adulthood to old age. Namibia has committed itself to the implementation of this concept.

Since Independence Reproductive Health related services have been provided through the traditional Maternal and Child Health programmes. These programmes basically take care of the mother and child and neglect the rest of the population segments.

After the International Conference on Population and Development (ICPD) in Cairo 1994, Namibia realised the need to provide these services in a holistic and integrated manner. Not only the programme responsible for provision of these services is renamed Reproductive Health, but also the services are integrated and, as recommended by the ICPD, the emphasis is placed on adolescent reproductive health as well as male involvement.

Adolescent Reproductive health and Sexuality have been neglected areas in Namibia. This is attributed to numerous taboos and myths resulting from limited communication between parent and child, teacher and learner, as well as adolescent and health worker. More crucially, the community at large is not prepared to discuss sexuality issues.

It is now necessary to break these taboos and discuss positively the facts of life, particularly in this challenging time of HIV/AIDS and increased sexually transmitted infections (STIs).

Regular screening of STI’s and appropriate counselling of all people with sexually transmitted infections is required from all service providers of reproductive health to prevent unnecessary infections as well as infertility. Cancers of the Reproductive system and sexual violence are also areas to be focused on in the implementation of Reproductive Health services.

This policy serves as a guide to health service providers in Namibia, general public and provides information about the importance of Reproductive Health among women and men. It also aims to provide direction to all stakeholders and should be used at all times.
### LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>CBS</td>
<td>Central Bureau of Statistics</td>
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<tr>
<td>DCC</td>
<td>District Co-ordinating Committee</td>
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<td>GNP</td>
<td>Gross National Product</td>
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<td>HIS</td>
<td>Health Information System</td>
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<td>HIV</td>
<td>Human Immune Virus</td>
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<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>EEC</td>
<td>Information, Education and Communication</td>
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<td>IUCD</td>
<td>Intra Uterine Contraceptive Device</td>
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<td>MCH/FP</td>
<td>Maternal Child Health and Family Planning</td>
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<td>MOHSS</td>
<td>Ministry of Health and Social Services</td>
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<td>MRC</td>
<td>Multi Disciplinary Research Centre</td>
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<td>MPYC</td>
<td>Multi purpose Youth Centre</td>
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<td>NBC</td>
<td>Namibian Broad Casting Corporation</td>
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<td>NACOP</td>
<td>National AIDS Co-ordinating Programme</td>
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<td>NAPPA</td>
<td>Namibia Planned Parenthood Association</td>
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<td>NDHS</td>
<td>Namibia Demographic and Health Survey</td>
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<td>NGO</td>
<td>Non Governmental Organisation</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>PMDRC</td>
<td>Policy Management, Development and Review Committee</td>
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<td>RH</td>
<td>Reproductive Health</td>
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<td>RMT</td>
<td>Regional Management Team</td>
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<td>SDP</td>
<td>Service Delivery Points</td>
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<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
TABLE OF CONTENTS

CHAPTER ONE  INTRODUCTION

CHAPTER TWO  SITUATIONAL ANALYSIS

2.1 Socio-demographic factors
2.2 Maternal and Child Health Services
2.3 Sexual Transmitted Infections
2.4 Adolescent and Youth Services
2.5 Sexuality and Fertility Behaviour
2.6 Harmful Traditional Practices
2.7 Cancers of the Reproductive System
2.8 Reproductive Health Services Consequences and implication of the situation

CHAPTER THREE  POLICY FRAMEWORK

3.1 Goal
3.2 Principles
3.3 Objectives
3.3.1 Outcome objectives
3.3.2 Output objectives
3.4 Strategies

CHAPTER FOUR  INSTITUTIONAL FRAMEWORK

4.1 Community level
4.2 Clinics and Health Centres
4.3 District Level
4.4 Regional Level
4.5 National Level
4.6 Other line Ministries
CHAPTER 2  SITUATION ANALYSIS

On attaining independence, Namibia adopted the PHC approach as the foundation and cornerstone of the health care system and focused on strengthening the preventive and promotive health services while maintaining the quality of the curative care. Reproductive Health is an essential component of PHC.

The Ministry of Health and Social Services is the leading agent for providing reproductive health services. These services are provided at different levels of the health care system starting from the community to specialised services. They are rendered by governmental, private and non-governmental institutions.

2.1. Socio-demographic Factors

Namibia had an estimated population of 1.7 million in 1998 with an estimated 3.2 % growth rate per year. It is projected that at this growth rate, the population could double in less than 29 years. The population density is 1.7 persons per square kilometer and about 72 percent of the population lives in rural areas according to the Central Bureau of Statistics (CBS) 1991

The population is very youthful in structure with children aged 0-14 years accounting for 42%, while the youth (15-30 years) account for 30.3% (National youth profile ’93)

Overall adult literacy is quite high. About 77 per cent of all persons aged 6 years and above are able to read and write.

Namibia is a culturally diverse and multi ethnic society. Though Afrikaans is a widely spoken language, English is used as the official language.

The marriage rate among women of childbearing age is about 42 per cent (NDHS 1992). 39% of all households are female headed.

The total fertility rate for women of childbearing age is 4.2 with marked difference between rural and urban areas of 4.8 and 3.6 respectively.

Namibia's Gross National Product (GNP) in 1992 stood at US$2,106 million giving a per capita income of US$1,670. However, it should be noted that the country's income distribution is rather skewed.

The majority of people are engaged in low productivity subsistence agriculture and informal employment. In 1994, the government accounted for 35% of total formal employment.

2.2. Maternal and Child Health Services/Status

Until the introduction of the Reproductive Health concept the emphasis in the MCH/FP programme was mainly on Family Planning, hence more than 97% of health facilities are providing Family Planning services.
However these services are short of targeting adolescents and men. Consequently, the contraceptive prevalence rate is still low (38%, Namibia Demographic and Health Survey, NDHS 2000).

At present the contraceptive method mix includes mainly injectables, oral contraceptives and male condoms. The Intra Uterine Contraceptive Device (IUCD) is only provided on a small scale due to limited availability and low demand. The female condom that has been piloted in 2000 has a knowledge base of 65% across the country.

At present 87% of pregnant women make at least one antenatal visit; the average number of visits is about four (4). The majority of women seek antenatal care services for the first time during the second trimester of pregnancy.

About 78% of deliveries are being assisted by a trained person while 29% of women obtain postnatal care after delivery (HIS, 2000).

Maternal mortality is estimated to be 27 1/100 000 live births (NDHS, 2000). The major causes of maternal deaths include ruptured uterus due to obstructed labour, ante and post partum haemorrhage, eclampsia and sepsicaemia. Recently HIV/AIDS is contributing considerably to maternal mortality. In addition to pregnancy related complications poor nutritional status also contributes to maternal morbidity. Poor access to services and late referrals are some of the indirect causes of maternal morbidity and mortality, while young age of women at first pregnancy and grand multipara carry a risk for maternal ill-health.

The traditional birth attendants' (TBAs) survey conducted in 1995 indicated that about 40% of women are being delivered by them. This figure is rather high and the fact that most of the TBAs are not trained could proof risky to the women's health. On the other hand, the 2000 NDHS suggested a decrease in levels of deliveries by the TBA which stands at 5.6 and deliveries else where are 15.8.

The magnitude of unsafe abortion is not known. However, according to evidence from the, death records in hospitals, abortion is likely to be a substantial cause of maternal death. A study carried out in 1999 in selected government hospitals suggested that about seventeen present (17%) died of abortion related complications.

Empirical evidence shows that infertility is a considerable problem although there are no exact data available. Infertility is also not openly discussed in most Namibian communities while the socio cultural preference is towards child bearing.

The threatening condition of HIV infection amongst childbearing population is a concern for the unborn baby, as the infection can be transferred during birth and breast-feeding. The MoHSS policy on breast-feeding how ever stresses that all women should put their babies to the breast within thirty (30) minutes up to an hour after birth. Alternative means of breast-feeding is an option to be explored in the future with in the context of mother to child transmission of HIV infection.

Infant mortality rate stands at 38/1000 live births (NDHS, 2000). Among the neonatal deaths, low birth weight and perinatal problems were identified as the leading causes. According to the Ministry of Health and Social Services health information system, (HIS) the institutional stillbirths rate stands at 26.7 per 1000 live births in 2000.

### 2.3. Sexually Transmitted Infections

Sexually Transmitted Infections (STIs) are a major public health problem and regarded as a co-factor for HIV transmission. Gonorrhoea and syphilis are among the most common STIs. The syphilis infection rate among antenatal care attendants ranges from 9% to 20%. Furthermore, in 2000, 22.3% of pregnant women screened at antenatal clinics of selected government facilities (sentinel cites) across the country were found to be HIV positive.

A National Aids Co-ordination Programme (NACOP, 1999) analysis of the HIV status in the country suggested that infection by sex and age groups shows that the age groups between fifteen (15) to forty five (45) are more infected, this is the country's economically active group. Similarly, women are more infected than their male counterparts, about fifty three percent (56%). All the same, the reports show a higher number
of males who are dying as a result of HIV/AIDS related causes.

Unprotected sex and multiple partners early onset of sexual activities among young people, limited condom availability and use as well as the high incidence of rape and sexual violence are some of the factors associated with the increasing spread of HIV/AIDS in the country.

AIDS in children is rapidly becoming a national problem, this is related to the high number of women of child bearing age who are infected with HIV, and the transmission rate from mother to child (which is at 30 to 35%), during pregnancy, labour and breast feeding of an estimated 30-35%.

2.4. Adolescent (10-19) years and Youth (19-30) Health

Early sexuality, pregnancy, HIV/AIDS and other sexually transmitted infections, are among the major sexual and reproductive health problems faced by adolescents and youth in Namibia. The youth health profile of 1993 revealed that 50% of all births are attributed to mothers under the age of 20 years. Teenagers in urban areas are twice as likely to become pregnant as compared to those in rural areas.

2.5. Sexuality and Fertility Behaviour

The generally held view in Namibia is strongly in favour of having many children. Utilisation of contraceptives is still low, in particular the use of condoms. A significant number of the population do not have the correct knowledge about condoms and their proper use. Limited negotiating skills among the majority of women, and non-co-operative attitudes of most men, coupled with cultural and traditional practices also contribute to the seemingly low utilisation of condoms, statistics from health facilities show an increase in the condom provision, it is however difficult to know that these condoms are being used or not. Multiple sex partners’ relationships seem to be the norm that could be contributing to the high increase of STIs and also as a result many men and women having children from different partners is a common feature.

Empirical evidence shows that gender based sexual violence is a significant problem in Namibia.

2.6. Harmful Traditional Practices

Currently there is little information regarding harmful traditional practices. It is assumed that the practice of dry sex is common in some areas of the country. This can facilitate the transmission of infections as well as cancers of the reproductive tract. Unhygienic circumcision of male children is also practised in some areas.

2.7. Cancers of the Reproductive System

Cancer of the breast is the second most common form of cancer in the country, while cancer of the cervix ranks fourth. Cancer of the prostate and endometrium are also common (HIS 1999). There is limited knowledge in the community on RH cancers. Currently some health facilities screen for cervical cancer and there is only one cancer-screening centre in Namibia. A limited number of health personnel are trained to screen for both cervical and breast cancer. There is still inadequate tracing of women who show signs of malignancy.

2.8. Reproductive Health Services

Reproductive Health services are composed of different components, which are considered to be vitally important. These components include family planning, safe motherhood, management of sexually transmitted infections including HIV/AIDS, new-born care, adolescent reproductive health, management of RH related violence, post abortion care and management of cancers of the reproductive system.

Information, Education and Communication (IEC) and Counselling are identified as strategies to assist in creating demand for RH services in the community.
Community participation and especially male involvement in Reproductive Health is seen as critical to the success of the programme as males still make most decisions in a number of communities and households. According to the NDHS of 2000, about 78% of pregnant women deliver in health facilities.

The consequences and implications of the current situation

In summary the situation with regard to Reproductive Health in Namibia is characterised by a youthful population, frequent occurrence of early and unwanted/unplanned pregnancies, HIV/AIDS, a relatively high maternal and perinatal mortality, low utilisation of contraceptives and frequently reported sexual violence.

The RH problems are further compromised by the constraints faced by the health system. Problems such as shortage of skilled personnel, inadequate referral facilities, limited availability of integrated RH care, difficult geographical access and socio-cultural barriers to acceptance of reproductive health services especially among men. Facilities do not ensure adequate privacy and confidentiality due to lack of space, while interpersonal communication and interaction between service providers and clients are poor.

A problem that also needs urgent attention is the frequent shortage of drugs especially the sexually transmitted infections (STI) drugs and the family planning commodities. Supplies and essential reproductive health equipment are also very often short in most health facilities.

Reproductive Health information, education and communication is being undertaken by the Ministries of Health and Social Services, higher Education Youth and Employment Creation, Basic Education, Sport and Culture, Foreign Affairs, Information and Broadcasting as well as non-governmental Organisations. The institutional framework for the co-ordination of these activities however is weak and information does not adequately reach the communities. There is therefore a need for developing a policy, which will clarify the implementation of Reproductive Health programmes amongst the various stakeholders sectors and at various stages/levels. The existence of a Reproductive Health policy will give appropriate guidance in service provision and management. It will further more ensure uniformity in all Reproductive Health activities in the country. Within the ongoing decentralisation process, the policy will define the roles of each stakeholder at different levels. On this basis, equitable resource mobilisation, allocation and distribution will be ensured to enhance maximum impact of RH services.

Chapter 3 POLICY FRAME WORK

3.1. Goal

The long-term goal is to promote and protect the health of individuals and families through the provision of equitable, acceptable, accessible and affordable quality reproductive health services.

3.2. Principles

The Government of Namibia has committed itself to the ICPD principles on Reproductive Health as laid down in that document (including the importance of addressing adolescent and gender issues at every stage of implementation). The programme of Action for ICPD draws attention to the many areas of unmet needs in the field of reproductive and sexual health, and its chapter on reproductive rights acknowledges the urgent need to address the adolescent reproductive health issues—hence the policy will be guided by the following principles:

a) Reproductive Health is a basic Human right for every Namibian.

b) Namibians should have equal and equitable access to Reproductive Health services whenever
required.
c) **Adolescents have the right to all information on sexual and reproductive health, and access to quality adolescent friendly services.**
d) All stakeholders should have the necessary knowledge and skills to be able to offer the required quality services.
e) People should not be denied services based on prejudice or biased tendencies.
f) Community involvement in the planning, provision and monitoring of RH services is crucial and will be encouraged.

### 3.3. Objectives

The objectives stated in this policy document will cover the period up to the year 2005, the same time frame as the objectives of the National Development Plan two.

#### 3.3.1. Outcome Objectives

a) To reduce the maternal mortality rate from 271 per 100,000 live births to 268 per 100,000 live births by the year 2005.
b) To reduce the infant mortality rate from 38/1000 live births to 25/1000 live birth by the year 2005.
c) To reduce the current level of neo-natal mortality by 1/3 by the year 2015.
d) To reduce low birth weight from 12% to 8% by the year 2005.
e) To reduce pen-natal mortality from the current level by 1/3 by the year 2005.
j) To reduce total fertility rate from 4.2 to 4 by year 2005.
g) To reduce the adolescent contribution to total pregnancy from 10% to 8% by 2005.
h) To provide adolescent friendly health services in 75% of all public health facilities by 2005.
i) To reduce the prevalence of HIV/AIDS among women aged 15 to 19 from 12% to 10% and 20 to 24 years from 20% to 15% respectively by 2005.

#### 3.3.2. Output Objectives

a) To decrease the number of institutional maternal deaths from 77 to 50 per 100,000 live birth by the year 2005.
b) To increase the contraceptive prevalence rate from 38% to 50% by the year 2005.
c) To increase detection of early cancers of the reproductive system by 30% by the year 2005.
d) To increase public awareness about harmful cultural practices and gender biased roles by the year 2005.
e) To increase access to adolescent friendly health services for 80% of all adolescents by 2005.

### 3.4 Strategies

The following strategies will be used to ensure effectiveness and sustainability of RH programmes. The specific guidelines and type of services to be rendered will be developed for each level.
a) Establish and deliver effective promotive, preventive, curative and rehabilitative Reproductive Health services at all levels of Health Care System including community level;
b) Establish and promote adolescent friendly health services at all levels of health care system including community;
c) Promote inter-sectoral collaboration, consultation and partnership, in the planning, implementation, monitoring and evaluation of Reproductive Health programmes, among line Ministries, NGOs and the private sector;
d) Enhance community involvement and participation in Reproductive Health programmes to promote ownership and generate demand for effective utilization of services;
e) Build management and skills capacity for effective delivery of Reproductive Health services at various levels in the health sector, other implementing agencies, NGOs, the private sector as well as at the community level;
f) Identify research needs, determine priorities, undertake research and disseminate findings for planning and strategy development;
g) Strengthen male involvement in RH programmes;
h) Strengthen IEC and Counselling activities within the RH programme
i) Mobilize adequate resources to be able to build and expand health facilities so that Reproductive Health Services are fully inter-grated and are rendered satisfactory;
j) Ensure adequate drugs, commodities as well as supplies.

CHAPTER 4 INSTITUTIONAL FRAMEWORK FOR POLICY IMPLEMENTATION

Reproductive Health services will be provided through a hierarchy of facilities and expertise starting from the community level and increasing in complexity as the levels progress. These services will be provided through existing community structures, including NGOs and private organisations, clinics, health centres, district hospitals, regional referral hospitals and the national hospital.

4.1 Community Level

The already existing health development committees could be enlarged to accommodate additional participants especially the traditional birth attendants to deal with RH issues. Each committee could include traditional birth attendants, community health workers, traditional healers, teachers, other extension workers and community leaders. Among the activities the community will identify Reproductive Health needs, mobilize resources in support of RH activities and advocate for change in community attitudes and harmful traditional practices. It will also identify the training needs of the community own resource persons.

Efforts will be made by the committees to sensitize the traditional elected community leaders to create a favourable climate for acceptance of Reproductive Health messages and services in the communities especially in dealing with adolescent RH. The committees will assist in identifying research priorities, participate in research and disseminate findings.

The package of services will depend on the needs of the community, the capabilities of the community leaders and community own resource persons as well as the support provided by the clinic health workers. Basic services will include family planning (community based maternal care providers still to be established with the assistance of NAPPA), basic maternal care, education, counselling, condom social marketing, STIIHIV/AIDS education, advocacy for the elimination of gender-based violence and harmful traditional practices.
4.2 Clinics and health centres

- All clinics and health centres will provide RH services;
- In an integrated manner with other health services. The Rh services will include;
- Ante-natal care, normal deliveries, (not only emergency deliveries), post-natal care (including pap-smears), family planning, immunization of pregnant women against tetanus, prevention and treatment of STIs, including information, education and counselling on Reproductive Health issues. Clinics will be strengthened in terms of personnel and equipment to be able to render the required services at all times.

Health centres will perform the same functions as the clinic but will do a bit more as it has more capacity in terms of space, human as well as material resources. They are expected to provide ANC, delivery and postnatal services on a larger scale.

The schools in collaboration with the district mobile teams from the local clinics or health centres will provide basic information and education on reproductive health issues to youth in schools. The ministry of health and social services will assist in the development and review of the life skills training and family life education curricula.

All identified reproductive health problems at this level especially sexually transmitted infections will be referred to the nearest health facility for management including counselling of clients. An efficient feedback mechanism should be established between the ministries of health and social services, ministry of basic education and culture, as well tertiary institutions.

Immunisation of girls 15 years of age against tetanus will also be conducted in schools by the mobile teams.

The district teams will also carry out outreach services to their communities. The RH services to be provided should be; ante-natal care, family planning, post natal care (with the exception of speculum examination), STI/HIV/AIDS education, condom promotion, immunisation of reproductive age against tetanus, and nutrition promotion.

Outreach services to the communities will be provided from specific district hospitals in collaboration with the clinics and health centres. Apart from general screening for minor ailments and immunization, the outreach services should include; ante natal care, family planning, STI information and treatment as well as condom promotion and distribution. Where shelter is conducive postnatal care should also be provided.

Detailed tasks concern the school health and the outreach services are outlined in the specific policy documents

4.3 District Level

The MOHSS District Co-ordinating Committee (DCC) will oversee the implementation of Reproductive Health activities. Resource mobilization and allocation at the district level will be guided by the current decentralization policy.

Services will be provided using mixed strategies of facility based, outreach and school health services. The district will ensure that staffs are trained to equip them with the knowledge and skills needed to provide quality RH services. Research priorities will be determined, and actual research carried out in collaboration with the regions. Research findings will be used for re-planning and other relevant interventional strategies. Each district will determine the detailed content of its Reproductive Health package of services based on the capacity of the district and the needs of their catchments populations.

District Hospitals
The district hospital will receive and attend to referrals from the lower levels of health services. It will perform deliveries, handle high-risk antenatal care, perform caesarean sections and sterilisations as well as and management of complications arising from childbirth, and during the neo-natal period. At this level, complications arising from STIs, abortion related are also managed.

4.4 Regional Level

The management of the RH programme will be within the context of the ongoing decentralization. The MOHSS regional management teams (RMTs) have the responsibility to plan, implement and evaluate, supervise, monitor, and also provide guidance and follow-up of district level activities with support from the national level. The RH activities will be co-ordinated within the already existing multi-sectoral Regional Development Committee chaired by the Governor.

This level will have the authority to recruit, identify staff training needs and improve their knowledge and skills through regular in-service training. It is also have the responsibility to procure RH equipment and supplies including maintenance and ensure quality of care and access to services. It will expand existing buildings to guarantee privacy of clients. **This level will support and monitor the activities of the private sector and NGOs to ensure their compliance with set standards and norms of the ministry of health and social services. It will identify priorities for research, conduct research and disseminate findings.**

**Intermediate Hospitals**

The intermediate hospitals will serve as referral centres for the districts.

4.5 National Level

**National referral hospital**

This level provide specialized services such as management of cancers of the reproductive system and other complicated reproductive health problems, which cannot be handled at the intermediate hospitals.

**Family Health Division**

The Ministry of Health and Social Services is the lead Ministry for providing Reproductive Health services and will co-ordinate all the Reproductive Health activities being implemented by other line Ministries, NGOs and the private sector. The responsibilities of the Reproductive Health sub division at national level will include: providing guidance, monitoring of performance and assuring quality of services to RH programme implementation in the country. It will also develop policies, standardise and review protocols, guidelines and procedures. The sub division will facilitate and give input and technical backstopping to lower levels where necessary on RH for managers and service providers at all levels. It will also advise top management on any RH issues that would need their attention for example the need to broaden the contraceptive range, therefore new contraceptive commodities on the market may need to be reviewed.

The National level will ensure the equitable distribution of services within the framework of the decentralized structure, assist in curriculum development for basic training and provide technical support for the implementation of RH programmes at all levels. This level should be responsible for co-ordination and prioritisation of research, development of a code of ethics and standard, for conducting and disseminating research findings.
4.6. Other line Ministries and NGOs:

In all aspects that are health related and specifically on RH the following should collaborate with the MOHSS.

4.6.1 The Ministry of Basic Education Sport and Culture

Strengthen existing school health services by introducing the school health promoting initiative in all schools and integrate RH issues into the life science curriculum. Provide counselling services for children and adolescents in schools on RH. Provide safe learning environment (no sexual harassment of learners by teachers or vise versa). Collaborate with MOHSS in the training of school teachers on RH issues.

4.6.2 Ministry of Higher Education, Youth and Employment Creation

- Strengthen existing and where possible expand multi-purpose youth centres (MPYC) for counselling adolescents in and out of school.
- Promote the RH related development of youth/adolescent in and out of schools.
- Provide information on Reproductive Health issues to adolescent.
- Training of youth officers on RH issues so that they in turn train others. Make MPYC available for MOHSS officials to orientate them to youth activities. Provide condoms to adolescents.

4.6.3 Ministry of Home Affairs (Women and Child Protection Units)

Assist women, men and children who have been physically and emotionally abused (services like counselling, referral to service providers or protective homes, as appropriate should be provided).

Create awareness and provide information, education and counselling services for those who were abused.

Disseminate RH sexuality information amongst the police forces and conduct training in there-areas of work on male involvement in RH.

4.6.4 Ministry of Foreign Affairs, Information and Broadcasting

- Provide information on the implementation of Reproductive Health Policy to all sectors.
- Provide information on Reproductive Health issues to the public at large.
- Create awareness among policy and decision makers, community leaders and the general public on RH issues concerning adolescents and youth.
- NBC national broadcaster will support RH by disseminating health information on its services through the provision of weekly/monthly slots on RH programmes.

4.6.5 Ministry of Women Affairs and Child Welfare

- Co-ordinate various activities and programmes for women and advise the RH programme on gender issues.
- Promote gender and Reproductive Health sensitivity in the community.
- Create awareness at community level about the importance of Reproductive Health and
how to improve the living standard and health status in the community.

- Advocate for gender equality and reproductive rights. Advocate for the elimination of any discrimination against women.
- Strengthen collaboration between all women organisations and other relevant bodies.

4.6.6 Ministry of Defence

- Provide appropriate information on sexuality and distribute condoms.
- Create awareness in gender and RH amongst the Forces.
- Treat STIs.
- Provide training and information as appropriate, on male involvement.

4.6.7 Office of the President (National Planning Commission)

- Mobilise resources for development and co-ordinates donor assistance.
- Co-ordinate the Reproductive Health Sub-programme which is the major component of the National Population Programme.

4.6.8 University of Namibia

The Medical and Health Science faculty should introduce the policy to all students they should continue conducting training on RH in the nurses training.

The Gender and Research unit within the Multi-Disciplinary Research Centre (MRC) is to contribute to the empowerment of the social well being of the Namibian people. Conduct research, share the findings and recommend interventions.

4.6.9 Non-Governmental Organisations (NGOs) UN agencies and other partners

The UN and other agencies played a significant role in supporting the RH services since Independence. Major supports were in terms of financial, material as well as technical. A lot of capacity of nationals has been built at all levels through this support. Many of the officials also serve on numerous committees of the Ministry and specifically of RH, thereby building capacity as well as providing valuable input. Continuous support is encouraged so that RH issues are realized to the fullest through out the country.

The NGOs will be responsible for providing counselling on RH issues, peer education, training of community groups, leaders and parents and advise accordingly.

Namibia Planned Parenthood Association (NAPPA)

NAPPA is one of the newly established NGO that is greatly involved in the execution of RH services in the community. The organization has created a lot of awareness and provided information, education and counselling services on Reproductive Health. The establishment of NAPPA have complimented the Reproductive Health activities been provided by the ministry of health and social services, especially in the communities. This organization needs to be supported to ensure its continuous existence.
The Government through the Ministry of Health and Social Services will mobilise adequate financial resources needed for the implementation of the Reproductive Health Programme according to the spelt out roles.

The Ministry will also mobilise community support as well as support from private organisations and donor agencies.

5.1 Human and Institutional Resources

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

5.2 Capacity building

All the personnel involved in RH Programme 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 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.

5.3 Infrastructural Resources

The Ministry of Health and Social Services and other line ministries shall in collaboration with other non-governmental organization endeavour to strengthen, consolidate and expand the provision of infrastructure needed for efficient RH service delivery to all target groups in urban as well as remote rural areas. The reproductive health services shall be provide through a hierarchy of facilities staring at the community level and increasing in level of care through clinics, health centres district hospitals and ultimately referral hospitals. In providing RH Services, maximum efforts should be made to ensure priority at all times.

CHAPTER 6 MONITORING AND EVALUATION

In accordance with National objectives and priorities, selected indicators for monitoring, and evaluation will be developed. Periodic reviews and evaluations will be undertaken to ensure that activities are carried out as planned and programme objectives are achieved. This will be done through progress meetings, quarterly and annual report writing. Continuous collection of information on morbidity, mortality and service utilization using the HIS will be carried out (ensured).

Monitoring and evaluation tools will be developed to collect data on the quality of care, availability and use of IEC materials, contraceptive supply levels and utilisation at service delivery points (SDPs).

Supportive supervision to lower levels will also be carried out from national level.

6.1 Indicators
6.1.1  Service indicators
   a) Proportion of health facilities able to provide a full range of reproductive care including antenatal, delivery and postpartum care, family planning and detection and treatment of STIs
   b) Proportion of health facilities able to offer the full range of essential obstetric care according to WHO definitions.
   c) Proportion of health care facilities with at least one provider trained in family planning.
   d) Proportion of health care facilities staffed by a skilled and trained midwife.
   e) Proportion of health facilities with at least one health care worker trained in the detection and management of STIs.
   f) Proportion of health care facilities with at least one health care provider trained in adolescent reproductive health.
   g) Proportion of health care facilities with at least one health care provider trained in gender issues.
   h) Proportion of health facilities providing adolescent friendly health services.

6.1.2  Health status indicators:
   a) Contraceptive prevalence rate
   b) Proportion of pregnant women with negative syphilis serology
   c) Proportion of antenatal care attendees testing negative for HIV
   d) Number of maternal deaths
   e) Number of stillbirths and neo-natal deaths
   f) Annual incidence of invasive cervical cancer cases
   g) Annual incidence of breast cancer
   h) HIV prevalence rate among adolescents
   i) Proportion of new STI among adolescents
   j) Teenage pregnancy rate

6.1.3  Quality of care indicators:
   a) Proportion of deliveries by Caesarean section
   b) Facility case fatality rates for direct obstetric complications
   c) Proportion of maternal deaths in which substandard care is identified as a factor
   d) Proportion of cases of STIs treated according to established protocols

6.2 Knowledge indicators:
   a) Proportion of adolescents who know about the prevention of HIV infection
   b) Proportion of males taking part in RH activities
   c) Proportion of train personnel in RH
   d) Knowledge of communities on services available regard RH
   e) Proportion of trained CORPS
6.3 Organisational indicators:

Proportion of districts/regions with functional inter-sectoral co-ordination committees

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.

Malaria profilaxis will also be provided to all pregnant women residing in malaria endemic areas

7. KEY IMPLEMENTATION PHASES 2001-2005

Strategy 1 Establish and deliver effective promotive preventive, curative and rehabilitative RH service in all facilities and a community level.

1. Improve quality of ante-natal, delivery post natal and new-born care through:-

**Major Activities**

- Training of health service providers at all levels including TBAs.
- Procure and distribute adequate equipment & supplies for facilities and outreach points.
- Provide services on iron supplementation, malaria prophylactics and nutrition.
- Provide post abortion care.
- Provide all RH services at outreach points.
- Improve communication and referral services including transport.
- Provide effective essential obstetric and new-born care.
- Create community awareness for prevention, early detection and correct management of cancers of reproductive system.

2. Improve detection and correct case management of STI and HIV/ AIDS.

Observe at all times the universal precautions of HIV infection in all places of services provision including home based care.

**Major Activities**

- Promote/encourage safer and responsible sexual behaviours and practices.
- Advocate and mobilise for prevention of destigmatization of STI, HIV/AIDS and support to people living with HIV/AIDS.
- Provide adolescent friendly RH information and services. Sensitise and involve parents and communities in adolescent RH needs and services.

Strategy 2 Enhance community participation and involvement with special emphasise on males in RH programmes to promote ownership and generate demand for effective utilization

**Major Activities**
• Provide community based RH services.

• Provide adequate, relevant and suitable EEC materials.

• Advocate for recognition of productive rights for women and men among politicians, senior policy makers and community leaders.

• Advocate for the elimination of gender based disadvantage at households and institutional level.

Strategy 3 Build management capacity for effective delivery of RH services at various levels in the health sectors, other implementing agencies, NGOs, and the private sector as well as the community level

Major Activities

• Conduct short and long-term courses for programme managers of various organisations with the purpose of integrating RH services.

Strategy 4 Promote inter-sectoral collaboration consultation and partnership, in the planning, implementation, monitoring and evaluation of RH programmes among the line Ministries, NGO's and private Sector.

Major activities:

• Strengthen net working amongst various sectors.

• Conduct periodic supportive supervisory visits to regions/districts to assess the level of implementation as well as to provide on the spot.

• Conduct mid-term reviews of programmes.

• Conduct end-term review.

Strategy 5 Identify research needs, determine priorities, undertake research and disseminate findings for planning and strategy development

Major Activities

• Develop research agenda

• Conduct other research activities on RH issues as appropriate.

• Determine the magnitude of violence related to RH.

Strategy 6 Create public awareness on Reproductive Rights, gender sensitivity and harmful cultural practices.

• Advocate among politicians, community leaders, and policy makers for change off gender disparities, harmful cultural practices and violence.

• Establish multi-disciplinary victim-friendly support services on violence related to RH.
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