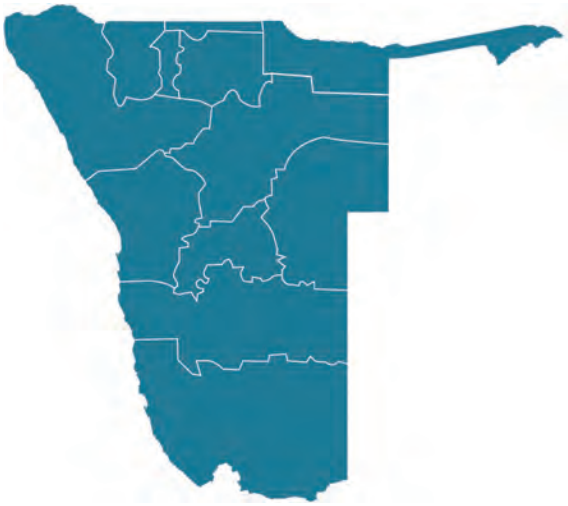
MCHIP Country Brief: Namibia



Selected Health and Demographic Data for Namibia	
Maternal mortality ratio (deaths/100,000 live births)	210
Neonatal mortality rate (deaths/1,000 live births)	18
Under five mortality (deaths/1,000 live births)*	69
Infant mortality rate (deaths/1,000 live births)	46
Modern contraceptive prevalence rate	55.1
Total fertility rate	3.6
Skilled birth attendant coverage (%)	81.4%
Antenatal care, 4+ visits (%)	70.4%
Sources: World Bank; WHO; UNPAF; UNICEF; MOHSS; Population & Housing Census 2011. *UNICEF <5 mortality ranking (1=highest mortality rate)	

Health Areas

- HIV/AIDS
- Family Planning

Program Dates	October 2012–August 2014					
Total Mission Funding	Redacted					
Geographic Coverage	No. (%) of regions	100%	No. of districts	35	No. of facilities	411
	HEP: 3 regions; 7 districts; 49 health facilities HIV Integration: 1 region; 2 districts; 9 facilities TP: 1 region; 3 districts; 5 facilities HIS: 14 regions; 35 districts; 411 health facilities VMMC: 2 regions; 2 districts; 48 health facilities					
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INTRODUCTION

The Government of the Republic of Namibia (GRN), with substantial foreign assistance and strong political commitment, was able to achieve a 35% decline in AIDS deaths and a 65% drop in HIV incidence (WHO 2012). The U.S. Agency for International Development (USAID) began providing assistance to Namibia at independence in 1990, and in 2003 increased support through the President's Emergency Plan for AIDS Relief (PEPFAR) for AIDS and TB prevention, care and treatment, and education (GHI 2012). Despite successes, Namibia still lacks sufficient human resources for health; rural communities are underserved; and vertical service delivery has resulted in a fragmented health information system.

Due in part to declines in HIV incidence and AIDS deaths, PEPFAR recently reclassified Namibia as a PEPFAR "transitioning country," resulting in a reduction in the prevention, care and treatment budget. The GRN is thus faced with developing and managing a reform agenda to improve the coordination of health service delivery, especially in rural areas, and in integrating HIV/AIDS services into existing primary health care services (PHC)—including providing staff salaries and capacity building.

As part of this agenda, the GRN's Ministry of Health and Social Services (MOHSS) established a cadre of Heath Extension Workers (HEWs) to strengthen access to health care. USAID provided technical assistance to the MOHSS, focusing on strengthening health and strategic information systems, and strategic coordination of partners and resources in the health sector (USAID 2012). The key partners supporting the MOHSS include: USAID, UNICEF, the World Health Organization (WHO), UNAIDS, the Namibia Planned Parenthood Association (NAPPA) and nongovernmental organizations (NGOs) such as LifeLine/ChildLine, C-Change, and IntraHealth International.

In September 2012, USAID/Namibia asked MCHIP to provide technical assistance to strengthen the quality of and access to health services. From October 2012–July 2014, MCHIP provided support to the GRN related to the HEW cadre; integration of HIV into PHC systems; the development of a Health Information System (HIS); a teen pregnancy prevention program in Kavango Region; and, a voluntary medical male circumcision (VMMC) program. Activities were implemented in Kunene, Osamuti, Ohangwena, Hardap, and Khomas regions.

KEY ACHIEVEMENTS

Institutionalization of the Health Extension Program (HEP)

MCHIP/Namibia and partners supported the MOHSS to develop and finalize the HEP strategy and SOP, both of which are critical to implementation and scale-up of HEP and were approved by the National Steering Committee. MCHIP also provided technical support to strengthen the Regional Health Team for Kunene, Ohangwena, and Omusati, which will in turn support district teams with HEP implementation. MCHIP/Namibia supported the MOHSS to identify and refine a cost-effective HEW training methodology aimed at institutionalizing the Health Extension Worker cadre into the Namibia health system. MCHIP/Namibia also offered technical support in the development of a HEP supportive supervision package, which is used by the Regional and District Health Supervisory Teams to support HEWs in implementing and improving the quality of HEP services. Significantly, the HEP child health training module includes screening and treatment of malaria and pneumonia, and treatment of diarrheal disease with zinc.

Lessons Learned Include:

- Continuous engagement with health facilities, government ministries, and other partners is a necessary foundation to scale up the HEP.
- Continuous supportive supervision must be a part of the HEP scale-up plan.
- High-quality training for HEWs, including refresher training, is necessary to ensure that HEWs have the skills and knowledge to perform, especially when new concepts, such as iCCM, are introduced.
- Introducing and implementing new interventions in selected districts prior to scaling up is important because it provides an opportunity to evaluate what works before scale-up to the entire HEP.

HIV/AIDS Integration into PHC Services

MCHIP supported the Hardap Regional Health Team to identify HIV integration gaps in service delivery, and use the information to develop an action plan for strengthening integrated, essential health care service at the primary care level. In collaboration with the MOHSS, the Hardap Regional Health Team led a facility gap analysis. The methodology and tools used for the assessment were based upon the current evidence related to patient-centered primary care and integration of vertical services. MCHIP maintained an element of standardization with the assessment by expanding upon the previously used UNFPA assessment tools, broadening the scope of integration to HIV and PHC services from HIV and sexual and reproductive health services.

MCHIP developed a technical report to document results and findings from the facility assessment, action planning with the regional managers and health facility staff, and results dissemination to inform the development of a "framework" for HIV integration with primary health services.

Lessons Learned Include:

- In order to assure full integration within facilities, it was important to clearly define the minimum package of care and offer comprehensive services regularly at primary care facilities.

Teen Pregnancy Prevention in Kavango Region

Addressing the high rates of teenage pregnancy in Kavango required a multi-pronged and sustainable approach. Recognizing the complexity of the problem, MCHIP supported "activation" of a regional task force, the KTPTF, drawn from government ministries, community leaders, and development partners, to leverage resources through a sector-wide approach. The key components of the program included planning for an intervention to prevent teen pregnancy, behavior change communication, and training of health service providers in youth-friendly sexual and reproductive health services. MCHIP also took into consideration the need to integrate the teen pregnancy prevention approach into other HIV prevention programs, particularly focusing on HIV infection among sexually active teens and school drop-out when pregnancy occurs. During the same period, MCHIP guided the KTPTF to develop and incorporate clinical components into the teen pregnancy prevention annual work plans.

Lessons Learned Include:

- Strengthen adolescent-friendly services. Parent and community sensitization is required as a means of strengthening services in this arena.

Health Information Systems

MCHIP supported the development of a five-year health information system strategy (2013–2017), which was approved by USAID in February 2014 and submitted to the MOHSS (Permanent Secretary's Office) for review. MCHIP also supported development of the Namibia

essential hospital and primary health care indicators, and provided capacity building for government officers to strengthen competencies in data analysis, use, and dissemination.

Lessons Learned Include:

- Link programs with essential indicators to monitor the effects of implementation over time.
- Health information systems should be integrated with all levels of service provision.

Voluntary Male Medical Circumcision

MCHIP supported NawaLife Trust to manage, develop, and disseminate information on VMMC. A formative assessment was conducted to explore attitudes, beliefs, and practices surrounding VMMC, which resulted in a strategy for future VMMC demand creation, advocacy, and service delivery activities.

The completion of the formative assessment had a positive impact on achieving immediate results. These results included completing training materials for community mobilization; identifying and designing VMMC activities among partners; reviewing and tailoring the MOHSS/Nawalife IEC materials; establishing regional trainers for VMMC community mobilization; training community mobilizers using the developed training manuals; and mass printing IEC materials for use in districts scaling up VMMC.

Lessons Learned Include:

- Demand creation is a key component to increasing the number of VMMCs. The demand and supply sides must be interrelated for any future success in this program area.

WAY FORWARD

MCHIP technical support contributed significantly to each of the five technical components described above. However, future efforts will need to focus on greater coordination between the MOHSS and other government ministries, regional agencies, and other partners including USAID and other development partners. As Namibia is a highly consultative environment, this collaboration is and must remain a key priority in order for the consortium of partners to attain the desired outcomes.

Expanding coverage can be done using integrated approaches. MCHIP experienced that integration approaches must be sector-wide to expand service coverage. The integration approach can focus on the health information system, HIV and primary health care services, and establishment of a strong link between the formal health system and the community.