



# Republic of Namibia

## DRAFT of the Consolidated National Reproductive and Child Health Policy

April 2008

## **FOREWORD**

As Namibia completes 18 years of Independence, we have much to celebrate as a nation.

The Ministry of Health and Social Services, mandated to provide clear guidance and services to improve the health status of the nation, has achieved many successes in the past years. However, as reported in recent studies, the country still faces the challenge of high maternal and infant mortality rates coupled with high HIV prevalence, adolescent pregnancy and inadequate male involvement in reproductive health. This shows that the reproductive health status of Namibians still needs urgent attention.

I am pleased to present to the nation this Consolidated National Reproductive and Child Health Policy, 2008. This policy provides clear direction to implementing agencies to achieve the reproductive health objectives more effectively. It aims to have all sectors on board in the process to attain improved reproductive health status for all Namibians. It is imperative that reproductive health is mainstreamed like gender, population, environment, poverty and HIV and AIDS issues, with which it is closely associated, either as a predisposing, causative or aggravating factor.

Reproductive health is critical to Namibia's achievement of the Millennium Development Goals in the areas of health, environment and poverty reduction. The strategic vision to promote reproductive health is provided in the third National Development Plan. This Consolidated National Reproductive and Child Health Policy address these key development challenges that our nation is already facing. Its successful implementation would reduce poverty and rapid population growth, and also reduce their consequences of rural-urban migration, spread of informal settlements, youth unemployment and crime. We must promote reproductive health with commitment and strong leadership from the Government, civil society and private sector and indeed all Namibians.

I therefore, urge all stakeholders, Government ministries, development partners NGOs, faith-based organisations, private businesses and the entire nation to take ownership of this policy, and to ensure that we implement it vigorously in all spheres of our society.

H.E. Hifikepunye Pohamba,  
PRESIDENT OF THE REPUBLIC OF NAMIBIA  
2008

## **PREFACE**

The Ministry of Health and Social Services has been making continuous effort towards improving the reproductive health status of the people of Namibia. Keeping in line with its commitment, the Ministry has reviewed and updated the existing policies addressing reproductive health and family planning issues to accommodate contemporary needs.

The first National Policy of Reproductive Health was launched in 2001. This policy was launched when the country had replaced the Maternal and Child Health/Family Health Programme with the Reproductive Health Programme. Earlier, in 1995, the country's Family Planning Policy was launched. Both these policies have addressed reproductive health issues and have made modest achievements.

The areas of overlap and existing gaps in the two policies - the National Policy of Reproductive Health and the Family Planning Policy - have been identified and this Consolidated National Reproductive and Child Health Policy is being presented as a consolidated version.

The Ministry of Health and Social Services, with the full support of all stakeholders, is committed to successfully implement this policy.

I acknowledge the work of the Reproductive Health Taskforce and its various sub-committees, the technical assistance of UNICEF, WHO and USAID, and both the technical and financial assistance of UNFPA. I acknowledge the work of the staff members of the Ministry of Health and Social Services in steering the process and in giving policy directions.

This policy has been produced through a series of consultative process amongst stakeholders. Individuals, institutions and organisations that made inputs at various stages of the consultative process included people living with HIV and AIDS, the Namibian Business Coalition for AIDS, the National Youth Council, line ministries, regional health teams, the University of Namibia and NGOs. I hereby express the profound appreciation of the Ministry to all these stakeholders.

This policy was debated and accepted by the National Advisory Committee on Population and Sustainable Development and the Cabinet. I am confident that together we will achieve our aim of providing a strong policy framework for an invigorated national effort to promote reproductive health and particularly, reduce maternal mortality.

It is our responsibility to ensure that the vision embodied in this policy becomes a reality.

Richard Nchabi Kamwi, MP  
Minister for Health and Social Services  
Republic of Namibia

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## **ABBREVIATIONS**

AFHS	Adolescent Friendly Health Services
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
ARH	Adolescent Reproductive Health
CACOC	Constituency AIDS Coordinating Committee
CBS	Central Bureau of Statistics
CPR	Contraceptive Prevalence Rate
COCs	Combined Oral Contraceptives
CSW	Commercial Sex Workers
DACOC	District AIDS Coordinating Committee
DWA	Department of Women Affairs
EC	Emergency Contraception
EPI	Expanded Programme of Immunization
EmOC	Emergency Obstetric Care
FDA	Food and Drug Administration
FGM	Female Genital Mutilation
FP	Family Planning
GBV	Gender Based Violence
GUS	Genital Ulcer Syndrome
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IDU	Injecting Drug Users
IEC	Information, Education and Communication
IMNCI	Integrated Management of Newborn and Childhood Illness
IUCD	Intra-Uterine Contraceptive Devices
LAM	Lactation Amenorrhea Method
MDG	Millennium Development Goals
MOAWF	Ministry of Agriculture, Water and Forestry
MOD	Ministry of Defence
MOE	Ministry of Education
MIB	Ministry of Information and Broadcasting
MLGHRD	Ministry of Regional and Local Government, Housing and Rural Development
MOF	Ministry of Finance
MOGECW	Ministry of Gender, Equality and Child Welfare
MOHSS	Ministry of Health and Social Services
MOHAI	Ministry of Home Affairs and Immigration
MOSS	Ministry of Safety and Security
MOWT	Ministry of Works, Transport and Communication
MSM	Men Having Sex with Men
MYNSSC	Ministry of Youth, National Service, Sports and Culture
NABCOA	Namibia Business Coalition on AIDS
NANGOF	Namibian Association of Non-Governmental Associations

NAPPA	Namibia Planned Parenthood Association
NANASO	Namibia Network of AIDS Service Organisation
NDHS	Namibian Demographic Health Survey
NFP	Natural Family Planning
NPCS	National Planning Commission Secretariat
NASOMA	National Social Marketing Association
ORS	Oral Rehydration Solution
PEP	Post Exposure Prophylaxis
PICs	Progestin-only Injectables Contraceptive
PMTCT	Prevention of Mother to Child Transmission
POPs	Progestin-Only Pills
RACOC	Regional AIDS Coordinating Committee
RARCO Committee	Regional AIDS and Reproductive Health Coordinating Committee
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
UDS	Urethral Discharge Syndrome
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
VDS	Vaginal Discharge Syndrome
WHO	World Health Organization

## **CHAPTER 1: INTRODUCTION AND BACKGROUND**

The Government of the Republic of Namibia is committed to improve the standard of living and quality of life of its people. The Namibian Constitution guarantees the fundamental human rights and freedoms (The Constitution of the Republic of Namibia, Chapter 3, page 5) including the rights to life, privacy, having a family and education. Its Principles of State Policy urge the State to provide access to public facilities and services, and to improve public health, implicit in which is the right to adequate access to qualitative reproductive health services. This is reinforced by the country being signatory to various international agreements.

The International Conference on Population and Development (ICPD) held in Cairo in 1994 recognised reproductive and sexual health as a human right. The Conference agreed that “Reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.” (United Nations 1995, paragraph 7.3). The same document urges governments and communities to promote the responsible exercise of these rights for all people through initiation of policies and programmes in the area of reproductive health, including family planning.

During the Fourth World Conference on Women in Beijing, in 1995, the governments also agreed that “The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences.” (United Nations 1996, paragraph 96).

The United Nations Millennium Summit in New York in 2000, resulted in all countries agreeing that it is imperative to reduce poverty and inequities. The need to improve maternal and newborn health was identified as one of the key Millennium Development Goals (MDGs), with a target of reducing levels of maternal mortality by 75% in 2015. The causes of maternal deaths range from issues of rights, access and inadequate care. Worldwide, women die from complications during

pregnancy, labour and delivery and after delivery. Achieving the MDG of improving maternal health and reducing maternal mortality requires actions from international and national bodies in addressing the above root causes.

A number of policies are already in place in Namibia to address the country's health, population and development programmes. These policies demonstrate the Government's commitment to attaining Namibia's Vision 2030, which takes into consideration the MDGs and the ICPD Programme of Action.

The Government of the Republic of Namibia, as a signatory to the ICPD, recognised Family Planning as a human rights issue and launched the country's Family Planning Policy in 1995. In 1997, the Reproductive Health Programme of Namibia, that replaced the Maternal and Child Health/Family Health programme, came into being. This transformation led to the birth of the National Reproductive Health Policy in June 2001.

The First and Second National Development Plans (NDP1 and NDP2), embody many of the Government's policies and programmes aimed at achieving integrated population and development objectives over the plan cycle, 1995-2000 and 2001-2006 respectively. These documents have specific chapters devoted to developmental issues, particularly to improving quality of life of the people and highlights population issues in development as well as the process to be followed in designing various policies such as population policy. The National Population Policy for Sustainable Human Development was launched in 1997. It is a comprehensive document aimed at contributing to the improvement of the standard of living and quality of life of the people of Namibia. It aimed to do this by reducing the growth rate of population, through the promotion of strategies that will lead to improvement of health, increasing adoption of family planning strategies, raising the status of women and development and utilisation of human resources.

Some other complimenting policies are also in place. These include the National Youth Policy, the National HIV/AIDS Policy, the National Gender Policy, the STI Guideline, the PMTCT Guideline, the Married Persons Equality Act and the Combating of Rape Act.

These policies and guidelines have contributed to modest achievements in Namibia. Nevertheless, several challenges remain. The effective implementation and enforcement of some of these policies, continuing violence against women and the critical need to ensure the incorporation of a gender perspective in all policies and programmes pertaining to

health, particularly reproductive health and HIV and AIDS, are to name a few.

Further, it is to be noted that poor reproductive health status has socio-economic consequences - rapid population growth, rural-urban migration of youths accompanied by proliferation of informal settlements around cities, high youth unemployment and crime. These consequences are beginning to escalate in Namibia. According to the Population and Housing Census 2001 (NPC 2003), Namibia's population was 1,830,330 of which 33% was urban while 67% was rural. Those less than 15 years are 42% of the population. The average number of children per woman is 4.1. The literacy rate of those older than 15 years is 81%. Those unemployed make up 31% of the population. The total poor households are 32% (NPCS 2007a). The NDP 3 target is to reduce poor households to 24% by 2013.

The MDGs, of reducing maternal mortality, infant mortality and protection of the environment, all depend on an effective reproductive health policy. Such a policy is expected to be an important intervention that can break the vicious cycle of poverty. This cycle consists of poor women in the 32% poor households, having children very early in life, and their daughters being consigned to the same fate.

This Consolidated National Reproductive and Child Health Policy aims to mitigate these challenges. This policy is a comprehensive document that has been developed by reviewing and updating the country's existing policies on reproductive health and family planning issues to accommodate contemporary social demands and scientific developments. It aims to address the gaps identified in the service delivery on reproductive health.

The Consolidated National Reproductive and Child Health Policy is the main implementation mechanism of the Population Policy.

Thus, in line with the Maputo Plan of Action's overarching goal, the Ministry of Health and Social Services, Republic of Namibia, in collaboration with the civil society, the private sector and developmental partners have joined forces and redoubled efforts, to effectively reach universal access to reproductive health by 2015.

The Consolidated National Reproductive and Child Health Policy will provide guidance to reproductive health services delivery including family planning in the country. Beyond this, the policy will promote access to reproductive health for every Namibian who needs and wants such

services. It will ensure that every client has good quality of care, including the choice.

Gender is an important focus in this Consolidated National Reproductive and Child Health Policy. There is a major emphasis on increasing male involvement in reproductive health. The policy describes how to encourage men and boys to look after their reproductive health while respecting and protecting the reproductive rights and health of women. This will be in terms of abstaining from alcoholism, drug abuse, rape, checking for prostrate cancers etc. Protection of reproductive health of adolescents, both male and female is stressed. Every effort has to be made to protect male adolescents who are sometimes abused by older men in families or in police holding cells and prisons.

Sensitisation of police and security personnel on gender issues for general security as well as to prevent sexual abuse of both men and women in emergency situations is a significant feature of this policy. Natural disasters like the floods in northern Namibia are a reminder to the importance of protection of reproductive health in emergency situations. Thus, the policy specifies the necessity of making available medical personnel, safe delivery kits, contraceptives, suitably trained security personnel and counselling facilities in all emergency shelters and refugee camps.

This policy will be implemented through public-private partnership, with services to be provided by both public and private institutions and facilities. The Government is committed to enabling and strengthening non-governmental organizations (NGOs), private and mission sector health care providers.

## **CHAPTER 2: SITUATION ANALYSIS**

### **2.1. REPRODUCTIVE HEALTH (RH) COMPONENTS**

#### **Definition of RH**

The World Health Organization (WHO) defines Reproductive Health as “state of complete physical, mental and social well-being 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 capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition is 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.

Outlined below is the situation analysis of the various reproductive health components and the programme management, both within and outside the health sector in Namibia.

#### **2.1.1. Family Planning**

It is important to put the Family Planning component in the context of a particular country. In Namibia, the importance of family planning to the improvement of quality of life has been recognised since Independence. Namibia has been meeting the demand for family planning by making the services available, accessible, acceptable and affordable to all women and men of reproductive age.

#### ***Family planning methods in Namibia***

Family planning is defined as voluntary action by individuals to prevent or aid conception, and implies the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility that aim to contribute to the health and well-being of women and children and their families, through the reduction of maternal deaths and illnesses resulting from unwanted and high risk pregnancies .

Family planning methods are broadly divided into Traditional (Natural) and Modern (Artificial) methods.

#### Natural/Traditional methods

- Natural Family Planning
- Withdrawal (Coitus Interruptus)
- Lactation Amenorrhea Method(LAM)

#### Modern Methods

- Oral contraceptives - *Mini pills / Progestin-Only Pills (POPs), Combined Oral Contraceptives (COCs) -Emergency contraception (EC)*
- Injectable contraceptives
- Implants
- Contraceptive patch
- Barrier methods - *Male condoms, Female condoms, Diaphragm, Spermicides*
- Intra Uterine Contraceptive Devices (IUCD)
- Voluntary Surgical contraceptives - *Female and Male sterilization.*

The Namibian Demographic Health Survey (NDHS) conducted for the past decade and half revealed a positive trend in awareness of at least one modern method of family planning among the age of 15-49 years. This awareness is reported to be 89% in 1992, 97% in 2000 and 98% in 2006. Contraceptive practice has also increased steadily in Namibia during the 1990's and 2000's. In 1992 the contraceptive prevalence rate (CPR) of all women was at 23%, in 2000 it had reached 38% for any method and in 2006 it is reported to be at 46% (MOHSS 2006a). The NDHS, 2006 preliminary report indicates that contraceptive usage is high in urban areas at 65% than rural areas at 45%. There is an increased awareness of family planning methods among all women but usage is still low.

Among married women, the use of any method has increased from 29% in 1992 to 44% in 2000 and 55% in 2006, while the use of modern methods in the same group increased from 26% to 43% and 53% respectively. The increase in the rate of contraceptive prevalence can be attributed to the provision of family planning services in all Government health facilities free of charge. It is estimated that currently about 60% of all health facilities provide comprehensive reproductive health services. Widespread use of modern methods is considered as the principal cause of fertility decline and reductions in its annual population growth rate in Namibia. The total fertility in Namibia or average number of births per woman declined from 5.4 in 1992 to 4.2 in 2000 and 3.6 in 2006. From the mid-1970s to 2000, the total fertility rate (TFR), dropped from 6.5 to 3.7, a decrease of 44% in nearly 30 years. However, this masks the

significant regional and urban-rural variation. According to NDHS 2006, TFR in urban areas is 2.8 and rural is 4.3. Omaheke region has the highest TFR at 5.1, while Khomas is lowest at 2.6.

In 1992, according to the NDHS, total unmet needs (for limiting and for spacing)<sup>1</sup> for family planning was 12% in all women and 24% in married women. In 2000, the total unmet needs for married women remained unchanged at 25%. But the trend had changed in the nature of the unmet needs among married women - with nearly 60% of unmet need falling for limiting purpose in 2000 in comparison with nearly 75% unmet need for spacing in 1992. This suggests that in order to increase contraceptive prevalence and ensure equity of services to people of all socio-economic levels in all areas of the country, the family planning programme has to reach all points by targeting the hard-to-reach non-users.

### **2.1.2 Maternal and Newborn Morbidity and Mortality**

The Maternal and Newborn Morbidity and Mortality components comprise of pre-conception care, antenatal care, intra-partum care, prevention of mother to child transmission of HIV/AIDS (PMTCT), emergency obstetric care, post abortion care, newborn care and post-natal care.

In Namibia, in order to deal with maternal complications and mortality from pregnancy, the Family Health Division of the MOHSS has adopted an approach of safe motherhood and newborn care, including PMTCT, that coordinates national efforts to ensure maternal and newborn health; monitor maternal and child health trends; engage in social mobilisation activities; and works with partners to improve the lives of the mother, children and families.

Complications of pregnancy and childbirth are the leading causes of death and disability for childbearing women in many parts of the world. The need assessment for emergency obstetric care (EmOC) conducted in Namibia in 2005 classifies the main causes of maternal mortality as direct and indirect. The common direct causes of maternal death in Namibia are severe bleeding, infection, eclampsia, obstructive labour and unsafe abortion. The indirect causes are conditions aggravated by HIV

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<sup>1</sup> Unmet need for *limiting* refers to pregnant women whose pregnancy was unwanted, amenorrhoeic women whose last child was unwanted and women who are neither pregnant nor amenorrhoeic and who are not using any method of family planning and who want no more children.

Unmet need for *spacing* includes pregnant women whose pregnancy was mistimed, amenorrhoeic women whose last birth was mistimed and women who are neither pregnant nor amenorrhoeic and who are not using any method of family planning and say they want to wait two or more years for their next birth.

and AIDS, anaemia, heart diseases, malaria, diabetes and violence directed at pregnant women.

Africa has the highest maternal mortality ratio in the world recording up to 1,000 per 100,000 live births. There has been a substantial increase in maternal mortality ratio in Namibia. In 2000, maternal mortality ratio was reported as 271 deaths per 100,000 and just six years later, the preliminary data of the NDHS 2006 said it went up to 449 per 100,000. This indicates the urgent need for concentrated efforts to bring it down (MOHSS, 2006a). The Health Information System data 2005/2006 reported 40 cases of facility maternal mortality. The NDHS, 2000 reported that about three quarters (75%) of births in Namibia are delivered at a health facility while 24% at home. The preliminary data of NDHS 2006 reveals that the percentage delivered in a health facility has slightly increased to 80%. This means that, by choice or necessity, 20% of women in Namibia give birth cared for only by a family member, a traditional birth attendant, or no one at all (MOHSS, 2006a).

Skilled attendance at delivery and immediately afterwards is critical to preventing maternal deaths and complications. In Namibia, 93% of births in urban areas are assisted by skilled birth attendance compared to 66% of births in rural areas. The public health sector in Namibia, as other African countries, has been affected by an exodus of medical personnel to overseas destinations and to the private sector in recent years. In Namibia nearly 60% of skilled personnel positions in public health facilities for the functioning of EmOC such as obstetrician, medical officers, anaesthetists and registered midwives were vacant (MOHSS, 2006b).

The Common Country Assessment Report (UN 2004) indicates that families and their sources of support lack the knowledge, money and transport to ensure that those in need receive proper healthcare. Over 40% of Namibians live further than one hour from a health facility. The MOHSS also lacks adequate resources to meet the requirement of basic emergency obstetric care<sup>2</sup> as it is only available in district and regional hospitals, too far for many pregnant women to reach in time (UN 2004). The need assessment on EmOC underscores the need for upgrading selected health facilities in each region to function as basic EmOC as the lack of basic EmOC means lack of access of EmOC services to the rural population and long distances of referrals resulting in delayed care (MOHSS, 2006b). EMoC has been piloted in some districts with

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<sup>2</sup> Basic essential obstetric care include parenteral antibiotics, oxytocics and sedatives for eclampsia, and the manual removal of placenta and retained products, the recommended minimum level as per UN guidelines is at minimum 4 BEmoC facilities per 500.000 people.

promising results, and the development of the Emergency Obstetric Care Curriculum for training doctors, midwives and nurses is ongoing.

Namibia is one of the countries with the highest HIV prevalence rates in the world, with 19% of pregnant women between the ages 15-49 years being infected, and HIV and AIDS constitute the most serious reproductive health challenge. With such a rate of HIV, reducing child mortality rate remains a challenge.

The MOHSS estimated in 2002 that every year 15,400 HIV-positive mothers give birth, leading to HIV infection of about 6,180 infants pre-partum, during labour or through breastfeeding. The underlying causes of mother-to-child transmissions are the mother's ignorance of her HIV status associated with stigma and culture of shame and fear, the cost implications of breast milk substitutes and, inadequate provision and uptake of PMTCT prophylaxis such as Nevirapine (MOHSS, 2004). To address this state of affairs, the Ministry introduced the PMTCT of HIV programme in the Katutura and Oshakati State hospitals in March 2002. Since then the services have been rolled out to all 34 district hospitals. In 2006, the PMTCT services were rolled out to 165 health centres and clinics (MOHSS, June 2006).

The NDHS of 2000, comparing with NDHS of 1992, reports that for the five years preceding each survey, under five mortality has decreased from 83 to 62 per 1,000 live births. The NDHS 2006 preliminary report however, reveals an increased number of under five mortality at 70 per 1000 live births for the five years preceding the survey. It was estimated that in 2001 for every 1,000 live births 52 children died within the first year and 71 die before age five in Namibia (UN, 2004). Infant mortality rate is reported to be high in rural areas at 52/1000 as compared to urban areas - 43/1000. Birth intervals of less than two years pose very high risk of neonatal survival (MOHSS, 2006 a). The leading causes of death among infants for the period 2002-2005 were pneumonia, gastroenteritis, AIDS, premature birth and slow foetal growth. The HIV prevalence among HIV exposed infants is reported to be at 15%. The draft National Development Plan III sets a target of reducing the under five mortality to 45 per 1000 live birth and increase the implementation of the integrated management of newborn and childhood illness (IMNCI) services from 35% to 60% health districts (NPC, 2007).

### **2. 1.3: Sexually Transmitted Infection Including HIV AND AIDS**

Namibia is reported to have high incidence of sexually transmitted infections (STI) that ranks 8th among all hospital consultations in 1998. The syndromic management was implemented as an intervention for STI

control in 1995, but due to inadequate human resources and capacity, its implementation was not as smooth as anticipated (MOHSS, 2005). Although the incidence of STDs has stabilized, recent data indicated that about 70,000 STI cases were reported in Namibia during the year 2006. The National STI Programme Annual Report shows that vaginal discharge syndrome (VDS) rates the highest at approximately 27,000 cases in 2006 although this has decreased significantly from 35,000 cases in 2000. VDS is followed by genital ulcer syndrome (GUS) and urethral discharge syndrome (UDS) at 15,000 cases in 2006. All pregnant women are offered routinely syphilis testing in Namibia. Analysis of syphilis data and correlation done between the prevalence of syphilis and HIV during the sentinel survey of 2006 reveal high rates of syphilis up to 12% in some sites, with the results ranging between 0.5- 12%, however there was no association observed with HIV prevalence (MOHSS, 2007).

The HIV prevalence has increased noticeably for the past 15 years. In 1992 the HIV prevalence was at 4.2%, rose to 15% in 1996 and within six years it peaked to 22% in 2002. However, a slight decline is observed between 2002 and 2004. The Sentinel Survey of 2004 reported HIV prevalence of 19%. The figure went up marginally to 19.9% in 2006 (MOHSS, 2006). One important strategy in the fight against HIV and AIDS is to encourage people to get tested for HIV. The preliminary data of the NDHS 2006 reveals that the percentage of women who tested for HIV has increased to 50% from 23% in 2000. But testing in male population remains relatively low, 24% and 32% respectively. This shows that more than half of the population have not been tested and efforts are required to address both institutional and community needs that are crucial to increased testing. Currently, several Voluntary Counselling and Testing Centres (VCT) are within reach and family planning methods like condoms, that provide both contraception and STI protection, are actively promoted in clinics. The MTPIII set targets to reach the general population with social mobilization and awareness intervention as well as increased access to VCT for the prevention of STI including HIV.

Apart from MOHSS, other sectors such as the Ministry of Defence have embarked on STI and HIV prevention efforts. The Ministry of Defence focuses on the three primary methods of STI and HIV prevention – abstinence, behaviour change and condom use (ABC) in edutainment sessions on bases, and in workshops and utilizing the popular informative video “*Remember Eliphaz*”. Other non-governmental organizations such as, Social Marketing Association (SMA), has also extended its behaviour change and HIV prevention activities to the police and other uniformed services, including a special focus on female police officers.

#### **2.1.4: Gender Based Violence and Harmful Traditional Practices**

Harmful traditional practices such as early marriages, female genital mutilation, and dry sex have been very common in Africa. Data to this effect are scarce in Namibia but several media reports and public outcry hint that, dry sex, female genital cutting, widow inheritance, initiation ceremonies for women and treatment for infertility that involve sex and unorthodox treatment often administered by traditional healers and 'pastors' are practiced in Namibia.

The increase of gender based violence in Namibia has serious and far reaching consequences in the country. Gender-based violence is an obstacle to the achievement of the objectives of equality, development and peace. It originates from cultural, traditional and religious attitudes and practices that perpetuate the lower status accorded to women in the family, workplace, the community and society at large. Cultural definitions of manhood and masculinity contribute to gender based violence for women. Most violence against women is carried out by their husbands or partners, although organized violence against women as a weapon of warfare is of growing concern. Rape is a common type of gender based violence in Namibia.

The gender based violence database, launched in 2006, revealed that among the cases reported; sex refusal has been one of the reasons that have resulted in physical and sexual abuse. The WHO Multi-country Study on Women's Health and Domestic Violence Against Women (2005), revealed the state of physical violence by a partner during pregnancy. Among those interviewed, referred to as ever-pregnant women, 6% were beaten during at least one pregnancy. Of these women, 49% had been punched or kicked in the abdomen. For 27% of the women beaten during pregnancy, the physical violence started when the woman was pregnant. The remaining 73% were also beaten before pregnancy (WHO, 2005).

#### **2.1.5: Adolescent and Youth Reproductive Health**

The Namibian Adolescent Friendly Health Services (AFHS) standard defines AFHS as services rendered to young people in friendly and conducive environment with the aim to enhance the total wellbeing of the adolescents.

Vision 2030 sets a target of reaching 90% of youth with correct sexual and reproductive health information by 2005. The Namibian MOHSS with the support of UNFPA and UNICEF implemented AFHS initiatives in six pilots districts from 2003-2005 with the aim of providing adolescents

age 10-19 years with appropriate sexual and reproductive health information and services. The Ministry of Youth, National Service, Sport and Culture is also implementing youth friendly health initiatives at multi purpose youth resource centres in different regions.

The report on Joint Rapid Assessment on AFHS in selected districts in Namibia highlights a number of cross-cutting issues that may contribute generally to adolescent health. The assessment highlights involvement of youth on matters related to AFHS through established youth structures, services providers' attitudes, waiting period before seeing health workers, privacy and confidentiality as major factors that facilitate or impede Adolescents' and Youth Health (NEDICO, 2005).

The NDHS of 2000 reported teenage pregnancy to be at 18% and NDHS preliminary data of 2006 indicates that 15% of women age 15-19 have begun childbearing process. Teenage pregnancy and child-bearing have serious consequences and contribute to many of the nation's enduring social problems. Apart from curiosity, teenage pregnancy is often associated to lack of knowledge about sexuality, contraception, how pregnancy occurs, and STIs. Youth and adolescents in interactions with parents, teachers and health workers may not admit to having had sex and thus the possibility of pregnancy. While the Joint Rapid Assessment indicates that 92% of exit and 89% of household interviews felt they were treated well by the health workers, national efforts, aimed at creating a supportive environment in which youth and adolescents can express their needs, fears and embarrassment without being judged, are nonetheless essential (NEDICO, 2005).

The report of the 2006 National Sentinel Survey reveals an HIV prevalence of 10% among the age group 15-19 years, 16% of age 12-24 and 26% aged 25-29 were reported to be HIV positive (MOHSS 2007).

A large number of primary and secondary schools in Namibia have life-skills programmes through the Ministry of Education which provide young people with facts about sexual and reproduction health, pregnancy, STIs and HIV and AIDS, and help to improve communication skills. These efforts are made possible by a range of development partners and NGOs through the support of extra curricular programmes, such as My Future is My Choice, Let's Talk, Windows of Hope, Stepping Stones, Feeling Yes Feeling No and True Love Waits.

### **2.1.6: Cancers of the Reproductive Systems**

The Reproductive Health Annual Report of 2006 reveals 61 cases of cancer of the cervix followed by 46 cases of cancer of the breast and 27 cases of cancer of prostate. STI is known to facilitate the transmission of cancer. Some public health facilities in Namibia screen for cervical

cancer and there is only one public facility in Namibia where advanced cancer screening is available. The number of health personnel trained in cancer screening is limited in Namibia.

The Cancer Association of Namibia has been involved in awareness creation of cancer and provision of screening services in Namibia. For the year 2005, breast cancer had the highest incidence with 179 cases reported, followed by 154 cases of prostate cancer, and 129 cases of cervical cancer. In 2007 the Cancer Association of Namibia carried out 7087 pap smear examinations country wide of which 6890 were negative. About 7% had various infections.

### **2.1.7: Malaria among Pregnant Women, Mothers, Children and Families**

The National Malaria Control Programme was launched in 1991, which was later renamed the National Vector-Borne Diseases Control Programme in order to include other vector borne diseases.

Malaria has been reported to be the leading cause of illness and death among children younger than five years and the third leading cause among adults particularly in the endemic area. It has also been reported to be the leading cause of health facility visits and consistently the top cause of hospital admissions of children under 13 years, accounting for 25%, 28% and 36% in 1999, 2000 and 2001 respectively. In 2002, malaria accounted for 26% of Out Patient Department cases, 21% admissions and 8% of all hospital deaths (MOHSS, 2005b). An average of 400,000 outpatients, and over 30,000 inpatients and 764 deaths are registered annually due to malaria. Between 1996 and 2003, the number of malaria cases averaged 238 per 1,000 Namibians. The regions in Namibia that are endemic are Kavango, Oshana, Oshikoto, Ohangwena and Omusati. HIS data indicates that between 1996 and 2001 Kavango region led the nation in malaria mortality, its rate averaging 120 per 100,000. The next worst affected regions were Oshana, Oshikoto, Caprivi, Omusati and Ohangwena with mean annual malaria mortality rates between 55 and 84 per 100,000. The use of bed nets, which is one of the most effective ways to prevent malaria transmission, has been however very low among children under five years of age at 7% (UN, 2004). This is underlined by the preliminary data of the NDHS 2006, which reveals that only 8% children under five years of age, in the urban area and 14% in rural area slept under a mosquito net the night before the survey. Low use of nets is due to lack of adequate awareness, poor distribution mechanisms and misuse of bed nets for fishing.

Although several studies in Africa have not found a major clinical interaction between HIV and malaria, malaria is reported to worsen the condition of HIV positive pregnant women and may increase the risk of

transmission of HIV to their babies. This is because malaria damages the placenta, with the danger of HIV being transmitted to the baby. (MOHSS, 2005 b). The NDHS 2006 preliminary data shows that 26% of mothers in urban area and 47% in rural area took anti-malarial drugs for prevention during pregnancy for the period of the last birth in the five years preceding the survey. The percentage of the pregnant women age 15-49 that slept under a mosquito net a night before the interview is also low, 10%.

### **2.1. 8: Infertility**

Infertility is defined by WHO as the absence of conception in 24 months of regular unprotected intercourse. The demographic definition of infertility capture both cases that cannot conceive and cases that are unable to carry a pregnancy to term and deliver a live birth which is referred to as pregnancy wastage.

Infertility affects an estimated 60 to 80 million women and men worldwide, the vast majority of whom live in developing countries. The prevalence of infertility varies widely both between and within countries. In sub-Saharan Africa, for example, national rates range from 7 to 29% among women aged 20 to 44. Rates for different ethnic groups within Namibia range from 14 to 32%. The primary causes of infertility range from anatomical, genetic, endocrinological, and immunological problems. Secondary causes which are preventable include STI and unsafe abortions. The leading preventable cause of infertility in developing countries is pelvic inflammatory disease (PID), which can scar the fallopian tubes. It is reported that prompt treatment of PID reduces but does not eliminate the risk of infertility (Larsen, 2004).

### **2.1.9: State Of Well-Being after the Reproductive Years**

Menopause refers to normal change in a woman's life when her menstruation stops, due to the decline of hormones oestrogen and progesterone, while andropause refers to biological change experienced by men during their mid-life, marked by a steady age-related decline in testosterone levels.

NDHS 2000, reports that 47% of women age 48-49 years were menopausal, while in NDHS 2006 it was 43%. Menopause is considered to be among the factors that influence the risk of pregnancy among women, as women who have not yet reached menopause may conceive as they do not use contraception believing that they have already reached menopause.

### **2.1.10: Post Abortion Care**

In Namibia abortion is legally allowed to be performed only when there is a threat to the pregnant woman's life, when pregnancy poses a threat to the pregnant woman's physical or mental health; and when pregnancy is the result of rape or incest or when there is fetal impairment. At the Cairo Conference, the governments of the world recognized unsafe abortion as a major public health concern, and pledged their commitment to reducing the need for abortion through expanded and improved family planning services. (United Nation, 1995) The Beijing Conference in 1996 affirmed these agreements. (United Nations 1996, paragraph 106).

Estimating the incidence of unsafe abortion maybe difficult, especially in Namibia where abortion is illegal, unless for reasons stated above. Nevertheless it posts a challenge

NDHS, 2000 attempted to measure the extent of unwanted or ill-timed pregnancy; 23% of the women indicated that they had fallen pregnant when they did not want to and only 5% revealed that they wanted to do something about it and 1% had done something about it. However, considering the real situation, this is considered an underestimation of the induced abortion in Namibia.

Lack of easy access to termination of unwanted pregnancies discriminates against poor households, who usually resort to unsafe abortions, while the rich and better off are able to procure safe abortions in spite of the above restrictions.

### **2.1.11: Male Involvement in Reproductive Health**

The perception, beliefs and knowledge of men about reproductive health, which varies by culture, religion and educational background, is a key factor in the access of both men and women to reproductive health services.

Men still largely view reproductive health as a women's affair. Lack of male involvement, as demonstrated by men's poor attitude towards reproductive health and limited use of services in NDHS data, is a key reason for poor reproductive health outcomes in Namibia.

The NDHS 2000 revealed that 25% of men agreed with the statement that a woman has no right to tell a man to use a condom and that contraception is women's business and men do not have to worry about it. In 2006, during the NDHS, 22% of men stated contraceptive is a

woman's business, indicating that between 2000 and 2006 the attitude of Namibian men towards contraceptive usage did not improve.

Similarly, NDHS 2006 reveals that the percentage of women who tested for HIV has increased to 50% from 23% in 2000 while testing in male population remains relatively low, 24% and 32% respectively. Male circumcision has been proven to aid prevention of HIV and AIDS, and this need to be surveyed.

## **CHAPTER 3: POLICY FRAMEWORK - GOAL, OBJECTIVES AND STRATEGIES**

As is explicit in the title, this Chapter lists the goals, principles and objectives of and outlines the strategies for effective implementation of this Consolidated National Reproductive and Child Health Policy. It takes into account the goals, objectives and strategies of the existing National Reproductive Health Policy and Family Planning Policy.

### **3.1. GOAL**

The overall goal of this Consolidated National Reproductive and Child Health Policy 2008 is to:

- Contribute to the Vision 2030 Goal on reproductive health status, which is to promote and protect the health of individual and families through the provision of adequate, acceptable, accessible, affordable and quality reproductive health services, irrespective of geographic location and socio-economic status; and
- Contribute to the NDP 3 (2009-2013) Goals of making quality healthcare accessible, affordable and equitable; prioritising improved access to healthcare and health facilities in previously underserved regions and targeting more resources towards the poor and urban areas.

### **3.2 PRINCIPLES**

The Policy will be guided by the following principles:

1. Reproductive health is a basic human right for every Namibian.
2. Namibians should have equal and equitable access to reproductive health services whenever required.
3. Adolescents have the right to all information on sexual and reproductive health and quality adolescent friendly health services.
4. All stakeholders should be empowered with necessary knowledge and skills to be able to appreciate the importance of reproductive health to poverty reduction, women empowerment and economic growth.
5. People should not be denied services based on prejudice or biased tendencies.
6. All stakeholders (parents, teachers, traditional chiefs, political leaders, women and men leaders), but particularly communities, should be involved in the design, planning, monitoring and evaluation of reproductive health services.

### 3.3. OBJECTIVES

<b>REPRODUCTIVE HEALTH COMPONENTS AND PROGRAMME COMPONENTS</b>	<b>OBJECTIVES AND TARGETS</b>
1. Family Planning	1.1. To increase Contraceptive Prevalence Rate from 46.6% in 2006/07 to 56.6% in 2013.
	1.2. To reduce Total Fertility rate from 3.6 in 2006/07 to 2.7 in 2013.
2. Maternal and New Born Morbidity and Mortality	2.1. To reduce Maternal Mortality Ratio from (Baseline NDHS 2006 prelim=449/100,000) in 2009 to 337/100,000 in 2013 (NDP 3 Target)
	2.2. To ensure that 90% of HIV positive pregnant women, their children and partners, have access to PMTCT services and receive a complete course of ARV prophylaxis to prevent mother to child transmission by 2013. (MTP 3 Target)
	2.3. To reduce neonatal mortality rate from 24/1000 in 2006/07 to 20/1000 in 2013.
3. Sexually Transmitted Infections	3. To increase percentage of STIs cases treated in public and private health facilities to 95%.
4. Gender Based Violence and Harmful Traditional Practices	4. Reduce cases of Gender Based Violence by 50% between 2006 and 2013.
5. Adolescent and Youth Reproductive Health	5.1 To contribute to the reduction of the teenage pregnancy rate by one quarter from 18% in 2006 to 13% by 2015. ( Roadmap to reduce Maternal and Child Mortality Target)
	5.2 To provide adolescent friendly health services in 95% of all public and private health facilities by 2013.
6. Cancers of the Reproductive Systems	6.1. To offer pap smear in 95% of public and private health facilities by 2013.
7. Malaria	7. Decrease malaria mortality from 428/100,000 in 2006 to 210/100,000 in 2013.
8. Infertility	8. To reduce the prevalence of infertility in women aged 15-49 years by 20% between 2008 and 2013.

9. After Reproductive Years	9. To increase the number of women aged 49 years and above who know the signs and symptoms of menopause.
10. Post Abortion Care	10. To increase the number of women who come to health facilities for Post Abortion Care and who are given sufficient information and who make a voluntary choice to use family planning services by 2013.
11. Male Involvement in Reproductive Health	11. To reduce the percentage of men who regard contraceptive as women's business from 22% in 2006/07 to 10% in 2013.
12. Reproductive Health Outreach Services within the health sector.	12. To improve outreach of reproductive health services, information and commodities in 75% of health facilities/districts by 2013.
13. Multi-sectoral Delivery of Reproductive Health Information and Services	13. To initiate community-based distribution of reproductive health information and services, (condoms and/or contraceptive pills) in 75% of the health districts by 2013, using various non-health sector based agents, e.g. Youth Mobilisers, Water Extension Agents, Agricultural Extension Agents, Social Workers etc.
14. RH Advocacy	14. To increase higher level advocacy for reproductive health so that there is a 50% increase in supportive public statements made by all levels of societal leadership (political, traditional, religious, professional, labour unions, professional associations and civil society).

The additional baselines would be determined and targets refined during the implementation of the policy, particularly during the development of a five-year strategic plan and mid-term review.

### **3.4. STRATEGIES FOR REPRODUCTIVE HEALTH COMPONENTS**

#### **3.4.1 Family Planning Services**

Rationale: All countries should take steps to meet the family planning needs of their populations as soon as possible and should, in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family planning methods and to related reproductive health service which are not against the law. The aim should be to assist

couples and individuals to achieve their reproductive goals and give them the full opportunity to exercise the right to have children by choice.<sup>3</sup>

The Ministry of Health and Social Services will continue to promote, protect and improve the health and well being of individuals, families and the population at large and the strategies to achieve the above will include the following:

1. All health facilities and out reach points to offer non-judgmental counselling and contraceptive information and services.
2. Wide range of contraceptive methods shall be provided in order to give clients a choice.
3. Advocacy and awareness activities shall be organised to discuss family planning issues.
4. Information, education and communication materials shall be developed in simple and appropriate languages.
5. Family planning services, including sterilization, shall be provided free of charge in Government health facilities.
6. Structures and systems for increasing access to family planning such as community-based family planning services shall be developed and implemented.
7. Training of health care providers for the delivery of a comprehensive range of family planning services shall be conducted.
8. Dual protection shall be promoted.
9. Assessing the extent of national unmet need for good-quality family planning services.
10. Intensifying of efforts to increase men's access to family planning information and services.
11. Formulating action plans that include measurable indicators of progress and performance.
12. Documenting and monitoring of the contraceptive usage.
13. Ensure a continuing improvement in the quality of services
14. All health facilities and outreach points to be linked to VCT and PMTCT services.

### **3.4.2. Maternal and Newborn Morbidity and Mortality**

**Rationale:** Safe motherhood begins before conception with proper nutrition and a healthy lifestyle and continues with appropriate prenatal care, the prevention of complications when possible, and the early and effective treatment of complications. The ideal result is a delivery of a

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<sup>3</sup> Programme of Action of the International Conference on Population and Development. Cairo, Egypt September 5-13, 1994, para7.16.

healthy infant at full term without complicated interventions and a healthy postpartum period in a positive environment that supports the physical and emotional needs of the woman, infant, and family.

Safe Motherhood provides societal benefits that include: healthier women who are better able to contribute economically to their families and communities; reduction in maternal death, neonatal deaths, deaths among children under 5, and children orphaned by maternal death; a reduced burden on public health and social welfare systems; and a reduction in abortions.

The following strategies will be used by MOHSS in addressing the maternal and newborn care needs:

1. Improve household knowledge and practices of care for mothers and children through activities of interpersonal IEC complemented with radio education programmers in local languages.
2. Support good preconception care as the first step in good prenatal care.
3. Promote the attendance of ANC visit during the first trimester with four or more follow up visit throughout pregnancy.
4. Identify and reduce possible causes of infertility such as PID and provide a wide range of information about infertility treatment options and referrals to infertility specialists.
5. Scale up maternal health services through the implementation of the Road Map For Accelerating The Reduction Of Maternal And Newborn Morbidity And Mortality.
6. Intensify tetanus vaccination for women of child bearing age and infants.
7. Incorporate EmOC in training of health care providers.
8. Strengthen systems for rapid transport of women with obstetric and gynaecological complications including strengthening the referral system.
9. Scale up neonatal care services including the strengthening and creation of neonatal resuscitation care in maternity units.
10. Increase coverage of child survival services (expanded programme for immunization [EPI], oral rehydration solutions [ORS]), early initiation of breast feeding, and other appropriate nutritional intervention.
11. Scale up Integrated Management of Newborn and Childhood Illnesses (IMNCI).
12. Assess the needs of non-functioning equipments and health units, rehabilitate and re-equip them to make them functional and operational.
13. Intensify family planning services for PMTCT of HIV by helping HIV-infected women avoid unwanted pregnancies.

14. Promote micronutrients intake for pregnant women, mothers and their children.
15. All maternal and newborn facilities and out reach points to be linked to VCT and PMCT services.

### **3.4.3. Sexually Transmitted Infections Including HIV AND AIDS**

**Rationale:** Sexually transmitted infections (STIs) are a public health problem particularly in the developing world. It is well documented that failure to prevent, diagnose and treat STIs at an early stage results in serious complications, including infertility and congenital blindness.

The following strategies for STI Control will be used by MOHSS with support of relevant stakeholders:

1. Intensification of efforts to effectively address STI including HIV AND AIDS at all level of health care system and at community level.
2. All STI health facilities and outreach points to be linked to VCT and PMCT services.
3. All antenatal women to be screened for syphilis and treated and their partners to be notified.
4. Diagnostic algorithms shall be updated based on clinical signs and symptoms to identify women at high risk for infections.
5. Treatment of STI shall be offered based on symptoms and risk assessment.
6. Priorities for future research to improve the evidence base of good practice in sexual health and HIV shall be set.
7. Training and development needs of the workforce of Syndromic Management Approach shall be offered.
8. Encourage and offer male circumcision in order to reduce vulnerability to STIs and HIV infection (together with the use of condoms. )
9. Make condoms available as widely as possible through condom corners at facilities, markets and truck stops and promote their use.
10. Strengthen the demonstration of female condoms and promote the use of female condoms.
11. Create environments that are supportive of sexual health with an emphasis on the reduction of stigma associated with HIV and STIs.
12. Develop strong national information campaigns.

### 3.4.4. Gender Based Violence and Harmful Traditional Practices

**Rationale:** Gender-based violence is violence that is directed against a person on the basis of gender and sex and includes physical, mental, sexual, verbal, economic, social and psychological abuse. Various international conventions encouraged reproductive health programmes to take a more holistic approach to gender and health by examining the gender issues that trigger health problems and addressing women and men's health needs throughout their life span. The Government of the Republic of Namibia has recognised the issues of gender and has ratified international conventions such as the Convention on the Elimination of all Forms of Discrimination Against Women in addressing some of the gender issues. Gender-based violence is dealt with specifically in two laws in Namibia: the Combating of Domestic Violence Act 4 of 2003 and the Combating of Rape Act 8 of 2000. Women in Namibia are about 51% of the total population; but, their contribution to the overall social and economic development process, as well as full participation in their own health is yet to be recognised. This continues to be aggravated by some customary discriminatory practices that exist in Namibia.

Strategies to meet gender-related goals and address gender based violence will cover the following:

1. Enhance women and men's awareness of their sexual and reproductive rights, by providing educational materials for both literate and illiterate population
2. Develop and/or implement strategies to address gender based violence in collaboration with other relevant stakeholders.
3. Incorporate gender concerns in reproductive health planning, implementation, monitoring and evaluation.
4. Build staff expertise in couple counselling and counselling clients of the opposite sex from that of the provider.
5. Research and develop and implement strategies to address harmful traditional practices such as early marriage, female genital mutilation and dry sex.
6. Strengthen the incorporation of health management and socio-legal aspects of gender based violence in the training curriculum of health workers and providers of social services.
7. Promote more frequent discussion of women's sex lives and domestic violence, during health consultations.
8. Health facilities to perform more systematic screening of women's reproductive health needs.
9. Health facilities to perform greater exploration of women's relationships with their partners during consultations.

10. Health facilities to encourage positive couple communication, decision making, and attitudes toward sexual and reproductive rights.
11. Strengthen the management of sexual violence and rape, including provision of emergency contraception and post exposure prophylaxis for HIV AND AIDS.

### **3.4.5. Adolescent and Youth Reproductive Health**

The Ministry of Health and Social Services and relevant stakeholders are to design, strengthen, coordinate and implement programmes with the full involvement of adolescents and youth in the positioning and delivery of youth-friendly services through the following strategies.

1. Provide adolescents and youth with education, information and appropriate, specific, user-friendly and accessible services without discrimination to address effectively their reproductive and sexual health needs; in and out school (youth centres, community centres, clubs etc.).
2. Take into account their right to privacy, confidentiality, respect and informed consent.
3. Health care providers will be supported to overcome their possible discomfort with adolescent sexuality, particularly of unmarried adolescents, since their discomfort with providing services to this group of clients was documented in most health facilities.
4. Health care providers will be equipped with the knowledge and appropriate skills to handle adolescents which include special history-taking skills such as probing carefully since adolescents often need time to reveal their problems.
5. Health service providers to clearly guarantee confidentiality by assuring adolescents and youth that they will not share the information about their visit to the health centre with anyone without their consent.
6. Health service providers, youth officers, youth mobilisers, and social workers to be trained to provide adolescents with appropriate counselling and other psychosocial support.
7. The approach of AFHS to be supported and strengthened in order to ensure that adolescents have access to needed services -
  - a. by reorienting existing services to better meet the needs of adolescents;
  - b. ensuring services are open at times and places where adolescents can reach them; and
  - c. ensuring that fees are affordable.

8. Various stakeholders are urged to implement programmes and offer services for female and male adolescents, in and out of school, to help them make the best life choices and protect themselves from unintended pregnancies and STIs.
9. Develop and implement IEC strategies for parents and educators to communicate to young people.
10. Strengthen efforts to reduce sexual abuse of young girls as well as sexual exploitation of teenage girls by men who are older, which contribute to an increased vulnerability to teenage pregnancy.
11. Strengthen efforts to reduce sexual abuse of young boys as well as sexual exploitation of teenage boys by women who are older, which contribute to an increased vulnerability to sexually transmitted diseases.
12. Prevent sexual abuse of young boys by older men, particularly by not detaining adolescent boys and older men, and younger boys and older boys in the same police or immigration cells.
13. Link all youth services and out reach points to VCT, PMCT and emergency contraception services.
14. Provide recreation facilities, psychological and career counselling, employment creation (vocational and business skills training and credit to aid self employment), drug abuse prevention and community volunteer service opportunities to youths and adolescents to facilitate healthy life choices and build self esteem.

### **3.4.6 Cancers of the Reproductive Systems**

**Rationale:** The reproductive system includes organs that serve as the means for reproduction. When cancer is found and treated early, both male and female have more treatment options and a better chance of survival. The reproductive organs self examination and screening programmes have the potential to detect abnormalities that may be related to cancers at a less advanced stage. Cancer prevention and control has been part of the reproductive health programme. It provides services aimed at promoting cancer prevention, reducing cancer risk, improving cancer detection, increasing access to health and social services, and reducing the stress of cancer. It enhances survivorship and quality of life for cancer patients and their families.

Services related to the cancers of reproductive organs shall be guided by the following strategy:

1. The knowledge base in medical, clinical, hospital and community settings regarding cancer issues and screening shall be expanded.
2. Services in terms of prevention, early detection, diagnosis, referral, treatment and palliative care shall be available.
3. Activities aimed at raising awareness of the reproductive cancers in the communities shall be conducted including provision of IEC materials on cancer warning signs.
4. Self examination for both men and women and annual cervical cytology screening shall be encouraged.

#### **3.4.7 Malaria among Pregnant Women, Mothers, Children and Families**

**Rationale:** Malaria in pregnancy in Namibia remains a major problem especially in the northern part where it is endemic. The population which is at risk of malaria constitute 65% of the country's total population (MOHSS, 2005 b). The strategies identified are:

1. Integrate malaria and nutrition services into obstetric care support the provision of appropriate and comprehensive STI/HIV and malaria prevention, care and treatment options for all pregnant women, mothers, children and families.
2. Intensify malaria prevention activities such as education on personal protection measures.
3. Promoting the use of and distribute insecticide-treated mosquito nets, and intensify malaria spraying programme.
4. Provide malaria prophylaxis to all pregnant women residing in malaria endemic area according to the National Malaria Policy.
5. Ensure effective case management of malaria illness for all women of reproductive age and children in malaria areas.

#### **3.4.8 Infertility**

**Rationale:** Reproductive health embraces the concerns of women who have attempted to conceive naturally without success. Infertility is a health problem which bears distinct physiological, psychological and social implications, as fertility is valued in Africa. Infertility is thus often associated with stigma which often leads to mental disharmony, divorce and ostracism. It is imperative to know that, infertility is not always a woman's problem as perceived by most communities, but can be due to the male factors or a combination of both male and female factors.

The Ministry of Health and Social Services in collaboration with relevant stakeholders plans to reduce the prevalence of infertility by:

1. Educating people about STI , their link with infertility; promoting the use of condoms; counselling high-risk individuals; promptly treating infected individuals and notifying their partners
2. Preventing postpartum infections by offering health education after delivery and training traditional birth attendants to use hygienic obstetric techniques and to refer deliveries to clinics.
3. Preventing post-abortion infections by promoting effective contraception, offering treatment for post-abortion complications.
4. Treating infertile couples effectively without adding substantially to existing health care costs by evaluating men as well as women.
5. Advising couples about the timing of intercourse and other behaviours, such as smoking and consumption of alcohol that can affect the odds of conception.
6. Counselling couples so they can cope with the social and psychological burdens of infertility and, if appropriate, quit treatment and consider non-medical options such as adoption.
7. Reassuring clients that family planning methods do not cause infertility
8. Educating the public that infertility is not just a woman's but can be to male factors.
9. Provide a wide range of psychological and sexual dysfunction services in the privacy.
10. Educate traditional healers and pastors to stop abusing desperate women seeking a cure for infertility by subjecting them to sexual exploitation and consumption of various herbs and concoctions, some of which may result in fatal consequences.

### **3.4.9 State of Well-Being after the Reproductive Years**

**Rationale:** Reproductive health is a lifetime concern for both men and women, from infancy to old age. Thus, both women and men need reproductive health care appropriate to their situation in the life cycle.

The Ministry of Health and Social Services, in collaboration with relevant stakeholders, can deal with mid-life concerns of both men and women by:

1. Promote an understanding of the body's changes during this phase of life in order to ease the transition.

2. Develop and strengthen education and services related to menopause, including hormone replacement therapy.
3. Prevention and treatment of problems associated with menopause/andropause and the post-menopausal period, such as osteoporosis.
4. Integrate appropriate services for menopause and andropause into existing SRH services delivery such as counselling and support groups.
5. Promote a healthy lifestyle, including education on diet and exercise.
6. Develop IEC programme on menopause and andropause.

### **3.4.10 Post Abortion Care**

**Rationale:** Unsafe abortion is one of the main causes of maternal mortality and morbidity, particularly amongst adolescents. Therefore, the following steps are planned to mitigate this problem.

1. All health facilities will educate communities to prevent unwanted pregnancies and take appropriate steps to help women avoid abortion, which, in no case should be promoted as a method of family planning.
2. Awareness of availability of post abortion care to be created amongst the general population so that people requiring this service would understand and be able to access it when needed.
3. All health facilities will provide for the compassionate treatment and counselling of women who have had recourse to abortion.
4. All health facilities to offer contraceptive information, services and treatment or referrals for complications of unsafe abortion, and reduce the need for abortion by promoting family planning services.
5. A programme to train health care providers in prevention and management of unsafe abortion.
6. A programme to compile and disseminate data through media and social mobilization on the magnitude and consequences of unsafe abortion.
7. Hospitals to offer management of complications from spontaneous and unsafe abortions.
8. Education on mechanisms for adoption to the general population and particularly targeted at pregnant teenagers as an option to unsafe abortions.
9. All health facilities, outreach points and counsellors involved in PAC are to link clients to VCT, PMTCT and PEP services.

### **3.4.11 Male Involvement in Reproductive Health**

**Rationale:** Men are critical to women's usage and access to reproductive health, while they need to pay attention to their own reproductive health.

To increase male involvement in reproductive health issues, the following strategies are adopted:

1. Promote the participation of both women and men in the development and implementation of reproductive health projects in the community by creating a forum where men can discuss and participate in reproductive health issues.
2. Improve male's knowledge of contraception and reducing fear or misunderstanding about methods.
3. Influence men's attitudes and behaviour towards women within the household and the local community, and to encourage them to adopt, or support their partner's and their own adoption, of contraceptive methods, VCT, PMTCT, PAC, PEP, ARVs and DOTS services. Including use of insecticide treated nets.
4. Intensify activities that involve men in reproductive health issues and programmes as clients, partners, and gatekeepers - a successful model is the Men's Forum held in some regions.
5. School curriculum to include sexual and reproductive health programmes for both girls and boys from primary school level.
6. Promote male circumcision as means to prevent HIV and AIDS.

### **3.5. STRATEGIES FOR REACHING SPECIAL AND VULNERABLE GROUPS, INCLUDING REFUGEES**

It is imperative that special strategies are put in place to reach:

1. Vulnerable groups include those living with a disability.
2. Commercial Sex Workers (CSWs) and Injecting Drug Users (IDUs)
3. Sexual minorities like Men having Sex with Men (MSM).
4. Youth, men and women, without forgetting the young adults who need to be targeted separately from youths.
5. Displaced persons and refugees from natural and manmade disasters such as conflicts and wars need to be targeted with emergency contraception, delivery kits and counselling.
6. Rural populations particularly those living in hard to reach terrains

7. Marginalised or minority groups like the nomadic San and Ovahimba in northern Kunene Region.
8. Orphans and Vulnerable Children (OVC)

Innovative approaches like using the services of various personnel like community based distribution agents, agricultural extension workers, social workers, teachers, adult education class instructors, peer educators, mobile phones; mass media etc. have been identified to reach special and vulnerable groups.

Innovative use would be made of traditional and modern communication media, including folklores, skits, dance and drama and print and mass media, mobile phones, internet etc. to reach to vulnerable groups and those rural communities

The approach would also be to reach to these various groups with information and services in the areas where they gather like youth centres, sports clubs, churches, bars etc. Also create an enabling environment and structure health services and facility opening hours that are suitable to these groups and which do not promote stigma or other barriers to access like cost etc.

Reproductive health would also be promoted during the various cultural festivals and activities.

### **3.6 STRATEGIES FOR A MULTISECTORAL APPROACH TO REPRODUCTIVE HEALTH**

**Rationale:** Reproductive health is a cross-cutting issue like HIV and AIDS, gender, population and environment, and should be mainstreamed in all sectors. Thus each sector is to carry out a bidirectional analysis to determine how reproductive health affects its activities and functions, and how its mode of operation affects reproductive health.

Reproductive health is an integral part of all four. It overlaps with HIV and AIDS in key programme areas; gender is critical to reproductive health, while reproductive health is an integral part of population policy. It is the failure of adequate understanding of reproductive health that does not allow families to limit family size. This contributes to poverty, overpopulation and environmental degradation.

To promote synergy and avoid overlap, duplication and wastage of resources, the strategy is for coordinating structures and mainstreaming mechanisms established to deal with cross-cutting issues like HIV and

AIDS, gender, population and environment and their capacity building mechanisms, particularly training curricula, guidelines and protocols to all be expanded to include reproductive health.

## **CHAPTER 4: INSTITUTIONAL FRAMEWORK FOR POLICY IMPLEMENTATION**

### **4.1. INSTITUTIONAL FRAMEWORK**

#### **Rationale**

A policy is only as good as its institutional and implementation framework. This chapter responds to the challenges faced by the current institutional framework as described in Chapter 2. It makes policy recommendations based on obligations and commitments required from Government ministries, civil society etc. This would also aid the development of a five year implementation plan. The five year implementation plan must be costed to enable it to be used to mobilise the needed resources.

### **4.2. ROLE OF THE MINISTRY OF HEALTH AND SOCIAL SERVICES**

#### **4.2.1. Programme Management and Service Delivery**

##### **4.2.1.1 National Level**

The MHOSS is the lead ministry for providing reproductive health services and will coordinate all the reproductive health activities implemented by other line ministries, NGOs, and private sector. The responsibilities of the Family Health Division, MHOSS will include providing guidance, coordination and prioritization of research; development of code of ethics and standards for coordination and dissemination of research findings; assist in curriculum development of basic training and monitoring of performance and assuring quality of services. Through coordination, the Family Health Division shall ensure that service delivery meets norms and standards, satisfies clients' needs and respects their rights. It will also develop policies, standardize and review protocols, guidelines and standard operating procedures. The subdivision will facilitate and give technical backstopping on reproductive health to the lower level including regional service managers and actual service providers. It will also advise top management on any reproductive health issues that would need their attention. It should be adequately staffed and resourced to manage a multi-sectoral reproductive health programme.

#### **National referral hospitals**

This level provide specialized services such as management of cancers of the reproductive system, management of obstetric complications and

other complicated reproductive health problems which cannot be handled at intermediate hospitals.

#### **4.2.1.2 Regional level**

The management of the SRH programme will be within the context of ongoing decentralization. The MOHSS regional teams have the responsibility to plan, implement, supervise, monitor and evaluate and also provide guidance and follow up of district level activities with support from national level. The SRH activities will be coordinated 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. This level has also responsibility to identify priorities for research, conduct research and disseminate findings; procure SRH equipments and supplies including maintenance and ensure quality of care and access to services. Regional level will support and monitor the activities of the private sector and NGOs to ensure their compliance with the set standards and norms of the MOHSS.

#### **Intermediate Hospitals**

The intermediate hospital will serve as the referral centre for the districts.

#### **4.2.1.3 District level**

The MOHSS District Coordinating Committee (DCC) will oversee the implementation of reproductive health activities. Resource mobilization and allocation at the district level will be guided by the currently decentralization policy. Services will be provided using collective strategies of facility based outreach and school health services. The district will ensure that staffs are trained and equipped with knowledge and skills needed to provide quality SRH services. Research priorities will be determined and actual research will be carried out in collaboration with the regional level. Each district will determine the detailed content of its reproductive health package of services based on the capacity of the district and the need of their catchments populations.

#### **District Hospitals**

The District Hospital will receive and attend to referrals from the lower level of the health services. It will perform deliveries, handle high-risk antenatal care and perform caesarean sections, sterilizations and management of complications arising from childbirth, and during the neonatal period. At this level, complication arising from STIs, gender based violence and abortion are also managed.

### **Clinics and Health Centres**

All clinics and health centres will provide SRH services in an integrated manner with other health services. The SRH services will include:

- Information, education and counselling on SRH issues.
- SRH history and risk assessment.
- Contraceptive information and services.
- STI testing for women and men and partner notification.
- Assessment and treatment of clients with STI symptoms.
- HIV testing and counselling.
- Cervical cytology screening and referral.
- Pregnancy testing and referral.
- Intrauterine contraceptive device insertion – contraceptive implant insertion.
- Ante-natal care, normal deliveries and post natal care

#### **4.2.1.4 Constituency and Community levels**

The already existing Village Development Committee shall be strengthened to accommodate additional services providers such as traditional birth attendants and to deal with reproductive health issues. The MHOSS intends to empower patients/clients and communities, to play a big part in reshaping services at local level. Each health development committee will have a task to sensitize the traditional elected community leaders to create favourable climate for acceptance of reproductive health messages and services especially in dealing with adolescent health. The committee will be a good source of input, but the health facilities will involve clients in different ways to make sure they hear the full diversity of views.

#### **Outreach services to the communities**

This will be provided from specific district hospitals in collaboration with the clinic and the health centres. Outreach service will include ante natal care, family planning services, immunization of reproductive age group against tetanus and nutrition promotion, STI information and treatment and condom promotion and distribution. Where shelter is conducive, post natal care service shall be provided.

#### **4.2.2. Establishing norms and standards**

This policy supports both men and women's ability to exercise their reproductive and other rights. It also emphasises health care workers' fulfilment of their ethical obligations. The regulatory authorities and

professional associations of the various health cadres would ensure ethical conduct of all staff, in both the public and private sectors, and strict adherence of the patient's charter by all health providers.

The policy underscores the need to ensure that all equipment and consumables procured to provide reproductive health services is suitable, appropriate and good quality

#### **4.2.2.1 Confidentiality**

Health care service providers have a duty to protect patients' information against unauthorized disclosures, and to ensure that patients who do authorize release of their confidential information to others do so freely and on the basis of clear information. The delivery of the reproductive health service shall be guided by the Confidentiality Policy and Patient charter.

#### **4.2.2.2 Privacy**

To the maximum extent possible, health service providers should ensure that facilities provide privacy for conversations between clients and providers, as well as for actual services. Privacy shall be accomplished, by providing a single procedure per room at any one time, putting up curtains on windows and doorways, and providing a simple cloth or paper drapes for the clients for the procedure.

#### **4.2.2.3 Services**

Standards for services will include:

- Open access
- Referrals between services
- The availability of a full range of clinically effective services
- Staff training, support, continuing professional development and lifelong learning
- Service monitoring, audit and evaluation
- Community involvement

#### **4.2.2.4 Information**

Standards for information for service users (and potential users) will cover:

- Information about the choice of services, including which elements of clinical care are available, where and when services are provided, and pathways between them.
- Information accompanying treatment or care that helps patients to adhere to it.

- Information about reproductive and sexual health.

#### **4.2.2.5. Research**

The research unit in the MOHSS would implement periodic surveys like the DHS, Facility Surveys etc.

#### **4.2.3 Ensuring provider skills and performance**

##### **Training programmes**

Training programmes, both pre- and in-service, shall be based on a competency approach including supervised practice sufficient to allow the health practitioner to demonstrate clinical competence. A variety of teaching and learning methodologies, which address both technical and clinical skills as well as attitudes and beliefs of the service provider, shall be utilized. There will be a particular focus on values clarification process which allows health providers to differentiate between their own values and the rights of the client to receive quality services. Linkages with a focus on tools for building the skills and capacity of community members will be established. All training will ensure that the health practitioners are competent to:

- Use a wide range of interpersonal communication skills to establish effective rapport.
- Communicate with all service users, respecting their human rights to be treated with dignity and respect, and to confidentiality.
- Effectively transmit and discuss sensitive information regarding sexual behaviour and pregnancy.
- Enable clients to make informed decisions.
- Recognise or suspect ectopic pregnancy from its signs and symptoms.
- Accurately recognize the signs and symptoms of STIs.
- Recognise signs of physical abuse.
- Administer drugs correctly.
- Accurately carry out service related procedure for which they are being trained.
- Make effective referrals to other appropriate services.
- Provide contraceptive information and services.
- Clean and ensure safety of all equipment used for the procedure
- Make accurate records.

Integrated curriculum would be used for in-service training, to reduce the amount of time staffs are away on training. Also a database of staff trained in various reproductive health components would be maintained, to avoid duplication and overlap. The aim is to offer all existing service providers with preliminary training within two years of the implementation of the policy, and to concentrate on refresher courses in

later years. The pre-service curriculum would be updated to reduce the duration and costs of in service training.

#### **4.2.4. Linkage with other Health Sector Policies**

##### **4.2.4.1. HIV and AIDS Policy**

Every effort would be made to integrate reproductive health and HIV and AIDS planning, programming and implementation.

##### **4.2.4.2. Road Map for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality**

The Roadmap is an integral part of this policy and is to be used accordingly.

##### **4.2.6. Linkages and partnering with the private health sector**

Private facilities would report data to MOHSS through existing mechanisms, irrespective of whether family planning and HIV AND AIDS commodities have been provided by the Government, donors or procured by the private facilities themselves.

#### **4.3. ROLE OF CENTRAL MINISTRIES**

Central ministries of economic planning and finance, are so called because they have oversight, coordination and control functions over the development and recurrent budgets of other ministries. Their approval must be sought before variations could be made in the approved recurrent and capital budgets of line ministries.

##### **4.3.1. National Planning Commission Secretariat**

The NPCCS is responsible for ensuring that the important linkage between health and poverty reduction, particularly between reproductive health and the vicious cycle of household poverty, is reflected in all National Development Plans, and key planning and financial instruments like the MTEF. Also reproductive health is key to achieving the goals of the National Population Policy for Sustainable Human Development as well as for achieving the Millennium Development Goals.

NPCS is urged to make reproductive health a major area of its work, with a capable Desk Officer and sufficient analytic work and budgets devoted to it within the NPCCS.

NPCS is to:

1. Investigate the impact of the consequences of poor reproductive health like high MMR, IMR, adolescent pregnancy etc. on development planning process and the national economy in collaboration with the MOHSS.
2. Ensure that all sectors adequately consider reproductive health related activities in their development plans and in the 5 yearly national development plans.
3. To improve its oversight of annual development plan and budgets through collaborating with each sector in designing the criteria for effective performance. These activities are further described in the sectoral list below.
4. Distribute information on reproductive health to its staff members and stakeholders.
5. Collect condoms from the Central Medical Stores, MOHSS and distribute it amongst the NPCS staff.
6. Build the capacity of its staff on the social sector to better appreciate the linkages between economic development, health, reproductive health, HIV and AIDS, gender, environment and poverty reduction, and to conduct analytic work in this area, with the aim of enhancing NPCS coordination role.
7. Promote capacity building for development planning in all line ministries with the establishment of planning directorates with capable staff.
8. Support donor coordination in the health sector to improve planning and service delivery for reproductive health and other health services. Donor coordination would ensure Program Approach, whereby the Government and donors support one costed health sector strategy (and costed sub sector strategies like the one for reproductive health), derive annual plans from and only fund activities from this sector strategy. The final destination is to pool funds and ultimately move onto budget support, but the first critical steps are for the Government and donors to have a common costed sector strategy.
9. Ensure that donors do not create parallel structures to national ones, and that Paris Declaration on Donor Coordination, Harmonisation and Alignment is adhered to.
10. Regularly review the population policy and ensure that the reproductive health policy is adequate to achieve the aims of the population policy.

**Central Statistical Bureau**

This is part of the NPCS. It would carry out census, periodic surveys etc.

#### **4.3.2. Ministry of Finance**

The Ministry of Finance (MOF) is to ensure sufficient budgetary allocations are made in NDP and annual budgets for reproductive health activities, particularly for the purchase of commodities (condoms, IUDS, pills, etc). The successful implementation of this policy depends on the availability of commodities to ensure informed client choice.

A specific budget line, to be created for reproductive health commodities by MOHSS, is to be approved and funded by the MOF. Reproductive health should also be mentioned in the Annual Budget speech as a sign of political commitment and the Government's recognition of the important linkage between poor reproductive health, HIV and AIDS, poverty and economic development.

Adequate budgetary allocations are also to be made for conducting regular surveys like the DHS, and annual maternal death reviews etc.

Ensure that the Customs Service offers reproductive health information and services to its personnel and their families as appropriate.

#### **4.4. ROLE OF LINE MINISTRIES**

All ministries are to support this policy by engaging in the continuum of activities below as within their mandate and capabilities:

1. Provide reproductive health information to the general public and their staff.
2. Senior officials carry out advocacy for reproductive health by making supportive statements at relevant public forums, and urging its stakeholders and clientele to do the same.
3. Provide reproductive health services by distributing condoms to its staff and the general public.
4. Train its outreach, extension and service delivery staff (example teachers, adult education officers, youth officers, agricultural extension agents, cooperative officers, social workers, employment officers etc) with technical support from MOHSS, to engage in community based reproductive health activities such as providing reproductive health information, counselling on reproductive health issues (gender based violence etc.), distributing condoms, supporting contact tracing ( women who miss ANC and immunization appointments), encouraging pregnant women to deliver in health facilities and providing support to the management of community based transport schemes to evacuate emergency obstetric cases to health facilities.

5. Provide reproductive health services in its health facilities if it has any.

In addition to the above, specifically:

#### **4.4.1 Ministry of Works**

In collaboration with the MOHSS, prioritise the maintenance of key rural roads leading to or connecting to health facilities aiming for them to function and be useable in all seasons all year round, with bridges etc. so as to reduce travel time for emergency obstetric and other health cases. This would assist in reducing MMR.

- All contractors are to be encouraged to provide reproductive health education and condoms to their employees, particularly those engaged in major construction work in rural settings.

#### **4.4.2 Ministry of Agriculture, Water and Rural Development**

Train its agricultural extension cadre at all levels so that they can include reproductive health and HIV activities in the package of services that they deliver to farmers and farm families. The agricultural extension technicians and research officers could be trained as Community Distributors of reproductive health commodities.

- Introduce a system of capacity building, supervision, monitoring and reporting to both MOAWS and MOHSS on reproductive health and HIV AND AIDS into the work of the Directorates of Extension and Engineering and Research and Training, the Agricultural and Rural Development Centres, and the content of Field and Farmers Days.
- Train and use agricultural extension technicians and research officers, who already have a scientific background and some training in HIV and AIDS, to carry out reproductive health work, with an emphasis on communication skills.
- Introduce reproductive health into the curriculum of the Schools of Agriculture and the Polytechnic. This would involve curriculum design and training of lecturers.
- Design reproductive health IEC/BBC targeted at farmers who think Family Planning is a sin.

#### **4.4.3. Ministry of Information and Broadcasting**

- Provide information on reproductive health to all Namibians.
- Create awareness amongst policy and decision makers, community leaders and the general public on reproductive health issues.

#### **4.4.4. Ministry of Justice**

- Law review to keep reproductive health and related laws in step with public health challenges, societal expectations and international conventions etc.
- Enforcement of existing reproductive health RH laws particularly as related to rape, GBV etc, without sacrificing human rights.

#### **4.4.5. Ministry of Education**

- Strengthen existing school health services by expanding the school health promotion initiative to all schools and further integrate reproductive health issues into the life science curriculum.
- Have teachers in rural communities lead advocacy and information dissemination for reproductive health.
- Provide counselling services to children and adolescents in schools on reproductive health.
- Provide safe learning environment, with no sexual harassment of learners by teachers or vice versa.
- Collaborate with MOHSS in the training of school teachers on reproductive health issues, such that all teachers are trained by 2012.
- Reforms are needed to reduce finance challenges faced by higher education students, leading to reproductive health risks by female students.

#### **4.4.6. Ministry of Youth, National Services, Sports and Culture**

Strengthen existing and expand multi-purpose youth centres for counselling adolescents in and out of school

- Promote reproductive health related development of youth /adolescents in and out of schools.
- Train youth and employment officers on reproductive health issues so that they can train officers.
- Make multi-purpose youth centre staff available for MOHSS to orientate them to advances in reproductive health issues.
- Provide condoms and other relevant reproductive health services to adolescents.

- Train Youth Officers, Employment Officers, youth forum coordinators, mobilisers and peer educators on reproductive health.
- Deliver reproductive health information and services in all multipurpose youth centres and in all youth groups and activities.

#### **4.4.7. Ministry of Home Affairs and Immigration Women and Child Protection Units**

- Assist women, men and children who have been physically and emotionally abused with services like counselling, referral to service providers or protective homes etc.
- Create awareness and provide information, education and counselling services to those who were abused.

#### **Immigration Service**

- Disseminate reproductive health information amongst the immigration officers and conduct training in their area of work on male involvement in reproductive health.
- Provide appropriate information on sexuality and distribute reproductive health commodities to immigration staff.
- Create awareness on gender and reproductive health amongst immigration officers.
- Disseminate information amongst immigration staff, immigrants and refugees and conduct training on male involvement in reproductive health.
- Provide reproductive health services like contraception and treatment of STIs etc to staff and refugees.
- Provide adequate security to prevent rape and other sexual abuse of minors, adolescent boys and girls and women in holding cells and detention camps.

#### **4.4.8. Ministry of Gender Equality and Child Welfare**

- Mainstream reproductive health in all its activities and advise the reproductive health programme on gender issues.

- Promote gender and reproductive health sensitivity at all levels.
- Advocate for gender equality and reproductive rights.
- Advocate for the elimination of any discrimination against women.
- Strengthen collaboration between all women organizations and other relevant bodies by strengthening the Namibian National Women's Organisation as an umbrella association of women's organizations in Namibia.

#### **4.4.9. Ministry of Defence**

- Provide appropriate information on sexuality and distribute reproductive health commodities.
- Create awareness on gender and reproductive health amongst the forces.
- Disseminate reproductive health information amongst the forces and conduct training on male involvement in reproductive health.
- Provide reproductive health services like treatment of STIs etc.

#### **4.4.10 Ministry of Environment and Tourism**

- Provide appropriate information on sexuality and distribute reproductive health commodities.
- Create awareness on gender and reproductive health amongst its employees, tourists and tourism sector staff (hotels, travel agencies, transport companies, tour guides etc.)
- Disseminate reproductive health information amongst all stakeholders in the tourism sector and conduct training on male involvement in reproductive health.
- Ensure adequate information and services on reproductive health and HIV and AIDS are made available to all residents of areas with major tourist sites and attractions, with particular emphasis on those located in rural communities.
- Provide information on where residents and tourists around tourism locations can access reproductive health services like emergency contraception, treatment of STIs and PEP against HIV and AIDS etc.

#### **4.4.11. Ministry of Higher Education, Technology and Employment Creation.**

- Provide information and services on reproductive health issues to adolescents using public and private vocational training centres, apprenticeship schemes, etc.
- Ensure introduction of integrated reproductive health and HIV and AIDS in the curriculum of primary, secondary and higher institutions, as well in professional schools like colleges of nursing, agriculture, teacher training colleges etc.

#### **4.4.12. Ministry of Foreign Affairs**

- Review and strengthen multilateral and bilateral relations to increase the pool of donors supporting reproductive health. Liaise closely with MOHSS and NPC to ensure that foreign assistance to reproductive health is timely and relevant.

#### **4.4.13. Ministry of Labour**

Improve employment creation policy with emphasis on self employment by improving the salmateneous delivery of the three key elements of self employment creation namely -vocational skills training, entrepreneurship skills training and access to credit. High unemployment and underemployment of the youths leads to poor reproductive health outcomes.

#### **4.4.14. Ministry of Safety and Security**

- Provide appropriate information on sexuality and distribute RH reproductive health commodities to prisoners and detainees.
- Create awareness on gender and reproductive health amongst the prison and police officers.
- Disseminate information amongst the prison and police staff and conduct training on male involvement in reproductive health.
- Provide reproductive health services like contraception, treatment of STIs etc to police and prison staff, detainees and prisoners.
- Provide adequate security to prevent rape and other sexual abuse of minors, adolescent boys and girls and women in police holding cells and prisons.

#### **4.4.15. Ministry of Regional and Local Government and Housing**

In urban planning prevent sitting clubs, film houses, pubs etc. near educational facilities.

#### **4.4.16. Disaster and Emergency Relief Management Agency and Committees**

- Provide contraception (including emergency contraception), delivery kits and counselling to all sites and shelters where displaced persons and refugees from natural and manmade disasters such as conflicts and wars located.
- Provide adequate security to prevent rape and other sexual abuse of minors, adolescent boys and girls and women in shelters and refugee camps.

#### **4.5. ROLE OF RESEARCH INSTITUTIONS**

Implement basic, policy and operational research to generate evidence to guide the programme implementation and evaluation. All studies are to be adequately disseminated, with an emphasis on recommendations for programme improvement.

##### **4.5.2. University of Namibia**

Various faculties, departments, units and research centres to carry out relevant research. Integrate reproductive health into the curriculum at the general studies level, and into the various professional courses and other relevant studies.

##### **4.5.3. Role of other public and private research organisations**

Other public entities with research capacity and private organisations like advertising companies etc. are urged to contribute to the advocacy, research and knowledge management to promote the reproductive health policy.

#### **4.6. ROLE OF NON GOVERNMENTAL ORGANISATIONS AND COMMUNITY BASED ORGANISATIONS**

NGOs and community based organisations (CBOs) are critical to the successful implementation of the reproductive health programme. They are to be encouraged to expand their roles in information dissemination, counselling, advocacy, capacity building of providers and communities, and service delivery, particularly to the parents, youths and political, religious and traditional leaders.

Leading NGOs like NAPPA, Namibia Red Cross, NANASO, and Namibia Men for Change (NAMEC), Cancer Association of Namibia and Lironga Eparu are to benefit from additional support to enable them scale up

their activities, while the creation of more NGOs particularly in the regions and district would be encouraged.

To facilitate the coordination of NGOs' activities and provide an interface for NGOs to relate to the MOHSS and other stakeholders in the implementation of this policy, NANGOF will host NGOs and CBOs reproductive health forums to be created at national, regional and district levels.

#### **4.7. ROLE OF BILATERAL AND MULTILATERAL DEVELOPMENT AGENCIES**

Bilateral and multilateral agencies will provide financial, material and technical assistance, particularly capacity building. To aid donor coordination and their interface with other stakeholders, a Donors RH Forum has to be established. Its secretariat would be supported by the donors.

#### **4.8. ROLE OF LEGISLATURE**

The Legislature, with the support of the Executive (MOHSS and the Health Professions Regulatory Bodies namely the Medical and Dental Council and the Nurses Council) and other stakeholders (professional associations, religious leaders, traditional leaders and the media) is urged to hold public hearings aimed to seek consensus on existing laws that may need to be amended and new legislation that may be desired. This will have to be done in an atmosphere devoid of sensationalism, and which seeks to balance the public health need to halt transmission of infections; protect and save the lives of mothers and adolescent girls; have vulnerable and special population access reproductive health services without stigma; protect professional ethics of health providers like confidentiality and being able to do the best for the patient; protection of human rights and adequate consideration of traditional, religious and other beliefs in considering legislation on abortion, adolescent reproductive health, CSWs, IDU, MSM and other reproductive health issues with ethical, socio-legal and medico-legal implications.

The MOHSS would interact with and regularly brief the relevant Parliamentary Committees - Health, HIV AND AIDS, Youth, Justice, Agriculture etc. Legislations that may need review are:

- *Married Persons Equality Act*
- *The Combating of Rape Act 8 of 2000*
- *The Combating of Domestic Violence Act 4 of 2003*
- *Medical and Dental Act 2004*

- *Nursing Act 2004*

#### **4.9. ROLE OF JUDICIARY**

The judiciary is urged to promote reproductive health by protecting reproductive and sexual rights, and ensuring justice for citizens on reproductive health issues that come before the courts, particularly rape, gender based violence, and professional negligence or misconduct in RH cases like surgical deliveries, lack of early detection of curable cancers etc.

#### **4.10. ROLE OF POLITICAL, TRADITIONAL, RELIGIOUS AND OTHER LEADERS**

Influential leaders as above, including former Presidents and Governors, First Ladies, whose opinions are respected by the public, and who shape public opinion and perceptions, are urged to lead advocacy by making public statements supportive of reproductive health. These prominent members of the society are urged to avoid making public statements that could stigmatise or create barriers for men, women, adolescents, special groups and vulnerable populations to access and receive reproductive health services.

Days on which such supportive statements could be made include World Population Day, International Women's Day, Mothers and Fathers Day, Children's day, Traditional Festivals, Independence Day, Christmas and New Year, etc.

The MOHSS in collaboration with friendly nations, and with technical assistance from donors would organize study tours to countries with best practices in reproductive health.

## **CHAPTER 5: OPERATIONALISATION OF THE POLICY**

### **5.1 Implementing Institutions and Committees at National, Regional; and District Levels and their Linkages with existing Health and other Sectoral Committees (e.g. HIV AND AIDS and Population)**

#### **5.1.1 National Level**

##### **5.1.1.1. National Advisory Committee on Population and Sustainable Development (NACPSD)**

Under the Population Policy, a Cabinet Level National Advisory Committee on Population and Sustainable Development (NACPSD) already exists, in which the Minister of Health is a key member. The reproductive health is a key component of the Population Programme. The Minister for Health would lead policy and advocacy in the implementation of the reproductive health policy.

##### **5.1.1.2. The National Reproductive Health Committee**

This policy makes provision for the establishment of a National Reproductive Health Committee (NRHC), a national multisectoral body to coordinate the implementation of the Consolidated National Reproductive and Child Health Policy. It will consist of Government ministries and representatives elected from umbrella associations of key stakeholders like the traditional institution, religious bodies, youth groups, women groups, etc and chaired by the Minister for Health. This committee will meet annually to receive reports of closing year and approve plans and budgets for the following year. Its secretariat would be the FHD of MOHSS.

##### **5.1.1.3. The Reproductive Health Taskforce**

The Reproductive Health Taskforce will advise the NACPSD and NRHC on the technical aspects as it relates to population, HIV and AIDS and other development issues. This is to promote coordination and synergy between the population, HIV and AIDS and reproductive health policies. It will be chaired by the Permanent Secretary, MOHSS with the Director PHC as deputy chair. It will consist of key line ministries, development agencies and research institutions. The taskforce will meet quarterly to review plans and receive reports on the implementation of the reproductive health programme.

The subcommittees of this taskforce will include those on Reproductive Health Commodity Security, PMCT Committee, relevant HIV and AIDS Committees, BBC Committee, NGO Reproductive Health Forum, Reproductive Health Donors Forum, Women Reproductive Health NGO Forum etc. **(See Fig 1 for Organogram).**

Given the scarce resources, and to avoid duplication, and achieve cost effectiveness and synergy between reproductive health and HIV and AIDS programming, the existing HIV and AIDS committees (Home Based Care, Palliative Care and Psychosocial Support) would incorporate reproductive health in their activities by creating sub-committees on reproductive health. This will strengthen the existing collaboration between the directorates of PHC and Special Programmes of the MOHSS, which are responsible for reproductive health and HIV and AIDS respectively.

Further, instead of creating a new committee on reproductive health and the workplace, NABCOA the existing organisation that manages the HIV and AIDS workplace programme would integrate reproductive health into its mandate.

Where appropriate, PHC and DSP will prepare joint operational plans.

#### **5.1.1.4. Reproductive Health Forums for NGOs, Women Groups and Development Partners**

To facilitate the coordination of NGOs, NANGOF, the umbrella body of Health NGOs will host a Reproductive Health NGO Forum whose secretariat would be in NAPPA, the leading reproductive health service delivery and advocacy NGO.

Women's Groups and Development Partners would also establish reproductive health forum.

The various reproductive health forums will provide an interface for these key stakeholder groups to relate to the MOHSS and other stakeholders in the implementation of this policy. These groups will operate at national, regional and district levels as appropriate. They will be self managing, and they would be sub-committees of the National Reproductive Health Taskforce and Regional HIV and AIDS and Reproductive Health Coordinating Committees – RARCOC (as described below).

The Women Reproductive Health Forum will consist of women NGOs, women professional associations, labour unions with predominantly female membership, women church groups, women CBOs etc. active in reproductive health programmes. The Development Partners

Reproductive Health Forum will consist of bilateral and multilateral institutions active in reproductive health.

### **5.1.2 Regional Level**

#### **5.1.2.1. Regional Development Committee and Regional HIV and AIDS and RH Committee (RARCOC)**

The existing Regional Development Committee, chaired by the Governor, will lead the advocacy in the implementation of this policy at the regional level. The existing **Regional HIV/AIDS Committee (RACOC)** will be expanded to incorporate reproductive health and it will be renamed as **Regional HIV/AIDS and RH Coordinating Committees (RARCOC)**. RARCOC is to be chaired by the Governor with the Regional Health Director as Deputy Chairperson. It will meet quarterly to receive reports of the previous quarter and approve plans and budgets for the ensuing quarter. Its secretariat would be the Regional Health Directorate of the Regional Health Office. Similar committees would also be created at the district level.

### **5.2 Programme Based Approach, Creation of Common Strategy, and Common Budget Framework with Funds for Programmes, Commodities, Regions and Partners Code of Conduct**

Improved donor coordination in the health sector is critical to improve planning and service delivery for reproductive health and other health services. Donor coordination will ensure a programme approach, where by the Government and donors support one costed health sector strategy (and costed sub sector strategies like the one for RH), derive annual plans from and only fund activities from this sector strategy. The final destination is to pool funds and ultimately move onto budget support, but the first critical step is for the Government and donors to have a common costed sector strategy.

Under the programme based approach funds would be created to support procurement of reproductive health commodities, and to support district and regions.

Partners, donors and the Government will sign a code of conduct that would guide their activities in the joint implementation of the costed reproductive health strategic plan that would be derived from this policy.

### **5.3. Preparing the costed Reproductive Health Strategic Plan and its relationship to the Road Map for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality.**

The costed reproductive health strategic plan will be produced as soon as possible to aid implementation of the policy. Every effort would be made to ensure synergy between the reproductive health strategic plan and the Road Map for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality. Activities will be implemented at community, constituency, and district, regional and national levels.

The Reproductive Health Taskforce will oversee the production of the costed reproductive health strategic plan and it will send it to the National RH Committee and National Advisory Committee on Population and Sustainable Development and regularly brief both bodies on the progress of its implementation.

### **5.4. Deriving sectoral and regional plans**

The strategic plan will include detailed sectoral and regional obligations and commitments. The sectoral and regional plans will be developed by the sectoral and regional representatives with technical support from the MOHSS and donors under the auspices of the Reproductive Health Taskforce.

### **5.5 Endorsement of Strategic Plan by Stakeholder Groups**

Women, youth, men, traditional leaders, religious leaders, business leaders and development partners would endorse the costed strategic plan.

### **5.6. Reproductive Health Commodity Security**

The Reproductive Health Commodity Security is key to the success of this policy. This policy aims to have 100% availability at all times of the various methods in all public and private outlets and health facilities. Stock out of reproductive health commodities have serious implications for unwanted pregnancies, HIV and AIDS, patient satisfaction etc.

The Reproductive Health Commodity Sub-Committee under the Reproductive Health Taskforce will coordinate the procurement, supply, management and distribution of commodities. It will liaise with the relevant stakeholders to ensure that commodities are provided for and regularly updated in the National Medicinal Policy, PMIS etc.

## **CHAPTER 6: MONITORING AND EVALUATION, RESEARCH AND KNOWLEDGE MANAGEMENT**

### **Rationale**

Sexual and reproductive health services shall be subjected to quality monitoring and evaluation. The regular and accurate collection of service statistics and regular monitoring and evaluation at the facility level are a key to maintaining and improving the quality of services delivered. Selected indicators for monitoring and evaluation shall be developed and periodic evaluation will be undertaken to ensure that activities are carried out as planned and programme objectives are achieved. The service statistics and other information gathered through monitoring and evaluation shall be shared and discussed with stakeholders and used to make decisions about improvements to services.

### **6.1 MONITORING**

This shall entail listening to providers who can have important recommendations to improve quality of care. At the facility level, processes and mechanisms for monitoring services include case reviews, logbook review, observation, checklists, facility surveys and maternal death audits, all of which can be used to improve quality of care.

Routine monitoring activities shall include but not be limited to:

- Analysis of patterns or problems in services using service statistics.
- Observation of counselling and clinical services to assess quality of interaction with the client throughout the process, to correct any shortfalls in adherence to technical standards, or other practices that jeopardise quality of care.
- Functioning of logistics system to ensure regular supply of reproductive health commodities, equipment and consumables
- Regular aggregation of data from facility level upwards.
- Assessment of progress to remedy problems identified in routine monitoring.
- Regular supervisory support visits

### **6.2. EVALUATION**

This shall entail assessing the relevance, effectiveness, efficiency, sustainability and impact of services using service statistics from monitoring, as well as special investigations to assess the extent to which programme goals are being accomplished. Evaluation shall be conducted looking at quantifiable indicators and also qualitative assessments at

health centre level, districts, regional and national levels. Periodic, client-based evaluations to assess client's experiences, complications, quality of care received and access to services will provide important information for improving clinic and outreach services. This will be done with questionnaires, observation guides, and exit interviews. Similar evaluations shall also be carried out with providers, to assess their attitudes, knowledge, practices, needs and ideas for improving services.

### **6.3 INDICATORS FOR MONITORING AND EVALUATING REPRODUCTIVE HEALTH SERVICES**

#### **Service indicators**

- Proportion of health facilities providing a full range of reproductive care including antenatal, delivery and postpartum care, PMTCT, family planning and detection and treatment of STI.
- Number of facilities with functioning basic essential obstetric care per 500 000 population.
- Number of facilities with functioning comprehensive essential obstetric care per 500 000 population.
- Proportion of health care facilities with at least one provider trained in family planning.
- Proportion of health care facilities with skilled and trained midwife.
- Proportion of health care facility with at least one health care provider trained in the detection and management of STIs.
- Proportion of health care facilities with at least one health care provider trained in adolescent reproductive health.
- Proportion of facilities with functioning communication system.
- Proportion of facilities with functioning transportation system.
- Proportion of district offering AFHS.
- Proportion of health facilities with protocol and guidelines on SRH.
- Number of traditional birth attendants referring clients to health facilities.
- Proportion of health facilities offering Pap smear.
- Proportion of health facilities providing AFHS.
- Proportion of health facilities offering PMTCT and PMTCT+.

#### **Health status indicators**

1. Total Fertility rate #.
2. Contraceptive Prevalence Rate %.
3. Maternal Mortality Ratio #.
4. Number of maternal death.
5. Number of still birth and neo-natal deaths.
6. Antenatal care coverage %.
7. Births attended by skilled health personnel %.
8. Perinatal mortality rate (per 1000).

9. Low birth weight prevalence %.
10. Prevalence of positive syphilis serology in pregnant women (15-49).
11. Prevalence of anaemia in women (15-49) (%).
12. Percentage of obstetric and gynaecological admissions owing to abortion (%).
13. Reported number of women with female genital mutilation.
14. Reported number of Gender Based Violence.
15. Prevalence of infertility in women (15-49) (%).
16. Reported incidence of urethritis in men (15-49) (%).
17. HIV prevalence among pregnant women (15-24) (%).
18. HIV prevalence among all pregnant women (%).
19. HIV positive pregnant women receiving HIV prophylaxis.
20. HIV prevalence among HIV exposed infants.
21. Proportion of new STI among adolescents.
22. Teenage pregnancy rate.
23. Annual incidence of cervix cancer.
24. Annual incidence of breast cancer.
25. Annual incidence of prostate cancer.
26. Number of women referred elsewhere, by reason.
27. Contraceptives provided, by type.
28. Proportion of women who come to a medical facility for post-abortion care who were given sufficient information to make a voluntary choice to undergo treatment and/or family planning options.
29. Percentage of male and female using condoms consistently.

### **Quality of care indicators**

- Proportion of deliveries by caesarean section.
- Facility fatal rate for direct obstetric complications.
- Proportion of maternal death in which substandard care is identified as a factor.
- Proportion of cases of STIs treated according to established protocols.

### **Knowledge indicators**

- Percentage of men/women aged 15-24 with comprehensive correct knowledge of HIV and AIDS.
- Percentage of all men/women with comprehensive correct knowledge of HIV and AIDS.
- Proportion of trained CORPS.
- Knowledge of communities on SRH services available.

### **Programme Management Indicators**

- Proportion of regions/districts with functional reproductive health intersectoral committees.

- Proportion of line ministries meeting their reproductive health programme obligations.
- Number and type of NGOs participating in the reproductive health programme and reporting regularly to the MOHSS.
- Percentage of estimated financial resources mobilised
- Implementation rate of budgeted reproductive programme resources.
- Number of public and private organisations participating in the reproductive health programme with adequate governance structures like democratically elected oversight board, independent management/executive team and annual financial audits to demonstrate financial prudence and judicious use of RH programme resources.

#### **6.4 STRATEGY FOR IMPROVING MONITORING AND EVALUATION**

- Advocate for allocation of national resources for conducting regular surveys, DHS, and annual maternal death reviews.
- Strengthen the monitoring and tracking system to aggregate, analyse and disseminate data received from the regional level.
- Collect, analyse and disseminate and timely submission of minimum national level information required for a global database
- Support operational research for evidence based action.
- Collaborate with the UN and other donor agencies in harmonizing data collection systems to ensure consistency.
- Support platforms for exchange and sharing of best practices.
- Ensure the diversity of user views is reflected in planning and monitoring by using a range of involvement mechanisms, including specifically involving people at the receiving end of the service.
- Develop monitoring tools at various level and monitor performance indicators for sexual and reproductive health and in line with national targets.
- Annual reviews and midterm reviews of the reproductive health programme.
- Higher levels to ensure feedback on data analyse to lower levels, as this aides planning, use of evidence in management and staff morale.
- Biannual multi-sector and regional support monitoring is to be carried out.

- Annual and mid-term reviews of the Reproductive Health Programme are to be done, and reports submitted to the National Reproductive Health Committee.

### **6.5. RESEARCH**

Research is key to advance policy development and service delivery. Emphasis would be on policy relevance and operational research. Priority issues are:

- Youth Migration Survey
- Male Involvement
- Male circumcision-practices and attitude.
- Cancers of Reproductive Health
- Teenage Abortion and Baby Dumping
- Harmful Traditional Practices

### **6.6. KNOWLEDGE MANAGEMENT**

All studies would be disseminated in hard and electronic copies, particularly to the training institutions. Competitive Research Grants will be established.

## **CHAPTER 7: RESOURCE IMPLICATION**

### **7.1. HUMAN, INSTITUTION AND INFRASTRUCTURE**

The Government through MOHSS will mobilize adequate financial resources needed for the implementation of the reproductive health programme according to the spelt out roles. The ministry, in collaboration with stakeholders, will identify the current level of investment in SRH and STI, including HIV, services, the cost effectiveness of those services, to identify any gaps in resources.

Local planning will need to match capacity to prioritise and set targets and set out the resources necessary for meeting the targets.

The SRH service budgets shall include costs of:

- Instruments, supplies and medications needed to improve existing services throughout the system.
- Adequate staff in the FHD, PHC Directorate and SP Directorate to carry workload of reproductive health and HIV and AIDS in MOHSS.
- Adequate staff in regional Reproductive Health Units and enough staff for quality service delivery in all types of health facilities, including the option of recalling retired nurses and utilization of volunteers.
- Training programmes
- Capital costs such as renovation of facilities.
- Strengthening community transport systems through use of mobile phones, bicycle and motorcycle ambulances etc.

### **7.2. MOBILISING RESOURCES FOR REPRODUCTIVE HEALTH**

The Ministry of Health and Social Services will equally mobilize resources in cash and in kind from communities, private organizations and donor agencies. The Ministry of Foreign Affairs and the National Planning Commission will assist in widening the pool of bilateral and multilateral foreign assistance sources.

The Ministry would hold an Annual Pledging Round in September of each year to mobilise resources for the following year.

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**Figure 1: INSTITUTIONAL FRAMEWORK FOR CONSOLIDATED NATIONAL  
REPRODUCTIVE AND CHILD HEALTH POLICY**