REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Essential District Health Package

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PREFACE

The development of this essential health package comes at a time of transformation of the Ministry of Health and Social Services in line with its stated vision to be the "leading public provider of quality health and social services.

The Ministry's commitment to ensuring that the health related Vision 2030 goals are fulfilled has been largely behind the many milestones realized especially in the past four years beginning with the comprehensive review of the sector in 2008 that was followed by the development of the health Strategic plan and formulation of the National Health Policy framework. The Ministry is also undertaking a major restructuring exercise to better define the functions and responsibilities of the various structures and programmes.

In order to further ensure an efficient and effective delivery of services that are integrated, high quality, affordable and accessible, the ministry is developing this package of essential health and social services that are to be delivered with focus on the district level as the Ministry become more responsive to the needs of the Namibian population.

I am certain that the service components identified for the various levels of care and the norms outlined in this document will enable health workers to be more productive as they focus their attention to cost effective interventions.

All health workers and managers at all levels are expected to utilize this package as a guide in their work. It should be noted that this is an attempt to focus on priority interventions. As such there may be other interventions excluded which may be relevant to a particular region or level of service based upon epidemiological considerations. These additional interventions are to be accommodated based upon the local situations within existing resource constraints.

I wish to thank all those in the Ministry who have contributed to the development of this package for the high quality of work they have exhibited. In particular, I would like to thank the Directorate of Primary Health Care which took the leadership in the development of the package.

I also want to thank WHO, UNICEF and USAID for their technical support in the development of this document.

It is my sincere hope that this package will be put to good use by planners, policymakers, implementers and stakeholders at various levels in Namibia.

MR. A. NDISHISHI
PERMANENT SECRETARY

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LIST OF ABREVIATIONS

ACT	Artemisinin-based Combination Treatment
ASRH	Adolescent Sexual and Reproductive Health
ARI	Acute Respiratory Infection
BCC	Behavioral Change and Communication
BEmONC	Basic Emergency Obstetrics and Neonatal Care
BF	Breastfeeding
BP	Blood Pressure
CBHC	Community Based Health Care
CBHW	Community Based Health Workers
CEmONC	Comprehensive Emergency Obstetrics and Neonatal Care
CPD	Cephalo Pelvic Disproportion
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
CT	Counseling and Testing
DHMT	District Health Management Team
DHT	District Health Team
ECHC	Early Childhood Health Care
EmONC	Emergency Obstetric and Neonatal Care
GAM	Global Acute Malnutrition
GF-ATM	Global Fund for AIDS, Tuberculosis and Malaria
GMP	Growth Monitoring and Promotion
GRN	Government of Republic of Namibia
HEW	Health Extension Workers
HIS	Health Information System
HMIS	Health Management and Information System
IEC	Information, Education and Communication
IECHC	Integrated Early Childhood Health Care
IMAAI	Integrated Management of Adolescent and Adulthood Illnesses
IMNCI	Integrated Management of Newborn and Childhood Illnesses
IPT	Intermittent Prophylactic Treatment (of malaria)
IRS	Indoor Residual Spraying
ITN	Impregnated Treated Nets
LLITNs	Long-Lasting Insecticide-Treated Nets
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MDR-TB	Multi-Drug Resistant TB
MISP	Minimum Initial Service Package
MoHSS	Ministry of Health and Social Services
MVA	Manual Vacuum Aspiration
NCDRD	Non Communicable related Diseases
NGO	Non-Governmental Organization
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PHAST	Participatory Health and Sanitation Training
PHCC	Primary Health Care Centres
P-ICT	Provider initiated Counseling and Testing
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission of HIV
RHMT	Regional Health Management Team

SADC	Southern African Development Community
SBA	Skilled Birth Attendant
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
TFC	Therapeutic Feeding Centres
USAID	United State Agency for International Development
UNFPA	United Nation Population Fund
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
XDR-TB	Extensively Drug Resistant-TB

EXECUTIVE SUMMARY

The Demographic and Health Survey (DHS) of 2006/2007 estimated Namibia's infant mortality rate (IMR) and under-five mortality rates (U5MR) at 46/1,000 live births and 69/1,000 live births respectively. Neonatal mortality at 24/1,000 live births constitute about 52% of infant mortality rate in the country. Child malnutrition is prevalent in Namibia with 29% of children under-five years of age being stunted, 17% are underweight and 8% are wasted. Only 69% of under-fives are fully immunized ranging from 35% in Kunene region to 81% in Omusati region, highlighting regional disparities in access to health services.

The 2006 DHS also estimated maternal mortality ratio (MMR) at 449/100,000 live births. 95% of mothers were found to have at least one Antenatal care visit and 70% had four or more visits during their last pregnancy. Only 33% of mothers received at least two doses of tetanus toxoid vaccine during pregnancy. The DHS also found that 81.4% of pregnant mothers delivered in the health facilities. Despite all these facts maternal mortality ratio (MMR) has apparently increased from 225/100,000 Live Births in 1992 to 449/100,000 live births in 2006. Access to safe drinking water in Namibia is universal with 97% of urban and 80%of rural residents having safe drinking water. However, only 58% of urban residents and 14% of rural residents have access to improved sanitary facilities.

Given the above situation, it is imperative for Namibia to focus on the provision of efficient and effective essential health package of services that are delivered in an integrated manner, building upon the distinct focus on Primary Health Care approach adopted since independence in 1990 as an optimized method of bringing improved services to the people of Namibia in a most affordable and convenient manner.

Of the major social determinants of health, the distribution of the population in Namibia stands out as a significant factor. It makes provision of social and welfare services expensive. In all parts of the country, the settlements are sparsely distributed with villages being far apart from each other. This includes settlements in the relatively densely populated northern regions. In addition, certain regions have challenging terrains, e.g., the Kunene region where predominantly Himbas live. This implies that the package of services especially at the village level will have to respond to the needs of communities which are living far away from the nearest health facility.

Over the years, the Ministry of Health and Social services has positioned itself to be the provider of efficient and effective health and social services. In 2008, the ministry conducted a comprehensive health sector review which made recommendations that have guided the development of health sector Strategic Plan for the period 2009 – 2013 that was approved by the Office of the Prime Minister (OPM) early in 2009. Through the strategic plan and the National Health Policy that were developed in 2010, the Ministry aims to make a major contribution towards the attainment of Namibia's Vision 2030 whose goals include the following: "Ensure a healthy, food secured and breast feeding nation, in which all preventable, infectious and parasitic diseases are under secure control and in which people enjoy a high standard of living, with access to quality education, health and other vital services, in an atmosphere of sustainable population growth and development."

The Ministry has also embarked on an ambitious restructuring process based on the recommendations of the health sector review and to respond to the aspirations of the National Health Policy and Strategic Plan.

In order to achieve its objectives, there is a need therefore for the Ministry to ensure the delivery of cost-effective interventions with greater emphasis on strengthening the district healthcare services. It is for this reason that this essential health package has been developed by the Ministry of Health and Social Services to provide the norms and standards for access to and delivery of services at all levels of care.

This document contains essential service packages at the district level. An example of the packages is demonstrated by the village level which provides an opportunity for greater improvement of health outcomes in communities:

Key services at village level include:

- Health promotion: Information, Education and Communication (IEC), social market ing of cost-effective preventive interventions and commodities: Oral rehydration salt (ORS)/zinc supplement, co-trimoxazole and artesunate combination therapy for children with pneumonia and suspected malaria, and impregnated treated nets (ITNs); promotion of exclusive breastfeeding, appropriate complementary feeding and hand washing.
- Active case finding of pregnant women and referral for antenatal care and skilled care attendance (delivery in health facilities).
- Active case finding and management and guidance for children with diarrhea, Acute Respiratory Infection (ARI) and fever; and referral of severe cases or those that have developed complications.
- Enumerating cases, keeping surveillance and notification of disease, with appropriate reporting including notification of maternal and neonatal deaths: provide early warning signals of outbreaks of diseases.

It is evident that with the review of the health system in 2008, development of the National Health Policy, the adoption of the health sector Strategic Plan and the restructuring of the health sector, the Ministry of Health and Social Services is committed to the improvement of health and social development outcomes in line with Vision 2030 goals. The implementation of this essential health package will be yet another milestone for the sector.

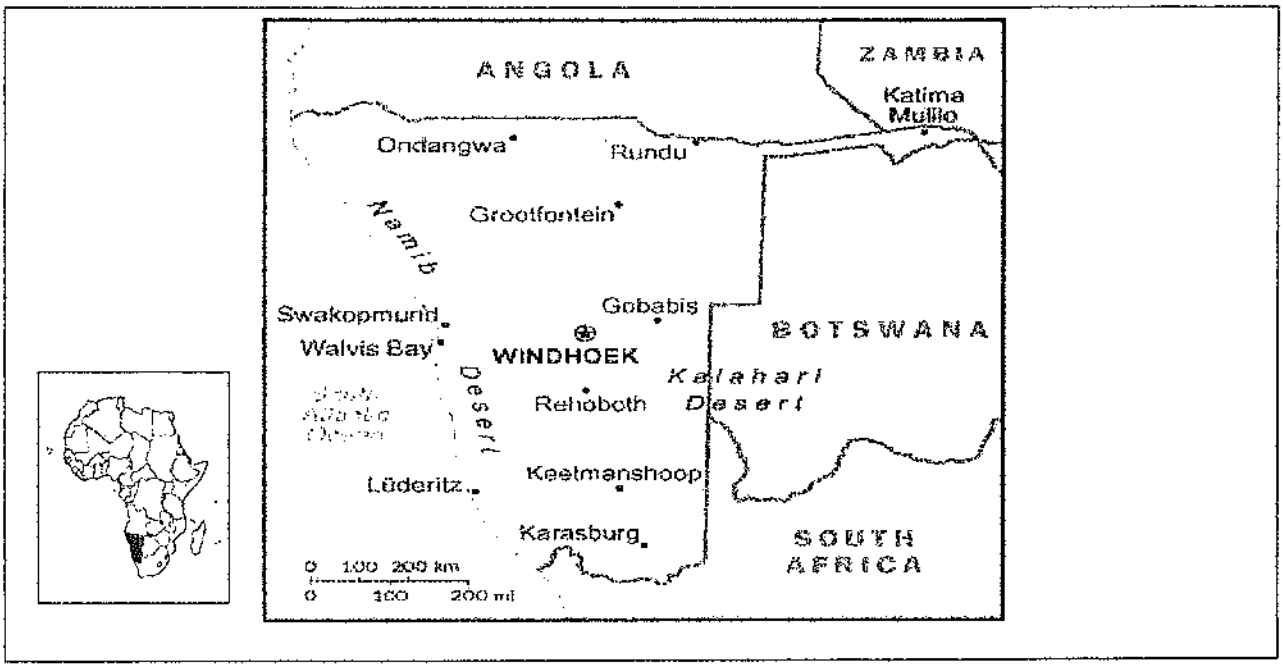
1. Introduction and Background

1.1 Geography

Namibia lies on the south-west coast of Africa and covers 842,000 square kilometers, between 12o and 25o East latitude and 17o 30" and 29o South longitude, making up 3% of Africa's land area. The Western Border is the Atlantic Ocean. To the North it frontiers Angola and Zambia, to the East, Botswana and to the East and south is the Republic of South Africa, see figure below.

Namibia is an arid country whose rainfall varies from 20 millimeters or less at the coast and only reaches a maximum of approximately 600 millimeters to the North East of the country. A large part of the country is covered by two of Africa's largest deserts, Namib to the West, Kalahari to the East. Namibia has widely contrasting terrain with vast low lying plains and ragged mountainous terrains that have poor communication and transportation infrastructure. The Northern Namibia is traversed by rivers and streams in low lying swampy areas that often flood during rainy seasons. Significantly these areas of the country are swampy marshland that form rich ecosystem for a number of human parasites and vectors that cause serious disease, such as schistosomiases.

Fig.1: Namibia and its frontiers

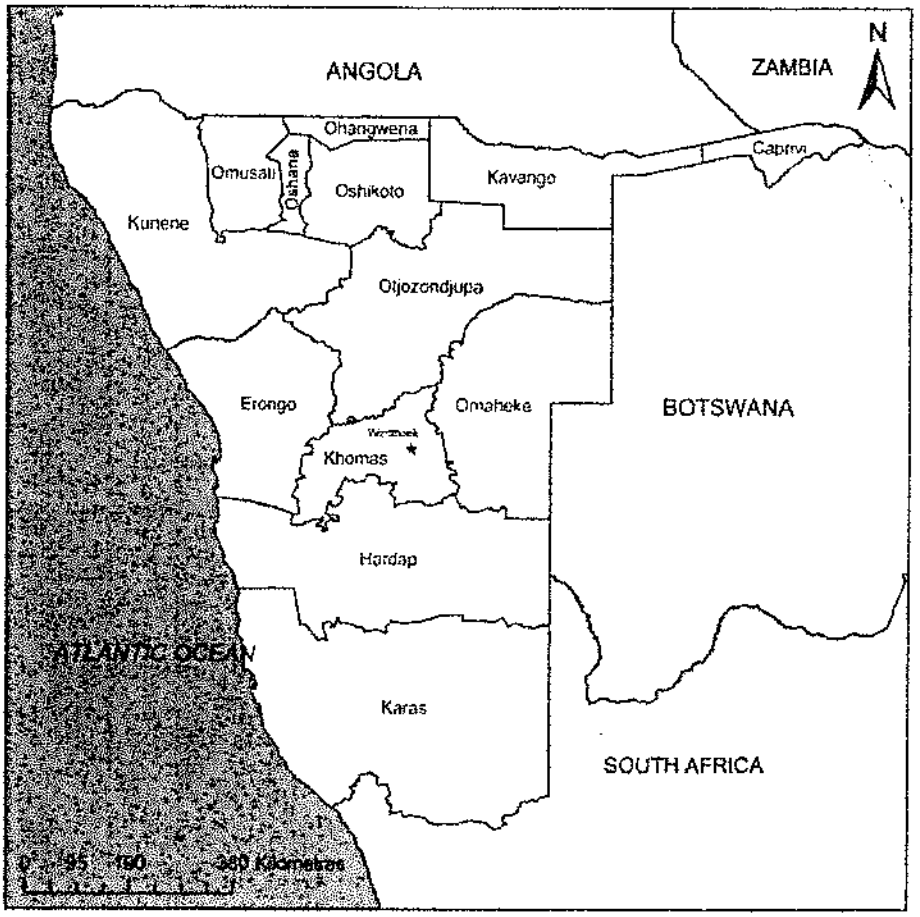


There are 35 health districts that form the population based development units. The district institutions and sub-sectors report to the regions. They are responsible for identification of challenges and opportunities for development and investment and are therefore important in generating the necessary information that informs policy and strategic decisions and directions. Because of the disparity in population density and geographical sizes, some regions are single districts.

Fig.2: Political and Administrative Regions

Regions of Namibia

1. Caprivi
2. Erongo
3. Hardap
4. Karas
5. Okavango
6. Khomas
7. Kunene
8. Ohangwena
9. Omaheke
10. Omusati
11. Oshana
12. Oshikoto
13. Otjozondjupa



Source: The Demographic and Health Survey 2006-2007

1.2. Population

The population of Namibian in 2011 was 2,113,077, of which 1,091,165 were female and 1,021,912 male. The population growth rate was estimated at 1.4 percent per annum. The population is mainly composed of young people, with 23 percent being under 15 years of age while only about 7 percent of the population has reached the age of 60 years and above.

The population is predominantly rural, with 57% living in rural areas while 43% live in urban centres. Overall, the population density is low, averaging 2.6 persons per square kilometer in the whole country, but there are very wide regional disparities in population densities. Two thirds of the population lives in the four northern regions and less than one-tenth lives in the south. Despite its small population, Namibia has a rich diversity of ethnic groups, including Afrikaners, Basters, Coloured, Damaras, Germans, Hereros, Namas, Ovambos, Sans, Tswanas and others.

Table 1: Population Distribution in Namibia

	Region	Capital	Population (2011)
1	Caprivi Region	Katima Mulilo	90,596
2	Erongo Region	Swakopmund	150,809
3	Hardap Region	Mariental	79,507
4	Karas Region	Keetmanshoop	77,421
5	Kavango Region	Rundu	223,352
6	Khomas Region	Windhoek	342,141
7	Kunene Region	Outjo	86,856
8	Ohangwena Region	Eenhana	245,446
9	Omaheke Region	Gobabis	71,233
10	Omusati Region	Outapi	243,166
11	Oshana Region	Oshakati	176,674
12	Oshikoto Region	Omuthiya	181,973
13	Otjozondjupa Region	Otjiwarongo	143,903

Source: Namibian 2011, Population and Housing Census

1.3. Socio Economic Determinants of Health in Namibia

Namibia has a relatively high GNP per capita estimated to be US$ 2,990. In spite of this, the Namibia Income Household & Expenditure Survey (NHIES) reveals large disparities between urban and rural areas where 67% of the population live. Overall, the GINI-coefficient for Namibia is 0.604 highlighting major income disparity with 25% of households in the lowest quartile, representing 35% of the population, accounting for only 7% of total income, while the top most 2% of households representing 1% of the population account for 16% of total annual income. Despite a satisfactory economic growth, however, the unemployment rate estimated at 36.7% in 2004 remains high.

The major natural wealth in Namibia comprises of minerals, especially diamonds, zinc, copper, marble, livestock, sea foods and limited fresh water fish. There is a significant reservoir of the African big game and some other wild animals that support a thriving tourism industry. There is a limited but significant value addition to the natural products, with a rapidly expanding manufacturing sector.

Of the major social determinant of health, the distribution of population in Namibia stands out as a significant factor. It makes provision of social and welfare services expensive. In all parts of the country, the settlements are sparsely distributed with villages being far apart from each other. This includes settlements in the relatively densely populated northern regions in those in farms. In addition certain regions have challenging terrains, e.g., the Kunene region where predominantly Himbas live. Further, Namibia has a wide variation in cultural beliefs and traditional practices on the one hand and a rapid transition through affluence, a factor that has significant health implications.

1.4 Health and Health Services

According to the Demographic and Health Survey (DHS) of 2006, the infant mortality rate in Namibia is 46/1,000 live births and the under-five mortality rate is 69/1,000 live births. Neonatal mortality at 24/1,000 Live Births constitute to 52% of the Infant mortality Rate in the country. Child malnutrition is prevalent in Namibia with 29% of children under-five years of age stunted, 17% are underweight and 8% are wasted. Only 69% of under-fives are fully immunized ranging from 35% in Kunene Region to 81% in Omusati. This highlights regional disparity in the provision of basic social services.

The DHS of 2006 also estimated maternal mortality ratio (MMR) at 449/100,000 live births. 95% of mothers had at least one Antenatal care visit and 70% had four or more visits during their last pregnancy. Only 33% of mothers received at least two doses of tetanus toxoid vaccine during pregnancy. The DHS also found that 81.4% of pregnant mothers delivered in the health facilities. Despite all these facts, maternal mortality ratio has increased from 225/100,000 Live Births in 1992 to 449/100,000 live births in 2006.

Access to safe drinking water in Namibia is universal with 97% of urban and 80%of rural residents having safe drinking water. However, only 58% of urban residents and 14% of rural residents have access to improved sanitary facilities.

A range of preventable diseases remain endemic in Namibia and the country has experienced outbreaks of epidemics that include H1N1 and meningococcal meningitis. HIV prevalence is among the highest in the world with an estimated 17.8% of the population being HIV positive.
The annual incidence of tuberculosis in Namibia is estimated at 662/100,000 population. This is among the highest rates in the world and the emergence of TB drug resistance is a challenge.

The overall access to health care in Namibia is reasonably good with about 76% of the population living with in 10Kms radius from a health facility and the infrastructures of road network is among the best in Africa. However, the human resources and managerial expertise for administering the health sector are inadequate. Existing health infrastructure and equipment favor curative care. Many hospitals are fairly new or still under construction. In addition, the facilities are unequally distributed among the regions.

Less than 40% of children under the age of five years have access to Integrated Management of Childhood Diseases (IMCI). It is evident that most immunization services are still provided by mobile teams at outreach posts. Several regional hospitals and most District Hospitals are unable to perform surgical operations because of lack of anesthetists as anesthesia is only administered by anesthetists or doctors. Similarly, there is poor access to mental health services and most psychiatric cases are only diagnosed at advanced psychotic stages and have poor follow up leading to severe disability among the patients and serious economic costs to their families. Contraceptive prevalence rate (CPR) stands at 46%, with relatively high unmet need for family planning.

1.5 Why an Essential Health Package

Since the Independence of Namibia, there has been a distinct focus on Primary Health Care as an optimized method of bringing improved services to communities in a most affordable and convenient manner. The impetus for change in guiding the principles of the new policy was spearheaded by

H.E. President Sam Nujoma and was supported by leading politicians, community leaders, international organizations, non-governmental organizations, senior officials in the ministry and the community.

Through a national workshop held in Oshakati in 1991, followed by a series of other workshops held at national, regional and district levels, a broad consensus on the approach to be followed in the implementation of primary health care/community-based healthcare (PHC/CBHC) was reached. The outcome of this consensus was the development and adoption of the PHC/CBHC guidelines that were launched by the President in 1992. The national health policy was reviewed in 1997 and the reviewed policy yet again emphasized the primary health care approach as the best strategy to address the citizens' health care needs (Namibia Economist 2004).

The overall orientation of the public health service is towards the provision of primary health care, where the predominant focus is on community health, preventative measures and on treatments that can be provided relatively easily, cheaply and quickly.

Most primary health care services are delivered through outreach points, clinics, health centers and district hospitals. More serious health conditions are generally referred to, and treated at, higher (secondary and tertiary) levels. Health centers and district hospitals offer secondary level care, while the most specialized and tertiary level care is offered at the main referral hospitals in the major cities including Windhoek.

This hierarchy allows for different facilities to be staffed and equipped appropriately to provide different kinds of health services. Greater cost-effectiveness is also achieved by channeling problems to levels where they are best treated.

The Sixty-Second World Health Assembly held in May 2009 has urged Member States to ensure political commitment at all levels to the values and principles of the Declaration of Alma-Ata, keep the issue of strengthening health systems based on the primary health care approach high on the international political agenda, and take advantage, as appropriate, of health-related partnerships and initiatives relating to this issue, particularly to support achievement of the health-related Millennium Development Goals and to accelerate action towards universal access to primary health care by developing comprehensive health services and by developing national equitable, efficient and sustainable financing mechanisms, mindful of the need to ensure social protection and protect health budgets.

The International Conference on Primary Health Care and Health Systems in Africa, meeting in Ouagadougou, Burkina Faso, from 28 to 30 April 2008, reaffirms the principles of the Declaration of Alma-Ata of September 1978, particularly in regard to health as a fundamental human right and the responsibility that governments have for the health of their people.

Over the years, the Ministry of Health and Social services has positioned itself to be the provider of efficient and effective health and social services. The Otjiwarongo document outlined the management structures of the ministry specifying the functions of the various levels. In 2008, the ministry conducted a comprehensive health sector review which made recommendations that have guided the development of health sector Strategic Plan for the period 2009 – 2013 that was approved by the Office of the Prime Minister (OPM) early in 2009.

Through the strategic plan and the National Health Policy which has also been recently developed, the Ministry aims to make a major contribution towards the attainment of Namibia's Vision 2030 whose goals include the following:

"Ensure a healthy, food secured and breast feeding nation, in which all preventable, infectious and parasitic diseases are under secure control and in which people enjoy a high standard of living, with access to quality education, health and other vital services, in an atmosphere of sustainable population growth and development."

The overall objective of the MOHSS Strategic Plan for the period 2009 – 2013 is to increase life expectancy from 49 years to 55 years by 2013. In order to achieve this, the MOHSS has articulated its vision and mission as outlined in the first strategic plan. These were again revised in 2014 as follows:

Vision: "To be the leading public provider of quality health and social services.

Mission: "To provide an integrated, affordable, accessible, quality health and social services that is responsive to the needs of the Namibian population.

The Ministry developed a second five years Strategic Plan and a Road Map that spelt-out the Ministry's priorities.

The Ministry has also embarked on an ambitious restructuring process based on the recommendations of the health sector review and the need to respond to the aspirations of the National Health Policy and Strategic Plan.

In order to achieve its objectives, there is therefore a need for the Ministry to ensure the delivery of cost-effective interventions with greater emphasis on strengthening the district healthcare services. There are known proven high impact interventions that have an impact on health outcomes specifically those serialized by the Lancet.

It is for this reason that this package has been developed to provide the norms and standards for access to and delivery of services at all levels of care.

2. Essential PHC Service Packages

2.1. Overview

The aim of Essential health packages is to focus scarce resources on interventions which provide the best 'value for money'. They provide the norms and standards for access to, and delivery of, services at all levels of care.

This document defines essential health package for Namibia highlighting the roles and responsibilities of the various service levels, including the village level health promotion and care by health extension workers and community health volunteers, clinics, health centres and district hospitals.

The technical service components in the essential package are to be delivered in an integrated manner based upon PHC principles. Each component addresses the most urgent health priorities (those that result in the highest numbers of deaths and disability) and the management systems to support health intervention initiatives.

Specific programs have been developed by the different directorates in the Ministry of Health and Social Services based on comprehensive policies, operational guidelines, procedures, manuals and protocols to ensure quality services under their respective mandates. These services are integrated into the care elements and services to be delivered through PHC approach.

For each of the service areas, a summary description is provided that explains the proposed services and the expected targets of the medium term health strategies and responses.

Primary Health Care principles that are outlined below have guided the development of the essentia' health package.

PHC Principles:

- Rights Approach: All Namibians have the right to enjoy good health through access to primary health care, referral and social services according to their need;
- Equity and Affordability: Health and social welfare services will be affordable and the principle of equity shall underpin the implementation of this guideline with special attention to the needs of vulnerable groups;
- Inter-Sectoral collaboration for maximizing the outcomes of health and social welfare interventions;
- Quality Of Care: Quality shall be the pivotal dimension for delivery of health and social services;
- Community involvement and participation: All Namibians will be encouraged and empowered to actively participate in the affairs of their own health. The public will be provided an enabling environment through supporting community health initiatives.
- Public-Private Partnership: Namibia has a pluralistic health system and this will continue. The private sector shall play an important role through partnership work with the public sector. Promotion of public-private partnerships will be encouraged.
- Gender Equality: Attention shall be given to gender issues and other social determinants of health will ensure that women and men, boys and girls can enjoy a healthy life and have access to health services according to their specific needs;
- Social Welfare: Continued attention will be given to social welfare needs of the population in close collaboration with other Government sectors.

The service components are outlined below:

2.2. Integrated Sexual and Reproductive Health Services

Integrated Reproductive Health Services are established to provide safe, affordable and quality sexual and reproductive health information and services to all through rights and life-cycle approach. The services include Sexual and Reproductive Health Services to men and women, Essential Obstetric and Neonatal Care, Adolescent Sexual and Reproductive Health Services and Management of cancer of the reproductive system.

2.2.1. Essential Obstetric and Neonatal Care

The DHS of 2006 estimates the MMR at 449/100,000 live births. Given the current estimated population of 2 million and a rate of natural growth of approximately 2.6%, about 12,000 mothers will have complications during pregnancy and child birth, with close to 359 dying every
year due to complications of pregnancy and childbirth. For each of these mothers, the risk of their baby dying within the first year of life is three more than that of the surviving mothers.

The majority of maternal and neonatal deaths can be prevented through the use of cost-effective interventions and technologies. In cognizant of this fact, the Government of Namibia has prioritized maternal and child health among its key health and development agenda for the country. Promotive, Preventive, curative and rehabilitative maternal and child health services therefore form the centerpiece of PHC services. Essential Obstetric Care in Namibia is modeled around establishment of readily accessible quality Emergency Obstetric and Neonatal (EmONC) care during pregnancy, delivery and in the postpartum period.

The objective of EmONC is to contribute to the reduction of maternal mortality ratio (MMR) by 75% by 2015. This will be done by increasing the percentage of women delivering in health facilities by a skilled birth attendant and ensuring access to EmONC services in these facilities. In order to achieve this objective, health facilities will be upgraded to provide basic and comprehensive Emergency Obstetric and Neonatal Care Services. EmONC will comprise the minimum initial service package for Sexual and Reproductive Health (SRH) and emergency preparedness and response

The EmONC services include:

(i) Counseling for early detection of pregnancy, seeking early ANC services and compliance with minimum of 4 antenatal care visits;

(ii) Focused antenatal care which aims at early initiation of antenatal care and attendance of at least 4 antenatal care sessions by all mothers. This should enable early identify and referral of high risk pregnancies for management by skilled health professionals.

(iii) Nutrition education and support for expectant and postnatal mothers.

(iv) Skilled care and hygienic handling for mothers and newborns by skilled birth attendants (SBA) at delivery based on EmONC principles.

(v) Early identification, provision of life saving first aid measures and rational/timely referral for life threatening complications, i.e. antenatal hemorrhage, infections and severe hyperten sive-renal disorders in pregnancy.

(vi) focused postnatal care to prevent complications or identify any complications early by critically observing the mothers at least once at 6hrs, 24-48 hrs, in 6 days, after 6 weeks and at six months, checking especially for post-partum bleeding and or sepsis, starting life saving management and referring the mother and child promptly for further treatment.

(vii) Post abortion care (PAC) to minimize mortality and prevent severe morbidity as a result of inevitable or incomplete abortions and

(viii) Prevention of mother to child transmission (PMTCT) of STI and HIV, and nutrition education and support for lactating mothers

(ix) Newborn care that aims to prevent the risk of death from hypothermia especially for the newborns with low birth weight and choking; baby friendly initiatives, i.e., prevention of pre-lacteal feeds, early initiation of breastfeeding and encouragement of exclusive breastfeeding; identification of malformations, convulsive disorders or other obvious developmental anomalies and referral for treatment.

Maternal and Peri-Neonatal Death Review will be done at all health facilities and community maternal and neonatal/child death notification will be promoted. According to the level of reporting, appropriate investigation and corrective measures will be taken. Construction and effective running of Maternity Waiting Homes (MWH) will be promoted in collaboration with the communities and relevant government and non-governmental sectors and organizations.

2.2.2. Family Planning

Family planning and women's health is an initiative based on women's reproductive health rights (RHR). The objective of this initiative is to increase the percentage of women in their reproductive years using effective methods of contraception from the current 46% to cover all the unmet needs by 2015.

Service elements are:

(i) Awareness raising on FP to empower women and men to practice conception by informed FP choices

(ii) Provision of appropriate choices of effective FP methods to enable delay in initiation of child bearing for girls and birth spacing for women who have established child bearing to allow full recovery of health in between pregnancies and to minimize maternal and child morbidity and mortality

(iii) Create awareness and provide screening for any long term disability caused by pregnancy and delivery that includes obstetric fistula

(iv) Training in self-palpation skills for masses in the breast and seeking examination or referral

(v) Encouragement to regularly attend clinics for Pap smear, provider initiated counseling and testing for HIV

(vii) Promotion of tetanus toxoid (TT) vaccination for Women of Reproductive Age (WRA) and

(iv) Condom programming for protected sex and syndromic management of STI and mass communication to promote voluntary counseling and testing (VCT)

2.2.3. Adolescent Friendly Health Services

Friendly Health Services will provide services for adolescents and young people to prevent sexually transmitted infections, adolescent pregnancies and HIV/AIDS and to promote the general well being of adolescents. Youth friendly service provision and care will be adopted to encourage health seeking behavior among young people. The goal is to increase health awareness and Reproductive Rights knowledge among the youth to at least 80% by 2015.

Service elements include:

(i) Gender and Sexuality education

(ii) Life Skills Education

(iii) Abstinence, Being Faithful, and Correct and Consistent Use of Condom (ABC) promotion

(iv) VCT/PICT

(v) Syndromic Management of STIs

(vi) Injury, Suicide and Alcohol and substance abuse prevention and (vii) Mental and Psychological counseling and health services.

2.2.4. Men's Involvement in Sexual and Reproductive Health

The involvement of men in Sexual and Reproductive Health Services will promote safe sexual practices and raise awareness on reproductive diseases. It will also promote the support of men for the sexual and reproductive health rights and services of their partners.

The service elements are:

(i) Promotion of equitable gender roles in family health care

(ii) Promotion of VCT/PICT

(iii) reduction of sexual partners and condom use

(iv) SMSTI

(v) male circumcision and

(vi) Awareness raising and referral for suspected prostate cancer and enlarged prostrate

2.3. Integrated Management of Newborn and Childhood Illnesses (IMNCI)

Namibia currently has disproportionate child mortality rate to its GDP among the nations of the Sub-Saharan Countries. According to the DHS 2006, the mean IMR was estimate at 46 /1,000 live births, while the under-five mortality rate (U-5MR) was 69/1,000 live births.

Integrated Management of Neonatal and Childhood Illnesses (IMNCI) is a strategy that addresses the major causes of neonatal, infant and child mortality namely Malnutrition, Measles, Malaria, ARI, Diarrhea, Hypothermia and Birth Asphyxia among others.

While approaching the child survival and development issues from a health perspective, IMNCI is an approach that includes all the technical aspects of neonatal and childhood illnesses and gives special focus on the wellness of the child and disease prevention.

The aim is to improve child survival and development.

The objective of implementing proven strategies is to reduce child mortality rate by 2/3rd by the year 2015.

The interventions to achieve these objectives are integrated in service packages under the following specific service norms:

2.3.1. Home Care for Malaria, Pneumonia and Diarrhea

This is a mix of community level actions that address the most common childhood illness by promoting preventive measures, recognizing signs of illness in children early and treating them safely while observing for danger signs and other reasons for referral to clinic, health center or hospitals for more technical assessment and appropriate treatment. The program will deliver behavior change communication on nutrition, growth monitoring and prevention, home treatment of malaria, diarrhea and recognition and referral of dehydration and pneumonia, through a network of community based providers trained in the competent use of simple algorithms to assess, classify and treat the sick children, while counseling mothers, fathers and other caregivers in child health seeking behavior. This will be carried out under the oversight of the Health Extension Workers (HEWs).

Community based child survival package will include, but not be limited to:

(i) Prevention and treatment of malaria

(ii) Prevention and treatment of diarrhea

(iii) Management of acute respiratory infection (ARI) and pneumonia

(iv) Mass campaigns for immunization

(v) Community based growth monitoring and promotion

(vi) Home management of mild malnutrition, vitamin A supplementation and periodic mass treatment for deworming

(vii) Referral of children with severe malnutrition and complications or those with malnutrition not responding to appropriate community based rehabilitation to Therapeutic feeding Centers

2.3.2. Expanded Program on Immunization (EPI)

The program target is to raise access to routine immunization (as measured by DPT-HepB-Hib-3 coverage) from the current 83% to 90% by 2015; however, all the coverage for all the other antigens will be monitored as well with the aim of attaining "herd immunity" that is 90% or more coverage by 2015. This will be attained through routine immunization of children daily in all health facilities, monthly immunization of children in through mobile outreach teams, mass immunization on acceleration days and NIDs and mop up immunization activities, and Maternal and Child Health Days.

2.3.3. Nutrition

The target of the nutrition interventions is to reduce severe malnutrition from its baseline levels o 17% underweight to reduce it by 75% by 2030. This program is an initiative to primarily preven malnutrition, but includes very specific measures for treatment of children who are severely mal nourished.

The services include:

(i) The promotion of exclusive breast-feeding for at least the first 6 months of life and provision of complementary feeding with continued breastfeeding for at least 24 months

(ii) Growth monitoring and promotion

(iii) Micronutrient supplementation and community based nutrition rehabilitation for children with mild to moderate malnutrition

(iv) Provision of treatment and rehabilitation for children who are severely malnourished at designated Therapeutic Feeding Centers and through community based integrated management of acute malnutrition and nutrition rehabilitation

(v) Ensure provision of quality food which are safe for human consumption

2.3.4. Home treatment for Malaria, Diarrhea and Pneumonia

In Namibia, Malaria accounts for < 10% of all consultations at outpatient departments. Diarrhea and other enteric infections are common in Namibia because of poor sanitation and use of surface water or water from unprotected sources. As in all countries with high child mortality rate, it is estimated that diarrhea associated deaths account for 20% of childhood deaths. Reduction of the period o breast feeding and early introduction of weaning foods (before six months) that tend to set in with affluence and urbanization significantly increase the diarrhea morbidity and the risks of deaths from severe dehydration.

Acute respiratory infection (ARI) is also prevalent in Namibia. There is reliable data on the frequency and intensity of ARI in Namibia, but it is estimated that on average a Namibian child will have at least six episodes of ARI per year. The severe and dangerous form of ARI is acute lower respiratory tract infection or pneumonia. Like diarrhea, pneumonia is a common cause of childhood deaths in developing countries and Namibia is not an exception.

ARI is common in cold environment. Pneumonia occurs more commonly in children that are weaned at an early age, or those that suffer from malnutrition as a result of complications of other infections such as malaria, vaccine preventable diseases including measles and HIV/AIDS.

Vitamin A deficiency also increases the risk of developing pneumonia and dying from complications of vaccine preventable childhood illnesses. Another predisposing factor for developing lower respiratory tract infections including pneumonia is keeping children in smoky places. Protein energy malnutrition (PEM) and micronutrient deficiency especially vitamin A and zinc, aggravate the severity of infections and increase the risks of deaths in childhood.

2.4. Integrated Management of Adolescent and Adult Illnesses

HIV/AIDS and Tuberculosis (TB) are particularly a menace in the HIV infected populations in Namibia. Namibia has a uniquely high prevalence of HIV/AIDS and Drug resistant TB. This warrants the expansion and scaling up of Integrated Management of Adolescent and Adulthood Illnesses in the country. Being a neighbor of countries who have a circulating Wild Polio Virus (WPV) and meningococcal meningitis, Namibia is prone to outbreaks of these diseases and other communicable diseases including HIV/AIDS. In Namibia, the prevalence of human immunodeficiency virus (HIV) infection is high.

2.4.1. Malaria

Malaria is transmitted throughout the year in the swampy lowlands. In all other areas incidence of Malaria increases during rainy or flooding seasons as well as in association with movement of populations with little immunity to endemic areas when outbreaks occur or the disease reaches epidemic proportion. Even though the incidence and deaths due to malaria are decreasing, there is a need for vigilance and avoid complacence on the basis of the current achievements. The reduction of malaria morbidity and mortality will result into a collection of population cohort who does not have immunity to the disease; and any outbreak could lead to a devastating effects on the population affected. Since malaria is among the top leading contributors to the burden of diseases, The WHO and MOHSS are embarked on elimination of Malaria from Namibia. This entails the cross border collaboration among the Southern African Development Community (SADC) countries as the elimination could not be realized without the involvement of all countries. The malaria program in Namibia is within the Directorate of Special Programs (DSP). The program has to have an integrated approach to maximize the health outcomes of the country.

2.4.1.1. Prevention

The objective is: to increase population coverage with effective malaria prevention as part of an integrated vector control strategy that utilizes all approaches including long asting insecticidal nets, indoor residual spraying and environmental management when and where most suitable and sustainable.

The services are:

(i) Awareness creation sensitization and education

(ii) Mass distribution of Long Lasting Insecticide Treated Nets (LLITNs),

(iii) Distribution of LLTNs through ANC, immunization and Maternal and Child Health Days

(iv) In-door Residual Spraying (IRS) of dwelling or institutional structures.

2.4.1.2. Case Management

The objective is: to provide wide access to diagnosis and highly efficacious artemisinin-based combination therapy to all affected by malaria using a mix of approaches that include public and private health care providers, trained and supervised commercial sector workers and community distribution.

The services are:

(i) Use of algorithms for assessment, classification and treatment of children under the age of five promptly with appropriate (ACT) at all levels of the health care delivery systems within 24 hours

(ii) Early detection of signs of malaria prompt confirmation of diagnosis of malaria and treatment for older children and adults at all levels of the health care delivery systems

(iii) Recognition of danger signs of malaria, referral and prompt initiation of second line treatment with quinine

2.4.1.3. Malaria in Pregnancy

The objective is: To deliver a package consisting of LLITNs, Intermittent Presumptive Treatment (IPT) and effective treatment to pregnant women through comprehensive and focused antenatal care services involving all levels of health care including the communities.

The services include:

(i) Counseling of mothers to attend ANC and get at least two (2) doses of IPT

(ii) Early detection of fever in pregnant mothers, test for malaria at health facilities and provision of treatment with appropriate medicines

(iii) Complementary distribution of IPT through community based maternal health workers or midwives and

(iv) Detection and treatment of anemia

2.4.1.5. Malaria - IEC, Social Mobilization and Advocacy

The objectives is: To mobilize all sectors of society to promote malaria control and increase adoption of positive behavior, based on a comprehensive malaria communica tions strategy that includes all available media and communication channels.

The services are:

(i) Awareness creation on malaria and its effects

(ii) Promotion of acquisition and on sleeping under LLITNs, ANC and IPT and use of simple algorithms for home management of malaria for children under the age of five years

(iii) Compliance counseling for proper use of LLTNs

2.4.2. Diarrhea, enteric infections and infestations

According to 2011 Population and Housing Census, access to sanitary methods of fecal disposal is still low, only 31% of the majority rural residents of Namibia have access to improved sanitary facilities. Thus intestinal infestation and enteric infections are still common and can occur in epidemics from time to time especially during the changes from dry to wet seasons and vice versa.

The service elements for management of enteric infections include

(i) Raising community awareness on the causes of diarrhea and its prevention. Mothers are to be encouraged to continue with the healthy infant feeding and weaning practices

(ii) Training communities on safe use of potable water and promotion of hand washing before and after handling food, after toilet including after cleaning or handling children's feces

(iii) Raising awareness on safe disposal of feces including those of children

(iv) Promoting immunization especially against measles and

(v) Regular administration of vitamin A (every six months) for all children under age six months to five years

(vi) All parents and other people who care for children are to be taught to (a) recognize out breaks of diarrhea early and immediately alert staff at the nearest health facilities

Additional gastro enteric infection and infestation related services are regular deworming of children through periodic mass campaigns and school health programs; and health education of recognition of other enteric infections especially abdominal pain, progressive fever and generalized weakness, constipation or small loose stools that signify typhoid fever. Such are to be referred to health facilities for laboratory investigation, diagnosis, treatment with antibiotics.

Other services for prevention of diarrhea directed to communities are:

(i) Awareness raising and sensitization workshops for village health committees. Participatory Health and Sanitation Training (PHAST) for community health workers and the community. Facilitation for practical identification of water points, their protection and discouragement of risky sanitary practices by identifying them and developing community based interventions. Emergency preparedness by identifying early warning signs for out breaks of diarrhea and developing responses and reporting. Construction of demonstration toilets and protection of water sources in schools, market places and administration centers, and any other strategic places such as community gathering venues.

2.4.3. Acute Respiratory Infection (ARI)

Older people and children under the age of five with pneumonia must be referred promptly to the health facilities to start treatment with oral antibiotics immediately. In addition to treatment with oral antibiotics some might require injections and oxygen if they develop respiratory failure.

2.4.4. Tuberculosis

Tuberculosis in Namibia is among the major public health problems especially with the advent of HIV/AIDS and the poor and nomadic life style of the populations. It is among the major causes of morbidity and mortality. The estimated incidence of new sputum smear positive TB cases is 662 per 100,000 Population. In addition, there is an alarming rate of Multi-Drug Resistant (MDR) and Extensively Resistant (XDR) TB in the country. However the cure rate for those who are enrolled in treatment is 82%.

This situation is likely to be worsened by the HIV epidemic which is estimated at 18.2% prevalence in the general population according to the ANC Sero-Prevalence Survey Report of 2012. The HIV sero-prevalence rate among TB patients in Namibia is 60%.

HIV fuels the prevalence of the TB epidemic by promoting the rapid progression of recent and latent mycobacterium tuberculosis infection into active disease. TB in people living with HIV/AIDS poses a greater risk of increased transmission of tuberculosis in to the community, on the other hand, TB has a profound effect on the course of HIV/AIDS infection because it accelerates the process of transit from asymptomatic HIV to AIDS Related Complex (ARC) or to overt AIDS. The overall goal of the TB program is to contribute to the improvement of the quality of life of the people of Namibia by reducing drastically the burden of the TB in line with the Millennium Development Goals and Stop TB Partnership Targets.

The service elements are:

(i) Continue the expansion of the TB treatment centers to reach all those who need it by integrating services at all levels of the health care delivery system to improve patients access to effective diagnostic and treatment services. This requires high political commitment with sustained financing to the tuberculosis control in Namibia

(ii) Promotion of effective community involvement in tuberculosis and patient centered care through advocacy, communication and social mobilization

(iii) Ensure that all laboratory facilities in Namibia submit TB slides for quality control to ensure quality and consistency

(iv) Ensure that all treatment centers use standard treatment regimen and are regularly supervised and patients supported

(v) Ensure that all TB treatment centers have regular supply of TB drugs and

(vi) Ensure that 100% of the TB treatment centers receive regular and effective supervision and monitoring from all levels of the health management and impact assessment is done

2.4.5. Sexually Transmitted Infections (STI), Human Immunodeficiency Virus infection and Acquired Immunodeficiency Syndrome (HIV/AIDS)

Sexually transmitted diseases are a common cause for illness in health facilities in Namibia. STIs feature as the most common cause of illness in some health facilities in Namibia. Moreover, ANC Sentinel Surveillance report of 2012 shows that an HIV prevalence rate of 18.2%.

Epidemiologically, Namibia faces a massive threat from HIV by following factors:

(i) It is surrounded by countries with high HIV prevalence

(ii) It has an open border with Angola where there are millions of people that were displaced by prolonged civil war

(iii) Has high levels of unemployment and poverty and

(iv) Its women and girls are not adequately empowered and violence against women and girls is rampant. So far data from different sources which include counseling and testing cent ers, maternal health services centers that offer prevention of mother to child transmission of HIV (PMTCT) and TB treatment centers indicate that HIV/AIDS epidemic is in a generalized phase. Data from the ANC clinics extrapolated to the whole population indicates an HIV prevalence rate of 18.2%.

The approach to STI and HIV control are aimed at ensuring adequate access to integrated prevention, treatment, care and support for all especially marginalized populations. This entails the creation of a supportive environment for a sustainable and effective response to HIV in communities of Namibia, In addition the PHC service packages will enhance the HIV program efforts to scale up comprehensive HIV care and treatment and ensure equitable access to services for all especially the vulnerable populations and expand access to comprehensive adherence counseling, psychosocial support and care for PLWHA. Special programs will target specific populations at risk such as sex workers, adolescents, long-distance truck drivers, uniformed services and prisoners.

The service elements include,

(i) Awareness creation on the causes, risk factors complications and dangers of STI and HIV

(ii) Promotion of safer sexual behavior including condom promotion, procurement and distribution

(iii) Encouragement of prompt health care-seeking behavior in case of experiencing symptoms and signs of STI

(iv) Comprehensive case management of STI at health facilities

(v) Prevention and care of congenital syphilis and neonatal conjunctivitis

(vi) Promotion of provider initiated counseling and testing (PITC)

(vii) Referral linkage with HIV testing and other HIV prevention, treatment and care services, as appropriate and

(viii) Home based care and adherence counseling for PLWHA already on treatment

2.4.6. Neglected Tropical Diseases

The Ministry of Health and Social Services (MoHSS) recognizes neglected tropical diseases (NTDs) as major public health problems that have the potential to affect the health and wellbeing of Namibians. These include Sleeping sickness/trypanosomiasis, schistosomiasis and soil-transmitted helminthiasis (STH). There is a need to monitor and ensure effective control of these diseases.

The service elements include

(i) Health education to create awareness on the causes, dangers and impact and means of prevention of the diseases

(ii) Promotion of interventions to reduce the contact between people and the parasites and/or vectors, through provision of protected water sources, encouragement of construction and proper use of toilets and avoidance of unprotected water sources by all and

(iii) Preventive chemotherapy through mass drug administration and other complementary approaches recommended by the WHO

Briefly, the actual activities are:

- Schistosomiasis control that includes prevention of transmission with a single, annual dose of the drug praziquantel, mass treatment with albendazole, identification and treatment of cases with albendazole and health education to increase number and use of toilets.
- Trachoma mapping, community distribution of topical antibiotics for mass treatment and the visual health program
- Trypanosomiasis surveillance and control

2.4.7. Primary Eye Care

Blindness in many developing countries causes a significant burden to the visually impaired persons, families, communities and the country at large. The major causes of blindness in developing countries are infection like trachoma and measles and nutritional deficiencies, especially vitamin A deficiency, which leads to corneal ulceration and lifelong blindness.

The Primary Health Care (PHC) interventions will be developed to provide opportunity to integrate primary eye care as a component of PHC. Intricate relationships exist between primary health care and primary eye care. Social and community development that include provision of adequate clean water, growing of green vegetables rich in vitamin A, and construction and maintenance of pit latrines to promote health through change in behavior and environmental management leading to reduction or elimination of factors contributing to eye diseases and blindness.

Primary eye care activities

Promotive and preventive activities:

- Promotion of nutrition education (Vitamin A), eye health education and prevention and treatment of eye infection and Vitamin A deficiency.
- Dissemination of information which should include location where treatment can be obtained, seeking out and compliance with treatment given.
- Creation of awareness that most of the eye diseases are preventable and treatable.
- Giving of health education on personal and environmental hygiene, nutrition, sanitation and protection of the eye
- Stimulation of individual and community participation in activities to prevent blindness and become involved in community based treatment programs such as for trachoma prevention and treatment initiatives.

Conditions that can be treated at the Village, PHC Clinics and Health Centers are as follows:

Acute conjunctivitis: can be recognized by redness of the conjunctiva and purulent discharge without loss of vision. Treatment can be achieved by cleaning of the eye lid with moist cotton swap followed by application of tetracycline eye ointment. If there is no improvement, the patient should be referred to higher centers.

Ophthalmia neonatorum: Red eye, swollen lid and purulent discharge occurring in a child within the first month of birth and caused by maternal gonococcus or Chlamydia infection. It is a serious and potentially blinding disorder that must be recognized and treated immediately. Irrigation of the eye followed by installation of tetracycline ointment should be started immediately. The mother as well as the father should be treated with systemic Erythromycin. To prevent ophthalmia neonatorum all newborns should have tetracycline ointment instilled into their eyes immediately after birth and birth attendants and midwives should be instructed on how to do this.

Trachoma: Chronic and endemic conjunctivitis caused by Chlamydia trachomatis. It is endemic in developing countries and Namibia is not an exception. Poor personal and environmental hygiene as well as lack of water are the aggravating factors of trachoma. If not treated, trachoma can lead to permanent blindness. Treatment of active disease consist of twice daily application of topical tetracycline for at least 6 weeks as well improvement in personal and environmental hygiene.

Allergic conjunctivitis: This includes most of the conditions that cause chronic redness and itching without discharge and visual loss such as blepharitis, allergic conjunctivitis and irritation from dust. These conditions can be treated by Antihistamine or zinc sulphate for a short time. Recurrences are common and no steroid should be used for treatment.
Traumatic sub-conjunctival hemorrhage: Appears suddenly as a bright red patch on the white part of the eye without pain or loss of sight or discharge. No treatment is necessary but the patient should be assured that it heals quickly without sequel. Sub-conjunctival hemorrhage associated with visual loss should be referred to a higher eye care facility.

Conjunctival foreign bodies: Foreign bodies under the lid should be detected by averting the lid. They should be removed by cotton tipped applicator following which an antibiotic ointment should be instilled into the eye.

Corneal foreign bodies: These rest on the surface of the cornea and can be detected with simple touch and loupe. They can be removed under local anesthesia. This condition should be referred to a facility where there is an ophthalmologist.

Corneal abrasions: This can be recognized as irregularities in the epithelial surface of the cornea and confirmed with examination with blue filter of the ophthalmoscope after staining with fluorescin. Prophylactic antibiotics and eye pad will result in rapid healing.

Equipment and medicines that can be availed by at clinics and health centers include visual acuity chart as well as magnifying equipment. Main drugs include tetracycline ointment, local anesthetic drop and Zinc sulphate or other antihistamine drops for allergic conjunctivitis. Visual acuity assessment is perhaps the most important clinical examination that can perform at clinic and health center. Nurses should be able to recognize a blind person from measuring visual acuity and refer such person to higher level health facility where further assessment and diagnosis can be performed to determine the cause of the blindness.

Training: Forms an important component of primary eye care. Nurses should receive training in visual acuity assessment and recognitions of basic conditions that usually present in rural clinic such as conjunctivitis, trachoma, allergic conjunctivitis and complaints of poor vision.

Cataract Surgery: Trained general medical practitioners/doctors can effectively and safely provide cataract surgery at PHC levels such as at health centers and district hospitals.

Conditions that can be cared for in schools

Hand washing and face washing can prevent diarrhea and eye and other infections among school children. Screening for refractory errors can be conducted by nurses and teachers who are trained to use Snellens chart. This can start from identifying children that are performing poorly for unknown reasons or those with difficulty in reading and writings.

2.4.8. Oral Health

Oral health is a state of being free from acute and chronic diseases of the mouth and oral cavity as a whole. Oral health addresses oral infections; malnutrition induced diseases of the mouth including cancrum oris, cancer of the periodontal, oral sores, birth defects such as cleft lip and palate, periodontal (gum) disease, tooth decay and tooth loss, and other diseases and disorders that affect the oral cavity.

Risk factors for oral diseases include unhealthy diet, tobacco use, poor oral hygiene and malnutrition. The Ministry of Health and Social Services shall embrace the WHO Global Oral Health Program whose objectives are reoriented to development of policies in oral health promotion, oral diseases prevention and treatment. The approach is to empower communities to develop and implement oral health programs with focus on disadvantaged groups as per the PHC concept.

The components of oral health include:

(i) Creation of awareness on oral health and promotion of self-care oral hygiene practices through brushing and effective control of diet to minimize nutrition risk factors for dental diseases

(ii) Child focused oral health education and prevention aimed at getting better dental status in the future generation through brushing sessions at schools, mobile outreach for screening and simple treatment and referral for complicated cases including

(iii) Integration of safe water and sanitation programs

(iv) Integration of the WHO global strategies on diet, physical activity and health and discouragement of tobacco use to reduce risk factors to oral cancer, oral mucosal lesions and periodontal disease.

2.4.9. Mental health

Service elements for mental health include:

(i) Awareness creation at community level on mental disorders and their manifestations in local settings

(ii) Support for parents of infant with mental impairment

(iii) School-based interventions, such as teacher to pupil counseling, peer to peer counseling, identification and referral of children with poor school progress, counseling and referral of children with mental disorder which can be manifested with loss of concentration, poor per formance and Adolescent delinquency

(iv) Workplace and unemployment counseling programs for youths and adults,

(v) Activity programs for elderly people

(vi) Abandonment of domestic violence, substance abuse, home and school truancy and gender related violence

(vii) Interventions to develop counseling and support programs for chronic diseases including HIV, cancer and others, assertiveness, self-reliance and appropriate participation, which are in turn components of mental health.

2.4.10. Community based prevention and care for common injuries and rehabilitation

Injury is a very common cause for death and disability in developing countries. Injuries could be due to motor vehicles accidents, violence, and war, natural and man-made disasters among others. Injuries can lead to long term disability and loss of productivity. A large number of injuries can be prevented by simple measures, starting from awareness of risk factors in the homes, and in the surrounding environment. Motor vehicle associated injuries are on the increase especially in developing countries including Namibia. It is claiming a significant number of lives and causes millions of dollars worth of public and private properties.

First aid is easy to learn, and everyone can and should have basic first aid knowledge. The care given before emergency medical help is available can literally mean the difference between life and death. For example, a blocked airway can kill someone in three to four minutes. A simple procedure such as opening someone's airway which can be performed by a non-medical person can save lives.

The care for people with injury and community based rehabilitation for people with chronic debilitating conditions comprise the following service elements:

(i) Identification and awareness creation on the most common local injuries

(ii) Preparedness for early and ongoing treatment of accidents, including mass accidents and injuries to prevent unnecessary deaths or disability

(iii) Provide basic counseling and care for people affected by disability or potentially disabling disease conditions (leprosy, TB of the spine, trauma, cerebral malaria, etc)

(iv) Define and maintain referral procedures for specialized or specific services (eye surgery, prosthetics, etc),

(v) Provide simple basic assistive devices (toilet chairs, crutches, etc), either locally produced or sourced from specialized organizations

(vi) Identify people with functional (physical and mental) impairments at early stages for timely referral and

(vii) Maintain surveillance of disabilities among the population

2.5. Integrated Disease Surveillance and Response (IDSR)

For some key diseases and conditions, reliance on the monthly or quarterly reports of the HMIS is not sufficient as time is crucial for early detection and timely response for outbreaks and epidemics. The IDSR is a reporting system which enables more frequent monitoring of cases of a limited range of diseases or disease conditions falling into four categories:

- Diseases of epidemic potential, e.g., meningitis, cholera,
- Diseases targeted for eradication, e.g., measles, polio, malaria
- Diseases targeted for elimination, e.g., Guinea worm disease
- Diseases and conditions of major public health significance, e.g., malaria, childhood diarrhea, pneumonia, tuberculosis, maternal and neonatal mortality and others.

Through monitoring of disease and disease conditions at all levels, an appropriate and rapid response can be put in place.

2.6. Health Education and Promotion

Health promotion is an approach for improvement of health and social status and prevention of diseases and disabilities. It is a paradigm shift from provision of information, education and communication (IEC) alone. It is led by Behavioral Change Communication (BCC), but in addition includes facilitation of behavior change by providing inputs that enable and reward the behavior change.

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities for ownership and control of their own health. The process draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation in health care. This entails continuous provision of support for personal and social development through providing information and education for health and social development. It involves enhancement of life skills to increases the options available to people to exercise more control over their own health and their environments, and subsequently enable them to make choices conducive to improved health status.

In Namibia, Health Promotion aims at increasing awareness and demand for essential health services, with major focus on prevention of diseases and promotion of health. It also addresses the emerging or re-emerging diseases and disease conditions that have serious public health implications such as TB and HIV/AIDS, trauma and related disability. The approach is to facilitate learning throughout life cycles, in order to prepare people to respond appropriately to their health needs.

Schools and other educational facilities and networks provide strategic entry points to improvement of health within the schools and institutions, which can then be transmitted to the home, work place, administrative, cultural and recreation venues. Efforts must be made to integrate health messages into other sectors including education, agriculture, information and communications technology, gender and child welfare, labor and social welfare, youth, national service, sports and culture and religious affairs among others.

Health professionals and their respective counterparts in other sectors are to work together towards a better health with synergy and complementarities to contribute to the pursuit of a better health and social advancement. Captive audience including schools, women, youth and men's economic and social groups should be engaged as partners in the joint initiatives in this process of learning for transformation. The PHC Service Package in each region should develop protocols for community based health promotion activities

The following are summary description of some health promotion initiatives:

2.6.1. The Promotion of health seeking behavior

The overall aim of health promotion is to ensure a healthy life style in communities, prevent diseases and create demand for health care services.

The service elements include:

(i) Awareness creation and counseling during home visits

(ii) Advice and counseling during visits to facilities

(iii) Social mobilization for uptake of preventive and promotive health services

(iv) Production and distribution of culturally appropriate health information, education and communication (IEC) materials. In addition, all campaigns shall be accompanied by health education and social mobilization messages. Behavior Change Communication to support compliance to ANC, immunization, growth monitoring and promotion (GMP), possession and sleeping under LLTNS, use of water from protected sources, safe sexual and reproductive health behaviors including prevention of STI and HIV/AIDS

2.6.2. Basic package of health and nutrition for Schools

Basic education has the highest potential for instilling a lasting societal change; therefore schools will be used as entry points into the communities to open channels between the health sector and broader social, economic and environmental sectors. The Basic Package for School Health which was developed by UNICEF and WHO will serve as a standard guideline in all schools. The objectives are to maintain optimal health of school pupils, to induce healthy life style and responsibility for your own health in the new generations and to transfer health messages to the homes, villages and communities of the students. Adolescents should benefit from knowledge about reproductive health and rights in preparation for healthy reproductive lives.

Promotion of safe water sources, appropriate use of toilets, house ventilations, kitchens, and play grounds should be undertaken. Health promotion in schools should be prioritized to ensure the sustained improvement of health of most school children while passing health messages to the surrounding communities. Health messages can be passed through school exercises, e.g., young and lower grade learners can be given reading exercises that promote health seeking practices such as taking infants for immunization and growth monitoring, keeping infants under LLITNs, making under-fives sleep under bed nets, and reinforcing staple diets with high protein supplements. Schools drama, participatory educational theatres, folk music and first aid contests are to be organized. School letters to parents should also be used to pass health messages. School health inspection and growth monitoring outreach should be carried out regularly by school health teams to monitor and evaluate the outcome of the initiatives.

2.6.3. Community based nutrition and food security program

This initiative will address food production, preservation, preparation and dietary practices in close collaboration with the relevant ministries such as ministries of agriculture, water, environment, education, gender and child welfare and others. Groups that include women, youth, farmers and schools will be sensitized and provided with necessary inputs for farming, animal and poultry production in sufficient quantities to bridge the gaps in their food insecurity.

Women will be taught income generation skills and opportunities for benefiting from micro financing. They will also be trained in proper storage of grains and pulses and methods of preservation of perishable foods such as vegetables, milk and meat, that are appropriate to their local situations. Community groups will be facilitated to invest in low level technologies and other methods of food production and preservation that they are willing to adopt and invest in.

In schools, the aim will be to have farms that will not only make the schools food sufficient, but also to be a source of extra income. The demonstration projects will be used as forums for training in nutrition and dietetics, construction of safe and energy conserving kitchens and appropriate food granaries.

2.6.4. Community management of environmental health and hygiene

This should create awareness and provide skills in protection of water sources, promotion of use of latrines and education on personal hygiene. The programs will include education in physical safety, accident and snake-bite prevention and first aid, promotion of oral health and community based mental health programs.

The places where people live, work, learn, and play will protect and promote their health and safety. At household level, this initiative will promote health through safe and healthy home environments, with a focus on equitable gender role assignment and responsibility for health; in particular, the empowerment of men to be more involved in the health and social well being of their families.

At community level, the aim is to increase the number of communities which protect and promote better health and safety. In schools, Package of Health for Schools model will be adopted and delivered to increase the number of schools that protect and promote better health, safety and development of all pupils and staff.

At the work place, this initiative will promote healthy and safe workplaces to prevent workplace-related fatalities, illnesses, injuries, and health risks. This will include gender relationships and perspectives at work place using STI and HIV/AIDS as entry points. Training in prevention and first aid for physical injuries, snake-bite and Cardio-Pulmonary Resuscitation (CPR) are highly relevant to the Namibian situation. Other work place interventions will target lifestyle related diseases including obesity, high blood pressure and diabetes.

Health promotion will be largely a community based affair, but will be supported by health talks and the construction of demonstration for safe living environments prioritizing water sources, toilets, clean residential and work place environments, well ventilated houses to minimize respiratory infections, safe kitchens, food storage, nutrition and dietetics and cookery, safe snacking foods, safe housing, LLITNs and how to use them in local circumstances, home gardens and, fish ponds and poultry farms among others.

2.7 Monitoring and Evaluation

Monitoring and evaluation (M&E) is essential in assessing the implementation of essential health package in order to make necessary adjustments to correct weaknesses and scale up best practices. M&E is also useful for adjustment of future programs and plan of actions. The M&E will be integrated at all levels of the health care system to monitor the implementation of the essential package. Monitoring and Evaluation tools and guidelines will be developed toguide health workers and managers to implement M&E.

The M/E activities will be carried out by all levels of the health care management system. Health Information Systems, Regional and District Health Management Teams and partners will play an important role in this process. Periodic evaluation will be conducted through the existing systems such as Demographic and Health Survey (DHS), and other national, regional and local surveys as required.

2.7.1. Health Management Information System (HMIS)

The Health Management Information System (HMIS) including Health Information System (HIS) will be the tool for monitoring the implementation and impact of essential interventions of PHC package of at all levels of the health care delivery system. A periodic analysis of the routine HMIS reports will be done to guide future plans and programs around Primary Health Care. Analysis of the existing indicators to monitor the implementation and impact of PHC will be done and review of indicators conducted as required.

The major gap in the existing HMIS of Namibia is that there is no comprehensive inclusion of indicators from community health interventions, which is the backbone of the Primary Health Care approach. For effective monitoring of epidemiological data, coverage, and logistics at the community level, a separate format is required to reflect the contents of the community level interventions of Primary Health Care.

2.7.2. Operational research

The bulk of health problems and health systems challenges in developing countries lie at the marginalized and disadvantaged communities. The information gap at that level is huge. Therefore, to guide the design and implementation of essential health package as well as the development of policies and programs. Operational research will be promoted at the community, first, second and tertiary level health care delivery system.

3. District Service Components and Norms

The components and service norms of selected/priority essential areas are outlined in the tables below:

Table 2: PHC Service Packages at a Glance

Component	Sub-components	Service Norms
Integrated Reproductive Health Services	Essential Obstetric Care EmONC, PMTCT,PNC, FP)	*Quality focused antenatal, safe hygienic delivery and post natal care emphasizing early recognition of complications, life saving interventions appropriate to each level and expedient rational referral; PMTCT and prevention and management of STI in pregnancy. Maternal and Newborn Nutrition. The EmONC has two types BEmONC provides the signal functions of basic EmONC: (i) I.V antibiotics administered, (ii) I.V oxytoxics administered, (iii) I.V Anti-convulsants, (iv) Manual Removal of the placenta, (v) Assisted delivery by Vacuum Extraction, (vi) Manual Vacuum Aspiration (MVA) of retained products of conception and post Abortion Care (PAC), (vii) Neonatal Resuscitation; and CEmONC -- comprehensive EmONC which provides the full EmONC functions plus (i)caesarian section and (ii) blood transfusion..*
	Protective SRH for women	*Safe temporary and emergency contraception permanent contraception, management of obstetric fistula, infertility, prevention and management of STI and HIV/AIDS screening for and early treatment for cervical and breast cancer; empowerment for gender equitable reproductive practices; and childhood female reproductive (physical) anomalies.*
	Adolescent SRH	*Empower young people and provide services that enable them make reproductive and sexual decisions that will ensure their health now and in the future by preventing adolescent pregnancies, STI, HIV/AIDS and secondary infertility. Gender equitable roles training, promotion of ABCD, and Improved nutrition for adolescent girls .*
	Men's SRH	*Counseling on gender equitable sexual roles, shared responsibilities regarding male involvement in to know and act to improve women's health and participate in contraception; male circumcision, recognition and management of men's RH problems in Childhood, physical anomalies, adolescence delayed or disturbed puberty and adults sexual dysfunction, infertility, prevention and management of STIs and HIV/AIDS and gender based violence and in Old Age, PADAM (Partial Androgen Deficiency in Aging Male) and prostatic hypertrophy.*
Child Health and nutrition	Integrated Essential Child Health Care	*Expanded Program on Immunization (EPI) - Achieve and maintain coverage with all the vaccines currently available for preventable childhood illnesses according to GAVI guidelines.* *Essential Child Nutrition Action: Promotion of exclusive breast feeding up to six months starting with initiation of breastfeeding within 30mins to 1hour of birth, starting complementary feeding from sixth months and continue breast feeding for 24 months. Growth monitoring and promotion and micronutrient supplementation and community based nutrition rehabilitation, referral of unexplained failure to thrive and malnutrition.* *An integrated early childhood care(IECHC), approach to managing common childhood illnesses - Malaria, Childhood diarrhea, Acute respiratory infections (ARIs) Pneumonia, anemia, malnutrition, intestinal parasites and common epidemic outbreaks. This combines the Community Based Child Survival Program (CBSP) and Integrated Management of Newborn and Childhood Illnesses (IMNCI); and care of special children – those with anomalies and developmental impairment.*

Endemic diseases	Management of local endemic diseases	*Preventive services and IEC on Malaria, Diarrhea ARI and Pneumonia, TB, STI and HIV/AIDS, meningitis and enteric infections.* *Case management: provision of treatment for common endemic illness as close to the population as possible.*
Non-Communicable diseases and conditions	Community based prevention, care for common injuries and rehabilitation	*Empower communities to prevent and provide appropriate immediate care for injuries including rational referral and identify and care for people with various physical and functional impairment and chronic debilitating conditions integrating them in as near normal community life as possible.*
	Visual health, Oral Health and Mental Health	*Visual health: school based eye care programs, face washing sessions for younger children, health education and training of teachers on visual acuity testing and simple remedial measures for RE mass topical antibiotic treatment as and when necessary.* *Oral Health: School based programs, train teachers on sessions for brushing and inspection for cavities for the young children.* *Oral health education and checkups at PHCU and PHCCs* *Mental health: Psychosocial programs for stressful conditions, awareness raising, community based counseling and community programs for gender based violence, substance and alcohol abuse, and behavioral counseling and referral for serious psychiatric conditions.*
	Non-Communicable Dietary related diseases (NCDRD)	*NCDRD: Management and counseling of dietary practices that may exasperate or promote dietary related diseases. e.g. Prevention: Health staff to provide practical advice to clients and families on the benefits of healthy diets and increased levels of physical activity* *Educate and Support the clients to adopt healthier composition of food by:* • *reducing salt* • *decreasing saturated fats* • *limiting intake of free sugars* • *limit salt consumption from all sources and ensure that salt is iodized* • *increase consumption of fruits and vegetables* *Educate the community on Early detection of NCD-RD through screening for cancer, Hypertension, Cardiovascular diseases and Diabetes.* *Provide appropriate treatment for NCD and continuous counseling on healthy diet and physical activity* *Assess nutritional status of all clients attending health facility to determine overweight and obesity and counsel according the National Guidelines on NCDRD* *Develop IEC materials with coherent, simple and clear messages on healthy diets and management of NCDRD in local languages*
tion .nity health	Awareness sensitization and BCC on the priority health problems	*Maternal and child health care(promotion of ORT, use of ITNs, immunization, breastfeeding, complementary feeding, hand washing ,antenatal care, skilled attendance at birth, etc); IECHC, Endemic common infective diseases, community based environmental safety, injury prevention and first aid, safe water use and sanitary practices, reproductive practices including family planning and sexual behavior. healthy lifestyle physical and recreational activity,*
	School Health and Nutrition (Health Promotion School Initiative)	*Skill based training on physical injuries, drowning, accident and snake-bite prevention and management as entry point to intersectoral integrated development promotion: information, education and behavior change communication for health and school based nutrition program school food security program : Food production, preservation, preparation and dietary practices and hunger prevention, healthy lifestyle physical and recreational activity at schools* *Gender perspectives of health and development: Skill based adolescent reproductive health*

	Community based nutrition and food security	*Empower communities to develop a range of environmentally friendly and sustainable, collective community actions for production, exchange, preservation, storage, of a range of food that ensure prevention of hunger and preservation of optimal nutritional status of female and male children and adults Nutrition*
	Community actions for safe environment, water and sanitation	Development of community capacities to gain sustained access to improved water supply and sanitation services and promotion of safe hygienic practices (to include education about use of latrines, hand-washing with soap and water and clean water sources).
	Disease surveillance and emergency preparedness	*Community based identification and reporting of known disease outbreaks: meningitis, cholera, trachoma, staphylococcal conjunctivitis; recognition of unusual outbreaks and community disasters preparedness and response*
M&E and Operations Research	Routine Health Management Information System, Periodic Surveys and special studies/ investigations	Ensuring shared responsibility for collection and interpretation of health related information, data, statistics or experiential studies. Extending the routine health data/statics collection from state to community based level to inform planning and evaluation of programs. Integration of existing parallel systems into an overall HIS.

Table 3: Summary of Integrated Reproductive Health Care Emergency Obstetric and Neonatal Care (EmONC)

Service	Community (Village) level	Primary Health Care: Clinic	BEmONC Primary Health Care Centre (PHCC)	EmONC: District hospital
Focused Antenatal Care	1. Identification of pregnant mothers and counseling for Early initiation and compliance with ANC, 2.Referral for antenatal care, PMTCT and STI prevention and treatment 3. Nutrition counseling, for mothers, micronutrient supplementation iron, and folic acid and vitamin A. 4. Malaria prevention, LLINs and IPT 5. Preparation and timely referral for BEmONC or	As at Community/Village level plus: 1. Identification and referral of high risk cases or complications to appropriate EMNOC centre: High Risk/Complications: CPD, fluid retention, previous C/section, multiple pregnancy and grand multiparity, antepartum hemorrhage, severe edema, severe antepartum fits : refer to CEmONC. 2. Moderate risk, infection, Post partum hemorrhage: Volume replacement – Intravenous transfusion Infection: Cotrimoxazole Pallor: Iron, folate and multivitamins, HBP, Refer to BEmONC.	Services provided 8 hours daily all working days a week. All activities PHC level plus: 1. Liaisons with a Reproductive health focal point 2. All signal functions of Basic EmONC. - normal deliveries - treatment of moderate obstetric complications *including i.v., antibiotics, MVA* 3. Identification of high risk cases and referral to CEmONC or State Referral Hospital.	Services provided 8 hours daily all working days a week. All activities of BEmONC plus: 1. Liaisons with a reproductive health focal point 2. All signal functions of Comprehensive EmONC (at antenatal Preparation)

	CEmONC according to risk status including arrangements for residential waiting homes	3. Monthly Antenatal care Mobile Clinic services.		
Care of uncompl icated Delivery	Referral of all mothers in labor to BEmONC PHCC for clean hygienic assistance of uncomplicated delivery. Clean hygienic assistance of delivery for precipitous labor, while transferring to PHCU/PHCC	Provision of Clean hygienic assistance of uncomplicated delivery for abrupt labor, oral misoprostol (or cytotec),	Clean hygienic assistance of uncomplicated delivery: gloves, cotton wool, clean blade, soap, oral misprostone-cytotec, Obstructed labor and Haemorrhage: refer to CEmONC Immediate care after birth, neonatal resuscitation, vaccinations	Comprehensive non surgical and surgical obstetric services 24hrs. Immediate care after birth, neonatal resuscitation, vaccinations,
Emergen cy Obstetric and Neonatal care	Awareness raising on high risk labor CPD and other obstructed labor, Hemorrhages, Fever, Convulsions – refer to CEmONC.	Identification of hemorrhage and stabilize with Intravenous fluid for volume replacement as case is transferred to refer to CEmONC; Transfer of obstructed labor, eclampsia, high fever and sick neonates to EmONC centres.	*The signal Functions of Basic EMoNC:* *I.V* antibiotics administered I.V Oxytoxics administered I.V Anti-convulsants Manual Removal of the placenta Assisted delivery by Vacuum Extraction Manual Vacuum Aspiration of retained products of conception Neonatal Resuscitation	*The signal Functions of Comprehensive EmONC:* *IV* antibiotics administered I.V Oxytoxics administered I.V Anti-convulsants Manual Removal of the placenta Assisted delivery by Vacuum Extraction Manual Vacuum Aspiration of retained products of conception Neonatal Resuscitation Surgical obstetrics : Cesarean section and emergency hysterectomy Implement 10 steps to successful breastfeeding
Focused Postnata l Care	Maternal and Newborn counseling encourage utilization of PNC and Child Health Services	1.Maternal and Newborn care counseling Referral for PNC and Child Health Clinics 2.Identification, treatment and immediate referral to Hospital: Postpartum hemorrhage/ inevitable or incomplete abortion Volume replacement with Intravenous Infusion , MVA and misprostone To PHCC: Infection: Cotrimoxazole	1.Counseling Referral for PNC and Child Health Clinics 2.Immediate treatment for Puerperal complications: (i) *Postpartum hemorrhage/ inevitable or incomplete abortion* Volume replacement with IV fluids, MVA/PAC and parenteral oxytocics or oral misoprostol (ii) *Infection*: Parenteral antibiotics *(iii) Anaemia*: Iron, folate and/or referral Convulsion: Clear	1.Counseling Referral for PNC and Child Health Clinics at Health facilities 2.Immediate treatment for Puerperal complications: (i) *Postpartum hemorrhage/ inevitable or incomplete abortion* Volume replacement with IV fluids, MVA/PAC and parenteral oxytocics, oral or intravaginal misoprostol post partum vitamin A supplementation (ii) *Infection*:

		Pallor: Iron, Folate and Multivitamins Convulsion: Clear airway, Sedate	airway, iv anticonvulsants	Parenteral antibiotics *(iii) Anaemia*: Iron, folate and/or referral Convulsion: Clear airway, iv anticonvulsants Implement 10 steps to successful breastfeeding

Table 4: Summary of Integrated Reproductive Health Care Preventive Reproductive Health Services

Service	Services at community level	Services at Primary Health Care Clinic	Services at BEmONC Primary Health Care Centre (PHCC)	EmONC District hospital
Family Planning and Reproductive Women's Health Services	Awareness raising and health education/promotion for demand creation for RH and counseling of women and their sexual partners to accept FP services, Condom promotion and supply	Daily Counseling of women and their sexual partners to accept FP/WH services. Provision of oral FP commodities, Condom promotion and supply. Plus Monthly outreach: BP check, STI, VCT Pap Smear, contraceptives-IUD and Sc implants Palpation for breast masses by quarterly appointments Cancer screening for male and female	Daily Counseling of women and their sexual partners to accept FP/WH services. Provision of oral FP methods, Condom promotion and supply. BP check, VCT Pap Smear, contraceptives-IUD and implants, Palpation for breast masses by quarterly appointments. Cancer screening for male and female	Daily Counseling of women and their sexual partners to accept FP services. Provision of oral FP methods, Condom promotion and supply. BP check, , VCT Pap Smear, contraceptives-IUD and Sc implants Palpation for breast masses by quarterly appointments. Surgical male and female contraception Cancer screening for male and female
Adolescent SRH and Young People	Counseling on sexuality and ABCD Promotion of VCT. In school counseling, Out of school - youth groups social marketing. Nutrition counseling	Youth focused services: CT, and counseling for ABC. Condom supply Daily service at specified time. Nutrition counseling	Provision of Youth focused services daily service at specified time: VCT and counseling for ABC and nutrition. Condom supply	Youth Friendly Services, focus on sexual and reproductive health interventions, special attention for pregnant teenagers, and nutrition counseling and post-abortion care for young girls.
Men's RH	Advocacy for gender equitable sexual roles. Counseling and referral for CT. Social marketing of condoms Awareness creation on male reproductive organ	Counseling for gender equitable sexual roles, CT. Condom distribution Identification and referral for male reproductive organ disorders, urethral stricture, enlargement of and cancer of	Counseling for gender equitable sexual roles, VCT, Social marketing of condoms Identification and referral for male reproductive organ disorders, urethral stricture, prostate hypertrophy and cancer	Limited care on male reproductive organ disorders, urethral stricture, male circumcision, outreach surgery for prostatic hypertrophy Referral for all prostatic and testicular cancer.
	disorders, urethral stricture, prostate hypertrophy and cancer and testicular cancer.	prostate and testicular cancer.	and testicular cancer. Case identification and referral	

Table 5: Summary of Integrated Management of Neonatal & Childhood Illnesses

Service	Services at Community level	Services at Primary Health Care Clinics	Services at Primary Health Care Centres
Expanded program on immunization	Promote EPI among parents and care givers Identify under-five immunization defaulters, counsel and refer Prepare and mobilize communities to attend Mass outreach/mobile immunization or during vaccination campaigns. Surveillance and reporting of cases of Vaccine preventable diseases	Daily routine /Monthly routine outreach/ mobile immunization at static centers Counsel referred under-five Screen all child health cards for under 5yrs visiting health facilities for immunization defaulters and immunize, Prepare and mobilize communities to attend Mass immunization. Surveillance and reporting of cases of Vaccine preventable diseases	Daily routine immunization, seven /six days a week Counsel referred under-five immunization defaulters and immunize, Prepare and mobilize communities to attend Mass immunization. Surveillance and reporting of cases of Vaccine preventable diseases
Nutrition	1.Baby friendly initiatives: Counseling on prevention of pre-lacteal feeding, exclusive breast feeding for first six months and introduction of complementary feeding for up to 24 months. 2. Community based GMP, Counseling and training/demonstrations in diet rich in protein and calories by selection and enrichment of local weaning diet. 3. MUAC screening and supplementary feeding for moderate malnutrition and for families with children at risk . Referral of severe malnourished cases to TFC 4. 4. Mass de-worming and Vitamin A supplementation .	1.Baby friendly initiatives: Counseling on prevention of pre-lacteal feeding, exclusive breast feeding for first six month timely and early weaning and continued feeding for 24 months, 2.Community based GMP and Counseling and training/demonstrations in diet rich in protein and calories by selection and enrichment of local weaning diet. 3. GMP malnutrition and for children in families of at risk child. Referral of malnutrition cases 4.Mass de-worming and Vitamin A supplementation .	1.Baby friendly initiatives: Counseling on prevention of pre-lacteal feeding, exclusive breast feeding for first six month timely and early weaning and continued feeding for 24 months, 2. GMP and counseling and training/demonstrations in diet rich in protein and calories by selection and enrichment of local weaning diet. 3. Nutrition rehabilitation protocol for the moderate and severe malnourished children.
Integrated Management of Neonatal & childhood illness	*Community Based Child Survival Program* 1. Awareness and promotion of ITNs on NIDS and Mass distribution days. 2. Train Community Based Health Workers on simple use of	1. Algorithm guided treatment of Malaria with ACT or second line treatment. 2. Algorithm guided treatment of moderate dehydration from diarrhea with ORS, and severe dehydration or diarrhea with	1. Algorithm guided treatment of Malaria with ACT or second line treatment. 2. Algorithm guided treatment of moderate dehydration from diarrhea

	algorithms to assess, classify or refer cases of Home Management of Malaria (treatment of uncomplicated fever with ACT. 3. Referral of children with danger signs to PHCCs: Severely cold body, severely hot body, inability or refusal to feed, lethargy, fast breathing, skin pinch returns very slowly 4. Awareness on recognition of diarrhea training of CBHWs and parents on use of ORS, zinc supplement, encouragement of increased frequency of feeding during and post diarrhea. 5. Training parents on recognition of pneumonia by counting number of breaths per minute, chest in drawing and early treatment with cotrimoxazole for cases of cough, rapid breathing, in chest in drawing and nasal flaring. Encouragement of increased frequent feeding during and post ARI. 6. Sedation for cases of convulsions and referral for first time convulsion. 7. Encouragement of Isolation of sick children and quarantine for children during epidemic outbreaks of cholera and meningitis.	danger sings with IV ½ DD ringers solution. Use of zinc and other micronutrient supplement, encouragement of increased frequency of feeding during and post diarrhea. 3. Algorithm guided treatment pneumonia by counting number of breaths per minute and in chest in-drawing nasal flaring with parenteral antibiotics- amoxicillin and provision of oxygen . 4. Sedation for cases of convulsion and referral for first time convulsion. 5. Epidemic and outbreak management - cholera and meningitis, measles, whooping cough, polio yellow fever, RV fever etc.	with ORS, and severe dehydration or diarrhea with danger sings with IV ½ DD ringers solution. Use of zinc and other micronutrient supplement, encouragement of increased frequency of feeding during and post diarrhea. 3. Algorithm guided treatment pneumonia by counting number of breaths per minute and in chest in-drawing nasal flaring with parenteral antibiotics- amoxicillin and provision of oxygen . 4. Sedation for cases of convulsion and referral for first time convulsion. 5. Epidemic and outbreak management - cholera and meningitis, measles, whooping cough, polio yellow fever, RV fever etc. 6. Coordination of activities including.

4. Health Service package by Level of Care

4.1. Overview

The service norms and standards are matched with the existing structures of the Ministry of Health and Social Services and the policies and guidelines of the country. The National Health Policy Framework of Namibia and the human resource for health policy and strategy have also been taken into account in the development of this package.

The services are summarized by level in matrices at the end of the section to facilitate the acquisition of the correct equipment and standardized essential medicines and supplies at all levels of the health care delivery system.

4.2 Community Level

At the village level, care is provided by Health Extension Workers (HEWs) or other community volunteers. These categories of cadres are still not functional, but a HEWs strategy has been developed and the numbers required, training and remuneration packages proposed. The HEWs will be selected by the community in line with the recruitment criteria; they will be trained and deployed to the communities who selected them.

Their key functions include:

(i) Health education and promotion

(ii) Dispensing of household level preventive health commodities such as condoms, LLITNs and water-guard (chemicals) for water purification and limited number of medications allowed for household level use for prompt treatment which include, co-trimoxazole, ORS/ zinc and ACT

(iii) Active case finding of pregnant women and referral for Antenatal care and delivery

(iv) Active case finding and treatment and guidance for children with diarrhea, ARI and fever; and referral of severe cases. Active case finding for notifiable conditions, reporting and referral of cases, or those that have developed complications

(v) Active case finding and referral of malnutrition cases, and tracing of default cases from therapeutic feeding programme

(vi) Counselling on essential nutrition actions and appropriate feeding for infants and young children. Counselling on making and eating therapeutic foods

(vii) Encourage health lifestyle through increased physical activity and health diets

(viii) Enumerating cases, community health information reporting and surveillance including maternal and neonatal deaths notification

(ix) Alertness to unusually high rate of any type of illness to provide early warning signals of outbreaks of diseases and

(x) Promote and report DOTs implementation

The village health committees provide administrative oversight and support. They are elected community members who should be representative of the whole community and maintain a gender balance with equal numbers of women and men.

The committees:

(i) Maintain liaison between the Ministry of Health and Social Services service provider and the community,

(ii) Encourage and facilitate community-based health development initiatives especially protection of water sources, construction of toilets and other environmental sanitation measures

(iii) Assist the community in identifying candidates of HEWs

(iv) Maintain oversight over the local health services (v) mobilize communities to support construction of health posts/infrastructure and maintenance.

Key services at community level include:

Health promotion: IEC, social marketing of cost-effective preventive interventions and commodities: Oral rehydration salt (ORS)/zinc supplement, co-trimoxazole and artesunate combination therapy for children with pneumonia and suspected malaria, and ITNs; promotion of exclusive breastfeeding, appropriate complementary feeding and hand washing. Counselling on essential nutrition actions and appropriate feeding for infants and young children. Counselling on making and eating therapeutic foods Encourage health lifestyle through increased physical activity and health diets

- Active case finding of pregnant women and referral for antenatal care and skilled care attendance (delivery in health facilities).
- Active case finding and referral of malnutrition cases, and tracing of default cases from therapeutic feeding programme
- Active case finding and treatment and guidance for children with diarrhea, ARI and fever; and referral of severe cases or those that have developed complications.
- Enumerating cases, keeping surveillance and notification of disease, with appropriate reporting tools including notification of maternal and neonatal deaths; provide early warning signals of outbreaks of diseases.

4.3 Community Health Post

Every community or group of villages within close proximity with a population of 2,000-5,00(or number 500 to 1000 families will have a health post that provides a one stop health and socia services, information and promotion materials. At this post first aid services and information fo health, health promotion and other demonstration materials will be provided. Such a post should be entirely managed by the Health Extension Workers/Health Assistants. It should provide agricultura and animal production information where appropriate, other livelihood earning information and dem onstration and a means of communication to clinic level for advice or call for help. It should house the community based HIS, Health Assistants/Health Extension Workers (HEWs), will use these fa cilities as their station for providing promotive, preventive and curative services.

The village health post will promote hygiene and sanitation and also support outreach services such as oral health and LLTN distribution.

Summary of health specific services provided at Community/Village level Preventive care and health promotion: IEC, social marketing of preventive interventions and commodities; promotion of exclusive breastfeeding, appropriate complementary feeding, use of ITNs and hand washing. Counselling on essential nutrition actions and appropriate feeding for infants and young children. Counselling on making and eating therapeutic foods. Encourage health lifestyle through increased physical activity and health diets

- Curative care for common and uncomplicated diseases – ORT and start of treatment for pneumonia and malaria in children under five. Adherence counseling for people with chronic diseases diagnosed at higher level will also be reinforced.
- Adherence counseling for Antenatal care, Birth and emergency planning for normal deliveries at health facilities and community based distribution of family planning methods and condoms.
- Referral to Clinic, Health Center or District Hospital for further investigation or treatment where required
- First aid for trauma (stabilization and referral)
- Home treatment and outpatient care for moderate malnutrition, follow-up patients who have been treated for severe acute malnutrition, tracing of default cases from therapeutic feeding programme
- Vitamin A Supplementation
- Training of community volunteers on various preventive and, promotive health services
- Home visit and follow up of client after discharge
- Administrative and support activities (HMIS, maintaining registers, reporting)

4.4. Primary Health Care: Clinics

A clinic should provide Primary HealthCare services including Basic Emergency Obstetric Care and should be able to stabilize mothers and their newborns before referral to higher level health facilities. As a first referral health facility, it offers a wider range of diagnostic and curative services that include basic laboratory diagnostics. It can also keep patients for 24-72 hours observation.

A clinic should be staffed with qualified health professionals as per prescribed Ministry's standard and norms. Specifically they provide parenteral treatment and minor surgical procedures.

Key activities of a clinic are: EPI, IMNCI, Infant and young child feeding and counseling, Growth monitoring and promotion, nutritional assessment

(i) The signal functions of basic EmONC, i.e., i.v. antibiotics, i.v. oxytoxics, i.v. anti-convulsants, manual removal of the placenta, assisted delivery by vacuum extraction, manual vacuum aspiration of retained products of conception (MVA), neonatal resuscitation

(ii) Family planning

(iii) Adolescent sexual reproductive health (ASRH), child birth assistance

(iv) Antenatal care (ANC), (v) postnatal care

(vi) Curative care (including parenteral administration of medicines and fluids

(vii) Diagnose, classify and referral of severe malnutrition with complications

(viii) Stabilization of people with critical injuries or illness and referral

(ix) Suturing of minor injuries, trauma and dental care

(x) Follow-up of TB and HIV patients and syndromic management of STIs, provision of counseling for HIV testing and PMTCT services. Provide all preventive, promotive and rehabilitative services. Ensure data collection and reporting using daily tally sheets, registers and monthly report forms as per M&E guidelines.

Summary of key services provided at PHC-Clinic

- Preventive care and health promotion
- 24-hour basic Emergency Obstetric and Neonatal Care.
- I.V. antibiotics administered
- I.V. oxytoxics administered
- I.V. anti-convulsants
- Manual removal of the placenta
- Assisted delivery by Vacuum Extraction
- Manual vacuum aspiration of retained products of conception
- Neonatal resuscitation
- Curative care (including I.M. injections and I.V. lines for I.V. fluids and antibiotics)
- Nutrition Assessment
- Home treatment and outpatient care for moderate and severe acute malnutrition
- Diagnosis and referral of severe malnutrition with complications
- Family planning
- First aid for emergency conditions and referral
- Suturing of injuries and trauma (first aid for trauma, stabilization and referral)
- Removal of stitches on pos operative and healed would
- Dental care (on fixed days by dental technician, once service is available)
- Follow-up of TB, HIV and other chronic diseases
- Syndromic management of STIs
- Basic Laboratory examinations
- Screening for STIs/HIV and counseling for HIV testing and PMTCT services
- Basic eye care on fixed days by the ophthalmic assistants and referrals of cases to higher level.
- Training and follow-up of Health Extension Workers
- Health Information System (clinical documentation, regular reporting, including maternal and neonatal death notification)
- Administrative and support activities (e.g. register keeping, drug management and maintenance)
- Growth monitoring and promotion
- Breastfeeding promotion
- Complementary feeding practices
- Nutrition Counseling
- Routine Vitamin A Supplementation
- Routine deworming from 1 year

4.5. Primary Health Care: Health Centre

Health Centers are a second level referral centers. They provide all services provided by the clinics and in addition they provide inpatient services and can have up to 10-20 beds and as per Ministry's guidelines. Laboratory services are available with a range of services including urinalysis, hemoglobin, screening for syphilis and others.

Summary of key services provided at Health Center

- Preventive care and health promotion
- 24-hour basic Emergency Obstetric and Neonatal Care
- I.V. antibiotics administered
- I.V. oxytoxics administered
- I.V. anti-convulsants
- Manual removal of the placenta
- Assisted delivery by Vacuum Extraction
- Manual vacuum aspiration of retained products of conception
- Neonatal resuscitation
- Curative care (including I.M. injections and I.V. lines for I.V. fluids and antibiotics)
- Home treatment and outpatient care for moderate and severe acute malnutrition
- Inpatient stabilization care for severe acute malnutrition with complications
- First aid for emergency conditions and referral
- Small surgery (incl. first aid for trauma, stabilization and referral)
- Dental care (on fixed days by dental technician, once service is available)
- TB diagnosis and treatment (DOTS)
- Laboratory examinations
- Storage of vaccines, drugs and clinical supplies.
- Screening for STIs/HIV and provision of VCT and PMTCT services
- Basic eye care on fixed days by the ophthalmic assistants and referrals of cases to higher level.
- Removal of stitches on pos operative and healed would.
- Administration of NSAID medicines for further management.
- Family planning
- Observation, with 10-20 beds
- Training and follow-up of clinic staff and Health Extension Workers
- Health Information System (clinical documentation, regular reporting, audits)
- Administrative and support activities (e.g. register keeping, drug management and maintenance)
- Nutrition Assessment
- Growth monitoring and promotion
- Breastfeeding promotion
- Complementary feeding practices
- Nutrition Counseling
- Routine Vitamin A Supplementation
- Routine deworming from 1 year
- Observation and admissions (short periods)

4.6 District Hospital

The district hospital is central to the provision of promotive, preventative, curative and rehabilitative services on a 24 hour basis. The District hospital performs Diagnosis and treatment of common diseases injuries and has casualty services for the immediate treatment of injuries, medical and surgical emergencies with a resident doctor service.

Summary of key services provided

- Preventive care and health promotion
- 24-hour comprehensive Emergency Obstetric and Neonatal Care (includes caesarean section and blood transfusion, laparatomy for ectopic pregnancy).
- I.V. antibiotics administered
- I.V. oxytoxics administered
- I.V. anti-convulsants
- Manual removal of the placenta
- Assisted delivery by Vacuum Extraction
- Manual vacuum aspiration of retained products of conception
- Neonatal resuscitation
- Curative care (including I.M. injections and I.V. lines for I.V. fluids and antibiotics)
- Home treatment and outpatient care for moderate and severe acute malnutrition
- Treatment of severe acute malnutrition with complications or no appetite (Inpatient management according to protocol)
- Maternal and child health care services
- Outpatient services
- Basic diagnostic facilities for X-ray, ultra-sound and laboratory investigations
- Inpatient stabilization care for severe acute malnutrition with complications
- First aid for emergency conditions and referral
- Minor surgery (incl. first aid for trauma, stabilization and referral)
- Dental care (on fixed days by dental technician, once service is available)
- Basic eye care on daily basis by ophthalmic assistant
- Selected major surgeries where skills and means are available
- Post Abortion Care (PAC)
- Male circumcision.
- TB diagnosis and treatment (DOTS)
- Laboratory examinations
- Screening for STIs/HIV and provision of VCT and PMTCT services
- Diagnosis and care for non-communicable diseases
- Social work, oral health, mental health, counseling, eye care, etc. which may be provided on a permanent or intermittent basis depending on the size of the community served.
- Storage of vaccines, drugs and clinical supplies.
- Logistics and support to PHC services at health centre, clinic and community level.
- Training and follow-up of clinic staff and Health Extension Workers
- Health Management Information System (collection, analysis, utilization and regular reporting, audits)
- Administrative and support activities (e.g. register keeping, drug management and maintenance)
- Nutrition Assessment
- Growth monitoring and promotion
- Breastfeeding promotion and implementation of 10 steps to successful breastfeeding
- Monitoring of the implementation of the International Code on the marketing of breastmilk substitutes
- Complementary feeding practices
- Nutrition Counseling
- Vitamin A Supplementation
- deworming from 1 year

5. Management Committees

The village health committees, health facility committees and district health management teams will be strengthened to enable them to facilitate the implementation of essential health package at each level.

5.1 Village Health Committee

Roles and responsibilities:

- Identify the health needs in their communities.
- Facilitate the selection of HEWs, provide guidance, support and motivation to them and promote cooperation and respect among HEWs, other community volunteers and the community.
- Support and assist implementation of the activities of health workers and CHCPs at the primary facility and support service delivery.
- Organize health activities at community level such as the provision of health posts/ mobile clinic venues for outreach services, national health events and awareness campaigns
- Mobilize resources and determine the contribution by the community for a programme/project/initiative. Resources required for CBHC at this level may include provision of a place for community meetings, gathering of any contributions in kind and/or funds from community members and other resources including incentives for Health Extension Workers/Health Assistants.

5.2. Health Facility Committees

Health facility (clinic and Health Center) committees will provide administrative support and mentor-ship to the communities they are serving. They consist of the head of the health facility, one nurse midwife, a pharmacy technician, a health inspector and two from the community (one man and one woman) elected by the community. They should be representative of the whole community and must maintain a gender balance with women and men equally represented. The roles and responsibilities of the committee are:

- Implementation of community health activities
- Promotion of community participation and involvement
- Improving community ownership and development of local leadership
- Ensure an effective referral system and surveillance
- Undertake monitoring and Evaluation
- Prepare monthly work plans by health committees
- Support and undertake outreach health programs
- Conduct health education and promotion
- Undertake health campaigns and awareness programs
- Ensure efficient and cost-effective use of resources
- Review maternal, peri-neonatal and malnutrition deaths and act on findings

5.3 The District Health Management Team

The District Health Manager in the proposed new structures of the Ministry of Health and Social Services is overall team leader of the District Health Management Team (DHMT) which ensures that the standards of services and implementation of the district health plan of action that is in tandem with National Health Policy.

The DHMT coordinates with other authorities and stakeholders and partners overseeing health activities by all agencies or stakeholders working in the district. The DHMT facilitates the District Health Forums that have specific responsibilities for the development of integrated sector wide district health plan. The DHMT ensures the implementation of the National health policy and strategies and monitor the integrity of health workers under their jurisdiction. The DHMT together with relevant sectors coordinates the overall health activities in the district:

Roles and responsibilities:

- Undertake overall coordination of implementation of essential health package
- Conduct assessment and analysis of local health and managerial needs
- Carry out joint strategic planning based on local needs and problems
- Oversee the management and use of health information systems
- Coordinate the implementation of health and social development services
- Undertake monitoring and evaluation of the implementation of essential health package.
- Ensure an effective referral system and epidemiological surveillance
- Provide technical oversight to services provided at all peripheral centres
- Ensure an efficient and cost-effective use of resources

In view of the shortage of skilled human resources, some functions could be implemented in partnership with private and para-statal health and laboratory institutions. It is important that all health interventions in the district are coordinated by the DHMTs.

5.4 Table 6: Services at the Health Posts

Catchment Population: 5,000 population				
Service profile		**Human Resources (Total)**	**Facilities**	**Equipment**
Integrated Reproductive Health Services	Essential Obstetric Care: Site for Outreach/mobile ANC monthly, Normal deliveries, Counseling for compliance with ANC, referral of infections to B-EmNOC, Hemorrhages, eclampsia and severe sepsis to C-EmNOC	Technical staff - HEWs/ Health Assistants (Security staff /cleaner)	Counseling Rooms First Aids Room Resource Library Auditorium Meeting hall Latrine Water store Additional are tuck shops Handicraft centre Other Demonstration areas: *Farm* *Fish pond*	Baby weighing scale Adult weighing scale Height boards MUAC tapes Bicycles
	Protective Sexual and Reproductive Health (SRH) for women			
	Adolescent SRH			
	Men's SRH			
Community Based Health Care	*Integrated Essential Child Health Care* *EPI:* Mobile/Outreach Immunization of children, support health campaigns ENA: Promotion of BF infant feeding and weaning practices, GMP, management of moderate malnutrition and severe malnutrition to health facility Community based child survival			
	Management of local endemic diseases			
	Control of neglected tropical diseases		*Animal shed*	
	Community based prevention, care for common injuries and rehabilitation			
	Visual health, Oral Health and Mental Health			
	Disease surveillance and emergency preparedness			

Health Promotion	Awareness sensitization and BCC on the priority health problems			
	School Health and Nutrition Assessment and counseling			
	Community based nutrition and food security			
	Community actions for safe environment, water and sanitation			
	Non-communicable dietary related diseases			
M&E and Operations Research	Routine Health Information System, Periodic Surveys and special studies			

Table 7: Services at the PHC Clinics

Catchment population: 50,000				
Service profile		Human Resources	Infrastructure	Equipment
Integrated Reproductive Health Services	Essential Obstetric Care: Daily ANC treatment for ordinary infections and SSTI, conduct normal deliveries, counseling for compliance with ANC, and for delivery at health facilities. Referral of APH and severe PPH to CEmNOC and Severe Hypertensive renal diseases in Pregnancy and eclapmsia to State Hospital	Registered, Enrolled HEWs including Community Counselors, Administrative officer Institutional worker, driver & cleaner Supportive Community component e.g. Traditional Birth Attendants (Community Midwives)	Consultation Rooms Maternal Care room – ANC, PNC and FP including Pap Smear and Breast palpation Treatment room Dispensing area / Store Cold chain store unit Waiting area Latrine Protected water source. Staff residential houses. Electricity supply	Stethoscopes Otoscope Sphygmomanometer Thermometer Baby scale Adult scale Height boards Muac tapes, Beds, bedding, general and Delivery tables - Fetoscope Equipment for basic EmONC – MVA, Delivery forceps, vacuum extractor Surgical toilet tray set Manual resuscitation equipment Oxygen supply (portable oxygen concentrators) Autoclave / Sterilizing facility Cold chain &
	Protective Sexual and Reproductive Health (SRH) for women			
	Adolescent SRH			
	Men's SRH			
Community Based Health Care	Integrated Essential Child Health Care Daily immunization of children monthly, support NIDs and mop up campaigns Promotion of BF infant feeding and weaning practices, GMP, management of mild to moderate malnutrition and referral of severe malnutrition with complications to TFC Integrated Management of Childhood Illnesses (IMCI)			
	Management of local endemic diseases			
	Control of neglected tropical diseases			
	Community based prevention, care for common injuries and rehabilitation			Laboratory equipment Domestic Refrigerator and RCW42/50 EG Refrigerator Motor vehicle BP machines Weighing scales
	Visual health, Oral Health and Mental Health			
	Disease surveillance and emergency preparedness			
Health Promotion	Awareness sensitization and BCC on the priority health problems			
	School Health and Nutrition assessment and counseling			
	Community based nutrition and food security			
	Community actions for safe environment, water and sanitation			
M&E and Operations Research	Routine Health Information System, Periodic Surveys and special studies			

Table 8: District Hospitals and Selected Health Centers

Catchment Population: 200,000 Population				
Service profile		**Human Resources**	**Facilities**	**Equipment**
Integrated Reproductive Health Services	Obstetric Care, Emergency obstetric care (EMOC), Comprehensive emergency obstetric care (CEmONC) that includes Emergency, Obstetric and neonatal Care (EmONC) ,Post Abortion Care (PAC), PMTCT, Post Natal Care (PNC), Family Planning (FP) Including Caesarean Section and Emergency Hysterectomy	Technical Medical officers Registered, ,Nurse/ Midwife, Enrolled Nurse/ Midwife and Anaesthetic Nurses, pharmacist assistant Dietitian (Clinical and Community) Administrative Officer (Administrative Assistant), Computer Technician, Security staff/cleaner Supportive Community component e.g. Traditional Birth Attendants Community Midwives and HEWs	Consultation Rooms Counseling center Delivery room Maternity General wards – pediatric beds, Male beds, female, Children's Dispensing area / Store Cold chain Unit Sterilization Unit Waiting area Latrine Safe water source	Stethoscopes Otoscope Sphygmomanometer Thermometer Baby scale Adult scale Height boards Muac Beds, bedding general and Delivery tables - Fetoscope Equipment for basic EmONC Minor surgery equipment Manual resuscitation equipment for neonates Surgical theatre for Caesarian Section, ruptured ectopic pregnancy and emergency hysterectomy for ruptured uterus. Will also serve other emergency surgeries. Autoclave / Sterilizing facility Cold chain &
	Protective SRH for women			
	Adolescent SRH			
	Men's SRH			
Community Based Health Care	Integrated Essential Child Health Care			
	Management of local endemic diseases			
	Control of neglected tropical diseases			
	Community based prevention, care for common injuries and rehabilitation			
	Visual health, Oral Health and Mental Health			
	Disease surveillance and emergency preparedness			
Health Promotion	Awareness sensitization and BCC on the priority health problems			
	School Health and Nutrition assessment and counselling			
	Community based nutrition and food security			

6. Management and Administrative Arrangements

6.1. Management

The management system for implementing essential health package through a Primary Health Care approach should be participatory where members of the communities are adequately represented and in a decentralized health service delivery system. The national health policy framework has already established a structure for governance that starts from the National to the community level.

Some of the services can be outsourced: The approach is to contract some agencies that will concurrently build the capacity of local community resource people or community based organizations (CBO) to conduct some none core health services. The other is to establish an exit strategy that will leave behind a grand alliance in health service delivery. The aim is to establish sound functional strategies that will focus on:

- Developing adequate human resource for planning, delivery, monitoring and evaluation
- Enhancing health promotion
- Ensuring transparency, accountability and cost effectiveness in the management of financial resources for health
- Establishing a monitoring and evaluation system and appropriate information technology to ensure efficiency in the collection, analysis and reporting of health information and knowledge for evidence based health service delivery and management at all levels

Harnessing the comparative strengths o f Civil Society Organizations (CSOs) and Non Governmental Organization (NGOs) in the delivery of Primary Health Care activities at the community level where the government cannot reach. The Ministry of Health and Social Services will promote partnership, community involvement, inter-sectoral collaboration with all line ministries, use of appropriate technologies and cost effective interventions, promote equity without compromising the quality of services and undertake capacity building for betterment of the management of Primary Health Care service delivery.

The provision of regular supportive supervision and constructive feedback to the lower level of the system to improve overall quality and performance of the system will be promoted. Material and technical support will be provided to health service providers at all levels.

A bottom up health planning, implementation, monitoring and evaluation and promotion of research will be promoted at the community and at all levels of the Primary Health Care delivery system.

6.2. Logistics system for efficient delivery of essential package

*The implementation of essential PHC packages needs commodity inputs including vaccines, medi*cines, equipments, tools, vehicles and other supplies. These inputs have to be appropriately selected, quantified, and reach the health facilities in time. Any delay or shortage may cause a problem in service provision and result in the dissatisfaction of the community and loss of confidence and frustration of the health workers at all levels. For this to materialize, there needs to be a well functioning logistics management system as well as the resource requirements carefully budgeted for in the medium-term and short-term implementation plans for Primary Health Care interventions. Inputs from the communities, local and international development partners, NGOs, Civil society organizations, line ministries and other partners should be solicited to deliver integrated primary health care interventions at all levels.

6.3. Health Information System (HMIS)

Collection and interpretation of selected health service indicators/data is an essential component of Primary Health Care. It enhances health service delivery and management through evidence based decision making processes.

It is critical that information from the community/Clinics/Health Centers, District Hospitals, private sectors, NGOs and civil society organization operating in the ground in the areas of PHC be collected, collated and analyzed at the various levels to feed into the national Health Information System (HIS).

6.3.1 Notifiable diseases

Special attention must be paid to notification of diseases. The following is a list of notifiable diseases:

Table 9: List of Notifiable diseases and conditions

Group A diseases Immediate/Weekly Reporting	Group B Diseases Monthly Reporting
1. Cholera 2. Diarrhoea with blood (shigellosis) 3. Measles 4. Meningitis 5. Viral Hemorrhagic Fever 6. Yellow fever 7. Relapsing fever 8. Acute jaundice syndrome 9. AcuteFlaccid paralysis (AFP/Poliomyelitis) 10. Neonatal tetanus 11. Acute watery diarrhea 12. Maternal and Perinatal Mortality	1. Plague 2. Druncunculosis 3. Lymphatic filariasis 4. Tuberculosis 5. Leprosy 6. HIV/AIDS 7. STIs 8. Malaria 9. Pneumonia 10. Schistosomiasis 11. Rabies 12. Trypanosomiasis

7. Conclusion

It is evident that with the review of the health system in 2008, the development of the National Health Policy, the adoption of the health sector Strategic Plan and the restructuring of the health sector, the Ministry of Health and Social Services is committed to the improvement of health and social development outcomes in line with Vision 2030 goals. The implementation of this essential health package will be yet another milestone for the sector.

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