

REPUBLIC OF NAMIBIA



MINISTRY OF HEALTH AND SOCIAL SERVICES

**National Policy**  
**on**  
**Community Based Health Care**

**MINISTRY OF HEALTH AND SOCIAL SERVICES**

**National Policy**  
**on**  
**Community Based Health Care**

**DIRECTORATE OF PRIMARY HEALTH CARE SERVICES**  
**DIVISION: FAMILY HEALTH**  
**SUB-DIVISION: COMMUNITY-BASED HEALTH CARE AND SCHOOL HEALTH**  
Private Bag 13198  
Windhoek  
Namibia  
Tel: (061) 203-2723  
Fax: (061) 234968  
Email: [aschikwambi@globalfund.com.na](mailto:aschikwambi@globalfund.com.na)  
February 2008

## **FOREWORD**

The Government of the Republic of Namibia recognises that health is a fundamental human right of all Namibians and is committed for achieving health for all Namibians. With this in mind, the Government, through the Ministry of Health and Social Services (MoHSS), adopted the Primary Health Care (PHC) approach for provision of health care services, with Community Based Health Care (CBHC) as a strategy to achieve community participation and involvement in their own health. Communities and civil society are currently participating in a wide range of health related programmes, the most common ones focus on health education, HIV/AIDS, malaria and tuberculosis. They are usually supported by Community-Based Organisations (CBOs), Non-Governmental Organisations (NGOs), Faith-Based Organisations (FBOs) and the MoHSS.

The MoHSS has developed this Community-Based Health Care Policy that lays out the framework for the implementation of community health care and support which is holistic and responsive to the needs of communities and in particular for households.

The aim of the CBHC policy is to further empower communities to take charge of initiatives that will promote public health, reduce morbidity and mortality among children, adolescents and adults as well as to enhance community ownership of joint efforts and self-reliance in resource mobilisation and problem solving.

The MoHSS has created a strong support system for community health care. New health facilities have been built; health workers have been trained in Participatory Rural Appraisal (PRA) techniques to enable them to work with communities; and outreach teams are in place. This document provides a practical approach to the use of community structures, coordination of responsibilities and the sustainable use of community health care providers in CBHC.

It is my earnest belief, that all health workers and other community development workers in Namibia, regardless of their level of functions, should fully acquaint themselves with the contents of this policy. This will lead towards gaining comprehensive understanding of the health care system in Namibia and the respective roles and responsibilities of key role players thus improving service provision in community health care.

.....  
**DR RICHARD NCHABI KAMWI, MP**  
**MINISTER of HEALTH AND SOCIAL SERVICES**

## **PREFACE**

This policy on Community Based Health Care (CBHC) has been developed using the 1992 Primary Health Care/Community Based Health Care guidelines as its basis. It has incorporated input from a series of intersectoral meetings, experience of best practice, and most recently from a National Conference on Volunteerism and a National Consultative Workshop on Community/Home-Based Care. The consensus of ideas, strategies and actions are hereby acknowledged.

The CBHC policy gives a brief overview of key health issues currently faced by the Namibian communities and describes the policy goal, principles, objectives and strategies that will lead to better service delivery at all levels and from partners that contribute to improved health of communities.

This document is structured as follows:

- Chapter 1 gives the background; discusses rationale and how the document was developed;
- Chapter 2 gives a situation analysis of CBHC in Namibia;
- Chapter 3 presents the policy framework;
- Chapter 4 outlines institutional framework for policy implementation at the different levels and with its partners including NGOs; CBOs and FBOs
- Chapter 5 highlights the resource implications;
- Chapter 6 presents the process of monitoring, evaluation and reporting

The Ministry of Health and Social Services acknowledges the active participation of its partners in developing this policy. The partners are equally expected to continue rendering support during the implementation of this policy. Special gratitude goes to the CBHC Staff, the Family Health Division within the Directorate of Primary Health Care Services and the office of the Deputy Permanent Secretary. Also, the Ministry would like to thank UNICEF and USAID for financial support towards the production of this document.

This national policy calls for better coordination and integration of services and is intended for use by all those involved in CBHC in Namibia. It will facilitate the implementation of Primary Health Care programmes within the Namibian context.

It is my trust that this policy will provide the foundation upon which we will achieve Health for All Namibians.

This policy will be revised periodically taking into consideration the continuous changing of community health situation in the world.

.....  
**Mr. KAHIJORO KAHUURE**  
**PERMANENT SECRETARY**

## ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CACOC	Constituency Aids Coordinating Committee
CBHC	Community based Health Care
CBO	Community Based Organisation
CDC	Constituency Development Committee
CHC	Clinic Health Committee
CHPA	Chief Health Programme Administrator
CHCP	Community Health Care Provider
CHW	Community Health Worker
CMO	Chief Medical Officer
CORPs	Community's Own Resource Persons
DCC	District Coordination Committee
DOT	Direct Observation Therapy
FHD	Family Health Division
HBC	Home Based Care
HIS	Health Information System
HIV	Human Immuno-deficiency Virus
HW	Health Worker
IEC	Information-Education-Communication
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
MoHSS	Ministry of Health and Social Services
MGECW	Ministry of Gender Equality and Child Welfare
NANGOF	Namibia Non-governmental Organisation Forum
NDHS	National Demographic Health Survey
NGO	Non Governmental Organisation
PHCS	Primary Health Care Services
PMO	Principal Medical Officer
PMTCT	Prevention of Mother to Child Transmission
PRA	Participatory Rural Appraisal
RACOC	Regional Aids Coordinating Committee
RDCC	Regional Development Coordinating Committee
RMT	Regional Management Team
TB	Tuberculosis
TBA	Traditional Birth Attendant
TH	Traditional Healer
TOTs	Training / Trainers of Trainers
UNAM	University of Namibia
UNICEF	United Nations Children's Fund
VDC	Village Development Committee
VHC	Village Health Committee
WHO	World Health Organisation

## TABLE OF CONTENTS

FOREWORD .....	I
PREFACE .....	II
ABBREVIATIONS.....	III
<b>CHAPTER 1: INTRODUCTION.....</b>	<b>6</b>
1.1 BACKGROUND .....	6
1.2 RATIONALE .....	7
<b>CHAPTER 2: SITUATION ANALYSIS .....</b>	<b>9</b>
2.1 THE HEALTH STATUS.....	9
2.2 COMMUNITY BASED HEALTH CARE.....	9
<b>CHAPTER 3: POLICY FRAMEWORK .....</b>	<b>11</b>
3.1 GOAL.....	11
3.2 PRINCIPLES.....	11
3.3 OBJECTIVES.....	12
3.4 DEFINITIONS .....	12
3.4.1 Community Resource Persons .....	12
3.4.2 Community Health Care Providers (CHCP).....	12
3.5 STRATEGIES .....	13
3.5.1 Support for Community Health Care Providers (CHCP) .....	13
3.5.2 Strengthen human resources .....	13
3.5.3 Integrated management of CBHC services.....	14
<b>CHAPTER 4: INSTITUTIONAL FRAMEWORK FOR IMPLEMENTATION ....</b>	<b>16</b>
4.1 ROLES AND RESPONSIBILITIES OF MINISTRY OF HEALTH .....	16
4.2.1 Ministry of Education .....	18
4.2.2 Ministry of Agriculture, Water and Forestry .....	18
4.2.3 Ministry of Regional and Local Government, Housing and Rural Development .....	18
4.2.4 Ministry of Gender Equality and Child Welfare (MGECW).....	19
4.2.5 Ministry of Defence .....	19
4.2.6 Ministry of Information and Broadcasting (MIB) .....	19
4.2.8 The National Planning Commission .....	19
4.3 ROLES AND RESPONSIBILITIES OF LOCAL AUTHORITIES; CIVIL SOCIETY AND DEVELOPMENT PARTNERS .....	19
4.3.2 Village Health Committee (VHC) or the Community or Clinic Health Committee (CHC).....	19
4.3.5 University of Namibia.....	20
4.3.6 Development Partners .....	20
<b>CHAPTER 5: RESOURCE IMPLICATIONS .....</b>	<b>21</b>
5.1 FINANCIAL RESOURCES.....	21
5.2 HUMAN AND INSTITUTIONAL RESOURCES.....	21
5.3 SUPPORTIVE SUPERVISION .....	21
5.4 TRAINING, TOOLS AND I.E.C. MATERIALS .....	21

5.5 EQUIPMENT, SUPPLIES AND HOME-BASED CARE KITS .....	22
5.6 ADDITIONAL SERVICES FOR THE CARE PROVIDER .....	22
5.7 FUNDING SOURCES .....	22
<b>CHAPTER 6: MONITORING, EVALUATION AND REPORTING .....</b>	<b>23</b>
<b>GLOSSARY.....</b>	<b>24</b>
<b>REFERENCES.....</b>	<b>26</b>

# CHAPTER 1: INTRODUCTION

## 1.1 BACKGROUND

Primary Health Care has been the main focus for the promotion of 'Health for All'. The Primary Health Care (PHC) approach was adopted by the Ministry of Health and Social Services (MoHSS) at Independence and has been used to guide the restructuring of the health sector in Namibia. In line with achieving its objective of Health for All Namibians, the government has been gradually shifting resources to the disadvantaged regions, focusing on preventive services and basic care provided by clinics, mobile health teams and community health care providers, in order to balance the inequalities in the formerly disadvantaged regions. The MoHSS has made progress in streamlining and restructuring what was a curative-based health system to be a more community orientated system. The introduction of Integrated Management of Childhood Illnesses (IMCI) to many health districts is one example.

The Primary Health Care approach comprises of preventive, promotive, curative and rehabilitative services delivered in collaboration with other sectors, communities and partners in health. It is guided by seven principles as outlined in the MoHSS 1998 Policy Framework "Towards Achieving Health and Social Well-being for all Namibians". They are: Equity – to ensure equitable distribution of services/resources; availability; accessibility and affordability of health and social services; community involvement - to ensure active participation in planning, organising, implementation, monitoring and evaluation of services by communities; sustainability; intersectoral collaboration and quality of care.

Community-Based Health Care (CBHC) is a strategy for achieving the goals of PHC within the overall objective of national health. As an integral part of PHC, CBHC reinforces the PHC concepts and principles. CBHC deals with all health-related matters affecting the communities directly. Clinics, health centres and mobile outreach services as well as a number of specific community-based health interventions are the primary health care services directly involved with communities and as such they are part of CBHC. In addition, many Community Based Organisations (CBOs), Non Governmental Organisations (NGOs), Faith Based Organisations (FBOs), private sector organisations and practitioners, and community based traditional health practitioners actively complement the work of the government in an effort to provide much needed support to community members especially in the area of health and social services. HIV/AIDS, malaria and tuberculosis have placed a high burden on communities which has prompted many community members to involve themselves in voluntary work. This work is very vital to the Namibian nation and is strongly supported by the government.

Community-Based Health Care is a comprehensive and integrated community programme, involving health, agricultural, and economic activities undertaken by individuals, families and groups within the community. Communities identify and prioritize their own problems and needs and mobilise resources to address these.



CBHC includes information, education and training concerning prevailing health problems in communities and the methods of preventing and controlling them; promotion of proper nutrition, maternal and child care; immunisation against the major infectious diseases; prevention and control of locally endemic diseases such as diarrhoeal diseases, acute respiratory infection and malaria; reproductive health services, including family planning and the prevention and control of sexually transmitted infections with particular emphasis on HIV/AIDS; appropriate treatment for common diseases and injuries; oral health; mental health; rehabilitation for people with disabilities; school health, environmental health and the improvement of living conditions. Closely linked to community health outcomes are the provision of other basic needs - improved living conditions, adequate supply of safe water and basic sanitation.

CBHC extends coverage of services and increases the number of potential beneficiaries by bringing more people under the direct influence of development activities. Participation by all those concerned results in a better coordination of resources and activities. It ensures benefits are gained from the use of local knowledge, skills and resources.

Community-Based Health Care (CBHC) is guided by a programme within the Primary Health Care Directorate of the MoHSS. This programme cuts across and aims to support all other Primary Health Care programmes in their activities at community level.

## 1.2 RATIONALE

The National PHC/CBHC Guidelines were launched in 1992. These gave the MoHSS the mandate to design, develop and implement programmes that focus on promotion of health at the community level. In addition, they provided a base for decentralisation and inter-sectoral collaboration with joint identification and prioritisation of needs at the community level by all sectors including Non Governmental Organizations (NGOs).

With the increasing number of clinics, mobile health teams and community health care providers who fulfil a vital role in bringing health care to the household level, the PHC/CBHC Guidelines (MoHSS 1992) are no longer specific enough to guide and support the implementation of a community based approach to Primary Health Care. With growing experiences in community work and with increasing numbers of stakeholders involved in the implementation new challenges have evolved.

The *PHC/CBHC Capacity Building Programme Review 2000* recommended the following:

- The CBHC programme needs to be revisited by all stakeholders;
- The responsibility of Community Health Workers (CHWs) should be reviewed, for example, they should be involved in outreach service activities;
- Supervision and support to both health workers and CHWs need to be strengthened;
- The concept “collaboration” requires thorough analysis and good understanding by all key stakeholders; and above all,
- The MoHSS should develop a policy for the CBHC Programme.

This policy document is the realisation of these recommendations.

A national rapid assessment on community volunteers and CBHC (CBHC) Programmes was carried out in 2006. Key findings included:

- The huge variation that exists between the simple definition of volunteers (people who freely offer their time, knowledge and skills) and what volunteers expected to receive in practice;
- The variation in the work involved, time spent and distances travelled by volunteers;
- The variation in the duration and content of training which volunteers received;
- The variation in the way volunteers were rewarded and supported;
- A general agreement across all regions that volunteers should be rewarded and that an incentives package should be defined and standardised.

At a National Conference on Volunteers held in December 2006, it was recommended that volunteers should receive adequate tools, recognition and reward. However, it was noted that any remuneration and supervision could imply that volunteers were in fact employees under the Labour Act and therefore it was recommended that Namibia Non-governmental Organisation Forum (NANGOF) or volunteers organisations individually, should apply for volunteer exemption from the Ministry of Labour. There was general support to standardise volunteer incentives but there was recognition that a wide variation existed in the capacity of NGOs, FBOs and CBOs to raise funds, and a similar variation in the actual work of the volunteers.

A National Consultative Workshop on Community/Home-Based Care was held in February 2008 to look at standardizing the provision of community/home-based care and the subsequent training required for community/home-based care providers. The relevant recommendations and outcomes of that consultation have been incorporated into this policy, including the recommendation to move away from the general term *volunteer* to the more specific term **Community Health Care Provider (CHCP)** when referring to individuals who provide health care services within the community but who are not staff members of an organisation, ministry or institution.

It is the main aim and intention of this policy therefore to build on the strengths and address the challenges that have come to light and to move CBHC in Namibia forward in an effective and sustainable way.

## **CHAPTER 2: SITUATION ANALYSIS**

### **2.1 THE HEALTH STATUS**

The level of health in Namibia is well below what could be expected from the country's Gross Domestic Product level. There are several contributing factors to this: the vastness of the surface of Namibia and the low population density in most areas, the many population groups, which vary in languages, economic activities, cultural identity and social behaviours and the former health system, which did not address the needs of the rural communities.

Namibia's health status is as follows: Life expectancy was estimated by the National Population Census (2001) for men and women as 47.6 and 50.2 years respectively. This is considerably lower than the average for middle-income countries, which is 67 years.

The infant mortality rate (IMR) declined from 57 per 1,000 (NDHS 1992) to 52 per 1,000 live births (National Population Census, 2001). Also, the under-five mortality has improved from 83 per 1,000 (NDHS 1992) to 71 per 1,000 live births (National Population Census, 2001). However, the maternal mortality ratio has increased from 225 maternal deaths per 100,000 to 271 per 100,000 live births (NDHS 2000) and further to 446 per 100,000 live births (2007 NDHS Preliminary Data).

The major causes of death among children under five years of age (accounting for 75% of total) remain diarrhoea, malnutrition, malaria, and HIV/AIDS all of which are largely preventable and treatable (HIS, 2005). Major causes of death in adults are HIV/AIDS, Pulmonary Tuberculosis, Pneumonia, Diarrhoea/ Gastroenteritis and Malaria (HIS, 2005)..

HIV/AIDS has become the principal public health problem in Namibia. According to 2006 HIV Sentinel Survey, 19.9% of pregnant women tested positive for HIV. According to the data on mortality in hospitals compiled by MoHSS, HIV/AIDS has become the most frequent cause of death since 2000. In 2006, the HIS reported that HIV/AIDS accounted for 23% of all reported deaths and for 36% of deaths in the age group of 15 to 49 years. HIV/AIDS related diseases are also major causes of hospitalisation. The number of patients with this diagnosis increased from 355 in 1993 to 17,553 in 2006.

### **2.2 COMMUNITY BASED HEALTH CARE**

Over the last ten years, there has been an increasing number of community based organisations and larger NGOs and FBOs that have become involved in delivering CBHC at the household level. This has been largely in response to the increasing number of people infected and affected by HIV/AIDS and TB but some programmes focus on broader public health issues. In 2007, NANGOF registered more than 290 civil society organisations that jointly support more than 20,000 volunteers, most of whom provide health care and support.

Human resources have been developed through the re-orientation of hundreds of health workers in PHC/CBHC including Participatory Rural Appraisal techniques and thousands of

community health care providers have come forward and have been trained to deliver various aspects of community health to individuals and households.

A huge part of community based health care is the provision of home based care, as an essential component of the continuum of care for persons living with HIV/AIDS and other diseases. Home-based care is the holistic, comprehensive care of clients that is extended from the health facility to the client's home through family participation and community involvement within available resources and in collaboration with health care workers. It encompasses clinical care, nursing care, palliative care, counselling and psycho-spiritual care and social support. Referring to Palliative Care, the National Policy on HIV/AIDS states that:

1. All patients shall be provided with adequate and effective palliative care at all times. Appropriate training and resources shall be made available to care providers;
2. Appropriate pain medication shall be made available at the appropriate level in the health system and community and personnel shall be trained in a step-wise approach to pain management which will include relevant narcotic medication when indicated.

Home based care aims to facilitate the continuity of the client's care from health facility to the home and community and to empower the clients, the family and the community with the knowledge and skills needed to ensure long-term care and support;

The outreach points (visited by outreach team), clinics, and health centres are situated in the community. They are the primary level of health care within a health district and provide the direct link between the formal health system and the community. Outreach services aim to provide the same high quality and essential package of services as offered at fixed clinics (Refer to the MoHSS Draft Outreach Policy, 1999).

Another important point of contact between the health system and the community is through schools. (Refer to the Draft School Health Policy, 2007).

Considerable progress has been made towards CBHC for all citizens but there is often a lack of community participation, integration and coordination between all the key role players. Namibia is experiencing inadequate human resources at all levels in the MoHSS to plan, organise, coordinate and implement CBHC and Outreach Service activities; CHCPs often experience inadequate resources and supervision and support from the community, their support organisations, or from the MoHSS. The responsibilities of different stakeholders in supporting (CBHC) and Community Health Care Providers (CHCPs) are often not well understood. If the challenges are not addressed, CBHC services will continue to be fragmented and the quality will vary from one area to another. The CBHC Policy is a result of a continuous process of deconcentration and devolution of responsibility, authority, ownership and resources towards our communities.

By supporting CBHC programmes, a significant contribution will be made to reducing infection rates of diseases and improving health outcomes.

## CHAPTER 3: POLICY FRAMEWORK

### 3.1 GOAL

The goal of this policy is to empower and motivate communities to initiate, strengthen and own community actions and household practices that will promote health, prevent illnesses and provide palliative care in order to reduce morbidity and mortality and improve the quality of life of all Namibians.

### 3.2 PRINCIPLES

The following principles will guide the implementation process of this policy namely: equity, availability and accessibility, affordability, community involvement, sustainability, justice, inter-sectoral collaboration and quality of care:

1. Volunteerism will be promoted and supported as a cornerstone for achieving **quality community care**.
2. The health care system at local level will strive to build partnerships to support Community based health care activities with the community at large, Community Health Care Providers (CHCPs) and their supporting civil society organisations;
3. A participatory approach focusing on community involvement, community ownership and community leadership will be used when identifying health needs, planning, implementing, monitoring and evaluating CBHC activities;
4. CBHC will be considered as a process whereby gradually and continuously people increase their control over social, political, economic and environmental factors affecting their health status;
5. The approach for community based health care in Namibia will be flexible and tailored to meet the individual needs of districts, communities and households;
6. Local traditional beliefs, practices and behaviours will be recognised and considered when planning new initiatives; positive practices being encouraged and promoted, and potentially negative practices being discouraged.
7. Gender equality will be promoted in order to achieve an equal basis for development of men and women;
8. The specific unique needs of children and their healthcare will be addressed and promoted;

9. CBHC is an integral and fundamental component of the health system and at all times the focus will be on integration of activities in order to enhance effectiveness and efficiency;
10. Intersectoral coordination, collaboration and respect between key partners and sectors will form part of all CBHC activities;

### **3.3 OBJECTIVES**

The following are the objectives the CBHC policy:

1. To empower communities to increase awareness and knowledge and improve attitudes and practices related to the prevention, treatment, care (including both curative and palliative) and rehabilitation of most common diseases
2. To set standards for CBHC to ensure the effective implementation of quality programmes.

### **3.4 DEFINITIONS**

#### **3.4.1 Community Resource Persons**

Communities have a wide range of local expertise and particular individuals are resource people for community based health care. Individuals such as principals, teachers, Constituency Councillors, Constituency Development Committee members, extension workers, and many others are all community resource people. In other communities members of constituency care committees for orphans and vulnerable children visit homes which have a high number of such children, especially elderly or youth headed household. These are all examples of community resource people.

#### **3.4.2 Community Health Care Providers (CHCP)**

Community health care providers are persons trained to promote health and welfare at community level. They may be volunteers or paid providers. They include Traditional Healers, Traditional Birth Attendants, Home-Based Caregivers, Community Health Workers (CHWs), Peer Counsellors, Health Educators, Health Promoters, Family Visitors and other persons engaged in health, as well as extension workers from other sectors.

- Traditional healers are highly respected in communities and community members have confidence in their information. Traditional healers have immense influence in their communities and can present a positive or a negative force towards the promotion of health and development, depending on their conviction and involvement.
- Traditional Birth Attendants (TBAs) are found in many communities in Namibia. They are often greatly respected in their communities and have an important role to play in contributing to reproductive health care. TBAs will be supported to follow the reproductive health guidelines of the MoHSS and they will be trained to promote the

Prevention of Mother to Child Transmission (PMTCT) services and the national policy on infant and young child feeding.

- Health Promoters concentrate on the promotion of health, disease prevention and rehabilitation.
- Peer Educators / Peer Councillors / Community Counsellors are predominantly youth or workplace employees who provide information and education on sexual and reproductive health and HIV/AIDS/STI/ TB issues;
- Home based care givers visit and care for chronically ill patients. They usually guide other household members to give the daily care required by the patient but they also help with household chores such as cleaning, cooking, washing clothes as well as direct palliative care. They may also perform other roles such as overseeing the supervision and welfare of the children. In many households affected by HIV/AIDS, HBC givers give support and love to orphans and vulnerable children, checking that their basic needs are met and encouraging them to stay in school.
- People living with HIV/AIDS and ex-TB patients are encouraged to join support groups and community health care provider to be treatment supporters, buddies and become Direct Observation Therapy (DOT) supervisors.
- Village/Community/Clinic Health Committee members and many community health community health care providers serve as a link between the community and the health facility and lead the community in community based responses to TB, HIV/AIDS and other health initiatives.

### **3.5 STRATEGIES**

The key strategies to strengthen the delivery of quality community based health care services are to:

#### **3.5.1 Support for Community Health Care Providers (CHCP)**

- 1 CHCP will receive on-going accredited training, resource materials, support, supervision, recognition, and reimbursement for costs incurred through their work.
- 2 Community involvement and participation in CBHC programmes will be promoted during needs assessment, planning, implementation, monitoring and evaluation
- 3 Communities, civil society service providers, health workers, community development workers, other community resource people, local authorities and Regional Councils all have a responsibility towards supporting community health care providers.

#### **3.5.2 Strengthen human resources**

1. CBHC guidelines, training standards and integrated training manuals and supervisory tools will be developed to guide the implementation of this policy at different levels.

2. Training of Trainers and therefore of CHCPs will be standardised and accredited by the Namibia Qualifications Authority. Each CHCP trained by the MoHSS or its partners will receive a performance and attendance certificate and an agreement of duties. This will clearly outline the expected roles and responsibilities of each CHCP and the agreed upon provision of incentives;
3. Structured supportive supervision and refresher training shall be provided to all CHCPs;
4. The facilitation skills of MoHSS staff who work directly with communities will be strengthened to build a stronger relationship between the communities and the health facility;
5. Resource mobilisation mechanisms including incentives for CHCPs will be established and strengthened and additional ways of assuring the sustainability of community programmes will be continuously explored.
6. Appropriate guidelines and practices on decentralisation and integration of CBHC services as well as on mobile outreach services will be developed;

### **3.5.3 Integrated management of CBHC services**

1. The integrated management of CBHC services, involving all relevant stakeholders, will be strengthened and supported at the appropriate levels, to increase the impact and effectiveness of CHCPs;
2. Monitoring and coordination between the community, the health facility and traditional healers will be strengthened. The specific roles and responsibilities outlined in the Traditional Health Practitioners legislation (to be promulgated) will be adhered to.
3. Basic health services consisting of a balanced mix of health promotion, disease prevention, primary and emergency curative and palliative care, rehabilitative and referral services, with focus on priority community health challenges, will be provided.
4. MoHSS CBHC functions will be decentralised and integrated to regional and local authorities, in line with Government's Decentralisation Policy, to promote ownership and sustainability of community health initiatives, ensuring that adequate resources are made available;
5. The CBHC function and staffing of all MoHSS health facilities at primary level will be strengthened and community oriented approaches will be used in providing basic health services aiming at building self-reliance in the people, creating the opportunity for all to realise their full potential and motivating them to be both activists as well as main beneficiaries of PHC/CBHC;



6. Monitoring and evaluation will be strengthened, using integrated teams where appropriate.
7. The CBHC and welfare information data bank within the Health Information System (HIS) will be strengthened in order to reflect a true profile of the community needs and developmental activities;
8. Essential health information will be jointly analysed and shared with communities and families to encourage active participation in CBHC activities;

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

The Government of the Republic of Namibia places a high premium on the active participation of communities in health and social welfare services. The objective is to make communities masters of sustainable PHC programmes in their own environments. As outlined under the policy principles, there are many important partners in CBHC. The institutional framework for the implementation of this policy therefore, includes line ministries, the private sector, NGOs, CBOs, FBOs and communities at large.

This Chapter summarises the role of different actors at community, district, regional and national level that will be engaged in the policy implementation process. More detailed roles and responsibilities are defined in the Guidelines.

### **4.1 ROLES AND RESPONSIBILITIES OF THE MoHSS**

#### **4.1.1 Sub-Division: CBHC AND School Health, Division of Family Health**

- Coordinate and promote quality CBHC programmes at national and regional level through the Family Health Division in the PHC Directorate to avoid duplication of services and to facilitate national coverage;
- Provide technical support to implementing districts and partners;
- Monitor outputs achieved by the national programme, NGOs and other stakeholders; review and promote best practices and commission relevant research.
- Standardise training content and ensure course accreditation
- Coordinate and promote an effective supply chain of materials and supplies

#### **4.1.2 Regional and District level**

- The MoHSS Regional Management Team (RMT) consisting of the Regional Director (RD), the Regional Chief Medical Officer (CMO) and various Health Programme Officers as well as the Regional Administrator (Chief Control Officer) will be responsible for planning, coordination for supportive supervision and monitoring of CBHC activities within the region. They will mobilise and allocate resources to ensure that enough supplies are available for the outreach services, clinics and health centres;
- The District Coordination Committee (DCC) including the Principal Medical Officer (PMO), the PHC supervisor, the hospital matron (PRN), district health inspector, social worker and the district administrator (control officer) will oversee and coordinate the implementation of the CBHC activities and projects at district levels.

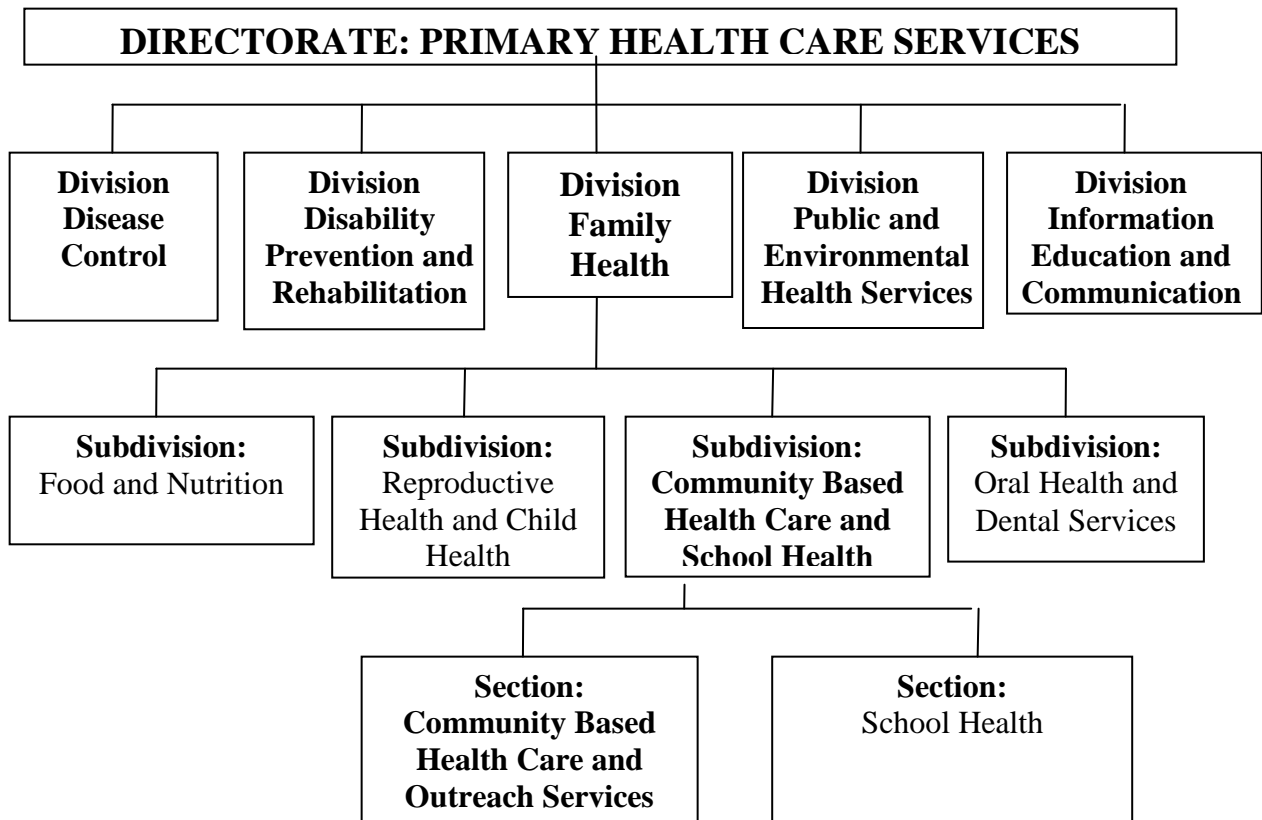
#### **4.1.3 Local level Clinics, Health Centres and Outreach Points**

- Participate in mobilisation and sensitization concerning the recruitment, orientation, training, refresher training and supervision of community-based health care providers and act as the referral centre for CHC providers;
- Keep records of the activities of community and home based care providers;

#### 4.1.4 Roles of other MoHSS Programme Policies

- The Integrated Information, Education and Communication Division in the Directorate of Primary Health Care Services will support community sensitisation and mobilisation activities for all PHC programmes.
- Other policies and guidelines such as the I.E.C. policy, the Reproductive Health Policy, National HIV/AIDS policy, the Medium Term Plan for HIV/AIDS, the Guidelines for CBHC, the School Health Policies, the Outreach Services, and many other operational policies will guide the relevant CBHC activities.

**Figure 1 The structure for community based health care in the MoHSS**



#### 4.2 ROLES AND RESPONSIBILITIES OF OTHER MINISTRIES

#### **4.2.1 Ministry of Education (MoE)**

- The National Training Authority, currently within the Ministry of Education shall approve unit standards for training courses before these can be accredited by the Namibia Qualifications Authority.
- Schools will encourage staff and learners to promote health amongst themselves and to motivate their families and communities to participate in various community health activities. (Refer to the School Health Policy).
- The National Literacy Programme, in cooperation with the CBHC, should develop health information literacy materials on promotion of health and the fight against HIV/AIDS, malaria, TB, diarrhoeal diseases and malnutrition (among other key health issues).

#### **4.2.2 Ministry of Agriculture, Water and Forestry (MAW &F)**

- The extension workers (agriculture and water) and community water committees will sensitize communities regarding maintenance and use of clean water supplies and the production and use of nutritionally rich foods, and will provide technical support to CHCPs on agricultural and development issues.
- The Regional Food Security and Nutrition Technical Committee, together with the Regional Food Security and Nutrition Coordinator, will support community-based food security and nutrition initiatives and interventions to reduce poverty and food insecurity.

#### **4.2.3 Ministry of Regional and Local Government, Housing and Rural Development (MRLGH & RD)**

- Regional Development Coordinating Committees (RDCC), Constituency Development Committees (CDC), Local Authorities and the Village/Community Development Committees (V/CDC) will support and monitor the CBHC activities carried out by MoHSS and other partners;
- Regional AIDS Coordinating Committees (RACOCs) and Constituency AIDS Coordinating Committees (CACOCs) will coordinate linkages between communities and different service providers and between different service providers; The National Policy on HIV/AIDS (2007) states that Regional AIDS Coordination Committees (RACOCs), Constituency AIDS Coordination Committees (CACOCs), traditional authorities and local authorities shall help ensure that communities have access to home based care and will support groups and organisations which provide home based care.

#### **4.2.4 Ministry of Gender Equality and Child Welfare (MGECW)**

- Community activators, community liaison officers, social workers and community childcare workers within the MGECW will help identify and families and family members in need of health care.
- They will offer technical support concerning women and children to CHCPs.

#### **4.2.5 Ministry of Defence (MoD)**

- The MoD provides logistics and personnel during National Immunisation Days and during national emergencies. They can provide tents, transport, shelter for meetings and training as well as assistance to CHCPs.

#### **4.2.6 Ministry of Information and Broadcasting (MIB)**

- The MIB will create awareness among political and community/opinion leaders and the community at large on community health and development issues concerning children and household community practices.
- The NBC Radio and TV broadcaster will support weekly/monthly CBHC programmes by facilitating discussions on community health issues.

#### **4.2.8 The National Planning Commission (NPC)**

- The NPC Secretariat has developed the Namibia/Civic Organisations Partnership Policy that describes a working partnership between Government and civil society. The Policy aims to enhance the environment for civic participation and to enhance capacity of partners for such participation.

### **4.3 ROLES AND RESPONSIBILITIES OF LOCAL AUTHORITIES; CIVIL SOCIETY AND DEVELOPMENT PARTNERS**

#### **4.3.1 Local Authorities and Village Development Committees**

- Support and monitor the CBHC activities carried out by MoHSS and other partners.
- Coordinate the mobilisation of resources and determine the contribution by the community for a programme/project/initiative.
- Establish a village or community health sub committee

#### **4.3.2 Village Health Committee (VHC) or the Community or Clinic Health Committee (CHC)**

- Establish membership including the head of the local health facility as the secretary, community and church leaders, teachers, TBAs, traditional healers and community health care providers.
- Identify and coordinate the needs in their communities.
- Support and assist the identification, coordination, and implementation of the CBHC activities.

- Mobilise resources and determine the contribution by the community for a programme/project/initiative

#### **4.3.5 NGOs / FBOs / CBOs**

- Facilitate community needs assessment, mobilisation and sensitisation;
- Undertake management of community health care providers including their selection, orientation, training, training follow up, supportive supervision, and addressing care for the carers, in consultation with MoHSS and according to the MoHSS Guidelines for Implementing CBHC Services;
- Provide support to CHCPs either financially, materially or in kind;
- Work in partnership with the MoHSS to provide the necessary equipment and materials for the CHCPs to provide quality services.

#### **4.3.5 University of Namibia**

- Faculty of Health Sciences will further develop and incorporate Participatory Rural Appraisal (PRA) modules into the relevant training curricula.

#### **4.3.6 Development Partners**

- Provide financial, material and technical support to develop capacity on public/community health issues of nationals at all levels.

## **CHAPTER 5: RESOURCE IMPLICATIONS**

### **5.1 FINANCIAL RESOURCES**

The Government through the MoHSS and other Ministries shall mobilise adequate resources needed for the implementation of the CBHC policy. Primary health care approaches are not a cheap alternative to conventional health care. Due to its high population coverage the cost per person is high, however, it is lower than the cost of hospital care and is the best approach to reach the poor and thereby contribute to national development. The Ministries will also mobilise community support as well as support from private organisations and development partners.

### **5.2 HUMAN AND INSTITUTIONAL RESOURCES**

The level of development and the capacity of local structures and organisations, which serve as a basis for CBHC, vary between communities. Adequate human resources refer to personnel levels, their competencies and motivation. Additional personnel requirements, in terms of community health care providers and salaried staff, will vary from region to region and district to district depending on the population density, resources of the community and the number and type of health facilities available. The number of providers to be trained and supported depends on the needs of the respective communities. Organisations that run CBHC programmes with community health care providers should ensure they have acceptable working conditions. For additional information please refer to the Code of Conduct of Voluntary Organisations, the Minimum Terms and Conditions of Engagement of Volunteers and the CBHC Guidelines section on *Management of CHCPs*.

### **5.3 SUPPORTIVE SUPERVISION**

Supervision of community health care providers is an essential strategy for ensuring delivery of quality services. Each provider shall receive quality supportive supervision monthly, including: technical, emotional, spiritual and administrative components and CHCPs shall be managed, supported, supervised and evaluated by a permanent staff member, trained in supportive supervision.

### **5.4 TRAINING, TOOLS AND INFORMATION, EDUCATION AND COMMUNICATION (I.E.C.) MATERIAL**

Training, tools and I.E.C. material are essential to assist providers to perform their responsibilities and job descriptions effectively. These tools will enable them to give health education, provide care and support, treat patients minor and common illnesses and record/report data on CBHC activities.

## **5.5 EQUIPMENT, SUPPLIES AND HOME-BASED CARE KIT**

CHBC organizations and the government should ensure that qualified CHCP receive the necessary tools, basic medications and supplies. Many of these are supplied in a home based care kit which shall be replenished by the **Ministry**. Standardized equipment, supplies and kit contents are found in the CBHC Guidelines.

## **5.6 ADDITIONAL SERVICES FOR THE CHCP**

In addition to the above, the following elements are essential elements of support for community health care providers.

- Recognition and rewards from their CBHC service organisations, government and community leaders;
- An identification card and other means of identification e.g. T-shirt, hat, umbrella which boosts community confidence and promotes the programme;
- A contribution towards expenses incurred in carrying out their duties e.g. transporting or accompanying clients and communication costs;
- An agreed upon description of duties and expectations;
- Remuneration that is agreed upon with the CBHC service organisation and reflects the level of quality service provided and the hours served.

## **5.7 FUNDING SOURCES**

This policy is advocating for community involvement and participation in health and development. However, this does not imply any shifting of the burden for health care from existing services to communities. More accurately, it implies a sharing of responsibilities between health professionals and communities in which they are advocates of their needs and health professionals are responsive to those needs. Financing CBHC programmes is the responsibility for all – the individual, the family, the community, NGOs and the government.

The MoHSS will therefore endeavour to establish mechanisms that permit joint support and make resources available directly to community health enterprises themselves. International agencies and donor organisations will also be encouraged to adhere to this principle to ensure that funds are earmarked to promote community action for health. At operational/implementation level, the MoHSS District Coordinating Committee (DCC) in collaboration with the Constituency Development Committee (CDC) will mobilise material, financial and human resources to support service delivery, research and human resource development.



## CHAPTER 6: MONITORING, EVALUATION AND REPORTING

Monitoring is essential to track the progress of a programme – particularly its inputs, activities and results. Periodic evaluations assess what changes in the community have taken place as a result of the programme. Monitoring plans will vary from one community based health care programme to another however all will aim to assess the progress towards achieving this Policy’s core objectives:

1. To empower communities to increase awareness and knowledge and improve attitudes and practices related to the prevention, treatment, care (including both curative and palliative) and rehabilitation of most common diseases
2. To set standards for CBHC and ensure the effective implementation of quality programmes.

The priority is for all CBHC programmes to develop appropriate **indicators** and tools for monitoring and evaluating change relating to these two objectives. In addition, it is highly desirable to track the policy’s guiding principles of community involvement, gender equality and collaboration between key partners. Individual programmes may also want to track other changes, according to their specific strategies and plans. Specific indicators will measure performance in terms of numbers reached, the quality of service delivery and most importantly what impact has our work achieved.

Monitoring and evaluation provides an opportunity for accountability to all stakeholders. It helps project management to:

- supervise programme implementation to keep the programme on track;
- facilitate active learning and make informed decisions regarding programme management and service delivery;
- ensure the most effective and efficient use of resources; and
- evaluate and share the extent to which the programme has made its desired impact.

The Guidelines for Implementing CBHC describe the key monitoring tools in CBHC – supportive supervision, qualitative and quantitative data collection, regular integrated reviews and planning. The guidelines illustrate the flow of information, for monitoring and reporting purposes, from community to district, regional and national level.

## **GLOSSARY**

### **Community**

Is a group of people, with common interests, values, norms and lifestyle, under recognised leadership. This is referring to both geographical areas and interest groups.

### **Community Based Health Care**

Community-based health care is a strategy to operationalise and ensure effective community participation in Primary Health Care. It addresses all aspects of health care (preventive, promotive, curative and rehabilitative) at community level and it may address issues such as: environmental health, reproductive health, training of community members and income generating activities.

### **Community Based Health Information System**

Information on diseases, new births, deaths and statistics on health care activities documented and provided by CHCPs to the interested partners.

### **Community Development Committee**

A community committee recognised by the Regional or Local Authority as representatives of that given community, and calls community meetings to make participatory decisions.

### **Community Health Care Providers**

Any person in the community who provides health care services either from a government facility or privately, e.g. Community Health Workers (CHWs), Health Educators, Health Promoters, Home Based Care volunteers, Traditional Birth Attendants (TBAs), Traditional Healers (THs), community health committee members and private practitioners engaged in health

### **Health District**

Refers to the community level operational area and organisational entity of the Ministry of Health and Social Services the geographic coverage area of which may include one or more regional constituencies and/ or local authorities within a given administrative region. The population in the given health district is equal to the catchment population of the correspondent district hospital.

### **C/Home Based Care**

It is a holistic, comprehensive care of clients that is extended from the health facility to the client's home through family participation and community involvement within available resources and in collaboration with health care workers. It encompasses clinical care, nursing care, counselling and psycho-spiritual care and social support.

### **Household**

A household is defined as a person or a group of persons living together and sharing a common source of food.

**Orientation**

The main objective of orientation is to introduce new ideas, skills or methods of work to the existing staff category or CHCP.

**Outreach Services**

The delivery of mobile clinic services that include health education, illness prevention and treatment of common illnesses to remote health posts within the catchment area of a health district

**Participatory Rural Appraisal (PRA)**

PRA has been defined as a family of approaches and methods used to enable local people to share, enhance and analyse their knowledge of life and conditions to plan and act.

**Palliative care**

Palliative care is care that “improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual” (WHO 2002).

**Supportive supervision**

Supervisory visits and other methods conducted by trained staff with operational staff or community health care providers with the aim of providing in-service training, support, orientation and encouragement.

**Technical support**

Assistance given to operational staff involves planning skills, orientation, equipment and material as well as advisory and consultancy services.

**Trainer of Trainers (TOT)**

A TOT is a person trained in communication and or facilitation skills, who conducts training and orientation at operational levels.

## REFERENCES

- Brown L. (DRAFT Sept 2006) Achieving Standards of Care and Quality Improvement in Programming for Children Affected by HIV/AIDS,
- Dhillon H.S.and Charles D.A (1994). Human relations communication and leadership programme to strengthen the links among health workers, supervisors and the community Geneva: WHO
- Flahault, Piot, D M.Franklin A.(1988). The Supervision of Health personnel at District level. Geneva:WHO
- Gill W.(1990). Community Health Workers in National Programmes: Just Another Pair of Hands. Open University Press.
- Haile M.K, Mary E.Taylor, Peter A. Berman (1998). Community Health Workers: the way forward.Geneva: WHO
- Iipinge .S, Faculty of Medical and Health Sciences, University of Namibia (2000). Evaluation of the PHC/CBHC Capacity Building Programme.of MoHSS since 1992 –1998. Windhoek: UNAM
- Linus K.(1999). Healthcare in the Village: Caprivi District. UNICEF: Namibia,.
- Ministry of Health and Social Services (1992). Namibia Demographic and Health Survey, Windhoek: MoHSS
- Ministry of Health and Social Services (1992). The Official Primary Health Care/Community Based Health Care Guidelines. Windhoek, MOHSS
- Ministry of Health and Social Services (1993). Executive Summary of the Health Baseline-Survey. Windhoek: MoHSS
- Ministry of Health and Social Services (1994) A Resource Manual for Health Management Teams in Developing Monitoring/ Supervisory Tools. Windhoek: MoHSS
- Ministry of Health and Social Services (1995) Report of the First National Symposium on Community Health Initiatives: MOHSS.
- Ministry of Health and Social Services (1995).Integrated Health Delivery: The challenge of Implementation. A situation analysis and practical implementation guide, Windhoek: MoHSS.
- Ministry of Health and Social Services (1998). Towards Achieving Health and Social Well-being for all Namibians: A policy Framework: Windhoek: MoHSS
- Ministry of Health and Social Services (2001).Mid Term Review of the Government of Namibia and UNICEF Programme of Cooperation 1997 – 2001. Windhoek: MoHSS.
- Ministry of Health and Social Services (2004 – 2009). The National Strategic Plan on HIV/AIDS (Medium Term Plan III) Windhoek: MoHSS,

Ministry of Health and Social Services (2006) Report of an Assessment of Community Community health care providers and Community Based Health Care programmes. MoHSS

Ministry of Health and Social Services (2007) Report of the National Conference on Community health care providers

Ministry of Health and Social Services (2007) The National Policy on HIV/AIDS

Ministry of Regional and Local Government and Housing. (1996). National Early Childhood Development Policy. Windhoek: MRLGH

National Planning Commission (2001). National Population Survey, Windhoek: NPC

Oakley P. (1989) Community Involvement in health development: An examination of the critical issues Geneva : WHO.

World Health Assembly (1994). Community Action for Health: Background document – technical discussions Geneva: WHO

World Health Organisation (1990) The Community Health Worker: Working Guidelines for training and Guidelines for adaptation. Reprint. Geneva: WHO

Yates D. (1999). Study on Community Mobilisation Strategies. UNICEF: Namibia

Yates D. (2006) Outcomes and Quality Standards for Core Services (for OVC). FHI / USAID