

**NAMIBIA**

**GLOBAL HEALTH INITIATIVE  
2011-2015/16**

## Table of Contents

Acronyms .....	3	
1. Vision of the Global Health Initiative in Namibia.....	5	
2. Namibia Context and Priorities.....	7	
Country Context.....	7	
Health and Development Challenges.....	8	
<b>Table 1: Key Health and Population Indicators (Namibia).....</b>	<b>10</b>	
GRN Response to Health and Development Challenges.....	11	
<b>Figure 1: Key GRN Principles and Values for Health (National Health Policy Framework) .....</b>	<b>12</b>	
USG Health Programs in Namibia .....	13	
Opportunities for Moving Forward GHI Principles and Achieving GHI Targets... 14	Table 2: Applying GHI principles to illustrative USG programming in Namibia .....	16
3. GHI Objectives, Program Structure and Implementation.....	17	
Overarching Health Goal and Expected Impacts .....	17	
Outcomes and Results .....	18	
Intermediate Results and Activities.....	20	
4. Monitoring and Evaluation .....	30	
5. Learning Agenda .....	31	
6. Communication and Management Plan .....	32	
GHI Coordination .....	33	
GHI and Other Donors .....	33	
Communication.....	33	
7. Linking High Level Goals to Programs.....	33	
8. Annex 1: USG Namibia GHI Strategy Results Framework.....	35	

## Acronyms

Acquired Immune Deficiency Syndrome	AIDS
Antenatal Clinic	ANC
Antiretroviral / Antiretroviral Therapy	ARV / ART
Centers for Disease Control and Prevention	CDC
Civil Society Organizations	CSO
Community-Based Organizations	CBO
Country Operational Plan (PEPFAR)	COP
Demographic Health Survey	DHS
Emergency Obstetric and Newborn Care	EMONC
Gender Based Violence	GBV
Global Fund to Fight AIDS, TB and Malaria	GFATM
Global Health Initiative	GHI
Government of the Republic of Namibia	GRN
Gross National Income	GNI
Health Care Worker	HCW
Health Extension Worker	HEW
Health Systems Strengthening	HSS
Human Immunodeficiency Virus	HIV
Human Resources for Health	HRH
Integrated Management of Adolescent and Adult Illness	IMAI
Integrated Management of Childhood	IMCI
Male Circumcision	MC
Millennium Challenge Corporation	MCC
Millennium Development Goals	MDG
Maternal Neonatal and Child Health	MNCH
Monitoring and Evaluation	M&E
Ministry of Gender Equality and Child Welfare	MGECW
Ministry of Health and Social Services	MOHSS
Ministry of Regional and Local Government, Housing and Rural Development	MRLGHRD
National Health Policy Framework	NHPF
National Strategic Framework for HIV and AIDS	NSF
Orphans and Vulnerable Children	OVC
Public Affairs Section	PAS
Partnership Framework / Partnership Framework Implementation Plan	PF / PFIP
People Living with HIV/AIDS	PLHIV
President's Emergency Plan for AIDS Relief	PEPFAR
Prevention of Mother-to-Child Transmission	PMTCT
Primary Health Care	PHC

Public Health Laboratory Network	PHLN
Reproductive Health	RH
Tuberculosis	TB
United Nations	UN
United Nations Children’s Fund	UNICEF
United States Agency for International Development	USAID
United States Government	USG
University of Namibia	UNAM
Women and Child Protection Units	WACPU
World Health Organization	WHO

## 1. Vision of the Global Health Initiative in Namibia

The next five years (2011-2015/16) will be a critical period for the health sector in Namibia. The Government of the Republic of Namibia (GRN) is embarking upon significant reforms that will increase its ability to manage, coordinate and finance health services. It is also an important time for reshaping the partnership between the United States Government (USG) and GRN to strengthen government leadership and enhance local ownership of the national HIV response as well as other health programs. The USG/GRN HIV/AIDS Partnership Framework (PF), signed in September 2010, highlights and supports the evolution of the HIV/AIDS response from an emergency program, to a long-term, sustainable model. This effort will include a gradual reduction of donor funding, an increase in locally-managed and financed programs, and a transition of USG support to a “technical assistance model<sup>1</sup>.” The success of this transition will have a tremendous impact on Namibia’s ability to sustain quality health services, to increase access and utilization of services and, ultimately, to improve the health status of the Namibian population.

Therefore, the USG Namibia Global Health Initiative (GHI) Strategy focuses on an effective transitioning approach that will increase government and civil society (including the for-profit sector) capacity to manage, coordinate and finance the health sector.<sup>2</sup> Although USG agencies in Namibia receive predominantly HIV/AIDS and tuberculosis (TB) funds, investments have and will continue to significantly impact the whole health sector.<sup>3</sup> The strategy applies all of the core GHI principles -- country ownership, smart integration, systems strengthening, strategic coordination, leveraging resources, improved monitoring and evaluation (M&E), a focus on women and girls and an emphasis on innovation.<sup>4</sup> Increasing efficiencies will be a key to achieving the country’s ability to finance, sustain and scale up services. The main priority of the GHI strategy is to accelerate the achievement of GHI and Namibian health targets and mainstream GHI principles in USG and Namibian health programming.

In addition to supporting a coherent and comprehensive transitioning approach, the GHI strategy focuses on investments that will help the GRN and civil society partners to accelerate and expand access to quality health services particularly for women, children and underserved populations whose access to healthcare is limited by social and economic barriers. Although Namibia is considered an upper-middle income economy, large disparities persist both between certain population groups and also between geographical areas. In addition, women and children face particular obstacles that impede both access and utilization of services, and Namibian men have significantly lower utilization rates for all health services. The GHI strategy will demonstrate how the government and civil society can increase access to and utilization of services for underserved populations through, for example, improving coordination of HIV and TB prevention and control programs; increasing community awareness and action about gender issues, especially gender-based violence and male involvement in family health decisions, and;

---

<sup>1</sup> Office of the Global AIDS Coordinator, *Guidance for Partnership Frameworks and Partnership Framework Implementation Plans Version 2. As of December 2011 the Namibia PFIP was under development.*

<sup>2</sup> For purposes of this document, USG/Namibia defines civil society as including the private sector.

<sup>3</sup> As illustrated in the Results Framework, USG investments will have a direct impact at the outcome level and an indirect impact at the impact and goal levels. Indirect contributions at the impact level will contribute to Namibia’s progress towards achieving the Millennium Development Goals for health.

<sup>4</sup> The World Health Organization uses the word “integration” to describe multiple activities and resources that are organized, coordinated and managed to ensure the delivery of more efficient and coherent services in relation to the cost, output, impact and use (acceptability) of health care. The U.S. Government uses the term “smart integration” to emphasize integration where it makes technical, financial and cultural sense. Integration is not an end in itself and should be pursued where it results in improved services for a gamut of health needs. It often makes sense to integrate incrementally by building on a strong vertical program. (Source: U.S. Government. *Guidance for Global Health Initiative Country Strategies: GHI Guidance 2.0*. Washington, D.C. May 2011. Available from: <http://www.ghi.gov/documents/organization/165092.pdf>.)

expanding integration of prevention of mother-to-child transmission (PMTCT), maternal and child health (MNCH) and reproductive health (RH) services to facilitate “one stop shopping” for women and children.

The strategy will focus on two cross-cutting areas -- transition and access -- which will build on the robust PEPFAR program which has national coverage. By 2015 the GHI Strategy will have contributed to a reduction of maternal and child mortality, as well as decreased HIV incidence and prevalence, and prolonged survival of persons living with HIV/AIDS. Other expected results include:

- 1) Expanded GRN, civil society (including NGOs and the private sector) leadership and capacity to steward the health sector.
- 2) Increased domestic resources for health through ongoing and innovative financing strategies.
- 3) More equitable resource allocations (needs based) within the health sector, with a focus on expanding access to and utilization of primary health care services.
- 4) Scaled-up integrated HIV/AIDS, PMTCT, MNCH and RH services with increased coverage of underserved populations including women and girls.
- 5) Strengthened public-private partnerships that mobilize additional resources for the health sector and expand availability of services to a broader population.
- 6) Improved long-term planning for Human Resources for Health (HRH) and local health provider/manager capacity.
- 7) Increased financial and service efficiencies that will reduce program costs, such as male circumcision and ARV costs to the government.
- 8) Enhanced data collection, data analysis and interpretation, and data use at national and sub-national levels.

## 2. Namibia Context and Priorities

### Country Context

Namibia is one of Africa's largest, yet least populous nations. With an estimated population of 2.2 million and a land-mass the size of France (824,292 square kilometers), Namibia's people are distributed unevenly in urban centers and rural communities across enormous distances with a population density of 2.6 people/square kilometer. Namibia's projected population growth rate remains at 1.87%, and the government anticipates continued growth in demand for health and other social services through the current 30 year planning cycle<sup>5</sup>. In 2010, nearly 60% of the population was under the age of 24, two-thirds of which was estimated to be under the age of 18<sup>6</sup>. Table 1 contains additional key demographic indicators.

Based on Gross National Income (GNI) per capita, the World Bank has classified Namibia as an Upper Middle Income Economy<sup>7</sup>. However, substantial income inequalities exist (Namibia's Gini coefficient, an international measure of income and wealth distribution, historically ranks among the highest in the world).<sup>8</sup> Current World Bank estimates suggest that up to 38% of Namibians live in poverty.<sup>9</sup> Chronically high unemployment – up to 51% in the formal sector, according to recent GRN estimates – is an important contributing factor to elevated rates of poverty.<sup>10</sup>

In 2011, the GRN launched an ambitious stimulus program designed to upgrade the nation's infrastructure and thereby spur both investment and employment. The program's success is yet to be determined but, combined with significant reforms in the education sector, could provide the basis for a decrease in poverty rates. Namibia currently depends on revenues from the common South African Customs Union (SACU) pool for 30% of its budget and could be hard hit by a revision of the formula used to distribute these revenues. In addition, the economy is heavily dependent on fluctuating mineral prices, with revenues from uranium and diamonds comprising 8 % of the budget. Mining, fishing and agriculture are expected to remain the pillars of the economic for the next decade. According to recent visits from IMF and World Bank teams, Namibia's outlook for the next one to three years is stable. However, both institutions have urged caution given the continuing global economic crisis and its potential spill-over impact on Namibia.

---

<sup>5</sup> Government of the Republic of Namibia. Vision 2030, 2004.

<sup>6</sup> Population Division of the Department of Economic and Social Affairs of the UN Secretariat, World Population Prospects: The 2010 Revision, <http://esa.un.org/unpd/wpp/index.htm>. Accessed Tuesday, September 27, 2011.

<sup>7</sup> In 2010, the World Bank estimated Namibia's per capita GNI at \$4,500. This placed Namibia near the bottom of the range (\$3,976 - \$12,275) for inclusion in the Upper Middle Income Economy category. Source: <http://data.worldbank.org/country/namibia>.

<sup>8</sup> The United National Development Programme estimated Namibia's Gini Coefficient at 0.63 (out of 1.00) in 2007.

<sup>9</sup> The World Bank: <http://data.worldbank.org/country/namibia>.

<sup>10</sup> The broad measure includes in its denominator those who looked for work plus those who did not look for work; the strict measure of unemployment includes in its denominator only those who were actively looking for work; in this regard, it is estimated to be 37.6% (National Labor Force Survey 2008)

## Health and Development Challenges

Despite the strength of Namibia's formal economy (mining, fishing and tourism), the country faces a number of similar health and development challenges that confront lower-income neighbors in the southern African sub-region. Namibia ranks 105 out of 169 countries on the United Nations' (UN) Human Development Index, a measure of countries' progress on indicators in Health, Education and Income.<sup>11</sup>

HIV/AIDS remains a significant source of morbidity and mortality, and a major drain on national and international resources for health. In 2008/09, the national HIV/AIDS response consumed 27.5% of total national expenditures on health.<sup>12</sup> The HIV/AIDS epidemic is mature, generalized, and driven by heterosexual and mother-to-child transmission.<sup>13</sup> In 2008/09, HIV prevalence among adults aged 15-49 years was estimated at 13.3%, with an estimated 5,163 new infections per year, and approximately 173,000 people living with HIV (PLHIV).<sup>14</sup> The 2010 Antenatal Clinic (ANC) Survey reported HIV prevalence among pregnant women attending ANC was 18.8%, a decline from the peak ANC prevalence estimate of 22% reported in 2002.<sup>15</sup> TB is a major contributor to HIV-related mortality. With a TB notification rate of 598 cases per 100,000 population (of which 50% are co-infected with HIV), Namibia is faced with one of the largest national TB epidemics in the world.

Beyond HIV/AIDS and TB, the country faces substantial challenges in the areas of maternal and child mortality, as well as nutrition, general health promotion, and access to facilities with skilled health care workers (Table 1). Namibia has a high national maternal mortality ratio (449 maternal deaths per 100,000 live births) as compared to other upper middle income economies.<sup>16</sup> Maternal access to skilled birth attendants is also closely linked to economic inequality. While UNICEF statistics indicate that 81% of Namibian women deliver with a skilled birth attendant present, these numbers change dramatically when stratified by wealth: 98% of Namibian women in the upper 20% wealth bracket gave birth with a skilled birth attendant present, but only 60% for women in the lowest wealth quintile benefitted from the same level of service.<sup>17</sup> An increase in under-five mortality has also been observed over the last decade, with many deaths associated with preventable or treatable conditions. At 69 deaths per 1,000 live births, Namibia's under-five mortality rate is substantially below the regional average for sub-Saharan Africa, but considerably higher than other countries in the Upper Middle Income category. Despite these challenges a 2009 mid-term review of Namibia's progress towards achieving its MDG for health found that Namibia has "achieved" or will "likely" or "possibly" achieve 12 of 18 (67%) health targets by 2015.

Namibia's high rates of poverty and unemployment also exacerbate chronic and seasonal food insecurity, and contribute to elevated levels of childhood stunting (29%), wasting (7.5%) and being underweight (16.6%). Alcohol misuse, negative gender norms, low high school graduation rates,

---

<sup>11</sup> UN Development Programme (UNDP). Namibia Human Development Indicator Profile.

<http://hdrstats.undp.org/en/countries/profiles/NAM.html>. Accessed 28 September 2011.

<sup>12</sup> Government of Namibia, Health Systems 20/20 Project, World Health Organization, and UNAIDS. December 2010. Namibia Health Resource Tracking: 2007/08 & 2008/09. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.

<sup>13</sup> Ministry of Health and Social Services. *HIV/AIDS in Namibia: Behavioral and Contextual Factors Driving the Epidemic*. Windhoek. 2008.

<sup>14</sup> Ministry of Health and Social Services. *2008/09 Estimates and Projections of the Impact of HIV/AIDS in Namibia*. Windhoek. 2009.

<sup>15</sup> Ministry of Health and Social Services. *Report on the 2010 National HIV Sentinel Survey*. Windhoek. 2010.

<sup>16</sup> According to 2006/07 DHS, Namibia's maternal mortality ratio was 449 maternal deaths per 100,000 live births.

<sup>17</sup> UNICEF. Namibia statistics. [http://www.unicef.org/infobycountry/namibia\\_statistics.html#85](http://www.unicef.org/infobycountry/namibia_statistics.html#85). Accessed 28 September 2011.

seasonal migration for work, transportation barriers, limited involvement of men in family decisions related to health, and literacy challenges also contribute to Namibia's national disease burden and relatively low life expectancy (Table 1). At a structural level, limited (but growing) capacity to train healthcare workers in Namibia has inhibited Namibia's ability to fully implement comprehensive and integrated health services in all of its facilities. The impact of staffing shortages has been especially severe in rural areas, where a lack of clinical staff limits service delivery, quality assurance and other supportive supervision. Because of the shortage of public healthcare workers, the Namibian health care system is heavily dependent on expatriate physicians and other skilled clinicians. This dependence creates uncertainties about retention and contributes to a high turn-over rate. Government is currently engaged in an exercise to restructure the Ministry of Health and Social Services (MOHSS); inherent in this exercise is an effort to define and implement staffing norms that reflect patient loads and disease burdens faced by districts and facilities.

**Table 1: Key Health and Population Indicators (Namibia)**

Key health and population Indicators	
Estimated population (2011) <sup>1</sup>	2,184,091
urban	35%
rural	65%
Estimated child population under 18 years (2011) <sup>1</sup>	921,184 (42%)
Life expectancy (m/f) <sup>5</sup>	48/50
GNI per capita (PPP, current international \$) <sup>6</sup>	US\$ 6,350
Health facilities <sup>7</sup>	411
Hospitals	45
Health Centers	47
Clinics	295
Free standing VCT	8
Sick Bay	9
Fertility rate <sup>6</sup>	3.3
Contraceptive prevalence rate <sup>4</sup>	47%
Unmet need for family planning <sup>4</sup>	7%
Maternal Mortality per 100,000 live births (2006) <sup>4</sup>	449
Births attended by skilled attendants (2006) <sup>4</sup>	81.4%
Post natal care within 48 hours <sup>4</sup>	20%
Under five mortality per 1,000 live births (2006) <sup>4</sup>	69
Infant mortality per 1,000 live births (2006) <sup>4</sup>	46
Neonatal mortality per 1,000 live births (2006) <sup>4</sup>	24
Children under 5 underweight (2006) <sup>4</sup>	
2SD: moderate	16.6%
3SD: severe	3.8%
Children under 5 stunted (2006) <sup>4</sup>	
2SD: moderate	29%
3SD: severe	10%
Children under 5 wasted (2006) <sup>4</sup>	
2SD: moderate	7.5%
3SD: severe	1.9%
Estimated adult HIV prevalence (2010/2011) <sup>2</sup>	13.3%
HIV ANC prevalence (2010) <sup>3</sup>	
15-49	18.8%
15-24	10.3%
Estimated number of people living with HIV <sup>2</sup>	174 000
HIV infected individuals receiving ART (2009/10) <sup>2</sup>	75,681 (March 2010)
Estimated number of children orphaned by AIDS-related illness (2009/10) <sup>2</sup>	68,874
Male circumcision rate (2006/7)	21%
<b>TB notification rate per 100,000 population<sup>8</sup></b>	<b>589</b>
Sources:	
<sup>1</sup> CBS/NPC (2001) Population Projections 2001-2031;	
<sup>2</sup> MOHSS (2009) Estimates and Projections of the Impact of HIV/AIDS in Namibia;	
<sup>3</sup> MOHSS (2010) Report on the 2010 National HIV Sentinel Survey;	
<sup>4</sup> MOHSS & Macro (2008) Namibia Demographic and Health Survey 2006/2007.	
<sup>5</sup> CBS (2001) National Population and Housing Census	
<sup>6</sup> 2009 World Bank Development Indicators	
<sup>7</sup> MOHSS (2009) Health Facility Census	
<sup>8</sup> MOHSS (2010) Annual TB Report	

## GRN Response to Health and Development Challenges

Prior to independence in 1990, economic inequalities were mirrored in the public healthcare system developed by the Apartheid government. Among other inequalities in health care services, the public health system lacked both adequate healthcare facilities and a sufficient number of health care workers available per 1,000 to serve the black majority. Moreover, restrictions in the education system prevented most black Namibians from acquiring the pre-requisite skill levels for healthcare professionals, a handicap that the country is still struggling to overcome.

Namibia has, however, made great strides in remediating some of these structural inequalities. The public healthcare network now includes 46 hospitals (district, intermediate; including public, faith-based and private), 49 Health Centers, and approximately 350 clinics and other healthcare service points.<sup>18</sup> Facilities are distributed across all 13 regions; however, specialist services are concentrated in hospitals, which lie in urban areas. Domestic funding for health has increased steadily since 2001 when Namibia signed the Abuja Declaration committing to allocate 15% of total government spending to health. In 2008/9, the GRN spent 14.3% of its annual budget on health. Under the Namibia Institute of Pathology, a robust network of diagnostic laboratories provides laboratory services to public and private healthcare facilities. However the health sector currently lacks an integrated public health laboratory system and national public health laboratory. The private healthcare sector has also flourished since 1990, and Namibians' access to trained healthcare workers has improved, although national figures are skewed by the high number of health care workers (HCW) in the private sector. In 2008, a review of Namibia's health and social service sector found that while Namibia has more HCW (three per 1,000 persons) than most of its neighbors in sub-Saharan Africa,<sup>19</sup> the majority work in the private sector (8.8 HCWs per 1,000 persons). Currently, approximately 16% of the population is covered by private medical aid schemes with the remaining 84% presumably receiving services in the public sector (PSEMAS and NAMAF records).

Health and development policies and programs in Namibia are implemented and monitored through a framework of national strategies, led by Vision 2030 – Policy Framework for Long-Term National Development, which calls for national investments and action in five core areas: Education, Science and Technology; Health and Development; Sustainable Agriculture; Peace and Social Justice; and Gender Equality.<sup>20</sup>

Within health and development, GRN strategies are linked to and led by the National Health Policy Framework, 2010-2020 (NHPF) and the National Development Plans. The NHPF describes a strategy to expand and promote the delivery of accessible, sustainable, and equitable quality healthcare through an integrated, multi-sectoral, primary healthcare (PHC) model (Figure 1). Investments in the primary health care model – and efforts to integrate vertical health service delivery programs, such as HIV/AIDS, TB and malaria, into the PHC system, may be associated with some of the improvements Namibia has reported on key health care indicators over the last decade. These include:

- Since 2000, malaria incidence has decreased substantially due to the introduction of insecticide-treated bed-nets and artemisin combination therapies – both delivered through primary health

<sup>18</sup> Ministry of Health and Social Services (MoHSS) [Namibia] and ICF Macro. 2010. Namibia Health Facility Census 2009. Windhoek, Namibia. MoHSS and ICF Macro.

<sup>19</sup> 3 HCW/1000 population is above the WHO benchmark of 2.28 specified in the WHO 2006 report.

<sup>20</sup> Government of the Republic of Namibia. *Vision 2030 – Policy Framework for Long-Term National Development*. Office of the President. Windhoek. 2004.

care and community-based networks. As a result, reported malaria deaths in Namibia fell from 1,728 in 2001 to 46 in 2009.<sup>21</sup>

- Measles immunization rates are high (84%) compared to other countries in the region. In 2008, Namibia reported it was on track to meet its children under-five immunization targets under the Millennium Development Goals (MDG).<sup>22</sup>
- PMTCT coverage exceeds 70% and Namibia has endorsed the global goal of eliminating mother to child transmission by 2015.<sup>23</sup> High PMTCT and ART coverage has contributed to a decrease in estimated annual HIV/AIDS incidence from 2001-2009 (UNAIDS, Spectrum Model Estimate).<sup>24</sup>

The first two bullets are excellent examples of where the GRN has moved forward health programs outside of HIV/AIDS and TB and is already taking over increased management and financial support.

Although MDG goals for maternal, newborn and child mortality are ambitious, already significant improvements in immunization coverage, malaria control, and increased contraceptive coverage along with plans for MTCT elimination and increased maternal access to ARV treatment as well as expanding the health extension worker program nationally will increase the likelihood of achieving these goals.

**Figure 1: Key GRN Principles and Values for Health (National Health Policy Framework)**

**National Health Policy Framework Principles and values**

- All Namibians have the **right to enjoy good health** through **access** to primary care and referral level services according to need.
- Health and social welfare services will be **affordable** and the principle of **equity** and fairness will underpin the commitment expressed in this policy framework; special attention will be given to the needs of vulnerable groups.
- The new policy framework is for the **government**, emphasising that the responsibility for health and social welfare is not the prerogative of one single government sector.
- **Intersectoral collaboration** in terms of active engagement of other sectors in targeted health action, is a dimension which adds strength to interventions.
- **Quality of care** is and will be a pivotal dimension of all health services.
- **All Namibians will be encouraged and empowered to actively participate** in activities, which promote good health and prevent ill health at individual, family and community level, hence complementing the health and social welfare services. The public system will provide an enabling environment for this to happen through supporting community health.
- Namibia has a **pluralistic health system** and this will continue. The private sector for profit and not-for-profit plays an important role. The private sector will work together with the public system in accordance with their complementary role under the tutelage of the MOHSS. Formation of symmetrical **public-private partnerships** will be encouraged.
- Attention 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; researched efforts are required to uncover the social dimensions as determinants for health and social problems.
- Continued attention will be given to **social welfare** needs of the population in close collaboration with other Government sectors.

<sup>21</sup> Roll Back Malaria Country Profile (Namibia), 2009.

<sup>22</sup> Government of the Republic of Namibia. *2<sup>nd</sup> Millennium Development Goals Report-Namibia*. 2008.

<sup>23</sup> Government of the Republic of Namibia, National Strategic Framework for HIV and AIDS Response in Namibia 2010/11-2015/16, 2010.

<sup>24</sup> Government of the Republic of Namibia. *2008/09 Estimates and Projections of the Impact of HIV/AIDS in Namibia*. December 2009.

The GRN has committed to a substantial absorption process and is in the process of identifying funding to absorb all donor supported medical officers at the facility level. The GRN has also submitted additional budget requests to the Ministry of Finance to increase allocations to cover all donor supported positions relevant to the MOHSS (over a three year period), a greater proportion of costs for ARVs, and a greater proportion of bio-clinical monitoring. Also, as directed by Cabinet, the MOHSS is preparing a financial sustainability plan for the HIV/AIDS response; initial discussions are underway to absorb costs through greater efficiencies, health insurance, private sector and establishing a contributory trust fund for HIV/AIDS.

## **USG Health Programs in Namibia**

USG support for Namibia's health sector is focused on the national HIV/AIDS response, including TB and TB-HIV activities. Between 2004 and 2011, the USG provided approximately US\$634 million through the President's Emergency Plan for AIDS Relief (PEPFAR) and since 2005, child survival resources focused on TB totaling \$8.9 million. USG investments in HIV/AIDS prevention, care and treatment programs account for nearly half of total health expenditures on HIV/AIDS in Namibia. In (USG) fiscal years 2010/11, HRH – including training and direct salary support for clinical, non-clinical professional, administrative and support, and volunteer workers in support of the HIV/AIDS response – accounted for more than 30% of the USG/PEPFAR budget for Namibia. PEPFAR Namibia's substantial focus on human resources is rooted in a well-documented and chronic shortage of healthcare workers in Namibia's public healthcare sector, and has been recognized as a key element in Namibia's successful scale-up of PMTCT and antiretroviral therapy (ART) services.<sup>25</sup>

Given the increased focus on country ownership and sustainability, the USG is working with GRN to transition clinical and non-clinical positions from donor (USG or Global Fund to Fight AIDS, TB and Malaria (GFATM)) support to the GRN staff establishment. The budget for USG-funded salaries was reduced by 5% in 2011, and will decline further over the course of the Partnership Framework Implementation Plan (PFIP) period (through 2016). Other areas of USG investment include technical assistance for pharmacy and other stock management; laboratory consumables for bio-clinical monitoring of patients on antiretroviral therapy (ART); support for mass media, other behavior change communications strategies; community-based health care programs, including programs for orphans and vulnerable children and people living with HIV/AIDS; capacity building for civil society organizations; and contributions to biomedical prevention programs, including blood safety and male circumcision.

Although a transition plan has been launched for USG support for salaries, HRH investments will continue to play an important role in USG health budgets for Namibia in coming years. As USG investments in HRH shift from direct salary support, HRH support will continue to focus on pre-and in-service training, and will include increased technical assistance to strengthen the GRN's ability to plan for, recruit, retain and manage an expanded HRH workforce, engage with civil society, and protect the gains made in service delivery with donor support. Looking ahead, it is anticipated that these investments in HRH will directly contribute to GHI targets in the area of improving access to quality health care services. Within PEPFAR, some funds have historically been invested in cross-cutting areas that align with the GHI principles. Ongoing investments in this area include support for health (and

---

<sup>25</sup> The Capacity Project. *Health Workforce "Innovative Approaches and Promising Practices" Study: Strategy for the Rapid Start-up of the HIV/AIDS Program in Namibia: Outsourcing the Recruitment and Management of Human Resources for Health*. 2006.

other) systems strengthening, coordination and private sector involvement, strategic information, gender, nutrition, and child survival.

The vast majority of USG assistance to Namibia is through PEPFAR and Millennium Challenge Corporation (MCC) funding. USAID/Namibia also receives child survival funding for TB. These resources complement PEPFAR activities under treatment, care and support (including TB/HIV co-infection) to combat TB in areas with the highest TB and multi-drug resistant TB case rates. Also, in alignment with the USG GHI principles and to support the attainment of health-related MDG, PEPFAR Namibia is investing funds in the MOHSS to support the implementation of the GRN's national "Roadmap for the Accelerated Reduction of Maternal and Neonatal Mortality." Examples of USG-supported activities that are contributing to the maternal and neonatal mortality roadmap include mobile clinics to increase access (see Text Box 7), improved blood safety for comprehensive emergency obstetric care (EMOC) (see Text Box 4), piloting of the health extension worker program (see Text Box 6), and establishing bi-directional referral systems for improved continuum of care from the household to the facility to detect early signs of complications during pregnancy and the post-natal period.

USG investments in systems strengthening including HRH, information systems and expanded domestic resource mobilization contribute significantly to strengthening health services beyond HIV/AIDS and TB. Lastly, HIV/AIDS workplace activities are incorporated in all ongoing MCC-supported projects.

## **Opportunities for Moving Forward GHI Principles and Achieving GHI Targets**

The GRN places a high priority on health in its development agenda. Vision 2030 and the NDP III identify good health as a fundamental tenet of development. The PEPFAR PF is aligned with both the National Strategic Framework for HIV/AIDS 2010/11-2015/16 and the NHFP 2010-2020 as well as other key GRN strategies. The National Health Policy emphasizes primary health care and systems strengthening. With USG and UN support, the MOHSS carried out a comprehensive review of health systems in 2008/09. The study provides a critical analysis of key health systems (human resources, financing, governance, leadership, organizational structure and health service delivery) and offers concrete recommendations to address gaps and strengthen systems. ***The MOHSS has moved forward aggressively on many of the recommendations that align with the GHI principles of systems strengthening, country ownership, and strategic coordination and leveraging. Increasing efficiencies and reducing duplication of structures and functions is a major thrust of the review and a key element of new reforms that the MOHSS is initiating.*** For example, the MOHSS is developing a new Directorate on Health Information and Research with a mandate to integrate and streamline many parallel data collection and reporting systems. The USG, as part of GHI, will be supporting the MOHSS in the development and roll-out of the integrated information system. This is an example of the kind of cross-cutting impact PEPFAR investments will have on the outcomes and impacts sought through this GHI strategy.

To begin to address inequalities in the health sector and to better implement primary health care, the MOHSS is piloting a community health extension program that will utilize a new cadre of community extension workers. These Health Extension Workers (HEW) will provide integrated prevention education, illness detection and referral services and facilitate better linkages between health facilities and the communities.<sup>26</sup> Fundamental to this initiative are the goals of increasing support for the highest

---

<sup>26</sup> MOHSS is currently developing a pilot HEW project (see textbox page 25) in one region which was selected for its logistical challenges, scarcity of health facilities, high burden of disease and the presumption that a successful model developed in this region will be applicable nationwide.

impact interventions and community engagement in crafting health services delivery systems that are maximally responsive and effective. The USG is assisting the MOHSS to pilot this program. Based on the outcomes of the pilot, the USG will continue to support the program's roll-out, to increase access to integrated sustainable quality healthcare services. In addition, the MOHSS is advocating closer linkages and integration of PMTCT and pediatric HIV care and treatment services into MNCH, ANC and reproductive health services at regional, district and community levels to increase access to services. Both the Health and HIV/AIDS strategies call for increased private-public partnerships, which GHI can support to expand access to services and mobilization of resources.

The National Strategic Framework for HIV/AIDS 2010/11-2015/16 highlights the importance of women and the girl child. The Framework calls for the reduction of the vulnerability to HIV infection and mitigating the impact of HIV and AIDS on women and children. Namibia has ratified the Convention on the Elimination of All Forms of Discrimination against Women and has carried out legal reforms and implemented appreciable measures to address gender inequalities and gender-based violence (GBV). Some of the progressive laws include: the Combating of Domestic Violence Act (No. 4 of 2003); Maintenance Act (No. 9 of 2003); Combating Rape Act (No. 8 of 2000) and the Married Persons Equality Act (No. 1 of 1996). Zero-tolerance GBV awareness campaigns are conducted annually. Fifteen Women and Child Protection Units (WACPUs) established in all of Namibia's 13 regions respond to incidents and threats of abuse and provide services for abused women and children

PEPFAR Namibia's Gender Challenge Fund initiative provides one of several opportunities for the USG team to partner with the MGE CW in support of GHI goal and to strengthen programs that aim to enforce GBV legislation, strengthen GBV coordination structures and data collection systems, expand gender equality sensitization programs at the community, regional and national levels, promote child protection programs, as well as build capacity for local responses on GBV with traditional leaders, schools, and community-based organizations (CBO).

Although MDG Goals 4 and 5 are ambitious, there is great potential for substantial reductions in maternal and child mortality due to the GRN's 1) commitment to overall health sector reform and primary health care, 2) continued success and support for strong child health programs such as immunization and malaria programs, 3) expansion of an outstanding PMTCT program to MTCT elimination, along with 4) increased coverage and better integrated HIV/AIDS, MCH and RH interventions and TB prevention and case management programs, and 5) focus on integrated services at the community level. GHI's direct support to MTCT Elimination and improved PMTCT linkages with maternal, newborn, child health and reproductive health programs, improved quality and coverage of HIV/AIDS programs including pediatric AIDS, and support for systems strengthening across all health services will contribute to MDGs 4 and 5.

**Table 2: Applying GHI principles to illustrative USG programming in Namibia**

Past Way of Doing Business	Now: Application of GHI Principles	Illustrative Activity
Salary support to address critical HRH shortage in public sector	<b>HSS:</b> Long-term workforce planning	Technical assistance for workload assessments, HRH projections and HRH policy
Directly finance activities	<b>HSS:</b> Capacity building to support GRN and other stakeholders to increase budget allocations (both equitably and efficiently) for health- including donor-financed activities	Technical assistance to develop a national health insurance policy and equitable regional resource allocation formula for MOHSS, and conduct cost efficiency studies on drug procurement
Development of largely vertical information systems to meet HIV/AIDS response needs	<b>M&amp;E/Integration:</b> Integrating, streamlining, and linking of information systems across health - ultimately between public and private sectors.	Technical assistance and infrastructure support for a national database server for health, new integrated health information and research directorate, and streamlining of reporting systems for CSO
Focus on service delivery	<b>Sustainability:</b> Focus on technical assistance to develop MOHSS capacity and ensure sustainability	Support development of financial motivation letters to increase financing for health commodities, HRH and other services. Support for restructuring process of the MOHSS, including PHC
Strengthening laboratory in public sector	<b>HSS:</b> Forging network of laboratories between public and private sectors	Support organizational development in MOHSS to manage national lab network
Strengthening of HIV/AIDS focused / relevant directorates in Ministries	<b>Local Ownership:</b> Ministry wide institutional strengthening	MGEWCW assistance broadened beyond Directorate of Child Welfare—to include all 3 directorates of the Ministry as well as both national and regional levels.
Focus on disease-based service delivery	Focus on <b>'smart' integration</b> of services.	Integration of non-HIV medications into ART clinic pharmacies
Tracking of isolated gender related indicators through PEPFAR Implementing Partners	<b>Gender:</b> Support to strengthening data systems of MGEWCW and other ministries	GRN data systems track gender outcomes related to GBV and child protection
Working through largely international partners	<b>Local Ownership:</b> Increase work directly through local partners	Transition of local sub-partners to prime partner status and increased direct funding of GRN Ministries.
Support to Permanent Task Force for Orphans and Vulnerable Children	<b>Integration:</b> Support multi-sectoral management structure and framework for National Agenda for Children 2012 – 2016	Develop advocacy strategy for MGEWCW to engage partner ministries on commitments to vulnerable children
USG primary financial supporter of MC	<b>Innovation:</b> Exploring way to increase GRN and private sector coverage of MC	Creation of insurance tariff to cover MC as a preventative measure
HIV specific quality assurance	<b>Integration:</b> Quality assurance across the health sector	Technical assistance to MOHSS quality assurance unit
Reducing HIV transmission in newborns (PMTCT)	<b>Integration:</b> Comprehensive MNCH services which also address elimination of MTCT	Support to IMAI and PMTCT integration

### 3. GHI Objectives, Program Structure and Implementation

Please see GHI Namibia Results Framework, Annex 1

#### Overarching Health Goal and Expected Impacts

Per the Results Framework (attachment 1) at the Goal Level, the GHI strategy supports the GRN's development priority **Improved Health Status of Namibians**. Because of the particular vulnerabilities of women and children, the strategy focuses on **decreased morbidity and mortality of the most vulnerable groups including women, children and underserved populations**.

Although many health status indicators have improved in Namibia, maternal mortality has doubled from 225/100,000 live births in 1992 to 449/100,000 in 2006/07 (DHS). Approximately 173,000 adults and children are living with HIV/AIDS and the ANC survey found a mean prevalence of 18.8% among pregnant women. With the high rates of TB, including multi-drug resistant TB, Namibia is faced with one of the largest epidemics in the world contributing to excessive mortality, particularly among persons living with HIV/AIDS. In addition, the strategy targets underserved groups that face particular economic and geographical barriers to health services. The current USG program offers a robust platform to contribute to improvements in the goal level health impacts. Application of key GHI principles of smart integration, systems strengthening, increased attention to women and gender issues, leveraging and coordination will improve effectiveness of ongoing programs. In support of GRN health priorities and aligned with GHI health targets, the Namibia GHI strategy will focus on achievement of the following results:

#### Illustrative Indicators and Targets by 2015/16

- Annual Number of HIV infections reduced by 50%.
- Reduced maternal mortality from 449 per 100,000 live births in 2006/7 to 56 per 100,000.
- Reduced Infant deaths from 46 per 1000 live births in 2006/7 to 19 per 1000 live births.
- Reduced under-five deaths from 69 per 1000 live births in 2006/7 to 28 per 1000 live births.
- Reduced TB mortality rate from 6% in 2008/9 to less than 5.0%.
- Reduced mortality and morbidity of underserved TBD.

## Outcomes and Results

In order to achieve goal level results over the next five years the GHI Strategy's major thrust is **Increased Utilization of Sustainable Quality Health Services**. The GHI strategy stresses sustainable and quality services as critical to achieving overall impact. In the next five years, it is expected that Namibia will be increasing its ownership (management, coordination, financing) of key health services such as the HIV/AIDS response, and therefore transitioning to increased sustainability of services. ***In partnership with the GRN and civil society, the USG wants to ensure that during this transition to sustainability, the quality of services are maintained and increased as more services are funded out of domestic resources and directly managed by local partners. Therefore, the focus of GHI in Namibia over the next five years will be on increasing utilization of sustainable quality services.***

**Rationale:** Even though Namibia is considered an upper middle income economy, disparities exist between populations in regards to utilization of health services. Poverty, distance to facilities, limited coordination and organization of services and weak referral systems all impede access to and timely utilization of health services. Namibia's Gini Coefficient of 0.63 reflects one of the largest income disparities in the world and currently unemployment is at 51%.<sup>27</sup> In the more remote northern areas where 60% of the population lives, health services often remain out of reach to residents in sparsely settled rural areas. Rural areas lack well trained health staff, and where facilities exist, equipment and commodities that are needed for quality health services, are often lacking. The health of women and children among these underserved populations is particularly impacted. These access issues have continually affected reaching health impact targets, which include PMTCT elimination.

The USG through PEPFAR has supported the scaling up of the ART, TB and home-based care and treatment services/programs throughout the country. By June 2010, 94,130 PLHIV were receiving ART in public and mission facilities<sup>28</sup>. This represented about 90% of need.<sup>29</sup> However, with the new 350 CD4 threshold level in place, the percentage of those eligible and not on treatment has increased. HIV prevalence varies widely across regions with prevalence highest in the north, where 60% of the population lives. The 2010 ANC surveillance survey recorded ANC prevalence ranging from 4.2% in Rehoboth to 35.6% in Katima Mulillo. Outreach points have helped to provide antiretroviral (ARV) and TB drugs beyond the facilities, but access problems exist. Adherence to TB drugs and loss-to-follow-up continue to be issues resulting in low utilization of TB services in some geographical areas.

On the prevention side, Namibia has been working toward a combination prevention strategy that includes counseling and testing, social behavior change, blood safety, condom social marketing, PMTCT, post exposure prophylaxis and more recently, male circumcision (MC). Although there are high levels of PMTCT coverage, loss-to-follow-up of the infected mother/infant pair continues to be a problem, particularly where patients live long distances from facilities providing ART. The Integrated Management of Childhood Illness program is only in 58% of health facilities and therefore, a large group of children do not receive needed childhood illness treatment services.<sup>30</sup> In 2006, only 32% of men and 50% of women reported ever having been tested for HIV and known their status, and studies confirm the continuation of high risk sexual behavior aggravated by pervasive alcohol use.<sup>31</sup>

---

<sup>27</sup> Refer to footnote 9.

<sup>28</sup> USG PEPFAR/Namibia 2010 Annual Progress Report

<sup>29</sup> MOHSS. 2010 *Estimates and Projections Report*

<sup>30</sup> Ministry of Health and Social Services Namibia and Macro International Inc. 2008. *Namibia Demographic and Health Survey 2006-07*. Windhoek, Namibia and Calverton, Maryland, USA: MOHSS and Macro International Inc.

<sup>31</sup> Government of the Republic of Namibia, National Strategic Framework for HIV and AIDS Response in Namibia 2010/11-2015/16, 2010.

**Way Forward:** With GHI and the GRN’s commitment to high-impact public health programs and health reform, the opportunities to increase utilization of sustainable quality services are high. Under the GHI strategy, the USG will build on its extensive HIV/AIDS platform to address gaps, particularly for women and children and underserved populations. USG resources have been assisting the government to meet its staffing and commodity needs and providing technical assistance to develop policies, strategies and operational guidelines. In addition, USG technical staff contribute to national Technical Advisory Committees and Technical Working Groups which ensure that HIV/AIDS/STI and TB services benefit from the most current evidence-based interventions. Under the GHI strategy, the USG will increase its efforts to support systems that will lead to increased capacity of the government to manage, finance and coordinate the health sector. Both investments in health systems and strategic investments to improve access to health services including increasing integration of health services, improving the continuum of care and referral linkages, and addressing gender issues, should all lead to increasing utilization of quality sustainable health services even as key HIV/AIDS services continue to scale up. The GHI principles of “smart integration,” systems strengthening, a focus on women, girls and gender equality, strategic coordination, leveraging resources, innovation, improved systems strengthening and an emphasis on M&E will be applied to address many of these issues and improvements in health outcomes.

Although overall USG resources are projected to decline, steadfast application of GHI principles to promote overall efficiencies in the health sector will contribute significantly to GRN’s achievements. It will be important to carefully monitor benchmarks for transitioning through utilization, quality and equity indicators as well as increased domestic funding and absorption of health workers into the GRN civil service. Therefore in support of GRN health priorities and aligned with GHI health targets, the Namibia GHI strategy will focus on achievement of the following results:

#### **Illustrative Indicators and Targets by 2015/16**

- Percentage of HIV infected pregnant women who received ART to reduce the risk of mother to child transmission increased from 70% in 2007 to 95%.
- Percentage of adults and children (0-14) with HIV still alive at 12 months after the initiation of ART increased from 69% in 2007 to 90% for adults and from 82% to 95% for children.
- Distribution of health services by district TBD
- Percentage of HRH recruited vs. recruitment target TBD
- Percentage of PLHV with new smear positive TB that will be successfully treated increased from 73% in 2007 to 85%.

## **Intermediate Results and Activities**

Given the unique situation of Namibia as an upper middle income economy with health service access and utilization disparities and Namibia being targeted for transitioning by the USG, the GHI strategy focuses on two critical cross-cutting areas and intermediate results: 1) Increased Government and Civil Society Capacity (Including Private Sector) to Manage, Coordinate and Finance the Health and Social Sectors Through Improved Systems; and 2) Accelerated/ Expanded Access to Quality Health Services in Underserved Populations. The USG provides assistance to multiple GRN ministries in support of the multi-sectoral response. These include, but are not limited to: MOHSS, MGECW, Ministry of Defense, Ministry of Regional and Local Government, Housing and Rural Development, Ministry of Safety and Security, the Ministry of Finance and the Public Services Commission.

### **Intermediate Results 1: Transitioning: Increased Government and Civil Society (Including Private Sector) Capacity to Manage, Coordinate and Finance the Health and Social Sectors through Improved Systems**

**Rationale:** Successful transitioning in Namibia will depend on the country's capacity to finance, manage and coordinate the health and social sectors as donors reduce funding and move away from the direct management of programs. Improving health systems and integrating services will be the key to increased efficiencies and greater Namibian capacity to mobilize domestic resources, increase equitable allocations of resources, improve use of strategic information, strengthen human resources, increase effective multi-sectoral coordination, continue scale-up of the highest impact public health programs, and ultimately to sustain quality health services. Only with stronger health systems, built on the GHI principle of "smart integration," will Namibia be able to sustain and increase the utilization of quality health services. Building on the GRN Vision 2030, the NHPF 2010-2020, the NSF for HIV/AIDS, and the USG/GRN PF, the GHI strategy will strengthen key country systems including financing, human resources/management, information systems/M&E, laboratory, health service delivery and planning and coordination. The 2008/2009 MOHSS Systems Review provides a comprehensive assessment of health systems' gaps and issues. With USG and donor support, the GRN is already moving forward on many of the recommendations that came out of this HSS review. . Under GHI, the USG will provide targeted technical assistance and resources to strengthen systems and increase efficiency. The GHI's focus on health systems will go beyond HIV/AIDS and TB programs and will, for example, strengthen the GRN's overall capacity to do workforce and financial planning as well as support the integration and streamlining of information systems across all health services. USG-supported training and technical assistance will provide state-of-the-art education to health cadres that will be providing integrated health services at the national, local and community levels.

#### **Illustrative Indicators and Milestones:**

- Increase spending on health from 8.3% of GDP in 2009
- % of GRN health expenditures for priority services
- development of a GRN health allocation formula for improving service equity larger % of formally employed have low-cost health insurance (currently baseline is around half)
- MOHSS develops costed long-term HR strategy
- Public health sector vacancy rates reduced
- Functioning integrated management information systems in place
- Partner Plans Aligned to Health Development Plan

#### **Illustrative Activities**

**Financing:** In order to increase domestic funding for health overall and promote more equitable allocation of resources across the health portfolio, USG technical assistance and resources will increasingly focus on the following GHI activities:

- 1) Improve GRN financial planning, including developing systems and capacity to track all health resources, (e.g., expenditure data and conducting selected costing studies and training for analysis and interpretation of cost data);
- 2) Support the MOHSS in its efforts to develop an equitable resource allocation formula for comprehensive health services at the regional, district and facility level ; for example, development and use of health databases that include information on geographic disease burden, population size and other relevant epidemiological and demographic indicators related to access to care
- 3) Increase private sector resource mobilization by expanding access to comprehensive low-cost health insurance products in the formal workforce; and
- 4) Support to civil society organizations to develop diversified resource mobilization strategies given the anticipated declines in donor funds in Namibia, (e.g., strengthening NGOs to sell and market commercially viable services to the public and private sector).

#### ***Text Box 1: Smart Integration: Maximizing efficiencies as one path to achieving financial sustainability***

As Namibia takes increasing ownership of the AIDS response and the health system, the need to achieve greater efficiencies with existing resources becomes all the more critical. In this regard, the USG is working to promote improved health outcomes with existing resources (both financial and human). For example, currently the private sector procures ARVs for twice as much as the public sector. One of the principal payers of ARVs in the private sector is PSEMAS -- the largely government-financed medical aid scheme for civil servants whose members are eligible to access outpatient care in the private sector. If private sector providers accessed ARVs through the public sector procurement channels, this would reduce a major cost-driver for HIV/AIDS treatment services—and translate into a significant cost-savings for the GRN. Currently, the USG is producing the needed analysis to show the cost-benefits of unified ARV procurement through the public sector. By understanding the cost-drivers of health services, Namibia will be able to achieve more with less. Similar examples can be found with Male Circumcision, where in some private sector facilities, general anesthesia and the rental of an operating theater is standard practice. The USG is exploring alternative approaches to conduct MC safely and in a more cost-efficient manner which would significantly decrease costs, including the recent approval of private insurance coverage of MC. Other efficiency-related areas that the USG will consider supporting include task shifting of HIV/AIDS services, like MC and IMAI, to less costly and more readily

**Strengthening Human Resources:** Building on the Partnership Framework, the GHI in Namibia will continue to develop the capacity of technical program managers at national and decentralized levels, increase human resource capacity through multiple activities, including long-term workforce planning and management; health care and social worker development through pre-service education; and the absorption of USG-funded staff by the GRN and local partners. USG technical assistance and resources will increasingly focus on the following GHI activities:

- 1) Assist the MOHSS and the MGECW to develop long-term human resource management plans that focus on retention and recruitment and priority skills;
- 2) Assist the MOHSS and the MGECW to develop costed human resource strategies to catalyze their restructuring efforts;
- 3) Support MOHSS to strengthen its human resource information system to provide needed data for policy and decision making;
- 4) Twinning arrangements with local educational institutions such as the University of Namibia, Polytechnic of Namibia and the National Health Training Center for pre-service nursing, public health and laboratory education;
- 5) Support for scholarships for critical health worker cadres such as doctors, pharmacists and laboratory workers;
- 6) Support for long-term public health and epidemiology training for data usage;
- 7) Piloting and support for the roll-out of the new HEW cadre; and
- 8) Support task-shifting, including curriculum development and training for nurses (rather than physicians) including screening and treatment of minor opportunistic infections, nutrition assessments, managing pre-ART patients and stable ART clients; and for other cadres of facility and community based health workers.

**Text Box 2: Smart Integration: Sustaining the Health Workforce beyond Donor Support**

In 2010, the USG Namibia team identified more than 5,500 clinical, non-clinical professional, administrative and support, and community-based volunteer positions that were directly supported with PEPFAR funds. This equates to a third of the country's total PEPFAR budget. Under the first phase of PEPFAR, such salary was intended as an emergency measure to address workforce shortages in the scale-up of the HIV/AIDS response. With the shift to a long-term sustainable approach, the USG team is now focusing on transitioning needed positions to the government payroll and to strengthening the capacity of the GRN to identify its health workforce needs as well as to develop strategies for recruitment and retention. In terms of transitioning positions, the USG and GRN have jointly developed a human resource inventory system to track positions that are funded by donors (including the GFATM) and to match them to existing vacancies within the Ministry of Health and Social Services' staff establishment, as well as that of other related line Ministries. This inventory is managed by an inter-governmental Human Resources for Health Technical Working Group, which has led GRN efforts to request additional funds for human resources from the Ministry of Finance, and to work with the Public Service Commission to create new healthcare worker positions, where necessary. In October 2011, the MOHSS took a bold step in committing to finance (approximately \$7 million GRN value) all previous USG and GFATM supported medical officers in early 2012.

**Increased Use of Strategic Information, Including M&E, Surveillance and Operational Research for Evidence-Based Decision Making Information:** The GHI strategy will help the GRN to develop a vision for an integrated and harmonized data and reporting system resulting in more accurate data and more effective use of information for decision making. Previous support in this area focused on HIV/AIDS and TB M&E systems whereas future USG investments will affect the broader health sector. USG technical assistance and resources will increasingly focus on the following GHI activities:

- 1) Comprehensive assessment of all health and human resource information systems to determine strengths and weaknesses and inform new integrated HIS strategy;

- 2) TA and resources for the development of the new Health Information and Research Directorate within the MOHSS;
- 3) TA to the MOHSS for the development of a data warehouse that will link all MOHSS data bases and information systems;
- 4) TA to the MGECSW to develop and roll out a ministry-wide information-sharing strategy; and
- 5) Support for mentoring, pre-service and in-service training in epidemiology, M&E, and public health informatics and laboratory skills in collaboration with local universities that will increase expertise in data collection, analysis, interpretation, and use among public health professionals.

**Text Box 3: Smart Integration: Streamlined and Integrated Information System**

The MOHSS review found that health information systems in the MOHSS are numerous, fragmented and not well linked/coordinated. The actual number of systems is estimated at over 20. Based on the review's findings, exciting work is underway in Namibia to harmonize and link existing data collection and management systems and bring HIV, TB, malaria and other health data collection into a single comprehensive national system. The MOHSS has prioritized the formation of a new Health Information and Research Directorate for which the USG is providing organizational and technical support. The development of this new Directorate provides an opportunity to plan a way forward for designing comprehensive national systems by conducting systems and capacity assessments and centralization for institutionalizing health information systems strategies and policies. A national M&E data warehouse is currently being developed through funding from the GRN and development partners, in collaboration with a local academic institution. The objective of this project is to deliver a "one-stop" service for accessing a broad range of health information including non-health sector information and to improve data use for decision-making. In addition the USG will collaborate with the GRN and other development partners to harmonize reporting mechanisms to reduce the burden on partners' reporting to several organizations and to standardize aggregation and finalization of results at a national level.

**Public Health Laboratory System:** One of the major barriers to the delivery of quality care has been the lack of laboratory services in most health clinics and health centers throughout Namibia. Long turnaround times associated with shipping specimens to distant laboratories has meant that test results are delayed. These delays, in turn, lead to higher rates of loss-to-follow-up among patients who cannot easily travel to-and-from the clinic. Finally, key aspects of laboratory-based surveillance, M&E and operational research are not fully enabled due to the lack of a national public health laboratory. The MOHSS has taken the lead in establishing a Public Health Laboratory System (PHLS) in Namibia. A National Public Health Laboratory Policy and Strategic Plan that will strengthen MOHSS oversight of laboratory services are being finalized. USG technical assistance and resources will increasingly focus on the following GHI activities:

- 1) Support the establishment of a Public Health Laboratory in Namibia including laboratory-based surveillance;
- 2) Improve MOHSS capacity to monitor, evaluate and implement changes across the public and private laboratories network within the PHLS;
- 3) Strengthen Clinical Laboratories capacity to manage quality, cost-effective, accessible and sustainable laboratory services for Namibia; and
- 4) Improve MOHSS capacity to monitor, evaluate and implement changes across the public and private laboratories within the PHLS.

**Coordination and Programming:** In 2010, the GRN developed a National Coordination Framework for HIV and AIDS. The Framework, which is linked to the NSF, identifies the roles, responsibilities and mandates of key organizations involved in planning and coordination and describes their relationships at the national, regional and local levels. The structure is overseen by the National AIDS Council (NAC), which receives reports from, in descending order of seniority, the National AIDS Executive Committee (NAEC), relevant Technical Advisory Committees (TACs) for HIV/AIDS, Regional AIDS Coordinating Committees (RACOCs) and Constituency AIDS Coordinating Committees (CACOCs). USG technical assistance and resources will increasingly focus on the following GHI activities:

- 1) Planning and coordination capacity building to support GRN efforts to coordinate the multi-sectoral HIV/AIDS response;

- 2) Developing the capacity of the Ministry of Regional, Local Governments, Housing and Rural Development to support the RACOCs' work to coordinate community-based prevention and promotion organizations;
- 3) Enhanced coordination with GFATM and the Joint UN programs; and
- 4) Support for increased engagement of PLHIV in planning, program development and program implementation.

**Intermediate Result 2 ACCESS: Accelerated/Expanded Access to Quality Health Services by Underserved Populations Including Women and Children**

**Rationale:** The 2008 Health and Social Service Systems Review reported that 21% of health facility clients interviewed had to travel over 10 kilometers for services and 13% traveled greater than 21 kilometers. The report stated that “the vastness of the country causes geographical accessibility challenges, high opportunity costs and lack of transport,” and that outreach/mobile services “are not functioning optimally.” The study concluded that “the referral system is overall poor and as a result, no continuity of care is provided.” Like many governments in the region, the GRN has moved forward to integrate PMTCT into ANC, has supported outreach points, made progress in implementing an Integrated Management of Childhood Illness (IMCI) strategy in about 47% of facilities, and is now moving forward with the implementation of an Integrated Management of Adolescent and Adult Illness (IMAI) plan. Even with the integration of PMTCT into ANC, loss-to-follow-up for infected mothers and exposed children remains a significant problem. Most facilities lack staff who can do community outreach to track down HIV infected mothers and their exposed children, as well as ART and TB patients who default on treatment. HIV-positive mothers and children are often seen at different facilities on different days. Comprehensive EMOC services are only available in four of 34 hospitals, and basic EMOC is only offered in a few health centers. The Review estimated the unmet need for EMOC in Namibia at over 80%. Both the GRN and the USG are working together to increase “one stop shopping” for women and children and for underserved populations by increasing the integration of services, strengthening the continuum of care through improving referral linkages and coordination of services, improving the facility-community linkages, and expanding and improving community based services.

**Illustrative Indicators and Milestones:**

- % of HIV infected infants born to HIV positive mothers is reduced to 4% by FY 2015/16
- annual number of new HIV infections has reduced by 50% by FY 2015/16
- # of HEWs deployed to communities providing integrated services increased
- % of ever married/partnered women aged 15-49 who experienced any physical or sexual violence by an intimate partner in the past 12 months decreased
- # of PMTCT sites with RH services increased
- development of training materials and protocols for intensified TB case management and 3Is treatment protocol
- vulnerable people (including OVC, PLHIV, women, and girl child ) understand their human and legal rights and are empowered to access services

## Illustrative Activities

**Integrated/Comprehensive HIV/AIDS, Maternal, Neonatal, and Child Health (MNCH) and Reproductive Health (RH) Services:** The GRN has embarked on an ambitious plan to strengthen primary health care services (including MNCH and RH). To assist GRN and civil society organization (CSO) partners' activities to improve access to critical services and strengthen a continuum of care for mothers and children, USG technical assistance and resources will increasingly focus on the following GHI activities:

- 1) Support MOHSS in development or revision and implementation of HIV/AIDS, MNCH and RH related policies and guidelines and other information, education and communications (IEC) materials;<sup>32</sup>
- 2) Support MOHSS efforts to eliminate MTCT through universal access to PMTCT that is increasingly integrated into routine ANC services.
- 3) Improve EMOC (and neonatal) services in selected facilities and support GRN efforts to expand access to maternal waiting homes;
- 4) Improve linkages and patient flow between PMTCT and ART services;
- 5) Support curriculum development and training of MOHSS healthcare workers to roll-out a comprehensive package of services for infected mothers that emphasizes a continuum of care, including diagnosis, delivery, postnatal care and long-term follow-up, nutritional support, TB and malaria services and postpartum family planning;
- 6) Expand access to reproductive health services for PLHIV; and
- 7) Training of health care providers in cervical cancer screening and counseling on infant and young child feeding.

### **Text Box 4: Smart Integration: Blood Safety - An HIV Prevention Program Contributes to Maternal Health and Systems Strengthening**

Since 2004, PEPFAR support for blood donor education has helped reduce the prevalence of HIV in donated blood from above 1% to 0.5% in 2010. Part of the decline is due to increased blood donor mobilization among high school students (a historically low HIV-prevalence population), and other efforts to educate the public on healthy lifestyle choices. But PEPFAR support to The Blood Transfusion Service of Namibia has also strengthened the delivery of *blood transfusion services* in Namibia far beyond the program's original HIV prevention mandate. Blood transfusions – a pillar of EMOC -- are now available in 31 healthcare facilities nationwide, with 13 facilities providing full cross-matching services. Expanded access to quality blood transfusion services has improved doctors' ability to prescribe *and receive* blood when needed. PEPFAR has supported the revision of Namibia's national guidelines on the appropriate use of blood, as well as training for clinicians, to reduce wastage and the adverse effects of unnecessary transfusion. Because labor and delivery wards are large consumers of blood, PEPFAR's HIV prevention investments in blood safety are having a measurable impact on the strength of Namibia's healthcare system – and, ultimately, the health and well-being of mothers and their babies.

<sup>32</sup> USG funding for IEC material development will focus on technical assistance. Funding for printing and other distribution will be transitioned to the GRN.

**Text Box 5: Smart Integration: Virtual Elimination of Mother-to-Child Transmission by 2015**

The GRN launched PMTCT services in 2002 at two health facilities in Windhoek, the national capital. Since then, PMTCT has been expanded and integrated into more than 90% of all health facilities offering ANC services nationwide. With the adoption of provider-initiated HIV testing and counseling (PITC), an 'opt-out' policy, and the use of rapid HIV testing with same day results, more than 90% of all ANC attendees are tested for HIV and counseled on HIV and PMTCT. Of these women, nearly 90% receive ART to reduce the risk of transmitting the virus to their infants (2010 ANC Sentinel Surveillance Report). Because of this high coverage, MOHSS estimates suggest mother-to-child transmission (MTCT) rates have begun to decline, meaning fewer babies require extensive (and expensive) HIV/AIDS care and treatment. In 2006/07, the proportion of infants less than nine weeks old who tested HIV positive through the early infant diagnosis program was 10.4%; by 2010/11, this proportion had declined to just over 2% (October 2011 MOHSS PMTCT Program Progress Report). The GRN has demonstrated a high level of political commitment to PMTCT, which is linked to government's broader "Roadmap" to reduce maternal mortality by 2015. During the UN General Assembly Special Session in New York in 2010, President Hifikepuno Pohamba committed Namibia to pursuing the "virtual elimination of MTCT in Namibia." This commitment has since been echoed by the Minister of Health and Social Services, Dr. Richard Kamwi, who said in October 2011 that "no baby should be born with HIV in Namibia." To achieve the elimination targets, Namibia has committed to further reducing the rate of MTCT to under 2% per year overall, and to less than 5% among breastfeeding infants. The MOHSS is developing a virtual MTCT elimination plan, and is working with USG and other development partners to strengthen PMTCT service delivery, monitor progress toward the elimination goals, and ensure children born to Namibia's first "HIV-free" generation receive appropriate and timely primary healthcare services throughout childhood and adolescence.

**Coordinated TB/HIV Services:** Of 12,625 TB cases notified in 2010, 56% were HIV positive.<sup>33</sup> There is a national level TB-HIV/AIDS Technical Working Group. Annual and strategic planning is done by the HIV/AIDS, TB and malaria programs under the MOHSS, however coordinated implementation remains limited. Specific challenges include quality, inconsistent, and routine M&E data on TB screening in HTC including PMTCT and isoniazid preventive therapy (IPT) in HIV clinics and TB screening in ART settings, HTC including PMTCT; inadequate linkages between the community and facility-based programs; low ART coverage among HIV/TB co-infected patients, limited accessibility to follow-up care for HIV/TB co-infected patients; low intensified TB case finding and IPT coverage; staff shortages and high staff turnover. In addition, laboratory-based surveillance for TB and MDR TB remains limited and there is an ongoing threat to basic program principals such as consistent directly observed therapy throughout the country. USG technical assistance and resources will increasingly focus on the following GHI activities:

- 1) Strengthen coordination bodies at national and sub-national levels for the implementation of the "3 Is";<sup>34</sup>
- 2) Expand implementation of integrated TB-ICF-IPT intensified case finding for PLHIV in 79 health facilities in selected districts and improve linkages between facility and community based health workers;
- 3) Provide rapid TB diagnostic tests for all PLHIV suspects in selected districts and strengthen TB lab capacity;
- 4) Support priority TB-HIV operational research;
- 5) Develop training materials, and job aids for facility- and community-based health workers on TB screening; designate focal persons for intensified case finding at regional, district and facility levels;
- 6) Expand implementation of TB-ICF in community centers through TA and financial support to CBOs;
- 7) Strengthen TB laboratory capacity, including provision of rapid TB diagnostic tests for all TB suspects.
- 8) Support implementation of the national TB infection control (IC) policy, including administrative and environmental TB IC in relevant settings.

<sup>33</sup> MOHSS. *National Tuberculosis and Leprosy Programme Annual Report: 2010-2011*. Windhoek. 2010.

<sup>34</sup> The "Three I's" were developed by WHO to promote the essential interventions related to HIV/TB. The three "I's" are: 1) Intensified TB case finding; 2) Isoniazid preventive therapy, and; 3) Infection control for TB. Source: <http://www.who.int/hiv/topics/tb/3is/en/index.html>. Accessed 3 October 2011.

**Integrated Community-Based Prevention/Promotion, Care and Treatment Services:** In order to specifically address challenges some patients have accessing health care facilities, the MOHSS (with USG and UN support) is piloting a community HEW program to bring services closer to the communities and households. The USG is also strengthening community outreach services linked to facility-based HIV/AIDS care and treatment programs, and through support to community-based NGOs and mobile and fixed outreach sites. In support of the GRN's HEW program, and to improve CSOs' ability to work with the GRN and support GRN community outreach initiatives, USG technical assistance and resources will increasingly focus on the following GHI activities:

- 1) Ensure technical assistance coupled with resources to the MOHSS to support the pilot HEW project in Opuwo District;
- 2) Provide support to the National Health Training Center to support the development of curriculum, training materials and job aides for HEW;
- 3) Strengthen M&E support of the HEW pilot and roll-out;
- 4) Support for the strategic deployment of mobile clinics; and
- 5) Provide support and resources to community-based organizations to conduct door-to-door HIV prevention counseling, condom distribution, and referrals.

**Text Box 6: Smart Integration: New Health Extension Worker Will Provide Integrated Services**

Namibia's health system is largely facility-based. Given the vast distances between communities and facilities, access to health care is a major challenge. Many easily preventable and treatable conditions (such as diarrhea, pneumonia, TB) are often exacerbated with delays in reaching health services. This leads to worsening health outcomes in terms of maternal mortality, under 5 mortality, and infant mortality rates. In this regard, it becomes critical to bring health services to the community. To date, such work is largely done by donor-funded NGO volunteers, a cadre which is not wholly reliable given the declines in donor funding and the high attrition rates of volunteers (as found in the MOHSS systems review). To address this issue, the MOHSS intends to create a new community-based health extension worker cadre that will provide an integrated package of services. Health extension workers will motivate individuals, families and communities to play a greater role in the improvement of their own health status and to seek health services in a timely manner. To support this effort, the USG, together with UNICEF and WHO, is providing considerable technical assistance to pilot the HEW concept (specifically in the areas of curriculum development, training, and planning). In addition, the USG has supported the MOHSS to develop a budget submission to the Ministry of Finance, so that domestic resources can be generated to finance salary related costs of the new cadre.

**Continuum of Care:** To address high loss-to-follow-up rates of both HIV exposed infants and their mothers and suboptimal ART retention rates, the USG is supporting the strengthening of community-based services to support tracing of mother-infant pairs and ART patients. Community-based nurses are providing supportive supervision for volunteers and appropriate care for clients who are in need of and unable to access health facilities. Discussions are ongoing with the MOHSS for the scope of practice of these community based nurses to be expanded to include appropriate clinical services. The GRN, with GHI support, is leading the development of a Standards of Practice for these community nurses. USG technical assistance and resources will increasingly focus on the following GHI activities:

- 1) Develop and roll out a comprehensive package of basic child survival interventions until 24 months for the HIV-exposed and infected child, improve early diagnosis and follow-up at six weeks post-delivery and through improved linkages with MNCH services and IMCI;;
- 2) Pilot bi-directional referral system between facilities providing pre-ART and ART care and communities;
- 3) Provide nutrition assessment, counseling and therapeutic food in 64 health facilities that integrate nutrition services into ART and MNCH clinics;
- 4) Strengthening PLHIV support groups to improve access and retention in services;

- 5) Increase livelihood support for underserved and vulnerable populations; and
- 6) Support decentralization of health services to the community level.

**Text Box 7: Smart Integration: Increasing Access through Primary Health Care Mobile Clinics - a promising public-private partnership**

Mobile clinic initiatives in Namibia have typically focused on offering singular interventions such as for immunization or HIV/AIDS counseling and testing. To broaden this effort, the USG is helping to support an interesting public-private sector initiative to increase access to services by bringing an integrated package of primary health care services to communities. Currently in a pilot phase, the PHC mobile clinic initiative works through the following model: 1) A private corporate entity procures the mobile clinic vehicle; 2) Employers in remote locations (such as farms) pay for the clinic to offer health care services to their employees and dependents (these payments pay for the transport and operational costs); and 3) On route to these locations, the mobile clinic offers services to communities based on an agreement with the GRN, in which all commodities are provided by the MOHSS and the National Institutes of Pathology covers related services. The clinic visits each point along its route once a month and provides basic PHC services through a registered nurse, including follow-up, referrals, and even picking up chronic medication for patients who would have to otherwise travel long distances to the clinic.

**Empowering Men, Women and Girls through Gender Sensitive Programming:** The National Gender Policy and ensuing Plan of Action represents the GRN commitment to achieving gender equality and the empowerment of both men and women in Namibia. The Gender Policy recognizes that women in Namibia face increased prevalence of HIV/AIDS, high rates of gender-based violence (GBV) and continued pervasive gender and intra-household inequalities. In 2010, the Namibian police's WACPU reported 11,854 cases of GBV, including 3,074 instances of rape, a 294% increase over the 1,044 rapes reported in 2009 likely due to better reporting. With support from the Spanish Government, UN MDG fund, the GRN is finalizing an action plan to combat GBV. USG resources will support implementation of this action plan in two focus regions working mainly to promote zero tolerance of GBV at the community level, strengthening national and regional GBV coordination structures along with GBV data management.

There are also traditional barriers for both women and men to accessing and using services in Namibia. The gender inequalities within the family setting continue to undermine women's decision-making powers around their health and consequently result in delays in seeking appropriate health care, a factor in the rising maternal mortality in Namibia. HCT, PMTCT, Care and Support programs report low levels of male utilization and involvement and most treatment and care services are weak on utilizing a family-centered approach.

One of the key objectives of Vision 2030 is to create a society in which women and men enjoy equal rights and equal access to basic services, as well as opportunities to participate in and contribute towards the political, social, economic and cultural development of Namibia. The GHI strategy promotes this objective and gender sensitive programming will be central to all USG-supported projects.

In November 2011 the USG in Namibia conducted a gender assessment which found existing programs to be "gender accommodating" (acknowledging the role of gender norms and inequities and seeking to develop actions to adjust or compensate for them). Under GHI, the USG will strive to move to more focused "gender transformative" programming, striving to change gender norms. USG technical assistance and resources will increasingly focus on the following GHI activities:

- 1) Positive male norms at the clinic and in the community;
- 2) The establishment of safety nets and psychological support for child victims of abuse;
- 3) Community sensitization on violence through schools, traditional leaders, churches;
- 4) Training of community court duty bearers in line with national legislation on gender issues;
- 5) Training of line ministry staff to provide adequate support and referrals to victims of GBV, and strengthening national and regional level coordination and monitoring capacity of the MGECW; and
- 6) USG assessment of integration of gender into ongoing and planned activities (in process).

***Text Box 8: Smart Integration: Male and Community Engagement in GBV and Gender Inequalities***

GHI resources will support the GRN to operationalize its National Gender and GBV action plans by promoting community sensitization and capacity of community leaders to mitigate GBV, training field-level line ministry staff in strengthening sexual GBV referral systems and services, and –enhancing the capacity of the MGECW to monitor and coordinate activities at both regional and national levels. Other efforts will include male engagement activities that explicitly address norms about masculinity related to HIV/AIDS; promoting couple voluntary counseling activities; involvement of men in maternal and child health including PMTCT, family planning, in addition to care and support activities. Utilizing a family-centered approach for health care services will be the foundation of all GHI-supported programs as this lessens the strain on women and girls who traditionally bear the burden for care at the household level. In order to improve women’s financial independence and ability to exercise their rights to seek care early, women’s empowerment and access to productive resources will be done through actively linking vulnerable women, especially OVC care givers, to household economic strengthening programs.

## 4. Monitoring and Evaluation

M&E of the GHI strategy will be aligned with MOHSS reporting processes and indicators. Indicators used by GRN and development partners for HIV/AIDS and TB/HIV have been harmonized in the National Strategic Framework for HIV and AIDS. Where appropriate, these indicators are disaggregated by age and/or sex and region to strengthen reporting on outcomes. In other not yet harmonized areas, indicators from GRN strategic plans, international guidance, and/or USG requirements will be utilized. Indicators for assessing program transition and health systems strengthening will be agreed upon by key stakeholders through a USG-funded indicator development initiative with GRN and other development partners. This initiative will also support efforts to harmonize GRN and development partners’ reporting structures. Other milestones showing progress in the implementation of the GHI strategy (e.g., quality of service delivery in ART facilities) will be addressed qualitatively. The USG team in Namibia will report performance metrics to headquarters on an annual basis the Performance Plan and Report submitted each year through December through the Foreign Assistance Coordination and Tracking System (FACTS). These indicators have been incorporated into the strategy matrix.

Data sources will include routine program monitoring data collected through a variety of information systems including the Health Information System in facilities and the System for Program Monitoring which collects HIV, TB, and malaria data from non-facility-based sites. Namibia is currently piloting a M&E data warehouse, which is a user friendly web-based portal that pulls together health indicators from different data sources. Surveys and surveillance will provide other data for measuring indicators. A population-based survey with HIV testing is being planned for 2012 and will provide outcome and impact data that cuts across health areas. An integrated biological and behavioral survey in 2011-2012 will provide baseline data for men who have sex with men and commercial sex workers. In addition, a national research and evaluation agenda (coordinated by the GRN) includes activities that will measure

the progress of the NSF and cut across the areas of HIV and TB interventions for the general population, PLHIV, OVC, and groups at high risk including adolescents and girls. Program process, outcome, and impact evaluations will be core activities for assessing health outcomes and impacts. Moreover, other activities include the National Composite Policy Index (NCPI) determination and the National Health Accounts and various sub-accounts.

Mutual accountability of activities will come through joint planning and monitoring of most of the USG GHI activities through the national advisory, planning and reporting systems. As noted in the NSF and PF, a joint annual review including GRN and development partners will provide a forum for discussing program outputs, outcomes and impacts for GHI and PF activities. GRN has already lead the effort to harmonize indicators with development partners (PEPFAR, GFATM, and UN) when developing the National Multi-Sectoral HIV/AIDS M&E Plan 2010/11-2015/16. In addition, USG funds have been prioritized for work with GRN and other development partners, specifically the GFATM, to align indicators and reporting systems to decrease burden on implementers and on M&E staff.

#### 4. Learning Agenda

USG proposes several activities that will inform the progression of GHI results framework priorities. Under the direction of GRN strategic documents such as the NSF, MOHSS National Health Policy Framework, the National HIV Policy, and the National HIV/AIDS Research Agenda, USG Namibia will promote targeted monitoring, evaluation, and operational research activities to inform program planning. Following discussions with GRN and relevant partners, the USG will seek to develop the following activities in support of the GHI strategy objectives:

- 1) Evaluation of the scale-up of innovative approaches to prevention, care and treatment. As high impact service delivery programs scale up, evaluations and operational research should be incorporated as part of the implementation plan. Namibia is in the process of moving beyond routine monitoring to plan and implement evaluations and other research. An example is the planning of a comprehensive program review of the highly successful PMTCT program that will include process, outcome and impact evaluations in addition to assessments of other programmatic elements. At a time of decreasing global funding, it is imperative to assess outcomes and impact of interventions not only for understanding the return on investments but also to plan the next phases of service delivery effectively.
- 2) Assessments and evaluations to measure PEPFAR contributions to non-HIV systems and programs to include identification of select indicators to measure cross-cutting impacts. For example, evaluation of reproductive, maternal, neonatal and child health services. Current reporting formats focus on areas with direct PEPFAR funding; however efforts for assessing outputs, outcomes and impacts in other health sectors and disease areas could be expanded to understand the extent of USG investments. Activities could include the addition of reporting indicators for routine M&E and operational research targeting specific health programs.
- 3) An important component of the GHI strategy is emphasizing reproductive, MNCH services. As part of this learning agenda, a teen pregnancy assessment and a study on maternal mortality will provide valuable data in two areas in which more information is needed on how individual, community, and government factors affect health outcomes for women and girls. USG will also support the development of M&E systems within the GRN and community-based organizations to track indicators related to PMTCT, ART services and ANC clinics.
- 4) Assessments of programmatic and financial transition elements. The transition of USG support, particularly HRH financing, to GRN and other indigenous organizations will require close monitoring to assure that quality health service delivery is not adversely affected and to provide evidence for decisions affecting the scope and pace of transition. Outcome and impact of transition efforts will be incorporated

into USG evaluation plans. As this is an evolving process, innovative M&E methods must be created to assess the following elements: development of sufficient human resource capacity and expertise; implementation of effective technical assistance models; costing exercises to assess efficiencies; sustainability of programs; country ownership. Transition indicators for routine monitoring of HRH and other transition domains are being currently discussed in various stakeholder forums, and USG Namibia looks forward to collaborations with experts and other countries undergoing transition to develop appropriate tools and analytical methods for assessing transition.

## 5. Communication and Management Plan

Under the leadership of the U.S. Ambassador, the interagency coordination of activities that contribute to outcomes and goals described in the GHI strategy will utilize existing coordination structures, including the involvement of national Technical Advisory Committees defined in the NSF in planning, and enhancing. These structures may be adapted as the need arises, and will be enhanced by liaising with broader interagency, civil society (including the private sector) and government coordination structures. Under the PF, Namibia established an inter-ministerial coordination structure, the PF Steering Committee, which includes representation from nearly twenty key stakeholders across eight ministries and civil society. Through quarterly meetings, the PF Steering Committee, chaired by the PEPFAR Coordinator, the head of Donor Coordination for the National Planning Commission and the Deputy Permanent Secretary of the MOHSS, works to ensure that USG supported programs are well coordinated and aligned with national roadmaps on MNCH, FP/RH, HIV, and other health issues. USG will continue to be actively involved with, and where funding permits, provide financial and technical assistance to GRN structures including the Technical Advisory Committees under the NAEC, the MOHSS HRH Steering Committee (and HRH Technical Working Group), the Social Security Commission's Health Insurance and Finance Technical Advisory Committee, the Health Extension Worker Steering Committee, the Permanent Task Force for Children, the Maternal Health Task Force and the Office of Prime Minister's Task Force on Malnutrition.

Within the USG, the Department of State, the United States Agency for International Development (USAID), the U.S. Centers for Disease Control and Prevention (CDC), the U.S. Department of Defense, and the U.S. Peace Corps engage in multi-layered planning, implementation, and reporting systems through well-choreographed technical and management teams. The established PEPFAR structure ensures both technical and managerial participation from all agencies at all levels. New coordination efforts are underway in Namibia to ensure that GHI goals are reflected in all USG assistance programs.

A core GHI coordination team, chaired by the GHI Lead (PEPFAR Coordinator) with multi-agency participation, will serve as a sub-committee under the PEPFAR Management Team and be responsible for overseeing progress toward achieving the Intermediate Results described in the GHI strategy. This GHI Coordination Team will interact with and seek guidance and contributions, as relevant, from additional representatives who have not been included in the previous PEPFAR structures, including the Embassy's Political, Public Affairs and Economic Growth Officers, MCC and USAID's Program Officer. By including a broader spectrum of USG staff in GHI consultations and planning, USG Namibia seeks to foster greater collaboration among all USG agencies, leverage the capacities and strengths of each agency, and increase program efficiencies and integration in the pursuit of sustainable population-level public health impacts. The GHI coordination model will be flexible and will work to reduce planning, implementation and program evaluation burdens.

The U.S. Ambassador or delegate (e.g., the Deputy Chief of Mission) will provide overall policy guidance to the GHI Coordination Team. Technical decisions will continue to be made through a bottom-up process, with inter-agency structures providing recommendations and technical advice to the Ambassador and GHI Coordination Team.

## **GHI Coordination**

A well-defined and effective bilateral relationship is critical to the success of the GRN-USG partnership. The U.S. Ambassador will set the tone and communicate the USG's broad strategic outlook through regular bilateral dialogue with the highest levels of government. Additionally, engagement with other stakeholders in government and civil society (including the for-profit sector) will also occur at all levels of the USG coordination structure (from leadership to technical).

## **GHI and Other Donors**

GHI will also build on and leverage the substantial multi-lateral partners and coordination structures and resources already in place in Namibia. Partner governments and international agencies, including Germany, Spain, the European Union, Japan, and the UN agencies meet regularly to discuss donor support to the health sector. Many of these partners also sit on the Namibian Coordination Committee for the GFATM. GFATM continues to play a significant role in Namibia and is currently engaged in a similar transition phase, highlighting increased need for enhanced coordination and planning.

## **Communication**

The Embassy's Public Affairs Section (PAS), the USAID/Namibia Development Outreach and Communications Officer, and CDC Namibia's Branch Chief for Policy and Communications will convey and/or promote GHI principles to the GRN and civil society. Together these communication specialists will lead the development of a clear, mission-wide communication and outreach strategy. Activities outlined in the GHI Communications Strategy will reflect and enhance the USG mission's broader efforts to promote USG foreign policy goals. PEPFAR, MCC and other relevant programs will build on existing media, social networking, policy and advocacy structures, as well as civil society networks to share information, key messages, and maximize the use of media outlets with the greatest reach within Namibian society. PAS staff will work with the GHI Coordination Team to produce supportive and clear documentation to local stakeholders.

## **6. Linking High Level Goals to Programs**

USG investments aim to accelerate and sustain Namibian health targets that align with GHI health impacts and promote the GHI principles. The GHI strategy for Namibia builds upon the 2010/11-2015/16 PEPFAR PF and the dialogue around the PFIP. The PF was developed in close collaboration with the GRN and has a primary objective of "strengthening GRN leadership in the national AIDS response" and building "human resource capacity." It states that "over the five-year period covered by the framework, the GRN intends to assume greater responsibility for the management and the financing of activities currently funded by PEPFAR." The PF notes that the USG will support GRN's efforts to increase

domestic health spending and re-orient USG assistance toward sustainable, evidence-based and cost effective programs. The GHI strategy fully supports these overarching objectives as well as the objective of improving the health status of all Namibians through investments that increase the utilization of quality sustainable health services.

USG investments in Namibia, described in the 2011 PEPFAR Country Operational Plan and the USAID Operational Plan, and being planned for in the 2012 documents support a number of critical activities that are assisting the GRN and local partners to assume greater management and financing of the health sector as well as increasing access to health services by underserved populations. The GHI strategy captures many of these activities in: 1) Section Three; 2) the Results Framework; and in the 3) Matrix.

**Key IR 1 Transitioning and HSS activities include:** 1) strengthening the GRN human resources long-term planning capacity including prioritizing positions that the government will finance; 2) carrying out expenditure tracking and costing studies for interventions such as male circumcision; 3) establishing a public health laboratory system; 4) establishing an integrated and streamlined health information system; and 5) improving the capacity of RACOCs to coordinate a multi-sectoral response. **Milestones over the next 18 months include:** 1) completion of the GRN HRH Long Term Strategy that includes retention, recruitment, and hiring priorities; 2) completion of three critical costing studies including male circumcision and procurement of ARVs through the public sector for the PSEMAS program; 3) development of a GRN Health Allocation Formula for improving service equity; and 4) approval of the MHSS Restructuring Plan including the Directorate of Health Information and Research.

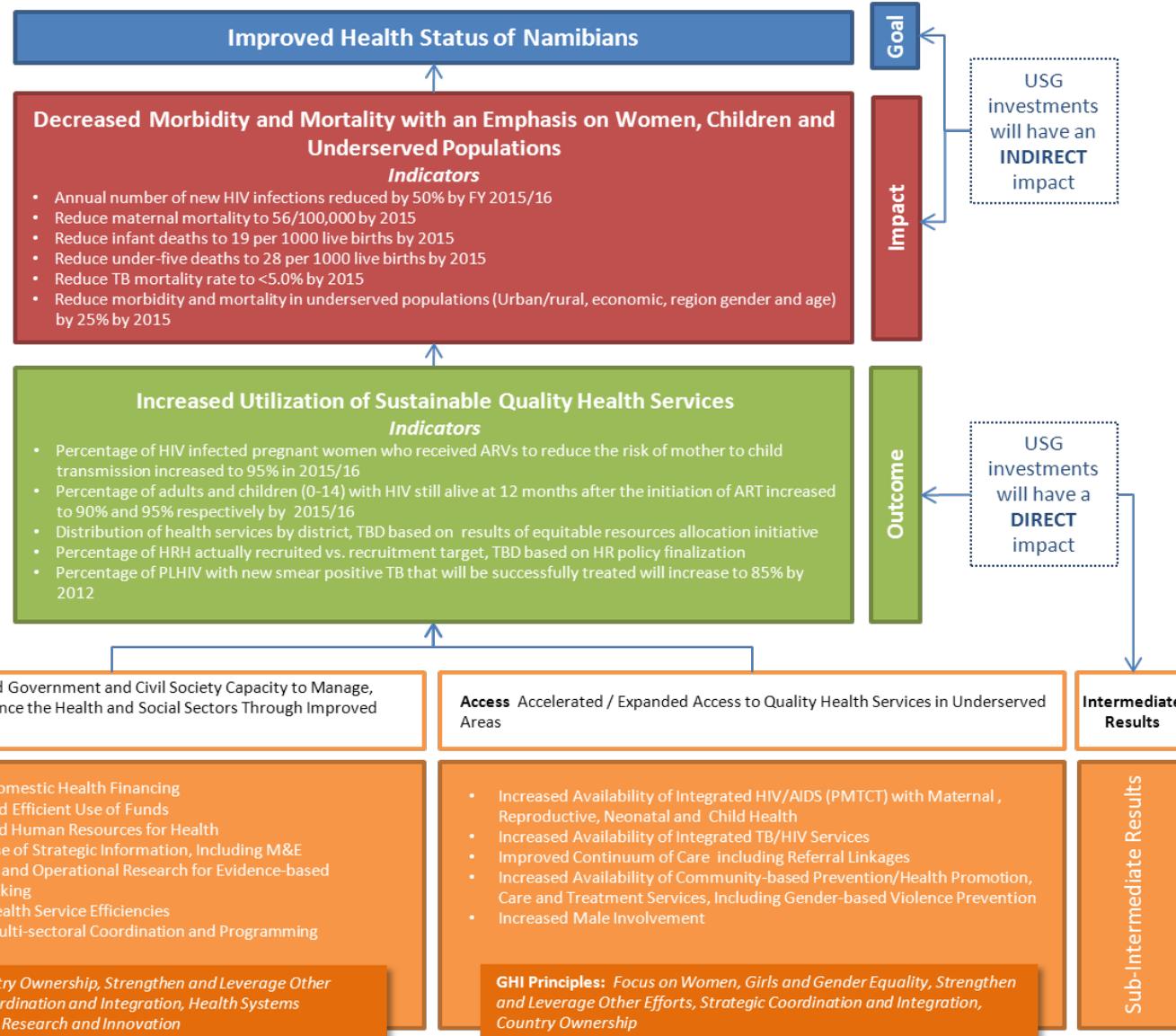
**Key IR 2 Accelerated and Expanded Access activities include:** 1) training and rolling out of the new HEW cadre; 2) integrating RH services into PMTCT sites; 3) implementing the 3 Is, intensified case finding of TB, isoniazied preventive therapy, and infection control of TB for PLWHA in 79 facilities and expanded programming in communities; 4) expanding training and community sensitization about gender issues including, GBV; and 5) strategic deployment of mobile clinics. **Milestones over the next 18 months include:** 1) completion of the HEW pilot project and use of results for national planning; 2) completion of study on teenage pregnancy; 3) development of training materials and protocols for implementation of the 3Is; 4) completion of the USG gender assessment and integration of recommendations into programming. By the end of the five year GHI strategy period, it is expected that the health impacts and results identified in the Results Framework and Matrix will have been achieved, notably:

- 1) Increased domestic financing for health from GRN and the Namibian private sector;
- 2) More equitable resource allocations within GRN budgets (needs-based instead of historical);
- 3) Increased evidenced-based decision- and policy-making in the public and private healthcare sectors;
- 4) Improved local health worker capacity, especially in the public sector;
- 5) Increased absorption of PEPFAR-funded staff into the GRN civil service;
- 6) Stronger public-private partnerships in health and other development-related program areas (e.g. strengthened public-private partnership unit within the MOHSS);
- 7) Increased GRN support to CSOs;
- 8) Operational, integrated information systems within public and private health and social services sectors;
- 9) Service integration to reduce redundancies and client costs while ensuring the quality of services;
- 10) Implementing lower cost approaches in specific technical programs, e.g. MC; and
- 11) Expanding community based services and innovative approaches like mobile units to reach underserved populations.

# Annex 1: USG Namibia GHI Strategy Results Framework

**Critical Assumptions**

- GRN remains committed to health sector priorities as outlined in the National Development Plan, the National Health Policy Framework, and the National Strategic Framework for HIV and AIDS.
- Domestic funding for health increases over time.
- USG, Global Fund and other donor resources will decline over time.
- Human capacity developed by USG and other donors will benefit Namibia.



\* Civil Society includes: Private Sector, For Profit and Not-for-Profit

Goal

## Improved Health Status of Namibians

Improve the Human Development Index (HDI) from 0.542 in 2008 to 0.55 by FY 2015/16\*

Impact

### Decreased Morbidity and Mortality with an emphasis on women, children and underserved populations

- Annual number of new HIV infections reduced by 50% by FY 2015/16\*
  - Reduce maternal mortality to 56/100,000 by 2015\*\*\*
  - Reduce infant mortality to 19 per 1000 live births by 2015\*\*\*
  - Reduce under-five deaths to 28 per 1000 live births by 2015\*\*\*
    - Reduce TB mortality rate to <5.0% by 2015\*\*\*
- Reduce morbidity and mortality in underserved populations (Urban/rural, economic, MARPs, gender, geographically, women and children), TARGET TBD

Outcome

### Increased Utilization of Sustainable Quality Health Services

- Percentage of HIV infected pregnant women who received ARVs to reduce the risk of mother to child transmission increased to 95% in 2015/16\*
- Percentage of adults and children (0-14) with HIV still alive at 12 months after the initiation of ART increased to 90% and 95% respectively by 2015/16\*
  - Distribution of health services by district, TARGET TBD
    - Equity: Distribution of services by district, Health Service by Wealth Quintile):
    - Efficiency: Cost per hospital bed day and cost per outpatient visit
    - NHA: Percentage of GRN resources allocated to priority services
    - TBD target
    - Efficiency and/or Equity Indicator
    - Equity: Distribution of services by district, Health Service by Wealth Quintile):

**Efficiency: Cost per hospital bed day and cost per outpatient visit**  
**NHA: Percentage of GRN resources allocated to priority services**  
**TBD target**

- Efficiency and/or Equity Indicator

**Equity: Distribution of services by district, Health Service by Wealth Quintile):**

**Efficiency: Cost per hospital bed day and cost per outpatient visit**  
**NHA: Percentage of GRN resources allocated to priority services**  
**TBD target**

**Percentage of HRH actually recruited vs. recruitment target, TARGET TBD**

- Percentage of PLHIV with new smear positive TB that will be successfully treated will increase to 85% by 2012

**Transition: Increased Government and Civil Society Capacity to Manage, Coordinate and Finance the Health and Social Sectors Through Improved Systems**

Namibia GHI Intermediate Results	Key National Priorities	Key Priority USG Activities	Namibia specific GHI indicators and milestones	Namibian and GHI health goals	Key GHI Principles	Key Partners
<b>Increased domestic health financing and equitable allocation of funds</b>	Increasing domestic health spending (National Health Policy)	<ul style="list-style-type: none"> <li>• improve GRN financial planning, systems development &amp; capacity to track resources</li> <li>• increase private sector resource mobilization</li> </ul>	Increase spending on health from 8.3% of GDP in 2009  % of GRN health expenditures for priority services <ul style="list-style-type: none"> <li>• Private sector expenditure on health increases</li> </ul>	Reach and sustain allocation in line with Abuja Declaration target of 15% of total government spending  GHI:	<ul style="list-style-type: none"> <li>• Country ownership,</li> <li>• strengthen and leverage other efforts,</li> <li>• strategic</li> </ul>	<b>MOHSS, MOF?</b>

Strengthened Human Resources for Health	Framework)	<ul style="list-style-type: none"> <li>expand health databases that link to SI data to inform equitable allocation of funds</li> </ul>	<ul style="list-style-type: none"> <li>Budget motivation for donor HRH transition is accepted in part or in full</li> <li>Larger % of formally employed have low-cost health insurance (currently baseline is around half)</li> <li>Equitable Resource allocation formula developed</li> </ul>	<p>Improved health financing strategies that reduce financial barriers to essential services, including increased government/private sector funding and reduced out-of-pocket payments</p> <p>Steps to reduce disparities in health outcomes by providing essential quality health services</p> <p>Total health expenditures per capita, also % financed by country</p>	<p>coordination and Integration,</p> <ul style="list-style-type: none"> <li>Health Systems Strengthening,</li> <li>M&amp;E, Research and Innovation</li> </ul>	MOHSS
	strengthen human resource management system (health systems review)	<ul style="list-style-type: none"> <li>support to develop long term HR management, focusing on retention and recruitment</li> </ul>	<ul style="list-style-type: none"> <li>MOHSS develops costed HR strategy</li> </ul>	<p>complete and implement MOHSS restructuring plan</p> <p>GHI: Increased #s of available and trained health service providers, public health workers and community workers appropriately deployed in the country providing quality health services;</p>		MOHSS
		<ul style="list-style-type: none"> <li>support to local education institutions for pre-service nursing, public health and lab education</li> </ul>	<ul style="list-style-type: none"> <li>number of health workers newly recruited at primary health care facilities in the past 12 months as a % of planned recruitment target</li> <li>distribution of health workers by occupation, region and health morbidity patterns</li> </ul>			UNAM, Polytechnic of Namibia
		<ul style="list-style-type: none"> <li>support for scholarships for critical health worker cadres</li> </ul>	<ul style="list-style-type: none"> <li>MGECCW proposed structure to OPM is approved</li> <li>MOHSS submits proposed costed structure to OPM</li> <li>HRH transition occurs without adversely affecting the quality of health services</li> </ul>			MOHSS, MGECCW, OPM
		<ul style="list-style-type: none"> <li>support for MPH degree program</li> <li>pilot Health Extension Worker cadre</li> </ul>	<ul style="list-style-type: none"> <li>vacancy rate decreases to an acceptable level</li> <li>Reduced staff turnover to 2% by 2012 (MOHSS strategy plan)</li> </ul>			UNAM
Create a skilled workforce (MOHSS Strategic Plan 2009-2013)				MOHSS		

		<ul style="list-style-type: none"> <li>• support task shifting for nurses and lay community counselors</li> </ul>	<ul style="list-style-type: none"> <li>• Reduction in absenteeism to 4% 2011, 2% 2012, 2% 2013</li> </ul>			<b>MOHSS</b>
<b>Increased Use of Strategic Information, including M&amp;E, surveillance and operational research for evidence based decision-making</b>	Improve Information Management System (MOHSS Strategic Plan 2009-2013)	<ul style="list-style-type: none"> <li>• Support creation of Directorate of Health Information and Research</li> </ul>	<ul style="list-style-type: none"> <li>• Functioning integrated management information systems in place (99% by 2011, 100% by 2012)— MOHSS strategy plan</li> <li>• The country's functional M&amp;E system provides indicator values for 90% of the NSF results framework indicators by FY 2015/16^</li> </ul>	Improved functioning of integrated laboratory systems, surveillance, M&E		<b>MOHSS</b>
		<ul style="list-style-type: none"> <li>• support for integrating and streamlining parallel data collection and reporting systems</li> </ul>	<ul style="list-style-type: none"> <li>• National Data Warehouse has incorporated all health indicators by 2015</li> </ul>			<b>MOHSS</b>
		<ul style="list-style-type: none"> <li>• support for MGECW information sharing strategy</li> </ul>	<ul style="list-style-type: none"> <li>• National research agenda updated annually• Directorate of Health Information and Research established</li> </ul>			<b>MGECW</b>
		<ul style="list-style-type: none"> <li>• support for long term epidemiology and laboratory training program</li> </ul>	<ul style="list-style-type: none"> <li>• number of pre-service and in-service graduates in epidemiology, M&amp;E and Public Health Informatics increases by 2015</li> </ul>			<b>Polytechnic of Namibia, MOHSS, UNAM, NIP</b>
<b>Public Health Laboratory System</b>	To establish an organizational and laboratory management system that provides good governance, coordination,	<ul style="list-style-type: none"> <li>• Support the establishment of a Public Health Laboratory in Namibia</li> <li>• Improve MOHSS capacity to monitor, evaluate and implement changes across the public and private laboratories network within the PHLs;</li> </ul>	<ul style="list-style-type: none"> <li>• Establishment of NPHLS Directorate/division</li> <li>• Establishment of an Integrated Data and Quality Management Systems</li> <li>• Establishment of a fully functional NPHL</li> <li>• Development and establishment of National PHLN.</li> </ul>	Improved functioning of integrated laboratory systems, surveillance, M&E		

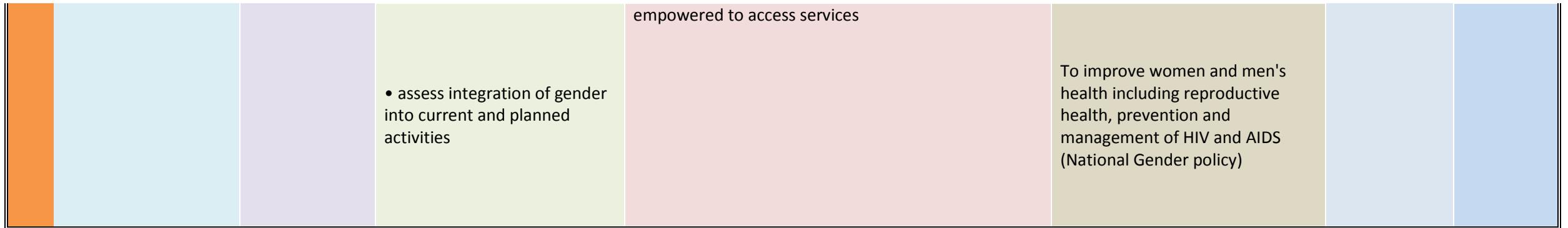
	<p>access and accountability at all levels</p>	<ul style="list-style-type: none"> <li>• Strengthen Clinical Laboratories capacity to manage quality, cost-effective, accessible and sustainable laboratory services for Namibia.</li> <li>• Improve MOHSS capacity to monitor, evaluate and implement changes across the public and private laboratories within the PHLs</li> </ul>				
<p><b>Increased multi-sectoral coordination and programming</b></p>	<p>Improved stakeholder relations and coordination</p> <p>Strengthen the stewardship role of the MOHSS(MOHSS Strategic Plan 2009-2013)</p>	<ul style="list-style-type: none"> <li>• Develop planning and coordination capacity of NAC and NAEC</li> <li>• Strengthen technical advisory capacity of the TACs</li> <li>• Develop the capacity of MRLGHRD to support the RACOCs</li> </ul>	<ul style="list-style-type: none"> <li>• Bi annual partner coordination meetings held</li> <li>• National Health Assembly established and meetings held annually</li> <li>• 100% of partner plans aligned to National Health Strategic Plan by 2015</li> </ul>			<p><b>MRLGHRD</b></p>
<p><b>Access: Accelerated/expanded Access to Quality Health Services in Underserved Areas</b></p>						

Namibia GHI Intermediate Results	Key National Priorities	Key Priority USG Activities	Baseline info/Namibia specific GHI targets	Namibian and GHI health goals	Key GHI Principles	Key Partners
<p><b>Increased availability of integrated HIV/AIDS (PMTCT) and maternal, Reproductive, Neonatal and Child Health Services</b></p>	<p>To accelerate the reduction of maternal and child morbidity and mortality in Namibia towards the achievement of the MDGs 4 &amp; 5 (RoadMap)</p>	<ul style="list-style-type: none"> <li>• Support comprehensive PMTCT services</li> </ul>	<ul style="list-style-type: none"> <li>• %births attended by skilled birth attendant baseline (2006/7): 81% (NDHS)</li> <li>• % of women with at least 4 ANC visits baseline (2006/7): 70%(NDHS)</li> </ul>	<p><b>Maternal Health</b> GHI goal: Reduce maternal mortality by 30 percent across assisted countries.</p> <p><b>Child Health</b> GHI goal: Reduce under-five mortality rates by 35 percent.</p> <p><b>HIV</b> <b>GHI goals:</b></p> <ul style="list-style-type: none"> <li>• support the prevention of more than 12 million new HIV infections</li> <li>• provide direct support for more than 4 million people on treatment</li> <li>• support care for more than 12 million people, including 5 million orphans and vulnerable children</li> </ul> <p><b>Family Planning and Reproductive Health:</b> <b>GHI goal</b></p>	<ul style="list-style-type: none"> <li>• focus on Women, Girls and Gender Equality</li> <li>• country ownership</li> <li>• strengthen and leverage other efforts</li> <li>• strategic coordination and integration</li> </ul>	<p><b>MOHSS</b></p>
	<p>To scale up the provision of comprehensive package of PMTCT services around the four prongs (prevention of unintended pregnancies,</p>	<ul style="list-style-type: none"> <li>• Improve EMOC services</li> </ul>	<p>Proportion of health centers offering Basic EmOC services (Roadmap) Proportion of hospitals offering Comprehensive EmOC services (Roadmap)</p>			
		<ul style="list-style-type: none"> <li>• improve linkages between PMTCT and ART services</li> </ul>	<ul style="list-style-type: none"> <li>• IMAI successfully rolled out to the target number of sites</li> </ul>			
		<ul style="list-style-type: none"> <li>• support curriculum development and training for HIV infected mothers</li> </ul>	<ul style="list-style-type: none"> <li>• % of pregnant women attending ANC aged 15-24 who are HIV infected reduced from 11% on 2008 to 5% by FY 2015/16</li> <li>• % of HIV infected infants born to HIV positive mothers is reduced from 12 % in 2007 to 4% by FY 2015/16^</li> <li>• % of HIV infected pregnant women who received ARVs to reduce the risk of mother-to-child transmission increased from 70% in 2007 to 95% in FY 2015/6^</li> </ul>			
		<ul style="list-style-type: none"> <li>• support to improve EID</li> </ul>				

	<p>primary prevention, prevention of MTCT, and treatment of mother and child) so that services are readily available, accessible and being utilized by all people in need, and to reduce the probability of HIV transmission where exposure has occurred to newborns.</p>	<ul style="list-style-type: none"> <li>• support nutrition assessment and counseling on IYCF</li> </ul>	<ul style="list-style-type: none"> <li>• % infants born to HIV infected women receiving ARV prophylaxis to reduce the risk of MTCT in the first week of life increased from 67% in 2007 to 95% in FY 2015/16^</li> <li>• annual number of new HIV infections has reduced by 50% by FY 2015/16^</li> <li>• HIV prevalence among sex workers reduced from 70% to 40% ^</li> <li>• Life expectancy has increased from 51.6 yrs to 55 yrs ^</li> <li>• % of people reported dying from AIDS has decreased from 23% to 18%^</li> </ul>	<ul style="list-style-type: none"> <li>• Prevent 54 million unintended pregnancies by reaching a modern contraceptive prevalence rate of 35 percent across assisted countries;</li> <li>• reduce from 24 to 20 percent the proportion of women aged 18-24 who have their first birth before age 18.</li> </ul> <p>Namibia Goal - virtual elimination of PMTCT by 2016</p>		
<p><b>Coordinated integrated TB/HIV services</b></p>	<p>Reduce TB prevalence and mortality rates by 50% relative to 1990 levels in Namibia by 2015®</p>	<ul style="list-style-type: none"> <li>• Strengthen coordination for 3 'I's in 4 districts</li> <li>• expand implementation of TB intensified case finding for PLHIV in 79 health facilities</li> <li>• develop training materials for facility and community based health workers on TB screening</li> </ul>	<ul style="list-style-type: none"> <li>• Number of registered HIV positive TB patients who have taken at least one dose of CPT/total number of HIV positive TB patients maintained at 98%~</li> <li>• Number of TB patients with a known HIV result/total number of TB patients increased from 79% in 2009 to 95% in 2015~</li> <li>• Number of registered HIV positive TB patients on ART at the end of TB treatment/total number of HIV positive TB patients increased from 35% in 2009 to 95% in 2015~</li> </ul>	<p><b>Tuberculosis (TB):</b> GHI goals:</p> <ul style="list-style-type: none"> <li>• Contribute to the treatment of a minimum of 2.6 million new sputum smear positive TB cases and 57,200 multi-drug resistant (MDR) cases of TB</li> <li>• Contribute to a 50 percent reduction in TB deaths and disease burden relative to the</li> </ul>		<p><b>MOHSS, KNCV</b></p>

		<ul style="list-style-type: none"> <li>• expand implementation of TB-ICF in community centers</li> <li>• Provide rapid TB diagnostic tests for all PLHIV</li> </ul>	<ul style="list-style-type: none"> <li>• % of PLHIV with new smear positive TB who have been successfully treated has increased from 73% in 2007 to 85% in FY2015/16^</li> <li>• TB mortality</li> <li>• TB prevalence</li> </ul>	1990 baseline.	
	<b>Improved Continuum of Care, (including Referral Linkages)</b>	<ul style="list-style-type: none"> <li>• improve early diagnosis and follow-up at six weeks post-delivery and through improved linkages with MNCH services and IMCI, develop and roll out a comprehensive package of basic child survival interventions until 24 months</li> <li>• Pilot bi-directional referral system between facilities providing pre-ART and ART care and communities</li> <li>• Provide nutrition assessment, counseling and therapeutic food in 64 health facilities that integrate nutrition services into ART and MNCH clinics</li> <li>• Strengthen PLHIV support groups to improve access and retention in service</li> <li>• Increase livelihood support for underserved and vulnerable populations</li> <li>• Support decentralization of health services to the community level</li> </ul>			
<b>Increased Availability</b>	Develop	<ul style="list-style-type: none"> <li>• support the pilot HEW in</li> </ul>	<ul style="list-style-type: none"> <li>• Number of HEW trained</li> </ul>	Namibia goal:	<b>MOHSS</b>

	<p><b>of community-based Prevention/Health Promotion, Care and Treatment Services, including Gender-based violence Prevention</b></p>	<p>adequate, formalized and structured community based health services (Strat Plan)</p>	<p>Opuwo</p> <ul style="list-style-type: none"> <li>• support the development of curriculum, training materials for HEWs</li> <li>• support m&amp;e of the pilot HEW project</li> <li>• support for the strategic deployment of mobile clinics</li> </ul>	<ul style="list-style-type: none"> <li>• 100% of community health workers on the establishment with requisite training by 2011</li> <li>• Over 4000 HEWs will be trained by 2015</li> <li>•</li> </ul>	<p>To provide adequate, formalized and structured community based health services (Strat Plan)</p>		
	<p><b>Women, Girls and Gender Sensitive Programming</b></p>	<p>To effectively contribute to the attainment of creating a society in which women and men enjoy equal rights and access to basic services (National Gender policy)</p>	<ul style="list-style-type: none"> <li>• promote positive male norms at clinic and community level</li> <li>• establish safety nets and psychosocial support for child victims of abuse</li> <li>• sensitize community on violence</li> <li>• train community leaders and members in national legislation on gender issues</li> <li>• train staff to provide support services and referrals for survivors of GBV</li> <li>• Promote male involvement in health care especially PMTCT</li> </ul>	<ul style="list-style-type: none"> <li>• Percentage of ever married/partnered women aged 15-49 who experienced any physical or sexual violence by an intimate partner in the past 12 months</li> <li>• Number of people reached by an individual, small group or community level intervention or service that explicitly addresses gender-based violence and coercion related to health</li> <li>• Number of people reached by an individual, small group or community level intervention or service that explicitly addresses the legal rights and protections of women and girls</li> <li>• Number of people reached by an individual, small group or community level intervention or service linked to a health program that explicitly aims to increase access to income and productive resources of women and girls</li> <li>• Vulnerable people are empowered: vulnerable people (including OVC, PLHIV, women, and girl child ) understand their human and legal rights and are</li> </ul>	<p>To achieve gender equality and the empowerment of women in socio-economic, cultural and political development of Namibia</p>		



Comments:  
 \* targets from NSF  
 \*\* targets from the MOHSS Strategic Plan 2009-2013  
 \*\*\* 2010 MDG targets

Source  
 ~ National Tuberculosis and Leprosy Programme Monitoring and Evaluation Plan 2011-2015  
  
 ^ NSF  
 ® Second Medium Term Strategic Plan for Tuberculosis and Leprosy