



**REPUBLIC OF NAMIBIA**

**MINISTRY OF HEALTH AND SOCIAL SERVICES**

# **Community-Based Health Care**

## **Policy**

(Including Roles)

**Draft**

**1/11/2007**

**MINISTRY OF HEALTH AND SOCIAL SERVICES**

**Community Based Health  
Care  
  
Policy**

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## **FOREWORD**

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

The aim of the CBHC policy is to further empower communities to take charge of initiatives that will promote public health, reduce morbidity and mortality among children, adolescents and adults as well as to enhance community ownership of joint efforts and self-reliance in resource mobilisation and problem solving. The policy lays out the framework to further build, support and sustain capacity at community and household levels by encouraging the community to work in partnership with the Ministry of Health and Social Services (MoHSS) and other related partners in health and development.

The MoHSS has created a strong support system since Independence. New health facilities have been built; health workers have been trained and continue training in participatory rural appraisal (PRA) techniques to enable them to work with communities. This forms a support mechanism to Community's Own Resource Persons (CORPs) in CBHC activities. This important document is providing a practical approach to the use of community structures, coordination of responsibilities and the sustainable use of CORPs in CBHC.

The policy aims to develop a community based care and support based approach which is holistic and responsive to the needs of our communities and in particular for households. We need to guard against a tendency where services at household and community level become the mere continuation of vertical programmes.

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

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

## PREFACE

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

The CHBC policy gives a brief overview of key health issues currently faced by Namibian communities and analyses the community based health care response. It describes the policy goal, principles, objectives and strategies that will lead to better service delivery at all levels of the ministry and from partners that contribute to improved livelihood of communities.

This document is structured as follows:

- Chapter 1 gives the background; discusses rationale and how the document was developed;
- Chapter 2 gives a situation analysis community based health care of Namibia;
- Chapter 3 presents the policy framework;
- Chapter 4 outlines institutional framework for policy implementation at the different levels and with its partners including NGOs;
- Chapter 5 highlights the resource implications;
- Chapter 6 presents the process of monitoring and evaluation and
- Chapter 7 outlines key implementation phases of the policy.

This official policy is calling for better coordination of services and is intended for use by all those involved in community based health care in Namibia and will facilitate the implementation of PHC programmes within the Namibian context. It is my trust that this policy will provide the foundation upon which we will achieve Health for All Namibians.

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

.....  
 KAHIJORO KAHUURE  
 PERMANENT SECRETARY

## ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infections
CBHC	Community based Health Care
CBRPs	Community Based Resource Persons
CBO	Community Based Organisation
CDC	Constituency Development Committee
CHC	Clinic Health Committee
CHPA	Chief Health Programme Administrator
CHV	Community Health Volunteers
CHW	Community Health Workers
CLC	Community Learning Centre
CMO	Chief Medical Officer
CORPS	Community's Own Resource Persons
DCC	District Coordination Committee
EPI	Expanded Programme of Immunisation
FHD	Family Health Division
GDP	Gross Domestic Product
HIS	Health Information System
HIV	Human Immune Deficiency Virus
HW	Health Worker
IEC	Information-Education-Communication
IECD	Integrated Early Childhood Development
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
MOHSS	Ministry of Health and Social Services
MGECW	Ministry of Gender Equality and Child Welfare
NANGOF	Namibia Non-governmental Organisation Forum
NDHS	National Demographic Health Survey
NGO	Non Governmental Organisation
NID	National Immunisation Day
PHCS	Primary Health Care Services
PMO	Principal Medical Officer
PMTCT	Prevention of Mother to Child Transmission
PRA	Participatory Rural Appraisal
RDCC	Regional Development Coordinating Committee
R/N	Registered nurse
RMT	Regional Management Team
SHPA	Senior Health Programme Administrator
TB	Tuberculosis
TBAs	Traditional Birth Attendants
TH	Traditional Healer
TOTs	Training / Trainers of Trainers
UNAM	University of Namibia
UNICEF	United Nations Children's Fund
VDC	Village Development Committee
V/CHC	Village/Community Health Committee
WHO	World Health Organisation

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## **CHAPTER 1: INTRODUCTION**

### **1.1 BACKGROUND**

At independence in 1990, Namibia inherited a health service delivery structure that was segregated along racial lines and based entirely on curative health services. The system for service delivery was two-tier (District and Central Hospitals) and resulted in an unequal allocation of resources and services. The ethnic-based second-tier health system was poorly funded and administrators could not raise the necessary income to provide basic health care services to all Namibians. As a result there were large inequalities in the delivery of health care services in the country.

Since the concept of Primary Health Care (PHC) was defined and given international recognition at the Alma-Ata conference in 1978, Primary Health Care has been the main focus for the promotion of ‘Health for All’. The Primary Health Care (PHC) approach was adopted by the Ministry of Health and Social Services (MOHSS) at Independence and has been used to guide the restructuring of the health sector in Namibia. In line with achieving its objective of Health for All Namibians, the government has been gradually shifting resources to the disadvantaged regions, focusing on preventive services and basic care provided by clinics, mobile health teams and volunteers, in order to balance the inequalities in the formerly disadvantaged regions. The MOHSS has made progress in streamlining and restructuring what was a curative-based health system to be a more community orientated system. The introduction of Integrated Management of Childhood Illnesses (IMCI) to many health districts is one example.

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

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

CBHC is a strategy to operationalise PHC and as such it adheres to the above principles. CBHC deals with all health-related matters affecting the communities directly. Clinics, health centres and mobile outreach services as well as a number of specific community-based health interventions are the primary health care services directly involved with communities and as such they are part of CBHC. In addition, many CBOs, NGOs, FBOs and private sector organisations actively complement the work of government in an effort to provide much

needed support to community members especially in the area of health and social services. HIV/AIDS, Malaria and Tuberculosis have placed a high burden on communities which has prompted many community members to involve themselves in voluntary work. This work is very vital to the Namibian nation and is strongly supported by the government.

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

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

## 1.2 RATIONALE

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

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

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

This policy document is the realisation of these recommendations.

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

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

At a National Conference on Volunteers held in December 2006, it was recommended that volunteers should receive adequate tools, recognition and reward. However, it was noted that

any remuneration and supervision would imply that volunteers were in fact employees under the Labour Act and therefore it was recommended that Namibia Non-governmental Organisation Forum (NANGOF) or volunteers organisations individually, should apply for volunteer exemption from the Ministry of Labour. There was general support to standardise volunteer incentives but there was recognition that there was a wide variation in the capacity of NGOs, FBOs and CBOs to raise funds, and a similar variation in the work of the volunteers.

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

### **1.3 METHODOLOGY**

The development of this policy has taken place in a number of stages. A multi-sectoral task force group was formed to discuss the need and the process of reviewing the 1992 PHC/CBHC guidelines and has guided the process for developing this policy.

The process involved an extensive literature review and a review of the Community-Based Health Care Programme in order to identify the strengths and weaknesses. The review was commissioned by the MOHSS and implemented by the University of Namibia (UNAM) in 1999 with funding assistance from the MOHSS and UNICEF. A draft policy document was formulated on the basis of the recommendations of the review and circulated for consultation within the Family Health Division (FHD) of the Primary Health Care Services (PHCS) Directorate and sent out to stakeholders. This was followed by a consultative workshop with all appropriate partners.

The contributions and recommendations from the policy consultative workshop were then incorporated into the draft policy which was re-circulated to workshop participants to ensure that the changes made were representative of the workshop's input.

Further updating and amendments were made in early 2007, following the national rapid assessment on community volunteers and CBHC programmes and the National Conference on Volunteers in 2006. This final draft policy document was then submitted to the Primary Health Care Management committee for input and approval.

## **CHAPTER 2: SITUATION ANALYSIS**

### **2.1 THE HEALTH STATUS**

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

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

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

The major causes of death among children under five years of age (accounting for 75% of total) remain diarrhoea, malnutrition, malaria, and acute respiratory infections all of which are largely preventable and treatable (HIS, 2000).

HIV/AIDS has become the principal public health problem in Namibia. According to 2006 HIV Sentinel Survey, 19.9% of pregnant women tested positive for HIV. According to the data on mortality in hospitals compiled by MOHSS, HIV/AIDS has become one of the most frequent causes of death since 1996. In 2006, the HIS reported that HIV/AIDS accounted for 23% of all reported deaths and for 36% of deaths in age group of 15 to 49 years. HIV/AIDS disease is also a major cause of hospitalisation. The number of patients with this diagnosis increased from 355 in 1993 to 17,553 in 2006.

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

#### **2.2.1 What is Community Based Health Care?**

CBHC is a strategy for achieving the goals of PHC within the overall objective of national health. As an integral part of PHC, CBHC reinforces the PHC concepts and principles. Community Based Health Care is a community programme on health and care, in which the community is actively involved in identifying their problems and needs, prioritising them and mobilising their own resources to meet those needs. The community fully participates in dealing with appropriate activities required to solve the problems. It plans them within the available resources, implements and evaluates them. The programme is usually comprehensive and integrated, involving health, agriculture, and economic activities by individuals, families and groups within the community.

Working closely with communities to develop a true and equal partnership and to foster a high level of participation and involvement in health related activities has a number of significant advantages both for the community members themselves and for the partner organisations. It increases people's sense of control over issues that affect their lives; people's willingness to identify problems and felt needs and to find solutions. This results in feelings of ownership, self-reliance, confidence and self-esteem. Also, CBHC encourages unity, strength, and a spirit of solidarity amongst community members. It can help to create healthy competition for group achievement and ensures capacity building. By participating in development projects, community members can promote equity by ensuring those with the greatest need and the greatest risk have their needs prioritised.

CBHC includes information, education and training concerning prevailing health problems in communities and the methods of preventing and controlling them; promotion of proper nutrition, maternal and child care; immunisation against the major infectious diseases; prevention and control of locally endemic diseases such as diarrhoeal diseases, acute respiratory infection and malaria; reproductive health services, including family planning and the prevention and control of sexually transmitted infections with particular emphasis on HIV/AIDS; appropriate treatment for common diseases and injuries; oral health; mental health; rehabilitation for people with disabilities and school health.

Closely linked to community health outcomes are the provision of other basic needs - improved living conditions, adequate supply of safe water and basic sanitation.

A household or a family forms the smallest unit of health care. This unit requires support from the wider social environment in order to maintain its own health needs. Therefore, CBHC concentrates on raising awareness, identifying resources and support systems that are available to the family, and detecting potential problems.

Community's Own Resource Persons (CORPS) such as Community Health Workers (CHWs), Health Educators, Health Promoters, Community Health Volunteers (CHVs) Home Based Care volunteers, Traditional Birth Attendants (TBAs), Traditional Healers (THs), community health committee members and private practitioners are working as agents for change and primary care givers. They link the community with the formal health system.

The health posts (through outreach services), clinics, and health centres are situated in the community. They are the direct link between the formal health system and the community.

Outreach services will aim to provide the same high quality and essential package of services as offered at fixed clinics (Refer to the MoHSS Outreach Policy).

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

### **2.2.2 Home Based Care**

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

Home based care aims to:

- Facilitate the continuity of the client's care from the health facility to the home and community;
- Promote family and community awareness of disease prevention and care related to chronic illnesses;
- Empower the clients, the family and the community with the knowledge and skills needed to ensure long-term care and support;
- Raise the acceptability of PLWHAs by the family/community, hence reducing the stigma associated with AIDS;
- Streamline the patient/client referral from the institutions into the community and from the community to appropriate health and social welfare facilities;
- Facilitate quality community and homecare;
- Mobilise resources necessary for sustainability of the services.

The National Policy on HIV/AIDS states that RACOCs, CACOCs, traditional authorities and local authorities shall take a leading role in ensuring that communities have access to home based care and in supporting groups and organisations which provide home based care. It also states that:

1. Government shall support its partners to ensure that home based care volunteers receive standardised quality training, adequate supervision and a standardised volunteer incentive package;
2. Government shall assume responsibility for the provision of a nationally standardised HBC kit and its replenishment for home based caregivers to ensure continuous, quality care and proper standards of infection control;
3. Health workers and HBC organisations shall promote a two-way referral system between HBC volunteers, traditional health providers and health facilities;
4. Government shall develop and put into place monitoring and evaluation systems for HBC volunteers.

Referring to palliative care, the National Policy on HIV/AIDS states that all patients shall be provided with adequate and effective palliative care at all times. Appropriate training and resources shall be made available to care providers.

### 2.2.3 Achievements of the MoHSS

The 2000 CBHC review and more recent situation analyses have found a number of important achievements:

- i) At the strategic level, policy documents, guidelines, standard/protocols, training manuals on PHC/CBHC and decentralisation have been developed:
  - the CBHC programme forms an important part of the second National Development Plan (NDP2)
  - The National Strategic Plan on HIV/AIDS – the Third Medium Term Plan (MTP-III) and the MTP I 2004-2009 on Tuberculosis both recognise the vital role of community based health care in the continuum of prevention, treatment, care and support services.
  - Manual on House – to – House Counselling and Services Provision for Community Volunteers, 2001
  - Participatory Rural Appraisal (PRA) Training Manual for Health Workers and other Community Development workers, 2002
  - Community-Based Health Care Monitoring register for CORPs, 2002
  - Guidelines on Project Proposal Development for Health Care Providers and Community Dev. workers, 2003.
- ii) Developed supervisory checklists for community volunteers, conducted supportive supervision and participated in CBHC evaluations/reviews.
- iii) Provided technical support and backstopping to regions, districts and other ministries.
- iv) Intersectoral coordination and collaboration has increased through participation on various committees.
- v) Research through a baseline survey of community practices in IMCI pilot districts, community volunteer assessment and programme evaluation.
- vi) Human resources have been developed through the re-orientation of hundreds of health workers in PHC/CBHC including Participatory Rural Appraisal techniques and training thousands of volunteers in various aspects of community health.
- vii) Communication, Coordination and collaboration:

An intersectoral working group on CBHC was established at national level. Participants are relevant programme managers of the MOHSS, and other line ministries as well as members of NGOs who support or implement CBHC activities. Responsibilities of the working group are amongst others: Sharing of information and strengthening of partnership amongst the stakeholders in different sectors; social mobilisation to ensure community participation and involvement in health related activities; capacity building on training of CORPs.



#### **2.2.4 Achievements of Civil Society Organisations**

Over the last ten years, there have been an increasing number of community based organisations and larger NGOs and FBOs that have become involved in delivering CBHC at the household level. This has been largely in response to the increasing number of people infected and affected by HIV/AIDS and TB but some programmes focus on broader public health issues. Many volunteers have come forward and have been trained to provide various CBHC services to individuals and households.

NANGOF has a database of NGOs, CBOs and FBOs that lists more than 18,500 volunteers working in the community. These community volunteers fulfil a wide range of roles and responsibilities that centre around providing health education about preventable diseases including HIV, caring for and rehabilitating the sick, offering psychosocial support, taking care of orphans and vulnerable children (OVC), raising awareness of social issues like rape and domestic violence and being members of community health or HIV/AIDS committees. The assessment report found that on average, most volunteers indicated working 4 or more hours per day and more than 4 days per week. Most volunteers were selected by community structures, using general criteria.

#### **2.2.5 Community Own Resource Persons**

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

Traditional healers are highly respected in communities and community members have confidence in their information. Traditional healers have immense influence in their communities and can present a positive or a negative force towards the promotion of health and development, depending on their conviction and involvement.

Traditional Birth Attendants (TBAs) are found in many communities in Namibia. They are often greatly respected in their communities and have an important role to play in contributing to reproductive health care. TBAs will be supported to follow the reproductive health guidelines of the MOHSS and they will be trained to promote the Prevention of Mother to Child transmission (PMTCT) services and the national policy on infant and young child feeding.

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### 2.2.6 Types of Community Based Health Volunteers

Volunteers form the largest group of community own resource persons. Different communities have different needs and civil society organisations have their own priority focal areas so there is often considerable overlap between the names, roles and responsibilities of their volunteers. Some examples are given below:

- Health Educators, Health Promoters, Community Based Resource Persons, Community Health Volunteers, and Community Health Workers tend to concentrate on the promotion of health, disease prevention and rehabilitation.
- Peer Educators / Peer Councillors / Community Councillors are predominantly youth or workplace employees who provide information and education on sexual and reproductive health and HIV/AIDS/STI issues;
- Village/Community/Clinic Health Committee members and many community health volunteers serve as a link between the community and the health facility and lead the community in community based responses to TB, HIV and AIDS.
- Home based care givers visit and care for chronically ill patients. They usually guide other household members to give the daily care required by the patient but they often get involved in helping with household chores such as cleaning, cooking, washing clothes as well as direct patient care. They may also perform other roles such as overseeing the supervision and welfare of the children.
- In many households affected by HIV/AIDS, HBC givers and OVC committee members give support and love to orphans and vulnerable children, checking that their basic needs are met and encouraging them to stay in school.
- In other communities members of constituency care committees for orphans and vulnerable children visit homes which have a high number of such children, especially elderly or youth headed household
- People living with HIV/AIDS and ex-TB patients are encouraged to join support groups and volunteer to be treatment supporters to new patients as “treatment buddies” and DOT supervisors.

Most experienced NGOs, FBOs and CBOs know the importance of working through local traditional structures and they also work in close cooperation with local clinic, health centre and hospital staff. However, coordination and cooperation between all these role players remains a challenge that is discussed below.

### **2.2.7 Problems and Challenges**

*There are a number of prominent challenges that currently exist:*

*i.       **The link between communities and health services at primary level***

- The role of Village Development Committee (VDC) and Village Health Committee (VHC) in CBHC is not well understood. Many such community structures are not functioning and few Primary Health Care facilities work in cooperation with a VDC or VHC.
- Poor coordination and collaboration between key stakeholders and other sectors working at community level results in wasted resources and duplication of efforts;
- The responsibilities of different stakeholders in sustaining community volunteers is not clear;
- A curative view of health care services is still common in many communities.

*ii.       **Resourcing CBHC***

- Namibia is experiencing inadequate human resources at all levels in the MoHSS to plan, organise and coordinate CBHC and Outreach Service activities;
- The initial training and refresher courses that CORPs and their trainers receive vary considerably in content and duration;
- Training materials vary in content;
- Due to inadequate human and financial resources, supplies and transport at all levels, the implementation of CBHC is not as effective and efficient as it should be;
- CORPS experience inadequate funds and essential tools and materials to facilitate their work, such as refilling HBC kits or accessing transport to reach community members or to get to health facilities.

*iii.       **Support for Community Volunteers***

The 2006 Assessment of Community Volunteers confirmed the following constraints:

- The majority of CORPs work without adequate support from either the communities they serve or from the health care system;
- There is much variation in the way that volunteers are rewarded – most receive skills development and recognition, but some receive varying in-kind and monetary incentives.

*iv.       **Understanding of the role of the volunteer***

- Given that home-based care is now a widely accepted practice in Namibia, often other volunteers, without the same degree of type of training are considered and called upon to provide home-based care, regardless of their training

*v.        **Monitoring***

- The lack of appropriate and reliable indicators to guide, monitor and evaluate CBHC activities at all levels, has resulted in poor supervision and inadequate reporting from districts and regions. This makes coordination, management and planning for future CBHC activities very difficult.

### **2.3 THE IMPLICATIONS OF THE CURRENT SITUATION**

Considerable progress has been made towards community based health care for all citizens but there is often a lack of community participation, integration and coordination. If the challenges are not addressed, CBHC services will continue to be fragmented and the quality will vary from one area to another. Volunteers will continue to have a high drop-out rate as they are not adequately supported and motivated to continue.

This policy will emphasise coordination, intersectoral collaboration, and community participation in all development activities. It is important to strengthen the link between the health facilities, our communities and other partners and to maintain it in a viable and effective way. By so doing, equitable resource mobilisation, allocation, and distribution as well as community contribution will be ensured to enhance maximum impact of community health services.

This policy will describe and explain the roles of stakeholders at all levels, including communities. The standardisation of training and training materials will move training to become competency-based rather than certificate based. Accredited training will lead to more career opportunities for volunteers and staff in civil society. Support mechanisms and mechanisms for monitoring and evaluation will also be strengthened.

The ongoing process of decentralisation within the public sector will be guided by the existence of the Community-Based Health Care Policy, but on the other hand, the policy itself is a result of this process.

## **CHAPTER 3: POLICY FRAMEWORK**

### **3.1 POLICY GOAL**

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

### **3.2 POLICY PRINCIPLES**

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

1. CBHC volunteers make a significant contribution to CBHC within the larger group of Community Own Resource Persons and relevant stakeholders will contribute to meeting their needs;
2. The health care system at local level will strive to build partnerships to support Community based health care activities with the community at large, Community Own Resource Persons (CORPs) and their supporting civil society organisations;
3. A participatory approach focusing on community involvement, community ownership and community leadership will be used when identifying health needs, planning, implementing, monitoring and evaluating CBHC activities;
4. CBHC will be considered as a process whereby people increase their control over social, political, economic and environmental factors affecting their health status;
5. The approach for community based health care in Namibia will be flexible and tailored to meet the individual needs of districts, communities and households;
6. Local traditional beliefs, practices and behaviours will be recognised and considered when planning new initiatives; positive practices being encouraged and promoted, and potentially negative practices being discouraged.
7. Gender equality will be promoted in order to achieve an equal basis for development of men and women;
8. The CBHC policy will be implemented within the exiting health system and integration of activities will be aimed at all times in order to enhance effectiveness and efficiency;
9. Intersectoral coordination and collaboration between key partners and sectors will form part of all CBHC activities;

10. Appropriate technology in communication and implementation of community-based services including projects/initiatives will be promoted.

### **3.3 POLICY OBJECTIVES**

The following are the objectives the CBHC policy:

1. To increase awareness and knowledge related to the prevention, treatment, care and rehabilitation of most common diseases in communities;
2. To ensure that community and households attitudes and practices are improved, health and welfare initiatives supported and ill health prevented.
3. To set standards for CBHC guideline development to ensure the effective implementation of quality programmes.

### **3.4 POLICY STRATEGIES**

The key strategies which are detailed in the sections below are to:

- Support CBHC volunteerism
- Develop appropriate guidelines and standardised, accredited training;
- Strengthen the integrated management of CBHC services;
- Strengthen resource mobilisation including human resources through accredited training, supportive supervision, monitoring and evaluation and particularly resources that address the needs of volunteers;
- Strengthen implementation.

These strategies will be used to ensure effectiveness, efficiency, and sustainability of CBHC programmes. Guidelines will be developed to guide the policy implementation at different levels.

#### **3.4.1 Support CBHC Volunteerism**

Volunteerism will be promoted and supported as a cornerstone to achieving community based health care. Volunteers are motivated people who freely offer their time, knowledge and skills to make a positive change in their communities, whilst they also build their own capacity<sup>1</sup>. It is widely accepted that volunteers need on-going training, resource materials, support, supervision, recognition, and reimbursement for costs incurred through their work.

Communities, civil society service providers, health workers, community development workers, local authorities and Regional Councils all have a responsibility towards meeting the needs of volunteers and these are detailed in Chapter 4. By supporting community based health

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<sup>1</sup> This definition was approved by the National Conference on Volunteerism, December 2006.

programmes, a significant contribution can be made to reducing infection rates of malaria, TB, HIV and other diseases.

### **3.4.2 Guidelines, Training Standards and Training Materials**

1. Appropriate guidelines and practices on decentralisation and integration of CBHC services will be developed;
2. Integrated training manuals, appropriate for the type of work of the specific volunteer, and supervisory tools for community health workers will be developed;
3. Training of Trainers and therefore of CORPs will be standardised and accredited by the Namibia Qualifications Authority. Each CORP trained by the MOHSS or its partners will receive performance and attendances certificate and a copy of a job description. This will clearly outline the expected roles and responsibilities of each CORP and the agreed upon provision of incentives;
4. Continuous and regular supportive supervision, and refresher training will be conducted.

### **3.4.3 Integrated management of CBHC services**

1. The integrated management of CBHC services, involving all relevant stakeholders, will be strengthened and supported at the appropriate levels, to increase the impact and effectiveness of CORPs;
2. All stakeholders will integrate various “vertical” community based activities into more holistic approaches for example, HIV/AIDS, TB, Malaria, Nutrition, Water and Sanitation, Reproductive Health and other similar activities.
3. MoHSS CBHC functions will be decentralised and integrated to regional and local authorities to promote ownership and sustainability of community health initiatives;
4. Health facilities and their staff will be linked with communities through a framework of community own resource persons - CORPS, village/community /clinic health committees, health posts and/or outreach teams including supportive supervision and referral and report back system to the nearest health facility;
5. The links between the conventional health services and the traditional medical practices will be strengthened and coordinated.
6. All health facilities at primary level will use community oriented approaches in providing basic health services aiming at building self-reliance in the people, creating the opportunity for all to realise their full potential and motivating them to be both activists as well as main beneficiaries of Primary Health Care/Community Based Health Care;

7. The community based health and welfare information data bank within the HIS will be strengthened in order to reflect a true profile of the community needs and developmental activities;

#### **3.4.4 Resourcing**

1. Human resources at community level – the community resource persons - will be strengthened through accredited training, supportive supervision, monitoring and evaluation. The specific roles and responsibilities outlined in the Bill of Traditional Healers will be adhered to.
2. Resource mobilisation mechanisms including incentives for community volunteers will be established and strengthened and additional ways of assuring the sustainability of community programmes will be continuously explored;

#### **3.4.5 Implementation**

1. A healthy life style through multiple communications channels will be promoted and essential health information will be provided to communities and families for them to understand and actively participate in CBHC activities;
2. Basic health services consisting of a balanced mix of health promotion, disease prevention, primary and emergency curative care, rehabilitative and referral services will be provided.
3. Quality health care from community health providers will be assured through:
  - the assignment of clear roles, manageable tasks and quality training of CORPs and private service providers;
  - linking CORPs to health services, community committees and other communities structures to strengthen for support and supervision;
4. Teamwork, coordination, inter-sectoral collaboration, and networking with governmental institutions, Non-governmental Organisations (NGOs), Community-Based Organisations (CBOs) and Faith-Based Organisations (FBOs) will be established and strengthened through information sharing, intersectoral committee meetings for joint planning, training, implementation and evaluation at all levels;
5. Community involvement and participation in CBHC programmes will be promoted during needs assessment, planning, implementation, monitoring and evaluation.
6. Monitoring and evaluation will be strengthened, using integrated teams where appropriate.



### **3.5 The CBHC Policy's Key Results Areas**

#### **Results Area 1: Enabling Environment**

Strengthened enabling environment to increase effectiveness of community health and welfare workers and CORPs, including TBAs, traditional healers and volunteers.

#### **Results Area 2: Coordination and management**

Strengthened coordination of CBHC programmes and activities at all levels

#### **Results Area 3: Resourcing**

Strengthened resource mobilisation that enables volunteer service providers & their partners to contribute jointly to providing a broad package of incentives for volunteers.

#### **Result Area 4: Implementation**

Improved delivery of quality CBHC services to households.

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

The Government of the Republic of Namibia places a high premium on the active participation of communities in the health and social welfare services provided at their levels. This implies communication, consultation and co-operation between all development workers and communities in respect of attitudes, interventions and actions towards the causes of poor health and welfare. The objective is to make communities masters of sustainable PHC programmes in their own environments. As outlined under the policy principles, there are many important partners in CBHC. The institutional framework for the implementation of this policy therefore, includes line ministries, the private sector, NGOs, CBOs, FBOs and communities at large.

This Chapter describes the role of different actors at community, district, regional and national level in supporting the policy implementation process.

### **4.1 COMMUNITY LEVEL**

#### **4.1.1 The Community**

Communities are not homogenous entities, but are complex structures comprising of individuals and groups that have contrasting needs, resources and aims. Communities have strength within their existing structures and wherever possible these should be used in the implementation of CBHC projects.

The responsibilities of the community and their representatives, the traditional leaders, should include to:

1. Assist in the selection of volunteers
2. Support the volunteers ( e.g. venues, resources);
3. Promote cooperation between volunteers and the community;
4. Appreciate, value, encourage and respect the volunteers.

#### **4.1.2 Community Owned Resource Persons (CORPs)**

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

The roles and responsibilities of Community Own Resource Persons (CORPS) include:

1. In many communities they act as agents for change and catalysts for development

activities – from encouraging literacy to raising awareness on health and welfare needs and rights.

2. One of the most important developmental and promotional roles of CORPs is to act as a bridge between the community, the formal health services and other sectors. CORPs therefore, will participate in outreach services and mobile clinics.
3. They will refer patients/clients to clinics, health centres and other related services, if and when necessary.
4. CORPs will guide the community and the community health committee in identification of community needs, their analysis, prioritisation and implementation of appropriate actions. They sensitise and mobilise the community for health and development actions;
5. CORPS will play a role in collecting and recording data to feed into community based information systems through the nearest health facilities.
6. Preventive tasks of CORPs will include dissemination of health and development information to community members; the distribution of Oral Rehydration Salt and condoms; and the education and development of skills for households on the prevention of common illnesses.
7. Curative tasks will vary according to the local situation. Important areas are:
  - a. early recognition of signs and symptoms of common illnesses;
  - b. basic first aid interventions;
  - c. home based care;
  - d. ensuring that individuals and families with specific health needs (e.g. social problems, HIV/AIDS, family planning) are aware of the services available and referred to facilities for further management.
  - e. Supervision of treatment e.g. TB DOT, ART, and nutrition.

The personal responsibilities of the CORPs should include to:

1. Be committed service providers with the aim of making a positive change to the overall well-being of the community, in a sustainable manner;
2. Share the knowledge they have and transfer their skills to other community members e.g. household carers;
3. Be faithful to the commitment and exemplary;
4. Be trustworthy and confidential;
5. Mobilise the community and improve its living standards;
6. Attend positively to vulnerable groups;
7. Recognise the norms, values and taboos of the community;
8. Work according to the structure of the community;
9. Be accountable and responsible (to the necessary structures).
10. Write and submit regular reports as necessary and provide feedback

11. Support one another in the volunteer roles.

#### **4.1.3 Village and Community Health Committees**

The Village Health Committee (VHC) or the Community or Clinic Health Committee (CHC) will be a sub-committee of the Village Development Committees (VDC). In un-proclaimed areas, community health committees will be formed and will fulfil the role of the VDC in respect to health. The head of the local health facility will be a member of the Village or Community Health Committee. Other members will be community and church leaders, teachers, TBAs, traditional healers and community volunteers. The chairperson of the VHC will be elected from its members and they will all serve as volunteers.

Roles of local level health committees such as Village Health Committees and Community Health Committees include:

1. Local level health committees have a key role to play in the identification and coordination of the needs in their communities;
2. They will facilitate the selection of CBHC volunteers, provide guidance, support and motivation to them and promote cooperation and respect between volunteers and the community;
3. They will support and assist implementation of the activities of health workers and CBHC volunteers at the primary facility and support service delivery;
4. They will play a role in organising health activities at community level such as the provision of health posts/mobile clinic venues for outreach services, national health events and awareness campaigns;

#### **4.1.4 Outreach Services**

The smallest functional health provision unit in the community health care programme is a health post, manned by trained CORPs. The functions at the health post include health education and promotion; environmental sanitation; growth monitoring and promotion; treatment of simple injuries and common diseases and referral of moderate and severe cases; defaulter tracing and notifications; community mobilisation related to national health and social welfare events. Health posts serve as regular visiting point for outreach services and supervision of CORPs.

Isolated communities without a clinic will be visited on a regular basis by outreach teams of health workers. Outreach clinic routes will be worked out in such a way that a feasible number of health posts are visited per month. Outreach clinic routes will take into account the clinic/health centre catchment areas. Outreach services will aim to provide the same high quality and essential package of services as offered at fixed clinics. Outreach teams will consist of staff from the district and the clinic/health centre responsible for the relevant catchment area.

**Roles of Outreach Teams**

1. Outreach teams will strive to establish a good relationship with CORPS.
2. Outreach teams will adequately refill home based care kits of CORPs.
3. Health information statistics collected by the outreach team will regularly be shared with the respective catchment area.

**Roles of CORPS to support outreach services**

1. The CORPS will regularly brief the outreach team, clinics/health centres and staff on all matters related to CBHC within the relevant catchment area.
2. The CORPs will be involved in creating the link between the community and the health workers.
3. They will assist the outreach session by mobilising the communities to attend before arrival of the outreach teams.
4. During the outreach session, the CORPS may assist with weighing children, giving health education and supporting the outreach team.
5. Between outreach visits, CORPS may supervise TB DOTS, monitor ART, follow-up certain cases and report to the community after the visit.

**4.1.5 Clinics and Health Centre Facilities**

A clinic is the smallest health facility permanently staffed with professional health workers rendering PHC services to the community, while a health centre is a facility bigger than a clinic and smaller than a district hospital. It provides short-term in-patient care and has a maximum of 10 beds.

Clinics and/or health centres are responsible for primary health care and public health of the population within their catchment area. Each catchment area's boundaries within a district shall be clearly determined and each clinic/health centre shall have a map that describes the boundaries and clarifies the location of the population within the catchment area. Each clinic/health centre will regularly update the health statistics of the catchment area (openly displayed graphs related to the trends and incidences of main diseases) and share this information with the community during clinic/village health committee meetings and IEC sessions. In order for clinics and health centres to adequately fulfil their support role to CORPs they will be supported and regularly supervised by the PHC supervisor and other district staff.

Clinics and health centres offer front-line services in PHC and are in direct contact with communities. The roles and responsibilities of the clinics and health centres in CBHC include:

1. Clinic nurses will promote local leadership in health development through participatory planning and regular review with the community;

2. Facilitate participatory needs assessment, planning and regular review with the community;
3. Clinic and health centre nurses will participate in the mobilisation to encourage volunteerism, and in the recruitment, selection, orientation, training and refresher training of CORPs;
4. Clinic nurses will assist in the management, coordination and supervision of volunteers to fulfil their responsibilities, according to an agreement with the volunteer service provider.
5. Clinic nurses will arrange meetings with CORPS at least four times a year to share experiences, identify needs and address challenges.
6. Clinics and health care centres will keep records of the activities of CORPs;
7. The clinic and/or health centre will be the referral centres for CORPs;
8. Clinic nurses (assisted by CORPs) will provide health education; curative care of common diseases, nutrition promotion, immunisation, environmental sanitation, and follow-up of TB/ART defaulters. They will promote and support community health-related projects.
9. Clinic and health centres will provide and adequately refill home based care kits on a regular basis, in line with ministerial policy/guidelines and keep records;
10. Compile and provide reports to MoHSS district level on CBHC activities.

## **4.2 LOCAL GOVERNMENT AND DISTRICT LEVELS**

### **4.2.1 Local Government Structures**

Constituency Development Committees (CDC), Local Authorities (LAs) and the Village Development Committees (VDC) will support and monitor the CBHC activities carried out by MoHSS and other partners. These bodies may have sub-committees that focus on health and HIV/AIDS.

These local government structures will coordinate the mobilisation of resources and may determine the contribution by the community for a programme/project/initiative. Resources required for CBHC at this level may include provision of a place for community meetings, gathering of any contributions in kind and/or funds from community members and other resources including incentives for CORPs.

The councillor together with the District Primary Health Care Supervisor will co-ordinate CBHC activities and submit community health issues to the CDC and Regional Development Coordinating Committee (RDCC) for discussion and problem solving. The regional councillors and the Health Programme Administrators will work in close cooperation with these committees at the regional level. Together they will co-ordinate and submit CBHC issues to the District Coordinating Committee and the Regional Management Team of the MoHSS and the RDCC for discussion.

#### **4.2.2 The MoHSS's District Coordination Committee (DCC)**

The District Coordination Committee (DCC) is the coordinating committee for all health activities in the district. Members are amongst others: the PMO, the PHC supervisor, the hospital matron (PRN), district health inspector, social worker and the district administrator (control officer). Any other resource person can be co-opted to the meeting of the DCC.

The district hospital will provide essential clinical back up services and comprehensive care to all patients who CORPS, clinics and health centres cannot treat. It will receive and attend to referrals from the lower level of health services and will give feedback to the relevant referrer. Additionally, the district hospital will provide staff to offer training of primary level staff and of CORPs and to provide relief duties at health centre and/or clinics.

The roles and responsibilities of the MoHSS District level include:

1. The DCC will oversee and coordinate the implementation of the CBHC activities and projects at district levels.
2. The prioritisation of services to be delivered by CORPs in the district will be planned by the DCC in collaboration with the VDC/VHC, Constituency Development Committee, Local Authority and any other stakeholder and/or committee concerned with CBHC activities at community level;
3. The DCC will mobilise and allocate resources and will ensure that enough supplies are available for the outreach services, clinics and health centres;
4. The DCC will mobilise and allocate resources for supplies of tools and incentives for CORPS;
5. The District PHC Supervisor will coordinate, amongst others the district CBHC and outreach services. He or she will promote the CBHC agenda at different forums such as the District Coordination Committee (DCC) or any other intersectoral committees.
6. Support the community service provider in conducting a participatory needs assessment.
7. Support the CBHC service provider to design and deliver both orientation and training of volunteers.
8. The PHC supervisor in cooperation with the PMO and other staff will ensure regular integrated and supportive supervisory visits to clinics, health centres and CORPs.
9. The nurse in charge of CBHC/outreach services in the district will maintain an inventory of all CHWs/CORPS in the district desegregated by clinics. The inventory will indicate the name and address of the CORPs and the training courses received. It will also contain information on equipment / supplies / incentives issued to the CORPs.
10. The Registered Nurse (R/N) will monitor the proper use of all supplies given to CORPs. The replenishing of supplies for CORPS such as HBC kits will be made from the district health facility budget and the records of their stock levels will be kept at the clinic/health centre level.

11. The District will serve as the monitoring centre for health statistics collected in the district. After a preliminary evaluation of data they are forwarded to the regional/central level. Feedback about the collected data will be given to the clinic and health centre staff and the communities at large.
12. The District will compile and submit reports to regional level.

### **4.3 REGIONAL LEVEL**

#### **4.3.1 The Regional Council**

CBHC activities require coordination with other sectors. This will be done through multi-sectoral Regional Development Coordinating Committees (RDCC) and the Constituency Development Committees (CDC). The Regional Health Director of Health and Social Welfare Services will be a member of the Regional Development Coordinating Committee (RDCC) and the Regional AIDS Coordinating Committee - a sub-committee of the RDCC.

The responsibilities of the Regional Council will be to:

1. Strengthen coordination committees between local regional and national levels to promote integrated and effective community health care, including other sectors.
2. Promote use of effective feedback mechanisms between communities and coordination committees at sub-national levels.
3. Promote the integration of CBHC services at sub-regional level (HIV/AIDS, TB, malaria, nutrition, rehabilitation, water & sanitation etc).
4. Organise regular public events at all levels that give recognition to contribution made by volunteers.
5. Hold annual partnership meetings at regional and local levels to set resource contributions towards CBHC programmes to ensure sustainability.
6. Establish efficient resource mobilisation mechanisms.
7. Build capacity of members of coordination committees and strengthen support mechanisms.

#### **4.3.2 The MOHSS Regional Level**

The Directorate Management Team (DMT) consists of the Regional Health Director (RHD) for Regional Health & Social Welfare, the Regional Chief Medical Officer (CMO) and various Health Programme Officers.

The roles and responsibilities of the Directorate Management Team include:

1. The DMT will be responsible for planning, coordination for supportive supervision and monitoring of CBHC activities. DMT will ensure that national policy is correctly interpreted and operationalised in the respective districts.



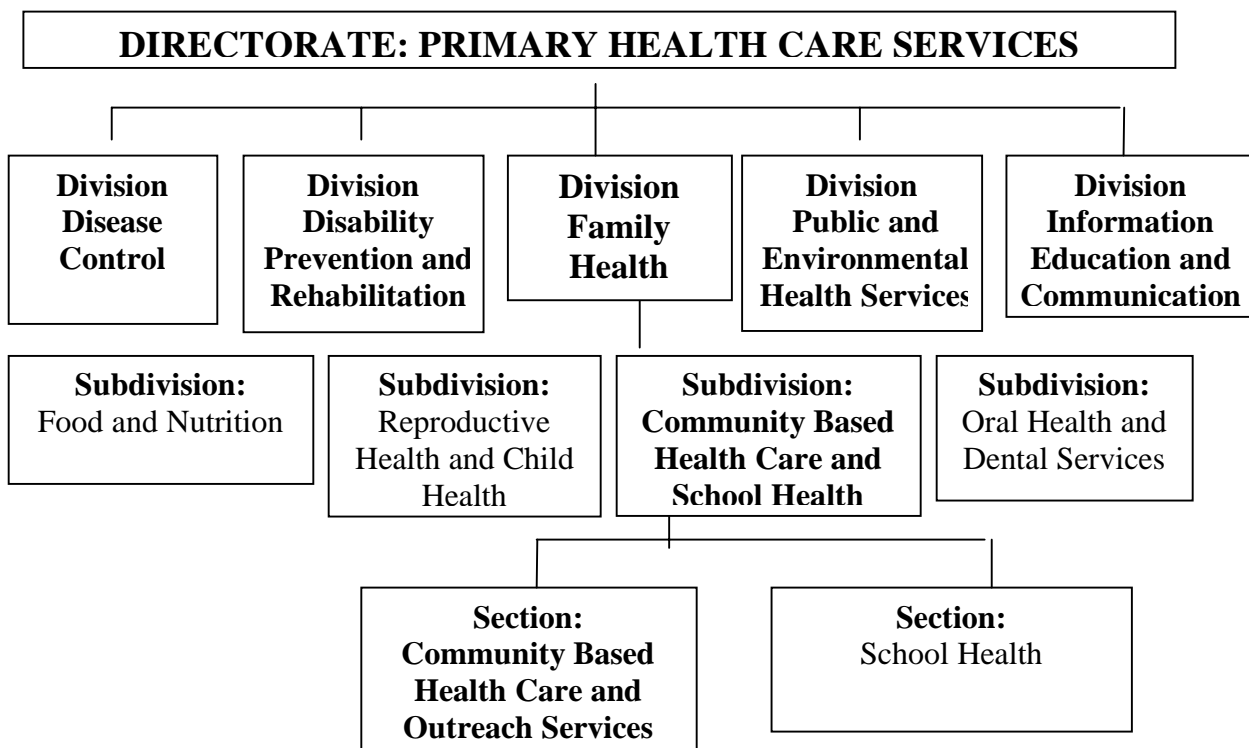
2. The Chief Health Programme Administrator (CHPA) for Family Health Services, who is a member of the DMT, will promote the CBHC agenda at the Regional Development Coordinating Committee meetings in collaboration with the RHD.
3. In addition, the RHD will raise community health issues at the national meetings.
4. The CHPA for Family Health Services will compile health information from the districts' management information system (MIS) and other sources on CBHC activities on monthly basis. Feed back about the compiled data will be given to the district level, through the RDCC.

## 4.4 THE NATIONAL LEVEL

### 4.4.1 The Ministry of Health and Social Services

#### *The CBHC programme in the Directorate of Primary Health Care Services*

The MOHSS is the lead Ministry for providing health and social services in the country. It is responsible for the formulation, resourcing, monitoring and evaluation of the CBHC policy. It will provide guidelines and will facilitate and/or coordinate relevant training. It will maintain an active inventory of all CBHC projects/initiatives. It will monitor outputs achieved by the national programme, review and promote best practices and commission relevant research. It will be kept informed of the CBHC activities being implemented by NGOs, other ministries and the private sector by the Directorate Management Teams at regional level.



The Sub-Division of Community Based Health Care is based within the Division of Family Health, in the Directorate of Primary Health Care. The responsible person for CBHC in the

Family Health Division of the MOHSS at national level is the Chief Health Programme Administrator (CHPA) for CBHC, Outreach & School Health Services. The CHPA for CBHC will participate on intersectoral working groups at national level. He/she is answerable to the Deputy Director of the Family Health Division.

The CHPA will be assisted by two Senior Health Programme Administrators, one responsible for Outreach Services & CBHC and the other for School Health Services. They will promote CBHC issues with all relevant stakeholders within and beyond the Ministry through the Deputy Director of the Family Health Division.

The detailed responsibilities of the sub-division will include development of CBHC implementation guidelines and procedure manuals for health workers and CORPs; technical support to implementing districts and partners; conducting of needs assessments and community based appraisals; training of health workers, CORPS awareness creation and advocacy for CBHC support at high levels of decision making; resource mobilisation; collection of regular data, compilation of reports; formulation of policy recommendations and operational research.

The responsibilities of the MoHSS at national level will be to:

- 1 Develop policies and guidelines, training manuals and workbooks on aspects of CBHC and orientate partners on them.
- 2 Provide a central coordinating point for effective CBHC implementation and volunteer management.
- 3 Direct and assist the various players to jointly provide more productive services.
- 4 Assist community wide efforts to recognise, promote and popularise volunteerism. This should include raising public awareness about the value of volunteerism through print and broadcast media.
- 5 Advocate for volunteerism by organising and supporting volunteer day celebrations.
- 6 Advocate for the integration of volunteerism in the education system such that volunteerism is accredited.
- 7 Develop policies that support volunteerism and volunteer management including giving opportunities to good volunteers to be absorbed into the government system should relevant positions exist.
- 8 Establish a budget line for supporting volunteer management.
- 9 Provide funds for community based health care programmes including a contribution to a package of incentives.
- 10 Regularly review guidelines on the implementation of CBHC including volunteer management.
- 11 Monitor implementation of policies and funding.
- 12 Carry out surveys to evaluate the impact of CBHC programmes.

- 13 Disseminate findings of evaluations of all community health programmes to encourage sharing and learning from experiences;

### ***CBHC in the Context of Other MoHSS Programme Policies***

The work of the IEC Division in the Directorate of Primary Health Care Services is designed to support community sensitisation and mobilisation activities for all PHC programmes.

The CBHC policy will be implemented in recognition of the IEC policy and of other programme policies and guidelines such as the Reproductive Health Policy, National HIV/AIDS policy, Third Medium Term Plan for HIV/AIDS (MTP-III), the Home Base Care guidelines, the School Health Policy, the Outreach Services Policy, and many other operational policies related to CBHC activities.

## **4.5 OTHER PARTNERS IN CBHC**

The role of other sectors in the implementation of PHC services cannot be over emphasised. There are numerous extension workers both from the government and the NGOs who are working in health related fields, especially in rural areas. These range from literacy officers, through agricultural extension workers, to community activators, and other community development workers. In order to enhance the work of these various cadres, more co-ordination of efforts among them is very essential. There is need for coordination at national, regional and district level.

For other sectors to become involved in supporting community involvement in health, the CBHC programme in the Ministry of Health and Social Services will become more proactive in advocating for joint collaboration, co-ordination and provision leadership.

The following partners play very important roles with regard to CBHC:

### **4.5.1 Civil Society Organisations – NGOs, FBOs and CBOs**

As detailed in the Situation Analysis chapter above, civil society is playing a major role in carrying out a range of community health services at local level. In 2007, NANGOF has registered more than 290 civil society organisations, many of which are supporting more than 20,000 volunteers to provide health care and support. These NGOs, FBOs and CBOs need to be supported for continuous and sustainable development. They should report to the Primary Health Care Supervisor at district level so that their activities are known.

### **Roles of Civil Society Organisations**

1. At the outset of a CBHC programme or new initiative, a needs assessment of the community will be conducted;
2. The community will be actively involved at all stages of the programme;

3. Civil Society Organisations will manage their volunteers, according to the MoHSS Guidelines on CBHC and NANGOF's Code of Practice;
4. The civil service organisations will build capacity of CORPs, with the participation of MoHSS nurses, through training, refresher courses and during supervision;
5. The volunteer service organisations will work in partnership with the MoHSS to provide tools for their volunteers;
6. The volunteer service organisations will provide supportive supervision;
7. NGOs, FBOs and CBOs will be transparent with their staff and volunteers, particularly regarding their financial status.
8. NGOs, FBOs and CBOs will be responsible for collecting and collating data on activities and impacts of CBHC to track progress for their own purposes and for national programming.

#### **4.5.2 Ministry of Education**

The National Training Authority, currently within the Ministry of Education approves unit standards for training courses before they can be accredited by the Namibia Qualifications Authority. Both these institutions will have a major role to play in standardising the various CBHC training courses that are currently provided by a range of trainers.

Schools have an important role to play in health and social welfare services. Provision of health education to school children will not only encourage them to promote health amongst themselves but will also enable them to play a significant role in motivating their families and communities to participate in various community health activities. Schools are involved in CBHC through the school health education programme and healthy school initiative ([refer to the School Health Policy](#)).

In addition to its many schools, the Ministry of Education (MOE), has established thirteen Community Learning Centres, one in each region. They play a role in informing, educating and coordinating community extension services.

The National Literacy Programme in Namibia of the MOE provides an important avenue for the CBHC approach as there is great potential to involve the 3,000 literacy promoters in the promotion of health and prevention of ill health especially in the fight against HIV/AIDS, malaria, diarrhoeal diseases, and nutrition (among other key health issues). Further health information literacy materials will be developed and cooperation between the two programme officers at national level will be strengthened.

Other important programmes in this ministry for closer collaboration are behaviour change programmes such as Windows of Hope, My Future is my Choice and Health Promoting Schools.

### **4.5.3 Ministry of Agriculture, Water and Forestry**

This sector has the biggest potential to positively impact the health on the nation through the provision of water and food. The extension workers (agriculture and water) and community water committees have a key role to play on community sensitisation and mobilisation regarding maintenance and use of clean water supplies and the production and use of nutritionally rich foods. Also, they will provide supervisory and technical support to CORPs on agricultural and development issues. The Regional Food Security and Nutrition Technical Committee, together with the Regional Food Security and Nutrition Coordinator, will support community-based food security and nutrition initiatives and interventions to reduce poverty and food insecurity.

### **4.5.4 Ministry of Regional and Local Government, Housing and Rural Development**

Ministry of Regional Local Government, Housing and Rural Development (MRLGHRD) through its Regional Development Coordinating Committees (RDCC), Constituency Development Committees (CDC), Local Authorities and the Village/Community Development Committees (V/CDC) will support and monitor the CBHC activities carried out by MOHSS and other partners. The regional councillors and the Health Programme Administrators will work in close cooperation with these committees at the regional level. Together they will co-ordinate and submit CBHC issues to the RDCC for discussion. At the constituency/village level, the councillor together with the District PHC supervisor will co-ordinate CBHC activities and submit community health issues to the CDC and RDCC for discussion and problem solving.

### **4.5.5 Ministry of Gender Equality and Child Welfare**

The focus of the Ministry of Gender Equality and Child Welfare (MGECW), which deals with issues concerning women groups, families, mothers, fathers and children, also impacts on CBHC. The MGECW is emphasising early childhood development as a key concern for the Chief Liaison Officers. Field workers and other staff, are part of planning, implementation and monitoring of the relevant sections of this policy, especially with regards to the implementation of the Reproductive and Child Health services.

The Community Activators and Community Liaison Officers in the Division of Community Development and Early Childhood Development and the Social Workers and Community Childcare Officers in the Directorate of Child Welfare Services, are well placed to offer supervisory and technical support to CORPs. Community Liaison Officers have already established a supportive relationship with many other community development workers in their regions. These co-workers offer the MoHSS a mechanism to reach many more communities through networking and co-ordination.

### **4.5.6 Ministry of Defence**

The Ministry of Defence plays an importance role in the provision of PHC services in the country during National Immunisation Days and during national emergencies by providing logistics and personnel. Their role is crucial for other CBHC and Outreach services, such as providing tents, transport, shelter for meetings and training as well as assistance to CORPs.

#### **4.5.7 Ministry of Information and Broadcasting**

This ministry creates awareness among political and community/opinion leaders and the community at large on community health and development issues concerning children and household community practices. It will provide information on the implementation of the CBHC policy to all sectors and community at large. The NBC Radio and TV broadcaster will support weekly/monthly CBHC programmes by facilitating discussions on community health issues.

#### **4.5.8 The National Planning Commission**

The NPC Secretariat has developed the Namibia/Civic Organisations Partnership Policy that aims for the Government, in consultation with civil society, to create a working partnership that works for the entire country, its citizens and their civic organisations and for the Government. The following objectives aim to guide and support its implementation strategies:

- to create a greater commitment for civic participation through the promotion and encouragement of active citizenship
- to enhance a conducive environment for civic participation and partnership through the voluntary registration of civic organisations and the formulation a Code of Good Practice;
- to bring the government closure to the people through the creation of partnership opportunities that is of benefit to government, civic organisations as well as civil society
- to enhance capacity of partners i.e. government and civic organisations to enter into partnerships that will jointly respond to development challenges and opportunities in an efficient, effective and sustainable manner:

#### **4.5.9 University of Namibia**

The University of Namibia (UNAM) has a faculty of Medical and Health Sciences. Its training curriculum is already PHC/CBHC/IMCI integrated. The Ministry and the above Faculty will further develop and in corporate Participatory Rural Appraisal (PRA) modules into the nurse's pre-service training curriculum. PRA is an appropriate approach for preparing communities to participate in their own health.

#### **4.5.10 Development Partners**

The UN agencies, donor agencies, the private sector and international NGOs have been playing a significant role in supporting and delivering CBHC services since independence. Major financial, material and technical support has developed capacity on public/community health issues of nationals at all levels. Also, some development partners serve on committees of the ministry and other organisations, specifically on community health issues. By doing that, valuable input and ongoing capacity building is provided. Continuous support is required for sensitising and mobilising all Namibians at all levels to contribute to their own livelihood.

## **CHAPTER 5: RESOURCE IMPLICATIONS**

The Government through the MOHSS and other ministries will mobilise adequate resources needed for the implementation of the CBHC policy according to roles, as spelt out in Chapter 4.

PHC and CBHC is not a cheap alternative to conventional health care. Due to its high population coverage the cost per person is high, however, it is lower than the cost of hospital care.

The Ministries will also mobilise community support as well as support from private organisations and development partners.

### **5.1 HUMAN RESOURCES**

The level of development and the capacity of local structures and organisations, which serve as a basis for CBHC, varies between communities. Additional personnel requirements, in terms of volunteers and salaried staff, will vary from region to region and district to district depending on the population density, resources of the community and the number and type of health facilities available. Adequate human resources does not only refer to personnel levels but also their competencies and motivation. The number of volunteers to be trained and supported depends on the needs of the communities.

The official structure and establishment for the Ministry of Health and Social Services specifies the qualified health staff required for the CHBC programme,. To effectively implement CBHC, it is imperative that all posts will be filled, especially those at the level of the community.

### **5.2 CAPACITY DEVELOPMENT**

To establish community involvement using a participatory method demands a substantial commitment to train community members. Participants from the health sector and other sectors will be thoroughly orientated in CBHC and trained to take up these responsibilities. Financial and other resources will be mobilised to provide knowledge and skills for personnel providing CBHC services, including managers and CORPs.

Over the next three years, the MoHSS will aim to standardise core skills for various category of CBHC volunteers. A high number of CORPS has already been trained but the course contents and length of training varied considerably. Initial training for home based care will be a minimum of two weeks theory mixed with two weeks practical. Pre- and post test training will evaluate training methods and Certificates of Achievement will be awarded as well as Certificates of Attendance.

Follow up and refresher training of these volunteers will be carried out and ongoing support will be provided by NGOs, FBOs, CBOs and the GRN. The MoHSS will support the development of training materials and their translation into local languages and languages for people with disabilities e.g. Braille.

MoHSS staff at community and district level will participate in the training of community volunteers and other CORPS. Supervisory visits to the CORPS in action will be carried out by one of the trained TOTs, as part of the accreditation process to becoming a fully fledged, skilled CBHC volunteer. Meetings with CORPS and clinic nurses should be held quarterly.

### **5.3 TOOLS, KITS AND I.E.C. MATERIALS**

CORPS will need some basic equipment, supplies and Information, Education and Communication (I.E.C.) materials to fulfil their responsibilities and job descriptions effectively. These tools will enable them to give health education, provide care and treat patients with minor and common illnesses and record and report data on CBHC activities. Providing resources to CORPS is considered to be an investment in the capacity of the health care system.

Trained CORPS will be provided with basic kits after training. The provision of information and education alone is not enough. The CORPS need to be able to respond to some of the community health needs in a tangible way such as assessing fever, dehydration and malnutrition then providing first aid and, if necessary, referral to a health facility.

The contents of the kits will depend on the local situation and on the training the CORP has received. The kit contents for a home-based caregiver will vary from that of a CORP trained in health promotion and first aid. Standards for different community health providers will be elaborated in the specific guidelines.

The supply of pharmaceuticals to CORPS will depend on several critical factors in the community, the crucial one being access and closeness to health services and adequate training of CORPS. In situations of poor access to health facilities, the supply of some essential life saving drugs such as anti-malarial and or simple analgesics to trained CORPS will be considered. In the districts where this need is identified, a system of effective monitoring and replenishing to sustain supplies will be instituted (as described under 4.1 and 4.2 earlier).

Replenishment of the kits will be budgeted for by the MoHSS. The clinic nurse will re-stock the kits on a monthly basis either when the CORPS visit the nearest health facility or when the outreach team visits the health post.

CORPS will also be supplied with visible identification which boosts community confidence, promotes the programme and is seen by many volunteers as an incentive. Examples widely used include ID cards, bags, hats, uniforms such as T shirts, and umbrellas. Some CORPS such as HBC volunteers may need protective gloves, aprons and shoes.



## 5.4 TRANSPORT and other REIMBURSEMENTS

CORPs are expected to visit households, hold community meetings and give regular feedback to the clinic or NGO service provider. They accompany sick patients to a health facility which may be up to 10 km from their homes. Most CORPs have no transport and walk which is very time consuming and renders the CORPs less effective. Many report that they have spent their own money to get patients to a health facility and it is appreciated that private motor vehicle owners in rural areas and taxis in urban areas are expensive. Many have used their cell phone credit or telephone to organise transport and referrals, to seek advice and to coordinate with their supervisor and fellow volunteers. Volunteer service providers and their partners will strive to include reimbursements in their incentives package for CORPs.

For large target areas the provision of transportation means (e.g. bicycles) to CORPS will be considered.

One of the biggest challenges of CBHC programme is the establishment of a regular supervision and monitoring system and regular clinic meetings will play an important role. Long distances and insufficient transport have been hindering effective supervision in the past. It is therefore of utmost importance that transport for the supervision of clinics, districts and regions will be made available from the pool of cars of the district health services. Possibilities for shared transport will be explored within the MOHSS and with other sectors. Joint monitoring with other sectors will foster collaboration, coordination and partnership and at the same time, reduce the financial burden of the district.

## 5.5 RECOGNITION AND MOTIVATION

Any organisation that provides a service using volunteers will give recognition, appreciation and motivation to them. This will include, but not be limited to:

- Assess performance and give feedback to the volunteers on their assessment
- Hold public ceremonies to give awards and certificates of achievement
- Include volunteers in staff activities and other organised events – ceremonies, retreats, outings, end of year parties
- Involve volunteers in strategic planning & design & in decision making process
- Employ volunteers through internal recruitment when staff vacancies occur so that there are career paths for volunteers.

## 5.6 REMUNERATION

The community, together with the volunteer service provider, may decide on additional suitable recompense for volunteer services and will be responsible for providing such incentives for services in cash or in kind. Decisions on whether, or how much, CORPs should be remunerated and who should be responsible should be discussed with all partners. It will depend on the type of functions they are expected to perform. CORPs receiving financial incentives are expected to be accountable to the relevant authority for the performance of the set tasks and responsibilities.

The continuation of the provision of incentives offered at the beginning of a programme should be ensured in order to avoid high attrition rates known to follow any reduction of remuneration.

A person who receives any remuneration whether in cash or in kind, is regarded as an employee. The Labour Act of 2007 (Act no. of 2007) is hereby recognised and will be referred to in all matters regarding employment issues. Furthermore, any person receiving more than N\$300 will be registered under the Social Security Act. Applications for exemption to the Labour Act can be made with the Minister of Labour.

## **5.7 FUNDING SOURCES**

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

Community involvement and participation in CBHC activities are therefore not regarded as relieving the Ministry of Health and Social Services of the responsibility of providing communities with support. Nevertheless, letting the community raise its own funds, will help to ensure its sustained involvement in CBHC activities.

The MOHSS will therefore, endeavour to establish mechanisms that permit joint support and make resources available directly to community health enterprises themselves. International agencies and donor organisations will also be encouraged to adhere to this principle to ensure that funds are earmarked to promote community action for health.

At operational/implementation level, the MoHSS District Coordinating Committee (DCC) in collaboration with the Constituency Development Committee (CDC) will mobilise material, financial and human resources to support service delivery, research and human resource development.

All partners in a community based health care programme should share the responsibility for resourcing, whether with funds or in kind. Funding to support volunteer programmes can also come from local authorities and be channelled through district and constituency committees.

## **CHAPTER 6: MONITORING AND EVALUATION**

### **6.1 Why Monitor and Evaluate?**

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

- 1. To increase awareness and knowledge of communities related to the prevention, treatment, care and rehabilitation of most common diseases;**
- 2. To ensure that community and households attitudes and practices are improved, health and welfare initiatives supported and ill health prevented.**
- 3. To set standards for CBHC guideline development to ensure the effective implementation of quality programmes.**

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

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

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

## 6.2 Quality Standards<sup>2</sup>

In general, “quality” is understood to be the degree to which services for individuals and communities produce **desired outcomes** and are consistent with current **professional knowledge**.

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<sup>2</sup> This section on quality standards has been adapted from Yates D. 2006 *Outcomes and Quality Standards for Core Services (for OVC)*. FHI / USAID

Quality is the degree to which programmes:

- Achieve expected results,
- Meet contractual obligations,
- Maintain compliance with established standards,
- Identify opportunities for improvement, and
- Develop and act upon improvement plans.

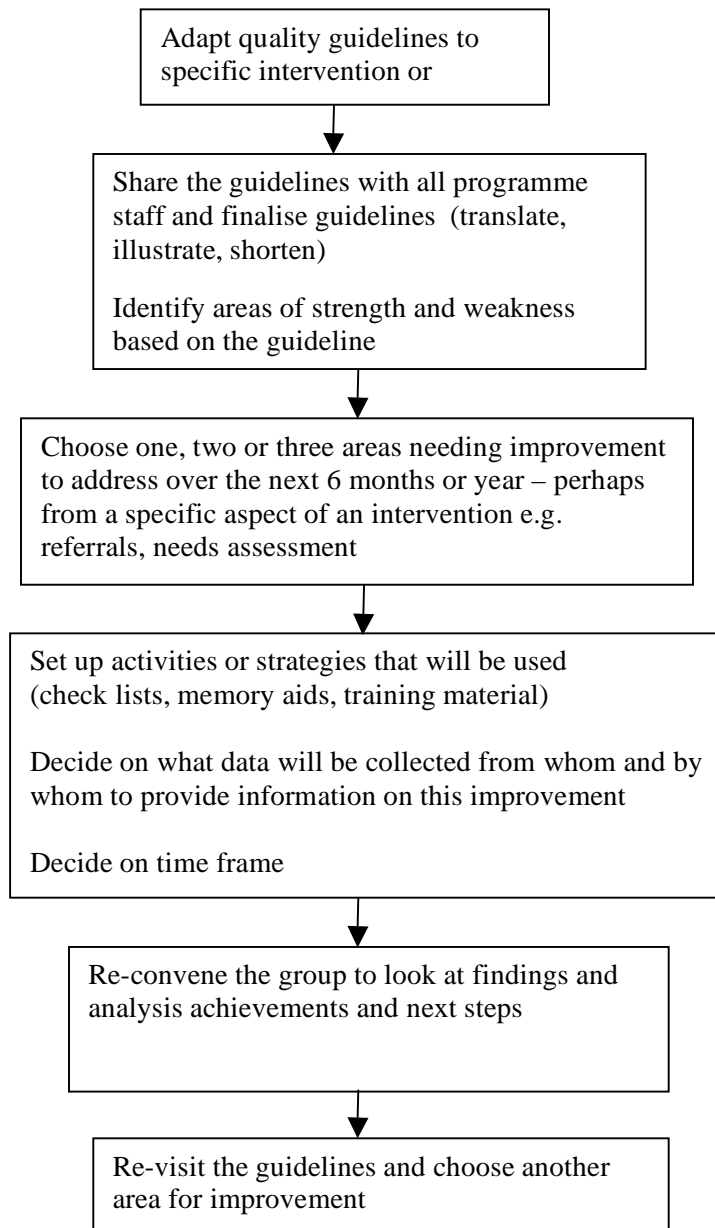
Nine dimensions of quality have been developed for community care as described in the table below:

<b>Dimensions of quality<sup>3</sup></b>	<b>Explanation</b>
<b>1. Safety of client/volunteer</b>	The degree to which risks related to CBHC are minimised.
<b>2. Access</b>	The lack of geographic, economic, social, cultural, organisational, or linguistic barriers to services.
<b>3. Technical performance</b>	The degree to which tasks are carried out in accord with programme standards and current professional practice.
<b>4. Continuity and linkages</b>	Referrals Links between prevention and care programmes. Networks with appropriate agencies.
<b>5. Compassionate relations</b>	The establishment of trust, respect, confidentiality and responsiveness achieved through ethical practice, effective communication and appropriate socio-emotional interactions.
<b>6. Appropriateness</b>	The adaptation of services to needs or circumstances: gender, age, disability, culture or socio-economic factors.
<b>7. Participation</b>	The participation of communities and target beneficiaries in the design and delivery of services and in decision-making. Continuum of participation: informed → consulted → participating
<b>8. Effectiveness</b>	The extent to which desired results or outcomes are achieved and documented, measured and shared.
<b>9. Sustainability including mobilising community inputs</b>	Strengthen communities to ensure long term sustainability.

These dimensions of quality CBHC, could be used to develop standards or quality guidelines for the different activities and programmes undertaken. This has already been done for partners in Namibia working in support of orphans and vulnerable children (OVC), in accordance with the National Plan of Action for OVC in Namibia. The process could be replicated for a wide range of CBHC programmes. Service Providers could follow the process below to examine and improve the quality of their service.

<sup>3</sup> Adapted from *Achieving Standards of Care and Quality Improvement in Programming for Children Affected by HIV/AIDS*, DRAFT – September 23, 2006, Lori DiPrete Brown

### Quality Improvement Flow Chart



The tables below provide examples of how these dimensions of quality care could be used to develop standards or quality guidelines for different CBHC programmes.

If an outcome is being achieved, then it is likely that many of the quality guidelines are already being followed. These quality guidelines can be integrated into an organisation's monitoring and evaluation system and its management system. If outcomes are not being achieved, then the quality guidelines should be examined to see where the programme may be falling short.

The tables below could be developed into checklists for supervisory support and self-assessment; structured supervision guides; feed-back on performance and supportive visits.

**Table of specific quality standards for Home Based Care**

<b>Quality Area</b>	<b>Specific quality guidelines Example: Home Based Care</b>
<b>1. Safety</b> a) Clients b) Volunteer	a.) Confidentiality kept a.) Universal precautions maintained b.) HBC volunteers trained in proper safety procedures incl. universal precautions. b.) Trained in self-defence b.) Given ID cards, bicycle helmets/reflector vests etc when appropriate. b.) Personal safety issues are important
<b>2. Access</b> Geographic, economic, social, cultural, linguistic or organisational barriers addressed	<ul style="list-style-type: none"> <li>• Community members made aware of location of nearest healthcare facility;</li> <li>• Encouraged to seek health care</li> <li>• Volunteers must live in the area they serve</li> <li>• Volunteers must respect the culture of their clients, should speak a common language.</li> <li>• HBC volunteers should visit client at least once every month, with more frequent visits as needed</li> <li>• HBC volunteers are assisted with transport and other materials to facilitate their work e.g. bicycles, provision of shoes and umbrellas, or other means.</li> <li>• Access to community leaders and translators where applicable.</li> </ul>
<b>3. Technical standards and professional practice</b>	<ul style="list-style-type: none"> <li>• HBC volunteers are trained to know about health issues;</li> <li>• To monitor compliance with treatment for ART/TB</li> <li>• Watch for side effects;</li> <li>• Watch clients overall health, esp. opportunistic infections;</li> <li>• Monitor others in household for general health esp. children</li> <li>• Provide health education and general information on hygiene of family – home environment;</li> <li>• May need to assist with cooking, fetching wood, water domestic chores, cleaning, child care, according to the prevailing situation.</li> <li>• HBC volunteers should receive regular supervision.</li> </ul>
<b>4. Appropriateness</b> Gender, age, cultural, socio-economic	<ul style="list-style-type: none"> <li>• Health requirements of volunteers &amp; clients must be cared for in a holistic way based on age, gender, culture &amp; socio-economic status;</li> <li>• Selection of HBC volunteers must include mature people, able &amp; willing etc;</li> <li>• HBC volunteers trained in signs of sexual abuse of women and girls;</li> </ul>
<b>5. Participation</b> PLWHA, children, parents, community	<ul style="list-style-type: none"> <li>• Clients should fully participate in health related activities within jurisdiction;</li> </ul>

<p><b>6. Continuity and links between prevention and care (holistic)</b></p>	<ul style="list-style-type: none"> <li>• Networking among stakeholders</li> <li>• HBC Volunteers encouraged to monitor extended family visits to the household</li> <li>• HBC Volunteers monitor the location of younger siblings who may receive care elsewhere to support continued contact;</li> <li>• Clients and OVC are encouraged to manage conflict, grief, encourage play, record memories, be responsible in relation to sex, drugs and alcohol;</li> <li>• HBC Volunteers to provide necessary assistance and referral with follow-up to local social service unit, appropriate government ministry, political representative, church leaders, support group, medical or psychosocial professionals, etc.</li> </ul>
<p><b>7. Relationships</b></p> <ul style="list-style-type: none"> <li>• trust</li> <li>• respect</li> <li>• confidentiality</li> <li>• responsiveness</li> </ul>	<ul style="list-style-type: none"> <li>• Promote mutual respect between volunteer &amp; client and community</li> <li>• HBC Volunteers retain the same households to support and assist with transition when a new care provider is assigned;</li> <li>• HBC Volunteers maintain open communication and sensitivity to the losses, concerns, fears and psychosocial adjustment of the individuals in their care;</li> <li>• HBC Volunteers have communication skills, good rapport and a respectful attitude toward children;</li> <li>• Confidentiality is maintained;</li> <li>• Youth heads of households and other children feel respected and feel their needs are being met;</li> </ul>
<p><b>8. Effectiveness</b> (Outcomes measured, documented, shared)</p>	<ul style="list-style-type: none"> <li>• Outcomes are documented based on National Standards of M&amp;E.</li> <li>• Information is shared among stakeholders.</li> </ul>
<p><b>9. Sustainability</b></p>	<ul style="list-style-type: none"> <li>• HBC Volunteers are given proper recognition, supportive supervision, training and refresher training</li> <li>• Incentives must be used to keep volunteers;</li> <li>• Appreciation events are incorporated into activities;</li> <li>• HBC Volunteers help households to access social assistance grants and to refer to social workers when necessary.</li> <li>• <a href="#"><u>Linkages to Agricultural Extension, MGECW and other partners who can provide technical assistance so that volunteers can run Income Generating Activities</u></a></li> </ul>



**Table of specific quality guidelines for HIV Prevention training**

<b>Quality area</b>	<b>Specific quality guidelines Example: HIV prevention training</b>
<b>1. Safety</b> of Client and volunteer	Correct and accurate information regarding safety of different methods (ABC) is fully explained
<b>2. Access</b> Geographic, economic, social, cultural, linguistic or organisational barriers addressed	Course offered in convenient locations in local languages as required
<b>3. Technical standards and professional practice</b>	<ul style="list-style-type: none"> <li>• A recognised curriculum used</li> <li>• Trainers trained and supervised for more than 16 contact hours</li> <li>• Content addresses alcohol and associated risks</li> <li>• Correct and accurate information supplied at all times</li> </ul>
<b>4. Appropriateness</b> Gender, age, cultural, socio-economic	<ul style="list-style-type: none"> <li>• Messaging is targeted at a specific age group</li> <li>• Both female and male presenters</li> <li>• Behavioural risks assessments done</li> <li>• Various media and methods used (drama, video, role plays etc)</li> <li>• Traditional practices assessed for positive or negative impact</li> </ul>
<b>5. Participation</b> PLWHA, children, parents, community	<ul style="list-style-type: none"> <li>• PLWHA address the group</li> <li>• Parents and caregivers informed about content of training</li> </ul>
<b>6. Continuity and links between prevention and care (holistic)</b>	Links made to PSS programmes and with VCT if appropriate
<b>7. Relationships</b> <ul style="list-style-type: none"> <li>• trust</li> <li>• respect</li> <li>• confidentiality</li> <li>• responsiveness</li> </ul>	<p>Openness and honesty are practised</p> <p>Sufficient time given for explanations and questions</p> <p>Non-judgmental approach</p>
<b>8. Effectiveness</b> (Outcomes are documented, measured shared)	Pre- and post-tests for participants' knowledge
<b>9. Sustainability</b>	Mass media campaigns carry consistent message on prevention PLWHA trained to serve as positive speakers

**Table of specific quality guidelines for Health Assessment of Children**

<b>Quality area</b>	<b>Specific quality guidelines</b> <b>Example: Health assessments of children</b>
<b>1. Safety</b> of Client and volunteer	Volunteers trained in proper safety procedures, including universal precautions
<b>2. Access</b> Geographic, economic, social, cultural, linguistic or organisational barriers addressed	Families made aware of location of nearest health care facility and encouraged to seek health care
<b>3. Technical standards and professional practice</b>	Integrated management of childhood illnesses (IMCI); Growth monitored; Advocate for treatment for children who are eligible; Monitor compliance for children on ART; Checks immunisation cards.
<b>4. Appropriateness</b> Gender, age, cultural, socio-economic	Health requirements disaggregated by age of children (infant/toddler/child/adolescent)
<b>5. Participation</b> PLWHA, children, parents, community	Questions answered or referred
<b>6. Continuity and links between prevention and care (holistic)</b>	Links are made with VCT sites and HBC providers Need for strict adherence to ART emphasised Nutritional assistance if required
<b>7. Relationships</b> <ul style="list-style-type: none"> <li>• trust</li> <li>• respect</li> <li>• confidentiality</li> <li>• responsiveness</li> </ul>	Service provider maintains confidentiality Sufficient time given for explanations and questions
<b>8. Effectiveness</b> (Outcomes are documented, measured shared)	OVC not disadvantaged in receiving preventative or curative health services Early recognition and treatment for childhood diseases
<b>9. Sustainability</b>	Community members trained to recognise and refer children with dehydration, diarrhoea, low body mass, and in basic hygiene for regular preventative health care

**Table of specific quality standards for Food and Nutrition**

<b>Quality area</b>	<b>Specific quality guidelines</b> <b>Example: Supplemental feeding scheme</b>
<b>1. Safety</b> Minimising risk of harm, avoiding further destruction of family structures, reducing stigma	Food distribution point is secure and clean Food is free of contaminants and safe to eat Food is stored on pallets above the ground, in sealed packaging Food preparation follows hygienic procedures-hand washing, clean surfaces Foods prepared as near to serving time as possible
<b>2. Access</b> Geographic, economic, social, cultural, linguistic or organisational barriers addressed	Distribution site is convenient for recipients Distribution occurs on the schedule promised Assessment of level of food-insecurity is undertaken and is understood by the community
<b>3. Technical standards and professional practice</b>	Food provided is appropriate to the setting (can be prepared easily, is acceptable to recipients) Pots and utensils are clean and sterile Food storage and preparation follow standards guidelines (see appendix) Nutritional status is monitored Needs of breastfed and weaning children are addressed
<b>4. Appropriateness</b> Gender, age, cultural, socio-economic	Absence of gender-based disparities in food distribution Pregnant teens receive appropriate additional nutrition HIV-positive mothers and pregnant women receive appropriate advice about feeding their newborns and about weaning foods Most food insecure are targeted
<b>5. Participation</b> • children • parents • community	Caregivers and recipients participate in decisions about what they will receive and how it will be distributed Recipients contribute to the preparation and/or clean-up Families and caregivers know how to prepare food distributed Nutritional education is provided
<b>6. Continuity and links between prevention and care (holistic)</b>	Regular visit by health care professional Links established with schools
<b>7. Relationships</b> Trust, Respect, Confidentiality Responsiveness	Recipients perceive that food is distributed with dignity Service provided does not lead to social stigma for recipients
<b>8. Effectiveness</b> Outcomes are documented, measured, shared	OVCs, patients on TB DOTS and ART have two or more meals a day OVCs and patients do not die of malnutrition OVCs achieve median height and weight for their community
<b>9. Sustainability</b>	Links established with agricultural extension workers and other providers of food support Private sector contributions recognised and encouraged.

## **6.3 Monitoring tools**

### **i. Supportive Supervision**

Supervisory / supportive visits will aim to improve the quality of service delivery by addressing performance, capacity and confidence building of the CORPs. Every opportunity will be taken to discuss and address the expectations of the community, the needs of the volunteers and other issues.

All key partners in each CBHC programme will know their role in supporting and motivating the volunteers. Programme managers will ensure that the resources required for regular supportive supervision are provided for in the implementation plan. Programme supervisors will supervise the CORPS, with the possible assistance of Community Health Committee members, whilst the district PHC supervisor/Principal registered nurse will supervise the clinic/health centre staff. The main function of the national and regional levels will be to supervise each of the next lower level.

The MoHSS will carry out periodic integrated supervisory and supportive visits at all levels. This will be done through: integrated community working group planning / review meetings, and biennial and annual report writing. Examples of monitoring tools used for supervision can be found in the Guidelines on Implementing CBHC Services.

### **ii. Qualitative and Quantitative data collection**

Each service provider and the Sub-Division CBHC will be responsible for recording and analysing both quantitative data (numbers) and qualitative (e.g. levels of satisfaction) to measure progress and change.

Ongoing collection of community-based information on service delivery according to the programme policy indicators will be carried out on a regular basis. The clinic will record relevant data and submit it to District levels quarterly to enter onto the Health Information System.

### **iii. Regular reviews and planning**

Information collected through monitoring will feed into regular internal reviews. An external evaluation will be conducted at least every five years to assess achievements, opportunities and challenges and to adjust annual and strategic plans.

### **iv. Indicators**

#### ***Outcome / Impact level Indicators:***

- Increased number of clients / patients cared for by CORPs
- Increased number of clients / patients referred to health facilities, when required
- Positive change in knowledge, attitudes, behaviour and practices relating to health in target communities;

***Process Indicators***

- Improved level of community participation:
  - Increased No. of community members (M/F) participating in programme planning, implementation and management.
- % of CORPs in communities in regular contact with health facilities.

***Management Indicators***

- A functioning system of coordination, collaboration and referrals for effective community health care in place:
  - A community health care structure (e.g. V/CHC and AIDS Committees providing effective coordination and collaboration
  - CBHC regularly discussed at MoHSS meetings at district, regional and national levels
  - Level of integrated management of community based health care activities: HIV/AIDS, TB, Malaria, Nutrition, Water, Sanitation and Reproductive Health
- A community based information system within the HIS improved and sustained.
- Increased level of confidence among programme beneficiaries in programme management.

***Implementation Indicators***

- No. of community health volunteers trained, supervised, supported and skills up-graded.
- No. of people reached through community based health care
- Level of satisfaction with service provision

## **GLOSSARY**

### **Community**

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

### **Community Based Health Care**

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

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

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

### **Community Development Committee**

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

### **Community Health Providers**

Any person in the community that provide health care services either from a government facility or privately, e.g. Community Health Worker (CHW), TBA, traditional healers, pharmacists and any other private persons engaged in health care delivery.

### **Community Health Worker**

A community member, who works as a volunteer or compensated by the communities' he/she serves, trained in basic health care by health professionals.

### **Community's Own Resource Persons (CORPS)**

Community's Own Resource Persons (CORPS) are volunteers at community level concerned with the health of the population. are working as agents for change and primary care givers. Community Health Workers (CHWs), Health Educators, Health Promoters, Home Based Care volunteers, Traditional Birth Attendants (TBAs), Traditional Healers (THs), community health committee members and private practitioners engaged in health, as well extension workers from other sectors belong to this group.

### **Early Childhood Development (ECD)**

Early Childhood is defined as the period of a child's life from conception to age of eight years. Development is defined as the process of change in which the child comes to master more and more complex levels of moving, thinking, feeling and interacting with people and objects in the environment. Development involves both a gradual unfolding of biologically determined characteristics and the learning process.

### **District**

Refer to an operational area of the Ministry of Health and Social Services which include one or more constituencies in a given region. The population in the given district is equal to the catchment population of the correspondent District hospital.

**Home Based Care**

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

**Household**

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

**Orientation**

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

**Outreach Services**

The delivery of mobile clinic services to remote health posts that include health education, illness prevention and treatment of common illnesses.

**Participatory Rural Appraisal (PRA)**

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

**Palliative care**

Palliative care refers to all care from the time a person is diagnosed with HIV infection, and includes psychosocial support and pain management.

**Supportive supervision**

Visits conducted to the operational staff with the aim to give them in service training, support and orientation.

**Technical support**

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

**Trainer of Trainers (TOT)**

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

**Volunteer**

Volunteers are motivated people who freely offer their time, knowledge and skills to make a positive change in their communities, whilst they also build their own capacity.

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