Namibia
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Contents

Articles

Avant-propos

Namibia:Foreword/fr

Le contenu en Français sera bientôt disponible.

This analytical profile provides a health situation analysis of the Namibia and, coupled with the **Factsheet** [1], it is the most significant output of the African Health Observatory. The profile is structured in such a way to be as comprehensive as possible. It is systematically arranged under eight major headings:

1. Introduction to Country Context
2. Health Status and Trends
3. Progress on the Health-Related MDGs
4. The Health System
5. Specific Programmes and Services
6. Key Determinants

This analytical profile does not merely recount tales of misery – it also shows significant advances that have been made in the last decade. The profile shows clearly that health systems are the key to providing a range of essential health care. African governments and their partners need to invest more funds to strengthen their health systems.

Please note that this is a work in progress and some sections are in the process of being completed. It will also be continually updated and enriched to bring you the best available evidence on the health situation in Namibia. We hope it will be useful to you, to countries and partners in their efforts to improve health and health equity in the Region.

The profiles that are shown on these pages are detailed and analytical and consist of a combination of text, graphs, maps and illustrations. If you are interested in getting statistical profiles only, these are available on the *Factsheet* [1].

We gratefully acknowledge the inputs of country and subregional focal points on health information, data and statistics. Without their contribution these profiles would not have been possible. We also thank the African Health Observatory focal points at WHO Country Offices for coordinating the production of the profiles and those who reviewed and gave their input to earlier drafts of the profiles.

References

[1] http://www.aho.afro.who.int/profiles_information/images/6/67/Namibia-Statistical_Factsheet.pdf

Introduction au Contexte des Pays

Etat de santé et tendances

Namibia:Health Status and Trends/fr

Le contenu en Français sera bientôt disponible.

This section of the analytical profile is structured as follows:

Namibia:Analytical summary - Health Status and Trends/fr

La traduction n'est pas disponible en Français.

The health status of Namibia has been heavily impacted by the HIV/AIDS [1] epidemic and negatively affected by the country's unequal socioeconomic development. The top 10 causes of death are currently AIDS, diarrhoea, pneumonia, pulmonary tuberculosis, health failure, other respiratory system ailments, anaemia, malnutrition, stroke and malaria.

The Ministry of Health and Social Services has prioritized the implementation of three health Millennium Development Goals, namely goals 4, 5, and 6: to reduce child mortality, improve maternal health, and combat HIV/AIDS, malaria and other diseases, respectively.[2]

The 2001 Population and Housing Census showed a dramatic drop in life expectancy in Namibia since the previous census in 1991 – from 59 to 48 for men, and 63 to 50 for women. The main reason for this drop, as was the case in many countries in the WHO African Region, was the HIV epidemic.[3] Thanks to the concerted HIV response, as well as other health initiatives, Namibia has already exceeded its 2012 target as set by NDP 3 (ensure that life expectancy is 51 years); according to latest figures, life expectancy in Namibia is currently estimated at 62 years.[4]

Maternal, newborn, child and adolescent health have recently emerged as priorities for Namibia due to a range of concurrent factors. The maternal mortality ratio is on the increase (almost doubling between 1992 and 2007) and the under-five mortality rate is not decreasing fast enough.

Namibia is ranked 59th in the world for under-five mortality, which has decreased between 1990 and 2009 from 73 to 48 deaths per 1000 population.[5] Despite this decrease, the average annual rate of reduction is only 2.2, and Namibia is unlikely to meet either the under-five or infant mortality targets for the Millennium Development Goals.[6]

Newborn mortality accounts for 50% of child mortality. Infant and child mortality varies considerably between urban and rural areas, as well as across regions, with Ohangwena and Caprivi having the highest rates.

These trends occur in a context of increased delivery at health facilities, indicating weaknesses in the quality of services. At the same time, spending on maternal, child and adolescent health is declining and emergency obstetric care coverage is very low and inequitable. A 2005/06 survey of all hospitals found that only four out of 34 hospitals provided comprehensive EmOC.

Efforts are being made to build capacity and skills of health workers to provide quality essential services to mothers during pregnancy and after delivery. The 2011-2015 Strategic Plan for Nutrition includes strategic priorities to improve maternal nutrition and contribute to improved maternal health.

The National Strategic Framework on HIV/AIDS delineates additional relevant strategies to address issues related to HIV infection and unwanted pregnancies, abortion, etc. A Road Map for Accelerating the Reduction of Maternal and Neonatal Morbidity and Mortality (2010) was developed to guide Government and partners in achieving universal access to comprehensive quality maternal and neonatal health care, and accelerate progress towards achieving the Millennium Development Goals.

The primary direct causes of maternal mortality in Namibia are severe eclampsia (33%), haemorrhage (25%) and obstructed or prolonged labour (25%). The most common direct obstetric complications treated in Namibia in 2006 was obstructed or prolonged labour (38%). According to the MoHSS, HIV/AIDS is the leading indirect cause of maternal mortality in health facilities, accounting for 37% of total mortality. Other causes include malaria, tuberculosis, meningitis and pneumonia (MoHSS, 2010).

Child health is mainly based on immunization, micronutrient supplements, diagnosis and management of common diseases among infants and children such as diarrhoea, malaria and pneumonia (HIS 2006).

Immunization coverage varies between regions with recent measles outbreaks as an indication of low immunization coverage. Adequate immunization coverage remains a challenge in Namibia. The national immunization coverage for the reporting period stood at 67 percent, which is below the 80 percent target. (MoHSS, 2010)

Such a low coverage has a negative impact on the sustained elimination of neonatal tetanus, poliomyelitis, and measles. (MoHSS, December 2010) Growth monitoring is also an important part of child health and child malnutrition is found to be very high.

Infant and child care is organized and delivered through the package of Integrated Management of Newborn and Childhood Illness (IMNCI), which has achieved a high coverage. (MoHSS, July 2010) Mechanisms in place to coordinate sector-wide approaches to reducing mortality among mothers and children include: the UN Maternal, Child Health and Nutrition (UN-MNCH & Nutrition) coordination committee, the MNCH Management Committee and the National Alliance For Improved Nutrition (NAFIN). (WHO Namibia, 2011)

For a number of reasons, little is known about adult mortality in Namibia compared with infant and child mortality. First, while early childhood mortality can be estimated through the birth history approach, there is no equivalent for measuring adult mortality. Second, death rates are much lower among adults than young children, and hence estimates for particular adult age groups are associated with large sampling errors. Third, there is usually limited information available about the characteristics of adults who have died. While much the same can be said about data on childhood mortality, it is reasonable to expect that the characteristics of the parents will directly influence their children's chances of survival.

Adult mortality rates derived from the 2006-07 NDHS data are higher for males than females (10.4 and 8.3 deaths per 1,000 population, respectively). A comparison of the 2006-07 NDHS and the 2000 NDHS rates indicates that there was a substantial increase in adult mortality in Namibia during that period.

The rate for females almost doubled between the two surveys and the rate for males is 65% higher than it was in 2000. The MoHSS Strategic Plan 2009-2013 places priority on the top three communicable diseases: HIV/AIDS, tuberculosis and malaria.

Successful control of these major diseases requires cross-border cooperation with neighbouring countries in the context of the SADC Health Protocol, implementation of WHO resolutions and recommendations, and other relevant instruments. Despite the challenges, in recent years the country has made some progress in curbing the impact of major communicable diseases. Most updated estimates have highlighted the fact that the global health sector response to HIV/AIDS represents 55% of the overall response. (WHO, 2010)

The HIV prevalence dropped from 22% in 2002 to 18.8 in 2010 (MoHSS, November 2010). Data show that the HIV prevalence is decreasing in younger age groups (15–19 and 20–24), while prevalence in the older age groups appears to be increasing . Significant progress has been made in HIV/AIDS with regard to voluntary counselling and testing, the number of eligible patients on antiretroviral therapy (ART), and the number of facilities providing ART services.

At the end of March 2009, 64,637 patients were enrolled in ART programmes, representing 84% coverage of people eligible for treatment. This high coverage is one of the highest in the African region and does not include patients being treated in the private sector. In terms of prevention, there is a significant increase in reported condom use; however, much still needs to be done to reduce the number of new infections.

TB remains a serious concern in Namibia, which has one of the highest case notification rates in the world. Key approaches for tuberculosis prevention and control remain effective implementation of the directly-observed treatment short-course (DOTS) and expansion of community- and clinic-based DOTS.

The emergence of multidrug-resistant TB and the growing problem of extensively drug-resistant TB pose new challenges to improve the capacity for the management of identified cases, infection control in health facilities (including the provision of isolation wards), and strengthened surveillance and reporting. (WHO, 2010)

HIV infection is the major driver of the current TB epidemic. Of those TB patients tested, 59 percent were HIV positive. (MoHSS, December 2010) However, the number of TB cases notified has dropped from 16,156 in 2004 to 13,332 cases in 2009 (WHO Namibia, 2010).

The malaria mortality rate declined drastically from 96.5 per 100,000 population in 2000 to 8.4 per 100,000 population in 2008. (WHO Namibia, 2010) Namibia practices indoor residual spraying and promotes the use of insecticide-treated nets for malaria control. The annual incidence of malaria has dropped since 2000. Although malaria is virtually confined to the northern part of the country, malaria is still one of the leading causes of death among under-five children and adults in Namibia, with approximately 67% of the population living in malaria-endemic areas.

Namibia has a relatively efficient Surveillance and Emergency Preparedness and Response system in place. Despite this, the country experienced a number of epidemics such as cholera, crimean congo haemorrhagic fever, influenza H1N1 (2009), measles, meningococcal meningitis, polio and rift valley fever, just to mention a few.

In order to strengthen disease surveillance and response in the country, the Ministry of Health and Social Services has adopted the Integrated Disease Surveillance and Response strategy. The first IDSR guidelines were launched in 2003 and have recently been updated to further improve district-level capacity. (MoHSS, 2011)

There is growing concern about noncommunicable diseases (cancer, diabetes, cardiovascular diseases, hypertension, etc.) as a cause of morbidity and mortality, although there is lack of population-based data in this area. Between 2004 and 2008, institutional mortality due to cancer rose from 3.2% to 54.7%, while cardiovascular diseases (all types) rose from 5.3% to 21.2%, and diabetes mellitus rose from 1.0% to 14.6%. (WHO, 2010)

Diabetes alone is emerging as one of the greatest threats to health. Between July 2010 and July 2011, 3,650 new cases of the disease were recorded in the country's public health facilities. (WHO Namibia, 2011)

Poor diet and nutrition, tobacco use, physical inactivity and alcohol use (all of which are associated with increased risk of cancer, cardiovascular disease, diabetes and other chronic diseases) are the risk factors. NDHS figures since 1992 show an increasing trend in overweight and obesity. Strengthening health promotion and health extension is seen as a key intervention for improved health outcomes in this area.

Namibia has put in place a number of programmes to reduce the underlying causes of non-communicable diseases (NCDs). Most importantly, the restructuring of the health system is serving as an important opportunity to build synergies among programmes such as the NCDs, Tobacco Control Programme, IEC, health promotion, school health and community based-programmes.

In addition, planned activities such as the development of the NCD strategy and training in management and control of major NCDs, in particular diabetes, are expected to facilitate the implementation of community-based

interventions addressing the modifiable risk factors for NCDs. (WHO Namibia, 2011)

References

[1] http://www.aho.afro.who.int/profiles_information/index.php/Namibia:Analytical_summary_-_HIV/AIDS

[2] Windhoek, Government of Namibia, Ministry of Health and Social Services, 2010

[3] Namibia Demographic and Health Survey 2006-07 (pdf 2.6Mb). Windhoek, Ministry of Health and Social Services; and Calverton, Maryland, Macro International, 2008 (http://www.who.int/fctc/reporting/party_reports/namibia_annex1_demographichealthsurvey_2006.pdf)

[4] United Nations Children's Fund

[5] Levels & trends in child mortality. Report 2010. Estimates developed by the UN Inter-agency Group for Child Mortality (pdf). United Nations Children's Fund, 2010 (http://www.childinfo.org/files/Child_Mortality_Report_2010.pdf)

[6] The state of the world's children 2011. Adolescence: an age of opportunity. New York, United Nations Children's Fund, 2011 (http://www.unicef.org/sowc2011/pdfs/SOWC-2011-Main-Report_EN_02092011.pdf)

Progrès dans les OMD

Namibia:Progress on the Health-Related MDGs/fr

Le contenu en Français sera bientôt disponible.

In September 2000, 189 heads of state adopted the UN Millennium Declaration and endorsed a framework for development. The plan was for countries and development partners to work together to reduce poverty and hunger, and tackle ill health, lack of education, gender inequality, lack of access to clean water and environmental degradation.

Eight Millennium Development Goals (MDGs) were established, with targets for 2015, and indicators to monitor progress. Three MDGs relate directly to health; to reduce child mortality by two thirds (MDG 4), to reduce maternal deaths by three quarters and achieve universal access to reproductive health (MDG 5), and to halt and reverse the spread of HIV/AIDS, achieve universal access to treatment for HIV/AIDS by 2010, and halt and reverse the incidence of malaria and other major diseases (MDG 6).

Other MDGs have an indirect influence on health; MDG 1 has a target of halving the proportion of people who suffer from hunger; MDG 7 includes a target of halving the proportion of the population without sustainable access to safe drinking water and basic sanitation; and MDG 8 has a target to provide access to a affordable essential drugs in developing countries. Primary education (MDG 2) and empowering women (MDG 3) also lead to health gains.

MDG goals, targets and indicators are interdependent measures of progress.¬ They are not meant to limit priorities in health, nor define how programmes should be organized and funded.

This analytical report on progress on the MDGs is structured as follows:

6.0 Analytical summary

6.1 Introduction and methods

6.2 Health MDGs

6.3 Health-related MDGs

6.4 Issues and challenges

6.5 The way forward

6.6 Endnotes: sources, abbreviations, etc

6.7 Other MDGs (as key determinants)

Namibia:Analytical summary - Progress on the Health-Related MDGs/fr

Le contenu en Français sera bientôt disponible.

The Namibia 2013 Millennium Development Goals Report (MDGR) is the fourth progress report prepared since the Millennium Declaration (MD) was adopted by 189 member states of the United Nations (UN) at the Millennium Summit in New York in September 2000. Following the adoption of the MD, eight smart, measurable, achievable and realistic goals and targets – the Millennium Development Goals (MDGs) – were developed and these have been implemented by developing member countries with the support of the developed member countries. The eight MDGs are:

MDG 1: Eradicate extreme poverty and hunger

MDG 2: Achieve universal primary education

MDG 3: Promote gender equality and empower women

MDG 4: Reduce child mortality

MDG 5: Improve maternal health

MDG 6: Combat HIV and AIDS, malaria and other diseases

MDG 7: Ensure environmental sustainability

MDG 8: Develop a global partnership for development It should be noted that this is regarded as an interim report to be updated as soon as new data become available from the 2012/13 Demographic and Health Survey and 2013 Labour Force Survey.

The final report should be available by early 2014.

GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER

Namibia managed to achieve the poverty reduction targets ahead of 2015, but is not on target to achieve equitable distribution of income or eradication of hunger. The proportion of Namibia's population who live in 'poor' and 'severely poor' conditions have decreased by more than half over the past 13 years. This is a commendable reduction in poverty and means that less than one third (28.7 percent) of the population currently lives below the poverty line. Namibia has at the same time, significantly reduced the poverty gap ratio, surpassing the target to halve the poverty gap by 2015. However, inequality remains a serious challenge, with high poverty levels in rural areas, and among female-headed households, older pensioners and subsistence farmers. Two regions had poverty levels of 50 percent or more, while increased poverty levels were experienced in Khomas region. The gini coefficient has fallen but remains one of the highest in the world.

The unemployment rate of 27 percent is lower than the 52 percent in 2008 but it continues to be extremely high among Namibian youth (52 percent). Gross domestic product has grown modestly, hitting 5 percent per annum in 2012, while the share of the poorest decile more than doubled between 2003/04 and 2009/10. Hunger and malnutrition remain a serious concern for Namibia, especially with the current drought across many of the regions. Although Namibia has made great strides and achieved key milestones towards eradicating poverty and hunger, there are still challenges in terms of unemployment and unemployability, limited skilled and qualified human resources, limited research and development, food insecurity and malnutrition, and ongoing corruption and mismanagement of funds. Key interventions that should receive attention for the remaining period before the end of 2015 are the design of innovative ways to create employment, build Namibia's human capital, scale up a well-established social grant system, raise the budget allocation to education, health and food production programmes, speed up the processing of vital registration documents, and more effectively implement the Zero-Tolerance for Corruption strategy.

GOAL 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

Of the three MDG 2 targets that Namibia has set for herself to achieve by the year 2015, the net enrolment in primary education target has been achieved, the literacy rate is on target to be achieved, while the survival to Grade 8 target is not achievable if current trends continue. The net enrolment ratio in primary education stood at 99.6 percent in 2012. However, the gross enrolment rate for the past few years highlights inefficiencies in enrolling maximum numbers of children in age appropriate grades. The survival rate for Grade 7s was 86 percent in 2012, 14 percentage points short of the 100 percent target.

The literacy rate for 15 to 24 year olds was close to the 100 percent target at 94 percent in the year 2011. It is likely that the literacy rate target can be achieved by 2015. As with school enrolments, regional variations in literacy are evident, with Kunene having the lowest (59.4 percent) literacy rate in 2011, followed by Omaheke (70.7 percent) and Kavango (76.4 percent). The region with the highest literacy rate in 2011 was Khomas (97.4 percent), followed by Erongo (96.7 percent) and Karas (96.6 percent). This follows regional wealth trends, with the poorer regions having lower literacy rates and richer regions having higher literacy rates. One of the main thrusts of Vision 2030 is to transform Namibia into a high income, knowledge based economy.

Such an economy would be expected to alleviate poverty, satisfy the labour market and ultimately support Namibia's transition into an industrialized nation. Namibia has consistently shown commitment to improved education with innovative interventions such as the Education and Training Sector Improvement Programme, continued curriculum development, free primary education, the official reinstitution of early childhood development, and infrastructural development. However, the following challenges persists poor school management, lack of motivation among many educators, poor physical learning environments, slow roll-out of early childhood development, poverty, malnutrition and high levels of domestic violence. Some of the interventions that could be considered to expedite MDG implementation are: improve school management structures at school, circuit, regional and national levels, strengthen procurement and distribution of textbooks especially to rural areas, continued improvement of physical learning environments, expedite roll-out of early childhood development centres, expand the school feeding scheme to include all children, enact the Child Care and Protection Bill, implement and enforce school codes of conduct for teachers and learners, and implement the teenage pregnancy policy.

Key interventions to be considered for the remaining MDG period are: increase financial, material and human resources to implement legislation, policies and plans, ensure that gender-specific recommendations and significant action steps are included in the review of NDP 4, strengthen gender mainstreaming across different sectors, continue to expand nutritional programmes to support pregnant women and children, continue with awareness raising, and strengthen all interventions towards eradicating gender-based violence.

GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

Of the seven targets, three have already been achieved, two were on target to be achieved by the year 2015, while two were not on target. Gender parity targets have been reached for secondary education, literacy rates for 15 to 24 year olds and pre-primary education. The ratio of girls to 100 boys for secondary education was 112.3 in the year 2012, 101 for literacy in 2011 and 101.2 for pre-primary education in 2012. The target to have gender parity in primary education is on target to be achieved at 96.4 girls per 100 boys. Namibia was also on target to achieve 50 percent share of women in wage employment in the non-agricultural sector, having achieved 48 percent in 2008 and 35 percent in 2012. The gender parity target for tertiary education will likely not be achieved, taking current trends into consideration. The proportion of seats held by women in Parliament was 25 percent in 2013, still 25 percentage points from the targeted 50 percent. The Namibian Constitution is the starting point for gender equality in Namibia. Unlike many other national constitutions, Namibia's Constitution explicitly forbids sex discrimination.

Numerous milestones toward gender equality can be mentioned, but the establishment of the Ministry of Gender Equality and Child Welfare was certainly one of the most significant, cementing Government's commitment to the

cause of gender equality. A major bottleneck slowing down progress is the poor implementation of legislation, policies and plans, possibly due to low capacity and poor funding priorities. However, some key plans in Namibia, such as the NDPs, pay insufficient attention to gender issues. Other challenges include insufficient resources to mainstream gender equality adequately across different sectors, increased gender-based violence, the seeming inability of Namibia to translate gender parity on some levels into formal jobs and negotiation powers of women, inadequate disaggregation of data in national management information systems, and inconsistencies in data sources, research methodologies and data presentation.

GOAL 4: REDUCE CHILD MORTALITY

The target for MDG 4 is to ensure that, by 2015, under-five mortality rates are reduced by two-thirds. The three relevant indicators are to reduce both under-five mortality and infant mortality by two-thirds between 1990 and 2015, and to increase the proportion of one-year-old children immunised against measles. While the measles immunisation programme is on target, current data for Namibia show that it is unlikely to attain the reduction in child mortality targets by 2015. The infant mortality rate decreased from 57 deaths for every 1 000 live births in 1992 to 38 in the year 2000, but increased to 46 deaths per 1 000 live births in 2006/07.

A similar trend was experienced for under-five mortality, which increased from 62 deaths per 1 000 live births in the year 2000 to 69 deaths in 2006/07. The challenges that contribute towards increased child mortality rates include, inefficient and ineffective health service provision, lack of basic emergency skills among some health workers, insufficient health infrastructure and difficulties of access to health services especially for severely poor and marginalised groups. The interventions urgently needed to expedite achievement of the 2015 targets are infrastructural development (including equipment and space at health centres and clinics), increased budget allocation, strengthened capacity of health management systems, improved skills and commitment of health workers, strengthened community health structures and roll-out of the Community Health Extension Officer programme. The proportion of one-year-old children immunised against measles has increased steadily from the early nineties, from 63.5 percent to 72.2 percent in the year 2000 and 78 percent in 2006/07. This shows that Namibia is on target to achieve the immunisation target of 85 percent by 2015.

GOAL 5: IMPROVE MATERNAL HEALTH

The targets for MDG 5 are to: reduce by three quarters, between 1990 and 2015, the maternal mortality ratio; and achieve, by 2015, universal access to reproductive health. The current data for Namibia (based on 2006/07 NDHS) shows that Namibia has already achieved the target for births to be attended to by skilled health personnel, is on target to reduce the unmet need for family planning to zero, but is unlikely to meet any of the other targets for this goal by 2015, such as 56 maternal deaths for every 100 000 live births, 100 percent contraceptive prevalence, the adolescent birth rate reduced by 100 percent and an antenatal coverage of 100 percent. As with child health, Namibia is committed to reducing child and maternal mortality.

This is evident by the multi-sectoral institutional structures put in place, the Life Saving Skills/EmOC training of trainers, routine maternal death reviews, enhanced referral system, improved infrastructure and procurement of equipment, strengthened adolescent's sexual and reproductive health and rights, and improved PMTCT strategies among others.

Namibia has developed a 'road map' with the aim of expediting achievement of maternal health targets, but needs to overcome the following challenges: shortage of skilled health workers, high attrition, non-availability of essential drugs especially in rural areas, inappropriateness of the health infrastructure to provide required skills, slow implementation of decentralisation, inadequate community outreach, and inefficient record keeping and use of the monitoring and evaluation system. It is essential, therefore, to develop a health professional human resource plan, improve retention of health professionals, accelerate training, build the capacity of all categories of reproductive health service providers, ensure availability and maintenance of essential medicines and equipment, design clinics to

cater appropriately for all relevant health needs, speed up decentralisation, and strengthen community mobilisation and monitoring and evaluation.

== GOAL 6: COMBAT HIV AND AIDS, MALARIA AND OTHER DISEASES The three targets for this goal are, by 2015 to have halted and begun to reverse the spread of HIV, and the incidence of malaria and other major diseases, and by 2010, to have achieved universal access to treatment for HIV and AIDS for all those who need it. Of the six HIV and AIDS indicators that could be measured, trends from the early nineties show that Namibia had already achieved the ratio of 1.0 of school attendance of orphans to school attendance of non-orphans aged 14 years an below. Namibia is on target to achieve the 90 percent proportion of women aged 15 to 24 years with comprehensive and correct knowledge of HIV and AIDS, but not on target to achieve the same results for men of the same age group. The country is also on target to achieve the proportion (100 percent) of adults with advanced HIV infection who have access to antiretroviral treatment, although not target to achieve 95 percent of children with this access. The HIV prevalence target of 5 percent among the population aged 15 to 24 will also not be achieved, as it stood at 8.9 percent by 2012.

The overall national HIV and AIDS response in Namibia is guided by the respective short and medium term National Plans, the National Strategic Framework on HIV and AIDS and the National Policy on HIV and AIDS. In June 2011, Namibia committed itself to continuing its active response to HIV by endorsing the Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS, at the UN General Assembly High Level Meeting on AIDS. The Political Declaration on HIV and AIDS runs parallel to the MDGs, with ten targets to be achieved by 2015, which support the achievement of MDG 6. In 2013, a consultative mid-term review of progress against these targets was completed and outlined the way towards achieving them, while the NSF mid-term review and recommendations will pave the way forward.

The challenges in the overall response to HIV include financial and technical sustainability, effectiveness of treatment due to adherence issues, resistance and inadequate nutrition for PLHIV on treatment, slow roll-out of PMTCT Prongs 1 and 2, difficulties in implementation of PMTCT Option B+, slow uptake of voluntary medical male circumcision, and not responding appropriately to the key drivers of the epidemic, such as high risk populations. The overall monitoring and evaluation system is challenged by high staff turnover, inefficient use of available data, poor quality of data collected and absence of population based surveys and programme evaluations.

Taking the above challenges into consideration, it is pertinent to continue with quality improvement activities for antiretroviral treatment, strengthen capacity of CSOs to support adherence to treatment, intensify efforts for elimination of MTCT by 2015, expedite implementation of the National Policy on Male Circumcision for HIV Prevention, continue with current prevention, treatment and care and support interventions for key populations, implement Government's sustainability plan for HIV response, and strengthen the overall monitoring and evaluation system. In addition to targets set for HIV, MDG 6 strives to halt and begin to reverse malaria mortality by 2015. Namibia is on track to achieve this and has already achieved a reversal in the incidence of malaria. This Goal also aims to have universal coverage of children using insecticide-treated bed nets.

According to current trends, Namibia falls short of achieving this target by 2015. In relation to other major diseases, available data show that Namibia is doing well and had already achieved, by 2010, the target of 85 percent of tuberculosis cases treated successfully and reducing the number of people who died from tuberculosis to less than five. However, Namibia is not doing well in achieving the target on notification of tuberculosis cases as this stood at 545 per 100 000 population instead of less than 300.

GOAL 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

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The targets for MDG 7 are to: integrate the principles of sustainable
development into country policies and programmes and reverse the loss
of environmental resources; reduce biodiversity loss, achieving, by
2010, a significant reduction in the rate of loss; halve, by 2015, the
proportion of people without sustainable access to safe drinking water
and basic sanitation; and by 2020, to have achieved a significant
improvement in the lives of at least 100 million slum dwellers.
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Progress to date includes three of these being met, two on target to be met and three not on target. Namibia has already achieved the targets to provide safe drinking water to urban (99 percent) and rural dwellers (90 percent), and to have 19.4 percent (against the targeted 15 percent for 2015) of land coverage in 2013 as communal conservancy areas. Namibia is on track to have 20 percent of land coverage as state protected and 5 percent as community forest areas.

However, the target of halving the proportion of people without access to basic sanitation has not and will not be achieved by 2015. Related to this is a failure to meet targets for access to secure urban land tenure for poor people. Appropriate policies are in place but these need accelerated implementation. The constraints to environmental sustainability include slow implementation of the Water and Sanitation Policy (WASP) and a skills deficit to ensure access to basic sanitation, insecure access to land and tenure, slow and politicised efforts in conservation of fish resources, slow implementation of the Concessions Policy, environmental damage caused by mining, less than optimal use and management of groundwater, and slow promotion of good rangeland management and conservation farming.

Recommendations for the period until 2015 include speedy implementation of WASP, addressing the skills deficit for sanitation provision, ensuring secure access to land and tenure, rebuilding the pilchard ocean stock, seizing the opportunity to exploit Namibia's diverse wildlife and scenic landscape for tourism, ensuring environmentally sensitive extraction of natural resources, sustainably managing the demand for and use of Namibia's underground water resources, and pursuing implementation of incentives for the promotion of sustainable rangeland management and conservation farming.

GOAL 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

The final Goal refers to a global partnership and has a range of targets and indicators, some of which apply to the developed nations and others that apply to nations in various states of development. Namibia has adopted four indicators of achievement for itself. One measures the net official development assistance (ODA) flows it receives, and the others measure the degree to which ICT has developed, in the form of internet access and use, cellular/mobile telephone subscriptions, and regular land line telephone use. Namibia has already achieved all the targets set for this Goal.

Official development assistance increased from US$89 per capita in 1990 to US$131 per capita in 2011, surpassing the target of US$90 per capita. By 2013, 36 percent of Namibians had access to internet, against the 20 percent target of Goal 8. This could be attributed to increased cell phone subscribers and consequent internet access via cell phones. The proportion of cell phone subscribers increased from 31 percent in the early 2000s to 92 percent in 2010 and 115 percent in 2013. The proportion of land line subscribers increased steadily from 6.8 percent in 2005 to 8.1 percent in 2013 (surpassing the 7.5 percent target).

The government continues to engage vigorously in regional and international economic cooperation and groupings for mutual benefit and strives to effect structural transformation towards sustainable economic growth and development. It also recognises that regionally integrated markets are crucial for small economies like Namibia's to be able to grow and develop in the face of intensified economic globalisation. However, the following challenges

prohibits optimal progress in global partnership development: non-availability of an adequately skilled labour force, accountability for improved public service delivery and elimination of corruption, labour inflexibility, ineffective public sector and civil society cooperation, and inadequate access to financing.

Essential interventions for the remaining period before the end of 2015 are the identification of critical skills shortages for the economy to operate at a higher output level and consequently planning carefully for domestic skills development, strengthened institutional structures for public service performance and management accountability, making public key documents that would support the elimination of corruption and hold officials accountable for mismanagement of funds, government strengthening of the space for the private sector and CSOs to operate efficiently and in line with market forces, improved access to adequate financing, and provision of serviced land with tenure to ensure adequate collateral for the private sector to expand. LOOKING BEYOND 2015 The 189 UN member states implementing the MDGs will meet at a Special Session at the UN General Assembly on 25 September 2013 to discuss two main issues: 1) how to accelerate progress towards achieving the MDGs; and 2) to agree on a new set of sustainable development goals (SDGs) for all nations and a timetable for implementation. The Rio+20 UN Conference of 2012 resolved to develop a set of SDGs for the timeframe beyond 2015.

Many lessons can be learned from the MDGs that could influence the next set of SDGs, that is, the next set of SDGs needs to build on the successes and challenges of the current MDGs. Although UN member states have commenced discussions on a post 2015 agenda and have developed a draft international agenda, it is highly recommended that Namibia undertake an in-depth assessment closer to the end of 2015. The outcome of this assessment should be used to adapt the post 2015 SDG agenda for Namibia. The developmental focus should be more on women, children, youth, people with disabilities, marginalised people and the elderly. Based on the review of MDG achievements up to 2013, it is recommended that the following goals be considered for post-2015, in addition to the existing goals:

1 Addressing inequality

2 Promoting good governance

3 Expediting the decentralisation process, including fiscal decentralisation

4 Promoting sustainable development and addressing climate change

5 Ensuring food security

Achievement of these goals can be only be realised with the following enablers:

- Peace and security
- Good governance, transparency and efforts to fight corruption
- Strengthened institutional capacity
- Promotion of equality and access to justice and information
- Human rights for all
- Gender equality
- Domestic resource mobilization
- Regional integration
- A credible participatory process with cultural sensitivity
- Enhanced statistical capacity to measure progress and ensure accountability
- Prudent macroeconomic policy that emphasises fair growth
- A democratic and developmental state
- An enabling global governance architecture.

GOALS AND INDICATORS	BASELINE	STATUS	TARGET (2015)	TARGET/ GOAL ACHIEVABLE?
MDG 1: ERADICATE EXTREME POVERTY AND HUNGER				
Halve the proportion of individuals classified as poor (consumption expenditure on food and non-food items of N$377.96 per adult equivalent per month)	69.3% (1993/94)	28.7% (2009/10)	34.7%	**Achieved**
Halve the proportion of individuals classified as severely poor (consumption expenditure on food and non-food items of N$277.96 per adult equivalent per month)	58.9% (1993/94)	15.3% (2009/10)	29.5%	**Achieved**
Gini coefficient	0.7 (2003/04)	0.5971 (2009/10)	0.5	**Not on target**
Halve the poverty gap ratio (%) - Poor	37.7% (1993/94)	8.8% (2009/10)	4.5%	**Achieved**
Halve the poverty gap ratio (%) - Severely Poor	28.1% (1993/94)	4.2% (2009/10)	4.5%	**Achieved**
Employment to population ratio	43.1 (1997)	47.9 (2009/10)	-	**No target set**
Growth rate of GDP per person employed (N$)				**No target set**
Proportion of own account and contributing family workers in total employment	7.7 (1997)	10.9		**No target set**
GDP growth (p.a.)	3.6 (1993)	5 (2012)	6.3	**Not on target**
Double the share of poorest decile in national consumption	1.07 (2003/04)	2.4 (2009/10)	5 (MDG+)	**Not on target**
Children under five stunted, in % of all children under five	28.4% (1992)	29% (2006/07)	14.2%	**Not on target**
MDG 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION				
Net enrolment ratio in primary education (%)	89% (1992)	99.6% (2012)	100%	**Achieved**
Proportion of pupils starting Grade 1 who reach last grade of primary (survival to Grade 8) (%)	59% (1992)	86% (2012)	100%	**Not on target**
Literacy rate of 15-24 years-olds, women and men (%)	76% (1991)	94% (2011)	100%	**On target**
MDG 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN				
Ratio of females to males in:				
*Primary education (girls per 100 boys)	102 (1992)	96.4 (2012)	100	**On target**
*Secondary education (girls per 100 boys)	124 (1992)	112.3 (2012)	100	**Achieved**
*Tertiary education (females per 100 males)	162 (1992)	85.25 (2011)	100	**Not on target**
*Ratio of literate females to males (15-24 years)	110 (1991)	103 (2011)	100	**Achieved**
Pre-primary education (girls per 100 boys)	87.6 (2008)	101.2 (2012)	100	**Achieved**
Share of women in wage employment in the non- agricultural sector (%)	39 (1991) 49 (1997)	48 (LFS 2008) 35 (LFS 2012)	50	**On target**
Proportion of seats held by women in Parliament (%)	5.7 (1990-1995)	25.0 (2010-2013)	50	**Not on target**
MDG 4: REDUCE CHILD MORTALITY				
Infant mortality rate (deaths per 1 000 live births)	56.6 (1992)	46 (2006/07)	19	**Not on target**

Under-5 mortality rate (deaths per 1 000 live births)	83.2 (1992)	69 (2006/07)	28	**Not on target**
Proportion of 1-year-old children immunised against measles	75.7 (1992)	78 (2006/07)	85	**On target**
MDG 5: IMPROVE MATERNAL HEALTH				
Maternal health				
Maternal mortality ratio (deaths in 100 000 live births)	225 (1992)	449 (2006/07)	56	**Not on target**
Proportion of births attended by skilled health personnel (%)	68 (1992)	94.6 (2006/07)	95	**Achieved**
Universal access to reproductive health				
Contraceptive prevalence rate (%)	23 (1992)	46.6 (2006/07)	100	**Not on target**
Adolescent birth rate reduced by 100%	2 (1992)	15 (2006/07)	0	**Not on target**
Antenatal care coverage (at least one visit and at least four visits) (%)	56 (1992)	72 (2006/07)	100	**Not on target**
Unmet need for family planning (zero % unmet need)	24 (1992)	7(2006/07)	0	**On target**
MDG 6: COMBAT HIV AND AIDS, MALARIA AND OTHER DISEASES				
HIV and AIDS				
HIV prevalence among population aged 15-24 years (%)	8.2% (2006)	8.9% (2012)	5%	**Not on target**
Condom use at last high-risk sex for 15-49 years age group				
Women (%)	-	62.1% (2006/07)	85%	Lack of data
Men (%)	-	78.4% (2006)	90%	Lack of data
Alternative indicator Condom use with non-cohabiting partner (15-49 years)				
Women (%)	51% (2000)	62.1% (2006/07)	n/a	No target set
Men (%)	66% (2000)	78.4 (2006/07)	n/a	No target set
Proportion of population aged 15-24 years with comprehensive, correct knowledge of HIV and AIDS				
Women (%)	38.9% (2000)	64.9% (2006)	90%	**On target**
Men (%)	50.7% (2000)	61.9% (2006)	90%	**Not on target**
Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years	0.92(2000)	3 1.02 (2006)	1.0	**Achieved**
Proportion of population (adults and children) with advanced HIV infection with access to ARV drugs (%)				
Adults (%)	56% (2006/07)	81.5% (2011)	100%	**On target**
Children (%)	88% (2006/07)	83.9% (2011)	95%	**Not on target**
MALARIA				
Malaria mortality per 100 000 population	31 (1996)	0.4 (2012)	Halt and begin to reverse	**On target**
Proportion of children under 5 sleeping under insecticide-treated bed nets	10% (2000)	34% (2009)	Universal coverage by 2010	**Not on target**
Incidence of Malaria in 1 000 population	207 (1996)	1.4 (2012)	Halt and begin to reverse	**Achieved**

TUBERCULOSIS				
TB cases notified per 100 000 population	657 (1997)	545 (2011)	<300	**Not on target**
% TB cases treated successfully	58 (1996)	85 (2010)	85	**Achieved**
Death rates (%) associated with TB	7 (2000)	4 (2010)	<5	**Achieved**
MDG 7: ENSURE ENVIRONMENTAL SUSTAINABILITY				
Areas protected to maintain biological diversity as percentage of all land				
State protected areas	12.5% (1995)	18.3% (2011)	20.0%	**On track**
Communal conservancies	0.0% (1995)	19.4% (2013)	15.0%	**Achieved**
Freehold land conservancies	5.0% (1990)	6.0 (2012)	10.0%	**Not on target**
Community forests	0.0% (2003)	4.0% (2012)	5.0%	**On track**
Proportion of households with access to safe drinking water (%)				
Urban	99% (2003)	99% (2010)	100%	**Achieved**
Rural	78% (2003)	90% (2010)	87%	**Achieved**
Proportion of households with access to basic sanitation (%)				
Urban	59% (2003)	57% (2010)	98%	**Not on target**
Rural	14% (2003)	17% (2010)	65%	**Not on target**
MDG 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT				
Official development assistance to Namibia (US$ per capita)	89 (1990)	131 (2011)	903	**Achieved**
Internet users, percent of population	15% (2010)	36% (2013)	20%	**Achieved**
Cell phone subscribers, percent of population	31% (2006)	115% (2013)	61%	**Achieved**
Telephone lines, percent of households	6.8% (2006)	8.1% (2013)	8%	**Achieved**

Namibia:Introduction and methods/fr

Le contenu en Français sera bientôt disponible.

The Millennium Development Goals (MDGs) form an integral part of the global vision for a well-nourished, skilled, healthy populace, pursuing and sharing prosperity and wealth-creation in an equitable and environmentally sustainable manner. This agenda particularly resonates with Namibia as the country presided over the UN General Assembly and resultant Millennium Summit in 2000, which brought together the largest ever gathering of world leaders and articulated, through a set of eight goals and corresponding targets, that the "world as it is must give way to the world as it could be".

For Namibia, an arid landscape, enviably endowed with precious natural resources yet underdeveloped in human terms as a consequence of both inequitable distribution of resources by systems designed deliberately to deprive some segments of society, and ineffective measures to redress this in the post-Independence era, this global development agenda is fully in synch with her own aspirations. Accordingly, Namibia's Vision 2030, as interpreted for action by successive periodic National Development Plans, domesticates this global vision for a better world. National Development Plan 4 is specifically anchored on the 1st Millennium Development Goal which speaks of reduction of poverty and hunger through "increased and sustained economic growth, creation of wealth and employment; and even distribution of that wealth".

In this regard, the compilation of this Report, the fourth for Namibia, is not only a reflection of how the world has fared on its commitments on human development but equally reflects how Namibia has progressed on her own agenda. The Report highlights key policies that have had a significant impact on the push towards the achievement of the MDGs. It also summarises where Namibia's challenges have inhibited the realisation of the Goals.

As an overview, Namibia, riding on a set of bold and targeted interventions to build the momentum and truly galvanise her people around the MDGs, notwithstanding the stubbornness of the challenges still faced, has a great deal to be proud of. Specifically, the country has made commendable progress in the areas of poverty reduction, education, gender equality, health and environmental sustainability. To flag a few successes in the area of poverty reduction, Namibia has succeeded in meeting or is on target to meet all but two indicators, namely those relating to the gini-coefficient and the 'share of poorest quintile in national consumption'.

Equally, in terms of universal access to primary education, Namibia had achieved or is expected to achieve all targets within the agreed timeline. In particular, there has been a tremendous expansion in the enrolment of children in primary schools and also the survival rate to Grades 5 and 8. With respect to gender equality and the empowerment of women and girls, the ratio of female to male students enrolled in secondary school and the literacy rate have been attained. Under the health area and specifically related to HIV, the reduction in the HIV prevalence among the 15 to 19 and 20 to 24 year olds has been realised. Equally, we are proud of our achievements around to incidence of malaria per 1 000 population.

In regard to access to clean, drinkable water, 'full access' has been attained, while in terms of environmental sustainability, the proportion of protected areas has increased. The increase in the number of conservancies and community forests under the Community Based Natural Resource Management programme deserves special mention because of its positive impact not only in increasing wildlife numbers but also because of the benefits that local communities derive.

Notwithstanding these successes, there is still more to be done to guarantee greater impact on the reduction of poverty, curtailment of the prevalence of HIV and infant mortality, improved maternal health and increased allocation of land to freehold conservancies for greater wealth creation and distribution.

To ensure success and guard against the reversal of these gains, Namibia – commended for her active participation in international partnerships and cooperation which contributes to peace-making and peace-building – must remain engaged on the global front. In particular, Namibia must continue to build solid and mutually beneficial partnerships

with like-minded actors around the globe.

The Namibia 2013 Millennium Development Goals Report (MDGR) is the fourth progress report prepared since the Millennium Declaration was adopted by 189 member states of the United Nations (UN) at the Millennium Summit in New York in September 2000. The first report was prepared in 2004, followed by the second report in 2008 and the third in 2010. The 2013 MDGR will be the last report before 2015 when a final stocktake of progress towards the MDGs will take place. Namibia played a key role in the formulation of the Millennium Declaration, with the then President of Namibia, Sam Nujoma, being the co-Chair of the Millennium Summit, while the current Speaker of the National Assembly was the President of the fifty-fourth session of the UN General Assembly.

In the Declaration, world leaders committed themselves to "free all men, women, and children from the abject and dehumanizing conditions of extreme poverty". The Declaration outlines the key challenges faced by UN members, and a set of indicators and targets for addressing these challenges. Following its adoption, eight smart, measurable, achievable and realistic goals and targets – the Millennium Development Goals (MDGs) – were developed and these have been implemented by developing member countries with the support of the developed member countries.

The eight MDGs are:

MDG 1: Eradicate extreme poverty and hunger

MDG 2: Achieve universal primary education

MDG 3: Promote gender equality and empower women

MDG 4: Reduce child mortality

MDG 5: Improve maternal health

MDG 6: Combat HIV and AIDS, malaria and other diseases

MDG 7: Ensure environmental sustainability

MDG 8: Develop a global partnership for development

We will spare no effort to free our fellow men, women and children from the abject and dehumanizing conditions of extreme poverty, to which more than a billion of them are currently subjected. We are committed to making the right to development a reality for everyone and to freeing the entire human race from want. *Millennium Declaration*

As the MDGs' target year of 2015 approaches, it is an opportune time to take stock of Namibia's progress. Namibia has, no doubt, made considerable progress towards many of the goals, already achieving some and being on target to achieve others but also not on target to achieve some. Significant challenges, however, remain in achieving the overall goal of development, especially as it relates to economic growth, distribution of wealth, employment, food security, governance, gender (especially gender-based violence), and the cross-cutting impacts of HIV and climate change on agricultural production, education, health and other social issues.

Namibia has adapted the MDG targets and indicators, based on local circumstances and reflecting national development objectives and aspirations. The national set of targets and indicators is rooted in the national milestones of Namibia's Vision 2030 and the National Development Plan (NDP) 4. This set of targets and indicators provided the framework for the development of the 2013 MDGR.

The methodology for preparing the report encompassed an extensive literature review and a qualitative and quantitative assessment of the achievement of goals and targets, arrived at by consulting key stakeholders in the different fields. Four regional (sub-national) workshops were facilitated involving stakeholders from all 14 regions, complemented by a national stakeholder validation workshop with the participation of representatives from government, civil society organisations (CSOs), development partners and the private sector.

An assessment of progress towards the targets was conducted using the characterisation 'achieved', 'on target', or 'not on target'. Judgments about which of these would apply were based mainly on the following factors: the observable trend; a change in trend for better or worse; the distance from the final target; and the existence or otherwise of policy and institutional frameworks to support the realisation of the goals.

Following this Introduction and a further introductory section covering the development context of Namibia, this report is organised into nine main sections, the first eight corresponding to the eight Goals and the last examining the post 2015 development agenda. Each of the main sections presenting progress on the MDGs provides an introduction to the relevant goal, followed by a review of trends in relation to progress made to date (to the extent that data are available), the key milestones that support progress towards the goal, challenges and opportunities to accelerate implementation during the remaining two years, and proposed priorities for post 2015. A table under the status and trends section provides quantitative indicators which highlight the progress towards achievement of targets from the 1990 baseline, the original reference year for each MDG indicator, and the current status. The ninth chapter discusses the evolving national post 2015 development agenda beyond and/or complementary to the MDGs.

This report still uses out of date data, especially on health indicators, from the 2006/07 Namibia Demographic and Health Survey (NDHS). The 2012/13 NDHS and 2013 Labour Force Survey are current being done, and should be ready for public use at the beginning of 2014. This version of the MDGR should, therefore, be regarded as an interim report to be updated with new data in early 2014.

Namibia is situated in the south-western part of Africa and is bordered by five countries: South Africa, Angola, Botswana, Zambia and Zimbabwe, as well as the Atlantic Ocean to the west. Namibia consists of 14 administrative and political regions. The regions with the largest population are Khomas Region, where the country's capital is situated, followed by one northern and one north-eastern region, Ohangwena and Kavango respectively. The region with the smallest population is Omaheke, situated on the eastern side bordering Botswana, followed by Hardap and Karas regions in the south. Namibia is vast, with a geographic size of 824 000km2 and a population density of 2.6 people per km2. It has a total population of 2.1 million. Two thirds of the population live in rural areas, 44 percent of households are headed by females, while 37 percent of the population are younger than 14 years of age. Namibia is generally an arid country with highly variable rainfall, resulting in many people depending on dryland cropping for subsistence. Namibia largely depends on her natural resources, which include gold, zinc, diamonds, uranium, copper, fisheries, wildlife and the 'wide open spaces' (tourism).

Vision 2030 is the inclusive guiding agenda for Namibia's development towards becoming an industrialised nation, developed by her human resources, enjoying peace, harmony and political stability. The five-year NDPs have guided socioeconomic progress that resulted in more people today having access to education, being wealthier, having better health and having access to diversified goods and services, in an environment that is generally politically peaceful. Since Independence in 1990, the provision of basic social services has improved in both urban and rural areas. Social services are more equitably distributed, despite the geographic vastness of the country. Income inequality in Namibia has decreased slightly, albeit still being regarded as one of the highest in the world. Namibia has developed good infrastructure, such as roads, water supply, electricity, telecommunications, and sea and air transportation, which support domestic trade and industrial development. The good infrastructure has also strengthened regional and global integration and trade. This progress towards development is a result of Namibia's commitment to sustainable economic growth, and reduced poverty and inequality.

Although Namibia has grown economically since Independence and has made great strides in the provision of basic social services while maintaining a generally stable economic and peaceful political environment, challenges in relation to key social indicators hamper the country's ability to achieve all goals set for Vision 2030. Namibia has been classified as an upper-middle income country, but ranked 120 out of 187 countries on the UNDP Human Development Index (HDI) in 2011. With this classification comes the responsibility and challenge to provide better for the needs of the people, especially the 'poor' and 'severely poor'. However, Namibia continues to be one of the most income skewed countries, with a Gini coefficient of 0.5971 in 2009/10. Although unemployment had decreased to 27.7 percent by 2012, unemployment among the youth (20 to 24 year olds) is still above 50 percent (MLSW, 2013:13). Namibia has increased access to education but the country falls short in terms of quality of education and responsiveness to the needs of the labour market. The lack of a skilled and adequately trained workforce has reduced potential investment opportunities, resulting in limited manufacturing in the country. Limited manufacturing may

decrease the potential for employment and, thereby, increase poverty. Although overall poverty levels have decreased, some regions, such as Kavango and Caprivi, still report more than half of the population being poor and poverty is still increasing in some regions. The prevalence and incidence HIV have decreased at national level, although high, and in some cases rising, prevalence continues to be reported in some regions. A high incidence of gender-based violence, especially domestic violence and rape, disproportionately affects Namibian women and girls and has serious implications for the health and wellbeing of families and communities.

The National Development Plan 4 noted the following reasons for slow progress towards achieving planned development: “lack of proper execution, a lack of accountability, and spreading our efforts and resources too thinly” (NPC, 2013:x). With the implementation of NDP 4, Namibia endeavours to respond to these challenges with high and sustained economic growth, employment creation and increased income equality.

Namibia:Health MDGs/fr

Le contenu en Français sera bientôt disponible.

This analytical profile on Health MDGs is structured as follows:

1. Analytical summary
2. MDG Goal 4: Reduce child mortality
3. MDG Goal 5: Improve maternal health
4. MDG Goal 6: Combat HIV/AIDS, TB, malaria and other diseases

Namibia:Health-related MDGs/fr

Le contenu en Français sera bientôt disponible.

This analytical profile on Health-related MDGs is structured as follows:

1. Analytical summary - Health-related MDGs
2. MDG Goal 1: Eradicate extreme poverty and hunger
3. MDG Goal 7: Ensure environmental sustainability
4. MDG Goal 8: Develop a global partnership for development

Namibia:Issues and challenges - Progress on the Health-Related MDGs/fr

Le contenu en Français sera bientôt disponible.

MDG 1 :

The causes and effects of poverty are extensive, complex and multifaceted. The challenges faced by Namibia in responding to poverty lie mainly in the implementation of existing policies, plans and strategies as Namibia has created an enabling policy environment for poverty alleviation. The test now is to make programmes work on the ground and in areas where the needs are urgent and concentrated. Serious attention, therefore, needs to be paid to those regions with the highest poverty and inequality levels, rural areas, female-headed households, children, the disabled and pockets within well-off regions such as informal settlements in urban settings. This section highlights key challenges and recommends interventions that would realistically support acceleration of MDG 1 implementation for the remaining period until the end of 2015. The recommendations would need consideration within the frameworks of NDP 4 and respective sectoral plans, and in conjunction with recommendations made for the remaining seven MDGs.

Challenges	Interventions to expedite MDG implementation
Food insecurity and malnutrition at household level have a negative effect on overall development, most specifically for children.	• Raise awareness of household food security programmes • Food aid in the form of drought relief food or food-for-work should be directed to the most vulnerable first • Scale up the school feeding programme to provide for all children and not only OVC • Raise budget allocations for food production programmes, such as the Green Scheme and Dry Land Agricultural Programme • Continue to raise awareness of the most appropriate breastfeeding practices and improved nutrition for children and their mothers • Raise awareness about the importance of consuming fortified foods • De-worm all children between 1 and 5 years of age
Namibia has a long-standing and well-established social grant system but the distribution of the number of grants and amounts paid per person are still relatively low. The coverage of social grants is affected by inefficient budgets, but also the inability of eligible persons to gain access to such grants. Additionally, poverty stricken children who are not classified as orphans and many extremely poor households are not covered by current social grants.	• Speed up the registration and issuing of vital documents to enhance access to social grants • “More social workers are needed and they need to be freed up from administrative work in order to focus on child protection issues” (NDP 4:63) • Expand the social grant system to include children in poor and severely poor households • Social grants should be increased annually as inflation increases and the increments need to be higher than inflation because the individual payments are small in number • Reconsider the commencement of the Basic Income Grant (BIG)

Ongoing corruption and mismanagement of public funds are serious challenges, given that theft of public funds takes away resources geared towards development of the nation, especially the poor.	• Implement the Zero Tolerance for Corruption strategy more effectively
Strategies need to be designed in such a fashion that beneficiaries of poverty reduction programmes are active participants in their own development. Programmes and projects need to be designed in such a fashion that they do not increase dependency on government and other external support, but enhance self-sufficiency.	

MDG4:

Several road maps have been developed and workshops facilitated to accelerate the reduction of child mortality in the country's effort to reach MDG 4 by 2015. These have resulted in the design of strategies and the current implementation of a number of initiatives. Some of the key challenges and a set of recommendations towards expediting implementation and improving Namibia's chances of achieving this Goal within the remaining two year period are outlined below. The overall recommendation is based on the need for the public health sector to become more proactive in its responses.

Challenges	Interventions to expedite MDG implementation
The state of health infrastructures is such that there is a public outcry for improvement in buildings, equipment, water, sanitation, electricity and other facilities	• Urgent attention needs to be paid to the condition of infrastructure in public hospitals, health centres and clinics • An increased budget allocation is needed for regular maintenance of health infrastructure but such funds need to be well used, starting with a tendering process that is efficient and provides value for money • Increase the number of maternal waiting homes near major hospitals
While generally a good quality service is provided, some ineffective and inefficient management of health service provision at national, regional, district and local levels has contributed to lower quality health provision, especially as it relates to child health. This includes management of staff shortages.	• Strengthen the capacity of health management teams to plan, manage, implement, monitor and evaluate • An in-depth assessment is needed to determine the qualifications of health managers, with recommendations to strengthen overall management • Strengthen the Reproductive and Child Health sub-division • Enhance the capacity of personnel and infrastructure to provide AFHS • Strengthen follow-up mechanisms, including tracking of mothers and children through the health system
Lack of basic skills among some nurses to prevent child mortality, noting that a large proportion of newborn deaths is preventable. In addition, the undesirable attitude of some health personnel towards patients, discourage some from seeking medical support unless absolutely necessary.	• In-service training needs to be strengthened • Self-assessment tools that are already in place need to be utilised
Referral systems are weakened by poor communication between health service providers and patients, and lack of transportation to referral health facilities	• Establish community health committees and emergency committees to support access to health facilities and referrals • Such committees need to establish appropriate communication and transportation mechanisms relevant to an area and based on local resources • Roll out the Community Health Extension Officer programme currently being piloted in five regions

Difficult access to health services, especially for severely poor and marginalised groups	• Planning for infrastructure development needs to be based on current and projected future geographical distribution of people • Sufficient allocation of public funds needs to be allocated to infrastructure development • All health service providers need to be informed about the exemption of OVC so that is applied consistently • The exemption needs to be revised to include the severely poor as well, especially as some OVC are better off than some severely poor • Community Health Committees need to be established to improve access through better coordinated transportation and communication with health service providers
Low awareness of maternal and child health, especially in remote and poor areas, contributes to higher mortality rates in such regions.	• Promote maternal and child healthcare • Promotion of the involvement of the entire family in maternal and child health, especially involvement of males • Develop and disseminate culturally sensitive information, education and communication (IEC) materials on child health, prenatal care, postnatal care, PMTCT and family planning • A rights-based approach to awareness raising is needed, ensuring that parents know their own and their children's health rights • Continue to raise awareness of the importance of child immunisation • Expand health extension workers services to all thirteen regions to bridge the gap between facilities and the communities needing access
Illegal and unsafe abortions and baby-dumping contribute to increased child and maternal mortality.	• Raise awareness about abortions and baby-dumping, while current legislation is reviewed to decrease unsafe abortions and baby dumping
The existing M&E system is not used optimally to plan for child health.	• Strengthen the M&E of the Health Management Information System (HMIS) to make data more frequently available • Capacitate health professionals and administrators to apply available data from HMIS

MDG5:

Namibia needs to continue with the implementation of the above-mentioned Road Map with the aim of ensuring a continuum of care connected by effective referral links and supported by adequate skills, supplies, equipment, drugs and transportation. The challenges outlined and recommendations made here are also relevant to the child mortality goal (MDG 4).

Challenges	Interventions to expedite MDG implementation
The human resource challenges include shortage of skilled health workers, high attrition, language barriers between patients and some health professionals, and shortage of basic lifesaving skills among nurses.	• Design a health professional human resources development plan • Improve retention of health professionals with strategies such as scarce skills allowance, rural hardship allowance, and staff housing especially in rural areas • Accelerate training of all health workers, and design a long-term training plan • Build capacity of all categories of reproductive health service providers, including traditional birth attendants, nurses, midwives, etc.
Essential medicines including ergometrine, oxytocin, MgSO4 and others are unavailable at lower levels of healthcare delivery.	• Ensure the availability and maintenance of essential medicines and equipment at all MCH centers
Health infrastructure is not appropriate to providing all required services.	• Design clinics that cater appropriately for all health needs • Expand maternal waiting rooms
Slow implementation of decentralisation.	• Speed up the decentralisation and devolution of power to regions and districts, with appropriate budget allocation
Community outreach is challenged by limited male involvement, weak referral systems and the difficulty of maintaining momentum.	• Strengthen male involvement in sexual and reproductive health • Strengthen the already established AFHSs, Namibia Planned Parenthood Association, Multi-Purpose Youth Centres, etc., which provide a wide range of reproductive health services • Expand access to midwifery care in the community and use midwives as an avenue for awareness raising • Raise the level of family planning uptake, especially long-term methods, and continue reducing the prevalence of unmet need for contraceptives • Improve the referral system for responding to maternal emergencies • Institutionalise regular monitoring and evaluation at all levels of the healthcare delivery system
Monitoring and evaluation	• Emphasise the routine collection and processing of data on process indicators for monitoring progress towards maternal mortality reduction, in the context of Namibia's Road Map for Accelerating the Reduction of Maternal and Neonatal Morbidity and Mortality, using indicators set out in the Road Map and the Neonatal Health HMIS

MDG6:

Namibia is currently preparing the NSF mid-term review which will look at current progress, key successes, and challenges, and make recommendations for prioritised interventions based on lessons learned. It is essential for all stakeholders to focus on the recommendations from the mid-term review as this will pave the way for expediting achievement of the targets set in the NSF, but also other commitments such as the MDGs and UNGA Political Declaration targets from 2011. It is assumed that high impact interventions for prevention, treatment care and support for key, marginalised and severely poor population groups will be prioritised for scale-up. Furthermore, it will be important to manage strategically the integration of HIV into broader sexual and reproductive health and overall primary healthcare without jeopardising the progress and gains that have been made.

Challenges	Interventions to expedite MDG implementation
While extensive progress has been made with provision of ART, care and support, challenges remain with adherence, effectiveness of treatment due to inadequate nutrition for PLHIV who are on treatment, staff shortages, inadequate capacity of CSOs, and community outreach.	• Strengthen task shifting/sharing by increasing numbers of IMAI trained nurses with knowledge and skills to initiate ART • Use of point-of-care diagnostics needs to be expanded • Enhance scale-up towards increased geographical coverage to health centres and larger clinics • Continue with quality improvement activities, enhancing adherence to treatment and improving retention in care • Strengthen capacity of CSOs to deliver adherence support, such as an umbrella body for PLHIV organisations
Key challenges experienced by the PMTCT programme include slow roll-out of PMTCT Prongs 1 and 2, HIV and infant feeding, effective implementation of PMTCT Option B+, quality of services and adherence of clients to PMTCT services.	• Expand PMTCT to remaining health facilities with ANC facilities • Intensify efforts set for elimination of MTCT by 2015/16 • Improve quality of service for each of the four PMTCT prongs as well as critical enablers and synergies • Special focus on “undeserved and most at risk populations”, such as PLHIV, sero-discordant couples, adolescents and rural populations (MOHSS, 2013:16) • Build community systems critical for PMTCT performance in collaboration with CSOs • Roll out implementation of the national HIV and infant feeding guidelines
Slow uptake of voluntary medical male circumcision (VMMC) with a coverage of 21 percent in 2008.	• Expedite implementation of the National Policy on Male Circumcision for HIV Prevention of 2010 • Finalise the VMMC Draft Strategy and Implementation Plan to operationalise the policy
Although Namibia has a generalised epidemic, key populations (MSM, commercial sex workers, prisoners) are significant drivers of the epidemic due to stigma and discrimination, high risk behaviours, and poor access to services.	• Continue with current prevention, treatment, and care and support interventions for MSM, CSWs and prisoners
Due to Namibia's upper-middle income country status, donor funding is decreasing.	• The sustainability plan needs to be finalised and put into action to ensure increased efficiencies and effectiveness in the national response, and sufficient funds to keep the existing momentum in the country’s HIV response • This is especially important for civil society contribution to the response • Integrate investment approaches based on clear evidence of greatest impact • Strengthen cost effectiveness and efficiency
Namibia has a functional M&E framework but there is high staff turn-over and inefficient use of available staff, the quality of data collected is poor and there is a lack of HIV population based survey and programme evaluations to provide evidence for programme design, planning, implementation and M&E.	• Provide more attractive incentives for qualified M&E officers to remain in regions, for example, performance award incentives such as M&E Officer of the Year with a prize that could include additional training, a scholarship or money • Triangulation and verification measurements need to be strengthened at all levels • Carry out HIV population based bio-behavioural surveys • Surveys need to be carried out to inform the NSF, MDGs and 2011 UN Political Declaration

The main challenges facing the NVDCP are unsustainable financial, logistical and technical support, especially in malaria zones 1 and 2. Below are key the challenges and sets of recommendations, which complement the Malaria Strategic Plan (2010-2016) and should be used as a guide to accelerating implementation.

Challenges	Interventions to expedite MDG implementation
Shortage of staff at national, regional, district and health facility levels, and lack of training of all health workers in case management and diagnosis.	• Accelerate the proposed restructuring process for NVDCP specifically, including Malaria Elimination Officers • Employ additional spray operators • Expand annual training in case management and diagnosis to all health workers
Information challenges, including lack of a proper GIS for malaria specifically, no effective information management system for malaria, poor reporting from regions, and no active surveillance system.	• Purchase GIS hardware and provide most appropriate training via internal technical support • Establish, with the support of HMIS, an effective information management system for malaria • Establish an active surveillance system
Absence of annually updated Malaria Epidemic Preparedness Plan.	• Annual updates of the malaria preparedness plan, especially for district levels
Expiration of ITNs delivered more than three years ago.	• Expand and strengthen the procurement and distribution of insecticide-treated nets • Establish a procurement and supply management system
Limited IEC materials at regional, district and community levels	• Design standardised clinical algorithms (procedures) and posters for health workers • Design, produce and disseminate IEC materials that are age, sex and culturally appropriate
Shortage of community support programmes.	• Health extension workers could take on some of the community mobilisation tasks • Continue with national advocacy days • Appoint a focal person responsible for health promotion and communication • Harmonise malaria messages developed by different partners • Improve awareness raising on risk perception and prevention methods • Improve awareness of appropriate ways of using nets
Logistical challenges overall, but most specifically for spraying activities.	• Strengthen logistical support in relation to transportation and supervision
Lack of cross-border initiatives with Zambia, Botswana, Angola and Zimbabwe.	• Establish other cross-border initiatives similar to the Trans-Kunene Malaria Initiative

Although NTLP has laid a strong foundation for TB control in Namibia, innovative interventions are needed to reach targets such as reducing TB cases notified for all forms of TB to 299 or less per 100 000 population. Innovation will also be needed to keep the momentum for other TB related targets already met, such as 85 percent of TB cases treated successfully, and reducing the death rate associated with TB to four by the year 2015. Therefore, the implementation of the Medium Term Plan (MTP) II for TB and Leprosy (2010-2015) is essential. Below are some challenges and recommendations, which are complementary to the MTP II.

Challenges	Interventions to expedite MDG implementation
Inadequate institutional and human resource capacity (including specialists), and high staff turnover.	• The Public Commission needs to create a position at hospitals specifically catering for TB • Import specialist health skills, while Namibians are being capacitated • Reintroduce the bush allowance for those working in remote areas • Get laboratories to provide surveillance as well as clinical functions such as diagnosis
Limited TB workplace safety measures for health workers.	• Provide adequate ventilation in wards and other areas • Provide appropriate infrastructure to protect those not infected (including nurses) from becoming infected
Inadequate health infrastructure and equipment to offer effective services.	• Construct appropriate health facilities that are responsive to current health needs • Build accommodation for healthcare providers at each health facility, especially in remote rural areas
IEC materials are mostly confined to health facilities and not in the community.	• Urgently roll out Community Based Health Care Extension (currently at pilot stage in Kavango and Kunene) • Continue to mobilise and involve CBOs and NGOs, while Government should seek avenues to support CSOs financially • Training needs to be provided to Community Health Committees
Suboptimal functional collaboration between TB and HIV programmes.	• Strengthen coordination of responses between TB, HIV and other vector diseases
Poor accessibility of TB diagnostic services and DOTs observers due to distance from clinics.	• Bring medical care closer to the people with innovative strategies such as the use of Community Health Extension Workers
Unaddressed social factors, such as poverty, unemployment, overcrowding, smoking, silicosis, alcoholism, overcrowding and unemployment.	• Apply recommendations under MDGs 1, 2 and 3

Namibia:The way forward - Progress on the Health-Related MDGs/fr

Le contenu en Français sera bientôt disponible.

MDG1 :

Challenges	Interventions to expedite MDG implementation
Food insecurity and malnutrition at household level have a negative effect on overall development, most specifically for children.	• Raise awareness of household food security programmes • Food aid in the form of drought relief food or food-for-work should be directed to the most vulnerable first • Scale up the school feeding programme to provide for all children and not only OVC • Raise budget allocations for food production programmes, such as the Green Scheme and Dry Land Agricultural Programme • Continue to raise awareness of the most appropriate breastfeeding practices and improved nutrition for children and their mothers • Raise awareness about the importance of consuming fortified foods • De-worm all children between 1 and 5 years of age
Namibia has a long-standing and well-established social grant system but the distribution of the number of grants and amounts paid per person are still relatively low. The coverage of social grants is affected by inefficient budgets, but also the inability of eligible persons to gain access to such grants. Additionally, poverty stricken children who are not classified as orphans and many extremely poor households are not covered by current social grants.	• Speed up the registration and issuing of vital documents to enhance access to social grants • “More social workers are needed and they need to be freed up from administrative work in order to focus on child protection issues” (NDP 4:63) • Expand the social grant system to include children in poor and severely poor households • Social grants should be increased annually as inflation increases and the increments need to be higher than inflation because the individual payments are small in number • Reconsider the commencement of the Basic Income Grant (BIG)
Ongoing corruption and mismanagement of public funds are serious challenges, given that theft of public funds takes away resources geared towards development of the nation, especially the poor.	• Implement the Zero Tolerance for Corruption strategy more effectively
Strategies need to be designed in such a fashion that beneficiaries of poverty reduction programmes are active participants in their own development. Programmes and projects need to be designed in such a fashion that they do not increase dependency on government and other external support, but enhance self-sufficiency.	

MDG4:

Several road maps have been developed and workshops facilitated to accelerate the reduction of child mortality in the country's effort to reach MDG 4 by 2015. These have resulted in the design of strategies and the current implementation of a number of initiatives. Some of the key challenges and a set of recommendations towards expediting implementation and improving Namibia's chances of achieving this Goal within the remaining two year period are outlined below. The overall recommendation is based on the need for the public health sector to become more proactive in its responses.

Challenges	Interventions to expedite MDG implementation
The state of health infrastructures is such that there is a public outcry for improvement in buildings, equipment, water, sanitation, electricity and other facilities	• Urgent attention needs to be paid to the condition of infrastructure in public hospitals, health centres and clinics • An increased budget allocation is needed for regular maintenance of health infrastructure but such funds need to be well used, starting with a tendering process that is efficient and provides value for money • Increase the number of maternal waiting homes near major hospitals
While generally a good quality service is provided, some ineffective and inefficient management of health service provision at national, regional, district and local levels has contributed to lower quality health provision, especially as it relates to child health. This includes management of staff shortages.	• Strengthen the capacity of health management teams to plan, manage, implement, monitor and evaluate • An in-depth assessment is needed to determine the qualifications of health managers, with recommendations to strengthen overall management • Strengthen the Reproductive and Child Health sub-division • Enhance the capacity of personnel and infrastructure to provide AFHS • Strengthen follow-up mechanisms, including tracking of mothers and children through the health system
Lack of basic skills among some nurses to prevent child mortality, noting that a large proportion of newborn deaths is preventable. In addition, the undesirable attitude of some health personnel towards patients, discourage some from seeking medical support unless absolutely necessary.	• In-service training needs to be strengthened • Self-assessment tools that are already in place need to be utilised
Referral systems are weakened by poor communication between health service providers and patients, and lack of transportation to referral health facilities	• Establish community health committees and emergency committees to support access to health facilities and referrals • Such committees need to establish appropriate communication and transportation mechanisms relevant to an area and based on local resources • Roll out the Community Health Extension Officer programme currently being piloted in five regions
Difficult access to health services, especially for severely poor and marginalised groups	• Planning for infrastructure development needs to be based on current and projected future geographical distribution of people • Sufficient allocation of public funds needs to be allocated to infrastructure development • All health service providers need to be informed about the exemption of OVC so that is applied consistently • The exemption needs to be revised to include the severely poor as well, especially as some OVC are better off than some severely poor • Community Health Committees need to be established to improve access through better coordinated transportation and communication with health service providers

Low awareness of maternal and child health, especially in remote and poor areas, contributes to higher mortality rates in such regions.	• Promote maternal and child healthcare • Promotion of the involvement of the entire family in maternal and child health, especially involvement of males • Develop and disseminate culturally sensitive information, education and communication (IEC) materials on child health, prenatal care, postnatal care, PMTCT and family planning • A rights-based approach to awareness raising is needed, ensuring that parents know their own and their children's health rights • Continue to raise awareness of the importance of child immunisation • Expand health extension workers services to all thirteen regions to bridge the gap between facilities and the communities needing access
Illegal and unsafe abortions and baby-dumping contribute to increased child and maternal mortality.	• Raise awareness about abortions and baby-dumping, while current legislation is reviewed to decrease unsafe abortions and baby dumping
The existing M&E system is not used optimally to plan for child health.	• Strengthen the M&E of the Health Management Information System (HMIS) to make data more frequently available • Capacitate health professionals and administrators to apply available data from HMIS

Looking Beyond 2015

Improve skills, experience and the work environment	It is necessary to empower health professionals with skills and experience, and to provide a conducive working environment that will decrease the attrition levels of health professionals. Therefore: • Child-centred health approaches need to be understood and adopted across the healthcare system • Equip paediatric health professionals and semi-professionals with adequate knowledge and skills, including the interpersonal skills appropriate to working with children and parents • Equip ancillary workers, such as cleaners, with the knowledge and skills appropriate to a health facility through adequate training on the linkages between cleanliness and spread of viruses, and other relevant issues • Continuous evaluation of staff performance is needed and performance should be disciplined or rewarded on the basis of merit, including a system based on evaluation by patients • Involve the private sector in contributing to training of health professionals, as the public health sector plays an essential role in ensuring a healthy workforce • Strengthen local training institutions to prepare and provide qualified nurses for the sector, to reduce the cost of sending nurses to other countries for training • Provide housing to nurses who work in rural areas • Increase remuneration to decrease attrition of health professionals
Maintain 100% immunisation of under-fives	An immunisation programme is in place and has had a positive impact on infant and child mortality, but immunisation coverage is uneven in terms of diseases combated and geographical area. Therefore: • Continue to implement the Extended Programme for Immunisation (EPI) • Concentrate more on those regions that show lower numbers, while maintaining the higher numbers in others
Make optimal use of HMIS	It is necessary to strengthen the M&E system of the HMIS to ensure that data are available on request. Therefore: • Produce and make available reviews of every child death to inform future prevention, care and support • Data should be used at all levels, but special efforts should be made to get regional, district and hospital/clinic/health centre levels to use such data to improve services • The M&E system should be used to identify priority areas for improvement in relation to available resources • Importantly, data should be used to engage the community in preventive measures

Revise health budget allocation	Currently 88 percent of the MOHSS budget is allocated to operational costs (mostly salaries), and only 2 percent to primary healthcare. Therefore: • The budget needs to be results-driven, focusing on key priorities, and internal budget allocations also need to be linked to results • Budget allocations should be needs-driven
Provide alternative health services	Provision of alternatives to the current public and private services would increase the availability of healthcare generally and enhance user access and options. Therefore: • Assess opportunities for public-private partnerships • Assess opportunities to use NGOs and FBOs to provide health services, thereby reducing pressure on public health service infrastructure • Build on existing best practice for involving NGOs, FBOs and CBOs in strengthening the national health outreach programme
Strengthen coordination between sectors and with CSOs	Responding to child health cuts across different sectors, requires multi-sectoral coordinated approaches. Coordination of different sectors continues to be a challenge. Therefore: • Strengthen coordination between vital sectors such as health, water, sanitation and education • Enhance collaboration and coordination with CSOs, for outreach and support services
Respond to poverty and HIV	Many constraints to healthcare provision and access occur as a result of either poverty or HIV, and as a result of the interrelationship between these two factors. Therefore: • Continue to provide HIV prevention, treatment, and care and support services in collaboration with civil society organisations • Strengthen the social protection systems to include all poor and severely poor children
Respond proactively to the impacts of climate change	The impacts of climate change are increasingly visible, particularly evident as recurring droughts in southern regions and floods in northern regions. Therefore: • Proactively prepare for and be ready to respond to negative impacts imposed by climate change, such as changing to drought resistant grains, moving vulnerable population before floods commence, etc. • Emergency programmes of food aid in times of drought need to be continued, with more efficient distribution mechanisms.

MDG5 :

Challenges	Interventions to expedite MDG implementation
The human resource challenges include shortage of skilled health workers, high attrition, language barriers between patients and some health professionals, and shortage of basic lifesaving skills among nurses.	• Design a health professional human resources development plan • Improve retention of health professionals with strategies such as scarce skills allowance, rural hardship allowance, and staff housing especially in rural areas • Accelerate training of all health workers, and design a long-term training plan • Build capacity of all categories of reproductive health service providers, including traditional birth attendants, nurses, midwives, etc.
Essential medicines including ergometrine, oxytocin, MgSO4 and others are unavailable at lower levels of healthcare delivery.	• Ensure the availability and maintenance of essential medicines and equipment at all MCH centers
Health infrastructure is not appropriate to providing all required services.	• Design clinics that cater appropriately for all health needs • Expand maternal waiting rooms
Slow implementation of decentralisation.	• Speed up the decentralisation and devolution of power to regions and districts, with appropriate budget allocation

Community outreach is challenged by limited male involvement, weak referral systems and the difficulty of maintaining momentum.	• Strengthen male involvement in sexual and reproductive health • Strengthen the already established AFHSs, Namibia Planned Parenthood Association, Multi-Purpose Youth Centres, etc., which provide a wide range of reproductive health services • Expand access to midwifery care in the community and use midwives as an avenue for awareness raising • Raise the level of family planning uptake, especially long-term methods, and continue reducing the prevalence of unmet need for contraceptives • Improve the referral system for responding to maternal emergencies • Institutionalise regular monitoring and evaluation at all levels of the healthcare delivery system
Monitoring and evaluation	• Emphasise the routine collection and processing of data on process indicators for monitoring progress towards maternal mortality reduction, in the context of Namibia's Road Map for Accelerating the Reduction of Maternal and Neonatal Morbidity and Mortality, using indicators set out in the Road Map and the Neonatal Health HMIS

Looking Beyond 2015

Infrastructure development and maintenance	The development and maintenance of infrastructure is a major challenge that will require continuous focus. Therefore: • Promote and increase public and private financial investment in infrastructure for maternal healthcare, particularly clinics and health centres in rural and remote areas, including procurement of EmOC equipment, expansion of health posts in rural areas, construction of accommodation in remote areas and provision of maternal waiting rooms • Support infrastructure enhancements by improving provision of water and sanitation
Improve skills of health professionals responsible for maternal health	The fact that nurses and nurse midwives are not allowed to provide basic EmOC has proven to be restrictive in the provision of maternal healthcare. Therefore: • Revise and implement the long-term human resource strategy with key stakeholders such as line ministries, tertiary institutions and national and international development partners • With training and acquisition of improved knowledge and skills by nurses and mid-wives, change policy that would allow them to take on additional EmoC services • Continue to expand the cadre of community health extension officers
Strengthen community outreach	Community health extension officers programmes piloted in some regions have improved the quality of and access to health services. Therefore: • Extend the Community Health Care Extension Officers initiative • Enhance collaboration and coordination with CSOs, including co-financing their support services
Respond proactively to the impacts of climate change	The impacts of climate change are increasingly visible, particularly evident as recurring droughts in southern regions and floods in northern regions. Therefore: • Proactively prepare for and be ready to respond to negative impacts imposed by climate change, such as changing to drought resistant grains, moving vulnerable populations before floods commence, etc. • Emergency programmes of food aid in times of drought need to be continued, with more efficient distribution mechanisms
The combined impact of HIV and poverty in Namibia is severely undermining Government's efforts to reduce maternal mortality	With low immunity caused by HIV and poor nutrition due to poverty, many women succumb to diseases such as malaria and tuberculosis (TB). Therefore: • Strengthen integration of reproductive health, HIV and AIDS and PMTCT, TB and malaria services • Provide family planning as a component of the maternal, newborn and child health service package • Integrate recommendations from MDG1 for poverty alleviation

MDG6 :

Challenges	Interventions to expedite MDG implementation
While extensive progress has been made with provision of ART, care and support, challenges remain with adherence, effectiveness of treatment due to inadequate nutrition for PLHIV who are on treatment, staff shortages, inadequate capacity of CSOs, and community outreach.	• Strengthen task shifting/sharing by increasing numbers of IMAI trained nurses with knowledge and skills to initiate ART • Use of point-of-care diagnostics needs to be expanded • Enhance scale-up towards increased geographical coverage to health centres and larger clinics • Continue with quality improvement activities, enhancing adherence to treatment and improving retention in care • Strengthen capacity of CSOs to deliver adherence support, such as an umbrella body for PLHIV organisations
Key challenges experienced by the PMTCT programme include slow roll-out of PMTCT Prongs 1 and 2, HIV and infant feeding, effective implementation of PMTCT Option B+, quality of services and adherence of clients to PMTCT services.	• Expand PMTCT to remaining health facilities with ANC facilities • Intensify efforts set for elimination of MTCT by 2015/16 • Improve quality of service for each of the four PMTCT prongs as well as critical enablers and synergies • Special focus on “undeserved and most at risk populations”, such as PLHIV, sero-discordant couples, adolescents and rural populations (MOHSS, 2013:16) • Build community systems critical for PMTCT performance in collaboration with CSOs • Roll out implementation of the national HIV and infant feeding guidelines
Slow uptake of voluntary medical male circumcision (VMMC) with a coverage of 21 percent in 2008.	• Expedite implementation of the National Policy on Male Circumcision for HIV Prevention of 2010 • Finalise the VMMC Draft Strategy and Implementation Plan to operationalise the policy
Although Namibia has a generalised epidemic, key populations (MSM, commercial sex workers, prisoners) are significant drivers of the epidemic due to stigma and discrimination, high risk behaviours, and poor access to services.	• Continue with current prevention, treatment, and care and support interventions for MSM, CSWs and prisoners
Due to Namibia's upper-middle income country status, donor funding is decreasing.	• The sustainability plan needs to be finalised and put into action to ensure increased efficiencies and effectiveness in the national response, and sufficient funds to keep the existing momentum in the country’s HIV response • This is especially important for civil society contribution to the response • Integrate investment approaches based on clear evidence of greatest impact • Strengthen cost effectiveness and efficiency
Namibia has a functional M&E framework but there is high staff turn-over and inefficient use of available staff, the quality of data collected is poor and there is a lack of HIV population based survey and programme evaluations to provide evidence for programme design, planning, implementation and M&E.	• Provide more attractive incentives for qualified M&E officers to remain in regions, for example, performance award incentives such as M&E Officer of the Year with a prize that could include additional training, a scholarship or money • Triangulation and verification measurements need to be strengthened at all levels • Carry out HIV population based bio-behavioural surveys • Surveys need to be carried out to inform the NSF, MDGs and 2011 UN Political Declaration

Looking Beyond 2015

Prevention	• Invest in high impact interventions, such as VMMC, treatment as prevention, PMTCT (option B22), social condom marketing and contribution, HIV counselling testing, social and behaviour change communication, and alcohol abuse programmes, and strive for the elimination of MTCT • Enhance involvement of PLHIV • Target most at risk populations, such as men having sex with men, commercial sex workers, mobile populations, uniformed people, and those in MCPs • Strengthen male involvement in prevention interventions, such as PMTCT and couple counselling and testing for HIV • Strengthen community mobilisation, using local NGOs, FBOs, and CBOs • Integrate HIV into SRH and primary healthcare and phase out vertical programmes • The condom procurement and promotion strategy should be finalised and implemented, while it is essential for condom promotion and distribution to be part of reproductive health and family planning
Treatment, care and support	• Scale up ART provision, especially with the WHO guideline to increase the CD4 count for treatment enrolment to 350, including recruitment and training of more health workers, and giving the utmost importance to quality of care during scale-up • Strengthen early warning indicators for HIV drug resistance at facility level • ART literacy needs to be expanded, especially in rural and remote areas • Engage local NGOs, CBOs and FBOs to expand care and support, which will require financial support from central government to CSOs • Revise home-based care policy and align it with other relevant interventions at community level, given that many PLHIV are no longer chronically or terminally ill • Expedite the plan to appoint Community Health Care Extension Officers at constituency levels
Impact mitigation	• The most vulnerable and susceptible households need to be targeted first, including the poor and severely poor, child-headed households, households caring for OVC, the disabled, households headed by the elderly and households in remote areas • Expand income-generating activities for PLHIV and other vulnerable population groups • Expand the social grant system to include all poor and severely poor households and increase the value of the social grants to bring them into line with the current economic situation • Recruit and train more social workers, and use lay persons to reduce the pressure on social workers • Improve services provided at Namibia Children's Home, but at the same time strive to place children in need in conducive family home environments • Expedite the plan to appoint Community Health Care Extension Officers at constituency levels • Strengthen ECD, especially in rural and remote areas
Management of coordination	• Strengthen networking, collaboration and coordination between all sectors • Strengthen mainstreaming of HIV responses across sectors, ensuring that Focal Persons are those who have decision-making authority to influence effective mainstreaming • Put in place effective workplace programmes and structures • While wellness issues are included in sectoral strategic plans, a national Wellness Policy for the public sector is needed to guide mainstreaming and workplace programming • HIV and AIDS units need capacity building and more authority to influence decision-making • Motivate the finalisation and passing of the Child Care and Protection Bill • Strengthen child care and protection forums • Strengthen the overall M&E system to monitor and evaluate mainstreaming of HIV responses • The sustainability plan needs to be finalised and put into action to ensure increased efficiencies and effectiveness in the national response and sufficient funds to keep the existing momentum in the country's HIV response, especially to motivate continuing civil society contribution to the response • The private health sector and other private sector companies need to strengthen their investment in HIV responses • Re-establish an umbrella body for PLHIV with strong monitoring, evaluation and quality control mechanisms • Integrate HIV into overall SRH, maternal health and primary healthcare

Challenges	Interventions to expedite MDG implementation
Shortage of staff at national, regional, district and health facility levels, and lack of training of all health workers in case management and diagnosis.	• Accelerate the proposed restructuring process for NVDCP specifically, including Malaria Elimination Officers • Employ additional spray operators • Expand annual training in case management and diagnosis to all health workers
Information challenges, including lack of a proper GIS for malaria specifically, no effective information management system for malaria, poor reporting from regions, and no active surveillance system.	• Purchase GIS hardware and provide most appropriate training via internal technical support • Establish, with the support of HMIS, an effective information management system for malaria • Establish an active surveillance system
Absence of annually updated Malaria Epidemic Preparedness Plan.	• Annual updates of the malaria preparedness plan, especially for district levels
Expiration of ITNs delivered more than three years ago.	• Expand and strengthen the procurement and distribution of insecticide-treated nets • Establish a procurement and supply management system
Limited IEC materials at regional, district and community levels	• Design standardised clinical algorithms (procedures) and posters for health workers • Design, produce and disseminate IEC materials that are age, sex and culturally appropriate
Shortage of community support programmes.	• Health extension workers could take on some of the community mobilisation tasks • Continue with national advocacy days • Appoint a focal person responsible for health promotion and communication • Harmonise malaria messages developed by different partners • Improve awareness raising on risk perception and prevention methods • Improve awareness of appropriate ways of using nets
Logistical challenges overall, but most specifically for spraying activities.	• Strengthen logistical support in relation to transportation and supervision
Lack of cross-border initiatives with Zambia, Botswana, Angola and Zimbabwe.	• Establish other cross-border initiatives similar to the Trans-Kunene Malaria Initiative

Looking Beyond 2015

With the programme re-orientation from malaria control to elimination, it is essential sustain and scale up malaria prevention, treatment and management at all levels.

Review indicators	• The second indicator with regard to mosquito nets needs to be changed to use of mosquito nets by under-five year olds and not universal coverage because nets have been distributed extensively but the actual use of the nets is still a challenge • The incidence of malaria indicator should also be revised to bring it into line with the elimination strategy
Strengthen advocacy	It is necessary to continue to sensitise and mobilise all partners to support the malaria elimination campaign. Therefore: • Strengthen high-level advocacy to sustain and scale up malaria interventions towards elimination • Sustain current partnerships as these are essential for technical and programmatic interventions • Strengthen partnerships with community organisatons and campaigns
Improve information and surveillance	An information and surveillance system should be able to, "accurately estimate the burden of disease, to measure trends over time, to evaluate coverage and quality of interventions, to identify geographical and seasonal distribution of cases and to detect epidemics in a timely manner" (MOHSS, 2010d:8). Therefore: • Design, establish and implement a comprehensive information and surveillance system
Sustain financial and human resources	• Continue with mobilisation of additional domestic funds to assist in the implementation of malaria elimination • Strengthen the overall health system to reduce attrition • Strengthen public-private-partnerships
Mitigate climate change impacts on malaria programming and access to services	• Respond proactively to climate change and climate shocks, and continue to conduct assessments to determine impacts

Challenges	Interventions to expedite MDG implementation
Inadequate institutional and human resource capacity (including specialists), and high staff turnover.	• The Public Commission needs to create a position at hospitals specifically catering for TB • Import specialist health skills, while Namibians are being capacitated • Reintroduce the bush allowance for those working in remote areas • Get laboratories to provide surveillance as well as clinical functions such as diagnosis
Limited TB workplace safety measures for health workers.	• Provide adequate ventilation in wards and other areas • Provide appropriate infrastructure to protect those not infected (including nurses) from becoming infected
Inadequate health infrastructure and equipment to offer effective services.	• Construct appropriate health facilities that are responsive to current health needs • Build accommodation for healthcare providers at each health facility, especially in remote rural areas
IEC materials are mostly confined to health facilities and not in the community.	• Urgently roll out Community Based Health Care Extension (currently at pilot stage in Kavango and Kunene) • Continue to mobilise and involve CBOs and NGOs, while Government should seek avenues to support CSOs financially • Training needs to be provided to Community Health Committees
Suboptimal functional collaboration between TB and HIV programmes.	• Strengthen coordination of responses between TB, HIV and other vector diseases
Poor accessibility of TB diagnostic services and DOTs observers due to distance from clinics.	• Bring medical care closer to the people with innovative strategies such as the use of Community Health Extension Workers
Unaddressed social factors, such as poverty, unemployment, overcrowding, smoking, silicosis, alcoholism, overcrowding and unemployment.	• Apply recommendations under MDGs 1, 2 and 3

Looking Beyond 2015

The main themes to focus on beyond 2015, in line with the MTP II for TB and Leprosy, are detailed below.

Strengthen human resources	Continued availability and efficient use of qualified and competent staff at all levels of the programmes will contribute to their success. Therefore: • Efficient use of existing staff is paramount, taking into consideration the continued shortage of skilled personnel in specialised fields • Design innovative ways in which to attain specialists, such as better remuneration and incentives for working in remote rural areas • Staff on development partner support need to be converted to fulltime government funded positions • Dedicated positions at regional and district levels need to be created for TB and leprosy
Increase financial resources	Financial resources need to be provided in a proactive and timely manner. Therefore: • With projected reduced funding from external forces, Government needs to increase internal funding • Ensure more efficient use of scarce financial resources
Continue political commitment	• Continued political commitment is needed to create appropriate institutional structures, especially for an ever changing health profile
Effective programme governance	• Continue to strengthen management structures and systems for human, financial, infrastructural and technological development
Negative impacts of climate change	Climate events such as droughts and floods have negative impacts in two different ways: 1) droughts may affect a person's ability to continue treatment with decreased availability of nutritious foods; and 2) floods not only increase susceptibility to infection, but also hinder access to health facilities for treatment, care and support. Therefore: • Respond proactively to climate change and continue to conduct assessments to determine impacts

Namibia:Other MDGs/fr

Le contenu en Français sera bientôt disponible.

This analytical profile on Other MDGs is structured as follows:

- Analytical summary
- MDG Goal 1: Eradicate extreme poverty and hunger
- MDG Goal 2: Achieve universal primary education
- MDG Goal 3: Promote gender equality and empower women
- MDG Goal 7: Ensure environmental sustainability
- MDG Goal 8: Develop a global partnership for development
- Issues and challenges
- The way forward
- Endnotes: sources, abbreviations, etc

Le Système de Santé

Namibia:The Health System/fr

Le contenu en Français sera bientôt disponible.

Health systems are defined as comprising all the organizations, institutions and resources that are devoted to producing health actions. A health action is defined as any effort, whether in personal health care, public health services or through intersectoral initiatives, whose primary purpose is to improve health. But while improving health is clearly the main objective of a health system, it is not the only one. The objective of good health itself is really twofold: the best attainable average level – goodness – and the smallest feasible differences among individuals and groups – fairness. Goodness means a health system responding well to what people expect of it; fairness means it responds equally well to everyone, without discrimination

National health systems have three overall goals:
1. good health,
2. responsiveness to the expectations of the population, and 3. fairness of financial contribution.

WHO describes health systems as having six building blocks: service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance (stewardship). The 2008 Ouagadougou Declaration on Primary Health Care and Health Systems in Africa focuses on nine major priority areas, namely Leadership and Governance for Health; Health Services Delivery; Human Resources for Health; Health Financing; Health Information Systems; Health Technologies; Community Ownership and Participation; Partnerships for Health Development; and Research for Health.

This section of the analytical profile is structured along the lines of the WHO Framework and the priorities described by the 2008 Ouagadougou Declaration.

3	The Health System
3.1	Health system outcomes
3.2	Leadership and governance
3.3	Community ownership and participation
3.4	Partnerships for health development
3.5	Health information, evidence and knowledge
3.6	Research
3.7	Health financing system
3.8	Service delivery
3.9	Health workforce
3.10	Medical products, vaccines, infrastructures and equipment
3.11	General country health policies
3.12	Universal coverage

Namibia:Health system outcomes/fr

Le contenu en Français sera bientôt disponible.

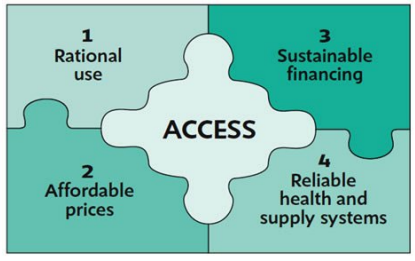
Health systems have multiple goals.[1] *The world health report 2000*[2]defined overall health system outcomes or goals as improving health and health equity in ways that are:

- responsive
- financially fair
- make the best, or most efficient, use of available resources.

There are also important intermediate goals: the route from inputs to health outcomes is through achieving greater access to, and coverage for, effective health interventions without compromising efforts to ensure provider quality and safety.

Countries try to protect the health of their citizens. They may be more or less successful, and more or less committed, but the tendency is one of trying to make progress, in three dimensions:

- First, countries try to broaden the range of benefits (programmes, interventions, goods, services) to which their citizens are entitled.
- Second, they extend access to these health goods and services to wider population groups and ultimately to all citizens: the notion of universal access to these benefits.



The health systems access framework[3]

- Finally, they try to provide citizens with social protection against untoward financial and social consequences of taking up health care. Of particular interest is protection against catastrophic expenditure and poverty.

In health policy and public health literature, the shorthand for these entitlements of universal access to a specified package of health benefits and social protection is universal coverage.

This section of the health systems profile is structured as follows:

3.1.2 General overview and systemic outcomes

3.1.2.1 Overall health system status

3.1.2.2 Achievement of the stated objectives of the health system

3.1.2.3 The distribution of health system's costs and benefits across the population

3.1.2.4 Efficiency of resource allocation in health care

3.1.2.5 Technical efficiency in the production of health care

3.1.2.6 Quality of care

3.1.2.7 Contribution of the health system to health improvement

3.1.3 Priorities and ways forward

References

[1] Everybody's business. Strengthening health systems to improve health outcomes. WHO's framework for action (pdf 843.33kb). Geneva, World Health Organization, 2007 (http://www.who.int/healthsystems/strategy/everybodys_business.pdf)

[2] The world health report 2000. Health systems: improving performance (pdf 1.65Mb). Geneva, World Health Organization, 2000 (http://www.who.int/whr/2000/en/whr00_en.pdf)

[3] The world medicines situation (pdf 1.03Mb). Geneva, World Health Organization, 2004 (http://apps.who.int/medicinedocs/pdf/s6160e/s6160e.pdf)

Namibia:Leadership and governance - The Health System/fr

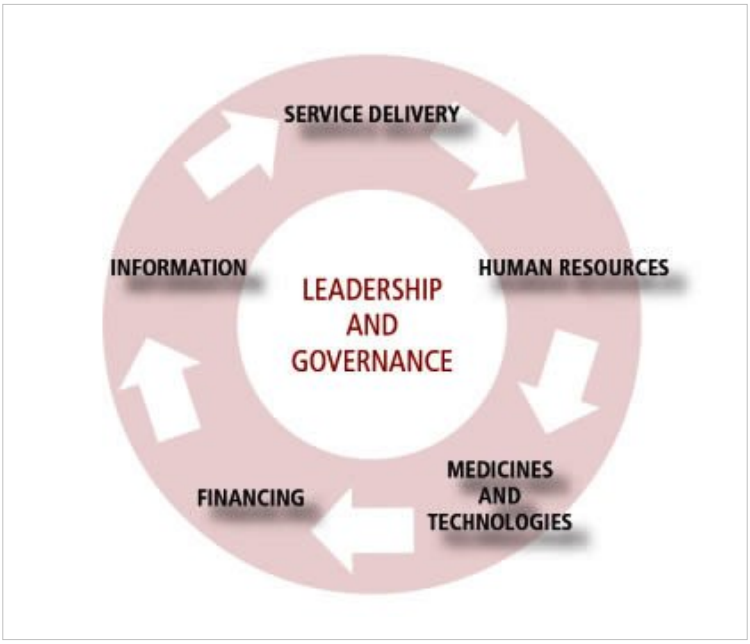
Le contenu en Français sera bientôt disponible.

The leadership and governance of health systems, also called stewardship, is arguably the most complex but critical building block of any health system.[1] It is about the role of the government in health and its relation to other actors whose activities impact on health. This involves overseeing and guiding the whole health system, private as well as public, in order to protect the public interest.

It requires both political and technical action, because it involves reconciling competing demands for limited resources in changing circumstances, for example with rising expectations, more pluralistic societies, decentralization or a growing private sector. There is increased attention to corruption and calls for a more human rights based approach to health. There is no blueprint for effective health leadership and governance. While ultimately it is the responsibility of government, this does not mean all leadership and governance functions have to be carried out by central ministries of health.

Experience suggests that there are some key functions common to all health systems, irrespective of how these are organized:

- *Policy guidance*: formulating sector strategies and also specific technical policies; defining goals, directions and spending priorities across services; identifying the roles of public, private and voluntary actors and the role of civil society.
- *Intelligence and oversight*: ensuring generation, analysis and use of intelligence on trends and differentials in inputs, service access, coverage, safety; on responsiveness, financial protection and health outcomes, especially for vulnerable groups; on the effects of policies and reforms; on the political environment and opportunities for action; and on policy options.
- *Collaboration and coalition building*: across sectors in government and with actors outside government, including civil society, to influence action on key determinants of health and access to health services; to generate support for public policies and to keep the different parts connected – so called "joined up government".
- *Regulation*: designing regulations and incentives and ensuring they are fairly enforced.
- *System design*: ensuring a fit between strategy and structure and reducing duplication and fragmentation.
- *Accountability*: ensuring all health system actors are held publicly accountable. Transparency is required to achieve real accountability.



An increasing range of instruments and institutions exists to carry out the functions required for effective leadership and governance. Instruments include:

- sector policies and medium-term expenditure frameworks
- standardized benefit packages
- resource allocation formulae
- performance-based contracts
- patients' charters
- explicit government commitments to non-discrimination and public participation
- public fee schedules.

Institutions involved may include:

- other ministries, parliaments and their committees
- other levels of government
- independent statutory bodies such as professional councils, inspectorates and audit commissions
- nongovernment organization "watch dogs" and a free media.

This section of the health system profile is structured as follows:

3.2.5 Regulation, monitoring and evaluation

3.2.5.1 Regulation – legislation

3.2.5.2 International health regulation

3.2.5.3 Monitoring and evaluation

3.2.6 Priorities and ways forward

3.2.7 Others

References

[1] Everybody's business. Strengthening health systems to improve health outcomes. WHO's framework for action (pdf 843.33kb). Geneva, World Health Organization, 2007 (http://www.who.int/healthsystems/strategy/everybodys_business.pdf)

Namibia:Community ownership and participation - The Health System/fr

Le contenu en Français sera bientôt disponible.

Health systems can be transformed to deliver better health in ways that people value: equitably, people-centred and with the knowledge that health authorities administer public health functions to secure the well-being of all communities. These reforms demand new forms of leadership for health. The public sector needs to have a strong role in leading and steering public health care reforms and this function should be exercised through collaborative models of policy dialogue with multiple stakeholders, because this is what people expect and because it is the most effective.

A more effective public sector stewardship of the health sector is justified on the grounds of greater efficiency and equity. This crucial stewardship role should not be misinterpreted as a mandate for centralized planning and complete administrative control of the health sector. While some types of health challenges, for example public health emergencies or disease eradication, may require authoritative command and control management, effective stewardship increasingly relies on “mediation” to address current and future complex health challenges.

The interests of public authorities, the health sector and the public are closely intertwined. Health systems are too complex: the domains of the modern state and civil society are interconnected, with constantly shifting boundaries. Effective mediation in health must replace overly simplistic management models of the past and embrace new mechanisms for multi-stakeholder policy dialogue to work out the strategic orientations for primary health care reforms.

At the core of policy dialogue is the participation of the key stakeholders. Health authorities and ministries of health, which have a primary role, have to bring together:

- the decision-making power of the political authorities
- the rationality of the scientific community
- the commitment of the professionals
- the values and resources of civil society.

This is a process that requires time and effort. It would be an illusion to expect primary health care policy formation to be wholly consensual, as there are too many conflicting interests.

Community ownership and participation[1]

However, experience shows that the legitimacy of policy choices depends less on total consensus than on procedural fairness and transparency. Without a structured, participatory policy dialogue, policy choices are vulnerable to appropriation by interest groups, changes in political personnel or donor fickleness. Without a social consensus, it is also much more difficult to engage effectively with stakeholders whose interests diverge from the options taken by primary health care reforms, including vested interests such as those of the tobacco or alcohol industries, where effective primary health care reform constitutes a direct threat.

This section of the health system profile is structured as follows:

3.3.1 Analytical summary

3.3.2 Participation as an individual, and user and provider interactions

3.3.2.1 Health literacy levels

3.3.2.2 People-centredness of care

3.3.2.3 Satisfaction with consultation processes

3.3.2.4 Patient health care behaviours

3.3.2.5 Structural issues

3.3.3 Local community mobilization

3.3.3.1 Services design issues at locality

3.3.3.2 Accountability of health services to locality and community watchdog functions

3.3.4 Civil society involvement

3.3.4.1 As a partner in policy-making

3.3.4.2 Accountability and "watchdog" functions

References

[1] Systems thinking for health systems strengthening (pdf 1.54Mb). Geneva, World Health Organization, 2009 (http://whqlibdoc.who.int/publications/2009/9789241563895_eng.pdf)

Namibia:Partnerships for health development - The Health System/fr

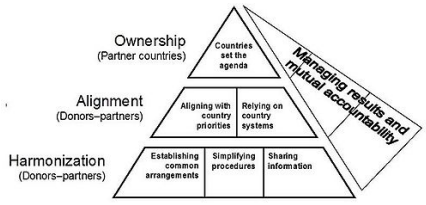
Le contenu en Français sera bientôt disponible.

There is a tension between the often short-term goals of donors, who require quick and measurable results on their investments, and the longer-term needs of the health system.[1] That tension has only heightened in recent years, where the surge in international aid for particular diseases has come with ambitious coverage targets and intense scale-up efforts oriented much more to short-term than long-term goals. Though additional funding is particularly welcome in low-income contexts, it can often greatly reduce the negotiating power of national health system leaders in modifying proposed interventions or requesting simultaneous independent evaluations of these interventions as they roll out.

Harmonizing the policies, priorities and perspectives of donors with those of national policy-makers is an immediate and pressing concern – though with apparent solutions. In addition, the selective nature of these funding mechanisms (e.g. targeting only specific diseases and subsequent support strategies) may undermine progress towards the long-term goals of effective, high-quality and inclusive health systems.

Even where this funding has strengthened components of the health system specifically linked to service delivery in disease prevention and control – such as specific on-the-job staff training – the selective nature of these health systems strengthening strategies has sometimes been unsustainable, interruptive and duplicative. This puts great strain on the already limited and overstretched health workforce. In addition, focusing on "rapid-impact" treatment interventions for specific diseases and ignoring investments in prevention may also send sharply negative effects across the system's building blocks, including, paradoxically, deteriorating outcome on the targeted diseases themselves.

Many of these issues have been recognized internationally, and a number of donors have agreed to better harmonize their efforts and align with country-led priorities – as outlined in the 2005 Paris Declaration on Aid Effectiveness [3] (see figure). However, although some progress has been made in applying the Paris Declaration principles, it has been slow and uneven. Change in the process and the nature of the relationship between donors and countries requires time, focused attention at all levels, and a determined political will.



Five mutually reinforcing principles of the Paris Declaration on Aid Effectiveness (2005)[2]

This section of the health system profile is structured as follows:

3.4.1 Analytical summary

3.4.2 Partnership for health and coordination mechanisms

3.4.2.1 Partnership coordination mechanisms

3.4.2.2 Main partners by category, objectives and powers

3.4.3 Harmonization and alignment in line with primary health care approach

3.4.3.1 Explicit policy on partners' coordination

3.4.3.2 Explicit policy on intersectoral collaboration and action

3.4.3.3 Major actions carried out through intersectoral collaboration

3.4.3.4 Stakeholders mapping by level and coordination structures

3.4.3.5 Community awareness and involvement in the implementation of global initiatives – Millennium Declaration, Paris Declaration, etc.

3.4.4 Sector-wide approaches

3.4.4.1 Multi-Donor Budget Support

3.4.4.2 International Health Partnership and related initiatives (IHP+)/development of National Health Compacts

3.4.4.3 Harmonization for Health in Africa

3.4.4.4 Joint Assistance Strategy

3.4.5 Public–private partnership and civil society

3.4.5.1 Private health sector mapping

3.4.5.2 Explicit policy on private sector involvement

3.4.5.3 Forms of engagement with private sector including contractual service agreements

3.4.6 South–South cooperation

3.4.6.1 Existence of formalized South–South cooperation

3.4.6.2 Mapping of areas of cooperation especially those related to health development

3.4.6.3 Experiences to be shared regarding the South–South cooperation

References

[1] Systems thinking for health systems strengthening (pdf 1.54Mb). Geneva, World Health Organization, 2009 (http://whqlibdoc.who.int/publications/2009/9789241563895_eng.pdf)

[2] The Paris Declaration on Aid Effectiveness (2005) (http://www.oecd.org/development/effectiveness/34428351.pdf)

[3] http://www.unrol.org/files/34428351.pdf

Namibia:Health information, research, evidence and knowledge/fr

Le contenu en Français sera bientôt disponible.

Data are crucial in improving health.[1] The ultimate objective of collecting data is to inform health programme planning as well as policy-making and, ultimately, global health outcomes and equity. A well-functioning health information system empowers decision-makers to manage and lead more effectively by providing useful evidence at the lowest possible cost.

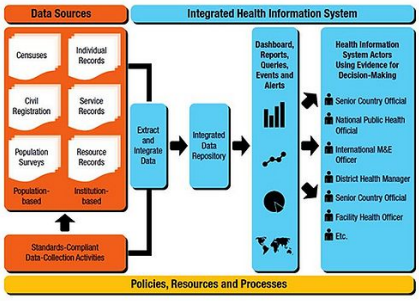
A health information system has been aptly described as "an integrated effort to collect, process, report and use health information and knowledge to influence policy-making, programme action and research". It consists of:

- inputs (resources)
- processes (selection of indicators and data sources; data collection and management)
- outputs (information products and information dissemination and use).

The role of a health information system is to generate, analyse and disseminate sound data for public health decision-making in a timely manner. Data have no value in themselves. The ultimate objective of a health information system is to inform action in the health sector. Performance of such a system should therefore be measured not only on the basis of the quality of the data produced, but also on evidence of the continued use of these data for improving health systems' operations and health status.

The availability and use of information enables:

- improved definition of a population
- recognition of problems
- setting of priorities in the research agenda
- identification of effective and efficient interventions
- determination of potential impact (prediction)
- planning and resource allocation
- monitoring of performance or progress
- evaluation of outcomes after interventions



The health information system[2]

- continuity in medical and health care
- healthy behaviour in individuals and groups.

It also empowers citizens by enabling their participation in health care, policy and decision processes; and empowers countries and international partners by enabling better transparency and accountability through use of objective and verifiable processes.

Health knowledge gaps are where essential answers on how to improve the health of the people in Lesotho are missing. This is an issue related to the acquisition or generation of health information and research evidence. The "know-do gap" is the failure to apply all existing knowledge to improve people's health. This is related to the issue of sharing and translation of health information, research evidence, or knowledge. Although there are major structural constraints, the key to narrowing the knowledge gap and sustaining health and development gains is a long-term commitment to strengthen national health information systems.

This section of the analytical profile is structured along the following lines:

3.5	Health information, research, evidence and knowledge
3.5.1	Analytical Summary
3.5.2	Context
3.5.3	Structural organization of health information
3.5.4	Data sources and generation
3.5.5	Data Management
3.5.6	Access to existing global health information, (evidence and knowledge)
3.5.7	Storage and diffusion of information, (evidence and knowledge)
3.5.8	Research (Generation of information, evidence and knowledge)
3.5.9	Use of information, (evidence and knowledge)
3.5.10	Leverage information and communication technologies
3.5.11	Endnotes: sources, methods, abbreviations, etc.

References

[1] Everybody's business. Strengthening health systems to improve health outcomes. WHO's framework for action (pdf 843.33kb). Geneva, World Health Organization, 2007 (http://www.who.int/healthsystems/strategy/everybodys_business.pdf)

[2] Framework and standards for country health information systems, 2nd ed. (pdf 1.87Mb). Geneva, World Health Organization, 2008 (http://www.afro.who.int/index.php?option=com_docman&task=doc_download&gid=6233)

Namibia:Health financing system/fr

Le contenu en Français sera bientôt disponible.

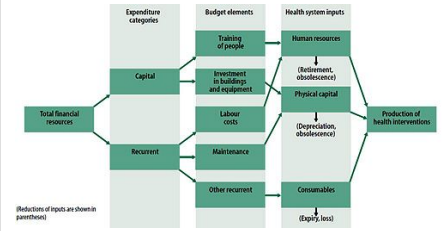
A good health financing system raises adequate funds for health, in ways that ensure people can use needed services and are protected from financial catastrophe or impoverishment associated with having to pay for them.[1] Health financing systems that achieve universal coverage in this way also encourage the provision and use of an effective and efficient mix of personal and non-personal services.

Three interrelated functions are involved in order to achieve this:

- the collection of revenues from households, companies or external agencies;
- the pooling of prepaid revenues in ways that allow risks to be shared – including decisions on benefit coverage and entitlement; and purchasing;
- the process by which interventions are selected and services are paid for or providers are paid.

The interaction between all three functions determines the effectiveness, efficiency and equity of health financing systems.

Like all aspects of health system strengthening, changes in health financing must be tailored to the history, institutions and traditions of each country. Most systems involve a mix of public and private financing and public and private provision, and there is no one template for action. However, important principles to guide any country's approach to financing include:



Health system inputs: from financial resources to health interventions

- raising additional funds where health needs are high, revenues insufficient and where accountability mechanisms can ensure transparent and effective use of resources;
- reducing reliance on out-of-pocket payments where they are high, by moving towards prepayment systems involving pooling of financial risks across population groups (taxation and the various forms of health insurance are all forms of prepayment);
- taking additional steps, where needed, to improve social protection by ensuring the poor and other vulnerable groups have access to needed services, and that paying for care does not result in financial catastrophe;
- improving efficiency of resource use by focusing on the appropriate mix of activities and interventions to fund and inputs to purchase;
- aligning provider payment methods with organizational arrangements for service providers and other incentives for efficient service provision and use, including contracting;
- strengthening financial and other relationships with the private sector and addressing fragmentation of financing arrangements for different types of services;
- promoting transparency and accountability in health financing systems;
- improving generation of information on the health financing system and its policy use.

This section of the health system profile is structured as follows:

References

[1] Everybody's business. Strengthening health systems to improve health outcomes. WHO's framework for action (pdf 843.33kb). Geneva, World Health Organization, 2007 (http://www.who.int/healthsystems/strategy/everybodys_business.pdf)

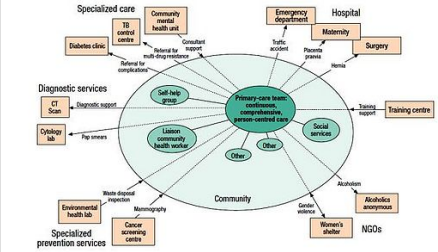
Namibia:Service delivery - The Health System/fr

Le contenu en Français sera bientôt disponible.

In any health system, good health services are those that deliver effective, safe, good-quality personal and non-personal care to those that need it, when needed, with minimum waste. Services – be they prevention, treatment or rehabilitation – may be delivered in the home, the community, the workplace or in health facilities.[1]

Although there are no universal models for good service delivery, there are some well-established requirements. Effective provision requires trained staff working with the right medicines and equipment, and with adequate financing. Success also requires an organizational environment that provides the right incentives to providers and users. The service delivery building block is concerned with how inputs and services are organized and managed, to ensure access, quality, safety and continuity of care across health conditions, across different locations and over time.

Attention should be given to the following:



Primary care as a hub of coordination: networking within the community served and with outside partners[2]

- *Demand for services*. Raising demand, appropriately, requires understanding the user's perspective, raising public knowledge and reducing barriers to care – cultural, social, financial or gender barriers.
- *Package of integrated services*. This should be based on a picture of population health needs; of barriers to the equitable expansion of access to services; and available resources such as money, staff, medicines and supplies.
- *Organization of the provider network*. This means considering the whole network of providers, private as well as public; the package of services (personal, non-personal); whether there is oversupply or undersupply; functioning referral systems; the responsibilities of and linkages between different levels and types of provider, including hospitals.
- *Management*. Whatever the unit of management (programme, facility, district, etc.) any autonomy, which can encourage innovation, must be balanced by policy and programme consistency and accountability. Supervision and other performance incentives are also key.
- *Infrastructure and logistics*. This includes buildings, their plant and equipment; utilities such as power and water supply; waste management; and transport and communication. It also involves investment decisions, with issues of specification, price and procurement and considering the implications of investment in facilities, transport or technologies for recurrent costs, staffing levels, skill needs and maintenance systems.

This section of the health system profile is structured as follows:

References

[1] Everybody's business. Strengthening health systems to improve health outcomes. WHO's framework for action (pdf 843.33kb). Geneva, World Health Organization, 2007 (http://www.who.int/healthsystems/strategy/everybodys_business.pdf)

[2] Framework and standards for country health information systems, 2nd ed (pdf 1.87Mb). Geneva, World Health Organization and Health Metrics Network, 2008 (http://www.afro.who.int/index.php?option=com_docman&task=doc_download&gid=6233)

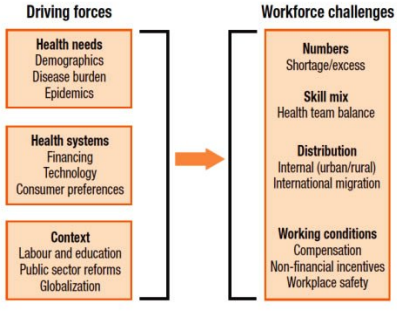
Namibia:Health workforce - The Health System/fr

Le contenu en Français sera bientôt disponible.

Health workers are all people engaged in actions whose primary intent is to protect and improve health. A country's health workforce consists broadly of health service providers and health management and support workers. This includes:

- private as well as public sector health workers
- unpaid and paid workers
- lay and professional cadres.

Overall, there is a strong positive correlation between health workforce density and service coverage and health outcomes.



Forces driving the workforce[1]

A "well-performing" health workforce is one that is available, competent, responsive and productive. To achieve this, actions are needed to manage dynamic labour markets that address entry into and exits from the health workforce, and improve the distribution and performance of existing health workers. These actions address the following:

- How countries plan and, if needed, scale-up their workforce asking questions that include: What strategic information is required to monitor the availability, distribution and performance of health workers? What are the regulatory mechanisms needed to maintain quality of education/training and practice? In countries with critical shortages of health workers, how can they scale-up numbers and skills of health workers in ways that are relatively rapid and sustainable? Which stakeholders and sectors need to be engaged (e.g. training institutions, professional groups, civil service commissions, finance ministries)?

- How countries design training programmes so that they facilitate integration across service delivery and disease control programmes.
- How countries finance scaling-up of education programmes and of numbers of health workers in a realistic and sustainable manner and in different contexts.
- How countries organize their health workers for effective service delivery, at different levels of the system (primary, secondary, tertiary), and monitor and improve their performance.
- How countries retain an effective workforce, within dynamic local and international labour markets.

This section of the health system profile is structured as follows:

References

[1] The world health report 2006: working together for health (7.11Mb). Geneva, World Health Organization, 2008 (http://www.who.int/whr/2006/whr06_en.pdf)

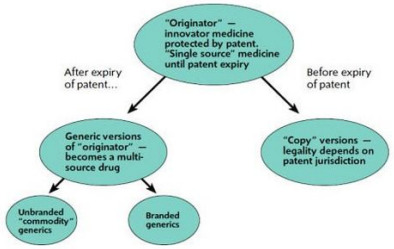
Namibia:Medical products, vaccines, infrastructures and equipment/fr

Le contenu en Français sera bientôt disponible.

A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost effectiveness, and their scientifically sound and cost-effective use.[1]

To achieve these objectives, the following are required:

- national policies, standards, guidelines and regulations that support policy;
- information on prices, international trade agreements and capacity to set and negotiate prices;
- reliable manufacturing practices and quality assessment of priority products;
- procurement, supply, storage and distribution systems that minimize leakage and other waste;
- support for rational use of essential medicines, commodities and equipment, through guidelines, strategies to assure adherence, reduce resistance, maximize patient safety and training.



Major components of the medicines market[2]

Major components of the medicines market are shown in the figure.

This section of the health system profile is structured as follows:

References

[1] Everybody's business. Strengthening health systems to improve health outcomes. WHO's framework for action (pdf 843.33kb). Geneva, World Health Organization, 2007 (http://www.who.int/healthsystems/strategy/everybodys_business.pdf)

[2] The world medicines situation (pdf 1.03Mb). Geneva, World Health Organization, 2004 (http://apps.who.int/medicinedocs/pdf/s6160e/s6160e.pdf)

Namibia:General country health policies/fr

Le contenu en Français sera bientôt disponible.

Public policies in the health sector, together with those in other sectors, have a huge potential to secure the health of communities.[1] They represent an important complement to universal coverage and service delivery reforms. Unfortunately, in most societies, this potential is largely untapped and failure to effectively engage other sectors is widespread. Looking ahead at the diverse range of challenges associated with the growing importance of ageing, urbanization and the social determinants of health, there is, without question, a need for a greater capacity to seize this potential. That is why a drive for better public policies forms a third pillar supporting the move towards primary health care, along with universal coverage and primary care (see figure).

Primary health care reforms necessary to refocus health systems towards health for all

The following policies must be in place:

- *Systems policies* – the arrangements that are needed across health systems' building blocks to support universal coverage and effective service delivery. These are the health systems policies (related to essential drugs, technology, quality control, human resources, accreditation, etc.) on which primary care and universal coverage reforms depend.
- *Public health policies* – the specific actions needed to address priority health problems through cross-cutting prevention and health promotion. Without effective public health policies that address priority health problems, primary care and universal coverage reforms would be hindered. These encompass the technical policies and programmes that provide guidance to primary care teams on how to deal with priority health problems. They also encompass the classical public health interventions from public hygiene and disease prevention to health promotion.
- *Policies in other sectors* – contributions to health that can be made through intersectoral collaboration. These policies, which are of critical concern, are known as "health in all policies", based on the recognition that a population's health can be improved through policies that are mainly controlled by sectors other than health. The health content of school curricula, industry's policy towards gender equality, or the safety of food and consumer goods are all issues that can profoundly influence or even determine the health of entire communities and that can cut across national boundaries. It is not possible to address such issues without intensive intersectoral collaboration that gives due weight to health in all policies.

This section of the health system profile is structured as follows:

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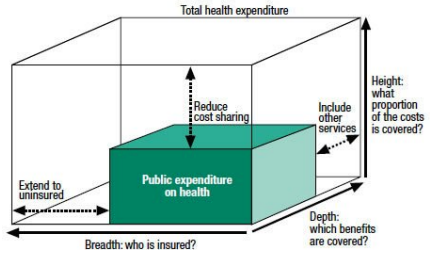
Namibia:Universal coverage/fr

Le contenu en Français sera bientôt disponible.

People expect their health systems to be equitable. The roots of health inequities lie in social conditions outside the health system's direct control. These root causes have to be tackled through intersectoral and cross-government action. At the same time, the health sector can take significant action to advance health equity internally. The basis for this is the set of reforms that aims at moving towards universal coverage, i.e. towards universal access to health services with social health protection. Health inequities also find their roots in the way health systems exclude people, such as inequities in availability, access, quality and burden of payment, and even in the way clinical practice is conducted.

The fundamental step a country can take to promote health equity is to move towards universal coverage: universal access to the full range of personal and non-personal health services required, with social health protection. The technical challenge of moving towards universal coverage is to expand coverage in three ways (see figure).:



Three ways of moving towards universal coverage

- *The breadth of coverage* – the proportion of the population that enjoys social health protection – must expand progressively to encompass the uninsured, i.e. the population groups that lack access to services and/or social protection against the financial consequences of taking up health care.
- *The depth of coverage* must also grow, expanding the range of essential services that is necessary to address people's health needs effectively, taking into account demand and expectations, and the resources society is willing and able to allocate to health. The determination of the corresponding "essential package" of benefits can play a key role here, provided the process is conducted appropriately.
- *The height of coverage*, i.e. the portion of health care costs covered through pooling and prepayment mechanisms, must also rise, diminishing reliance on out-of-pocket copayment at the point of service delivery. Prepayment and pooling institutionalizes solidarity between the rich and the less well-off, and between the healthy and the sick. It lifts barriers to the uptake of services and reduces the risk that people will incur catastrophic expenses when they are sick. Finally, it provides the means to reinvest in the availability, range and quality of services.

This section of the health system profile is structured as follows:

Programmes Spécifiques et Services

Namibia:Specific Programmes and Services/fr

Le contenu en Français sera bientôt disponible.

The specific programmes and services represent principally the major disease and services vertical programmes that are developed to some extent out of the regular system. These programmes and services include HIV/AIDS, malaria, tuberculosis, immunization and vaccines development, child and adolescent health, maternal and newborn health, gender and women's health, epidemic and pandemic-prone diseases, neglected tropical diseases, and noncommunicable diseases and conditions.

This section describes the specific programmes and services in the WHO African Region and is structured as follows:

4.1 HIV/AIDS

4.2 Tuberculosis

4.3 Malaria

4.4 Immunization and vaccines development

4.5 Child and adolescent health

4.6 Maternal and newborn health

4.7 Gender and women's health (including sexual and reproductive health)

4.8 Epidemic and pandemic-prone diseases

4.9 Neglected tropical diseases

4.10 Noncommunicable diseases and conditions

Namibia:HIV/AIDS/fr

Le contenu en Français sera bientôt disponible.

This analytical profile on HIV/AIDS is structured as follows:

Namibia:Tuberculosis/fr

Le contenu en Français sera bientôt disponible.

This analytical profile on tuberculosis is structured as follows:

Namibia:Malaria/fr

Le contenu en Français sera bientôt disponible.

The arid regions of Erongo, Hardap, Khomas and Karas are considered free of malaria transmission and almost risk-free. Some risk exists in the southern regions, but it is uncertain whether the cases reported in these areas are imported or locally acquired. The areas of high transmission and population density are located along the northern border of the country. (MoHSS, December 2010) In 2008 there were 128,531 (62/1,000) reported outpatient malaria cases and 5,233 (0.9/1,000) inpatient cases. A total of 199 deaths were reported in the same year. (HMIS data of August 2010) Transmission risk is currently estimated between 15% in low risk areas and 55% in high risk areas. (MoHSS, December 2010).

The National Vector-borne Diseases Control Programme (NVDCP) was introduced in 1991 and supported by the National Policy and Strategy for Malaria Control in 1995 (MoHSS, 1995). In 2006 a policy of parasitological diagnosis using Rapid Diagnosis tests (RDTs) was introduced.

The National Vector-borne Diseases Control Programme (NVDCP) has successfully introduced and rapidly scaled up all malaria control interventions, prioritizing high risk districts and achieving overall MDG targets of halving morbidity and mortality. Trends in outpatient cases, inpatient cases, and deaths exhibit a decline of 78 percent, 87 percent, and 88 percent respectively between 2001 and 2008.

Following the success of malaria control over the last ten years, and remarkable declines in local transmission of the disease, Namibia has also been recognized as one of four countries in southern Africa that is well positioned to reorient the malaria program from a malaria control program to an elimination program.

The current Malaria Strategic Plan 2010-2016 is a pre-elimination plan which aims to make a major impact on transmission and reducing incidence to less than 1 case per 1,000 in each district by 2016; this will position Namibia to follow through with the complete interruption of indigenous transmission by 2020. (MoHSS, November 2010).

The five strategic interventions set out in the plan are: The five strategic interventions set out in the plan are: programme and operations management; diagnosis and case management; surveillance, epidemic preparedness and response; integrated vector control; behaviour change communication and community mobilisation. (MoHSS, November 2010).

A National Malaria Elimination Task Force will be formed to oversee implementation with support from technical working groups. The NVDCP, an independent programme within the directorate Special Programs (DSP) in Windhoek and Oshakati, will coordinate day-to-day activities and inputs from partners. The programme will be rolled out using a decentralised approach including capacity building at district and community level. A new staff establishment for the NVDCP is proposed to address critical shortfalls in programme management and technical capacity. The team is currently funded jointly by the MoHSS and donors, but the goal is to eventually shift all posts so that they can be fully sustained by the MoHSS. At the regional level Regional Malaria Elimination Coordinators and Regional Clinic Mentors are proposed and District Malaria Elimination Officers are needed to support EHOs who currently conduct malaria activities under PHC.

The implementation of the elimination effort requires unprecedented support from all stakeholders and partners, including implementing partners that have capacity in laboratory systems, quality assurance systems, research, procurement and supply management, and behaviour change communication. (MoHSS, November 2010) In March of 2009, Namibia hosted the Inaugural meeting of the Elimination 8, a mechanism for eight Southern Africa Development Community (SADC) countries which have similarly committed to forging a sub-regional alliance to launch a united intensive offensive against malaria. Namibia will work with its neighbouring countries and development partners to contribute to the malaria elimination goals of the eight individual countries, and the sub-region as a whole. In particular, it will work closely with its neighbours to put in place programs that increase access to malaria interventions in the border districts (MoHSS, November 2010).

The total budget for the 2010-2016 strategic plan is US$93,052,380, to be met by the Namibian Government, together with development partners and other local and international stakeholders. (MoHSS, November 2010).

Systems that are currently used for malaria data collection are the Health Managaement Information System (HMIS), Integrated Disease Surveillance and Response (IDSR) system, and the weekly routine malaria surveillance system. Surveillance of malaria has previously been passive and focussed on data collection for monitoring and evaluation. With the new push towards elimination, surveillance will become a key intervention in the identification/diagnosis of cases and infections to map malaria foci for effective targeting of interventions and interruption of onwards transmission. The objective is therefore to strengthen the passive system and then create an active system. Regional Surveillance Officers are required in order to achieve this. (MoHSS, November 2010)

Namibia:Immunization and vaccines development/fr

Le contenu en Français sera bientôt disponible.

This analytical profile on immunization and vaccine development is structured as follows:

Namibia:Child and adolescent health/fr

Le contenu en Français sera bientôt disponible.

This analytical profile on child and adolescent health is structured as follows:

Namibia:Maternal and newborn health/fr

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This analytical profile on maternal and newborn health is structured as follows:

Namibia:Gender and women's health/fr

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This analytical profile on gender and women's health is structured as follows:

Namibia:Epidemic and pandemic-prone diseases/fr

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This analytical profile on epidemic and pandemic-prone diseases is structured as follows:

Namibia:Neglected tropical diseases/fr

Le contenu en Français sera bientôt disponible.

This analytical profile on neglected tropical diseases is structured as follows:

Namibia:Non-communicable diseases and conditions/fr

Le contenu en Français sera bientôt disponible.

This analytical profile on noncommunicable diseases and conditions is structured as follows:

Déterminants majeurs

Namibia:Key Determinants/fr

Le contenu en Français sera bientôt disponible.

This analytical profile on key determinants is structured as follows:

- 5.1 Risk factors for health
  - 5.1.2 Alcohol consumption
  - 5.1.3 Drug use
  - 5.1.4 Risk factors for chronic non-communicable diseases
  - 5.1.5 Risky sexual behaviour
  - 5.1.6 Hygiene (students)
  - 5.1.7 State of surveillance
- 5.2 The physical environment
  - 5.2.1 Analytical summary
  - 5.2.2 Vector-borne disease
  - 5.2.3 The urban environment
  - 5.2.4 Indoor air pollution and household energy
  - 5.2.5 Water, sanitation and ecosystems
  - 5.2.6 Climate change
  - 5.2.7 Toxic substances
- 5.3 Food safety and nutrition
  - 5.3.1 Analytical summary
  - 5.3.2 Food safety
  - 5.3.3 Nutrition
  - 5.3.4 State of surveillance
- 5.4 Social determinants
  - 5.4.1 Analytical summary
  - 5.4.2 Demography
  - 5.4.3 Resources and infrastructure
  - 5.4.4 Poverty and income inequality
  - 5.4.5 Gender equity
  - 5.4.6 Education
  - 5.4.7 Global partnerships and financial flows
  - 5.4.8 Science and technology
  - 5.4.9 Emergencies and disasters
  - 5.4.10 Governance

Namibia:Risk factors for health/fr

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This analytical profile on risk factors for health is structured as follows:

Namibia:The physical environment/fr

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This analytical profile on the physical environment is structured as follows:

Namibia:Food safety and nutrition/fr

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This analytical profile on food safety and nutrition is structured as follows:

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This analytical profile on social determinants is structured as follows:

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