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REGIONAL OFFICE FOR Africa

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NAMIBIA

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ABBREVIATIONS

AC	Assessed Contribution
AFHS	Adolescent Friendly Health Services
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ARCC	African Regional Certification Commission
ARI	Acute Respiratory Infection
ART	Antiretroviral Therapy
ARV	Antiretroviral Medicine
BNLSS	Botswana, Namibia, Lesotho, South Africa and Swaziland
CCS	Country Cooperation Strategy
CHS	Catholic Health Services
CDC	Centers for Disease Control and Prevention (Atlanta)
DOTS	Directly-Observed Treatment Short-course
DSP	Directorate of Special Programmes
EmOC	Emergency Obstetric Care
EPI	Expanded Programme on Immunization
FAO	Food and Agriculture Organization
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GFATM	Global Fund to Fight Aids, Tuberculosis and Malaria
GSM	Global Management System
GTZ	*Gesellschaft für Technische Zusammenarbeit* (German Technical Cooperation)
HAMU	HIV and AIDS Management Unit
HIV	Human Immunodeficiency Virus
HRD	Human Resources Development
HSS	Health Systems Strengthening
IDSR	Integrated Disease Surveillance and Response

IHR	International Health Regulations
IMCI	Integrated Management of Childhood Illness
IMNCI	Integrated Management of Newborn and Childhood Illnesses
IT	Information Technology
I-TECH	International Training and Education Centre on HIV
JICA	Japan International Cooperation Agency
KFW	*Kreditanstalt für Wiederaufbau* (Reconstruction Credit Institute)
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MDR-TB	Multidrug-resistant TB
MoHSS	Ministry of Health and Social Services
NANASO	Namibia Network of AIDS Service Organizations
NAPPA	Namibian Planned Parenthood Association
NASOMA	National Social Marketing Association
NEPAD	The New Partnership for Africa's Development
NCD	Noncommunicable Disease
NDHS	Namibia Demographic and Health Survey
NDP 3	National Development Plan 3
NGO	Nongovernmental Organization
NHA	National Health Accounts
NIP	Namibia Institute of Pathology
OPM	Office of the Prime Minister
PEPFAR	President's Emergency Plan for Aids Relief
PHC	Primary Health Care
PMTCT	Prevention of Mother-to-Child Transmission
PSEMAS	Public Service Employee Medical Aid Scheme
SADC	Southern African Development Community
SRH	Sexual and Reproductive Health
STI	Sexually-transmitted Infection
SWOT	Strengths, Weaknesses, Opportunities and Threats

TB	Tuberculosis
TIPC	Therapeutic Information and Pharmacovigilance Centre
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNAM	University of Namibia
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VC	Voluntary Contribution
VSO	Voluntary Service Overseas
WCO	WHO Country Office
WHO	World Health Organization
WR	WHO Representative
XDR-TB	Extensively drug-resistant TB

FOREWORD

The WHO Country Cooperation Strategy (CCS) crystallizes the major reforms adopted by the World Health Organization with a view to intensifying its interventions in countries. It has infused a decisive qualitative orientation into the modalities of our Organization's coordination and advocacy interventions in the African Region. Currently well established as a WHO medium-term planning tool at country level, the cooperation strategy aims at achieving greater relevance and focus in the determination of priorities, effective achievement of objectives and greater efficiency in the use of resources allocated for WHO country activities.

The first generation of country cooperation strategy documents was developed through a participatory process that mobilized the three levels of the Organization, the countries and their partners. For the majority of countries, the 2004-2005 biennium was the crucial point for refocusing WHO action. It enabled countries to better plan their interventions using a results-based approach and an improved management process that enabled the three levels of the Organization to address their actual needs.

Drawing lessons from the implementation of the first generation CCS documents, the second generation documents, in harmony with the Eleventh General Programme of Work and the Medium Term Strategic Framework, address the country health priorities defined in their health development and poverty reduction sector plans. The CCSs are also in line with the new global health context and integrate the principles of alignment, harmonization and efficiency as formulated in the Paris Declaration on Aid Effectiveness and in recent initiatives such as the Harmonization for Health in Africa (HHA) and International Health Partnership Plus (IHP+). They also reflect the policy of decentralization which enhances the decision-making capacity of countries to improve the quality of public health programmes and interventions.

Finally, the second generation CCS documents are synchronized with the United Nations Development Assistance Framework (UNDAF) with a view to achieving the Millennium Development Goals.

I commend the efficient and effective leadership role played by the countries in the conduct of this important exercise of developing the WHO Country Cooperation Strategy documents and request the entire WHO staff, particularly the WHO representatives and divisional directors, to double their efforts to ensure effective implementation of the orientations of the Country Cooperation Strategy for improved health results for the benefit of the African population.

Dr Luis G. Sambo
WHO Regional Director for Africa

EXECUTIVE SUMMARY

The attainment of the highest possible standard of health for all remains the major commitment of WHO. This second generation WHO Country Cooperation Strategy for Namibia will cover the years 2010-2015. It articulates WHO's role and renewed commitment to collaborating with the Government of Namibia for the next five years.

This Country Cooperation Strategy (CCS) is the result of an extensive and inclusive process which included a systematic analysis of documents, interviews and interactions with multiple stakeholders in health. The strategic direction was defined by considering WHO's comparative advantage in relation to national health priorities.

This CCS for 2010–2015 takes into consideration agreed international and regional development goals, including those in the United Nations Millennium Declaration, World Health Assembly resolutions, NEPAD Health Strategy, WHO Regional Committee resolutions, and African Union resolutions and recommendations. Strategic frameworks which also inform the direction of WHO's strategic agenda at national level are: Namibia Vision 2030, the third National Development Plan 2007/08-2011/12 (NDP 3), the Ministry of Health and Social Services (MoHSS) Strategic Plan 2009–13, WHO's Eleventh General Programme of Work, WHO's Medium Term Plan 2008–13, Strategic Orientations for WHO Actions in the African Region 2005–2009, and the United Nations Development Assistance Framework (UNDAF) for 2006-2010.

Namibia's health profile reveals that there is an observable decline in prevalence rates for communicable diseases. However, the country's disease burden remains quite high. The HIV prevalence rate among pregnant women fell from 19.9% in 2006 to 17.8% in 2008. Tuberculosis (TB) cases decreased from 790 in 2005 to 722 in 2007. At the same time the success rate of TB treatments rose from70% to 76% and to 83% in 2008. Malaria incidence fell from 238 per 1000 population in 2000 to 48 per 1000 in 2007. A major issue of concern is the continued increase of maternal mortality ratio and no progress in reducing the under-five mortality rate. The under-five mortality rate decreased from 83 per 1000 in 1992 to 62 per 1000 in 2000 but has since increased to 69 per 1000 in 2006/07. Similarly, the infant mortality rate decreased considerably from 57 per 1000 live births in 1992 to 38 per 1000 live births in the year 2000 but rose to 46 per 1000 live births in 2006/07. The maternal mortality ratio has almost doubled since 2000, from 271 to 449 per 100 000 in 2006/07. Noncommunicable diseases and conditions require greater attention.

Significant changes and developments have taken place in the Namibian health sector over the period 2001/02–2006/07. The National Health Accounts (NHA) study for this period reports that total health spending doubled over the five-year period. The total

resource envelope for health in 2006/07 accounted for 8.3% of gross domestic product (GDP), the second-highest level among countries in the BNLSS region (Botswana, Namibia, Lesotho, South Africa, and Swaziland), second only to South Africa. Government investment in health as a percentage of total government spending averaged 12.2% over the five-year period, short of the commitment of African governments at the Abuja summit to achieve 15% allocation to health by 2015. All these developments are strong evidence of government commitment to achieving the goals set to improve the quality of life for all Namibians. Another key trend observed in the said period is an increase in activity and contributions of other financing agents in health apart from government (the leading financier and manager of health), such as donors and their implementing agencies, as well as households. The current largest contributors among the donors and their implementing agencies in the health sector are the President's Emergency Plan for Aids Relief (PEPFAR), the Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM), UN agencies, Spanish Cooperation, German Technical Cooperation (GTZ), the Finnish Embassy and Synergos.

Since Namibia's admission as a WHO Member State in 1990, the WHO Country Office (WCO) has seen its work portfolio and internal organization grow considerably. Today, the Country Office operates from UN House, a newly-built and well-serviced UN office complex situated in Klein Windhoek. The total staff complement currently comprises 19 staff members, of which six hold continuing appointment contracts, nine are on fixed term contracts and four are temporary staff. Some of the key challenges facing the Organization are inadequate human resources, depleting funds, insufficient coordination among UN agencies and the lack of visibility of the work of the Country Office. The current global economic recession, inadequate human capacity in the MoHSS, and little synergy among development partners give cause for further concern.

A review of the previous CCS 2004–2007 reveals that the Country Office made considerable achievements in the area of health systems improvement and the prevention of communicable diseases. However, objectives were not fully met in some strategic priority areas such as noncommunicable diseases, maternal and child health, and health promotion. This is largely attributed to lack of funding, human resources at the WCO level and change in prioritization on the part of MoHSS, as well as inhibiting factors within the Country Office. The unfinished agenda has been incorporated in the new CCS.

To adequately respond to the identified needs in the Namibian health sector, the new strategic agenda identifies the following four strategic priorities for the period 2010-2015:

- Strategic Priority 1: Strengthening the Health System
- Strategic Priority 2: Combating Priority Diseases
- Strategic Priority 3: Improving Maternal, Newborn, Child and Adolescent Health
- Strategic Priority 4: Promoting a Safer and Healthier Environment

The first strategic priority lays the foundation for all the others. There is a necessary overlap between this priority and the other three. The intended outcome, focus areas and high-level strategies are outlined for each priority.

It is important to note that unforeseen health issues may arise as a result of disease outbreaks, different environmental hazards and other risk factors during the period 2010-2015. These will call for WHO support and will form part of the areas for Strategic Priority 2 and Strategic Priority 4.

STRATEGIC PRIORITY	OUTCOMES	FOCUS AREAS
1. Strengthening the health system	An efficient health system that is responsive to health needs and provides equitable and affordable access to quality health care	1.1 Governance 1.2 Human resource development 1.3 Health financing 1.4 Health information systems 1.5 Medical products, vaccines & technologies 1.6 Service delivery
2. Combating priority diseases	Improved prevention and control of communicable and noncommunicable diseases	2.1 HIV/AIDS and TB 2.2 Diseases targeted for elimination/eradication 2.3 Noncommunicable diseases and conditions
3. Improving maternal, newborn, child and adolescent health	Improved quality of and access to maternal, newborn, child and adolescent health services	3.1 Emergency obstetric care 3.2 Maternal and neonatal death reviews 3.3 Integration of reproductive health and HIV/AIDS 3.4 Immunization 3.5 Child nutrition and IMNCI 3.6 Adolescent health
4. Promoting a safer and healthier environment	Improved health security	4.1 Emergency preparedness, risk reduction and response 4.2 IHR (2005) 4.3 Environmental health 4.4 Health Promotion

WHO will strive to create a conducive environment needed for successful implementation of its strategic agenda. The Country Office will therefore strengthen its human resources and financial capacity to mobilize and provide timely, sufficient and good quality support. Furthermore, the Country Office commits to enhancing the level of understanding of WHO's role and mandate in Namibia, and will support the MoHSS in building and strengthening partner coordination while fostering private-public partnerships. Finally, WCO aims to enhance its collaboration with other UN agencies.

The progress made in implementing this strategic agenda will be assessed through regular monitoring and evaluation activities that will be carried out at both strategic and operational levels. At the strategic level, this will include annual and mid-term reviews and evaluations at the end of the lifespan of the CCS. At the operational level, biennial plans will operationalize the strategic priorities and corresponding strategies using clear indicators and targets.

SECTION 1

INTRODUCTION

This is the second generation Country Cooperation Strategy (CCS) for Namibia. It articulates WHO's corporate strategy at country level for the period 2010-2015. The strategic agenda is aligned with the Government of Namibia health agenda and reflects WHO's mandate, comparative advantage, policies, guiding principles, and global and regional agendas.

This strategic framework outlines WHO's cooperation with the Government of Namibia through its main partner, the Ministry of Health and Social Services (MoHSS). The CCS serves as a strategic framework for policy dialogue, planning, coordination and resource mobilization.

This CCS is a result of intensive multisectoral consultation with key stakeholders in the Namibian health sector, such as MoHSS, other government ministries, UN agencies, donors, the private sector, academia, civil society and the WHO Country Office (WCO) staff.

The strategic agenda has been inspired by various international, regional and national declarations and goals such as the Millennium Development Goals (MDGs); World Health Assembly resolutions; NEPAD Health Strategy; WHO Regional Committee and African Union resolutions and recommendations; the WHO global priorities stipulated in the Eleventh General Programme of Work and the Strategic Orientations for WHO Action in the African Region ; the WHO Mid Term Strategic Plan for 2008-2013; Namibia Vision 2030; and the United Nations Development Assistance Framework (UNDAF) 2006-2010. The CCS is based on the health needs of the country as defined in other important national documents such as the MoHSS Strategic Plan 2009-13; the National Health Accounts (NHA) 2001/02–2006/07; the MoHSS Health and Social Services System Review 2008; the National Development Plan for 2007/08-2011/12 (NDP 3); and other relevant documents.

This second CCS is a comprehensive agenda which contains, among others, the unfinished agenda of the first CCS and addresses the country's health needs and priorities. It not only covers the five-year countdown period to the achievement of the MDGs but also addresses health-related Millennium Development Goals 4, 5 and 6 and issues contributing to attaining the other MDGs. The agenda is articulated around four strategic priorities.

It is important to note that health emergencies may arise as a result of disease outbreaks, different environmental hazards (such as droughts and floods) and other risk factors during the period 2010-2015. This will also call for WHO support in risk assessment, risk reduction, and emergency preparedness and response. Depending on the scale of the emergency, resources may be diverted to address the immediate needs and could affect the implementation of other programmes.

WCO has tasked itself to support the Namibian Government in the four strategic priority areas while being well aware of the fact that the implementation of the agenda coincides with the current global financial and economic crisis and the slow recovery process. The WCO is, however, hopeful and committed to serving the country in its endeavours to reach its set health goals.

SECTION 2

COUNTRY HEALTH AND DEVELOPMENT CHALLENGES

2.1 Geography and socioeconomic profile[1]

The surface area of Namibia is 824 116 square kilometres. Geographical regions include the Namib Desert, Central Plateau and Kalahari Desert. The climate is mainly arid and semi-arid with sparse and erratic rainfall.

Figure 1: Map of Namibia

Environmental concerns include desertification, recurring drought and floods, depletion of natural resources, loss of biodiversity, decline of water quality, pollution from solid and domestic waste, and aquatic acidification.[2]

The population from the 2001 census was 1 830 330; population density is 2.2 persons per square km. Population growth rate is 2.6%.[3] The fertility rate is 3.6. Life expectancy as recorded in 2006 was 51.6. The percentage of households in rural areas with orphans and fostered children is 38% (2006/07). HIV prevalence rate is 17.8% (2008).[4]

Main exports are primary commodities (e.g. diamond, uranium and gold). Gross national income was US$ 4200 per capita in 2008; the country is therefore classified as an upper middle-income country by the World Bank.

The Human Development Index for Namibia in 2009 was was 0.686.[5] The illiteracy rate is 12%.

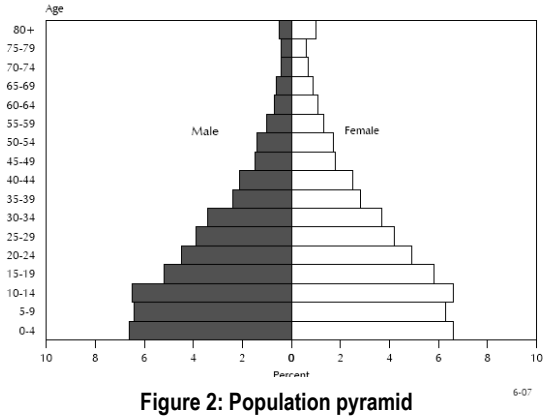

Figure 2: Population pyramid

1 Section 2 draws information mainly from Census 2001 and Namibia Demographic and Health Survey (NDHS) 2006/07.

2 Ministry of Environment and Tourism, Directorate of Environmental Affairs website, 2009.

3 Estimates from the African Development Bank in 2008 put the population at 2 130 000.

4 MoHSS, National HIV Sentinel Survey, 2008.

5 Human Development Report 2009, UNDP.

Nationally, 88% of households have access to an improved source of drinking water, but 20% of the rural population obtains water from unimproved sources. For 39% of rural households, it takes more than 30 minutes to obtain water.[6] Only 34% of households have access to improved sanitation facilities and mostly in urban areas. According to the latest NDHS, 78% of rural households do not have toilet facilities and this has been the pattern since 2000.

Repeated drought and floods have seriously affected the food security of mainly rural populations as successive harvests have been destroyed. Floods in 2009 led to severe water logging and affected nearly 700 000 people. According to FAO and WFP (FAO/WFP crops, livestock and food security assessment mission to Namibia, July 2009), 163 000 people in the north-eastern and central regions of the country are food insecure.

2.2 Government and politics

Before independence, Namibia was ravaged by war, social and economic discrimination, and racial and ethnic enmity. Since gaining independence in 1990, the country has enjoyed a stable multiparty democracy based on the rule of law. The policy of reconciliation has greatly helped create a harmonious society. The policy of affirmative action strives to remove the inherited inequity in employment opportunities and socioeconomic status. Social initiatives such as protection of human rights, access to health, education and training are being pursued vigorously to remove enormous social deficits.

Vision 2030 aims to transform Namibia into an industrialized nation and reverse a colonial legacy of income inequality and poverty. The Third National Development Plan (NDP 3) 2007/08-2011/12, adopted by Parliament in June 2008, translates Vision 2030 objectives into concrete policies and actions; the main theme is "Accelerated Economic Growth and Deepening Rural Development". More specifically, the plan seeks to achieve the medium term objectives of sustainable growth, employment creation, reduction of poverty and inequality in income distribution across the various regions, environmental sustainability, gender equality, and reductions in HIV/AIDS prevalence. NDP 3 is poverty focused and contains benchmarks consistent with the country's Poverty Reduction Strategy, the National Poverty Reduction Action Programme of 1998.

NDP 3 sets the following national health targets for 2012 based on the epidemiological profile prevailing in the country:

- Ensure that life expectancy is 51 years;
- Reduce the infant mortality rate from 46 to 38 per 1000 live births;

[6] NDHS 2006/07.

- Reduce the under-five mortality rate from 69 to 45 per 1000 live births;
- Reduce the maternal mortality ratio from 449 to 265 per 100 000 live births;
- Reduce the total fertility rate from 4.18 to 3.6 per woman;
- Reduce malnutrition among under-five children from 29% to 18%;
- Continue to improve the quality of life and environmental impact through the promotion of environmental health at all levels;
- Provide 95% disability coverage.

In its efforts to deliver on these targets, the MoHSS embarked upon a situation analysis (Health and Social Services Systems Review, 2008) which informed the development of the MoHSS Strategic Plan for 2009-13. The vision of the MoHSS as set out in this plan is to be "The leading public provider of quality health and social welfare services in Africa"; its mission is "To provide an integrated, affordable, accessible, quality health and social welfare service that is responsive to the needs of the Namibian population". The MoHSS Strategic Plan focuses on five strategies for governance, service provision, human resources, infrastructure and financing.

2.3 Health profile

Organization of the health system

The public health sector is structured in a three-tier hierarchy[7] with central, regional and district levels. The central level has devolved authority to 13 MoHSS regional directorates and 34 districts.

Churches and NGOs play a significant role in protecting and promoting the health and social welfare of the Namibian people. Many of the NGOs are involved in the delivery of community-based health care. Of these organizations, few are actually involved in the MoHSS planning processes, with the exception of NGOs that participate in the HIV/AIDS programmes.

The private sector is regulated by the Hospital and Health Facilities Act of 1994 (Act No. 36). The private sector facilities are licensed to provide health services to all patients and they complement the services of the public sector. In 2008, there were 844 private health facilities, registered or licensed with the MoHSS, mostly located in urban areas. These include 13 hospitals, 75 primary care clinics, 8 health centres and 75 pharmacies. In addition, there are 557 medical practitioners, including dentists, psychologists and physiotherapists (source NHA 2001/02-2006/07).

Governance

At independence, Namibia inherited a fragmented health system based on racial segregation and marked by a concentration of infrastructure and services in urban areas. Since independence, a number of health sector reforms have taken place.

[7] NHA 2001/02-2006/07.

The 2008 Health and Social Services System Review highlighted a number of governance challenges. Weaknesses in leadership were identified at all levels, as well as a duplication of structures and functions across various divisions and directorates, including a multiplicity of information systems. It also signalled the need for policy revision, most notably of the Public Health Act of 1919, which provides guidance for sanitation and hygiene, and the Health Policy Framework of 1998, among others. There is need of improvement in decentralization at regional and community level, and better coordination of internal programmes and donor activity with an emphasis on involving stakeholders in policy formulation and implementation.

In 2008, the Ministry began to participate in the African Public Health Leadership Initiative spearheaded by Synergos, and in 2009 the Ministry embarked on a process of restructuring which is intended to be completed by 2010.

A number of important policies and guidelines are in place and available at most health care facilities.

Health financing

Health remains one of the priorities of the government, thus receiving a relatively large share of public funding. Health is now the leading priority area for donors, accounting for 79% of all donor disbursements in Namibia, mainly targeting HIV/AIDS control efforts.

The public health care system, which provides services to the majority of the population, is funded predominantly through general taxation while the private health care system, which provides either comprehensive or partial coverage, is funded largely through employee and employer contributions through insurance schemes.

The 2008 Health and Social Services System Review identified the need for a review of budget preparation responsibility and processes. It also recommended the development or institutionalization of policies for retention of user fees at point of collection and exemption for those unable to pay, as well as a feasibility study for universal coverage.

Human resources development and management

The MoHSS has drafted a Long-Term Human Resource Framework (1997-2027) which focuses on current and future needs and supply of staff in the country.[8] The Medium-Term Human Resources Plan (1997-2007) and two five-year human resource development plans provide further guidelines.

There are three health workers per 1000 population in Namibia, a capacity a bit above the WHO recommendation. However, this number ignores a shortage in the public sector

[8] This section is informed by MoHSS Health and Social Services Review, 2008.

which has barely two health workers per 1000 population (HSSR Report). Moreover, within the public sector there are chronic shortages of frontline workers including doctors and nurses. The human resource crisis in the Namibian public health sector is characterized by a shortage of health professionals, high vacancy rates for all categories of staff, high attrition rates (mostly due to resignations), lack of a human resources retention strategy, staff burn-out (and incomplete implementation of the Employee Assistance Programme) and inadequate capacity at local health academic institutions to produce the required number of needed health workers.

Service provision[9]

There has been a significant increase in the coverage of various services, with a current network consisting of about 1150 outreach points, 265 clinics, 44 health centres, 30 district hospitals, three intermediate hospitals and one national referral hospital, as well as various social welfare service points. However, the referral system is weak, and as a result there is no continuity of care, largely due to lack of transport. Outreach and mobile services are not functioning optimally for the same reason. The essential National Health Service package is yet to be finalized and there is a need to define a district health service package. About 72% of health care facilities have health facility committees, and about 5000 community health care workers have been trained. However, there are no clear structures to support community-based health care services. A national strategy for health extension workers is being explored to formally establish linkages between health facilities and communities.

The National Drug Policy of 1998 provides comprehensive guidelines and regulations for public and private pharmaceutical sectors in line with WHO recommendations on national drug policies. This policy is currently under revision. The MoHSS operates a centralized procurement system for medicines and medical supplies which is run by the Central Medical Stores.

Between 2005 and 2008, the establishment of the national Therapeutic Information and Pharmacovigilance Centre (TIPC) and Pharmacy Management Information System contributed to improved pharmacy service provision and strengthened monitoring and evaluation across the country. The Namibia Institute of Pathology functions as the national medical laboratory and is the only provider of laboratory testing for the public sector. It plays a role as a national public health laboratory; supports different types of operational research; and can contribute significantly to the provision of relevant clinical data from its integrated laboratory information system.

Access, utilization and quality of care

The public and private not-for-profit health-care system serves 85% of the Namibian population and is accessed by the lower income population. The private for-profit health-care system serves the remaining 15% of the population, consisting of the middle and

[9] This section is informed by MoHSS Health and Social Services Review, 2008.

high income groups. Access to care is an issue for a large number of Namibians. Over 40% live further than 5km from a health facility.[10] For some, the nearest hospital is more than 300 km away and waiting times at health facilities vary according to region, with the worst figures recorded for Hardap, where 82% of patients reported waiting for more than 3 hours.[11] Furthermore, upon arrival at clinics, patients are often referred due to lack of equipment, staff or medicines. The ability to transport patients between facilities is severely hampered by a lack of working vehicles, with down rates of ambulances as high as 90% in some regions, and 42% overall.[12]

Primary Health Care

The adoption of the health policy and the PHC approach after independence brought health services closer to the population to improve coverage and access. According to the 2008 Health and Social Services System Review, the policy was successfully implemented in subsequent years with particular achievements in vaccination of children resulting in the elimination of neonatal tetanus and reduction of measles cases and deaths. However, this progress is not observable in all regions. For example, in Omusati and Omaheke, coverage increased by 39% and 53%, respectively, but Kunene and Karas regions experienced a reduction in immunization coverage.[5] Namibia experienced a polio outbreak in 2006 which was quickly contained with the technical and financial support of WHO, UNICEF and other partners. In October 2008, Namibia was recognized by the Africa Region Certification Commission as a polio-free country.

The strategy of Integrated Management of Childhood Illness (IMCI) has been implemented in 47% of health-care facilities, and IMCI training has been provided at in-service and pre-service levels. However, implementation of the strategy has been slow, and follow-ups and supportive supervision are inadequate. The major causes of child mortality in developing countries including Namibia are acute respiratory infections (ARIs), pneumonia, malaria, measles, malnutrition and diarrhoea. These diseases are adequately addressed in the IMCI strategies, tools and guidelines. However, neonatal death is contributing to 52% of infant mortality in Namibia; addressing the quality of neonatal care will have to be one of the government's highest priorities for the achievement of the MDG targets. Not enough has been done to improve the management of ARI, and community-based treatment of pneumonia has not yet been introduced. The high prevalence of diarrhoea is largely due to poor sanitation and hygiene practices, with sanitation coverage at less than 40%. Provision of adequate sanitation is a cross-cutting area between MoHSS and the Ministry of Regional and Local Government, Housing and Rural Development; however, collaboration between the different players is weak.

Although there has been an improvement on 1992 figures, malnutrition rates remain high, aggravating diarrhoea and infant mortality as a whole. Malnutrition among

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10 MoHSS Health and Social Services Review, 2008.

11 Consumer Exit Interview Review Tool as quoted in Strengthening Public Health through Leadership Development and Health Systems Innovation, Synergos, McKinsey & Company, Presencing Institute, July 2009.

12 MoHSS Essential Indicators Database 2006-07; see footnote 10.

5 Second Millennium Development Goals Report, Namibia, 2008.

children is prevalent, with 29% of children stunted, 17% underweight and 8% wasted. Also of concern is the slow reduction in under-five and infant mortality.

Antenatal care (ANC) attendance in Namibia is very high at 94.6%, although most women tend to delay the crucial first visit. A high proportion of women attending ANCs receive voluntary counselling and testing for HIV, and Prevention of Mother-to-Child Transmission (PMTCT) is integrated into ANC services. High percentages (81%) of births take place in health-care facilities. Despite these gains, the maternal mortality ratio has almost doubled since 1992, from 225 to 449 per 100 000 live births in 2006-2007. A contributing factor is the inadequacy of emergency obstetric care (EmOC). A 2005/06 survey of all hospitals found that only four out of 34 hospitals provided comprehensive EmOC.

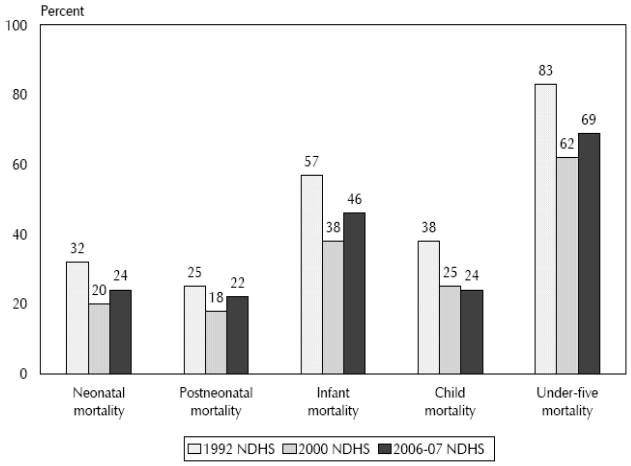


Figure 3: Trends in infant and child mortality, 1992 to 2006/07

Although there is a community-based health-care policy in place, health promotion is one PHC component that remains a challenge, partly due to the absence of health promotion strategies and resources.

Major communicable diseases

The HIV prevalence rate decreased from 19.9% in 2006 to 17.8% in 2008.[13] Between 1998 and 2008, there was a remarkable decline from 12% to 5.1% in HIV prevalence among young people aged 15-19 years old. 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. A new task force is expected to strengthen prevention efforts.

Although the number of notified cases of tuberculosis declined from 790 in 2005 to 722 in 2007, TB remains an extremely serious problem in Namibia, a country with one of the highest case notification rates in the world. The problem is compounded by the HIV

[13] MoHSS, National HIV Sentinel Survey, 2008

epidemic because 60% of TB patients also test positive for HIV. 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.

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.

Noncommunicable diseases

There is growing concern about noncommunicable diseases as a cause of morbidity and mortality, although there is lack of population-based data in this area. Health facility data indicate hypertension and diabetes as the leading causes of morbidity among adults, and cancers are on the increase. Mental, neurological, substance abuse (especially alcohol and marijuana) and psychosocial disorders are also problems. There is shortage of mental health facilities and staff, especially in rural areas. Reducing risk factors is one of the best ways to prevent chronic diseases, improve quality of life and increase life expectancy. 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. Many noncommunicable diseases (NCDs) share environmental or genetic factors that are amenable to preventative measures such as smoking, obesity, high alcohol consumption, physical inactivity, diabetes mellitus and lipid disorders.

The Namibia Demographic and Health Survey 2000 (NDHS) revealed that smoking seems to increase with age for both men and women, thus increasing their risk for NCDs. The survey showed that tobacco use is most common in Hardap, Karas and Omaheke regions. Among those interviewed, 28.7% living in the urban areas and 9.9% living in the rural areas smoke cigarettes or pipes.

In the 1992 NDHS, among women that gave birth in the previous five years (15-49 years of age), 21.3% had a body mass index (BMI) of >25kg/m^2 and 7.3% had a BMI of >30, indicating a high prevalence of overweight and obesity. In the 2006/07 NDHS in the same group of women 28% were overweight or obese with the BMI index of >25. The obese proportion with BMI index of >30 was 12.0%. This shows an increasing trend in overweight and obesity.

According to Globocan 2008 (IARC), Section of cancer information, in Namibia, the most frequent cancers among men are cancer of prostate, followed by cancer of the lip and oral cavity, Kaposi sarcoma and cancer of the lung. Among women, the five top cancers are cancers of the breast, cervix uteri and lip or oral cavity, Kaposi sarcoma and

colorectal. The risk of getting cancer before age 75 is estimated at 9.1% for males and 7.8% for females. To date, the major focus of health interventions has been on strengthening the prevention and control of communicable diseases, with little attention paid to NCDs and their associated risk factors. The health promotion policy, development of a health promotion strategy, and enactment of the Tobacco Control Bill are envisaged to facilitate an integrated approach to health promotion in all programme areas particularly those related to NCDs. To realize this, advocacy and resource mobilization efforts for the prevention of NCDs are urgently required to facilitate the implementation of appropriate interventions to curb the rising trends.

Infrastructure

Namibia has a large, dispersed and complex public sector health infrastructure, including a number of support facilities such as housing, offices, central stores, laundries and training centres (about 4500 buildings). This vast infrastructure is often poorly maintained due to lack of funding, poor supervision and unclear delineation of responsibilities between MoHSS and the Ministry of Works and Transport. A contributing factor is the lack of professional and maintenance staff for infrastructure. This deficiency affects all other sectors of health delivery. With the low priority given to capital projects in the centralized budget, and inadequate criteria for the establishment of new facilities, there are gaps and duplication in the provision of facilities in different locations. Laboratory capacity is constrained due to a shortage of buildings which are inadequate for the levels of testing required since the rise in HIV prevalence. The recent influenza A (2009) H1N1 pandemic underscored the need for adequate laboratory capacity.

2.4 Key challenges

Health systems	Severe institutional capacity gaps; Duplication of structures, systems and functions; inadequate organizational development. Human resources shortages and lack of retention policies. Policies and strategies for linkages between the formal structure and communities, and between the various partners in the health sector are outdated or lacking.
Communicable and noncommunicable diseases	High prevalence of HIV/AIDS and TB remain major challenges, as well as the emergence of MDR- and XDR-TB. NCDs are becoming major public health problems.
Maternal, newborn, child and adolescent health	The maternal mortality ratio is on the increase despite high ANC attendance and high rate of delivery at health facilities. Teenage pregnancy and HIV/AIDS among young people is a challenge; very low EMoC coverage; newborns constitute half of child mortality; malnutrition is high and under-five mortality rate is not decreasing at a fast enough pace. Only 69% of children aged 12-23 months are fully immunized.
Environmental Health	A number of emergencies have been experienced: floods, drought and disease outbreaks. There are gaps in response capacity at regional and local levels. Two thirds of the population have non-improved household sanitation facilities and nearly 20% of the population require 30 minutes or longer to obtain drinking water. There is little attention to ensuring quality of drinking water and sanitation standards. Occupational health and safety remain a challenge. Unhealthy life styles such as high alcohol consumption, unsafe sex and tobacco use are very common.

SECTION 3

DEVELOPMENT ASSISTANCE AND PARTNERSHIPS

3.1 Trends in development aid

The year 2008 marks Namibia's second national health accounts estimate for the period 2001/02-2006/07. The first estimate was done in 2002 for the period 1998/99-2000/01. With the new national health accounts, policymakers will be able to conduct evidence-based policy dialogue and formulation on all issues of health financing, including resource allocation and efficiency within the health sector.

Significant developments and changes can be observed in the Namibian health system over the period 2001/02-2006/07. Health spending has doubled over the past five years. Currently, Namibia spends 8.3% of its GDP on health, which places the country in second position among the BNLSS countries. This increase is mainly caused by the threefold increase in household contributions to insurance and a twelve-fold increase in donor contributions (Table 1).

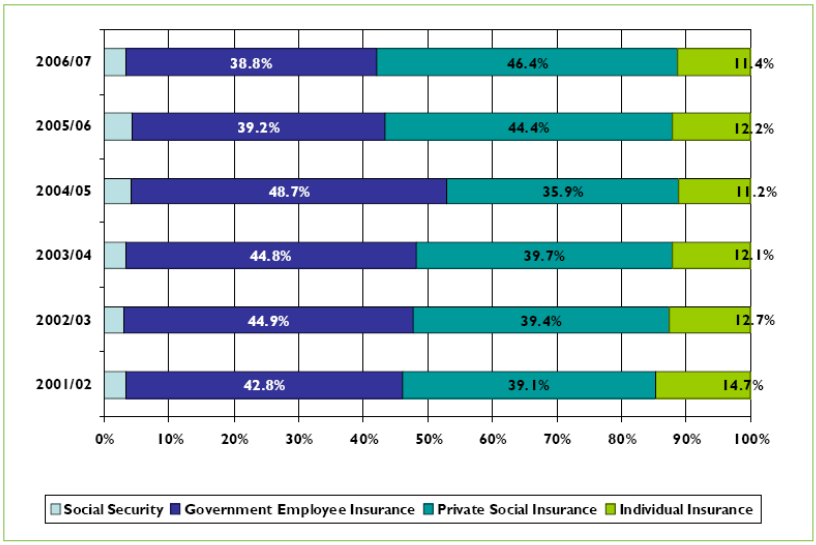
Table 1: Magnitude of change in financing agents, 2001/02 and 2006/07

Financing sources	2001/02 (N$)	2006/07 (N$)	Magnitude of Change
Public	1,174,387,258	1,712,593,763	1.5
Companies	264,490,485	346,313,196	1.3
Households	344,255,887	959,147,623	2.8
Donor	70,851,277	871,785,555	12.3

Source: National Health Accounts report, 2008.

Figure 4 shows that the number of entities controlling health funds was greater in 2006/07 than in 2001/02. The Namibian health system is benefiting from increased contributions and involvement of other stakeholders, particularly donors and their implementing agencies, as well as households. The government continues to be the leading financier and manager of health care services.

Figure 4: Financing agent contributions to total health expenditure

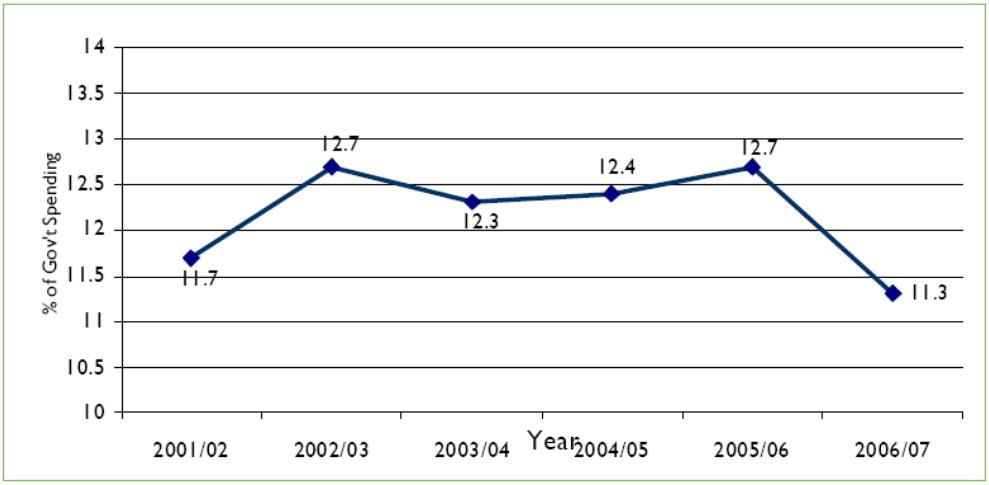


Source: NHA 2008

Health is the highest priority area of support from donors, accounting for 79% of all donor disbursements to Namibia. Donor funds are mainly channelled through NGOs and government (only 14% of the donor funds in 2006/07). The increased flow of funds directly to NGOs creates an important coordination challenge for the government which must determine where health resources are best allocated through evidence-based research and planning.

The average government spending on health as a percentage of total government expenditure dropped from 12.7% in 2005/06 to 11.3% in 2006/07 (Figure 5). This raises concerns in the light of the Abuja Declaration, through which Namibia together with other Heads of States pledged to commit 15% of national public spending to health.

Figure 5: Government spending on health as a percentage of total government expenditures

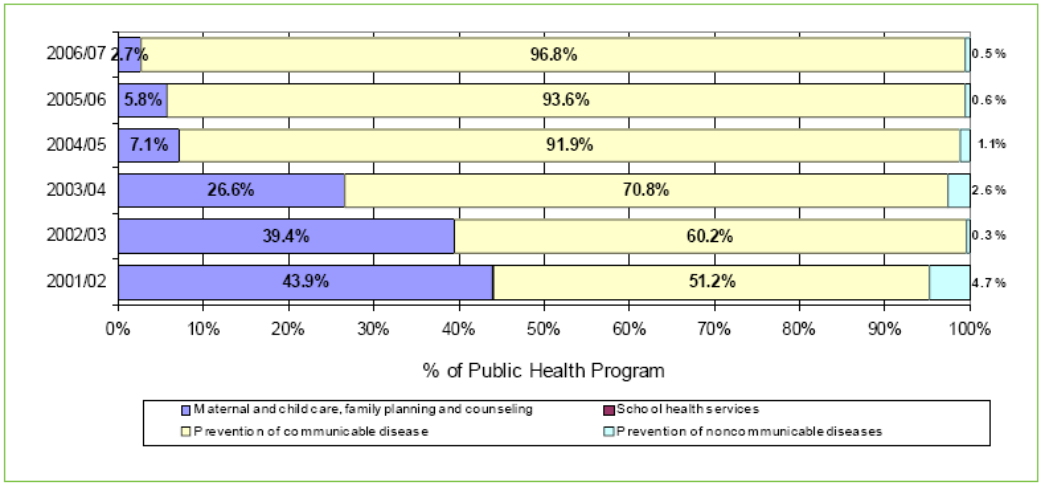


Source: NHA 2008

The National Health Accounts report (2008) states that achieving the national goals for health will require a greater financial commitment including developed countries delivering the increased foreign aid promised in the past few years.

An observable trend over the period 2001/02-2006/07 is that donor funding was mainly geared towards the prevention and control of communicable diseases such as HIV/AIDS. Other critical health areas such as NCDs; maternal, newborn and child health; and family planning were underfunded. The increase in maternal deaths and the slow reduction of child deaths in particular suggest that it is vital that resources are made available to reverse current mortality trends.

Figure 6: Types of public health programmes



Source: NHA 2008

As indicated, another observable trend is that donors are shifting their investment in health from government financing agencies to NGOs. NGOs play a significant role in health care organization and delivery, and the government has an important role to play in coordinating the various players in the health sector, avoiding parallel and duplicated efforts.

It must be noted, however, that although there has been an increase in development aid for health, there is an overall decline in development aid across all sectors. There is a growing trend among development partners to phase out support to Namibia as the country has graduated from a lower middle-income to an upper middle-income country according to World Bank country classification. However, with a Gini coefficient of 0.7, Namibia ranks as one of the leading countries in terms of income inequality. The richest 10% of the population amasses 65% of the country's income, while the remaining 90% of the population live on the remaining 35% of the country's income.

3.2 Major partners and donors

As identified in previous chapters, the Namibian health system receives contributions from government, donors and their implementing agencies, and households through private insurance and out-of-pocket payments.

It is important to note that as Namibia's status changed to an upper income country, a number of donors have left the country, significantly reduced their contribution or changed their area of contribution to development cooperation. Health is one such sector that witnessed a significant reduction in development partners.

Currently the largest contributors among the donors and their implementing agencies in the health sector are the President's Emergency Plan for Aids Relief (PEPFAR), GFATM, UN agencies, Spanish Cooperation, German Technical Cooperation (GTZ), the Finnish Government, Synergos and others.

The area of assistance and contributions from the major partners in health for the period 2009-2012 is presented in Table 2. It is important to note that at the time of preparing this document, some funding agents had not yet informed the MoHSS of their funding commitment for 2010–12.

Table 2: Development partner assistance to MoHSS projects and programmes

			Financial Support in N$'000			
Project/ Programme Name	**Area of Support**	**Region**	**2009/10**	**2010/11**	**2011/12**	**TOTAL**
1. NASOMA	The aim of NASOMA is to improve access to quality socially marketed products at affordable prices through effective and responsive service delivery as well as to create demand for information relevant to prevention of HIV transmission, and to facilitate and promote access to support services.	All regions	-	-	-	-
2. San Community Health Programme (Health Unlimited)	To improve the health status of rural San communities of Tsumkwe West and East	Omaheke	3539	-	-	3539
3. Nam-German Multisectoral HIV/AIDS Control (GTZ)	Support with the implementation of HIV/AIDS mainstreaming activities based on a Mainstreaming Strategy	Khomas Ohangwena Omusati	6800	-	-	6800
4. UNFPA* Support to Reproductive Health Services	To contribute to the adoption by young people of positive attitudes, values and behaviours	Caprivi Otjozondjupa Oshikoto Khomas	10 000	10 000	10 000	30 000
5. UNICEF** Maternal and Child Survival and Development	To strengthen basic maternal and essential obstetric care and AFHS Providing strategic support to key child survival programmes (EPI, IMCI, Caring practices, hygiene promotion, IYCF, malaria); Strengthen monitoring and follow up mechanism for HIV exposed/infected children with linkages to care and treatment; Strengthen national and regional capacities for surveillance, monitoring and management of malnutrition in children	National Plus 10 low performing districts in the following regions Khomas, Omaheke, Oshana, Kunene, Omusati, Ohangwena, Kavango Karas	11 760	9533	-	21 293
6. WHO Technical Cooperation Programme	Continuation of the technical support to strengthen the health sector in addressing priority as well as emerging health problems and promoting equity and efficiency of the health system	National	**15 590**	**22 965**	**15 309**	**53 864**
7. VSO Namibia HIV/AIDS Programme (UK)	Support MoHSS in CBR and HIV/AIDS by providing professional assistance (volunteers)	Kavango, Khomas, Kunene,	2285	3405	4413	10 103

Project/ Programme Name	Area of Support	Region	Financial Support in N$'000			
			2009/10	2010/11	2011/12	TOTAL
		Karas Otjozondjupa Caprivi Erongo				
8. Reduce the spread and impact of HIV/AIDS, USAID/ PEPFAR	Support MoHSS in PMTCT, management and staffing, laboratory infrastructure, palliative care, basic health care and support, ARVs, TB/HIV	All regions	133 700***	Not indicated	Not indicated	133 700
9. Czech TV Foundation (AIDS) PIN Programme	Socioeconomic empowerment of HIV/AIDS affected families and communities in Karas Region	Karas	904	710	475	2089
10. Strengthening of Regional Programme for control of HIV/AIDS (MdM- Spain)	Prevention and care of HIV/AIDS among communities in Erongo and Kunene regions	Erongo Kunene	5304	-	-	5304
11. Chinese Medical Assistance Programme	To use Chinese traditional medicine knowledge and skills such as acupuncture, medicines, massage moxibustion to improve national health and well-being	Khomas	3000	3200	3400	9600
12. Namibia Global Fund Programme	To support and strengthen MoHSS efforts in scaling up and fighting HIV/AIDS, TB, malaria	All regions	153 574	135 135	Funds for TB and malaria only, but not yet determined	288 709
13. Spanish International Development Cooperation Agency	Integrated support to the Kunene Regional Health System to improve safe motherhood and newborn care Support to Pharmaceutical Services in development of TIPC	Kunene	2008-2009: 8751	11 106	-	19 857

* The estimated amount budgeted for 2006-2010 is US$ 8 200 000 (UNDAF, 2005, p. 19).
** The estimated amount budgeted for 2006-2010 is US$ 8 200 000 (UNDAF, 2005, p. 19).
*** Half of this amount is handled by CDC, the other half by USAID. The expectation is that these amounts will increase in the next 5 years. Partnership framework for USG will be finished in November 2009.

Please note that the budget figures for some UN agencies could not be submitted at the time of writing: UNAIDS, UNHCR and UNDP.

3.3 Mechanisms of coordination

In 2005, the United Nations Development Assistance Framework (UNDAF) for 2006-10 was developed. UNDAF aims to guide integrated programming among UN agencies working in Namibia to support the government and civil society in reaching national economic and social development goals as stipulated in Vision 2030, the Millennium Development Goals and the Third National Development Plan.

UNDAF commits to the following three outcomes to address the "triple threat" facing Namibia:

- Strengthened HIV/ AIDS response;
- Improved livelihoods and food security;
- Strengthened capacity to deliver essential services.

The Framework is currently being reviewed and extended by two additional years to 2012 in order to respond more effectively to NDP 3 (2007/08-2011/12) and allow for the next UNDAF to align with NDP 4.

All UN agencies represented in Namibia (resident and non resident) are involved in the implementation of UNDAF. These agencies make efforts to harmonize their activities through programming in thematic and technical working groups which meet on a regular basis to coordinate, plan and discuss developments in the three UNDAF priority areas. Despite the great potential that UNDAF presents for joint planning and programming, practice reveals that it remains a challenge to fully harmonize work and provide integrated development assistance.

Other coordination mechanisms include the Development Partners Group which brings together bilateral partners, the UN and government under the co-leadership of the National Planning Commission and the United Nations. The Development Partners Group discusses, shares information and makes recommendations on developmental issues facing Namibia.

Although there is no formal mechanism from the MoHSS to coordinate health actions in the sector, a number of technical working groups and task forces exist, mainly in the area of HIV/AIDS and maternal and child health. Efforts are underway to establish formal coordination mechanisms in the health sector.

Key challenges in the areas of health development cooperation, provision of technical assistance and partnerships are related to the poor coordination and overlap of roles and responsibilities which leads to duplication of efforts, masks gaps in critical areas and inhibits maximization of investments in the sector.

SECTION 4

WHO POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS

4.1 Goal and mission

The mission of WHO remains "the attainment by all peoples of the highest possible level of health" (Article 1 of WHO Constitution). The WHO vision 2020[14] is "Overcoming diseases related to poverty, exclusion and ignorance in a context of good governance and autonomous development of a proactive health system, for a decent and worthy living, by the year 2020." The WHO 11th General Programme of work is a ten-year Corporate Strategy, operationalized through the Medium Term Strategic Plan and the Strategic Orientations in the African Region, plays a major role in guiding WHO work at country level towards the achievement of the vision and mission of the Organization.

4.2 New areas of emphasis

The WHO Eleventh General Programme of Work emphasizes the following WHO responses to the changing global environment:

- Providing support to countries in moving to universal coverage with effective public health interventions;
- Strengthening global health security;
- Generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health;
- Increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health;
- Strengthening WHO's leadership at global and regional levels and supporting the work of governments at country level.

4.3 Strategic directions

On the basis of the areas of emphasis, WHO has set out a six-point global health agenda underlying its contribution to building healthy populations and combating ill-health. The following interrelated agenda points provide a broad framework for the technical work of the Secretariat:

- Health development;
- Health security;
- Health systems;
- Evidence for strategies;
- Partnerships;
- Improving performance of WHO.

[14] Health-for-All Policy for the 21st Century in the African Region, 2002.

The Director-General has also indicated that the health of women in particular and the health of the Africa population in general are essential indicators of global health development and measures of her mandate.

4.4 Core functions

The WHO core functions, articulated in the Eleventh General Programme of Work and presented below, are based on the comparative advantage of WHO at all levels:

- Providing leadership on matters critical to health and engaging in partnerships where joint action is needed;
- Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;
- Setting norms and standards, and promoting and monitoring implementation;
- Articulating ethical and evidence-based policy options;
- Providing technical support, catalysing change, and building sustainable institutional capacity;
- Monitoring the health situation and assessing health trends.

4.5 Global and regional priorities

In order to be more effective and efficient in its interventions, WHO developed a Medium Term Strategic Plan 2008-13 with 13 strategic objectives based on priorities outlined in the Eleventh General Programme of Work to guide implementation for the next six years (2008–13).

The main health challenges to be addressed include maternal, newborn, child and adolescent health; malaria; HIV/AIDS and tuberculosis; noncommunicable diseases (cancer, cardiovascular diseases and diabetes); tobacco use; emergency preparedness and response; socioeconomic determinants and health; food safety and nutrition; mental health; blood safety; health systems; and promotion of healthy lifestyles.

The WHO Regional Office for Africa identified the following five priority areas as strategic orientations for the African Region for the period 2005-2009:

- Strengthening the WHO Country Offices;
- Improving and expanding partnerships for health;
- Supporting the planning and management of district health systems;
- Promoting the scaling up of essential interventions related to priority health problems;
- Enhancing awareness and response to key determinants of health.

Communicable diseases such as HIV/AIDS, malaria, tuberculosis and areas such as maternal, newborn, child and adolescent health remain important areas of work and should continue to be prioritized particularly in the context of health systems strengthening. Accelerated action and scaling up of interventions are essential to achieve national, regional and international health goals including the Millennium Development Goals.

SECTION 5

CURRENT WHO COOPERATION

5.1 Historical development of WHO country presence

In 1990, Namibia was officially admitted as a Member State of the World Health Organization. At that time, the WHO Country Office was operating with six staff members from shipping containers which were converted into offices at the MoHSS. The earlier years of the WHO programme of work were characterized by high levels of activity, widened scope of work and constant turnover of technical staff. Over the years, however, the working environment became more stable, professional and secure. The introduction of the CCS in 2003 played a crucial role in this regard.

Since the inception of WHO support in the country, its programme of cooperation with Namibia has been focused around the following main priority areas: improving health systems, human resources for health, communicable diseases surveillance, prevention and control of vaccine-preventable diseases, HIV/AIDS, sexually transmitted diseases, tuberculosis, malaria, and the promotion of reproductive and adolescent health based on primary health care principles.

In the past two biennia (2006-07 and 2008-09), the focus has remained the same but with the emphasis geared towards integrated disease surveillance, communicable diseases prevention and control, blood safety, reproductive health, maternal, child and adolescent health, nutrition, emergency and humanitarian action, environmental health and NCDs.

5.2 Human resources at country level

Human resources play a critical role in WHO work at country level. The total staff complement currently comprises 19 staff members, six of whom hold continuing appointment contracts; nine are fixed term staff and four are temporary staff. Some of the first staff members who joined the WHO Country Office in 1989/90 are still with the Organization today.

The WHO Representative (WR) heads the office and is assisted by technical officers and support staff. When needed, short-term consultants are brought in to complement the work of the team on the ground. The following positions are part of the Country Office structure: HIV/AIDS (1 position currently vacant, 2 filled), Disease Prevention and Control, Blood Safety, Expanded Programme on Immunization; Surveillance; Maternal and Child Health; Health Emergencies (2 officers); Health Promotion; Advocacy and Communications; Administrative Officer; Librarian; Health Systems (currently vacant). The structure and functions of the team are detailed in the organogram (attached in the annex).

WHO Namibia has been grappling with various challenges in the area of human resources. Inadequate funding and shortage of local expertise are some of the key factors that dictate the human resources pattern in the office. There is no official deputy WHO Representative position, so in the absence of the WHO Representative (WR), a senior technical officer acts on behalf of the WR. The position of the Administration Officer has been vacant for over seven years. The vacancies create an extra workload which at times affects the quality and performance level of the Country Office.

The Country Office has a performance management and development system in place which promotes performance assessment and professional development of all staff members. Although the system has been in operation for some time, it has not yet been fully integrated in the staff management practices. Thus there is a need for support in the area of performance appraisals, coaching and mentorship of staff.

The current leadership is committed to continuous professional development for all staff, an area that has been neglected for years. In 2009, a training and development needs assessment was carried out which resulted in the establishment of a staff development plan. Some trainers have already been contracted, and some training courses have been offered in communication, team building and report writing skills.

Weekly staff meetings serve as an important instrument to enhance internal communication. Apart from this, the professional staff meets on a bi-weekly basis to share developments in their specific areas of work.

5.3 Office location and conditions

The WHO Country Office is located in the newly built UN House situated in Klein Windhoek, one of the upmarket suburbs of the Namibian capital, Windhoek. The office has a modern appeal and complies with all UN Common Services Systems requirements, such as connectivity and minimum operating security measures. Most staff members work from this office and have access to the necessary IT equipment and infrastructure, adequate office furniture and supplies. Building and office cleaning services for all UN agencies are outsourced to UNDP. There is a sub-office located in Oshakati hosting two professional staff, a secretary and a driver.

Other physical resources include an information centre where all UN agencies have a desk, a shared video conferencing room and a multipurpose centre to host large gatherings. It is important to note that despite the good office conditions, there is limited space in the WCO which hampers office growth and affects productivity. Digital phones are used and the office telephone system is linked to the WHO regional and headquarters internal telephone systems. For this purpose the Global Private Network and local area networks have been put in place.

5.4 Financial resources

The priority areas of the 2010-2011 Plan of Action are in line with the CCS. The financial resources required to realize the strategic agenda 2010-15 will be sourced from WHO Assessed Contributions (AC) (quota contributions of Member States and miscellaneous income) and Voluntary Contributions (VC) from donor partners.

For the past two biennia (2006-07, 2008-09) the Country Office has experienced an increase in funding, with a 3% decrease in Assessed Contributions in the 2010-2011 biennium (Table 3). In biennium 2008-09, staff salaries comprised 87% of AC and 46% from VC.

Table 3: Financial resources overview, 2004-2011

Biennium	Total Budget* US$	Annual % of change
2004-05	AC: 1 942 000 VC: 1 233 000	
2006-07	AC: 2 109 000 VC: 1 144 000	+55.3 -0,08
2008-09	AC: 2 241 000 VC: 2 337 000	+5.8 +51.0
2010-11	AC: 2 182 000 VC: 2 867 000	-2.6 +18.4

* The total budget consists of AC from Member States and VC from donors and partners.

The global financial crisis and recession pose enormous threats for the funding base of the Country Office. The level of achievement of this strategic agenda is therefore heavily dependent on the extent to which sufficient resources are mobilized for the programmed activities.

5.5 SWOT analysis

A careful analysis of the internal and external environment of the Country Office produced the strengths, weaknesses, opportunities and threats (SWOTs) presented below. The outcomes played an important role in the strategic planning process that governed the development of this new strategic agenda. The implications derived from the SWOT analysis will be discussed in further detail in Chapter 7.

STRENGTHS	WEAKNESSES
Human resources: Team works well together despite the challenges Competence of technical staff in place **Technical resources:** Wealth of documentation available on any health area Intercountry and regional sharing of information Ability to establish technical networking and leverage technical assistance from other WHO offices **Service provision:** Capacity to provide effective response to emergency situations (disease outbreaks, etc) Capacity to generate evidence for policy, advocacy and practices **Leadership:** Strong leadership, effective communication, negotiation abilities **Purpose and planning:** WHO mandate, neutral and convening power	**Human resources:** Short-term contracts Need for more professional development Inadequate staffing (need for more in-house expertise on key priority areas) and vacancies in key areas **Finances and systems:** Shrinking funds Difficult to reallocate budget among strategic objectives Highly bureaucratic **Partnerships:** Insufficient collaboration with other UN agencies and partners **Service provision:** WHO not always providing sufficient quality support to the MoHSS (more administrative and less technical support) **Public relations:** Not good at promoting the strength of the Organization; insufficient advocacy efforts
OPPORTUNITIES	**THREATS**
Public relations: Increasing attention to health globally and high level commitment to health in the country; high expectation from partners **Service provision:** Capacity-building **Purpose and planning:** NDP 3, Vision 2030, MoHSS Strategic Plan **Partnerships:** Very close relationship with MoHSS High government commitment to health Community willingness to work with other partners; PHC Involvement of partners in health **Technical resources:** Mobilization of resources and expertise **Geographical situation:** Being physically in the country	**Human resources:** Insufficient staff in MoHSS and other partner agencies to address technical needs HIV/AIDS impact detrimental to economically active population including health workers; reliant on expatriate staff **Economic environment:** Reduction of donor funding due to global financial crisis Magnitude of unemployment, poverty and income inequality **Partnerships:** Lack of synergy among development partners Lack of collaborative planning processes with MoHSS **Public relations:** WHO not being a funding organization might impact its status/recognition and visibility of its role in the health sector Misconception of WHO role at implementation levels **Geographical situation:** Cross-border importation of communicable diseases

5.6 Unfinished Strategic Agenda 2004-07

Some challenges inhibited the full execution of the first generation CCS. The key areas that were not addressed in the CCS are listed below.

Priority Area 1: Improving Health Systems Performance

Focus Area 1.1: Human resources for health

- Provision of long- and short-term fellowships in priority specialized areas;
- Development of relevant research protocols in human resources issues (impact of HIV/AIDS on staff, stress and burn-out).

Focus Area 1.2: Health financing and social protection

- Institutionalization of National Health Accounts into health management information system/s;
- Mobilize additional resources from partners.

Focus Area 1.3: Policy formulation, monitoring and evaluation

Strengthening national capacity in:

- Operational research (health systems research);
- Health management information systems;
- Policy implementation;
- Strengthening collaboration with existing partners and advocating for new ones;
- Reinforcing MoHSS capacity to coordinate development partners in health.

Focus Area 1.4: Quality and equity in health care

- Health and poverty reduction strategies;
- Macroeconomics and health;
- Monitoring and evaluation of the implementation of Total Quality Management at MoHSS.

Priority Area 2: Disease Prevention and Control

- Policy and strategic plan development for prevention and control of noncommunicable diseases;
- Resource mobilization for noncommunicable diseases.

Priority Area 3: Health Promotion

- Finalization of draft health promotion strategy (communication strategy);
- Environmental health interventions with particular focus on developing strategies for rural sanitation.

SECTION VI

STRATEGIC AGENDA: PRIORITIES FOR COUNTRY COOPERATION

6.1 Introduction

The strategic agenda for this second generation CCS is based on the WHO guidelines for the development of country cooperation strategies. Annex 1 gives a full account of the consultative process that the WCO completed over a period of approximately three months.

One of the key success factors in the development of the CCS was the establishment of a multisectoral steering committee which played an important role in ensuring the overall quality assurance of the process and outcomes. Furthermore, the consultative nature of the process enabled WHO to reach out, in some instances for the first time, to key stakeholders in health, and in doing so establish potential collaboration with them. The close consultation process facilitated easier and faster consensus around and commitment for the strategic agenda. Annex 2 lists the various organizations and individuals who formed part of the external stakeholders' survey and consultation process.

The development of the MoHSS Strategic Plan created a foundation upon which development partners could effectively prioritize, plan, coordinate and budget their in-country support for programming activities. The second generation CCS is therefore formulated to support the Ministry's priorities and is aligned with the global and regional priorities of WHO.

Key national and WHO documents were used to provide necessary insights throughout the process. Some of these were WHO's Eleventh General Programme of Work 2006-2015, UNDAF 2006-10, Strategic Orientations for the African Region 2004–2009 and 2010–2015, WHO Medium Term Strategic Plan 2008–2013, MoHSS Strategic Plan 2009-2013, National Health Accounts Report (2008), Health and Social Services Systems Review Report (2008), Third National Development Plan 2008–12, Vision 2030 and various other important national documents and reports. Annex 3 gives a full overview of how the various strategic frameworks (at national and WHO global and regional levels, including the MDGs and UNDAF) are aligned in this CCS. This overview, coupled with the outcomes of the stakeholders' survey and SWOT analysis determined the new strategic orientation for the Country Office. During the consultative process, all 13 strategic objectives as prioritized in the WHO Medium Term Strategic Plan 2008-13 were deemed relevant for the Namibian context although in different degrees and are therefore covered in the four strategic priorities which comprise the new strategic agenda.

The WHO core functions which stipulate the Organization's mandate and comparative advantage helped in articulating a balance between the contributions of other development partners and WHO's specific role and contribution to the identified national strategic priorities.

It is also important to note that the strategic agenda for the second generation CCS takes into account the unfinished agenda from the first CCS, especially in the area of improving health systems performance which underpins all other strategic priorities. Furthermore, the new agenda recognizes the continued need to integrate health promotion in all strategic priorities. The next section presents an overview of the strategic agenda including the strategic priorities, focus areas and high level strategies.

6.2 Strategic Agenda 2010–2015

WHO's strategic agenda for the second generation CCS aims to achieve improved health outcomes for Namibia through four interrelated strategic priorities. The following four strategic priorities were identified:

(a) Strategic Priority 1: Strengthening the Health System;
(b) Strategic Priority 2: Combating Priority Diseases;
(c) Strategic Priority 3: Improving Maternal, Newborn, Child and Adolescent Health;
(d) Strategic Priority 4: Promoting a Safer and Healthier Environment.

For each priority area, the intended outcome, focus areas and high level strategies required to adequately address the strategic priority area are outlined. Detailed and measurable targets and indicators will be incorporated at the operational level during the development of biennial plans.

Key partners are highlighted and specific interventions are suggested for each strategic priority. It is important to note that the activities to be carried out will be identified in the various biennial plans for the coming periods 2010-11 through to 2014–2015. The narratives are partly based on researched documentation, the outcomes derived from the stakeholders survey, the strategic planning workshop and the consensus building workshop held with multiple key stakeholders in health.

Strengthening health systems lays the foundation for all the other areas (Figure 7). Health services being the most visible part of any health system, it will be critical to ensure that promotion, prevention, treatment and rehabilitation services are accessible, affordable and delivered in a continuum of care from home, workplace, community and health facility. Support will be provided to ensure improved access, coverage, equity and quality of health services.

Areas such as capacity building, resource mobilization, research, monitoring and evaluation are common to all the strategic priority areas; therefore, rather than duplicating these strategies, they will be covered under Strategic Priority 1.

It is important to note that health emergencies may arise as a result of disease outbreaks, different environmental hazards (such as droughts and floods) and other risk

factors during the period 2010–2015. This will call for WHO support in risk assessment, risk reduction, emergency preparedness and response, and will form part of strategic priorities 2 and 4. Depending on the scale of the emergency, resources may be diverted to address the immediate needs and could affect the implementation of other programmes.

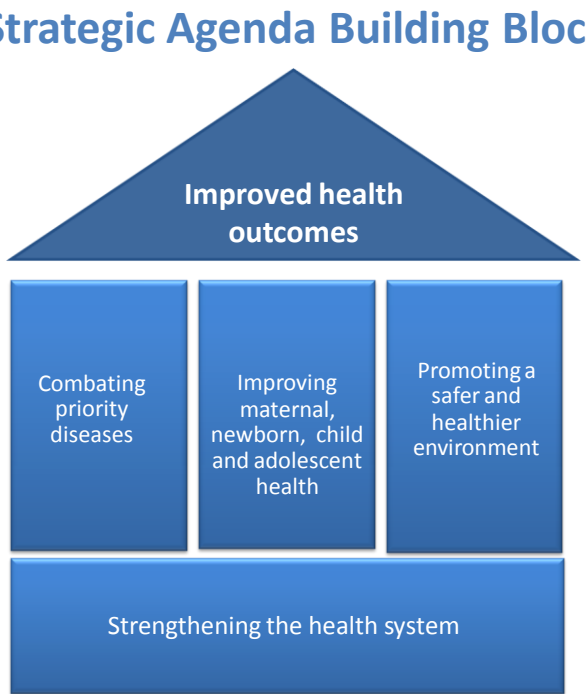


Figure 7: Strategic priorities 2010-2015

Strategic priority 1: Strengthening the Health System[15]

STRATEGIC PRIORITY	OUTCOME	FOCUS AREAS
1. Strengthening the health system	An efficient health system that is responsive to health needs and provides equitable and affordable access to quality health care	1.1 Governance 1.2 Human resource development 1.3 Health financing 1.4 Health information systems 1.5 Medical products, vaccines and technologies 1.6 Service delivery

[15] The six focus areas under this strategic priority are the six building blocks of the WHO HSS strategy as detailed in the WHO Framework for Action on HSS "Everybody's business- Strengthening health systems to improve health outcomes," 2007.

According to the WHO definition, a health system consists of all the organizations, institutions, resources and people whose primary purpose is to improve health. As identified in the 2008 Health and Social Systems Review Report and the 2006/07 NDHS, major health challenges such as increasing maternal mortality could be attributed to certain weaknesses in the health system, as listed below:

- Institutional capacity gaps, especially at leadership level;
- Lack of stewardship and coordination of multiple partners;
- Duplication of structures and functions at all levels;
- Inadequate organizational development;
- Multiple information systems;
- Limited integration of programmes and interventions;
- Outdated policies and strategies for linkages between formal structures and communities.

The key players in this area (outside of the MoHSS) include Synergos, Namibia Institute of Pathology (NIP), International Training and Education Centre on HIV (I-TECH), United States Agency for International Development (USAID), UN agencies (UNDP, UNFPA, UNAIDS, UNICEF and WHO) and Spanish Cooperation (see Section 3.2). The private health sector and parastatals can contribute significantly to the development of public health institutions and capacity-building. For example, the Health Professions Council can act as a key partner to assist with task shifting. Private institutions can also benefit from WHO technical assistance in terms of regulatory compliance and best practices. WHO will need to coordinate its efforts with all these organizations in order to optimize contributions, ensure regulation and integration, and avoid duplication of efforts. Moreover, as explained before, it is vital that WHO assist the Ministry in developing strong stewardship and coordination of partners. Another important stakeholder in this area is the National Planning Commission (NPC), which has a key role to play in the coordination of donor activity. Civil society organizations can assist with the definition and coordination of community-based interaction, which constitutes an extension of the public health system and is included as a priority for development under the Ministry's current Strategic Plan. There is an opportunity for WHO to possibly assist with the development of policies and guidelines on volunteerism.

Strengthening health systems falls within UNDAF Outcome 3: "Capacity to deliver essential services is strengthened". It will therefore be important for WHO to continue to collaborate with other UN agencies such as UNDP, UNAIDS, UNFPA and UNICEF, and partners, with an emphasis on providing norms and standards to guide implementation in their areas of focus.

STRATEGIES FOR FOCUS AREA 1.1: GOVERNANCE	
1.1.1	Facilitate the use of evidence to improve the existing or develop needed norms, standards, policies, legislation, frameworks and guidelines in accordance with the PHC strategy and approach, and which are human rights based, gender responsive and equity oriented
1.1.2	Strengthen the stewardship role of the MoHSS and policy dialogue with multiple stakeholders within and across the sector, including the private sector
1.1.3	Foster strategic partnerships and promote partner coordination, harmonization and alignment, as well as improved accountability
1.1.4	Enhance the generation and strategic use of information, intelligence and research for decision-making

WHO will support the Ministry of Health and Social Services to establish a health sector coordinating body which will require a review of existing cooperation and coordination mechanisms and the development of new or improved frameworks to ensure a better streamlined, comprehensive, effective and sustainable system. One important step in the partnership building process will be to define what is meant by *partnership* at every level including at community level. WHO support will be geared towards ensuring that adequate strategic policy options and systems design are articulated around provision of equitable and affordable services, particularly to disadvantaged and marginalized populations and that the oversight, regulatory and accountability functions of the Ministry are carried out efficiently, as well as to ensure that capacity is strengthened to address current issues and identify future challenges. Attention will also be given to establish better functional links between programmes, within and across the sector and including the private sector. Intelligence gathering and research play important roles in decision-making. The generation and use of information to support policy decisions will be promoted and supported.

STRATEGIES FOR FOCUS AREA 1.2: HUMAN RESOURCES DEVELOPMENT	
1.2.1	Enhance capacity for human resources development
1.2.2	Maximize potential of existing health workforce through retention and task shifting policies and innovative strategies such as performance-based incentives
1.2.3	Monitor the recruitment, management, deployment and availability of health workforce

There is a direct relationship between the ratio of health workers to population and survival of women during childbirth and children in early infancy. In Namibia, the overall ratio of health worker to population masks important gaps and imbalances in distribution between rural and urban areas and public and private sectors. The health worker shortage has been a major impediment to attaining the health MDGs. Therefore, additional assistance will be provided to the already established Medical School for

training health professionals such as doctors and pharmacists. Human resources development will also require strengthening existing pre-service training at UNAM, the Polytechnic of Namibia and National Health Training Centre, as well as in-service training and support. Efforts will be made to ensure more direct investment in training, supervising and providing incentives to health workers, as well as efficient utilization of the existing health workforce. Task shifting will assign additional simple health-care tasks to less skilled workers able to deliver them competently. WHO will also support better orientation of health worker training and development of career incentives to encourage service in rural and disadvantaged areas. Better strategies will be put in place to more actively engage communities and patients in their own health care.

STRATEGIES FOR FOCUS AREA 1.3: HEALTH FINANCING
1.3.1 Strengthen equitable, evidence and results-based resource allocation
1.3.2 Promote sustainable financing and social protection policies towards ensuring universal access to health care
1.3.3 Institutionalize the National Health Accounts
1.3.4 Strengthen the capacity for domestic and external resource mobilization

Health financing is one of the key areas of health systems strengthening that underpins all other strategic priorities. Although Namibia is an upper middle-income country, the socioeconomic inequalities are significant. Policies that remove financial barriers to access to health care exist but need to be strengthened. WHO will, therefore, support the Ministry's mobilization and allocation of domestic and external resources to ensure that resources reach areas of real need, applying the principles of evidence- and results-based resource allocation, as well as equitable allocation and distribution and adequate consideration to equitably address the needs of vulnerable and marginalized populations and those in rural areas, as well as orphans, widows and disabled people. Important partners that can help WHO to influence national budget allocations to health are the National Assembly, National Planning Commission and the SADC Parliamentary Forum. Health financing reforms that include sound institutional arrangements and evidence-based financial strategies should be put in place to guarantee access to health-care services and protect people against financial risk and catastrophic spending for health. Large inflows of external funding for health disguises the inequitable distribution of resources among programmes as these funds are mainly for HIV/AIDS and to a lesser extent TB and malaria. Strategies to transition to universal coverage and mechanisms for sustainable financing and social protection should be designed and implemented. WHO will support these efforts as well as the adoption of policies and strategies that will improve efficiency, promote transparency and enhance accountability in health financing systems.

STRATEGIES FOR FOCUS AREA 1.4: HEALTH INFORMATION SYSTEMS
1.4.1 Harmonize, rationalize and integrate the existing multiple health information systems
1.4.2 Promote the production, analysis, dissemination and use of reliable and timely health information at different levels for policy- and decision-making
1.4.3 Build capacity for operational and health systems research

Health information systems includes the broad scope of Integrated Disease Surveillance and Response (IDSR) and therefore is integral to implementing a number of the strategies listed in other strategic priorities. A harmonized, rationalized and integrated system will promote the production, collection, analysis, dissemination and use of reliable and timely health information at different levels including the private sector. While other partnership support to this domain is mainly confined to HIV/AIDS, TB and malaria as well as maternal and child health, it is imperative for WHO to maximize and support ongoing efforts.

STRATEGIES FOR FOCUS AREA 1.5: MEDICAL PRODUCTS, VACCINES AND TECHNOLOGIES
1.5.1 Strengthen capacity for the development of policies, legislation, regulation and strategies, including the establishment of a public health laboratory
1.5.2 Strengthen procurement capacity
1.5.3 Strengthen access to and quality, safety, access and use of medical products, vaccines and technologies
1.5.4 Explore introduction of eHealth

A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness as well as their scientifically-sound and cost-effective use. The strategy encompasses provision of support for the strengthening of pharmaceutical and medical diagnostics services as well as the establishment of a public health laboratory and further strengthening of the Namibian Blood Transfusion Services. The Ministry currently procures its medicines, vaccines and supplies directly and is self-reliant in this area. However, WHO can assist in identifying and implementing various other options for procurement. Capacity-building of national regulatory authorities and national reference laboratories will be pursued to guard against the introduction of counterfeit medical products. Strategy 1.5.3 is related to MDG 8 (Develop a global partnership for development, Target 8.E: access to affordable essential medicines/technologies), and UNDAF Outcome 2: "HIV response is strengthened". The government is self-reliant in procurement and distribution of vaccines, but more cost-effective options should be explored, and WHO will facilitate that process in collaboration with UNICEF. WHO will also continue to promote safety and efficacy of medicines and vaccines, monitoring of adverse events and provide support to expand immunization coverage.

As information and communications technology develops, the need to organize new ways of providing efficient health-care services has emerged and is being explored in many parts of the world, including in developing countries such as Namibia. There is a significant increase in the use of Information and communications technology applications in health care, commonly known as eHealth. eHealth is the use of digital data (transmitted, stored and retrieved electronically) to support health care, both locally and at a distance. WHO will explore, with the Ministry and other partners, possibilities of using eHealth to improve access to health care and minimize the shortage of qualified human resources in certain areas.

STRATEGIES FOR FOCUS AREA 1.6: SERVICE DELIVERY
1.6.1 Strengthen capacity to establish referral systems and programme linkages and reduce inequities in access to healthcare
1.6.2 Promote the establishment of functional linkages between health facilities and communities
1.6.3 Improve the quality of health services delivered at all levels
1.6.4 Strengthen capacity to achieve universal access to priority health interventions in the medium to long term

The strategy seeks to enhance the overall referral system which currently does not ensure continuum of care. The existing referral policy needs to be revised to address inherent inefficiencies. Although there has been a visible increase in participation of community based organizations in the provision of community-based health care, there is need for a stronger and more structural approach to establishing linkages between communities and health facilities. Further decentralization of roles and responsibilities and task shifting will facilitate establishment of these linkages. Furthermore, there is an urgent need to develop and implement an essential health services package at all levels of the health system of quality health services and ensure delivery of quality health services.

Linkages, coordination and interaction between national, regional and district levels have to be strengthened to ensure optimal service delivery and minimize inefficiencies. WHO will also continue to provide support and policy guidance to improve the organization and management of health services in such a way that effective, safe and quality services are provided in an equitable manner in a transition towards universal access to health care in the medium to long term AIDS and TB. Improved oversight and coordination of the private sector (both profit and not-for-profit) which currently provides services to an important segment of the population will need to be strengthened.

Strategic priority 2: Combating Priority Diseases

STRATEGIC PRIORITY	OUTCOME	FOCUS AREAS
2. Combating priority diseases	Improved prevention and control of communicable and noncommunicable diseases	2.1 HIV/AIDS and tuberculosis 2.2 Diseases targeted for elimination and eradication 2.3 Noncommunicable diseases

Most updated estimates have highlighted the fact that the global health sector response to HIV/AIDS represents 55% of the overall response. 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. The MoHSS receives support from a number of partners highly active in the response to HIV/AIDS , including donor organizations such as GFATM, PEPFAR, GTZ, *Medicos del Mundo* (supported by the Government of Spain), CDC, USAID and a range of civil society organizations such as Namibia Network of AIDS Service Organizations (NANASO), Catholic Health Services (CHS), VSO Namibia, People In Need Programme (PIN) and the National Social Marketing Programme (NASOMA), which are working at the implementation level. These organizations focus primarily on HIV/AIDS and to a much lesser extent on TB and malaria.

Similarly, UN agencies are involved in these areas through their commitment to UNDAF Outcome 1: "HIV response is strengthened" and 3: "Capacity to deliver essential services is strengthened". Private and parastatal health institutions have an important role to play in harmonizing prevention and control efforts, as well as addressing drug resistance. NIP plays a significant role in addressing the current and emerging public health concerns as the national medical laboratory for testing both epidemic- and non-epidemic-prone diseases and medical conditions in the public sector.

The focus for WHO in combating priority diseases will include assisting the MoHSS to coordinate health sector response and partnerships for HIV/AIDS and other priority programmes, in fulfilment of its role as coordinator of the multisectoral mainstreaming of the HIV/AIDS response and steward of the overall health sector. WHO will continue to promote a public health approach to HIV/AIDS, TB and malaria prevention, treatment, care and support. WHO will also work to ensure that other priority diseases are well resourced (as covered in Strategic Priority 1). Efforts will be supported to sustain current malaria control efforts and to eliminate malaria in the long term.

There is a particular need for the mobilization of financial resources and development of human resources capacity for the promotion of healthy lifestyles

(including influencing public policy and the development of health promotion and information, education and communication materials) and a multisectoral approach to combating NCDs which forms part of the unfinished agenda of the first CCS.

Research is another component of strengthening health systems that is essential for this strategic priority. Research capacity is needed to establish the epidemiological patterns of communicable and noncommunicable diseases and conditions, as well as sociocultural and economic determinants of health. WHO has a critical role in facilitating intersectoral and intrasectoral cooperation through advocacy, policy development and legislation.

STRATEGIES FOR FOCUS AREA 2.1: HIV/AIDS and TB

2.1.1 Enhance capacity for strategic planning, surveillance, monitoring and evaluation

2.1.2 Strengthen capacity to scale up priority interventions

WHO will continue to support existing efforts by focusing on four core functions: setting norms and standards; providing technical support; catalysing change and building sustainable institutional capacity; and monitoring the HIV/AIDS and TB situation and assessing HIV/AIDS and TB trends.

The main challenges in the prevention and control of these diseases are related to the dual epidemic, with around 60% of HIV patients estimated to be infected with TB. There is an increasing focus on prevention of HIV/AIDS to avert new infections, while strengthening the quality of treatment, care and support services to people living with HIV/AIDS. In line with the new WHO HIV/AIDS treatment guidelines, support will be provided to adequately transition from current to more efficacious treatment regimens in a sustainable manner.

Challenges related to drug resistance make surveillance and monitoring of both HIV/AIDS and TB treatment a continuing priority for research and technical support.

To strengthen the health sector response to HIV/AIDS, WHO will focus on the following major priority interventions:

(a) Enabling people to know their HIV status;

(b) Maximizing health sector contributions to HIV prevention;

(c) Accelerating the scaling up of HIV/AIDS treatment, care and support;

(d) Strengthening and expanding health systems towards universal access;

(e) Investing in strategic information to guide a more effective response.

The major partners in this endeavour will be UN agencies, UNAIDS in particular for which WHO is a cosponsor with primary responsibility for promoting and supporting health sector initiatives. Other major partners include GFATM, the United States government agencies, civil society, the private sector and the communities of people living with the diseases.

The actual package of priority interventions chosen by Namibia is based on practical considerations such as the nature of the country's epidemic; the context (cultural traditions, etc); the country's unique approach to service delivery (e.g. through some mix of public, nongovernmental and private providers); and the availability of financial, human and other resources. Selection and prioritization of interventions and service delivery approaches will continue to be refined as more detailed information about the epidemic is obtained.

STRATEGIES FOR FOCUS AREA 2.2: DISEASES TARGETED FOR ELIMINATION AND ERADICATION
2.2.1 Enhance capacity for malaria elimination
2.2.2 Strengthen capacity to sustain the achievements made towards elimination of measles and neonatal tetanus and eradication of polio
2.2.3 Strengthen supplementary immunization

The diseases that are targeted for eradication or elimination include polio, measles, neonatal tetanus and malaria. Namibia has already achieved the elimination of neonatal tetanus and is recognized by the African Regional Certification Commission (ARCC) as a polio-free country. The support that will be provided in this area will be focused on ensuring that the country maintains this status. The effort towards eliminating malaria is just starting in the country, with a marked decline in the burden of malaria in the past 3-4 years. Hence, WHO will be supporting the MoHSS to formulate appropriate strategies and action plans as well as build programme capacity for elimination of malaria. WHO will continue to support the MOHSS in devising optimal strategies for the integration of immunization with other interventions such as administration of vitamin A, distribution of insecticide-treated mosquito nets, growth monitoring and administration of anti-helminthics.

STRATEGIES FOR FOCUS AREA 2.3: NONCOMMUNICABLE DISEASES
2.3.1 Strengthen surveillance, monitoring and research to establish disease patterns and trends
2.3.2. Influence policy formulation, legislation and support planning for noncommunicable diseases and conditions
2.3.3 Promote healthy lifestyles and primary prevention

These strategies will focus on the assessment and reduction of the burden of noncommunicable diseases and conditions such as diabetes, cardiovascular diseases, chronic respiratory diseases, cancer and obesity which are associated with unhealthy

lifestyles, diet and physical inactivity, harmful use of alcohol, tobacco use and substance abuse. Implementation of mental health and disability prevention strategies will be supported and scaled up.

NCDs form an emerging epidemic largely preventable by reversing the trend of four risk factors: harmful use of alcohol, tobacco use, unhealthy diets and physical inactivity. It is important that the pattern of noncommunicable diseases and conditions is established through monitoring, surveillance, research and consultations with both public and private sector institutions. A clear policy and strategy needs to be defined and funds allocated to address the agenda through solid partnerships with all concerned stakeholders.

WHO will advocate for NCDs to be given due attention in development work; assist in assessing and monitoring the magnitude and distribution of NCDs and risk factors through regular conduct of the WHO STEP wise survey; assist in the development of policy and plans for the prevention and control of NCDs; support the implementation of NCD policy and strategic plan through the development of community-based approaches for healthy lifestyles and the promotion of community and private sector involvement. WHO will further assist in the formulation of the strategic plan for Communication for Behaviour Impact for NCDs and promote interventions to reduce the modifiable risk factors. In addition, WHO will promote partnerships for the prevention and control of noncommunicable diseases and conditions.

Strategic priority 3: Improving Maternal, Newborn, Child and Adolescent Health

STRATEGIC PRIORITY	OUTCOME	FOCUS AREAS
3. Improving maternal, newborn, child and adolescent health	Improved quality of and access to maternal, newborn, child and adolescent health services	3.1 Emergency obstetric care 3.2 Maternal and neonatal death reviews 3.3 Integration of reproductive health and HIV/AIDS 3.4 Immunization 3.5 Child nutrition and IMNCI 3.6 Adolescent health

This strategic priority will address the issue of quality and coverage of maternal, newborn, child and adolescent health services; as described in Section 2, maternal, newborn, child and adolescent health have recently emerged as priorities for Namibia due to a range of concurrent factors:

- Maternal mortality ratio is on the increase and the under-five mortality rate is not decreasing fast enough, while spending on maternal, child and adolescent health is declining and emergency obstetric care coverage is very low and inequitable.
- High maternal and child mortality occur in a context of increased delivery at health facilities, indicating weaknesses in the quality of the services being provided.

- Teenage pregnancy and HIV/AIDS among young people are public health concerns.
- Child malnutrition is very high and newborn mortality accounts for 50% of child mortality.

In view of this situation, strategies such as advocacy, resource mobilization, effective programme implementation and operational research will need to target maternal, newborn, child and adolescent health. The MoHSS requires support in the ongoing monitoring of indicators at a regional level which is crucial for timely and informed interventions.

MoHSS efforts in this area are supported by funding and technical assistance from, among others, USAID, Namibian Planned Parenthood Association (NAPPA), Synergos and Spanish Cooperation; multisectoral coordination is required with other ministries such as the Ministry of Gender Equality and Child Welfare.

UN agencies are also key partners (within UNDAF Outcome 3: "Capacity to deliver essential services is strengthened" as well as UNDAF Outcome 2: "Livelihoods and food security are improved"). At global level, a joint statement on maternal and newborn health was signed on 25 September 2008 by representatives of UNFPA, UNICEF, WHO and the Vice President of Human Development of the World Bank; this is another clear indication of organizational commitment to accelerate efforts to save the lives of women and newborns in light of MDGs 4 and 5. The objective of the statement is to harmonize approaches by UN agencies to improve maternal and newborn health at country level and jointly raise the necessary resources. Each agency will focus on its own comparative advantage. WHO will therefore focus on supporting the development of policies, norms, standards, guidelines, research, monitoring and evaluation. Already, a number of WHO guidelines and training materials for the Integrated Management of Pregnancy, Childbirth and Postpartum including HIV/AIDS are available for country level adaptation.

The national health training institutions have curricula for training in midwifery and child health. Support will be provided to review the standards of training and update the curricula accordingly.

STRATEGIES FOR FOCUS AREA 3.1: EMERGENCY OBSTETRIC CARE
3.1.1 Enhance quality of focused antenatal care
3.1.2 Strengthen the capacity to provide quality and equitable emergency obstetric and newborn care services
3.1.3 Promote availability of emergency obstetric care services at all levels

To ensure quality and equitable emergency obstetric and neonatal care, the strategies will focus on training, coaching, mentoring and supervision of frontline health workers on life-saving skills. Support will be provided for the development and implementation

of the minimum package for the delivery of emergency obstetric care and other essential services at different levels of the health-care system.

Advocacy efforts will be sustained to revise the scope of work of nurses and midwives, ensure availability of medicines at lower levels of the health system, and ensure effective and efficient linkages between community and health facility level and referral systems.

STRATEGIES FOR FOCUS AREA 3.2: MATERNAL AND NEONATAL DEATH REVIEWS

3.2.1 Institutionalize (and strengthen capacity to conduct) maternal and neonatal death reviews

There is further need to strengthen the capacity to conduct maternal and neonatal death reviews as they are essential for identifying and taking corrective measures against factors contributing to maternal and neonatal deaths at the district, regional and national levels. This will be done through support for training and orientation of the health workforce and establishing mechanisms for conducting the reviews.

Support will be provided for implementing the maternal death notification which is included in the draft Public and Environmental Health Bill.

STRATEGIES FOR FOCUS AREA 3.3: INTEGRATION OF REPRODUCTIVE HEALTH AND HIV/AIDS

3.3.1 Advocate for and strengthen capacity to deliver integrated services and interventions at all levels

3.3.2 Promote the harmonization of tools and guidelines

WHO will support the integration of sexual and reproductive health and HIV/AIDS through development of integrated and gender-responsive health service packages and development of comprehensive sexual and reproductive, maternal and child health policies that are gender-sensitive and rights-based. Harmonization of tools and guidelines on SRH, MCH, HIV/AIDS and PMTCT will be promoted.

This will enable the country to maximize and explore all available services and opportunities including those which are provided by the private and parastatal sectors and avoid isolated vertical programmes and services. WHO will promote the harmonization of existing tools and guidelines to ensure consistency of health delivery at all levels of the health-care delivery system, including in the private sector. An important component in this strategy will be building capacity of health workforce on the harmonized tools and guidelines including PMTCT.

STRATEGIES FOR FOCUS AREA 3.4: IMMUNIZATION

3.4.1 Improve immunization services

3.4.2 Advocate for the introduction of new vaccines and technologies

Immunization is critical to achieving the MDGs, particularly MDG 4. Many Namibian children still do not get the complete routine immunizations scheduled for their first year of life. Support will be provided for increasing coverage and quality of routine and supplemental immunization services. This will be done through technical and financial support in the areas of capacity-building of health workers to deliver quality immunization services; surveillance; ensuring maintenance of the cold chain; and developing a social mobilization strategy.

Namibia is self-reliant as far as funding for immunization services. The country has been certified polio-free and neonatal tetanus has been eliminated. However, there is a need for sustaining the gains and intensifying surveillance for early detection of and response to vaccine-preventable disease outbreaks.

The polio eradication agenda and the introduction of new vaccines and technologies will continue to be supported through partnerships with bilateral and multilateral organizations, civil society organizations, the private sector and established global partnerships for immunization including the polio eradication initiative, the measles partnership and the GAVI Alliance.

WHO will continue to support surveillance and monitoring of coverage trends to prevent children from being non-immunized or incompletely immunized.

STRATEGIES FOR FOCUS AREA 3.5: CHILD NUTRITION AND IMNCI

3.5.1 Advocate for the development and implementation of a strategic plan for nutrition

3.5.2 Enhance capacity to promote exclusive breastfeeding and adequate infant and young child feeding

3.5.3 Strengthen capacity to manage malnutrition and consequences of nutritional deficiencies

3.5.4 Promote the scaling up of IMNCI

Within Integrated Management of Newborn and Childhood Illnesses (IMNCI), activities will include support to policy development and integration. Improving child nutrition will address MDG 1 (nutrition) and MDG 4 (child mortality) targets. WHO will support the promotion of exclusive breastfeeding, adequate and safe weaning food, nutrition for infants and young children, institutionalization of growth monitoring, development of therapeutic feeding guidelines, and strengthening of nutrition surveillance. Support will also be provided for the incorporation of neonatal care in IMNCI and scaling up to all districts.

STRATEGIES FOR FOCUS AREA 3.6: ADOLESCENT HEALTH
3.6.1 Advocate for and support adolescent-friendly health services
3.6.2 Promote school health programmes

Teenage pregnancy and HIV/AIDS among young people are public health problems in Namibia. There is a need for adolescent-friendly health services in the context of integrated services for youth and promotion and strengthening of school health programmes to cater for health information and services for adolescents.

WHO will support the finalization of the standards and guidelines for adolescent and school health; support the conduct of a situation analysis on adolescent health; promote maternal and neonatal health services geared towards adolescent mothers; and promote counseling and family planning services for youths. In collaboration with other partners, WHO will also promote and support the strengthening of school health programmes to improve access to quality health information and counseling services to all adolescents.

Strategic Priority 4: Promoting a Safer and Healthier Environment

STRATEGIC PRIORITY	OUTCOME	FOCUS AREAS
4. Promoting a safer and healthier environment	Improved health security	4.1 Emergency risk reduction, preparedness and response 4.2 IHR (2005) 4.3 Environmental health 4.4 Health promotion

This strategic priority is aligned with MDG 7 (Ensure environmental sustainability) and contributes to other health-related MDGs. As described in Section 2, Namibia has recently experienced a number of emergencies related to climate change and environmental safety. These include droughts, floods and outbreaks of diseases such as cholera. Such events have underlined the need for better planning and coordination across a range of sectors, and the importance of attending to environmental health as a preventative measure. In addition, a number of gaps in the capacity for emergency response have become apparent at regional and local levels. Emergency response is currently coordinated by the Directorate of Disaster Risk Management (DDRM) within the Office of the Prime Minister, with responsibilities shared between various line ministries, such as MoHSS; Ministry of Regional and Local Government and Housing and Regional Councils; Ministry of Environment and Tourism; and Ministry of Agriculture, Water and Forestry. There is a recently launched national policy for disaster risk management.

Issues such as climate change and necessary cross-sector collaboration need to be taken into consideration. WHO will use its comparative advantage to support comprehensive planning at the national level, taking into account the regional preparedness and response needs. UN agencies play a pivotal role (under UNDAF Outcome 2: "Livelihoods and food security are improved") and organizations such as the Namibian Red Cross Society have been instrumental in initiating emergency appeals and responses.

Within the United Nations system, globally, WHO acts as the Health Cluster Coordinator, in the context of the emergency and humanitarian assistance. During crises, humanitarian health partners, led by the Inter-Agency Standing Committee Health Cluster will empower humanitarian country teams to better address health and other aspects of humanitarian crises. The WHO network for Health Action in Crises serves as a convener, provides information and services, and mobilizes partners to agree on standards and courses of action for the health response. The WCO is able to leverage timely and adequate support through this network and play a similar role at country level. The private sector and parastatals are keen to provide support in this priority area through sharing of information from private health libraries, and also through involvement in strategic planning and response. In conjunction with other partners, WHO will assist in identifying gaps in surveillance, monitoring and evaluation, and initiate studies where necessary. Unlike the 1969 International Health Regulations, which initially covered six quarantinable diseases, the IHR (2005) that came into force in June 2007 address all events that may constitute public health emergencies of international concern and are binding to all WHO Member States. WHO will provide support to Namibia in assessing IHR (2005) core capacities and development of a plan to address the identified gaps.

The focus on environmental health will address issues related to water quality, food safety, sanitation standards and health-related climate change impact. Promotion of safe and healthy environment will definitely be a priority.

It will also be important to promote healthy lifestyles and address social determinants of health which perpetuate health inequities and trap people into the vicious cycle of poverty and ill health.

STRATEGIES FOR FOCUS AREA 4.1: EMERGENCY RISK REDUCTION, PREPAREDNESS AND RESPONSE

4.1.1	Enhance capacity for disaster risk assessment, reduction, preparedness, response and early recovery
4.1.2	Strengthen health emergency coordination mechanisms at all levels

WHO will assist Namibia to enhance the capacity for health emergency preparedness and response through strategies for vulnerability, risk and capacity assessment; development of national emergency preparedness programme; support for coordinating mechanisms within the health sector; contingency planning; training of personnel in emergency preparedness and response; development of specific capacities such as mass

casualty management systems; coordination with other ministries and sectors within the country, such as the Directorate of Disaster Risk Management, emergency services, Department of Meteorology and coordination with the international humanitarian community.

WHO will also support assessment of safety of health infrastructure to hazards and hospital emergency preparedness; development of community-based approaches to risk reduction and disaster management which integrate emergency preparedness with PHC and community-based approaches to disaster management; facilitating evaluation of response to floods and other emergencies, and identification of strengths and gaps.

STRATEGIES FOR FOCUS AREA 4.2: INTERNATIONAL HEALTH REGULATIONS (2005)
4.2.1 Build core capacity for IHR (2005) requirements
4.2.2 Harmonize IDSR framework with IHR (2005)

International Health Regulations (IHR) 2005 came into effect in June 2007 and are binding for all Member States. The IHR require countries to build their core capacities to respond to and contain any public health threat of international concern, including those related to diseases. WHO will closely work with the MoHSS and other partners to build capacity in the area of surveillance at the ports of entry to detect and contain the spread of any public health emergency of international concern. In Namibia, IHR (2005) will be implemented in the context of Integrated Disease Surveillance and Response (IDSR). Therefore, the IDSR guidelines and tools will be reviewed, updated and harmonized in line with the IHR (2005).

STRATEGIES FOR FOCUS AREA 4.3: ENVIRONMENTAL HEALTH
4.3.1 Influence public policies to improve road safety
4.3.2 Enhance capacity to monitor food quality and ensure food safety
4.3.3 Strengthen capacity to monitor drinking water quality and sanitation
4.3.4 Advocate for improved occupational health policies and service delivery

WHO will support adoption and implementation of policies on improved road safety. The policy should also address management of road trauma through mass casualty management systems and emergency medical services at community and health facility levels.

WHO will complement the efforts of MoHSS and other partners in the area of sanitation and hygiene promotion by focusing on strengthening the capacity to ensure sanitation standards, water quality and food safety. WHO will also collaborate with the Ministry of Education in the implementation of school initiatives on hygiene promotion.

Namibia launched an occupational health policy in 2005. WHO will advocate for and assist in the effective implementation of this policy. Implementation of effective occupational health policy and policies on improved road safety will enhance disability prevention and rehabilitation.

STRATEGIES FOR FOCUS AREA 4.4: HEALTH PROMOTION	
4.4.1	Advocate for multisectoral involvement in promoting healthy lifestyles
4.4.2	Promote communities' and individuals' responsibility for own health
4.4.3	Disseminate information, evidence and best practices; and advocate for action on social determinants of health

Health promotion is a cross-cutting approach to all programmes. WHO will facilitate and support multisectoral and intrasectoral involvement in promoting sound strategies to harness capabilities and resources towards health promotion. Institutionalization of collection, analysis and use of data on major social and economic determinants of health in Namibia will be promoted. These data will serve the purpose of shaping culturally-sensitive, gender-responsive and health-related rights-based policies and strategies to promote health and development. It will also be used to sensitize communities and individuals about the importance of taking responsibility for their own health in a prevention-oriented approach. WHO will support health promotion efforts which will help reduce existing health inequalities as well as address inherent societal determinants, lifestyles, behaviours and environmental factors in a holistic manner.

6.3 WHO Strategic Objectives

In developing this new strategic agenda, WCO has taken care to align it with the country challenges and priorities and the Strategic Objectives in the WHO Medium Term Strategic Plan 2009-13. Table 4 provides an overview of this alignment.

Table 4: Key challenges in the health sector, WCO Strategic priorities and WHO Medium Term Strategic Plan 2008-2013 Strategic Objectives

Key challenges in the health sector	WCO CCS2 Strategic Priority and Focus Areas	WHO MTSP 2008-2013 Strategic Objectives
Communicable diseases: Generalized HIV/AIDS epidemic, with high prevalence and concurrent high TB prevalence and significant malaria morbidity and mortality	**2: Combating priority diseases** 2.1 HIV/AIDS and TB 2.2 Diseases targeted for elimination/eradication	To reduce the health, social and economic burden of communicable diseases To combat HIV/AIDS, TB and malaria
Noncommunicable diseases: NCDs are becoming major health issues, competing with the high burden of communicable diseases **Environmental safety and health:** High rate of road traffic related morbidity and mortality	**2: Combating priority diseases** 2.3 NCDs **4: Promoting a safer and healthier environment** 4.3 Environmental health	To prevent and reduce disease, disability and premature death from chronic non-communicable conditions, mental disorders, violence and injuries and visual impairment
Maternal, newborn, child and adolescent health: The MMR is on the increase despite high ANC attendance and high rate of delivery at health facilities Very low EmOC coverage Malnutrition is high and reduction of under-five mortality is stagnating Teenage pregnancy and HIV/AIDS prevalence among young people is high	**3: Improving maternal, newborn, child and adolescent health** 3.1 Emergency obstetric care 3.2 Maternal and neonatal death reviews 3.3 Integration of reproductive health and HIV/AIDS 3.4 Immunization 3.5 Child nutrition and IMNCI 3.6 Adolescent health	To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals
Environmental safety and health: Namibia has been experiencing a number of emergencies (floods, drought and disease outbreaks) Gaps in emergency preparedness and response capacity at regional and local level Inadequate access to safe water and sanitation facilities	**4: Promoting a safer and healthier environment** 4.1 Emergency Risk Reduction, Preparedness and Response 4.2 IHR (2005) 4.3 Environmental health	To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health
Unhealthy lifestyles: In Namibia, alcohol consumption is quite high; overweight and obesity is significant; tobacco use is widespread; the high prevalence of HIV/AIDS and STIs indicate high rates of unsafe sex	**2: Combating priority diseases** 2.3 NCDs 4.4 Health promotion **4: Promoting a safer and healthier environment**	To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex

Key challenges in the health sector	WCO CCS2 Strategic Priority and Focus Areas	WHO MTSP 2008-2013 Strategic Objectives
Social inequalities: Namibia is an upper middle-income country; however, social and economic inequalities are extremely high. Gender-based violence is very common. There are high levels of unemployment and poverty. There are severe institutional capacity gaps throughout the health system. Policies and strategies for linkages between the formal health structures and communities are lacking.	**1: Strengthening the health system** 1.1 Governance 1.3 Health financing 1.6 Service delivery	To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches
Maternal, newborn and child health: Malnutrition is high and reduction of under-five mortality is stagnating **Environmental safety and health:** An important proportion of the population is food insecure; there is increase on street vending of food; threats posed by importation of contaminated food; high prevalence of malnutrition and inadequate availability of safe drinking water in some regions, particularly in rural areas	**3: Improving maternal, newborn, child and adolescent health** 3.5 Child nutrition and IMNCI **4: Promoting a safer and healthier environment** 4.3 Environmental health	To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development
Health systems: There are severe institutional capacity gaps throughout the health system. There is a duplication of structures, systems and functions and inadequate organizational development. Policies and strategies for linkages between the formal structure and communities, and between the various partners in the health sector are outdated or lacking.	**1: Strengthening the health system** 1.1 Governance 1.2 Human resources development 1.3 Health financing 1.4 Health information systems 1.6 Service delivery	To improve health services through better governance, financing, staffing and management informed by reliable and accessible evidence and research
Health systems: Access to quality health services remains a challenge, given the shortage of human resources, the vastness of the country and the many competing demands in the health sector, diverting resources to communicable diseases such as HIV/AIDS; immunization coverage is very low in some districts; some new available vaccines are not yet introduced in the immunization schedule; outbreaks of vaccine-preventable diseases are occurring.	**1: Strengthening the health system** 1.5 Medical products, vaccines and technologies 1.6 Service delivery	To ensure improved access, quality and use of medical products and technologies

SECTION 7

IMPLEMENTING THE STRATEGIC AGENDA

In order for a strategic agenda of this magnitude to be effectively implemented it is important that all required resources, processes, structures and systems are carefully assessed and put in place. This section outlines the implications at country, Regional Office and Headquarters level.

This section is informed by the SWOT analysis that emerged from the stakeholder survey and workshop components of the CCS development process. In identifying the implications of the agenda for the Country Office, particular attention was paid to the weaknesses and threats identified.

7.1 Implications at country level

The WCO remains committed to "one WHO country strategy, plan and budget". This CCS therefore forms the basis for the development of the next three biennial plans and budgeting processes.

The four strategic priorities outlined in the strategic agenda have implications on the following four areas: human resources, finances, technical support and partnerships.

Human resources

As a technical agency, WHO is known for its comparative advantage in the area of technical advice to countries for the development of norms and standards, research, monitoring and evaluation in the health sector. According to the strategic agenda, it is imperative that the WCO address the following two key challenges:

- Attract and retain qualified and experienced human resources (both long- and short-term) with relevant technical skills to provide expertise in priority areas;
- Ensure continuous professional development of staff.

The recruitment, retention and development of staff therefore require continued attention. Professional staff in particular need to be recruited to provide technical support in the priority areas identified, with a special focus on health systems, HIV/AIDS and health security.

The realization of the strategic agenda also depends on the organizational culture as determined by the value systems and principles that guide the development of WHO staff. A core set of managerial and leadership values and competencies has been defined by WHO and will be actively promoted at the WCO.

The overarching WHO value system and principles, as articulated in Vision 2020: Health for All Policy for the 21st Century in the African Region (2002) will be streamlined in the work culture of the WCO. These values include:

Solidarity, based on the principles of partnership, transparency, tolerance, integrity and shared responsibility with individuals and communities;

Equity, based on the principles of availability of and universal access to essential health care;

Ethics, based on respect for human dignity and the principle of universal right to the fruits of progress achieved at the global level;

Cultural identity, based on the recognition of local values and traditions favourable to health and giving due consideration to the specificity of conditions in each country;

Gender equity, by ensuring equity between women and men in decision-making and utilization of health services.

Finances

WHO is not a funding agency. It mobilizes funds from a variety of sources for the implementation of its strategic agenda and the smooth running of internal operations.

As mentioned earlier, lack of successful resource mobilization impacted on the WCO ability to effectively implement and fully achieve some of the elements of the first CCS. Funding continues to be a major critical success factor for the current CCS. The new agenda is more comprehensive in terms of scope and approach, and its actual execution relies heavily on the extent to which the WCO succeeds in securing the necessary resources through the WHO Regional Office and Headquarters, as well as from country partners. The current global financial crisis requires the WCO to take an even more proactive and deliberate role in financial resource mobilization. Thus a key activity will be to mobilize additional financial resources to catalyse and complement national and partner efforts.

Technical support

Technical support is an important core function of the WHO mandate and comparative advantage. Over the years, the Country Office team has become used to a working approach and environment where there has been limited internal cross-sectional collaboration and learning. The new strategic agenda consciously strives to bring about a new working culture, one in which there is effective teamwork through the integration of programme activities.

It is important that the highest level of client service excellence is applied to partner requests, and that they are responded to with a sense of urgency and integrity across the Organization.

As mentioned earlier, technical support plays an important role in the work of WHO at Country Office level. Continuous professional development for both short- and long-term staff coupled with recruitment of highly competent staff will contribute to the desired high level of professionalism and quality of service delivery. Thus, three key actions are to:

- Develop an integrated team approach to programming;
- Improve flexibility in responding to partner requests;
- Continue to improve quality of technical support.

Partnerships

Health is an issue that involves multiple stakeholders: Governments, intergovernmental organizations, NGOs, local government, academic experts, private organizations, communities and others, all of which contribute to promote health and to ensure universal access to health care. Although considerable strides have been made in some areas, a concerted effort by all partners involved in health is needed to achieve the ultimate goal of better health for all. WCO is uniquely positioned to connect these stakeholders and catalyse improved efficiency through meaningful dialogue and interactions on health matters.

The multiple stakeholder survey, which informed the development process of the new strategic agenda, showed that there is lack of clarity about the WHO mandate and role in Namibia among some key partners. Addressing this issue will enable partners to collaborate more effectively with WHO.

The United Nations played a crucial role in articulating the Millennium Development Goals.

The UN realized that without ambitious and far-reaching reforms it will be unable to deliver on its promises and maintain its legitimate position at the heart of the multilateral system. The 2005 World Summit in New York gave the need for UN reform new impetus and laid the foundations for the UN "Delivering as One".

The attainment and realization of the health-related MDGs in Namibia will require improved collaboration and coordination with key UN agencies such as UNAIDS, UNICEF and UNFPA. The establishment of UNDAF has contributed considerably to this objective, but there is still a long way to go. It is therefore important that in coming years more serious efforts are made to ensure stronger integration and harmonization of planning and programming activities. In doing so, the realization of the slogan "Delivering as One", will truly be seen and felt on the ground in Namibia.

The MoHSS and WHO have roles to play when it comes to partnerships. In recognizing that private sector and civil society participation is critical in addressing

health issues, both organizations should work together to actively engage the private sector and set up public-private partnerships to help address Namibia's health challenges. WHO's main role is to support the basic groundwork for the Ministry to effectively execute its duties in partner coordination by reaching out and building stronger partner relations in both the public and private sectors. This exposure will in turn benefit WHO's work among the key players in health on a multisectoral level. When dealing with partnerships, it will be necessary to:

- Ensure that partners have a clear understanding of WHO's role;
- Build stronger UN collaboration ("Delivering as One");
- Strengthen capacity for partner coordination;

7.2 Support at other WHO levels

Responsiveness to country requests is one of the major issues that needs to be enhanced at country, regional and headquarters levels.

The WHO Regional Office for Africa is expected to provide the required managerial and technical support for implementation of the strategic agenda. It is important that the WHO Representative at country level has sufficient delegated authority to effectively execute the outlined agenda. Allocation and disbursements of funds should be expedited. Likewise, systems upgrades and migrations to new IT platforms including the deployment of the Global Management System for improved management, monitoring and evaluation should be facilitated.

At Headquarters, it is important that WHO continue to provide global policy advice, directives on health developments and guidance that relates to all WHO core functions. Headquarters and the Regional Office will play crucial roles in providing technical support and promoting mobilization of resources for implementation of the CCS.

SECTION 8

MONITORING AND EVALUATION

This CCS will be implemented in times of global financial turbulence. In addition, countries such as Namibia, which have committed themselves to the MDGs, will be at the peek of their efforts to reach the set targets. Monitoring and evaluation will therefore play a crucial role in assessing the progress made throughout the upcoming five years. In order to facilitate this process, a comprehensive plan for implementing the CCS will be developed which will outline monitoring and evaluation activities at both strategic and operational levels.

At the strategic level, annual reviews, a mid term review (half way 2010-2015) and a summative evaluation will be conducted. The final evaluation will be done at the end of the CCS in 2015 (including an in-depth case study). Apart from these, reports from other organizations such as UNDAF, MDG progress reports and MoHSS strategic plan progress reports will feed into the CCS monitoring and evaluation process.

The CCS will be operationalized through the biennial workplans with a results-based framework for the periods 2010-11, 2012-13 and 2014-15. These plans will contain clear indicators and targets at input, output and outcome level for the identified strategic priorities.

The Global Management System, which will be fully rolled out in the African Region in 2011, will be used to integrate the management of programmes and administrative processes. This system will facilitate better monitoring of staff, resources, workplans and procured goods at WHO Headquarters, Regional Office and Country Offices.

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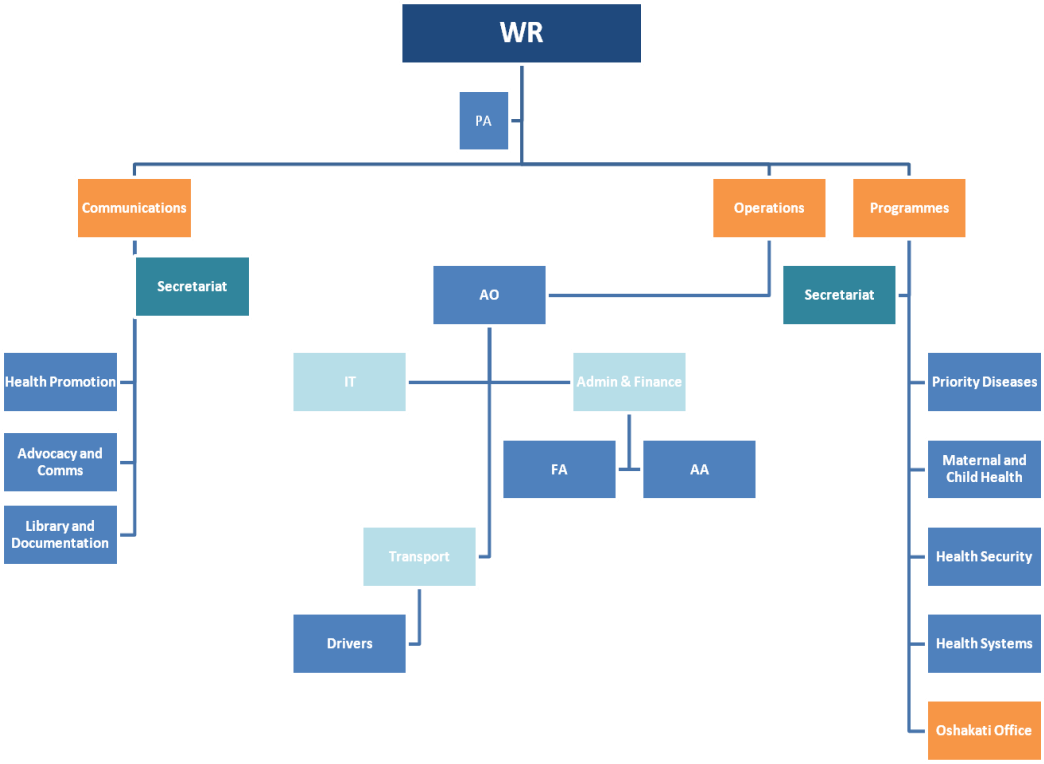
ANNEXES

Annex 1: Namibia Country Office Organogram



Annex 2: Detailed process of the CCS in Namibia

Phase	Description	Key deliverables
Phase 1: Initiation **6- 30 April 2009**	The final project scope of work was defined and the contract signed with a local consultancy firm. A multidisciplinary CCS steering committee was appointed and it met to define a shared understanding of the project framework, build commitment for the project, and agree on roles, responsibilities, reporting and meeting schedule. The final project management plan was defined and the initial stakeholder analysis exercise was conducted. A list was drawn up with the external stakeholders for the survey. The process of document collection and review started. Weekly consultations with the WHO Representative were held to oversee progress.	Steering Committee established Final Project Management Plan Inception report
Phase 2: Strategic Analysis **Early May-mid June 2009**	The external consultations were conducted through a multiple stakeholder survey among about 40 multisectoral organizations in health (see Annex 3). Invitations went out to all targeted organizations. Initially focus group discussion sessions were planned; however, due to time constraints and availability of partners these could not be carried out, so interviews were done instead. The interviews were about 60 minutes and the majority took place at the location of the interviewee. Apart from external interviews, a one-day workshop with WHO staff was held on 18 May 2009. The main objective was to review the first generation CCS and analyse current partner relations. The findings of the internal survey were analysed and reported to the Steering Committee during a gap analysis meeting held on 4 June 2009. A meeting with the Deputy Director of MoHSS Directorate HRD Policy and Planning produced a draft donor map indicating the various partners and the financial commitments for the coming three years (Section 3.2).	Interviews with WHO staff and external partners Stakeholder survey findings Initial gap analysis results and draft donor map Progress reports
Phase 3: Strategic Orientation definition **Mid June**	A 1½-day strategic planning workshop (16-17 June 2009) was held with WHO staff members, UN agency representatives and MoHSS directorate representatives, including the Deputy Permanent Secretary, Dr Norbert Forster. The outcomes of the previous phase, combined with an extensive document review and SWOT analysis, provided the necessary contextual information for defining WHO's strategic orientation. The main outcome of the strategic planning was a draft strategic framework consisting of four strategic priorities with strategies, focus areas and core functions. After the workshop, the draft framework was refined with WHO staff, and a list of implications and a monitoring and evaluation	WHO new strategic orientation Progress reports

Phase	Description	Key deliverables
	plan were drafted. The framework was then sent to workshop participants for their comments and buy-in. The comments received were reviewed and translated into the final draft version. WHO's strategic priorities and their implications in terms of constraints and challenges for the next years were defined in this phase.	
Phase 4: Strategic Buy-in Mid June – end June 2009	The outcomes of the previous phase served as an important foundation for this phase. Invitations were sent and a programme compiled. Preparations (including a practice session for individual presentations) were made with WHO staff. It is important to note that WHO staff presented the components of the strategic agenda. Consultants facilitated the group discussion with stakeholders. The main objective of this ½ day meeting (29 June 2009) was to present the final draft version of the CCS to all stakeholders who were involved in the external stakeholder analysis survey and to get their buy-in and final comments on the WHO strategic agenda. The prepared programme for the ½ day consensus-building meeting was compiled. Stakeholders in health took part in the consensus-building workshop and gave their suggestions and comments on the WHO draft strategic agenda.	Endorsed new WHO strategic orientation Progress reports
Phase 5: CCS Reporting Mid June – Early July	In this phase the actual CCS report (first draft) was compiled based on the outcomes derived from the previous phases. During this process several draft versions were presented to WHO staff.	CCS first draft Progress reports
Phase 6: CCS Review Mid July – end September 2009	The first draft underwent a series of reviews with government officials and other partners to ensure that it was in line with agreements made during the consensus-building workshop. The same document was sent to the Regional Office for endorsement by the Regional Director and subsequent review from Headquarters. The comments received were worked into the final version CCS. The country briefs were drafted hereafter based on the final version of the document.	CCS revisions from the various stakeholders, partners and the WHO Regional Office for Africa Final CCS version Country briefs Progress reports

Annex 3: List of partners involved in the development of the CCS**

Institution	Person/s	Position
Donor Organizations		
CDC	Mr Jeff Hanson	Country Director
Embassy of Finland	H.E. Ms. A. Luukainen	Head of Mission
	Mr J. Sykko	Counsellor
Embassy of Cuba	Ms V. Vallejera	Ambassador
Programme Management Unit for GFATM, MoHSS	Ms Pamela Onyango	Director
GTZ	Ms Kathrin Lauckner	Project Manager
JICA	Ms Janet McGrath	Programme Officer
I-TECH	Mr Deqa Ali	Country Director
Namibia Medical Aids Fund	Mr Afrikaaner	Senior Programme Co-ordinator
	Ms Munkanda	Programme Co-ordinator
PEPFAR	Mr Dennis Weeks	Director
	Ms Stephanie Marion Landais	Deputy Co-ordinator
Spanish Cooperation	Mr Asier Segurola	Project Officer
	Mr Alberto Quintana	Co-ordinator
Synergos	Mr Len Le Roux	Director
	Ms Kasee Mhoney	Project Manager
UNAIDS	Mr Robert Bennoun	UNAIDS Country Coordinator a.i.
UNDP	Mr S. Nhongo	UN Resident Coordinator
	Mr John Ashipala	Economist
	Mr Lebogang Motlana	Deputy Resident Representative
	Ms Lavinia Shikongo	Assistant Resident Representative
UNESCO	Mr Matthias Lansard	Education Specialist
	Dr Edem Adubra	Education Specialist
UNFPA	Mr F. Byomuhangi	UNFPA Representative
	Ms Letisia Alfeus	Programme Officer
	Ms Loide Amkongo	Programme Officer
UNHCR	Ms Joyce Mendes-Colle	UNHCR Representative
	Ms Maude Mugisna	Gender Advisor
UNICEF	Dr Agsotino Munyiri	Chief of Maternal, Child Survival and Development
USAID	Mr G. Gottlieb	Director

Institution	Person/s	Position
Government		
Ministry of Agriculture Water and Forestry	T.L. Nantanga	DD-CMSS & T
	Alta Strauss	Chief HR Practitioner
Ministry of Education - HAMU	Mrs Kahikuata	Head of Department
	Ms Felicity Haingura	Senior Education Officer
	Ms Ursula Gawanas	ELD Coordinator
Ministry of Finance	L.N. Uuyuni	Accountant
Ministry of Gender Equality and Child Welfare	Mrs Sirkka Ausiku	Permanent Secretary
	Ms S. Onesnius	DD-ECD
Ministry of Health and Social Services	Dr Richard Nchabi Kamwi	Hon. Minister
	Mr K. Kahuure	Permanent Secretary
	Dr N. Foster	Deputy Permanent Secretary
	Ms Tjipura	Director, Tertiary Health Care and Clinical Support Services
	Ms C. Usiku	Director Policy, Planning & HRD
	Mr Thomas Mbeeli	Deputy Director Policy, Planning & HRD
	Ms Zauna	Deputy Director, Policy, Planning & HRD
	Ms Hilma Auala	Deputy Director, PHC
	Ms Liza Van Ryhn	Deputy Director; Social Services
	Mrs Nghatanga	Director PHC
	Ms Jennie Lates	Deputy Director , Tertiary Health Care & Clinical Support Services
	Annatjie Thobias	Chief, HP, DSP
	Gertrude Platt	Chief HPA, DSP
	Mr Cedric Limbo	Chief, HP, Policy, Planning & HRD
	Ms M. Lagaria	SHPA-IBR, PHC
	Ms Rene Adams	Programme Manager
HPCNA	Mr C Weyulu	Assistant Registrar
Ministry of Regional and Local Government and Housing and Regional Councils	Mr E. Negonga	Permanent Secretary
Ministry of Environment and Tourism	Dr K. Shangula	Permanent Secretary
National Assembly	Mr J. Jacobs	Secretary National Assembly
	Chippa I. Tjirera	Deputy Director
National Planning Commission	Mrs D. Van Wyk	Development Planner
	Mrs Susan Lewis	Director Development Cooperation

Institution	Person/s	Position
	S.I. Amporo	Economist
NPC Secretariat	Vekondja Tjikuzu	Deputy Director
Directorate of Emergency Management Parliament Standing Committee	Mr Jafet Iitenge	Director
SADC Parliamentary Forum	Mrs Boemo Mandu Sekgoma	HIV/AIDS Policy Advisor
	Mr Deograteus Egedeo	HIV/AIDS Partnership & Information Officer
Private Sector/Parastatals		
Namibia Business Coalition on HIV/AIDS	Mr Peter Van Wyk	Chief Executive Officer
	Mrs Prudence Egumbo	Programme Manager
	Mrs Vallerie Niigunjo-Mbandi	Workplace Programme Co-ordinator
Namibia Blood Transfusion Services	Mr Wilkinson	Operations Manager
Namibia Medical Association	Dr Estie Martiz	Chief Executive Officer
Namibia Chamber of Commerce and Industry	Mr T. Shaanika	Chief Executive Officer
NIP	Mrs T. Angula	Chief Executive Officer
	Mr Harold Kaura	General Manager
PSEMAS - Methealth	Mr Nick Niel	Manager: Client Services
	Mrs Black	My Health – HIV/AIDS Unit
UNAM	Dr L. Haoses-Gorases	Dean: Faculty of Medical and Health Sciences & Coordinator
Civil Society		
Catholic Health Services	Mr Alexander Mumba	Financial Accountant
	Mr Matthias Spuehler	Management Consultant
NANASO	Mr M. Mulondo	Executive Director
	Mr E. Hambure	Network Member Support Officer
	Mr Joon Yoon	Business Development Advisor
Namibia NGO Forum Trust	Mrs Anna Beukes	Executive Director
Red Cross	Mrs Dorkas Kapembe-Haiduwa	Secretary General
	Mrs Naemi Heita	Programme Co-ordinator

Annex 4: Overview of strategic priorities in the health sector

WHO Mid-Term Plan 2009-13 Strategic Objectives	WHO Namibia CCS 2 Strategic Priority	Millennium Development Goals	UNDAF Commitments 2006-10	NDP 3 Programmes Affordable, quality health care	MoHSS Strategic Themes 2009-13
To reduce the health, social and economic burden of communicable diseases	2		Strengthened National Capacity	Control of Communicable Diseases (P4)	Service provision
To combat HIV/AIDS, TB and malaria	2	MDG 6: HIV/AIDS, malaria, TB	Strengthened HIV and AIDS response	Control of Communicable Diseases (P4)	Service provision
To prevent and reduce disease, disability and premature death from chronic non-communicable conditions, mental disorders, violence, injuries and visual impairment	2 and 4			Control of Non-Communicable Diseases (P4)	Service provision
To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence; improve sexual and reproductive health; promote active and healthy ageing for all individuals	3	MDG 4: Child mortality; MDG 5: Maternal health	Capacity development	Family Health Services (6) Youth Friendly Reproductive Centres (P9)	Service provision
To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact	4	MDG 7: Environment	Livelihoods and food security	Public and Environmental Health (P3)	Service provision
To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex	2			Health Promotion (P5)	Service provision

WHO Mid-Term Plan 2009-13 Strategic Objectives	WHO Namibia CCS 2 Strategic Priority	Millennium Development Goals	UNDAF Commitments 2006-10	NDP 3 Programmes Affordable, quality health care	MoHSS Strategic Themes 2009-13
To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches	1 and 3		Livelihoods and food security	Public and Environmental Health (P3)	Service provision
To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	4	MDG 7: Environment	Livelihoods and food security	Public and Environmental Health (P3)	Service provision
To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development	3 and 4	MDG 1: Nutrition	Livelihoods and food security	Public and Environmental Health (P3)	Service provision
To improve health services through better governance, financing, staffing and management informed by reliable and accessible evidence and research	1		Strengthened national capacity	Health Systems Planning & Management (P1) Tertiary & Clinical Health Care Services (P7) Hospital Care (P8)	Governance Human resource management Financial management Infrastructure development & management
To ensure improved access, quality and use of medical products and technologies	1	MDG 8: Development	Strengthened HIV/AIDS response	Health Systems Planning & Management (P1) Control of Communicable and Non-Communicable Diseases (P4) Family Health Services (P6)	Service provision

Annex 5: Partners matrix

WHO Country Cooperation Strategy 2010–2015 Namibia

Strategic Priority Area	Partners
Strengthening the health system	MoHSS, NIP, Synergos, I-TECH, USAID, UNDP, UNICEF, UNFPA, Spanish Cooperation, NPC, civil society organizations
Combating priority diseases	MoHSS, GFATM, PEPFAR, GTZ, *Medicos del Mundo* Spanish Cooperation, NANASO, CHS, VSO Namibia, PIN, NASOMA, UNICEF, UNDP, UNFPA, UNAIDS
Improving maternal, newborn, child and adolescent health	MoHSS, line ministries, CDC, PEPFAR, UNFPA, UNAIDS; UNICEF, UNESCO, USAID, NAPPA, Synergos, Spanish Cooperation
Promoting a safer and healthier environment	Office of the Prime Minister; Directorate of Emergency Management; MoHSS; Ministry of Regional and Local Government and Housing and Regional Councils; Ministry of Environment and Tourism; Ministry of Agriculture, Water and Forestry; UNDP; UNESCO; UNICEF; UNFPA