



**National Multisectoral Strategic Plan  
For  
Prevention and Control of  
Non-Communicable Diseases (NCDs) in Namibia  
2017/18 – 2021/22**



**Ministry of Health and Social Services  
Primary Health Care Directorate  
Family Health Division**

**Non-Communicable Diseases (NCDs) Programme  
November 2017**





**REPUBLIC OF NAMIBIA**

**MINISTRY OF HEALTH and SOCIAL SERVICES**

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For  
Prevention and Control of  
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2017/18 – 2021/22**

**Directorate: Primary Health Care Services  
Division: Family Health  
Subdivision: Reproductive and Child Health  
Section: Non-Communicable Diseases (NCDs)**

**Private Bag 13198, Windhoek  
Telephone: +264 61 203 2796  
Fax: +264 61 245 155  
E-mail: [doccentre@mhss.gov.na](mailto:doccentre@mhss.gov.na)**

**November 2017**

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## Foreword

Non-Communicable Diseases (NCDs), mainly Cardiovascular Diseases, Cancers, Chronic Respiratory Diseases and Diabetes Mellitus are the world's biggest killers.

According to a WHO estimate, NCDs accounted for 53% of the 14,000 total deaths in Namibia in 2012, which is higher than all the deaths from communicable diseases (e.g., HIV, Tuberculosis, Malaria), maternal and childhood diseases and nutritional disorders combined. About 21% of NCDs related deaths were due to Cardio-vascular diseases, 5% due to Cancers; 4% due to Diabetes Mellitus, 4% due to Chronic Lung diseases; 10% due to injuries and 9% of deaths due to other NCDs (Source: World Health Organization - NCDs Country Profiles, 2014).

Most of the premature deaths from NCDs are largely preventable by enabling all sectors, through public policies, to respond more effectively and equitably to the risk factors of NCDs, namely tobacco use, unhealthy diet, physical inactivity, and the harmful use of alcohol.

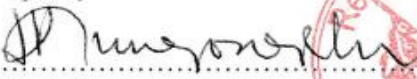
Recognizing the body of knowledge and experience regarding the preventability of NCDs, as well as the immense opportunities for global action to control it, Namibia endorsed the Moscow Declaration on NCDs in May 2011, and the UN Political Declaration on NCDs in September 2011. Therefore, Dr. Hifikepunye Pohamba, the previous President of the Republic of Namibia, committed Namibia to establish and strengthen multisectoral national policies and plans for the prevention and control of NCDs, and develop national targets and indicators, in line with the global targets set to be achieved by 2025.


In May 2013, the World Health Assembly adopted the global monitoring framework and endorsed the WHO Global Action Plan for the Prevention and Control of NCDs (2013-2020) to accelerate the achievement of the commitments made on NCDs by world leaders. The Ministry of Health and Social Services has adopted the indicators and targets in the WHO's global monitoring framework on NCDs to track implementation of the Namibia NCDs Multisectoral Action Plan through monitoring and reporting on the attainment of the 9 global targets for NCDs by 2025.

The Government of the Republic of Namibia has developed this Multisectoral National Strategic Plan for the prevention and control of NCDs, to reduce exposure to risk factors, enable health systems, Line Ministries and other stakeholders to play their part and work jointly in order to reach these national targets by 2025 and avert the high burden of mortality, disability and economic loss related with NCDs.

As Namibia gears up to address NCDs, it is also time to spread a broader awareness that NCDs constitute one of the major challenges for development in the 21st century and of the new opportunities of making global progress in the post-2015 sustainable development agenda.

We are looking forward to working with line Ministries and all relevant stakeholders, including communities to save lives, improve the health and well-being of present and future generations, as well as to ensure that the human-, social- and financial burden of NCDs do not undermine the development gains of past years in Namibia.

  
Saara Kuugongelwa-Amadhila (Dr.)  
Prime Minister





## Preface

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The Multisectoral Strategic Plan for the prevention and control of Non-Communicable Diseases (NCDs) is the first national strategic plan (2017/18 – 2021/22) that addresses chronic diseases and injuries in the country through coordinated multi-sectoral action for the promotion of healthy lifestyles and prevention, early detection, treatment and palliative care of individuals affected with these diseases.

Non-Communicable Diseases are diseases and conditions for which lifestyle and environmental factors make a major contribution. Major NCDs in Namibia included Cardio-Vascular Diseases (CVD), Diabetes Mellitus (DM), Cancers (all types), Chronic Respiratory Diseases, trauma due to road traffic injuries, as well as mental illnesses and disorders. In 2012, NCDs were responsible for 63% of the 56 million deaths that occurred globally. More than 40% of these deaths (16 million) occurred in people below 70 years (premature deaths). Almost three quarters of all NCDs deaths (28 million), and the majority of premature deaths (82%), occur in low- and middle-income countries. Majority of these premature deaths are preventable.

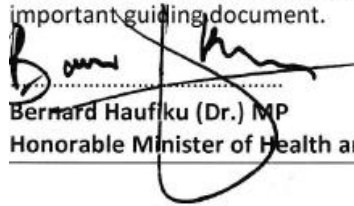
Known risk factors that are associated with NCDs are harmful use of alcohol, use of tobacco products, high intake of salt, sugar and saturated/trans-fats, low consumption of fruits and vegetables and physical inactivity. The Government of Namibia has adopted the Non-Communicable Diseases programme as an appropriate strategy to coordinate national efforts at prevention and control of NCDs including improvement of service delivery and provision of more equitable opportunities to all communities.

The Ministry of Health and Social Services, through the Non-Communicable Diseases Programme, aims to prevent and control chronic- or lifestyle diseases and conditions, under the Office of the Prime Minister and the active participation and support of other sectors including Line Ministries, Academia, private sector, Non-Governmental Organizations (NGO's), Civil Society Organizations (CSO's), Faith Based Organizations (FBO's) and Community Based Organizations (CBO's) since most of the determinants of NCDs and their risk factors lie well outside the purview of the Ministry of Health.

I wish to extend my gratitude to the National-, Regional- and District level staff of the MoHSS, Office of the Prime Minister (OPM), and all partners particularly the World Health Organization Country and Regional Offices for the technical and financial support provided. I would also like to acknowledge the support of Centre for Disease Control and Prevention (CDC), University of Namibia's School of Medicine and School of Nursing, Line Ministries, NGO's, as well as other stakeholders for their valuable contributions.

I would also like to thank the various Government Offices for their valuable input and commitment to the implementation of this Multi-Sectoral Strategic Plan aimed at reducing the burden of NCDs in Namibia.

Finally, a word of appreciation to the staff of the Non-Communicable Diseases Programme, the Family Health Division, as well as the Primary Health Care Directorate for their expertise towards the development of this very important guiding document.

  
**Bernard Haufiku (Dr.) MP**  
**Honorable Minister of Health and Social Services**



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## List of Abbreviations

CBO's	Community Based Organizations
CCF	Congestive Cardiac Failure
CDC	Centre for Diseases Prevention and Control
COPDs	Chronic Obstructive Pulmonary Diseases
CSO	Civil Society Organization
CVA	Cerebrovascular Accident (stroke)
CVD	Cardiovascular Diseases
DHS	Demographic Health Survey
DHCC	District Health Co-ordinating Committee
DM	Diabetes Mellitus
GNP	Gross National Product
HPCNA	Health Professions Council of Namibia
HPV	Human Papilloma Virus
HPT	Hypertension
MHIS	Management Health Information System
FBO	Faith Based Organization
IEC	Information, Education and Communication
MoAWF	Ministry of Agriculture, Water and Forestry
MoPESW	Ministry of Poverty Eradication and Social Welfare
MICT	Ministry of Information and Communication Technology
MITI	Ministry of Industrialization, Trade and SME Development
MoHETI	Ministry of Higher Education, Training and Innovation
MOEAC	Ministry of Education, Arts and Culture
MLIREC	Ministry of Labour, Industrial Relations and Employment Creation
MoME	Ministry of Mines and Energy
MoYNSSC	Ministry of Youth National Service, Sport and Culture
MoHSS	Ministry of Health and Social Services
NCDs	Non-Communicable Diseases

NDHS	Namibia Demographic and Health Survey
NGO	Non-Governmental Organization
RCHS	Reproductive- and Child Health Services
PHC	Primary Health Care
PP and HRD	Policy Planning and Human Resource Development
RACE	Regional Aids Co-ordinators in Education
RDC	Regional Development Committees
RMTs	Regional Management Teams
RTAs	Road Traffic Accidents
SBHS	School-Based Health Survey
SHPO	Senior Health Programme Officer
SWOT	Strength, Weaknesses, Opportunities, Threats
STEPs	Stepwise Approach
SP	Strategic Plan
WHS	World Health Survey
WHO	World Health Organization

## EXECUTIVE SUMMARY

The global burden and threat of Non-Communicable Diseases (NCDs) constitutes a major public health and socio-economic development challenge of the 21st century. NCDs are presumed to undermine social and economic development throughout the world, and also exacerbate inequalities between countries and within populations.

NCDs are responsible for almost 70% of all deaths worldwide and the majority of NCDs deaths occur during the most productive years of life. About 82% of the premature deaths, occurring before reaching 70 years of age, are happening in low- and middle-income countries. Thus, NCDs reduce economic output and prevent people around the world from living lives of health and wellbeing. The rise of NCDs has been driven primarily by four major life-style related risk factors: tobacco use, physical inactivity, the harmful use of alcohol and unhealthy diets.

Namibia is no exception to the growing global concern on the increasing burden of NCDs. Namibia is an upper middle income country with fast economic growth since independence in 1990. The country is bearing the double burden of communicable and noncommunicable diseases and rapid urbanization. There is also high income inequality among the population.

*Non-Communicable diseases such as Cardio-Vascular Diseases and Stroke, Diabetes Mellitus, Cancers, chronic lung diseases, injuries and accidents are responsible for 53% of all deaths in Namibia which is more than all other mortality causes combined.* The epidemic of NCDs poses devastating health consequences for individuals, families and communities, and threatens to overwhelm health systems. The socioeconomic costs associated with NCDs make the prevention and control of these diseases a major development priority for all countries including Namibia.

Thus, acknowledging the huge burden of NCDs in terms of morbidity, mortality and disability in Namibia and the urgency to act now, the government of the Republic of Namibia has prioritized the prevention and control of NCDs through a whole of government and multisectoral approach firmly believing that investment in NCDs is a priority for social and economic development.

Economic resilience and growth is stimulated by healthy population. Healthier people are more productive at work, remain working for longer and can increase their household savings as a result of better productivity and the avoidance of exposure to high cost of health care associated with premature occurrence of chronic noncommunicable diseases.

This national multi-sectoral NCDs Strategic Plan was developed through a long consultative process with all stakeholders and sectors to serve as a blue print for galvanizing the national multi-sectoral response for the prevention and control of NCDs for the next 5 years, 2017/18 – 2021/22.

**Goal:-** Its goal is to reduce the preventable and avoidable burden of morbidity, mortality and disability due to Non-Communicable Diseases in the country and achieve a healthy and productive population.

**Objectives:-** *The strategic plan has seven key objectives*

1. To raise the priority accorded to the prevention and control of Non-Communicable Diseases on the political agenda and at all levels through advocacy
2. To strengthen national capacity, leadership, governance, multisectoral collaboration and partnerships to accelerate country response for the prevention and control of Non-Communicable Diseases
3. To reduce modifiable risk factors for Non-Communicable Diseases and underlying social determinants through the creation of health promoting environments
4. To strengthen and orient health systems to address the prevention and control of Non-Communicable Diseases and the underlying social determinants through people centered primary health care and universal health coverage
5. Promote and implement evidence based strategies and interventions for prevention and control of violence and injuries particularly Road Traffic Accidents (RTAs)
6. To promote and support national capacity for high-quality research and development for the prevention and control of Non-Communicable Diseases
7. To monitor the trends and determinants of Non-Communicable Diseases and evaluate progress in their prevention and control

**Targets:-** *Namibia aims to achieve the following targets by 2022 and 2025 in line with the global NCD voluntary targets.*

1. A 15% relative reduction in premature mortality from cardiovascular disease, cancer, diabetes, or chronic respiratory diseases by 2022; and a 25% relative reduction by 2025
2. A 7% relative reduction in the use of alcohol by 2022; and a 10% relative reduction by 2025
3. A 7% relative reduction in prevalence of insufficient physical activity by 2022; and a 10% relative reduction by 2025.
4. A 20% relative reduction in mean population intake of salt/sodium by 2022; and a 30% relative reduction by 2025.
5. A 20% relative reduction in prevalence of current tobacco use in persons aged over 15 years by 2022; and a 30% relative reduction by 2025.
6. A 15% relative reduction in prevalence of raised blood pressure and/or contain the prevalence of raised blood pressure by 2022; and a 25% relative reduction by 2025.
7. Halt the rise in obesity and diabetes by 2022
8. 30% of eligible people receive drug therapy and counseling (including glycaemic control) to prevent heart attacks and strokes by 2022; and 50% by 2025.
9. A 50% availability of affordable basic technologies and essential medicines including generics, required to treat major non-communicable diseases in both public and private facilities by 2022; and 80% by 2025.

**Priority actions:** *Achievement of the planned NCDs targets is highly dependent on the immediate and sustained implementation of the following priority actions.*

1. Establish high-level (supra-ministerial) multisectoral coordination mechanism that facilitate, harmonize, resource and monitor the national response for the prevention and control of NCDs.
2. Active engagement of all concerned Line Ministries, government agencies and stakeholders to create an enabling policy and legal environment for prevention of NCDs and their risk factors

3. Appraise and update existing sectoral policies, regulations, strategies and guidelines that impact the major NCDs and their risk factors
4. Finance and implement the very cost-effective interventions for each risk factor and priority noncommunicable diseases
5. Strengthen the health system at all levels, emphasizing primary care, and define and finance a national set of NCD services, interventions, and health promotion focusing on prevention, early detection, curative, rehabilitative, and palliative cares.
6. Strengthen the training of health workforces and the scientific basis for decision-making through NCD-related research and partnerships.
7. Create and strengthen integrated national surveillance systems for NCDs, including vital registration systems capable of reporting cause of death, disease registries, and risk factor monitoring
8. Mobilize and track domestic and external resources for NCDs prevention and control, including through innovative financing mechanisms.
9. Protect the implementation of public health policies for NCDs prevention and control from interference by vested interests through comprehensive legislation and enforcement of national laws and regulations.

# 1 CHAPTER 1: INTRODUCTION

## 1.1 Global Burden of Non-Communicable Diseases

The global burden and threat of Non-Communicable Diseases (NCDs) constitutes a major public health challenge that undermines social and economic development throughout the world, and inter alia has the effect of increasing inequalities between countries and within populations.

Globally, the number of people affected by Non-Communicable Diseases has dramatically increased. In 2012, 38 million of the 56 million global deaths were due to NCDs. The leading causes of NCDs deaths in 2012 were: cardiovascular diseases (17.5 million deaths or 46.2% of NCDs deaths), cancers (8.2 million, or 21.7% of NCDs deaths), chronic respiratory diseases, including asthma and chronic obstructive pulmonary disease (4.0 million, or 10.7% of NCDs deaths) and Diabetes Mellitus (1.5 million or 4% of NCDs deaths). Thus, these four major NCDs were responsible for 82% of NCDs deaths globally (Global Status Report on NCDs, 2014).

NCDs has emerged as a major health and development challenge in the 21st century and 14 million people are estimated to die prematurely annually from NCDs. Of these deaths, 82% occur in low- and middle-income countries<sup>1</sup>.

Similarly, the burden of NCDs related morbidity is very significant and on the increase. The Global Burden of Disease (GBD) study showed that in 1990 47% of Disability Adjusted Life Years (DALYs) were from communicable, maternal, neonatal and nutritional disorders, 43% from Non-Communicable Diseases and 10% from injuries. However, by 2010, the GBD study showed that the trend had shifted to 35%, 54% and 11% respectively.

Cardio-Vascular Diseases (CVD) are the most important cause of morbidity and mortality worldwide and are responsible for 1 out of every 3 deaths. In developing countries deaths due to CVD are twice as high as in developed countries and occur on average 10 years earlier due to lack of effective preventions and treatment strategies.

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<sup>1</sup> Global Noncommunicable Diseases Status Report 2014, WHO 2014.

The majority of people who have a heart attack or a stroke have one or more CVD related risk factors, such as, hypertension, Diabetes Mellitus, smoking, elevated blood lipid or physical inactivity<sup>2</sup>. The prevalence of High blood pressure is also on the increase. In the year 2000, over 900 million people were hypertensive and of these, about 60% were in developing countries. This number is predicted to increase to 1.56 billion people by 2025.

Cancer is a leading cause of death worldwide and accounted for 8.2 million deaths (22% of all NCDs deaths) in 2012. This is an increase from the 2008 figure of 7.6 million cancer deaths worldwide. It is now among the top three leading cause of death in adults in developing countries. If no efforts are put in place to curb this rising trend, the current incidence rate for cancer of 12.7 million new cases annually will increase by 70% to 21.4 million new cases by 2030. Two thirds of these new cases will occur in low and middle income countries. In Africa the main factors leading to the increase in incidence of cancer are increasing tobacco and alcohol use, unhealthy diet, physical inactivity, environmental pollution and infectious agents<sup>3</sup>. Cancers associated with bacterial or viral infections, such as cervical, liver, Kaposi Sarcoma, Burkitt's lymphoma and stomach cancer, make up a larger share of total cases in the Region, and means that as many as 36% of cancers in Africa are infection-related, exactly double the world average<sup>4</sup>.

Obesity is the main risk factor for Type 2 Diabetes Mellitus and global increases in obesity have been mirrored with increasing rates of Type 2 Diabetes Mellitus. The WHO estimates that 1.5 billion adults (aged 15+) are overweight and at least 500 million are obese. Projections for 2015 show these numbers increasing to 2.3 billion and 400 million respectively<sup>5</sup>. About 2.6 million

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<sup>2</sup> WHO. CVD-RISK Management package for low-and medium-resource setting. Geneva World Health Organization, <http://whqlibdoc.who.int/publications/2002/9241545852.pdf>

<sup>3</sup> WHO AFRO. Cancer Prevention and Control: A Strategy for the WHO African Region. Yaounde, World Health Organization Regional Office for Africa, [http://www.afro.who.int/index.php?option=com\\_docman&task=doc\\_download&gid=2304](http://www.afro.who.int/index.php?option=com_docman&task=doc_download&gid=2304)

<sup>4</sup> Parkin, D.M. The global health burden of infection-associated cancers in the year 2002. *Int J Cancer*. 118 (12): 3030-44 (2006).

<sup>5</sup> WHO. Obesity and overweight - Fact sheet N°311. Geneva, World Health Organization, 2011



People die as a result of being overweight or obese<sup>6</sup>. The burden of Diabetes Mellitus is expected to increase from 366 million people with the disease in 2011 to 522 million by 2030 if nothing is done to halt or reverse the trend<sup>7</sup>.

A direct consequence of Diabetes Mellitus and hypertensive disease is the development of renal failure. Chronic kidney disease is a major determinant of poor health outcome of the major NCDs. In 2010, it was estimated that the number of deaths where chronic renal disease is listed as a main cause of death has increased by 82% compared to the number in 1990.

Chronic Respiratory Diseases (CRD) are a group of chronic diseases affecting the airways and structures of the lungs. Although multiple determinants serve to increase the burden of CRD, the direct and indirect exposure to tobacco smoke is the principal risk factor for their development. Poverty and socio-economic factors play an important role in increasing disease prevalence and severity through environmental determinants and may also result in adverse health outcomes caused by the lack of access to appropriate health care. Other important factors include heavy exposure to air pollution derived from indoor and outdoor sources, occupational related disorders, malnutrition and LBW, and multiple early lung infections. Asthma is the most common chronic disease in children. In 2005 asthma affected around 300 million people and it is expected that by 2025 there will be an additional 100 million cases and 239,000 deaths<sup>8</sup>. For asthma in addition to these risk factors, indoor allergens (for example house dust mites in bedding, carpets and stuffed furniture, pollution and pet dander), outdoor allergens (such as pollens and molds), second-hand tobacco smoke, smoke from fires and chemical irritants at home and in the workplace can cause asthma attacks.

Over 5.2 million deaths occur from injuries every year and non-fatal injuries account for about 10% of the global burden of disease. Injuries may be divided into two categories: unintentional

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<sup>6</sup> **Ezzati, M. et al.** Comparative quantification of health risks: global and regional burden of disease attributable to selected major risk factors. Geneva, World Health Organization

<sup>7</sup> **WHO.** Global report on diabetes. Geneva, World Health Organization, 2016.

<sup>8</sup> **Masoli, M. et al.** The global burden of asthma: executive summary of the GINA Dissemination Committee report. *Allergy*. 59 (5): 469-78 (2004)

injuries, including road traffic injuries, drowning, burns, poisoning and falls; and intentional injuries, which result from deliberate acts of violence against oneself or others<sup>9</sup>. In developing countries the majority of deaths due to RTAs are among pedestrians, passengers, cyclists, users of motorized two wheelers and occupants of buses and minibuses<sup>10</sup>. The WHO estimates that in Africa Road Traffic Accident (RTA) mortality rates are 28.3 per 100,000 population, the highest in any region in the world despite having the lowest number of motor vehicles per population<sup>10</sup>.

Violence includes a variety of forms and can occur in different contexts. It includes child abuse and neglect by parents and caregivers; violence between adolescents and young adults; violence between intimate partners; violence associated with property crimes; rape and other sexual violence; workplace violence; and the abuse of the elderly by relatives and other caregivers<sup>11</sup>. Globally there are around 520,000 deaths as a result of interpersonal violence. For every person who dies as a result of violence, many more are injured and suffer from a range of physical, sexual, reproductive and mental disorders<sup>12</sup>. The majority of victims are aged between 15-44 years of age. In the WHO Africa region there are a total of 311,000 deaths caused by intentional injury<sup>13</sup>.

The main modifiable risk factors for NCDs are behavioral; unhealthy diet, lack of physical activity, tobacco use and harmful use of alcohol, and biological risk factors such as raised blood pressure, raised blood glucose, obesity and raised serum cholesterol.

As the impacts of NCDs increase, and as global populations' age due to general improvements in social and economic environments, the annual NCDs deaths are projected to continue to rise worldwide. The greatest increase is expected to be seen in low- and middle-income regions.

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<sup>9</sup> WHO. Alcohol and Injury in Emergency Departments. Geneva, World Health Organization. [http://www.who.int/substance\\_abuse/publications/alcohol\\_injury\\_summary.pdf](http://www.who.int/substance_abuse/publications/alcohol_injury_summary.pdf)

<sup>10</sup> WHO. World Report on Traffic Injury Prevention. Geneva, World Health Organization. <http://whqlibdoc.who.int/publications/2004/9241562609.pdf>.

<sup>11</sup> WHO. Preventing violence. Geneva, World Health Organization, <http://whqlibdoc.who.int/publications/2004/9241592079.pdf>

<sup>12</sup> WHO. Violence and Injury Prevention. Geneva, World Health Organization, 2012.

<sup>13</sup> WHO. World report on violence and health. Geneva World Health Organization

According to WHO's projections, the total annual number of deaths from Non-Communicable Diseases (NCDs) will increase to 55 million by 2030, if business as usual continues. The increase in Non-Communicable Diseases is having a profound effect on disability trends. Overall, NCDs are estimated to account for about two thirds of all years lived with disability in low and middle-income countries. The toll of morbidity, disability and premature mortality due to Non-Communicable Diseases can be greatly reduced if preventive and curative interventions already available are expanded and made accessible to communities. Most premature deaths from Non-Communicable Diseases are preventable by influencing public policies in other sectors than health sector. This necessitated the development of a national Multisectoral Strategic Plan to address the multi-faceted nature of NCDs in a comprehensive manner.

## **1.2 General information about Namibia**

Namibia is an upper middle income country with a population of 2.3 million in 2016; 51.4% males and 48.6% females. Children under 15 years account for 36.4%, those between 15 and 59 years represent 57.3% while those 60 years and above constitute 6.3% of the population. The average life expectancy for Namibians is 65.8 years; 63.1 for males and 68.3 years for females. Namibia is experiencing rapid urbanization as evidenced in the increase in the proportion of the population living in the urban areas from 28% in 1991 to 48% in 2016. (NSA 20-17)

Non-Communicable Diseases such as Cardio-Vascular Diseases including Stroke, Diabetes Mellitus, Cancers are emerging as threats to the health system that is already burdened by infectious diseases such as HIV/AIDS, TB and Malaria.

Thus, the government of Namibia has developed this multisectoral Strategy to mitigate the increasing burden of NCDs and ensure healthy and productive life for all citizens.

## 2 CHAPTER 2: SITUATION OF NCDs and RISK FACTORS IN NAMIBIA

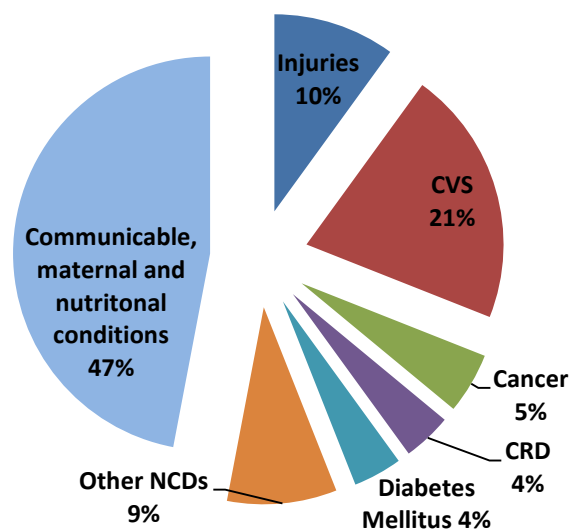
### 2.1 Burden of NCDs in Namibia

Namibia is no exception to the growing global concern on the increasing burden of NCDs. With a population of 2.3 million, Non-Communicable Diseases such as Cardio-Vascular Diseases and Stroke, Diabetes Mellitus, Cancers are emerging as threats to the health system that is already burdened by infectious diseases such as TB, Malaria and HIV/AIDS. According to the Health Management Information System (HMIS) data, there is a clear indication that NCDs contributed to a significant proportion of deaths in the country. The most common NCDs in Namibia are:

- Cardio-vascular Diseases (CVD), e.g. Hypertension, Stroke, Congestive Cardiac Failure (CCF) and other cardio myopathies
- Diabetes Mellitus-Mellitus (DM)
- Cancer
- Chronic Respiratory Diseases- Asthma, Chronic Obstructive Pulmonary Diseases (COPD)
- Road Traffic Accidents (RTAs),
- Violence and Injuries
- Mental health problems, and
- Oral and dental diseases and conditions

**Figure 1: Distribution of causes of mortality in Namibia, 2012**

Chart 1: Distribution of causes of Mortality in Namibia (2012)

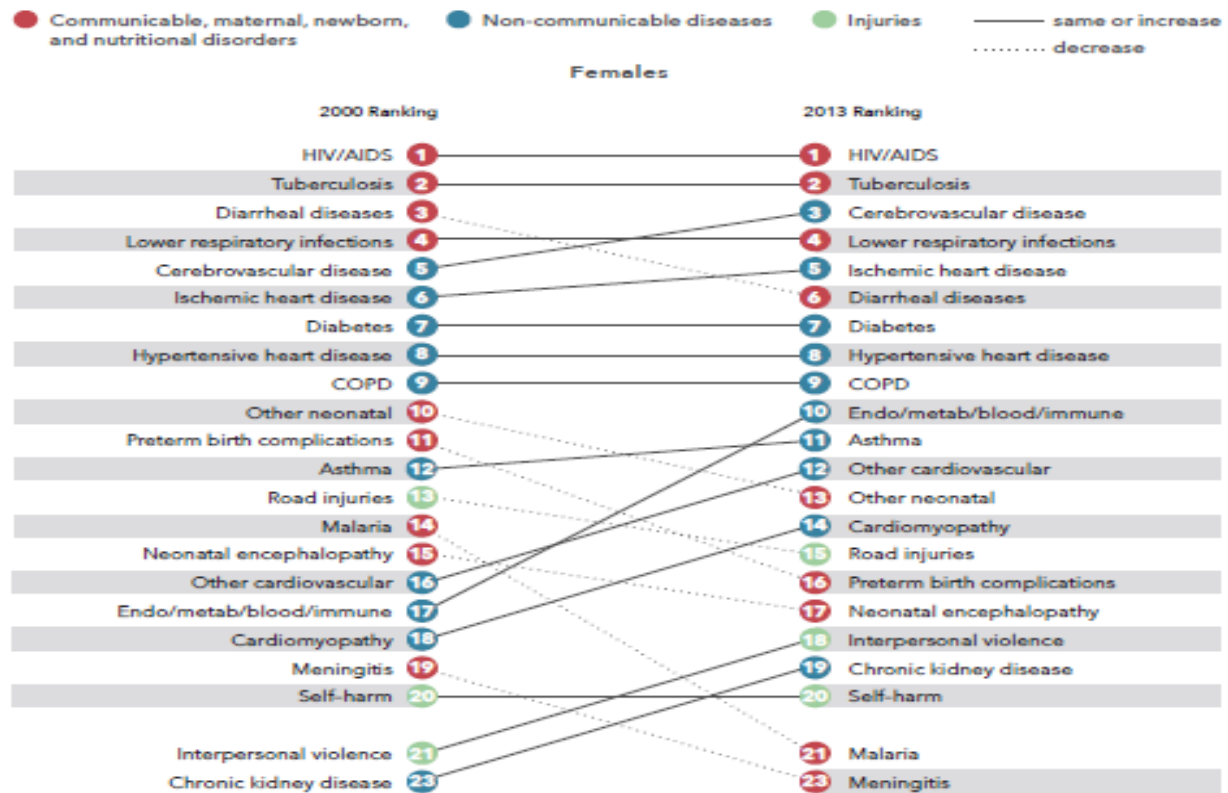


*(Source: WHO Non-Communicable Diseases (NCDs) Country Profile, 2014)*

### 2.1.1 Cardio-Vascular Diseases (CVD)

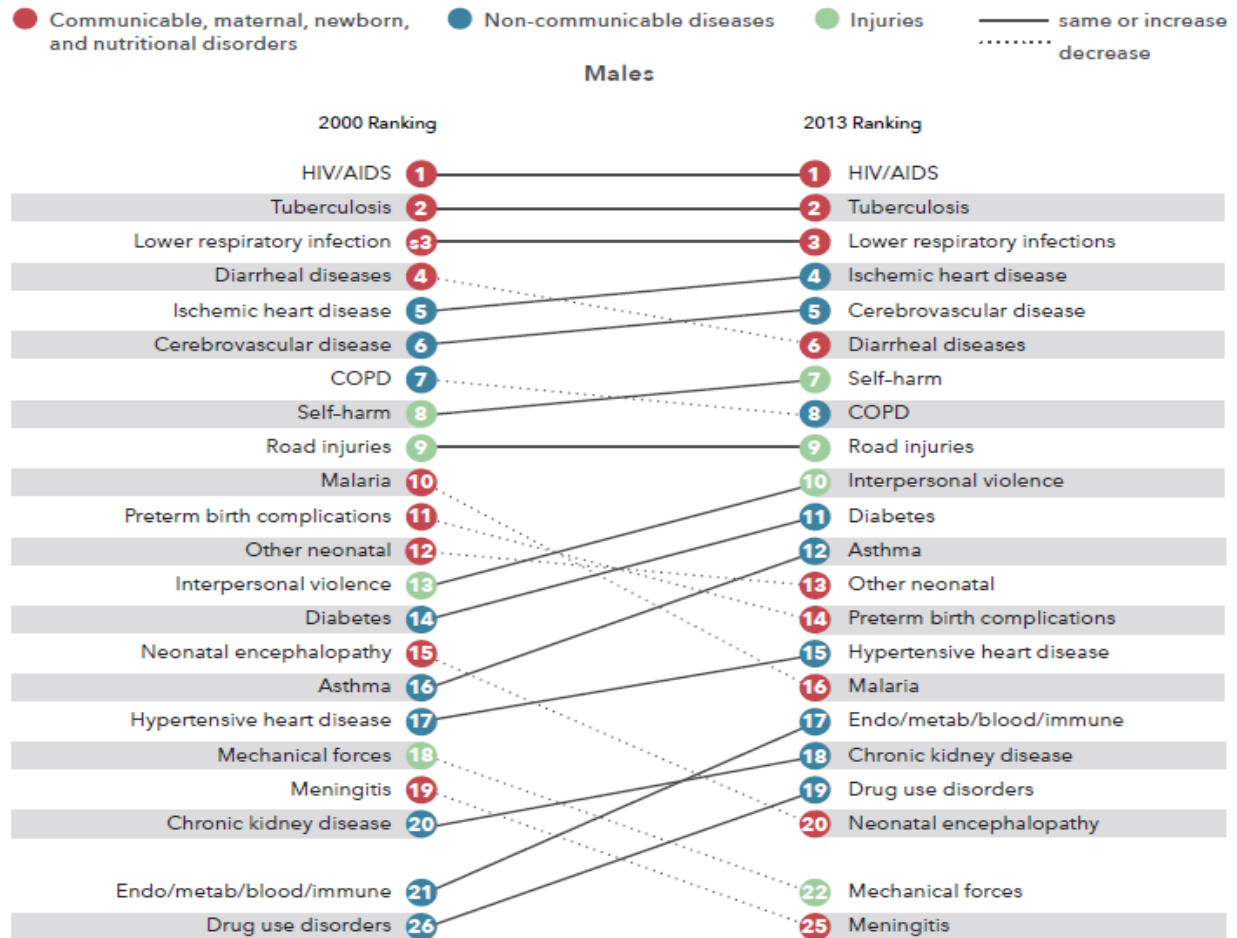
According to the WHO NCDs country profile for 2014, CVD are the most common NCDs in Namibia accounting for 21% of all mortality in 2012. According to the 2013 Global Burden of Disease report, cardiovascular diseases are the third most common cause of death next to HI/AIDS and Tuberculosis. Between 2000 and 2013, the ranks of CVD in Namibia for both males and females have increased with ischemic heart disease rising from fifth to fourth for males and sixth to fifth for females. Stroke (cerebrovascular disease) has increased from sixth to fifth for males, and from fifth to third for females. This highlights the importance of focusing attention on NCDs, especially cardiovascular diseases, and their associated risk factors, to tackle the rising importance of these leading causes of death in Namibia. Figures 2 and 3 show the leading causes of death for women and men in Namibia in 2000 and 2013 (Namibia: State of the Nation’s Health, Institute of Health Metrics and evaluation, 2016).

**Figure 2: Leading causes of death for females Namibia, 2000 and 2013**



Note: COPD = chronic obstructive pulmonary disease  
Endo/metab/blood/immune = Endocrine, metabolic, blood, and immune disorders

**Figure 3: Leading causes of death for males Namibia, 2000 and 2013**



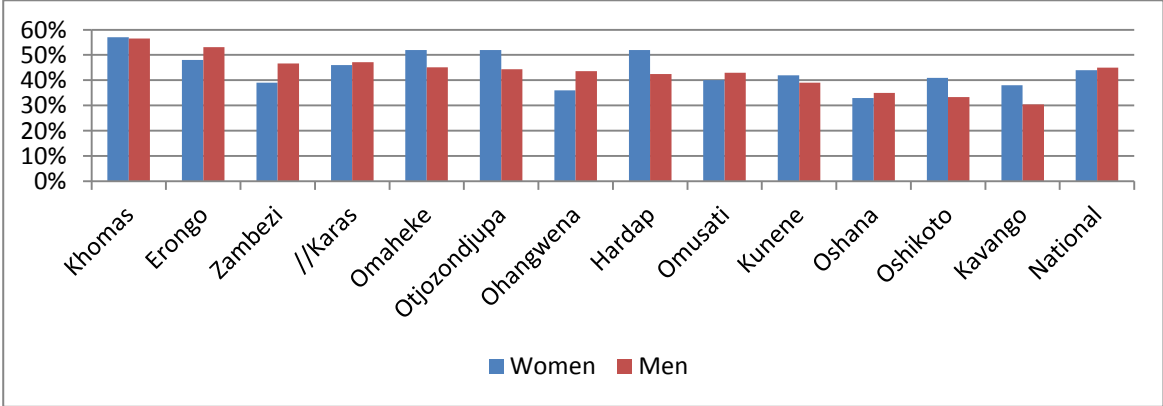
**Note:** COPD = chronic obstructive pulmonary disease  
Endo/metab/blood/immune = Endocrine, metabolic, blood, and immune disorders

*(Source: WHO/IHME, Namibia: State of the Nation's Health, Findings from GBD 2016)*

The risk factors for CVD in Namibia include smoking, lack of physical exercise, harmful use of alcohol, unhealthy diets and obesity. Rheumatic heart disease caused by poorly treated streptococcal throat infection is a common preventable CVD in Namibia. The most common CVD in Namibia include High Blood Pressure (HBP), Coronary Heart Disease (CHD) and RHD. According to the Namibia Demographic and Health Survey (NDHS) of 2013, 44% of women (50.6% urban, 38.3% rural) and 45% of men (50.8% urban, 37.8% rural) aged 35-64 years are hypertensive. The prevalence increases with age affecting 55% of women and 60% of men aged 50-64 years. However, 49% women and 61% of men are not aware that they have elevated BP.

The same report showed that the highest proportion of men and women aged 35-64, who suffer from High Blood Pressure (57%) are in Khomas region and the lowest among men of the same age were in Kavango (30%). Oshana region had the lowest proportion of women with High Blood Pressure (32%). Other regions have HBP percentages ranging between 30% and 56% for both men and women. Figure 4 shows HBP prevalence among women and men aged 35-64 years in all the 14 regions of Namibia.

**Figure 4: Hypertension among women and men age 35-64 years by region (NDHS 2013)**



**2.1.2 Chronic Respiratory Diseases**

These include diseases like Chronic Obstructive Pulmonary Diseases (COPDs) and Asthma. In 2012, it accounted for 4% of the total mortality in Namibia. Mortality from COPDs ranked 8<sup>th</sup> and 9<sup>th</sup> in males and females in 2013 with no change compared to 2000. On the other hand, mortality from bronchial asthma has increased from the 2000 ranking of 16<sup>th</sup> and 12<sup>th</sup> position to 12<sup>th</sup> and 11<sup>th</sup> levels in 2013 in males and females respectively. These diseases may start in childhood through exposure to infection, indoor air pollution and tobacco smoke and cause great disability and eventual death in older adults.

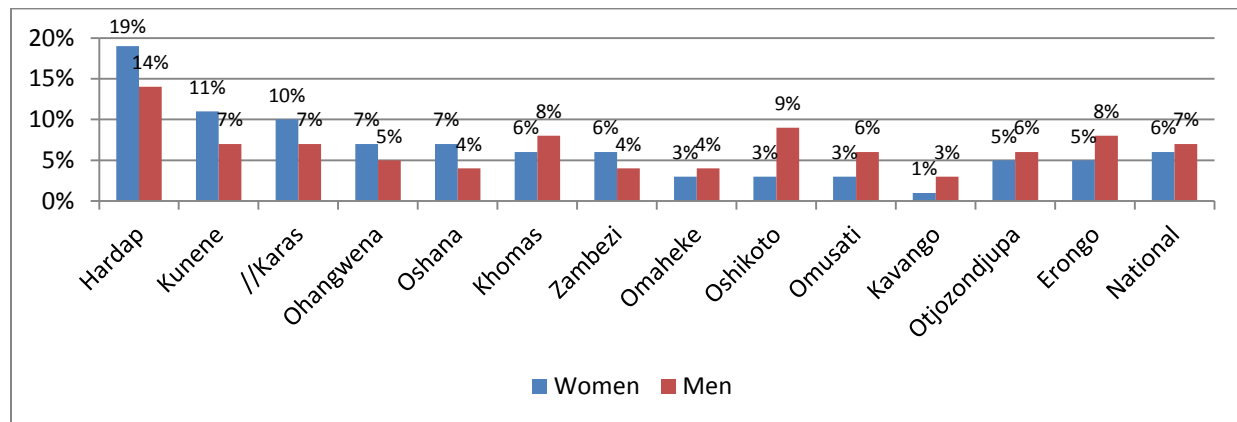
**2.1.3 Diabetes Mellitus**

Diabetes Mellitus accounted for 4% of all mortality in Namibia in 2012. Type 2 Diabetes Mellitus is increasingly occurring among young children. More so, complications from Diabetes Mellitus such as amputations and blindness are also increasingly being reported from health facilities. The risk factors for Diabetes Mellitus include obesity, unhealthy diet, lack of physical exercise and harmful use of alcohol. The NDHS 2013 data show that 6 percent of women and 7 percent of men have Diabetes Mellitus; i.e. fasting plasma glucose (FPG) values of 7mmol/L or higher or

report that they are currently taking Diabetes Mellitus medication. The NDHS also shows that 7 percent of women and 6 percent of men are pre-diabetic (i. e, FPG values are 6.1-6.9 mmol/L). However, only 3% of women and men age 35-64 were ever told to have diabetes of whom 67% of women and 74% of men were on treatment.

The data from the NDHS also shows that among women, Diabetes Mellitus increases with age; 3 percent of women age 35-39 have elevated FPG values or are currently taking Diabetes Mellitus medicine, as compared with 8 percent of women age 55-59. Obese women (12%) are much more likely than other women to have high blood glucose or Diabetes Mellitus. The data further show that urban women are twice as likely as rural women to be classified as having Diabetes Mellitus (8% versus 4 %). Regional data indicated that, women in Hardap have the highest prevalence of Diabetes Mellitus which is 19 percent, and women in Kavango have the lowest prevalence of 1 percent. Figure 5 shows the regional prevalence of Diabetes Mellitus among women and men ages 35-64 years in Namibia.

**Figure 5: Prevalence of Diabetes Mellitus in women and men 35-64 years in Namibia (NDHS 2013)**



The prevalence of Diabetes Mellitus is highest among women with more than a secondary education (7 percent) and women in the highest wealth quintile (9 percent). Men age 60-64 have the highest prevalence of Diabetes Mellitus (13%). Similar to women, the prevalence is highest among obese men (19%) and is higher among urban (8 %) than rural (5 %) men. Men in Hardap are most likely to have Diabetes Mellitus (14 %) and men in Kavango least likely (3 %). Diabetes Mellitus prevalence is high among educated people i.e. 2% prevalence among men with no education and 15% among those with more than a secondary education. The prevalence of Diabetes Mellitus generally increases with increasing wealth level.

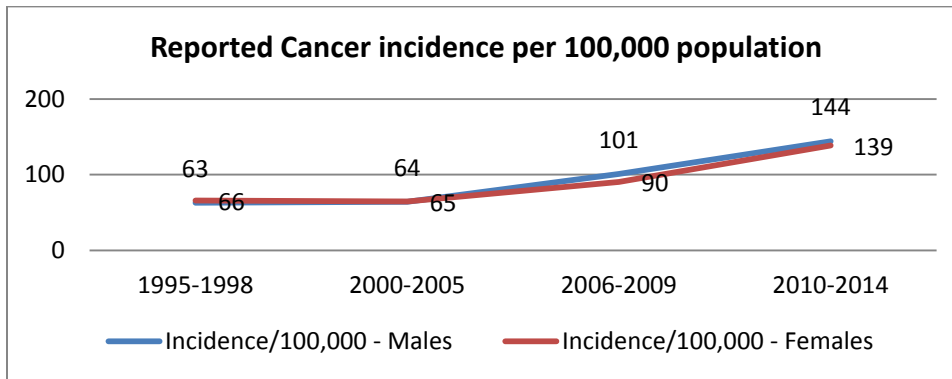


### 2.1.4 Cancers

Cancers were responsible for 5% of all mortality in 2012. The 5 most frequent cancers (ranking defined by total number of cases) in Namibia are Breast (15.9%), Kaposi Sarcoma (11.8%), Cervix (9.8%), prostate (9.7%), and Lip/oral cavity (5.8%)<sup>14</sup>.

Since the start of the national cancer registry in 1995, the reported cancer incidence (excluding Non-Melanoma skin cancers) per 100,000 population has more than doubled in both males and females between 1995 and 2014.

**Figure 6: Reported cancer incidence per 100,000 population, 1995-2014 (Cancer Registry Data)**



#### 2.1.4.1 Cervical Cancer

Cervical cancer is the 3<sup>rd</sup> most common cancer in Namibia. Cervical cancer ranks as the 2<sup>nd</sup> most frequent cancer among women in Namibia with 1118 cases reported during the period 2010-2014 comprising 19.4% of all cancers in females. Cervical cancer is caused by the oncogenic HPV virus. Data is not available on the HPV burden in the general population of Namibia. However, in Southern Africa, the region Namibia belongs to, about 3.2% of women in the general population are estimated to harbor cervical HPV-16/18 infection at a given time, and 61.8% of invasive cervical cancers are attributed to HPV subtypes 16 or 18.

Data from the 2013 NDHS on cervical cancer screening showed that 66% of women aged 15-49 years have heard of cervical cancer and 25% have had a cervical cancer examination (Pap smear test). Cervical cancer and Pap smear test awareness was noticed among women: aged 35 and older, who have 3-4 children, who are married or living together with partners, who live in

<sup>14</sup> Globocan. [http://globocan.iarc.fr/Pages/fact\\_sheets\\_population.aspx](http://globocan.iarc.fr/Pages/fact_sheets_population.aspx)

urban areas, with more than secondary education and those in the highest wealth quintile. Among women age 15-49 who have heard of cervical cancer examination, 93% had a Pap smear test while 2% had Visual Inspections with Acetic acid (VIA). The low percentage of women who had visual inspections is because VIA screening was not implemented in the public sector widely.

#### **2.1.4.2 Prostate Cancer**

Prostate cancer is the 4<sup>th</sup> most common diagnosed cancer in Namibia. In 2012, WHO estimates shows that there were a total of 88 deaths from prostate cancer in Namibia representing 11% of all cancer deaths for that year. Prostate cancer is the most common cancer in males during the period 2010-2014 with a total of 1128 cases reported accounting for 24% of all male cancers and its incidence increases with age. (Cancer Registry data, 2010-2014)

In terms of knowledge, 64% of men 40-64 years were aware of prostate cancer. Of these, 27% reported that they have had a test or examination for prostate cancer. This percentage increases with age, from 23% among men age 40-44 to 31% among men age 55-64. Urban men are nearly twice as likely as rural men to report having had a test or exam (29% versus 17%).

Forty-two percent of men in //Karas reported having had a test or exam for prostate cancer, as compared with 10 percent of men in Kunene. The percentage of men who have had a prostate cancer test or exam increases with increasing education and wealth. Men with more than a secondary education are nearly seven times as likely as men with no education to have had a test or exam (40% compared with 6 %). Similarly, men in the highest wealth quintile are more than three times as likely as men in the lowest quintile to report having had a test or exam for prostate cancer.

#### **2.1.4.3 Breast Cancer**

Breast cancer is the 2<sup>nd</sup> most common cancer in Namibia only preceded by skin cancer mainly Kaposi sarcoma. It is the leading type of cancer in women with a total of 1579 cases reported during the period 2010-2014 accounting for 27% of all female cancers. According to NDHS 2013, 33% of women aged 15-49 years ever had breast cancer examination; 31% self-examination and 23% clinical examination, respectively.

### 2.1.5 Violence and Injuries, Road Traffic Accidents

Injuries contribute significantly to mortality and morbidity in Namibia. According to the WHO NCDs country profile, injuries were responsible for 10% of the total mortality in 2012. Though unintentional injuries such as Road Traffic Accidents (RTA), poisonings, fires and falls are important cause of mortality and morbidity, intentional causes such as interpersonal/domestic violence especially against women are also significant<sup>15</sup>.

Data from the 2013 Namibian Global Burden of Disease study shows significant difference in mortality from RTAs, self-harm (suicide) and interpersonal violence between the two sexes and also increasing trend over time especially in males. For males, injuries feature prominently in the top 10, with suicide and interpersonal violence both rising in importance from 2000 to 2013 (self-harm increased from 8<sup>th</sup> to 7<sup>th</sup>; interpersonal violence increased from 13<sup>th</sup> to 10<sup>th</sup>; road injuries remained ninth). These same causes do not feature in the top 10 causes of death for females (self-harm remained 20<sup>th</sup>, road injuries were 15<sup>th</sup>, and interpersonal violence was 18<sup>th</sup>). Deaths from self-harm, road injuries, and interpersonal violence peak in males aged 20-24. Together, these causes account for almost 50% of all deaths in this age group.

Road traffic injuries are the 9<sup>th</sup> leading cause of death globally, and the principal cause of death among those aged 15–29 years. Road traffic crashes are responsible for over 1.25 million deaths each year, while estimate of the burden of non-fatal injuries goes up to 50 million. Half of all deaths on the world's roads are among those with the least protection, motorcyclists (23%), pedestrians (22%) and cyclists (4%). In the African Region, pedestrian and cyclist deaths account for 43% of all road traffic deaths.

Namibia suffers from a high burden of road traffic accidents. According to a 2012 WHO estimate, about 550 people are killed every year in road accidents. This results in a fatality rate of 24/100,000 population (2015) which is too high for the country's low vehicle and human population levels and it is also higher than the global average (18/100,000) and the average for upper middle income countries, (19/100,000). About 15,500 road accidents are reported

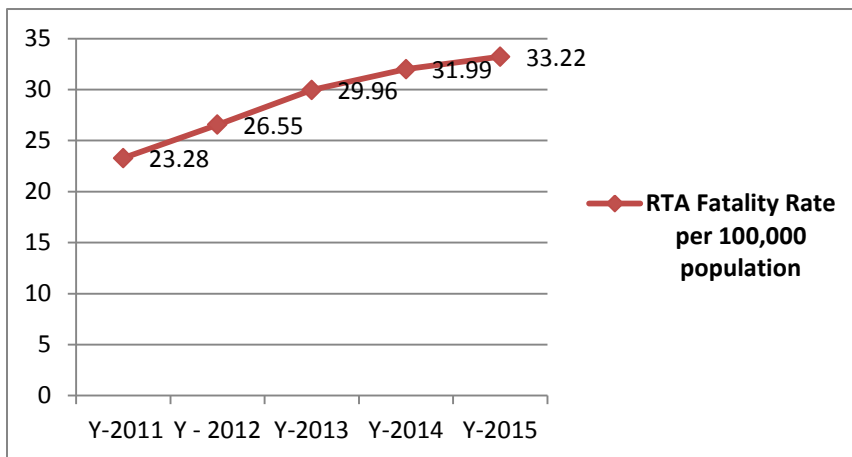
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<sup>15</sup> World Health Organization. Measurement and Health Information. April 2011

annually resulting in over 550 deaths and injuries to more than 3000 people. The economic cost of road accidents is also huge reaching about 2% of the gross domestic product.

The country is implementing the Namibian Decade of Action for Road Safety (2011-2020) in line with the global road safety action plan. However, the fatality, disability and economic loss from road traffic accidents remain a serious challenge. As illustrated in Figure 5 below, data from MVA Fund shows progressive increase in the rate of road accident fatalities from 23.3 to 32.2 per 100,000 populations between 2011 and 2015.

**Figure 7: Trends in Road Traffic Accidents fatality rate in Namibia, 2011-2015 (MVA Data)**



*(Source: Unpublished Report, MVA 2016)*

Gender based violence is also a major problem in Namibia. As per the NDHS of 2013, 33% of ever-married women age 15-49 reported ever having experienced physical, sexual, and/or emotional violence from their spouse, and 28 percent reported having experienced such violence in the previous 12 months. The same report showed that the highest percentage of women who experienced physical violence at the age of 15 years was in Kavango with 49%, followed by Omaheke with 42%, Karas with 41%, Kunene 36%, Otjozondjupa 33.5%, Oshikoto 32.8%, Khomas 32, 7%, Ohangwena 30%, Oshana 28.2%, Zambezi 27.5%, Erongo 27.0% and Omusati 19, 4%. Further research may be useful in determining the factors responsible for the high prevalence of physical violence in Kavango.

## **2.2 Risk Factors for NCDs in Namibia**

The major NCDs that are responsible for the significant proportion of morbidity and mortality share similar risk factors including use of tobacco and tobacco products, harmful use of alcohol, lack of physical exercise and unhealthy diets. These risk factors are prevalent in Namibia. A large percentage of Non-Communicable Diseases (NCDs) are preventable through the reduction of the four main behavioral risk factors: use of tobacco- products, physical inactivity, harmful use of alcohol and unhealthy diet.

### **2.2.1 Use of Tobacco Products**

Use of tobacco and tobacco products is a known risk factor for several NCDs including CVD, Chronic Respiratory Diseases, cancers and Diabetes Mellitus. In Namibia, use of tobacco includes smoking, snuff; chewing and other forms of use. The 2014 NCDs country profile indicates that Namibia has a high prevalence of tobacco smoking (20% average for both men and women; 30% for men and 9% for women).

According to the NDHS, about 5% of women use tobacco products with a mean age of first use of 34 years. 4.2 % of women age 15-49 smoke cigarettes, 0.3% smoke pipe, and 1.5% smoke other tobacco products. Older women are more likely to smoke than younger women; 1 % of women age 15-19 smoke cigarettes, as compared with 8 % of women age 40-44. Women in the older age group are also more likely to use tobacco other than cigarettes or pipes, and 40 % of women age 45-49 smoke tobacco products daily. One in six women in Hardap (16 %) smoke cigarettes and 5 % use tobacco in other forms. On the other hand, 1 % or less of women in Oshanaana and Oshanaana use either cigarettes or other types of tobacco. Seven % of women in Oshanaana use any type of tobacco, and 43 % smoke tobacco products daily. Women's level of education and wealth status are related to their propensity to smoke.

Smoking is more common among Namibian men than women; 19 % of men smoke cigarettes or pipe with a mean age of first use of 21 years. About 4.5% of men use other tobacco products. The likelihood for a man to smoke cigarettes or pipe increases with age, from 6 % among the age group of 15-19 years, to 21-24 % among older men. Across regions, men in Hardap are

most likely to smoke cigarettes or pipe (39 %) and men in Omusati least likely (8 %). There is little variation in tobacco use among men by residence, level of education, or wealth quintile.

### **2.2.2 Alcohol Consumption**

Harmful use of alcohol is a known risk factor for all the major NCDs including violence and injuries. Consumption of alcohol is widespread in Namibia. Data from the WHO NCDs country profile indicates that Namibia has one of the highest average total per capita alcohol consumption of 10.8 L for both men and women in the Region. Data from the NDHS shows respondents in the age groups 15-49 years who had ever consumed alcoholic drinks and the percent distribution by the number of days they had consumed alcohol in the last two weeks, according to background characteristics. One in two women (50 %) and almost three in five men age 15-49 (57 %) reported drinking alcohol at some point in their lives. Women age 25-39 are more likely to have ever consumed alcohol than women in the other age groups. Two in three women (68 %) in Oshikoto report that they have ever consumed alcohol. Women with more than a secondary education (63 %) and those in the highest wealth quintile are more likely than their counterparts in the other categories to report ever having consumed alcohol. The proportion of men who have ever consumed alcoholic drinks is highest among those age 25-29 (66 %), among men in Oshana (80 %), those with more than a secondary education (68 %), and among men in the highest wealth quintile (60 %).

### **2.2.3 Physical Inactivity**

Five percent of women and 12 percent of men age 15-49 were physically active at work, while 16 percent of women and 32 percent of men engaged in non-work-related physical activity. The vast majority of women (80 percent) and men (57 percent) were neither physically active at work nor engaged in non-work-related physical activity. Non-work-related physical activity is highest among women and men age 15-19, those in Zambezi, women and men with a secondary education or higher, and those in the highest wealth quintile. Nine percent did not engage in any physical activity in the week prior to the survey. Continuous non-work-related physical activity (5-7 days per week) is highest among women older than age 40, women in Hardap and Omaheke, women with no education, and those in the lowest wealth quintile. Among men, continuous physical activity is highest among those age 15-19, men in

rural areas, those in Oshana and Otjozondjupa, men with a secondary education or lower, and those in the second and fourth wealth quintiles.

#### **2.2.4 Unhealthy Diets**

The consumption of fruits and vegetables is below the recommended standard. On average both men and women consume fruits and vegetables 2 and 3 times per week respectively. However, there is variation in the consumption of fruits and vegetables by residence and socio-economic status. Women in Khomas eat fruit four days a week on average, as compared with one to three days a week among women in the other regions. Women in Oshana and Otjozondjupa are less likely to eat vegetables (only two days per week on average) than women in the other regions. Similarly, men in Zambezi, Erongo and Khomas regions consume fruits and vegetables more than three times per week while those from Otjozondjupa and Oshana take these foods 1-2 times per week. Overall, consumption of fruits and vegetables is higher among those with higher educational and socio-economic status.

Generally, socio-economic developments and rapid urbanization led to changing lifestyles resulting in a shift in dietary patterns. People are now consuming more foods high in energy, fats, free sugars or salt/sodium, and many do not eat enough fruit, vegetables and dietary fibre such as whole grains (e.g. unprocessed maize, millet, oats, wheat, brown rice). At least 400 g (5 portions) of fruits and vegetables a day are recommended.

Energy intake (calories) should be in balance with energy expenditure and total fat should not exceed 30% of total energy intake with a shift in fat consumption away from saturated fats (e.g. found in fatty meat, butter, palm and coconut oil, cream, cheese, ghee and lard) to unsaturated fats (e.g. found in fish, avocado, nuts, sunflower, canola and olive oils), and towards the elimination of industrial trans fats (found in processed food, fast food, snack food, fried food, frozen pizza, pies, cookies, margarines and spreads). Less than 10% of total energy intake from free sugars (2, 5) which is equivalent to 50 g (about 12 level teaspoons) for a person of healthy body weight consuming approximately 2000 calories per day, but ideally less than 5% of total energy intake for additional health benefits. Most free sugars are added to foods or drinks by the manufacturer, cook or consumer, and can also be found in sugars naturally present in honey, syrups, fruit juices and fruit juice concentrates. Salt is in almost everything we eat, from bread and cereals to cheese and cured meats.

Keeping salt intake to less than 5 g per day (equivalent to approximately 1 teaspoon) helps prevent hypertension and reduces the risk of heart disease and stroke. Most people consume far more salt than is needed to provide its health benefits. Most processed and prepared foods already contain high levels of salt, and often more is added to cooked foods.

### 2.3 Response to NCDs in Namibia

Namibia Vision 2030 underscores the importance of “healthy living” and the goal of eliminating the major causes of physical ill health as well as mental and social ailments in order to give the Namibian people the opportunity to lead a normal fulfilling life.

It is expected that the majority of Namibians will be living a healthy lifestyle and provided with safe drinking water as well as comprehensive and curative health services to which all have easy access.

In complementing Vision 2030 objectives, the Health Policy Framework provides a strategic framework to support improved health outcomes for people at risk of, or experiencing Non-Communicable Diseases or conditions and related complications. It recognizes that certain groups in the community and those with serious or chronic health problems are at heightened risk of long term debilitating diseases.

The Health Policy Framework provides the activities of the health sector that can be coordinated to address health promotion, primary, secondary and tertiary prevention. It covers both the public and private sectors and involves all the main actors in prevention and control of Non-Communicable Diseases.

Therefore, this National Strategy reinforces the Government’s commitment to national, regional and international initiatives such as:

- Moscow Declaration on NCDs, May 2011
- UN High Level Declaration on NCDs, September 2011
- Global action plan for the prevention and control of noncommunicable diseases 2013-2020, WHO 2013.
- Global status report on noncommunicable diseases 2014, WHO 2014.
- “Best Buys” and other recommended interventions for the prevention and control of non-communicable diseases, Updated (2017) Appendix 3 of the WHO Global Action Plan for the prevention and control of NCDs, 2013-2020.
- WHO Framework Convention on Tobacco Control, WHO 2003/updated in 2004 & 2005
- The Global Status Report on Alcohol and Health, WHO 2014
- Sustainable Development Goals
- Global Strategy on Diet, Physical Activity and Health, WHO 2004



- Global Plan for the Decade of Action for Road Safety 2011-2020
- SADC Protocol on Health, 1999
- Ottawa Charter on Health Promotion, 1986
- Alma Ata and Primary Health Care Declaration, 1978

Legislation is an important mechanism for helping to reduce Non-Communicable Diseases caused by tobacco use, harmful use of alcohol and by unhealthy diets. The mandates that guides the implementation of this strategy includes, but not limited to the following:

- The Health Sector Strategic Plan 2017/18-2021/22, Ministry of Health and Social Services 2017.
- The National Development Plan 5 (NDP 5, 2017/18-2021/22), Namibian National Planning Commission 2017.
- The Public and Environmental Health Act, 2015
- Mental Health Act, 2009
- Tobacco Products Control Act, Act No. 1 of May 2010
- Namibian Decade of Action for Road Safety (2011-2020)

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 harmful use of alcohol all of which are associated with increased risk to Cancer, Cardio-Vascular Disease, Diabetes Mellitus and other chronic diseases are the risk factors. Other risk factors for NCDs include biological agents that are responsible for cervical and liver cancers and some environmental factors such as air pollution, which contribute to a range of Chronic Respiratory Diseases including Asthma. Many NCDs share environmental or genetic factors that are amendable to preventive measures such as smoking, harmful use of alcohol, physical inactivity and inappropriate diet.

Efforts could also be made to look at controlling harmful use of alcohol through controls in alcohol legislation. Similar Legislations could also be used to reduce NCDs rates through controlling food quality through standards, labeling (to allow consumers to make good food choices) and to limit levels of fat, sugar and salt in food.

Although there are a number of national programs implemented in Namibia to prevent the onset of and reduce chronic Non-Communicable Diseases, this appear to be ineffective due to

poor coordination, limited budget and technical capacity at all levels of the health system. In addition, there is lack of activities directed towards establishing sustainable and integrated systems on control and surveillance of risk factors. Therefore, in line with WHO recommendations, there is a need to move from old risk/disease specific approaches towards cost-effective and integrated NCDs risk factors prevention and control program approach in order to challenge reduction of several risk factors.

Governments have recognized that quick gains against the epidemic of Non-Communicable Diseases can be made through modest investments in cost effective interventions. Widespread implementation of these interventions needs active engagement of sectors beyond health and a whole-of-government, whole-of-society and health-in-all policies approach

The Multisectoral NCDs Strategic Plan will help the government to address the challenges posed by chronic diseases with emphasis on the best approach to reduce the social determinants responsible for unhealthy lifestyles. Active engagement of all concerned Line Ministries, government agencies and stakeholders is critical to create an enabling policy and legal environment for prevention of NCDs and their risk factors.

Implementation of the strategy will significantly complement the Health Promotion Policy and other legislations, policies and guidelines related to Nutrition, Programme Document for Disability Prevention and Rehabilitation, Mental Health Policy (2009), School Health Policy (May 2008), Tobacco Control Act, Act No 1 of 2010; and the draft Alcohol Policy.

## **3 CHAPTER 3: VISION, PRINCIPLES, GOALS, OBJECTIVES and TARGETS**

### **3.1 Vision**

A healthy nation that is free from the avoidable burden of Non-Communicable Diseases.

### **3.2 Mission**

To have an improved quality of life of the population through the alleviation of the burden of Non-Communicable Diseases through the promotion of healthy lifestyles and the adoption of appropriate interventions by means of multisectoral action at community, district, regional and national level; as well as by improving surveillance and control of Non-Communicable Diseases and its risk factors through effective health promotion action, so that Namibians can reach the highest attainable standards of health and productivity at every age.

### **3.3 Guiding principles**

#### **3.3.1 Human Rights Approach**

To assure the rights of all people with Non-Communicable Diseases to access quality and affordable health care and interventions irrespective of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or status, as enshrined in the Universal Declaration of Human Rights. (Namibian constitution article 20)

#### **3.3.2 Equity-Based Approach**

It is essential to realize that the creation of inclusive, equitable and economically productive services for NCDs should cater for both the vulnerable groups and the entire society because unequal affliction by NCDs is ultimately due to the inequitable distribution of social determinants of health.

#### **3.3.3 Universal Health Coverage**

All people should have access; without discrimination, to nationally determined sets of comprehensive promotive, preventive, curative and rehabilitative health care services.

#### **3.3.4 Empowerment of People and Communities**

Enabling healthy supportive environments in communities to adopt healthy lifestyle and thereby reduce modifiable NCDs risk factors through their involvement in advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation.

#### **3.3.5 Multisectoral Action**

Ensuring participation of individuals, families, communities, line ministries and NGOs, FBOs, private sector and bilateral development partners for the effective prevention and control of non-communicable disease.

#### **3.3.6 Evidence Based Strategies**

Providing comprehensive, affordable, culturally sensitive and cost effective patient and people at risk- and population-oriented approaches based on latest scientific evidence and/or best practice.

#### **3.3.7 Efficient Resource Utilization**

Providing health promotive and preventive actions as well as continued primary health care and clinical services, based on available resources and infrastructure.

#### **3.3.8 Integration**

Providing integrated comprehensive approaches towards reducing common risk factors of major NCDs including policy making, capacity building, partnership, information dissemination and implementation in all aspects.

### **3.4 Goal**

To reduce the preventable and avoidable burden of morbidity, mortality and disability due to Non-Communicable Diseases in the country and achieve a healthy and productive population.

### **3.5 Objectives**

1. To raise the priority accorded to the prevention and control of Non-Communicable Diseases on the political agenda and at all levels through advocacy
2. To strengthen national capacity, leadership, governance, multisectoral collaboration and partnerships to accelerate country response for the prevention and control of Non-Communicable Diseases
3. To reduce modifiable risk factors for Non-Communicable Diseases and underlying social determinants through the creation of health promoting environments
4. To strengthen and orient health systems to address the prevention and control of Non-Communicable Diseases and the underlying social determinants through people centered primary health care and universal health coverage
5. Promote and implement evidence based strategies and interventions for prevention and control of violence and injuries particularly Road Traffic Accidents (RTA)
6. To promote and support national capacity for high-quality research and development for the prevention and control of Non-Communicable Diseases
7. To monitor the trends and determinants of Non-Communicable Diseases and evaluate progress in their prevention and control

### 3.6 Targets

Namibia aims to achieve the following targets by 2022 and 2025 in line with the global NCD targets.

1. A 15% relative reduction in premature mortality from cardiovascular disease, cancer, diabetes, or chronic respiratory diseases by 2022; and a 25% relative reduction by 2025
2. A 7% relative reduction in the use of alcohol by 2022; and a 10% relative reduction by 2025
3. A 7% relative reduction in prevalence of insufficient physical activity by 2022; and a 10% relative reduction by 2025
4. A 15% relative reduction in mean population intake of salt/sodium by 2022; and a 30% relative reduction by 2025
5. A 15% relative reduction in prevalence of current tobacco use in persons aged over 15 years by 2022; and a 30% relative reduction by 2025
6. A 15% relative reduction in prevalence of raised blood pressure and/or contain the prevalence of raised blood pressure by 2022; and a 25% relative reduction by 2025
7. Halt the rise in obesity and Diabetes Mellitus by 2022
8. 30% of eligible people receive drug therapy and counseling (including glycaemic control) to prevent heart attacks and strokes by 2022; and 50% by 2025
9. A 50% availability of affordable basic technologies and essential medicines including generics, required to treat major non-communicable diseases in both public and private facilities by 2022; and 80% by 2025.

## 4 CHAPTER 4: PRIORITY NCDs INTERVENTIONS

There are evidence based and effective interventions targeting the four shared risk factors and the four major NCDs as stated in the WHO's Global Action Plan for the Prevention and Control of NCDs 2013-2020 and the 2017 update to Appendix 3 of the same document. Besides, there are important overarching health system interventions and enabling policy actions that are essential to ensure national prioritization of the prevention and control of NCDs.

### 4.1 Effective interventions against the four key risk factors for NCDs

WHO has identified a set of population and individual level interventions which are affordable, feasible and cost-effective and which every country can implement and significantly reduce the burden of NCDs. These high priority interventions are known as "*Best Buys*". There are also other important WHO recommended interventions known as "*Good Buys*" that have been shown to be effective but for which cost-effectiveness analysis data is not available. Table 1 below shows the list of best buys and other WHO recommended and effective interventions (Good Buys) to tackle the burden of NCDs and their major risk factors.

Similarly, Table 2 shows the list of best buys and other WHO recommended and effective interventions for the prevention, treatment and care of the four major noncommunicable diseases.

**Table 1: WHO NCDs “Best Buys” and Other Effective WHO Recommended Interventions for preventing risk factors**

Major NCDs Risk Factor and WHO Recommended Interventions
<p><b><u>Tobacco Use</u></b></p> <p><b><i>Best Buys</i></b></p> <ol style="list-style-type: none"> <li>1. Increase excise taxes and prices on tobacco products</li> <li>2. Implement plain/standardized packaging and/or large graphic health warnings on all tobacco packages</li> <li>3. Enact and enforce comprehensive bans on tobacco advertising, promotion and sponsorship</li> <li>4. Eliminate exposure to second-hand tobacco smoke in all indoor workplaces, public places, public transport</li> <li>5. Implement effective mass media campaigns that educate the public about the harms of smoking/tobacco use and second hand smoke</li> </ol> <p><b><i>Other WHO Recommended Interventions</i></b></p> <ol style="list-style-type: none"> <li>6. Implement measures to minimize illicit trade in tobacco products</li> <li>7. Ban cross-border advertising, including using modern means of communication</li> <li>8. Provide cessation for tobacco cessation to all those who want to quit</li> </ol>
<p><b><u>Harmful Use of Alcohol</u></b></p> <p><b><i>Best Buys</i></b></p> <ol style="list-style-type: none"> <li>1. Increase excise taxes on alcoholic beverages</li> <li>2. Enact and enforce bans or comprehensive restrictions on exposure to alcohol advertising (across multiple types of media)</li> <li>3. Enact and enforce restrictions on the physical availability of retailed alcohol (via reduced hours of sale)</li> </ol> <p><b><i>Other WHO Recommended Interventions</i></b></p> <ol style="list-style-type: none"> <li>4. Carry out regular reviews of prices in relation to level of inflation and income</li> <li>5. Establish minimum prices for alcohol where applicable</li> <li>6. Enact and enforce an appropriate minimum age for purchase or consumption of alcoholic beverages and reduce density of retail outlets</li> <li>7. Restrict or ban promotions of alcoholic beverages in connection with sponsorships and activities targeting young people</li> <li>8. Provide prevention, treatment and care for alcohol use disorders and comorbid conditions in health and social services</li> <li>9. Provide consumer information about, and label, alcoholic beverages to indicate, the harm related to alcohol</li> <li>10. Enact and enforce drink-driving laws and blood alcohol concentration limits via sobriety checkpoints</li> </ol>



## **Unhealthy Diet**

### ***Best Buys***

1. Reduce salt intake through:-
  - a. the reformulation of food products to contain less salt and setting of target levels for the amount of salt in foods and meals
  - b. the establishment of a supportive environment in public institutions such as hospitals, schools, workplaces and nursing homes, to enable lower sodium options to be provided
  - c. behavior change communication and mass media campaign
  - d. implementation of front-of-pack labelling

### ***Other WHO Recommended Interventions***

2. Promote and support exclusive breastfeeding for the first 6 months of life, including promotion of breastfeeding
3. Implement mass media campaign on healthy diets, including social marketing to reduce the intake of total fat, saturated fats, sugars and salt, and promote the intake of fruits and vegetables
4. Implement nutrition education and counselling in different settings (for example, in preschools, schools, workplaces and hospitals) to increase the intake of fruits and vegetables
5. Implement subsidies to increase the intake of fruits and vegetables
6. Implement nutrition labelling to reduce total energy intake (kcal), sugars, sodium and fats
7. Replace trans-fats and saturated fats with unsaturated fats through reformulation, labelling, fiscal policies or agricultural policies
8. Reduce sugar consumption through effective taxation on sugar-sweetened beverages
9. Limiting portion and package size to reduce energy intake and the risk of overweight/obesity

## **Physical Inactivity**

### ***Best Buys***

1. Implement community wide public education and awareness campaign for physical activity which includes a mass media campaign combined with other community based education, motivational and environmental programs aimed at supporting behavioral change of physical activity levels

### ***Other WHO Recommended Interventions***

2. Ensure that macro-level urban design incorporates the core elements of residential density, connected street networks that include sidewalks, easy access to a diversity of destinations and access to public transport
3. Implement whole-of-school programme that includes quality physical education, availability of adequate facilities and programs to support physical activity for all children
4. Provide convenient and safe access to quality public open space and adequate infrastructure to support walking and cycling
5. Implement multi-component workplace physical activity programmes
6. Promotion of physical activity through organized sport groups and clubs, programmes and events

## 4.2 Effective interventions targeting the four major NCDs

Table 2: WHO NCDs “Best Buys” and Other Effective WHO Recommended Interventions for the four major noncommunicable diseases

Major NCDs and WHO Recommended Interventions
<p><b><u>Cardiovascular Diseases (CVDs) and Diabetes Mellitus</u></b></p> <p><b><i>Best Buys</i></b></p> <ol style="list-style-type: none"><li>1. Counseling and multi-drug therapy for people with high risks of developing heart attacks and strokes, including those with established CVD</li><li>2. Effective glycaemic control for people with diabetes, along with standard home glucose monitoring for people treated with insulin to reduce diabetes complications</li><li>3. Primary prevention of rheumatic fever and rheumatic heart diseases by increasing appropriate treatment of streptococcal pharyngitis at the primary care level</li><li>4. Secondary prevention of rheumatic fever and rheumatic heart disease by developing a register of patients who receive regular prophylactic penicillin</li></ol> <p><b><i>Other WHO Recommended Interventions</i></b></p> <ol style="list-style-type: none"><li>5. Lifestyle interventions for preventing type 2 diabetes and CVDs</li><li>6. Treatment of heart attacks and ischemic stroke with aspirin</li></ol>
<p><b><u>Chronic Respiratory Diseases</u></b></p> <p><b><i>Best Buys</i></b></p> <ol style="list-style-type: none"><li>1. Symptom relief for patients with asthma with inhaled salbutamol</li><li>2. Symptom relief for patients with chronic obstructive pulmonary disease with inhaled salbutamol</li><li>3. Treatment of asthma using low dose inhaled beclometasone and short acting beta agonist</li></ol> <p><b><i>Other WHO Recommended Interventions</i></b></p> <ol style="list-style-type: none"><li>4. Access to improved stoves and cleaner fuels to reduce indoor air pollution</li><li>5. Cost-effective interventions to prevent occupational lung diseases, for example, from exposure to silica, asbestos</li><li>6. Influenza vaccination for patients with chronic obstructive pulmonary disease</li></ol>
<p><b><u>Cancer</u></b></p> <p><b><i>Best Buys</i></b></p> <ol style="list-style-type: none"><li>1. Vaccination against human papillomavirus (2 doses) of 9–13 year old girls</li><li>2. Prevention of cervical cancer by screening women aged 30–49 years, either through:<ul style="list-style-type: none"><li>▪ Visual inspection with acetic acid linked with timely treatment of pre-cancerous lesions</li><li>▪ Pap smear (cervical cytology) every 3–5 years linked with timely treatment of pre-cancerous lesions</li><li>▪ Human papillomavirus test every 5 years linked with timely treatment of pre-cancerous lesions</li></ul></li></ol> <p><b><i>Other WHO Recommended Interventions</i></b></p> <ol style="list-style-type: none"><li>3. Prevention of liver cancer through hepatitis B immunization</li><li>4. Basic palliative care for cancer: home-based and hospital care with multi-disciplinary team and access to opiates and essential supportive medicines</li><li>5. Oral cancer screening in high-risk groups (for example, tobacco users) linked with timely treatment</li></ol>

### 4.3 Priority interventions for reducing deaths and injuries from Road Traffic Injuries

Although road traffic injuries have been a leading cause of mortality for many years, most traffic crashes are both predictable and preventable. There are evidence based interventions that are effective at making roads safer, mitigate damage and save lives. In 2017 WHO launched the **Save LIVES** package which provides an evidence-based list of priority interventions to be implemented by countries towards achieving SDG targets 3.6 and 11.2 on road safety and human settlements.

The core components of the **Save LIVES** technical package are based on the five pillars of the *Global Plan for the Decade of Action for Road Safety* and include; **Speed** management, **Leadership** on road safety, **Infrastructure** design and improvement, **Vehicle** safety standards, **Enforcement** of traffic laws and **Survival** after a crash. The Save LIVES package is expected to contribute to a 50% reduction in road traffic deaths and injuries across the world by 2020 and, as well as to improve road safety through access to safe, affordable, accessible and sustainable transport systems for all by 2030. Table 3 below shows the list of the Save LIVES package.

**Table 3 – Components and interventions of the Save LIVES Road Safety Package**

Acronym	Component	Interventions
S	Speed Management	<ol style="list-style-type: none"> <li>1. Establish and enforce speed limit laws nationwide, locally and in cities</li> <li>2. Build or modify roads which calm traffic, e.g. roundabouts, road narrowing, speed bumps and rumble strips</li> <li>3. Require car makers to install new technologies, such as intelligent speed adaptation, to help drivers keep to speed limits</li> </ol>
L	Leadership on Road Safety	<ol style="list-style-type: none"> <li>1. Create an agency to spearhead road safety</li> <li>2. Develop and fund a road safety strategy</li> <li>3. Evaluate the impact of road safety strategies</li> <li>4. Monitor road safety by strengthening data systems</li> <li>5. Raise awareness and public support through education and campaigns</li> </ol>
I	Infrastructure Design & Improvement	<ol style="list-style-type: none"> <li>1. Provide safe infrastructure for all road users including sidewalks, safe crossings, refuges, overpasses and underpasses</li> <li>2. Put in place bicycle and motorcycle lanes</li> <li>3. Make the sides of roads safer by using clear zones, collapsible structures or barriers</li> <li>4. Design safer intersections</li> <li>5. Separate access roads from through-roads</li> <li>6. Prioritize people by putting in place vehicle-free zones</li> <li>7. Restrict traffic and speed in residential, commercial and school zones</li> <li>8. Provide better, safer routes for public transport</li> </ol>
V	Vehicle Safety Standards	<ol style="list-style-type: none"> <li>1. Establish and enforce motor vehicle safety standard regulations related to: <ul style="list-style-type: none"> <li>▪ seat-belts &amp; seat-belt anchorages;</li> <li>▪ frontal &amp; side impact;</li> <li>▪ electronic stability control;</li> <li>▪ pedestrian protection; and</li> <li>▪ <i>Universal Child Safety Seat System</i> child restraint points</li> </ul> </li> <li>2. Establish and enforce regulations on motorcycle anti-lock braking and daytime running lights</li> </ol>
E	Enforcement of Traffic Laws	<ol style="list-style-type: none"> <li>1. Establish and enforce laws at national, local and city levels on: <ul style="list-style-type: none"> <li>▪ drinking and driving;</li> <li>▪ motorcycle helmets;</li> <li>▪ seat-belts; and</li> <li>▪ child restraints</li> </ul> </li> </ol>
S	Survival After a Crash	<ol style="list-style-type: none"> <li>1. Develop organized and integrated prehospital and facility-based emergency care systems</li> <li>2. Train those who respond to crashes in basic emergency care</li> <li>3. Promote community first responder training</li> </ol>

#### 4.4 Overarching health system actions

1. Strengthen and orient the health system to address noncommunicable diseases and risk factors through people-centered health care and universal health coverage
2. Integrate very cost-effective noncommunicable disease interventions into the basic primary health care package with referral systems to all levels of care
3. Explore viable health financing mechanisms and innovative economic tools supported by evidence to ensure universal coverage of NCDs interventions and services
4. Scale up cost-effective high-impact interventions including interventions to address behavioral risk factors and early detection and long term care of people affected by NCDs
5. Train the health workforce and strengthen the capacity of health systems, particularly at the primary care level, to address the prevention and control of noncommunicable diseases
6. Improve the availability of the affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases, in both public and private facilities
7. Develop and implement a palliative care policy, including access to opioids analgesics for pain relief, together with training for health workers
8. Expand the use of digital technologies to increase health service access and efficacy for NCD prevention, and to reduce the costs in health care delivery
9. Strengthen human resources and institutional capacity for surveillance, monitoring, evaluation and research
10. Establish and/or strengthen a comprehensive noncommunicable disease surveillance system, including reliable registration of deaths by cause, cancer registration, periodic data collection on risk factors and monitoring national response
11. Integrate noncommunicable disease surveillance and monitoring into national health information systems

#### **4.5 Enabling policy actions to raise the priority for NCDs, strengthen national leadership and multisectoral action**

1. Raise public and political awareness, understanding and practice about prevention and control of NCDs
2. Integrate NCDs into the social and development agenda and poverty alleviation strategies
3. Strengthen national capacity including human and institutional capacity, leadership, governance, multisectoral action and partnerships for prevention and control of NCDs
4. Prioritize and increase, as needed, budgetary allocations for prevention and control of NCDs
5. Engage and mobilize all stakeholders including the community, partners, civil society, academia, and the private sector to support the national effort in the prevention and control of NCDs
6. Establish a strong multi-stakeholder engagement mechanism with leadership at the highest level of government for effective coordination of the planning, implementation, and monitoring of the national response for NCDs through a joint accountability system

## 5 CHAPTER 5: STRATEGIC OBJECTIVES

### 5.1 Objective 1: To raise the priority accorded to the prevention and control of Non-Communicable Diseases on the political agenda and at all levels through advocacy

It is acknowledged that NCDs have received inadequate attention in the past, but have now become a priority area for the government. To raise the priority accorded to the prevention and control of Non-Communicable Diseases in the National agenda requires active and continuing advocacy for NCDs in order to sustain the attention and commitment of the Government

Therefore, comprehensive advocacy to both government and development partners will be initiated to highlight the huge burden of NCDs in terms of morbidity, mortality and disability in Namibia as well as ensure that government at all levels prioritize prevention and control of NCDs through a whole of government and multisectoral approach acknowledging that investment in NCDs is a priority for social and economic development.

#### 5.1.1 Key actions:

Key strategic interventions for implementation include:

- 1) Raise public and political awareness on the burden and socio-economic impact of NCDs and the benefit of preventing them
- 2) Advocate for prioritization of NCDs in the national development agenda
- 3) Orient other sectors and stakeholders, including civil society and the private sector, to create enabling legal, policy and regulatory environment which is conducive for the prevention and control of NCDs

#### 5.1.2 Roles and Responsibilities

##### **Government**

The government will, through its various Offices, Ministries and Agencies, formulate policies and guidelines that will address various facets of NCDs and create an enabling environment for effective coordination and implementation of comprehensive NCDs prevention and control programme. This will ensure that NCDs are embedded into the national health-planning processes and broader development agendas. In addition, it will generate actionable evidence

and disseminate information about the effectiveness of interventions or policies to intervene positively on linkages between Non-Communicable Diseases and sustainable development, including other related issues such as poverty alleviation, economic development, sustainable cities, non-toxic environment, food security, climate change, disaster preparedness, peace and security and gender equality, based on national situation. The government will also ensure that appropriate multisectoral partnerships are forged at the national, regional and district levels.

### **Role of Partners**

Partners will support the government's advocacy efforts to raise the priority accorded to NCDs. This is through encouraging the continued inclusion of Non-Communicable Diseases in their respective development cooperation agendas and initiatives, internationally- agreed development goals, economic development policies, sustainable development frameworks and poverty-reduction strategies.

### **5.2 Objective 2: To strengthen national capacity, leadership, governance, multisectoral collaboration and partnerships to accelerate country response for the prevention and control of Non-Communicable Diseases**

A whole-of government response to the prevention and control of NCDs is important to halt the rising burden of NCDs in Namibia. This requires the existence of an overriding political or legal mandate for multisectoral action, multisectoral governance processes and mechanisms to develop and implement policies that take the interests of different sectors into account and a framework for accountability that sets out the responsibilities of all line ministries and partners to achieve shared goals.

The Government through either the Prime Minister's Office must empower the Ministry of Health and Social Services and create the political mandate for the health ministry officials to work with their counterparts in other line ministries to ensure Multisectoral coordination and implementation of key policies.

Strengthening the capacity of the NCDs Prevention and Control Programme at all levels of the MoHSS (National, Regional and District) is a pre-requisite for the successful implementation and monitoring of the national response to NCDs. The unit for prevention and control of NCDs



within the ministry of health needs to be well-funded, and provided with adequate dedicated staff with the requisite skills and capacities, including those to forge multisectoral collaboration. NCDs program structures need to be created at regional and district levels to support implementation of planned activities. People undertaking NCDs work need both technical skills in the disciplines of public health and political and communication skills necessary to work with other sectors including the private sector.

In addition to Multisectoral collaboration, implementation of interventions for prevention and control of NCDs will require a focus on population wide interventions. Effective implementation of all population-wide interventions requires the emphasis to shift from information and health education for individuals to legal, fiscal, and regulatory actions by governments. Strong leadership is essential including involvement of civil society organizations and advocacy groups to resist attempts by powerful organizations with vested interests (e.g., the tobacco, food, and alcohol industries) to undermine the development and implementation of effective policies and laws.

### **5.2.1 Key actions:**

The key strategies for implementation include:

- 1) Establish high level NCDs Multisectoral Coordination Mechanisms at National and Regional levels for engagement, policy coherence and mutual accountability of different spheres of policy-making that have a bearing on Noncommunicable diseases with joint responsibility and accountability systems
- 2) Strengthen the national NCDs programme by establishing adequately resourced NCDs Sub-Division in the MoHSS and similar structures at the regional level
- 3) Develop annual NCDs operational plans at all levels and allocate resources
- 4) Create data base of policies and regulations related with NCDs and regularly appraise them for their alignment with latest global recommendations and national priorities
- 5) Empower communities to adopt healthy life styles and prevent NCDs
- 6) Strengthen Public Private Partnerships (PPP) to enhance collaboration on NCDs prevention and control interventions

## 5.2.2 Roles and Responsibilities

### Role of Government

The Government will be responsible for the formation of the NCDs Multisectoral coordination mechanism and ensure a whole-of-government and whole-of-society approaches, convene multi-stakeholder working groups, secure budgetary allocations for implementing and evaluating multisectoral action and monitor and act on the social and environmental determinants of Non-Communicable Diseases. The Government will also integrate the prevention and control of Non-Communicable Diseases into health-planning processes and development plans, with special attention to social determinants of health, gender equity and the needs of vulnerable populations.

It will ensure the provision of adequate, predictable and sustained resources for prevention and control of Non-Communicable Diseases and for universal health coverage, through an increase in annual budgetary allocations, and other finance mechanism of Government. The Government will in addition be responsible for conducting periodic assessments of epidemiological and resource needs, including workforce, institutional and research capacity; of the health impact of policies in sectors beyond health and of the impact of financial, social and economic policies on non-communicable diseases, in order to inform country action.

It will develop and implement a national multisectoral non-communicable disease policy and plan taking into account national priorities, in coordination with the relevant organizations and ministries, including the Ministry of Finance, increase and prioritize budgetary allocations for addressing surveillance, prevention, early detection and treatment of Non-Communicable Diseases and related care and support, including palliative care. The government will as well provide training and appropriately deploy health, social services and community work forces, and strengthen institutional capacity for implementing the national action plan.

## **Role of Partners**

Partners, including health and non-health sector development partners will support national authorities in implementing evidence-based multisectoral action, address functional gaps in the response to Non-Communicable Diseases (e.g. in the areas of advocacy, strengthening of health workforce and institutional capacity, capacity building, product development, access and innovation), in implementing existing international conventions in the areas of environment and labor and in strengthening health financing for universal health coverage.

They will support the mobilization of adequate, predictable and sustained financial resources and the necessary human and technical resources to support the implementation of national action plans and the monitoring and evaluation of progress. They will also promote capacity-building of relevant nongovernmental organizations at the national, regional levels, in order to realize their full potential as partners in the prevention and control of non-communicable diseases.

### **5.3 Objective 3: To reduce modifiable risk factors for Non-Communicable Diseases and underlying social determinants through the creation of health promoting environments**

The four major shared risk factors namely tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol contribute significantly to the growing non-communicable diseases burden in Namibia. Reduction in the levels of these modifiable risk factors in the population significantly reduces the disease burden due to NCDs.

It is important that legislative and regulatory measures need to be in place to minimize exposure to risk factors across the life course. Prevention and control of NCDs should target people at all stages of the life span starting from pre-natal life, infancy, childhood adolescence and adulthood. Even though the NCDs often appear in adulthood, exposure to the risk factors starts early in life. Reducing exposure to the NCDs risk factors requires interventions that engage non-health sectors and non-state actors in the prevention of tobacco use, reduction of physical inactivity, unhealthy diet, obesity and harmful use of alcohol and the protection of children from adverse impacts of marketing of unhealthy foods and beverages. This calls for

strengthening the capacity of individuals and populations to make healthier behavior and lifestyle choices that foster health and well-being.

### **5.3.1 Key actions:**

#### **5.3.1.1 The Government will provide an enabling fiscal, legal and legislative environment and has a leading role in promotion of Healthy Diet**

- 1) Promote the availability and affordability of healthy foods to all segments of the population including public institutions like schools, other educational institutions and the workplace
- 2) Support the development/adoption/review and the implementation of health related legislations and regulations on salt, saturated and trans fatty acids and refined sugar content of processed foods and the packaging, labeling and marketing of food products and beverages
- 3) Put in place mechanisms for economic incentives including taxes and subsidies that encourage healthy choices for foods and beverages
- 4) Reduce sugar consumption through effective taxation on sugar-sweetened beverages and also implement the WHO recommendations on the marketing of foods and non-alcoholic beverages to children
- 5) Develop and implement a national salt reduction action plan focusing on foods that contribute most to population intake
- 6) Update and disseminate national Food Based Dietary Guidelines and nutrient profiling of common foods
- 7) Strengthen the Implementation of the nutrition component in the school health programme
- 8) Implement effective mass media campaign on healthy diets and the prevention of overweight and obesity
- 9) Support and promote existing initiatives for optimal breastfeeding and complementary feeding

### **5.3.1.2 Promotion of Physical Activity**

- 1) Develop/ Review /Implement policies on physical activities in prevention and control of NCDs at all levels
- 2) Create public awareness on the health benefits of physical activity in prevention and control of NCDs at all levels
- 3) Promote the implementation of physical activity programs at all levels; in the community, public and private institutions, schools and workplaces
- 4) Advocate for policy and regulations for improved urban design conducive for physical activity

### **5.3.1.3 Tobacco Control**

- 1) Appraise existing national legislations and regulations on tobacco products including their implementation status
- 2) Update the tobacco legislations and regulations to come up with comprehensive FCTC compliant legislation especially as related to tax, price control, labeling, illicit trade and comprehensive ban on advertising, promotion and sponsorship
- 3) Increase excise taxes and prices on tobacco products
- 4) Enact and enforce comprehensive bans on tobacco advertising, promotion and sponsorship
- 5) Scale up of the implementation and enforcement of the Tobacco Control Act 1 of 2010 at all levels including the implementation of 100% smoke free environments in public places, work places and public transport
- 6) Raise public awareness on the dangers of smoking/tobacco use and exposure to second hand tobacco smoke, especially through effective mass media campaigns
- 7) Strengthen the implementation of tobacco Control initiatives in the curriculum of schools and institutions of higher learning
- 8) Establish/strengthen tobacco cessation services at all levels
- 9) Monitor and mitigate tobacco industry interference in the implementation of public health policies

#### **5.3.1.4 Reducing Harmful use of Alcohol**

- 1) Appraise existing national legislations and regulations on alcohol including their implementation status
- 2) Update the National Alcohol Policy and related regulations in line with the WHO Global Strategy to Reduce the Harmful use of Alcohol (2010), the WHO/African Regional Strategy for the reduction of harmful use of alcohol (2013), and the Global Action Plan for NCDs (2013) and its Updated Appendix 3 (2017)
- 3) Strengthen the implementation and enforcement of the Namibia Liquor Act and related regulations
- 4) Strengthen public awareness/mass media campaigns on the dangers of harmful use of alcohol and its related risks
- 5) Integrate alcohol abuse and substance use management and rehabilitation services at all levels including, Community, health care system, and workplaces
- 6) Strengthen the implementation of the component on prevention and control of alcohol use and substance abuse in the school health curriculum

#### **5.3.1.5 Environmental Risk Reduction**

- 1) Assess the magnitude of environmental, biological and occupational hazards
- 2) Appraise/update existing legal frameworks, policies, standards and guidelines to reduce exposure to environmental, biological and occupational risk factors to protect populations from environmental contaminants and occupational hazards that predisposes to NCDs
- 3) Develop multisectoral action plan to reduce the effects of environmental, biological and occupational hazards
- 4) Create public awareness on prevention and control of exposure to environmental, biological and occupational risk factors for NCDs
- 5) Availing vaccination, screening, early detection and treatment for infections that predisposes to NCDs

### **5.3.2 Roles and Responsibilities**

#### **Role of Government**

The Government will provide enabling fiscal, legal and legislative environment and has a leading role in developing, strengthening and enforcing national policies and guidelines on NCD behavioral risk factors. In addition, Government will put mechanisms in place to ensure that these policies are implemented effectively through multi-sectoral action and whole of government approach.

#### **Role of partners**

Partners will facilitate the implementation of the WHO FCTC; the global strategy to reduce harmful use of alcohol; the global strategy on diet, physical activity and health; the global strategy for infant and young child feeding, and the implementation of WHO' s set of recommendations on the marketing of foods and non-alcoholic beverages to children, by supporting and participating in capacity strengthening, shaping the research agenda, development and implementation of technical guidance, mobilizing financial support and regular monitoring of their implementation.

### **5.4 Objective 4: To strengthen and orient health systems to address the prevention and control of Non-Communicable Diseases and the underlying social determinants through people centered primary health care and universal health coverage**

Implementation of the NCDs interventions needs a functioning health-care system and a stepwise approach. Many health services are inadequate in terms of governance arrangements and health planning processes; health financing; health workers with appropriate skills; essential drugs and technologies; health-information systems; and health services delivery models for long-term patient-centered care that is universally accessible and affordable. A key requirement is a comprehensive approach to health-systems strengthening to deliver services for all common diseases during the lifetime, with a patient-centered model of delivery.

A welcome shift is towards strengthened primary health care as part of a service hub that provides the support needed to deliver these critical prevention and treatment services for NCDs with well-functioning referral linkages to secondary and tertiary care services. For

example, opportunistic screening of adults attending primary health-care facilities and the application of WHO's charts for assessment of cardiovascular risk (reference) with advice for tobacco cessation, are realistic first steps that need to be integrated into the primary health-care services.

The evidence that Primary Health Care (PHC) can deliver better health outcomes at lower cost is strong. People with NCDs or at risk of developing NCDs require long-term care that is proactive, patient centered, community based and sustainable. Such care can be delivered equitably only through health systems based on PHC. The key features of a health system where PHC is the focus of the delivery of care are:

- Person focus across the lifespan rather than a disease focus
- Accessibility with no out-of-pocket payments
- Distribution of resources according to population needs rather than demand
- Availability of a broad range of services including preventive services and coordination between different levels in the health system

#### **5.4.1 Key actions:**

The key strategies that will be implemented include:

- 1) Integrate cost effective NCDs interventions into the Primary Health Care (PHC) package with referral systems to all levels of care
- 2) Develop and disseminate integrated clinical guidelines and treatment protocols for NCDs prevention, care and treatment for all levels of health care
- 3) Build the capacity of the health workforce in terms of numbers and skills mix, at all levels, for the prevention and control of the Non-Communicable Diseases
- 4) Review and update the pre-service and in-service curriculum in training of health care workers to incorporate NCDs prevention and control
- 5) Integrate rehabilitation, palliative and end of life care into the primary health care platforms
- 6) Ensure availability of essential NCDs prevention and care medicines, supplies, technologies and link this to financing mechanisms to foster access, affordability and sustainability at the national and district levels



- 7) Advocate for the expansion of the national health insurance scheme to fully cover prevention and care of all NCDs
- 8) Build the capacity of CHWs in NCDs education and prevention, and in care and support for people suffering from chronic NCDs in the communities.

#### **5.4.2 Roles and Responsibilities**

##### **Role of Government**

The Government will exercise responsibility and accountability in ensuring the availability of non-communicable disease services within the context of overall health system strengthening. It will also make progress towards universal health coverage through a combination of domestic revenues and traditional and innovative financing, giving priority to financing a combination of cost-effective preventive, curative and palliative care interventions at different levels of care covering Non-Communicable Diseases and including comorbidities. It will identify competencies required and invest in improving the knowledge, skills and motivation of the current health care work force. In addition, the Government will incorporate the prevention and control of Non-Communicable Diseases in the training curricula of all health personnel including community health workers and social workers with an emphasis on primary health care.

##### **Role of Partners**

Partners will support the mobilization of adequate, predictable and sustained financial resources to advance universal coverage in national health systems, especially through primary health care. They will support Governments effort in strengthening health systems and expanding quality service coverage including through development of appropriate health care infrastructure and institutional capacity for training of health personnel such as public health institutions, medical and nursing schools.

In addition, they contribute to efforts to improve access to affordable, safe, effective and quality medicines and technologies for the prevention and control of NCDs.

## **5.5 Objective 5: Promote and implement evidence based strategies and interventions for prevention and control of violence and injuries particularly road traffic accidents**

Mortality, morbidity and disability from violence and injuries contribute significantly to the burden of NCDs in Namibia. There is an urgent need to focus on the immediate and remote factors that are responsible and provide strategic interventions to curb the rising prevalence of violence and injuries particularly road traffic accidents.

### **5.5.1 Key actions:**

The key strategies for implementation include:

- 1) Appraise and update national policies, plans, regulations and standards and guidelines for prevention of violence and road traffic accidents
- 2) Enhance public awareness on the risk factors for violence and road traffic accidents and their prevention and control
- 3) Strengthen pre-hospital care and ensure that they are well integrated with other public health and health care infrastructure
- 4) Improve the trauma care and rehabilitative services in the health care system
- 5) Initiate and implement community violence and road traffic accidents prevention and control programs including in private and public institutions and workplaces

### **5.5.2 Roles and Responsibilities**

#### **Role of Government**

The Government will develop and strengthen policies legislations and strategies to prevent violence and injuries. It will also implement evidence based interventions and support the health care system in provision of appropriate trauma and rehabilitative care services.

#### **Role of Partners**

Partners will engage in advocacy as well as provide technical and financial support for the implementation of violence and injury prevention programs. Partners will also support community mobilization and awareness creation on violence and injury prevention and mitigation programs

## **5.6 Objective 6: To promote and support national capacity for high-quality research and development for the prevention and control of Non-Communicable Diseases**

The National research agenda needs to be agreed upon to set priorities for research to answer specific problems and to generate data that will support efforts for resource mobilization and for monitoring effectiveness of interventions being implemented. Research in the NCDs field will be promoted to continuously strive to improve the prevention and control of NCDs as well as help inform and advocate for NCDs to key actors both in Namibia and to the Global community.

### **5.6.1 Key actions:**

The key strategies for implementation include:

- 1) Identify priority research areas on Non-Communicable Diseases and their risk factors
- 2) Strengthen capacity for NCDs research (human resource, infrastructure, equipment and supplies)
- 3) Advocate for resources for research on priority NCDs
- 4) Facilitate knowledge translation on conducted research to guide decision making by national government

### **5.6.2 Roles and Responsibilities**

#### **Role of Government**

Government will strengthen national institutional capacity for research and development, including research infrastructure, equipment and supplies in research institutions and human resources especially the competence of researchers to conduct quality research. Government will; in collaboration with research institutions and academia, develop and implement NCDs research agenda and increase investment in research, innovation and development as an integral part of the national response to non-communicable diseases. It will effectively use academic institutions and multidisciplinary agencies to promote research, retain research workforce, incentivize innovation and encourage the establishment of national reference centers and networks to conduct policy-relevant research. Strengthen the scientific basis for decision making through Non-Communicable Disease-related research and its translation to

enhance the knowledge base for ongoing national action. It will allocate budgets to promote relevant research to fill gaps around the national interventions priority agenda.

### **Role of Partners**

Partners will promote investment and strengthen national capacity for quality research, development and innovation, for all aspects related to the prevention and control of Non-Communicable Diseases in a sustainable and cost-effective manner, including through strengthening of institutional capacity and creation of research fellowships and scholarships. They will facilitate non-communicable disease-related research and its translation to enhance the knowledge base for implementation of the national action plan. In addition, partners will promote the use of information and communications technology to improve Programme implementation, health outcomes, health promotion, monitoring and reporting and surveillance systems and to disseminate, as appropriate, information on affordable, cost effective, sustainable and quality interventions, best practices and lessons learnt in the field of Non-Communicable Diseases.

### **5.7 Objective 7: To monitor the trends and determinants of Non-Communicable Diseases and evaluate progress in their prevention and control**

For better informed programme planning, the NCDs surveillance, monitoring and evaluation mechanisms need to be integrated in the existing routine data collection and reporting systems and tools for population based surveys. A framework for national and global monitoring, reporting, and accountability, with agreed sets of indicators, is essential to ensure that the returns on investments in NCDs meet the expectations of all partners. Continuous monitoring of the national progress will provide the foundation for advocacy, policy development and coordinated action and help to reinforce political commitment. In addition, the MandE framework will serve to monitor progress of national, regional and district strategies for the prevention and control of Non-Communicable Diseases.

### 5.7.1 Key actions:

The key strategies for implementation include:

- 1) Strengthen capacity for NCDs surveillance (human resource, infrastructure, equipment and supplies)
- 2) Integrate key NCDs monitoring indicators into the routine HMIS data collection and reporting systems
- 3) Conduct baseline and periodic NCDs and their risk factors surveys (STEPS surveys every 5 years)
- 4) Establish and maintain National Registry on some major NCDs
- 5) Allocate resources for routine and periodic surveillance of NCDs and their risk factors at national and regional levels
- 6) Facilitate dissemination of surveillance results to guide decision making by national government and subnational authorities

### 5.7.2 Roles and Responsibilities

#### **Role of Government**

Government will strengthen technical and institutional capacity including through establishment of public health institutes, to manage and implement surveillance and monitoring systems that will be integrated into existing health information systems, with a focus on capacity for data management, analysis and reporting in order to improve availability of high-quality data on Non-Communicable Diseases and its risk factors.

The Government will be responsible for the update of legislations pertaining to collection of health statistics, strengthen vital registration and cause of death registration systems, define and adopt a set of national targets and indicators based on the global monitoring framework for the prevention and control of NCDs. It will also integrate monitoring systems for the prevention and control of Non-Communicable Diseases, including prevalence of relevant key interventions into national health information systems, in order systematically to assess progress in use and impact of interventions.

It will identify data sets, sources of data and integrate NCD surveillance into national health information systems and undertake periodic data collection on the behavioral and metabolic risk factors (harmful use of alcohol, physical inactivity, tobacco use, unhealthy diet, overweight and obesity, raised blood pressure, raised blood glucose, and hyperlipidemia). It will also take into consideration the determinants of risk exposure such as marketing of food, tobacco and alcohol, with disaggregation of the data, where available, by key dimensions of equity, including gender, age (e.g. children, adolescents, adults) and socioeconomic status in order to monitor trends and measure progress in addressing inequalities.

Government will develop, maintain and strengthen disease registries, including for cancer, if feasible and sustainable, with appropriate indicators for better understanding of regional and national needs. It will contribute, on a routine basis, information on trends in Non-Communicable Diseases with respect to morbidity, mortality by cause, risk factors and other determinants, disaggregated by age, gender, disability and socioeconomic groups, as well as provide information to WHO on progress made in the implementation of national action plans and on effectiveness of national policies and strategies, coordinating country reporting with global analyses.

### **Role of Partners**

Partners will mobilize resources, promote investment and strengthen national capacity for surveillance, monitoring and evaluation, on all aspects of prevention and control of Non-Communicable Diseases. They will facilitate surveillance and monitoring and the translation of results to provide the basis for advocacy, policy development and coordinated action and to reinforce political commitment.

In addition, partners will promote the use of information and communications technology to improve capacity for surveillance and monitoring and to disseminate, as appropriate, data on trends in risk factors, determinants and Non-Communicable Diseases.

## 6 IMPLEMENTATION FRAMEWORK

### 6.1 Strategic Objective 1: To raise the priority accorded to the prevention and control of Non-Communicable Diseases on the political agenda and at all levels through advocacy

EXPECTED OUTPUTS	INDICATORS	ACTIVITIES	LEAD AGENCIES	SUPPORTING O/M/As	PARTNERS	TIME FRAME
1.1 NCDs prioritized in national development agenda	<ul style="list-style-type: none"> <li>- Number of advocacy documents on the burden and socio-economic impact of NCDs, and the costs of inaction</li> <li>- Number of advocacy sessions for public and political leaders</li> </ul>	1.1.1- Develop and disseminate advocacy tools on the linkage between NCDs and sustainable economic development 1.1.2-Conduct advocacy forums for raising public and political awareness on the burden of NCDs and the economic benefit of preventing them	OPM MoHSS	All other O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018/19
1.2 Increased awareness of other sectors and stakeholders on the magnitude of NCDs and their expected role in the multi-sectoral response for the prevention and control of NCDs	-Number of advocacy forums with other sectors and stakeholders for prioritization of the prevention and control of NCDs	1.2.1- Conduct advocacy and sensitization forums for other sectors and stakeholders on prevention and control of NCDs 1.2.2- Encourage/motivate other sectors and stakeholders to create enabling legal, policy and regulatory environment which is conducive for the prevention and control of NCDs	MoHSS OPM	All other O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018/19

**6.2 Strategic Objective 2: To strengthen national capacity, leadership, governance, multisectoral collaboration and partnerships to accelerate country response for the prevention and control of non-communicable diseases.**

EXPECTED OUTPUTS	INDICATORS	ACTIVITIES	LEAD AGENCIES	SUPPORTING O/M/As	PARTNERS	TIME FRAME
2.1 National and regional NCDs Multisectoral Coordination Committees in place and functional	- Reports of National and Regional NCDs multisectoral Coordination Committees established and functional	2.1.1- Establish high level NCDs <i>Multisectoral Coordination Mechanisms</i> at National and Regional levels for engagement, policy coherence and mutual accountability	OPM, MoHSS  Regional Councils and RMTs	All other O/M/As  Regional O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018 - 2019
2.2 National NCDs Technical Committee and disease specific TWGs in place and functional	- Reports of the different NCDs technical working groups/committees	2.2.1-Establish national NCDs Technical Committee and disease specific TWGs	MoHSS	All other O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018 - 2022
2.3 NCDs Sub-Division established in the MoHSS and regional levels	NCDs Sub-division established in MoHSS and regional levels Proportion of annual NCDs operational plans funded	2.3.1- Advocacy for establishment of adequately resourced NCDs Sub-Division in the MoHSS and regional levels	MoHSS	OPM, O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018- 2022
2.4 NCDs operational plans developed and resourced at all levels	NCDs action plans in place and budgeted for implementation	2.4.1-Develop annual NCDs operational plans at all levels and allocate needed resources	MoHSS	OPM, All other O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018 - 2022
2.5 Data base of policies and regulations related to NCDs in place and gaps identified for alignment with latest global evidences and national priorities	-Appraisal report of NCDs related legal provisions, policies and regulations	2.5.1-Conduct desk review of existing multi-sectoral policies and regulations related to NCDs  2.5.2-Create data base of policies and regulations related to NCDs	MoHSS	OPM, All other O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018



2.6 Communities and individuals empowered to adopt healthy life-styles	<ul style="list-style-type: none"> <li>- Number of NCDs related health promotion materials developed, translated, printed and disseminated</li> <li>- Number of social mobilization activities on NCDs</li> </ul>	<p>2.6.1-Develop IEC materials on healthy lifestyles and the prevention of NCDs</p> <p>2.6.2- Conduct mass media campaigns and social mobilization activities promoting healthy lifestyles</p> <p>2.6.3 Strengthen counseling services during clinical contacts</p>	MoHSS	OPM, All other O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018 – 2022
2.7 PPP forums on NCDs prevention and control strengthened	<ul style="list-style-type: none"> <li>-Number of PPP forums held on NCDs</li> <li>-Number of private partners engaged in NCDs prevention and controls activities</li> </ul>	2.7.1 Strengthen PPP to support and collaborate on NCDs prevention and control activities	MoHSS, Private sector	OPM, All other O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018 - 2022

**6.3 Strategic Objective 3: To reduce modifiable risk factors for Non-Communicable Diseases and underlying social determinants through the creation of health promoting environments**

EXPECTED OUTPUTS	INDICATORS	ACTIVITIES	LEAD AGENCIES	SUPPORTING O/M/As	PARTNERS	TIME FRAME
<b>3.1 Promote Healthy Diet high in fruits and vegetables and low in saturated fat/trans-fat, free sugar and salt</b>						
3.1.1 Increased intake of healthy foods including adequate levels of fruits and vegetables	<ul style="list-style-type: none"> <li>- Availability/number of policies, standards and plans on food security and healthy diet reviewed and implemented</li> <li>- Number of periodic implementation reports on food security programs</li> <li>- Availability of updated national Food Based Dietary Guidelines (FBDGs)</li> <li>- Number of health workers trained on FBDG and nutrition counseling skills</li> <li>- Number of healthy diet programs implemented at all levels</li> </ul>	<ul style="list-style-type: none"> <li>3.1.1.1- Promote availability and affordability (food security) of healthy foods to all segments of the population</li> <li>3.1.1.2- Establish policies on taxes and subsidies to ensure availability and consumption of healthy diet, particularly fruits and vegetables</li> <li>3.1.1.3- Increase availability of fruits and vegetables through home gardening promotion programme</li> <li>3.1.3.4- Update and disseminate national Food Based Dietary Guidelines (FBDGs) and nutrient profiling of common foods</li> <li>3.1.3.5- capacity building of health workers on FBDGs and counseling skills</li> <li>3.1.1.6- Implement mass media campaign on healthy diets, social marketing of foods and promote the intake of fruits and vegetables</li> </ul>	MAWF, MoHSS, MITC, MPESW, MITSMED MFMR	OPM, All other O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018-2022
3.1.2 Reduced intake of salt in the diet	<ul style="list-style-type: none"> <li>- Availability of national salt reduction targets and action plan</li> </ul>	<ul style="list-style-type: none"> <li>3.1.2.1- Develop and implement a national salt reduction action plan focusing on foods that contribute most to population salt intake</li> </ul>	MoHSS, MAWF MITC, MITSMED	OPM, All other O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018-2022

	<ul style="list-style-type: none"> <li>- Number of front packing labels enforced</li> <li>- Number of engagement sessions held with stakeholders on salt reduction measures</li> <li>- Number of mass media campaigns and meetings on salt reduction</li> </ul>	<p>3.1.2.2- Set target levels for the amount of salt in foods and meals and enforce reformulation of food products and meals to contain less salt/sodium</p> <p>3.1.2.3- Enforce front-of-pack labelling</p> <p>3.1.2.4- Establish policies for food procurement that encourage the purchase of products with lower salt /sodium content</p> <p>3.1.2.5- Conduct behavior change communication and mass media campaigns on salt reduction</p> <p>3.1.2.6- Engage food producers, processors, retailers, restaurants and catering services to progressively reduce salt in their products</p> <p>3.1.2.7- Assess the population’s baseline salt intake and at regular intervals</p>				
3.1.3 Reduced consumption of saturated fats/trans fats and sugars	<ul style="list-style-type: none"> <li>- Acts and regulations on saturated and trans fatty acids, salt and refined sugar content of processed foods available</li> <li>- Policy on taxation of sugar-sweetened beverages and foods</li> <li>- Number of WHO recommendations on the marketing of foods and non-alcoholic beverages to children enacted</li> </ul>	<p>3.1.3.1- Develop legislation and regulations on saturated and trans fatty acids, salt and refined sugar content of processed foods and the packaging, labeling and marketing of food products and beverages</p> <p>3.1.3.2- Replace trans-fats and saturated fats with unsaturated fats through reformulation, labelling and appropriate fiscal policies</p> <p>3.1.3.3- Reduce sugar consumption through effective taxation on sugar-sweetened beverages</p>	MoHSS MAWF, MITSD	MOEACC, MHETI, MOYS, MOF, MOTI, MOAWF, MURD, OPM, All other O/M/As	UN, NGOs, CBOs, FBOs, CCN UNAM, NUST, IUM, Welwitchia, etc...	2018– 2022

	- Reports of monitoring of implementation of diet related policies and regulations	3.1.3.4- Implement the WHO recommendations on the marketing of foods and non-alcoholic beverages to children				
3.1.4 Reduced risk of overweight, obesity and metabolic syndrome	- WHO recommended infant and young child feeding practices endorsed and implemented -Number of schools with nutrition in the curriculum -Proportion of schools implementing the nutrition component of the school health policy - Nutrition and physical activity programs incorporated into the school health policy	3.1.4.1- Promote and support recommended infant and young child feeding practices 3.1.4.2- Implement nutrition labelling to reduce total energy intake (kcal), sugars, sodium and fats 3.1.4.3-Limit portion and package size to reduce energy intake and the risk of overweight and obesity 3.1.4.4- Implement nutrition education and counselling in different settings including preschools, schools, workplaces and hospitals 3.1.4.5- Ensure the inclusion of nutrition and physical activity in the school health policy/strategy and curriculum 3.1.4.6- Introduce obesity management guidelines and services	MoHSS MOEAC, MBE, MHETI, MITSD MYNSS MICT	OPM, All O/M/As	UN, NGOs, CBOs, FBOs, CCN UNAM, NUST, IUM, Welwitchia, etc...	2018 – 2022
<b>3.2 Promote Physical Activity</b>						
3.2.1 Physical inactivity reduced	- Number of physical activity policy and guideline developed -Number of IEC materials on physical activity developed - Number of awareness campaigns held	3.2.1.1- Review/develop policies and guidelines on physical activity and sports 3.2.1.2-Create public awareness on the health benefits of physical activity through mass media campaign and community based education	MYNSS, MoHSS, MOEAC, MHETI, MICT,	OPM, All O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018 – 2022

	<ul style="list-style-type: none"> <li>- Number of workplace wellness programs and sport clubs</li> <li>- Number of advocacy sessions held for urban planners and politicians on improving urban design conducive for physical activity</li> <li>- Number of updated policies, guidelines and curricula for strengthening physical activity and sports in schools</li> <li>- Number of researches on physical activity patterns conducted and shared</li> </ul>	<p>3.2.1.3- Develop and Implement programs that promote physical activity in the community, public and private institutions and workplaces</p> <p>3.2.1.4- Advocate for policy and regulations for improved urban design conducive for physical activity</p> <p>3.2.1.5- Promote organized sport groups and clubs, programmes and events</p> <p>3.2.1.6- Strengthen physical activity programs in schools</p> <p>3.2.1.7- Monitor trends of physical activity in the population</p>				
<b>3.3 Reduce use of Tobacco products</b>						
3.3.1 Provisions of existing legislations and regulations on tobacco products appraised	- Appraisal report on provisions of existing national legislations and regulations on tobacco products and their gaps	3.3.1.1- Appraise existing national legislations and regulations on tobacco products including their implementation status	MoHSS, OPM	All O/M/As	UN, NGO, CBOs, FBOs, CCN	2018 – 2021
3.3.2 Tobacco legislations and regulations reviewed and updated to come up with fully FCTC compliant legislation especially as related to tax, price control,	-Number of sensitization sessions conducted -Number of authorities and stakeholders sensitized on tobacco legislations and regulations	3.3.2.1- Sensitize Legislative and Regulatory bodies on the Tobacco Control Act and related regulations and the gaps that need strengthening 3.3.2.2- Support revision of the tobacco legislation and regulations in order to make it more comprehensive in line with the WHO FCTC	MoHSS, MITSMED, MITS, MOF, MOJ, MOSS,	OPM, All O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018 – 2022

labeling, illicit trade and comprehensive ban on advertising, promotion and sponsorship	-Number of tobacco legislations and regulations reviewed and updated					
3.3.3 Effective public awareness (mass media) campaigns to discourage tobacco use conducted	-Number of awareness campaigns conducted - evaluation report on impact of awareness campaigns available	3.3.3.1- develop tobacco prevention IEC materials and translate into local languages 3.3.3.2- Conduct awareness programmes or trainings for media personnel and health workers 3.3.3.3- Conduct public awareness/mass media campaigns on the harms of smoking/tobacco use and second hand exposure to tobacco smoke	MoHSS, MICT MoEAC, MYNSS, MHETI	OPM All O/M/As	UN, NGOs, CBOs, FBOs, CCN	2018 – 2021
3.3.4 Tobacco control incorporated in the curricula of schools and higher learning institutions	-Proportion of schools and higher learning institutions with tobacco control in their curriculum -Proportion of schools and higher learning institutions sensitized on tobacco control	3.3.4.1 - School curriculum reviewed and revised to incorporate tobacco control 3.3.4.2- Sensitize students and staff in schools and higher learning institutions about the harms of smoking/tobacco use and second hand exposure to tobacco smoke	MOEAC, MHETI, MoHSS, MICT	OPM, All O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018 – 2022
3.3.5 Tobacco cessation services established	- Number of facility and community based tobacco cessation services available	3.3.5.1-Develop guideline for tobacco cessation services 3.3.5.2 - conduct training for providers on tobacco cessation interventions 3.3.5.3- Avail commodities for treatment of tobacco dependence	MoHSS	OPM, All O/M/As	UN, NGOs, CBOs, FBOs, CCN	2018 – 2022

3.3.6 Tobacco industry interference monitored and mitigated	- Tobacco industry interference monitoring and mitigation reports	3.3.6.1- Develop tools for monitoring of tobacco industry interference in the implementation of public health policies 3.3.6.2 - Monitor tobacco industry interference and implement mitigation measures	MITSMED, MOSS, MOF, OPM, MoFA, MoJ	All O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018 – 2022
<b>3.4 Reducing Harmful use of Alcohol</b>						
3.4.1 Provisions of existing legislations and regulations on alcohol appraised	- Appraisal report on provisions of existing national legislations and regulations on alcohol and their implementation status	3.4.1.1- Appraise existing national legislations and regulations on alcohol including their implementation status	MoHSS, OPM	All O/M/As	UN, NGO, CBOs, FBOs, CCN	2018 – 2021
3.4.2 National Alcohol Policy and related regulations reviewed and updated in line with the <i>WHO Global Strategy to Reduce the Harmful use of Alcohol (2010)</i> and the <i>Global Action Plan for NCDs (2013)</i> and its Updated Appendix 3 (2017)	-Number of stakeholders sensitized on prevention of harmful use of alcohol - Number of alcohol legislations and regulations reviewed and updated	3.4.2 .1- Sensitize policy makers and stakeholders on the national alcohol Acts and regulations and the gaps that need strengthening 3.4.2 .2- Revise/update the national Liquor Act and related regulations	MoHSS, MOJ, MITSMED, MOSS,	OPM, All other O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018 – 2022
3.4.3 Increased public awareness about the effects of the harmful use of alcohol	-Number of IEC materials on harmful use of alcohol developed, translated and disseminated -Number of awareness campaigns conducted to discourage harmful use of alcohol	3.4.3.1- Develop IEC materials on harmful use of alcohol 3.4.3.2-Conduct public awareness/mass media campaigns about the dangers of alcohol consumption and its related risks	MICT, MoHSS, MoHETI, MOEAC	OPM, All other O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018 – 2022

3.4.4 Curriculum on harmful use of alcohol and substance abuse in schools reviewed and strengthened	- Number of schools with curriculum on harmful use of alcohol and substance abuse	3.4.4.1 - Integrate the prevention of alcohol and substance abuse into the school health curriculum 3.4.4.2 - Sensitize teachers and students on alcohol and substance abuse	MOEACAC, MHETI, MoHSS	OPM, All other O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018 – 2022
3.4.5 Alcohol and substance abuse prevention, treatment and rehabilitation services availed at all levels; health care system, community, and workplaces	- Number of facilities offering rehabilitation services -Number of Community units offering alcohol rehabilitation services -Number of work places with rehabilitation services	3.4.5.1- Develop guidelines for rehabilitation of alcohol and substance abuse 3.4.5.2- Build the capacity of health care and social services providers 3.4.5.3-Integrate alcohol and substance abuse care and rehabilitation services at all levels	MoHSS, MPESW, MGECW, MYNSS	OPM, All other O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018 - 2022
<b>3.5 Environmental Risk reduction</b>						
3.5.1 Magnitude of the burden of environmental and occupational hazards documented to guide planning	Situation analysis report on the magnitude of environmental and occupational hazards	3.5.1.1- Assess magnitude of environmental and occupational hazards 3.5.1.2-Disseminate the findings and advocate for policy and regulatory actions	OPM, MME MoHSS, MLIREC MITSMED MURD, MoJ	OPM, All other O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018 – 2022
3.5.2 Existing policies, legal frameworks, standards and guidelines on environmental, biological and occupational hazards appraised and reviewed	- Number of advocacy sessions conducted - Number of legislations, policies and guidelines reviewed/ revised	3.5.2.1-Advocacy sessions conducted for policy makers and key stakeholders	OPM, MME MoHSS, MLIREC MITSMED MURD,	All O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018 – 2022



		3.5.2.2- Appraise/update legal frameworks, policies, and guidelines to reduce exposure to environmental, biological and occupational hazards	MOJ			
3.5.3 Increased public awareness on the hazards and prevention of environmental, biological and occupational risk factors	-Number of IEC materials developed and disseminated -Number of awareness campaigns carried out	3.5.4.1-Develop and disseminate IEC materials and mass media messages 3.5.4.2-Conduct public awareness campaigns including mass media communications	MoHSS MICT MURD MET MME	OPM All O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018 – 2022

**6.4 Strategic Objective 4: To strengthen and orient health systems to address the prevention and control of NCDs and the underlying social determinants through people centered primary health care and universal health coverage.**

EXPECTED OUTPUTS	INDICATORS	ACTIVITIES	LEAD AGENCIES	SUPPORTING O/M/As	PARTNERS	TIME FRAME
4.1 Cost effective NCDs interventions integrated into the Primary Health Care (PHC) package with referral systems to all levels of care	<ul style="list-style-type: none"> <li>- The WHO Package of Essential Noncommunicable (PEN) Guideline for PHC adapted</li> <li>- Number of health workers trained on PEN guideline</li> <li>- Number of facilities implementing the PEN guideline</li> </ul>	<ul style="list-style-type: none"> <li>4.1.1- Adapt the WHO PEN Guideline and job aids for PHC</li> <li>4.1.2- Train and mentor health workers on NCDs care</li> <li>4.1.3- Build health workforce in numbers and skills mix for NCDs</li> <li>4.1.4- Task shift basic NCDs care by optimizing the scope of practice of nurses</li> </ul>	MoHSS, MOEAC, Medical and Health Professional Training Institutions, HPCNA	OPM, All other O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018 - 2022
4.2 Integrated clinical guidelines and treatment protocols for management of NCDs for all levels of care in place	<ul style="list-style-type: none"> <li>-Number of guidelines and protocols developed and disseminated</li> <li>-Proportion of health facilities utilizing guidelines/ protocols</li> </ul>	<ul style="list-style-type: none"> <li>4.2.1-Develop integrated clinical guidelines and protocols for all levels of care especially referral facilities</li> <li>4.2.2- Train providers on NCDs treatment guidelines</li> </ul>	MoHSS, Medical and health professional training schools	OPM, All other O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018-2020
4.3 Palliative care and end of life care integrated to primary health care	<ul style="list-style-type: none"> <li>- Guidelines on end of life and rehabilitation care developed</li> <li>- Health workers trained on end of life care and rehabilitation</li> <li>-Number of PHC facilities implementing palliative and end- of-life care</li> </ul>	<ul style="list-style-type: none"> <li>4.3.1- Develop guidelines on Palliative care and end of life care</li> <li>4.3.2- Train providers on palliative care</li> <li>4.3.3- Integrate rehabilitation, palliative and end of life care into PHC</li> <li>4.3.4- Integrate rehabilitation, palliative and end of life care into preservice training curricula</li> </ul>	MoHSS, MOEAC, Medical and Health Professional Training Institutions, MOEAC	OPM, All other O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN, PPP	2018 - 2022

4.4 NCDs fully covered in the Medical Aid schemes	- Proportion of medical aid schemes fully covering NCDs	4.4.1- Advocate for full coverage of NCD prevention and control services to be included in national health insurance	MOF, MoHSS, Namibia Medical Aid Fund, MLIREC, MPESW, MOF	OPM, Health Professions Councils , All O/M/As	UN agencies, NGOs, CBOs, FBO, CCN	2018 - 2022
4.5 Capacity of health providers and program managers on prevention and control of NCDs strengthened at all levels of the health system	-Number of health workers, program managers trained in prevention and control of NCDs -Number of mentorship programs to improve quality of NCDs services - Number of health training institutions integrated NCDs in their curricula and train students	4.5.1-Train health workers, program managers on the prevention and control of NCDs 4.5.2-Establish ongoing mentorship programs to improve NCDs care 4.5.3- Incorporate NCDs care guidelines into preservice curricula and support preservice training	MoHSS, Medical and Health Professional Training Institutions, MHETI	Health Professions Councils , All O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018 – 2022
4.6 Cost effective medicines, supplies and technologies for screening, diagnosis, treatment and monitoring of NCDs available at all levels of the health system	-Number of tracer NCDs medicines and technologies available at Central Medical Stores and at facility levels - Stock out of essential NCDs medicines and supplies	4.6.1- Revise EML to incorporate essential NCD medications, technologies and consumables 4.6.2- Forecast, procure and distribute all the essential medicines and supplies 4.6.3-Alocate adequate resources for supplies	MoHSS	OPM, MOF O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN, PPP	2018 - 2022
4.7 CHWs capacitated in promotion of healthy lifestyles and in care and support for people suffering from NCDs in the community	- Number of CHW trained on prevention and palliative care	4.7.1-Develop guidelines for the training of CHWs on NCDs prevention and care 4.7.2- Train CHWs on NCDs prevention and palliative care	MoHSS	OPM, O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018 – 2022

## 6.5 Strategic Objective 5: Promote and implement evidence based strategies and interventions for prevention and control of violence and injuries particularly road traffic accidents

EXPECTED OUTPUTS	INDICATORS	ACTIVITIES	LEAD AGENCIES	SUPPORTING O/M/As	PARTNERS	TIME FRAME
5.1 Policies, regulations and strategies for prevention and control of violence and road traffic accidents promoted and implemented	<ul style="list-style-type: none"> <li>-Reports of reviews of legislations, regulations and strategic plans for the prevention and control of violence and road traffic accidents</li> <li>-Number of policy briefs on prevention of violence and injuries developed and disseminated</li> <li>-Number of implementation reports</li> </ul>	<ul style="list-style-type: none"> <li>5.1.1-Appraise existing policies and regulations on prevention of violence and injuries</li> <li>5.1.2- Review the implementation of the <i>Namibian Decade of Action for Road Safety (2011-2020)</i> and strengthen policy and implementation gaps</li> <li>5.1.3 Promote and enforce implementation of policies and regulations</li> </ul>	<ul style="list-style-type: none"> <li>MWT</li> <li>MVA</li> <li>MoHSS</li> <li>MoGECW</li> <li>MOSS</li> <li>MURD</li> </ul>	<ul style="list-style-type: none"> <li>OPM,</li> <li>O/M/As</li> </ul>	<ul style="list-style-type: none"> <li>UN agencies,</li> <li>NGOs, CBOs,</li> <li>FBOs, CCN</li> </ul>	2018 - 2022
5.2 Increased public awareness about the prevention and control of violence and injuries and road traffic accidents	<ul style="list-style-type: none"> <li>-Number of advocacy tools developed and disseminated</li> <li>-Number of advocacy forums held</li> <li>-Number of implementing agencies and stakeholders sensitized</li> </ul>	<ul style="list-style-type: none"> <li>5.2.1-Develop and disseminate advocacy tools on prevention of violence and road traffic accidents</li> <li>5.2.2-Conduct advocacy meetings and mass media campaigns on prevention of violence and road traffic accidents</li> </ul>	<ul style="list-style-type: none"> <li>MoHSS</li> <li>MICT</li> <li>MoGECW</li> <li>MVA</li> <li>MoSS</li> </ul>	<ul style="list-style-type: none"> <li>OPM,</li> <li>O/M/As</li> </ul>	<ul style="list-style-type: none"> <li>UN agencies,</li> <li>NGOs, CBOs,</li> <li>FBOs, CCN</li> </ul>	2018 – 2022

5.3 Pre-hospital care for trauma and accidents improved	-Number of community members trained on pre-hospital care -Number of community trainings held on pre-hospital care	5.3.1-Scale up training on prehospital care for trauma 5.3.2- Strengthen ambulance services for timely transfer to hospitals	MoHSS MVA	OPM, All other O/M/As	UN agencies	2018 – 2022
5.4 Trauma care and rehabilitative services improved	-Number of health facilities with improved trauma care services -Number of healthcare workers trained on trauma care	5.4.1-Update guidelines on trauma care 5.4.2- Expand trauma care and rehabilitative services 5.4.3- Build the capacity of health workers in trauma care and rehabilitation 5.4.4- Improve blood transfusion services	MoHSS MVA Private sector	OPM, All other O/M/As	Un agencies	2018 – 2022
5.5 Community violence and injury prevention and control programs initiated and implemented	-Number of community programs initiated -Number of institutions implementing the programs -Number of periodic implementation reports	5.5.1- Develop and disseminate guidelines for community violence and injury prevention and control programs 5.5.2- Conduct public awareness campaigns on prevention of violence and injuries	MoHSS MoGECW MoSS MVA MICT	OPM, All other O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018 – 2022

**6.6 Strategic Objective 6: To promote and support national capacity for high-quality research and development of research agenda for the prevention and control of NCDs.**

EXPECTED OUTPUTS	INDICATORS	ACTIVITIES	LEAD AGENCIES	SUPPORTING O/M/As	PARTNERS	TIME FRAME
6.1 Priority research areas on NCDs Identified	<ul style="list-style-type: none"> <li>- Number of priority research areas identified</li> <li>- List of priority research areas Identified</li> </ul>	6.1.1-Identify priority research areas on NCDs and their risk factors	MoHSS, Institutes of High Learning, Research institutions	O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018 - 2022
6.2 NCDs research capacity strengthened	<ul style="list-style-type: none"> <li>-Proportion of NCDs budget allocated to NCDs Research and infrastructure</li> <li>-Number of healthcare workers trained on NCDs research</li> </ul>	6.2.1-Advocate for resources for research on priority NCDs 6.2.2-Develop proposals and mobilize resources 6.2.3- Strengthen capacity for NCDs research (human resource, infrastructure, equipment and supplies)	MoHSS, MOEAC, Institutes of High Learning, MHETI, OPM	O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018 - 2022
6.3 Evidence generated and used for national policy and program planning	<ul style="list-style-type: none"> <li>- Synthesis report of local research findings for policy action</li> <li>- Number of dissemination forums for sharing research findings for policy makers and programmers</li> </ul>	6.3.1-Provide financial support for priority NCDs researches 6.3.2-Develop synthesis of local research and survey findings for policy action 6.3.3- Disseminate research findings for policy makers and programmers	MoHSS, Institutes of High Learning, Research institutions	OPM O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018 - 2022

## 6.7 Strategic Objective 7: To monitor trends and determinants of Non-Communicable Diseases and evaluate progress in its prevention and control

EXPECTED OUTPUTS	INDICATORS	ACTIVITIES	LEAD AGENCIES	SUPPORTING O/M/As	PARTNERS	TIME FRAME
7.1 NCDs surveillance and monitoring capacity strengthened	-Number of health workers trained on NCDs surveillance -Proportion of NCDs budget dedicated to NCDs surveillance and infrastructure - Key NCDs indicators incorporated and reported through the HIS	7.1.1-Strengthen capacity for NCDs surveillance (personnel, infrastructure, equipment, and supplies) 7.1.2- Allocate resources for routine and periodic NCDs surveillance 7.1.3-Update NCD indicators and reporting formats in the HIS	MoHSS, Higher Education Institutions, Research Institutions	O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018 – 2022
7.2 Baseline and periodic NCDs and risk factors data available for monitoring and program planning	-Reports of periodic STEPs NCDs and risk factor surveys	7.2.1-Conduct periodic NCDs STEPs surveys every 5 years	MoHSS, NSA, Research institutions NRUI	OPM, O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018 - 2022
7.3 National Registry established for major NCDs	-Number of functional disease specific registries	7.3.1-Establish National Registry on some major NCDs	MoHSS, NGOs, Private sector	OPM, O/M/As	UN agencies, CBOs, FBOs, CCN	2018 – 2022
7.4 NCDs surveillance results periodically disseminated to guide decision making by national authorities	- Number of dissemination forums and publications	7.4.1 Develop annual NCDs surveillance reports 7.4.2- Disseminate the NCDs surveillance reports regularly	MoHSS, NSA, Research institutions NRUI	O/M/As	UN agencies, NGOs, CBOs, FBOs, CCN	2018 - 2022

## 7 NON-COMMUNICABLE DISEASES COORDINATION MECHANISM

### 7.1 Programme Management

In order to effectively coordinate the national NCDs response including the implementation of the NCDs Strategy, there is a need to strengthen the current NCDs Program as part of the continued commitment of the Government for the prevention and control of NCDs in Namibia. It should be highlighted that strengthening of NCDs program is required at all levels; national, regional, district and community. In this regards, it is essential that the national NCDs program is upgraded to a Sub-Division level with all the required human and financial resources.

### 7.2 Non-Communicable Diseases Coordination Mechanism

The efficient and effective implementation of the National Multisectoral NCDs Strategic Plan require a multisectoral approach with effective partnership through involvement of relevant Governmental Institutions, Private Sectors, Partners, Faith Based Organizations (FBOs), NGOs as well as communities through local associations. It is important to note that this multisectoral approach will necessitate strong harmonization and coordination among all government sectors and stakeholders. This convening and coordination role rightly remains the responsibility of the Office of the Prime Minister (OPM) who has the leverage to bring onboard all concerned actors on the common agenda of the prevention and control of NCDs.

Thus, a national Multisectoral Coordination Mechanism, which coordinates the actions of different sectors for the common goal of prevention and control of NCDs, is central to the success of national NCDs prevention and control efforts and the attainment of national targets. Multisectoral coordination mechanisms offer a synergistic response to these diseases and their risk factors. Experiences with health concerns such as HIV and AIDS indicate that ***political leadership at the supra-ministerial level is critical to drive action within any multisectoral coordination mechanism.*** It is important for the mechanism to be anchored at the Prime Minister's Office level which has the power for guiding and commanding action across different line ministries and thereby ensuring the smooth functioning of the coordination system.



Two levels of coordination mechanisms are suggested; national level and regional level. At the national level, the mechanism has the mandate of developing policies, ensuring coordination between different sectors, mobilizing and allocating resources, reviewing progress in the implementation of the agreed action plan at the national and subnational levels, addressing obstacles to progress and reporting on international commitments.

The Regional level mechanisms are largely concerned with implementation of programmes, enforcement of relevant laws and reporting on activities. The regional level committee will be coordinated by the Regional Governor and the secretariat would be the Regional Health Directorate while heads of key sectoral offices and relevant NGOs in the region would be members.

In order to facilitate the needed technical support at the national level, the MoHSS will form a *National NCDs Technical Committee* with representation of the different departments of the MoHSS and key stakeholders. This committee will be chaired by the Director of Primary Health Care and will provide technical support for the planning, implementation and monitoring of the health system response for NCDs. This committee will also create different technical working groups for specific thematic areas (e.g. Cardio-vascular Diseases, Diabetes Mellitus-, Cancer prevention and control-, Tobacco products control, etc.) for rendering technical support in specific areas. The MoHSS will develop the terms of reference for the National NCDs Technical Committee and the different technical working groups which will be formed under it.

Below are the details of the composition and responsibilities of the national and sub-national coordination mechanisms for the prevention and control of NCDs in Namibia including the coordination organogram.

## Composition of National NCDs Multisectoral Coordination Committee

Responsibility	Institution
Chair/Coordinator	Office of the Prime Minister (OPM)
Secretariat	Ministry of Health and Social Services (MoHSS)
Members	<ol style="list-style-type: none"> <li>1. Ministry of Industrialization, Trade and SME Development</li> <li>2. Ministry of Agriculture, Water and Forestry</li> <li>3. Ministry of Higher Education, Training and Innovation</li> <li>4. Ministry of Education, Arts and Culture</li> <li>5. Ministry of Urban and Rural Development</li> <li>6. Ministry of Finance</li> <li>7. Ministry of Justice</li> <li>8. Ministry of Works and Transport</li> <li>9. Ministry of Information, Communication and Technology</li> <li>10. Ministry of Youth, National Service, Sport and Culture</li> <li>11. Association of Local Authorities in Namibia</li> <li>12. Association of Regional Councils of Namibia</li> <li>13. Ministry of Poverty Eradication and Social Welfare</li> <li>14. Ministry of Mines and Energy</li> <li>15. Namibia Roads Authority</li> <li>16. Motor Vehicle Accident Fund</li> <li>17. Namibian Police Force</li> <li>18. Ministry of Defense</li> <li>19. University of Namibia (UNAM)</li> <li>20. University of Science and Technology (NUST)</li> <li>21. Windhoek Central Hospital – A.B. May Cancer Centre</li> <li>22. Cancer Association of Namibia (CAN)</li> <li>23. Private sector representatives</li> <li>24. Civil Society, Health Professional &amp; Patients' Associations representatives</li> <li>25. Partners: WHO, UNICEF, UNFPA, UNDP, UNAIDS, FAO, CDC, I-TEC, etc...</li> </ol>

### Responsibilities of the coordination mechanism at the National- and Regional levels

#### National Multisectoral Coordination Mechanism for NCDs

- a. Provide political leadership and guidance to relevant sectors for NCDs prevention and control
- b. Enhance the integration of NCDs prevention and control in the policies and programmes of relevant ministries and government agencies
- c. Provide a dynamic platform for dialogue, stocktaking and agenda-setting, and development of public policies for NCDs prevention and control
- d. Facilitate development and resourcing of the multisectoral action plan on NCDs prevention and control
- e. Coordinate technical assistance for mainstreaming NCDs in the work of relevant sectors at the National- and Regional levels

- f. Monitor implementation of the action plan and review progress at the National- and Regional levels
- g. Report on inter-governmental commitments pertaining to NCDs prevention and control

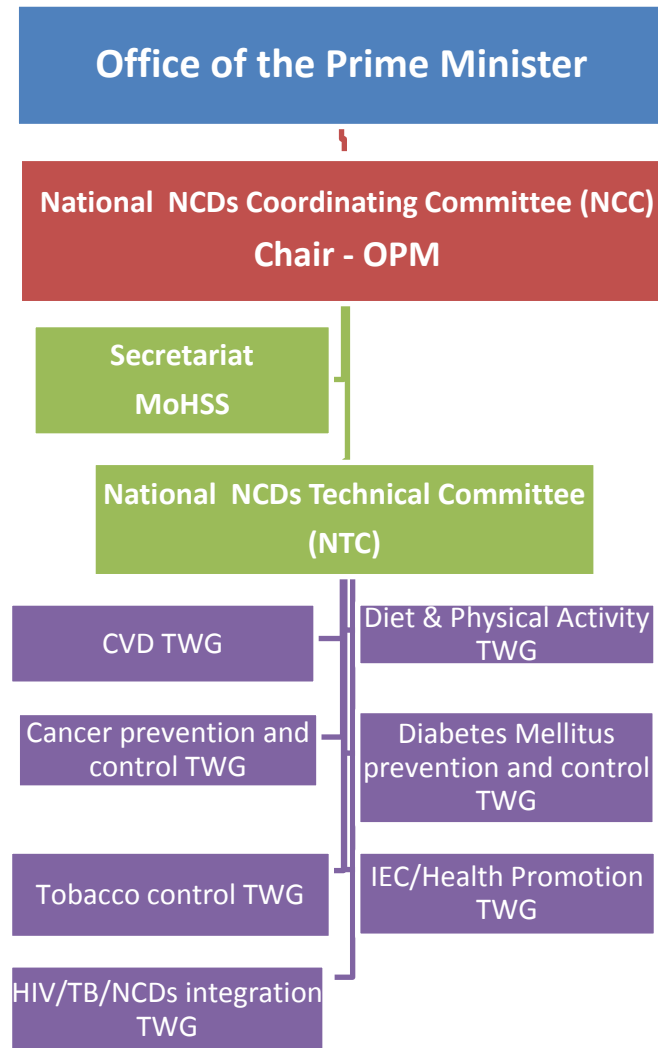
#### **Regional Multisectoral Coordination Mechanism for NCDs**

- a. Ensure effective implementation of the multisectoral action plan on NCDs prevention and control in the region
- b. Coordinate with relevant sectors to mainstream NCDs prevention and control in their programme implementation at Regional levels
- c. Identify and access local government resources for implementation of the plan
- d. Report on implementation of the plan to the National Coordination Mechanism

#### **Role of the Secretariat/MoHSS**

- a. Sensitize key stakeholders, Ministries, NGOs, FBO's, CSO's on NCDs prevention and control concerns
- b. Organize meetings of the Multisectoral Coordination Mechanism for NCDs
- c. Develop the agenda for the meeting in consultation with the chairperson and other sectors
- d. Facilitate the development of strategic and operational plan for NCDs prevention and control
- e. Request reports on progress of work from stakeholders, Ministries, NGOs, FBO's, CSO's and Regional coordination bodies
- f. Follow-up on decisions taken by the coordination body
- g. Arrange technical assistance to Line Ministries such as for environmental scans for policy initiatives, health impact assessments of policies and capacity assessments of sectors
- h. Identify knowledge gaps and advance research priorities to inform policy decisions
- i. Support stakeholder, Ministries, NGOs, FBO's, CSO's in accessing resources for implementing their commitments
- j. Facilitate bilateral/multilateral meetings to advance work on thematic issues and agreed goals
- k. Prepare consolidated reports on the implementation of the multisectoral action plan for NCDs prevention and control
- l. Facilitate monitoring and evaluation of the work of the coordination mechanism against agreed national- and global NCDs targets

## Namibia Non-Communicable Diseases Coordination Framework



## 8 ANNEXES

### 8.1 Annex 1: Monitoring Framework

Comprehensive National Monitoring Framework for the prevention and control of NCDs

Framework element	Indicator Name	Baseline (year)	2025 Target	Data source	Frequency of reporting	Reporting start year
Diabetes and obesity	Age-standardized prevalence of obesity and overweight among adults aged 18+ years	32% women (35-64yrs) 12% men (35-64yrs)	0% increase	NDHS 2013	5 years	2019
Tobacco use	Age-standardized prevalence of current tobacco smoking among persons aged 15+ years.	19% men (15-49yrs) 5% women (15-49yrs)	30% relative reduction	NDHS 2013	5 years	2019
Harmful use of alcohol	Total (recorded and unrecorded) alcohol per capita (15+ years old) consumption within a calendar year in liters of pure alcohol)	34 L - men 18.3 L - women	10% relative reduction	WHO 2014	5 years	2019
Physical inactivity (insufficient physical activity)	Age-standardized prevalence of insufficiently active adults aged 18+ years (defined as less than 150 minutes of moderate-intensity activity per week, or equivalent).	57% men (15-49yrs) 80% women (15-49yrs)	10% relative reduction	NDHS 2013	5 years	2019
Additional indicator - unhealthy diet	Age-standardized prevalence of adult (aged 18+ years) population consuming less than five total servings (400 grams) of fruit and vegetables per day.	No data	30% relative increase	STEPS survey	5 years	2019
Diabetes and obesity	Age-standardized prevalence of raised blood glucose/diabetes among adults aged 18+ years (defined as fasting plasma glucose value $\geq 7.0$ mmol/L (126 mg/dl) or on medication for raised blood glucose).	7% men(35-64yrs) 6% women(35-64yrs)	0% increase	NDHS 2013	5 years	2019
	Age-standardized prevalence of raised blood pressure among adults aged 18+ years (defined as systolic blood pressure $\geq 140$ mmHg and/or diastolic blood pressure $\geq 90$ mmHg).	44% women (35-64yrs) 45% men (35-64yrs)	25% relative reduction	STEPS survey	5 years	2019
Premature mortality from NCDs	Unconditional probability of dying between ages 30-70 years from cardiovascular disease, cancer, diabetes or chronic respiratory disease	No data	25% relative reduction	WHO statistics	Annually	2019 WHO Statistics

	Proportion of cervical and breast cancers diagnosed early	No data	60%	NCD program – National Cancer Registry	Annually	2018
Drug therapy to prevent heart attacks and stroke	Proportion of eligible persons (defined as aged 40 years and older with a 10year cardiovascular risk >=30% including those with existing cardiovascular disease) receiving drug therapy and counseling to prevent heart attacks and strokes	No data	50%	NCD register -- > PHC reports, DHIS	Annually	2018
Additional - palliative care	Access to palliative care assessed by morphine equivalent consumption of strong opioid analgesics (excluding methadone) per death from cancer	No data	20% relative increase	Palliative care HBC program	Annually	2018
Additional - screening	Coverage of cervical cancer screening for women between ages 30–49 years	24% (NDHS 2013)	80%	NCCP	Annually	2018
Additional - vaccination	Coverage of vaccination against hepatitis B among children under 5 years	90%	95%	EPI program	Annually	2018
Additional - vaccination	Coverage of vaccination against human papillomavirus (HPV) among girls aged 11 - 13 years	0%	95%	EPI program	Annually	2018
Additional - Drug therapy to prevent heart attacks and stroke	Proportion of diabetics and hypertensives receiving CVD risk mitigation counseling and treatment, whose disease is controlled (defined as BP < 140/90 for hypertension, and HbA1c <= 7 or fasting glucose for diabetes)	No data	70%	NCD register, PHC reports, DHIS	Annually	2018
Other indicators	Proportion of population with NCD prevention information (awareness)	No data	80%	STEPS survey	5 years	2019
	National (multi-sectoral) per capita spending on NCDs	21% of total health spending (2014/15 report)	20% relative increase	Health accounts audit	2 years	2019

## 8.2 Annex 3: Monitoring and Evaluation

The implementation of the strategy will be monitored and evaluated through the Monitoring and Evaluation Framework, which will cover all aspects of the strategy and complementing policies. The NCDs program together with relevant programs within the Ministry of Health and Social Services and other stakeholders will conduct monitoring and evaluation activities over the course of the implementation phase. Monitoring and evaluation will capture the various process measures and outputs which will guide program implementation. Overall outcome will be evident through demonstration of NCDs risk reduction and reduction in morbidity and mortality compared to base year.

### ***Targets and Indicators***

Due to the complexity and magnitude of risk factors shared across multiple sectors, NCDs interventions will take time to show population level outcomes in risk reduction. Targets will be set during the initial stage of implementation of the strategy and adjusted on a yearly basis.

#### **Short term indicators are process/output related to:**

- Mortality from NCDs: cause of death, age and sex, burden of disease calculations
- Health system capacity
- Availability of national guidelines
- Accessible and affordable medicines and diagnostics
- Quality of care
- Clinical audits
- Proportion of complications
- Efficiency of referral systems

#### **Medium term indicators**

- Increasing the age at which people start smoking - achievable in a 3-5 year time frame
- Tobacco prevalence among students
- Obesity in school children
- Obesity in adults

- Rate of Diabetes Mellitus amputations
- Number of people giving up tobacco smoking
- increased availability of vegetables and fruits
- Price reduction of vegetables and fruits
- Use of essential medicine for NCDs

**Long term indicators**

- Reduction in prevalence of; tobacco use, obesity in children, prevalence of Diabetes Mellitus, and deaths from heart diseases

All indicators developed under this surveillance system will, as far as possible, allow disaggregation to permit assessment of inequities in distribution of burdens, costs, and benefits by age, sex, income, occupation, education, and urban-rural disaggregation.



### 8.3 Annex 4: List of Legislations, Policies, Strategies and Guidelines

Republic of Namibia Office of the President (2004) *Vision 2030: Policy Framework for Long term National Development Document*. Windhoek: Office of the President

Tobacco Products Control Act (1 of May 2010)

Namibia Demographic and Health Survey (NDHS), MoHSS, 2013

Ministry of Health and Social Services, Report on the Namibia School-Based Student Health Survey (SBHS) 2004, Windhoek, 2008  
Ministry of Health and Social Services' Planning Division, 2008, the Health Sector and Health Sector Reform in Namibia, Windhoek, Namibia

Ministry of Health and Social Services, National Health Policy Framework 2010-2020, Windhoek, Namibia, 2010

World Health Organization (2002) *Health –for- all Policy for the 21<sup>st</sup> Century in the African Region: Agenda 2020*. Harare: Regional Office for Africa

World Health Organization Global Action Plan, 2013-2020

World Health Organization, 2004. Global Strategy on Diet, Physical Activity and Health, WHO Geneva, Switzerland

UN High Level Resolutions, September 2011, New York

SADC Protocol on Health 1999

Joint SADC Ministers of Health and Ministers Responsible for HIV AND AIDS' Resolutions, November 2011, South Africa

## 8.4 Annex 5: Multisectoral NCDs linkages

Annex 5.1 below connects the response to NCDs with the priorities of other sectors, making the links explicit and preparing for harmonization of policies, strategies and targeted interventions across sectors:

Sector	Policy/Intervention link
Sustainable development	Policies to address climate change, transport (links with physical activity, injury, and pollution), sustainable food production
Finance	Using fiscal instruments to reduce consumption of tobacco and harmful use of alcohol, raising revenue, and paying for health promotion
Social policy	Ensuring equity of access to prevention and care for services related NCDs. Reducing disparities in burden of NCDs among people of different social class (defined by age, sex, income, occupation, education, urban-rural areas)
Education	Enhancing the academic performance of school children through promotion of healthy behaviors. Strengthening work on health promoting schools and related activities to improve the health of students, teachers and the surrounding community
Industry, infrastructure, agriculture and trade	Assessing the health and environmental impact of all policies in these sectors, including NCDs in the formal impact assessment. Creating mechanisms of national reporting and accountability for these policies. Assessing the harmony between internationally agreed instruments and conventions (e.g. balancing public health impacts on adherence to trade agreements). Seeking new opportunities and comparative benefits for work with these sectors (e.g. introduction of new fruits and vegetables for agriculture, where applicable)
Civil Society organizations	Work with civil society and especially with women's groups to enhance the social norms to favor behaviors that reduce risk of NCDs. Empower communities to manage and cope with existing burdens of NCDs and disability, to maximize functioning in society and minimize impacts on households, through self-help, self-care and improved health literacy
Private sector	Seek opportunities for workplace health promotion extending the concept of occupational health and HIV and AIDS programs to cover the prevention of NCDs. Seek opportunities for consultation and cooperation where appropriate (e.g. physical activity promotion, salt reduction, food product re-formulation). Set standards and enforce these as and where appropriate
Health	Develop the capacity for health policy makers and civil society to understand the policy concerns of other sectors and to engage in meaningful and lasting dialogue. Seek synergies between infectious diseases and NCDs (e.g. addressing the intimate linkages between tuberculosis and smoking, or tuberculosis and Diabetes Mellitus)

Annex 5.2 below shows examples of potential health effects of multi-sectoral actions with respect to the four major risk factors.

Risk Factor	Desired outcome	Examples of multisectoral action	Sectors involved
<b>Tobacco</b>	Reduced tobacco use & consumption, including secondhand smoke exposure and reduced production of tobacco and tobacco products	Full implementation of the <b>WHO Framework Convention on Tobacco Control (FCTC)</b> obligations through coordination committees at the national and subnational levels	<ul style="list-style-type: none"> <li>• Legislature</li> <li>• Stakeholder ministries across government, <ul style="list-style-type: none"> <li>○ Customs/Revenue, Finance, Trade</li> <li>○ Education, Health, Agriculture</li> <li>○ Planning, Labour, Foreign Affairs,</li> <li>○ Social Welfare, Mass media, Justice</li> </ul> </li> </ul>
<b>Harmful use of alcohol</b>	Reduced harmful use of alcohol	Full implementation of the <b>WHO Global Strategy to Reduce the Harmful Use of Alcohol</b>	<ul style="list-style-type: none"> <li>• Legislature &amp; Local government</li> <li>• Ministries of <ul style="list-style-type: none"> <li>○ Trade, Industry, Finance, Customs</li> <li>○ Education, and Justice,</li> </ul> </li> </ul>
<b>Physical inactivity</b>	Decreased physical inactivity	<ul style="list-style-type: none"> <li>• Urban planning or reengineering for active transport and walkable cities</li> <li>• School-based programmes for physical activity</li> <li>• Incentives for workplace healthy lifestyle programs</li> <li>• Increased availability of safe environments and recreational spaces</li> <li>• Mass media campaigns</li> <li>• Economic interventions to promote physical activity (taxes on motorized transport, subsidies on bicycles and sports equipment)</li> </ul>	<ul style="list-style-type: none"> <li>• Ministries of <ul style="list-style-type: none"> <li>○ Education,</li> <li>○ Sports, and Youth</li> <li>○ Urban Planning,</li> <li>○ Transport,</li> <li>○ Customs/Revenue, Finance, Trade</li> <li>○ Labour</li> <li>○ Planning,</li> <li>○ Mass Media</li> </ul> </li> <li>• Local government</li> </ul>
<b>Unhealthy diet</b>	Substitution of healthy foods for energy-dense micronutrient poor foods	<ul style="list-style-type: none"> <li>• Reduced amounts of salt, saturated fat and sugars in processed foods</li> <li>• Limit saturated fatty acids and eliminate industrially produced trans fats in foods</li> <li>• Controlled advertising of unhealthy food to children</li> <li>• Increase availability and affordability of fruit and vegetables to promote intake</li> <li>• Offer of healthy food in schools and other public institutions and through social support programmes</li> <li>• Economic interventions to drive food consumption (taxes, subsidies)</li> <li>• Food security</li> </ul>	<ul style="list-style-type: none"> <li>• Legislature</li> <li>• Ministries of <ul style="list-style-type: none"> <li>○ Trade, Industry, Finance</li> <li>○ Customs/Revenue,</li> <li>○ Agriculture,</li> <li>○ Education,</li> <li>○ Energy, Transport</li> <li>○ Social Welfare</li> <li>○ Environment</li> <li>○ Mass Media</li> </ul> </li> <li>• Local government</li> </ul>

## 8.5 Annex 6: Glossary

**Health Promotion** is defined here as a “social enterprise” to improve health and equity. That is, through strengthening of communities; social, political and economic capital can be mobilized; enabling a “social enterprise” which can take action to address the negative.

**Disease Prevention** for the purposes of this strategy refers to actions that are aimed at eliminating or minimizing the impact of disease or disability:

**Primary Prevention:** actions that aim to protect the health of individuals through personal and communal efforts;

**Secondary Prevention:** measures available to individuals and communities for the early detection and prompt intervention to control disease and minimize disability

**Tertiary Prevention:** measures aimed at softening the impact of chronic disease and disability thereby minimizing suffering and maximizing years of useful life

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**Contributors for the preparation of the National Multisectoral Action Plan for the Prevention and Control of Noncommunicable Diseases 2017/18 -2021/22.**

<b>Institution</b>	<b>Name of contributors</b>
Office of the Prime Minister (OPM)	Abner Xoagub, Isak Poppas, Kaarina Amutenya
MoHSS, PHC, Non-Communicable Diseases Prevention & Control	Charlotte Buys
World Health Organization (WHO) – IST/AFRO & Namibia Office	Prebo Barango (Dr) IST/AFRO; Sirak Hailu (Dr) , Celia Kaunatjike
MoHSS, Primary Health Care Directorate (PHC)	Hilma Auala (Director PHC)
MoHSS, PHC, Oral Health and Dental Services	John Rutabanzibwa (Dr), Christian John
MoHSS, PHC, Reproductive- and Child Health Sub-division	Dorothea Diergaardt
MoHSS, Primary Health Care Directorate, Nutrition Division	Marjorie van Wyk, Hilde Nashandi, Nicole Angermund
MoHSS, PHC:IMNCI; FP/ADH; School Health Programme	Rose-Marie De Waldt; Foibe Moses; Aletta !Noabes
UNAM School of Medicine	Celestin Mbangtang (Prof), Linda Lukolo (Dr), Fola Adebanjo (Dr), Cilas Wilders (Prof), Lucia Nelumbu
UNAM School of Nursing; Humanities and Social Sciences	N. Anyolo, Kristofina Amakali (Dr); Rachel Freeman
MoHSS, A. B. May Cancer Centre & Khomas Medical Oncology	Peggy Emvula (Dr) ; Petronella Totong
Palliative Care Activist	Marjory Katjire
Centre for Diseases Prevention and Control (CDC)	Christa Fischer-Walker (Dr), Naemi Shoopala
International Atomic Energy Agency (IAEA), Vienna, Austria	Rolando Camacho (Dr)
UNFPA	Loide Amkongo, Filomina Ochurus
MoHSS, Windhoek Central Hospital	Zulnolla Barends, August Boois,
MoHSS, Katutura Hospital, Gynaecology & Surgery Ward	Iyaloo Simeon
MoHSS, PHC, Community Based Health Care	Tuutaleni Shilyomunhu
MoHSS, Disability Prevention and Rehabilitation	Milke Mushima, Albertina Barandonga
MoHSS, Public- and Environmental Health	Vasco Munsu
MoHSS, Directorate Special Programmes, Palliative Care	Dorothea Maloboka
MoHSS, Policy Planning & HRD	Charles Usurua
MoHSS, Information, Education, Communication Division	Dorothea Kambinda, Josephine Mbanga
MoHSS, Social Welfare Services	Betsy Basson, Beulah Denk, Geraldine Kanyinga, Angela !Naobes
MoHSS, Atomic Energy & Radiation Protection Services	Vera Uushona
MoHSS, Directorate of Health Information and Research	Emmy-Else Ndevaetela, Shirley-Ann Swartz
MoHSS, Information, Education, Communication Division	Dorothea Kambinda, Josephine Mbanga
MoHSS, Social Welfare Services	Betsy Basson, Beulah Denk, Geraldine Kanyinga, Angela !Naobes
MoHSS, Disability Prevention and Rehabilitation	Milke Mushima, Albertina Barandonga
MoHSS, Public- and Environmental Health	Vasco Munsu
MoHSS, Directorate Special Programmes, Palliative Care	Dorothea Maloboka
MoHSS, Policy Planning & HRD	Charles Usurua

MoHSS, Kunene Region	Auguste Day
MoHSS, Zambezi Region	Francesca Silumba
MoHSS, Otjozondjupa Region	Frieda Stephanus, Mary Muyenga
MoHSS, Kavango Region	Pauline Singarure
MoHSS, Oshana Region	Fares Kambowe, Lotte Nuule
MoHSS, Erongo Region	Tensius Muandi
MoHSS, Oshikoto Region RMT	Maria Shangula
MoHSS, Omaheke Region	Jacky Nguasena, Melanie Arnat
MoHSS, //Kharas Region	Rauna Namukwambi
MoHSS, Khomas Region RMT	Petra Ipinge
MoHSS, Ohangwena Region	Mina Shapopi
MoHSS, Hardap Region RMT	Elizabeth Cloete
MoHSS, Oshikoto Region	Justine Muteka
Ministry of Defense	Michael Iita
Ministry of Urban and Rural Development	<u>Mesag Haukena</u>
Ministry of Gender Equality and Child Welfare	Mishake Mubuyaeta
Ministry of Youth, National Service, Sports and Culture	Jakes Basson
Ministry of Industrialization, Trade & SME Development	Victoria Hofnie, Salome Idhenge
Ministry of Agriculture, Water and Forestry	Patrick Tibinyane
Ministry of Higher Education, Training and Innovation	Florence Kavirindi
Ministry of Works and Transport, Sub-division Employee Wellness	Ihana Kaangundue
Ministry of Education, Arts and Culture	Ben Muleko, James Yisa
Ministry of Poverty Eradication and Social Welfare	G. Kapepu
Ministry of Labour, Industrial Relations and Employment Creation	Unity Tjikuzu
International Training and Education Centre for Health (I-TECH)	Rachel Mhango
NABCOA, Khomas Region	Theopolina Mulokoshi
Health Work Business Coalition	Hetta Shongolo
Project Hope Namibia	Beauty Kwenda
GlaxoSmithKline	Carine Schiebler
Hilani Diabetes Clinic	Hilani Samuel
Cancer Association of Namibia	Lizette Horn
City of Windhoek	Nevia Mundia
National Road Safety Council	Bethino Mbirimuyo, Maano Shimanda





