World Health Organization

BRINGING IT ALL TOGETHER

Annual Report 2008

NAMIBIA

BRINGING IT ALL TOGETHER

Annual Report 2008

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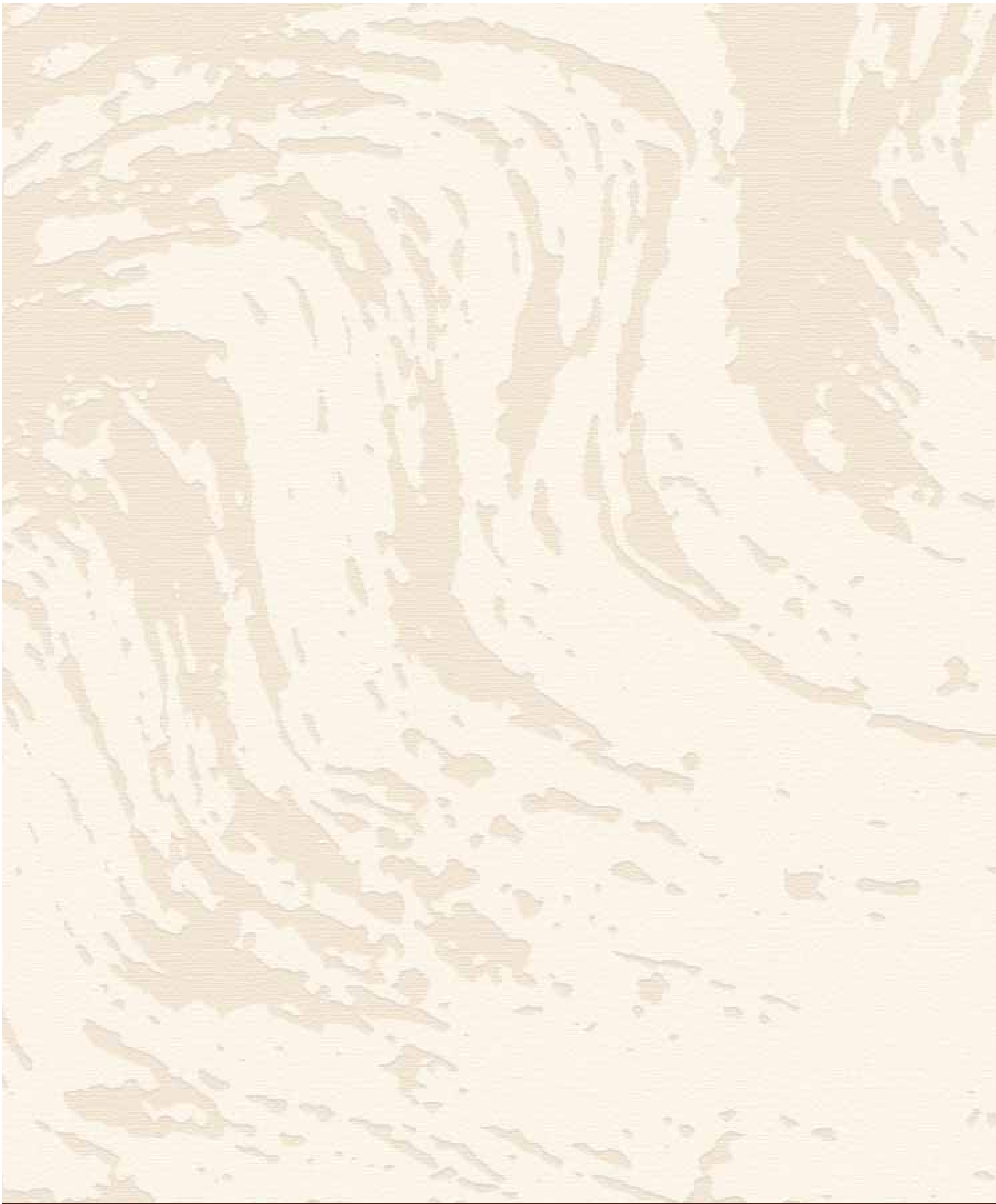

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Foreword

In 2008, Namibia witnessed a number of public health successes as well as challenges. Among the successes, we can notably enumerate the slight but encouraging decline in HIV prevalence, particularly among the age groups 15-19 years, the successful conclusion of a comprehensive health and social services systems review, the development of a five-year strategic plan, and the development of a road map for the reduction of maternal, newborn and child deaths. The polio-free certification status achieved through high quality surveillance standards and declared by the African Regional Certification Commission on Poliomyelitis Eradication was also a major achievement.

Some of the challenges faced this year by the health sector were of a global nature with a local impact. The global food and fuel crisis have certainly had an impact, although still probably not fully understood, on the ability of people to take care of their health and nutrition. To compound matters further, the entire world became aware of one of the most serious financial and economic crisis, of a magnitude and impact yet to be determined, particularly in low and middle income countries.

Another important challenge faced by Namibia in 2008, was the floods that caused much devastation in the northern Regions of the country. People were displaced and impoverished, food production was compromised, roads and bridges were destroyed and valued resources were diverted by the Government to confront the needs of affected populations. The emergency caused by the floods in northern Namibia is a concrete example of how climate change can impact our world in a large scale.

Extensively drug resistant tuberculosis, a virtually untreatable form of tuberculosis, has been recorded in 45 countries around the world, including Namibia. The Ministry of Health and Social Services demonstrated leadership and decisiveness in dealing with the situation. Appropriate measures were put in place and a vigorous surveillance system and infection control measures are being implemented to ensure that emergence of multi-drug resistant cases is minimized.

All these challenges remind us of the importance of supporting Government public health policies based on Primary Health Care, the cornerstone of effective and efficient health systems. Now, more than ever, we should ensure that we work better together, to maximize the opportunities to address social inequities and other gaps in access to affordable and quality health care, harness the potential of the private sector and expand the public sector network, to provide care as close to the home as possible.

This report presents the World Health Organization's interventions in the context of the country's national health responses to health challenges. It also provides contextual information within which interventions are provided, including the policy environment and the country's health profile. In this report, we attempt to tell our readers and partners how WHO is contributing to the strengthening of the health system in Namibia and how it made use of its comparative advantage to do the things it knows how to do best. We have endeavoured to leverage our resources with those of the Government of the Republic of Namibia and other development partners, mainly by providing strategic support that facilitates the strengthening of the national health system and the implementation of national programmes. Coordination and co-funding are key to our interventions and this report highlights these partnerships and the resultant outcomes. This report also presents a special feature on the National Blood Programme.

We hope to continue to count on the support of our valuable partners, number one being the Ministry of Health and Social Services, to address new trends in the health sector, tackle existing challenges and most importantly, contribute to the protection of the health of the people of Namibia.

The WHO Country Office in Namibia is committed to contribute to improving the quality of life for all Namibians. We share in the Nation's vision to become "A prosperous and industrialised Namibia, developed by her human resources, enjoying peace, harmony and political stability". We trust that, together, we can indeed attain this goal.

Dr Magda Robalo Correia e Silva
WHO Representative to Namibia

Acknowledgements

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Particular appreciation goes to the Ministry of Health and Social Services Directors of Primary Health Care, Special Programmes, and Policy, Planning and Human Resource Development who, in addition to providing important feedback on our operations, also provided statistical and other information that has been used in this report.

To our international and local implementing and funding partners: your collaboration is greatly valued, and we look forward to an even more fruitful time ahead.

We are very grateful to Ms Rita Motlana and Dr Ann Gasasira, the consultants who compiled the report, for their competence, experience and hard work. We also thank Ms Swapna Sharma, the editor of the report.

Finally, we would like to thank the health workers and people of Namibia that allowed us to capture visual images of the health system in action!

Abbreviations and Acronyms

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
ARCC	African Regional Certification Commission
ARV	Antiretroviral
ART	Antiretroviral therapy
CB-DOT	Community-based directly-observed TB treatment
CCS	Country Cooperation Strategy
CDC	Center for Disease Control and Prevention
CNR	Case-notification rates
DOTS	Directly-observed TB treatment – Short course strategy
EHO	Environmental Health Officer
EPI	Expanded Programme on Immunization
EPP	Estimation and Projections Package (model)
EU	European Union
EWI	Early Warning Indicators
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (German Technical Cooperation)
GUS	Genital ulcer syndrome
HCRW	Health Care Risk Waste
HDI	Human Development Index
Hep B	Hepatitis B
Hib	Haemophilus influenza type B
HIV	Human immunodeficiency virus
HIVDR	HIV drug resistance
HSS	Health systems strengthening
HSSSR	Health and Social Services Systems Review
IMF	International Monetary Fund
IMR	Infant mortality rate
IRS	Indoor residual spraying
IST ESA	WHO Intercountry Team for East and Southern Africa
ITN	Insecticide –treated bed nets
LGV	Lymphogranuloma Venereum
LLTN	Long-lasting treated nets
MCA	Millennium Challenge Account
MCH	Maternal and child health
MDG	Millennium Development Goals
MDR-TB	Multi-drug resistant TB
MER	Monitoring, evaluation and reporting
MoHSS	Ministry of Health and Social Services
MTEF	Mid Term Expenditure Framework
MTPI	Medium Term Plan 1 – The National Strategic Plan on TB

MTPIII	Third Medium Term Plan (The National Strategic Plan on HIV/AIDS)
MUS	Male urethral discharge
NAMBTS	Blood Transfusion Service of Namibia
NBPr	National Blood Programme
NCD	Non-communicable diseases
NDHS	Namibia Demographic and Health Survey
NDP	National Development Plan
NHA	National Health Accounts
NHIES	Namibia Household Income and Expenditure Survey
NIP	National Institute of Pathology
NTCP	National TB Control Programme
NVDCP	National Vector-borne Disease Control Programme
ODA	Overseas development assistance
OPD	Out patient department
OVC	Orphans and vulnerable children
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary health care
PITC	Provider-initiated testing and counselling
PMTCT	Prevention of mother-to-child transmission
RDT	Rapid diagnostic test
SACU	Southern African Customs Union
SADC	Southern African Development Community
SMA	Social Marketing Association
STI	Sexually-transmitted infection
STOP	Stop transmission of polio
TB	Tuberculosis
TB CAP	Tuberculosis Control Assistance Program
TESEF	Transformation of Economic and Social Empowerment Framework
TTI	Transfusion transmissible infection
TWG	Technical working group
U5MR	Under-five mortality rate
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNAM	University of Namibia
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USG	United States Government
VDS	Vaginal Discharge Syndrome
WHO	World Health Organization
XDR-TB	Extensively drug resistant TB

Executive Summary

The provision of quality and equitable health care to all its citizens remains a priority for the Government of the Republic of Namibia and all stakeholders in the health sector. WHO is a key partner of the Government in the health sector development initiatives. This 2008 Annual Report illustrates that numerous complimentary efforts are underway to achieve universal access to optimal health care.

Namibia's health care system has made good progress and seen notable rewards. The prevalence of HIV/AIDS and TB remains extremely high but ongoing efforts are producing encouraging declines in critical indicators. This is largely due to stakeholders' increasing focus on prevention-oriented interventions supported by strengthened treatment programmes with high coverage. The successful roll-out of malaria prevention strategies and the introduction of effective anti-malarial treatment has brought about a significant decrease in malaria incidence. In terms of the vaccine preventable diseases, Namibia achieved a polio-free status in October 2008 as certified by the African Regional Certification Commission. With regards to non-communicable diseases (NCDs), an umbrella approach is being adopted that shall enable the health system to obtain a better picture of the risk factors for, as well as overall burden of NCDs in the country.

However, there is still more to be done. Major concerns are noted with regards to the increasing maternal mortality, which has almost doubled between the Namibia Demographic and Health Surveys (NDHS) in 2000 and 2006-07. Malnutrition amongst children remains high, and continues to be a major underlying cause of death in the under-five age group. Droughts result in poor food production and floods precipitate other health-related challenges, which are exacerbated by the poor sanitation in rural settings. WHO has prioritised this aspect and shall continue to mobilize as many resources as possible to address it. With respect to communicable diseases, HIV/AIDS continues to be the leading cause of death with diarrhoea, tuberculosis and pneumonia also contributing significantly to mortality. Environmental health remains a challenge due to the inconsistent coverage of safe water and sanitation across the Regions.

This report highlights WHO's work in Namibia in 2008. It is divided in six sections: Section 1 presents the context of the Namibia health sector, with its profile, challenges and prospects. Section 2 informs about the geography of the country, population numbers and breakdown, economic situation, and political and administrative structure. It also highlights some health issues affecting the societal structure. Section 3 outlines the current health care system in Namibia and the national policy environment, – the national goals and strategies' linkage to the health sector and budgetary allocations. WHO's global mandate, priorities identified for the African region and strategy for Namibia are all explained in Section 4. Section 5 describes the country's health sector interventions and WHO's role in supporting the Namibian Government's initiatives, its activities and achievements. Finally, Section 6 addresses the conclusions that can be drawn from the earlier discussion and possible way forward for WHO's continued support to Namibia.

WHO's support to Namibia is guided by its strategic agenda that aims to:

- Improve performance of the health system to provide quality health services that are efficient and equitable;
- Reduce the burden of major communicable and non-communicable diseases, especially among poor and marginalised populations; and
- Enhance health promotion to reduce the major risk factors.

In the area of health systems strengthening, WHO has supported the Ministry of Health and Social Services (MoHSS) by providing technical and financial support, and facilitating national and regional activities. In 2008, WHO was part of the Health and Social Services Systems Review that contributed to the development of a strategic plan to guide MoHSS for the next five years.

Support was also provided for resource mobilization for the health sector initiatives and monitoring of progress. Global Fund has been one of the largest financial sponsors of HIV, TB and malaria interventions in the country since 2005. WHO made available technical assistance in the Global Fund Round 8 proposal development process, for development of the log frame for the activities of the proposal and finalization of the proposal. As regards monitoring progress, WHO served on the Steering Committee of the Government and UN agencies for the development of the second progress report on the achievement of the Millennium Development Goals.

Namibia currently faces some important challenges in improving maternal and child health. In this regard, WHO has provided assistance in the development of a Roadmap for accelerating the reduction of maternal and newborn morbidity and mortality. The Namibian Roadmap is guided by the generic WHO Roadmap template.

The provision of safe blood, blood products and services to meet the needs of all patients in a timely and cost-effective manner is a vital responsibility of any Government. Together with PEPFAR, WHO has been instrumental in strengthening the National Blood Programme of Namibia by providing technical support to develop blood safety policies, regulations and blood services infrastructure in the country. WHO has supported strategies to promote appropriate clinical use of blood and blood products and reduce unnecessary transfusions.

WHO support has been extended to reduce the burden of the major communicable diseases, HIV/AIDS, TB, malaria, polio and measles. WHO's support towards mitigating HIV/AIDS challenges is aligned to the Medium-term Plan 3. The Organization has supported advocacy for behaviour change; together with other partners it helped organize the country's first Male Conference on HIV/AIDS. WHO also provided funding and technical support for an etiological study on sexually-transmitted infections (STI) and technical support for the revision of the national guidelines on the syndromic management of STI. Other support in this area included revisions of the HIV Testing and Counselling Guidelines to include Provider-initiated testing and counselling, coordination of activities to promote and implement medical male circumcision, implementation of HIV drug resistance monitoring and surveillance.

Northern Namibia is a malaria endemic area. For malaria control, WHO support was extended through the National Vector-borne Disease Control Programme (NVDCP). With the support of WHO, health workers received training on malaria database management and Environmental Health Officers in vector control and planning.

Namibia is one of the three countries in the world with the highest case notification rates of tuberculosis (TB) in 2008. The national TB control initiatives are seen to be effective as the prevalence numbers are declining. Nevertheless, prevalence remains unacceptably high. In 2008, the country faced an additional threat with the emergence of multi drug resistant TB (MDR-TB) and extensively drug resistant TB (XDR-TB). WHO's support in 2008 to the TB programme was mainly related to the provision of technical assistance to address the MDR-TB and XDR TB.

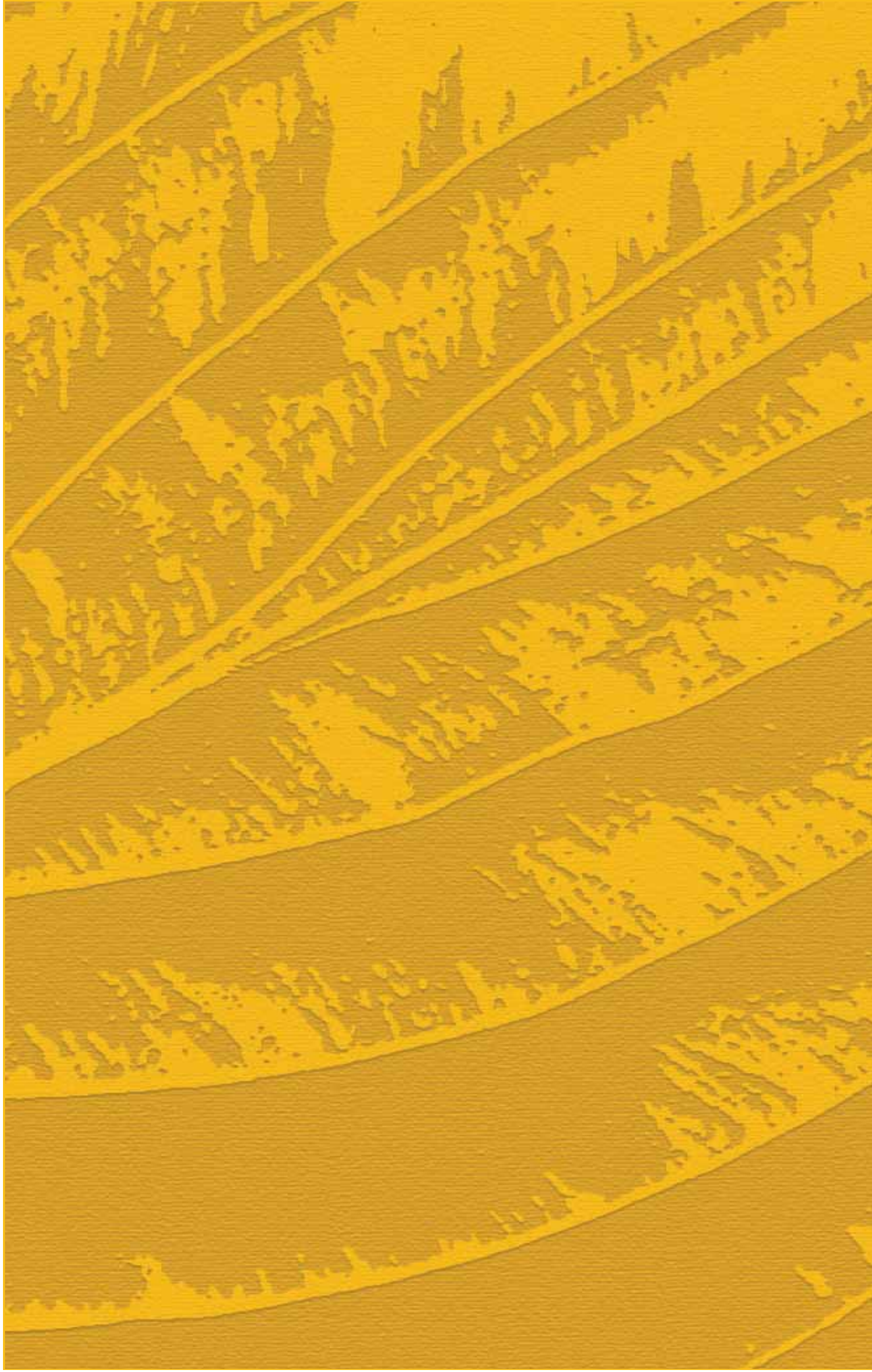
WHO has been supporting child immunization in Namibia for several years,including eradication of polio. Three Stop Transmission of Polio teams provided support for training and supervision of health personnel at regional and district levels.

For measles control, WHO works with the National Institute of Pathology measles laboratory by providing technical support, equipment and reagents required for diagnosis of the disease and maintenance of accreditation standards.

As regards non-communicable diseases, WHO helped conduct a survey to assess the risks factors associated with such diseases.

The year 2008, saw heavy flooding in the northern Regions of Namibia. WHO, alongwith other UN partners promptly responded to the emergency needs. The floods saw the outbreak of cholera in some parts of the country. WHO provided immediate technical assistance to control the spread of the epidemic, including supporting cross-border collaboration, as some of the neighbouring countries were experiencing floods and similar cholera outbreak.

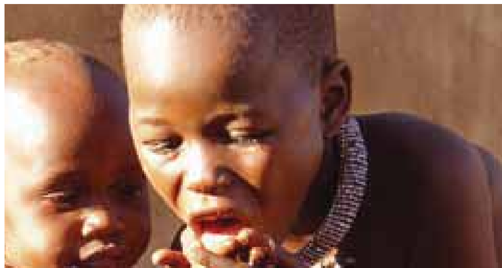
It is noted that Namibia faces a general challenge of limited human resource capacity to implement health sector programmes. Support was provided to the University of Namibia to finalize the process of establishment of a Medical School. WHO will continue to provide technical assistance in order to build human resource capacity at both technical and management levels, and achieve overall improvement and strengthening of the health systems.



Section 1

Introduction

Section 1



Introduction

The provision of quality and equitable health care services to all Namibians is one of the country's development priorities. Health is identified as being critical to the national development agenda and is one of the priority strategic areas in the country's key development document, Vision 2030.

Namibia faces several health challenges including a high HIV prevalence, one of the highest in the sub-Saharan African region. Namibia has high tuberculosis (TB) incidence that has seen it ranked as one of the four countries in the world with the highest TB estimated incidence in 2008. The steady increase in maternal mortality ratio (MMR) over more than 15 years is a challenge for the achievement of Millennium Development Goals (MDGs).

Health facilities are under pressure to respond to the country's growing health needs, while the human resource base of the health sector continues to lag behind the national health needs. This challenge is largely a result of the fragmented health care delivery system that was inherited at Independence from the South African Apartheid regime.

Shortly after Independence, a Primary Health Care (PHC) approach was adopted as the focus-orientation for the public health care system. The country has clear national and disease-specific policies, and over the last five years[1] has been one of the few countries in the African Region allocating on average 12.28% of total government expenditure to health. However, the intertwined burden of the HIV/AIDS and TB epidemics have required significant attention and placed additional strain on existing resources. As such, Namibia has had to draw from the support of development partners. Significant resource mobilization efforts have been successfully undertaken, and progress in various aspects of health has been noted.

WHO is a key partner in the health sector. Its comparative advantage lies in its scientific and technical knowledge, its neutral status, and convening power, drawn from its nearly universal membership.

WHO uses its technical knowledge to develop models of best practices that build on years of multi-country experience, in a manner that allows countries to customise responses to suit the local environment. Namibia benefits from this expertise and technical knowledge, enabling the country to design and implement its health programmes more effectively and efficiently.

This report aims to present the support that WHO has provided to the country in 2008. The support is typically continuous, long-term and sustained. Therefore, it is impossible to appreciate the current progress without acknowledging interventions implemented in the previous years as well as the partnerships that have contributed towards successful implementation of these interventions. Although the focus is placed on the support provided to Namibia's national health response in 2008, the report also provides contextual information on the support that preceded and influenced the outcomes of the period under review.

"The provision of quality and equitable health care services to all Namibians is one of the country's development priorities."

NOTES:

Section 2 • Geography, Demography, Social, Political and Economic Context

Section 2

"Namibia is located in the south-western part of Africa and covers a surface area of approximately 825,000 square km."

Geography, Demography, Social, Political and Economic Context

2.1 Geography and Demography

Namibia is located in the south-western part of Africa and covers a surface area of approximately 825 000 square km. The country shares borders with Angola, Zambia and Zimbabwe in the North, Botswana in the East and South Africa in the South. The Atlantic coastline makes up the western border. Namibia comprises three major geographic regions - the Namib Desert, the Central Plateau and the Kalahari Desert.

Namibia is one of the driest countries in Africa. However, the northern parts have a sub-tropical climate, particularly the areas bordering the Kavango and Kunene rivers. Average temperatures range between 9°C and 30°C in summer, and between -6°C and 20°C in winter[2].

The country has one of the lowest population densities in the world, reported at 2.2 persons per square km. The 2001 Population and Housing Census recorded a population of 1 830 330 and an annual population growth rate of 2.6%. The country is largely rural with only a third of the population reportedly living in urban areas. This sparsely and scattered population distribution presents administrative challenges, particularly with regards to providing equitable access to social and health services.[3] Namibia has a relatively young population with people under the age of 15 years comprising about 43% of the total population.

The average life expectancy at birth is 51.6 years; 50.9 years for males and 52.2 years for females.[4] The current life expectancy is about 10 years lower than the 1991 estimates, when aggregated life expectancy was 61 years (59 and 63 years for males and females respectively).[5] This decline is largely attributable to increased mortality associated with the HIV/AIDS epidemic since 1996. Life expectancy is projected to remain below the 1991 levels until after 2021, even if HIV/AIDS related mortality is expected to have peaked. Figure 2 illustrates the decreasing trends in life expectancy in Namibia and three other countries in the Southern African region that are similarly affected by the HIV/AIDS pandemic.

Figure 1: Namibia's geographical location and administrative Regions

2.2 Social Context

According to the NDHS 2006-07, under-five mortality and maternal mortality are on the increase, although the increase on the former is considered not to be of statistical significance. The same document estimates MMR at 449 per 100 000 live births, up from 271 per 100 000 live births in the 2000 NDHS[6].

The under-five mortality rate is estimated at 69 per 1000 live births, which is slightly up from 62 per 1000 live births reported in the 2000 NDHS[7]. Malnutrition is high in Namibia and has contributed to the increase in childhood mortality. Three in ten children under five years of age are stunted while one in ten are severely stunted. Overall, 8% of children under five are wasted, 17% are underweight while 4% are severely underweight[8].

Namibia also has a high number of orphans and vulnerable children (OVC). According to the 2001 census, approximately 97,000 children under the age of 15 had lost one or both parents. This number is projected to reach 250,000 by 2021[9]. The HIV/AIDS epidemic is said to be responsible for the increasing number of orphans in Namibia. According to estimates from a UNICEF Inception Report entitled, "A Situation Analysis of Orphan Children in Namibia", by 2006, AIDS orphans would comprise three-quarters of all orphans in the country.

Government estimations are that 1.2 million people live within 20 kms of a public health facility[10], leaving a sizeable portion of the population relatively far out of reach of health services. The provision of outreach services is therefore critical. To address this, 1,150 outreach points have been established across the country to provide basic health services[11].

The Third National Development Plan (NDP3) reports that Namibia is one of the top eight countries in the world that has the highest public expenditure on education. Significant sums are spent every year on this sector. Adult literacy in 2005 was reported to be 83.9%. The Second National Development Plan (NDP2) achievements as reported in the NDP3, indicates net enrolment in primary education as standing at 93.6%, although the completion rate was only 75.6%.

However, education is one of the country's biggest development challenges, largely due to effects of the dual education system that existed under Apartheid. The challenge is the quality of education that is provided from early childhood and pre-school levels to tertiary levels. The other issue is the insufficient level of training of technical resources that are required to satisfy the country's growing educational needs.

2.3 Political Context

Namibia attained Independence in 1990, after being governed by Germany in the early 20th century, and then later by the South African Apartheid regime. Today, Namibia is a politically stable country with a multi-party system in place that has seen four elections since Independence.

Namibia has an Executive that comprises the President, a Prime Minister and Cabinet Ministers. The Judicial system is based on Roman Dutch law that was inherited from South Africa, and the structure includes a Supreme Court, High Court and Magistrate courts. The Legislature is bicameral and includes National Council members from Regional Councils, and the National Assembly. The country is transitioning towards decentralisation through an administrative structure that comprises 13 Regional governments.

Apartheid effectively excluded the majority of Namibians from the productive/formal economy resulting in limited advancement of the majority of the population.

The dual administrative system offered under Apartheid limited social, economic and political opportunities to non-white groups in terms of employment, education, health care, etc. As a result, Namibia today grapples with significant social and economic disparities which translate into socio-economic challenges (high poverty, illiteracy, poor access to sanitation, etc.) that all demand immediate attention.

2.4 Economic Context

Namibia ranks 65 out of 175 countries on annual per capita income (US$1,800) and 124 on the Human Development Index (HDI). In Africa, the country has the fifth highest per capita income and the 11th highest HDI[12]. However, the country also has one of the largest income disparities in the world. According to the 2003/2004 Namibia Household Income and Expenditure Survey (NHIES), Namibia's gini-coefficient is 0.63. This reflects the significant gap between the more and less privileged people in society. This again is largely due to the country's history with Apartheid, that saw the majority of the population being deprived of equal social and economic development opportunities for decades.

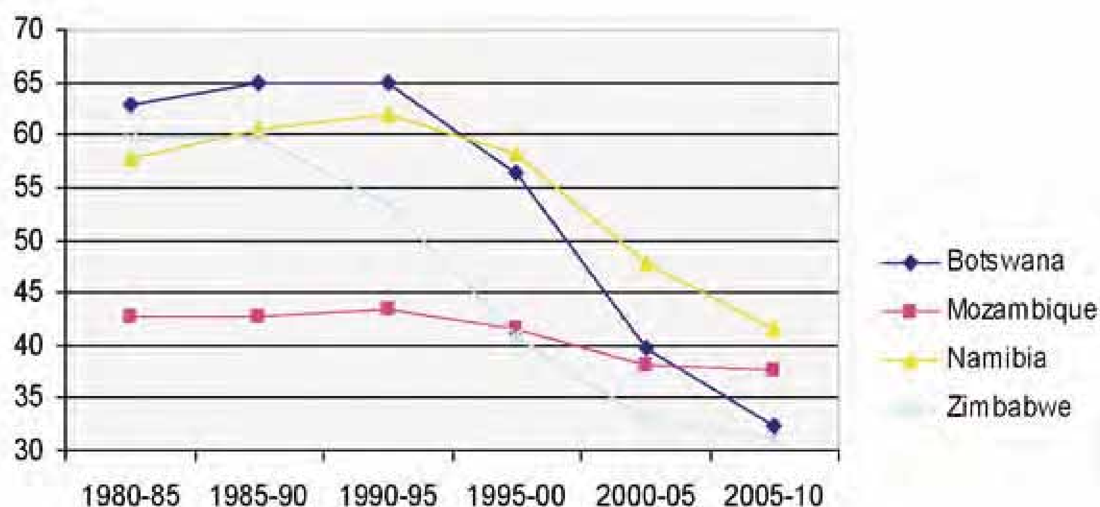
As a result, the country is faced with high rates of rural poverty[13] and unemployment, which reportedly was as high as 36.7% in 2004[14]. It is estimated that about 34% of the Namibian population live on less than US$1 a day and about 55% on less than US$2 a day. According to recently released statistics by the Central Bureau of Statistics that applied the Cost of Basic Needs approach, Namibia's proportion of poor people is 27.6% and the severely poor comprise 13.8%[15].

The country comprises two economies: the more formal and modern economic sector that includes mining, livestock production and fishing, and the informal, subsistence sector consisting of agriculture and herding. The formal sector provides the majority of the country's earnings. In 2007, Namibia's economy expanded by 3.8%, which was down from the 4% increase noted in 2006[16]. The gross domestic product (GDP) earnings for 2007 stood at N$49.6 billion up from N$46.3 billion in 2006[17]. This was largely boosted by the Southern African Customs Union (SACU) earnings which resulted in a surplus of balance of payments. The receipts from SACU contribute significantly towards Namibia's GDP. In 2007 these comprised close to 45% of the country's earnings[a]. With Namibia being one of the world's largest exporters of diamonds and uranium, mining accounts for approximately 12% of the country's GDP. Tourism is also one of the country's expanding sectors contributing significantly to the GDP. It increased by 9.3% (real growth) in 2007[18].

In the last decade, the country has generally exhibited positive growth, largely due to increasing global demands for minerals. However, according to the IMF, the country's economic growth is expected to slow to about 3% in 2008 and 2% in 2009, because of weakening demand for mineral exports[19].

According to the Bank of Namibia 2007 Annual Report, the average annual inflation for the year 2007 increased to 6.7%, up from 5.1% the previous year, largely as a result of increasing food prices and the volatility of oil prices[20]. More recent data, that takes into consideration the current turbulence in the global financial market, showed the annual rate of the Consumer Price Inflation at 9.7% in May 2008[21].

Figure 2: Changes in life expectancy in four Southern African countries from 1980-85 to 2005-10



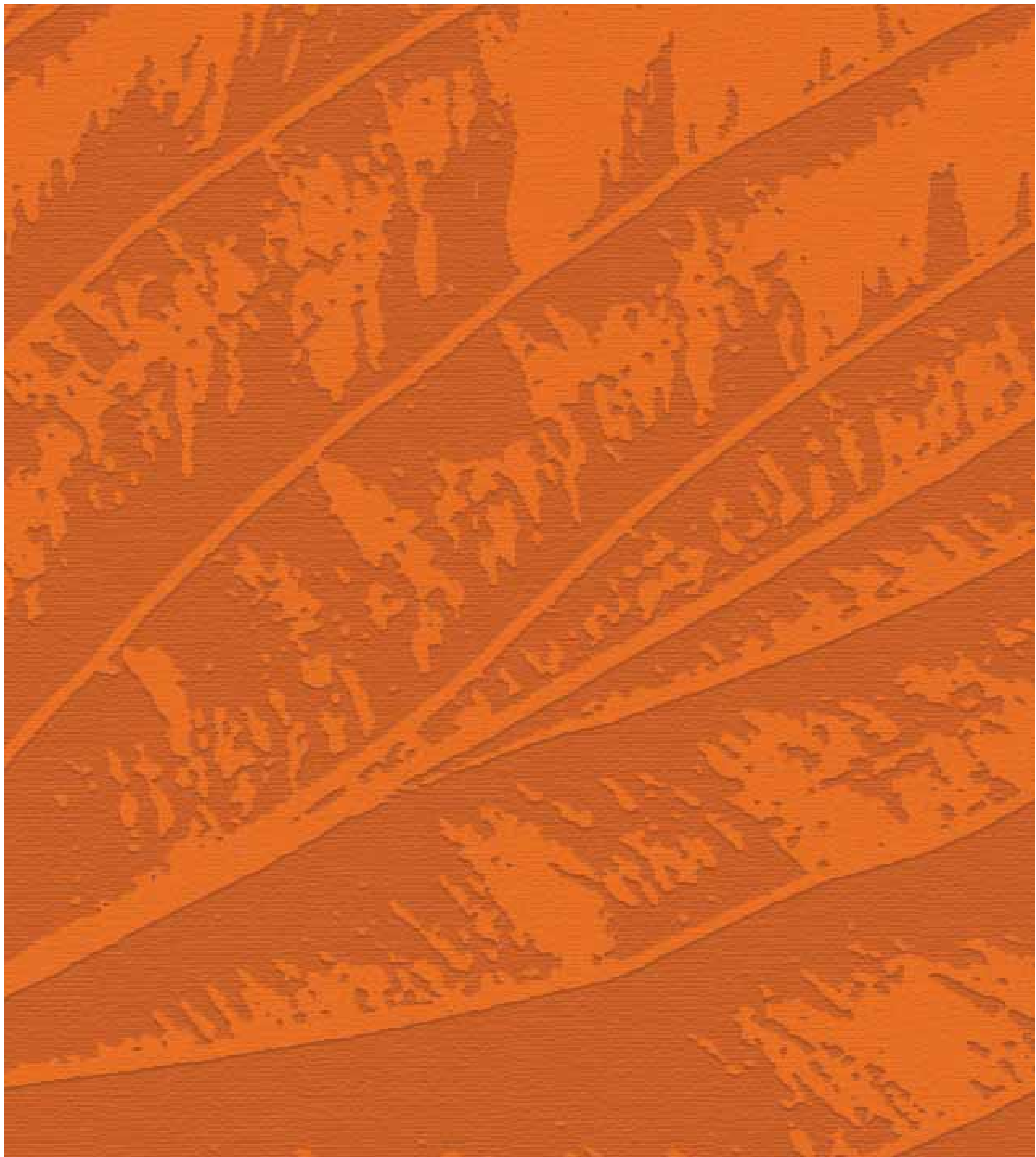
Source: UN DESA/Population Division 2007; Projection made by the mid-term review team

[a] Namibia is part of the five-member Southern African Customs Union, a regional block within which no tariffs are placed on goods produced and traded within Member States. Earnings from imports are shared amongst Member States.

NOTES:

Section 3

National Policy Environment and Resources



Section 3

"A prosperous and industrialised Namibia, developed by her human resources, enjoying peace, harmony and political stability".

Vision 2030

National Policy Environment and Resources

3.1 National Goals, Objectives and Strategies, and their Linkages to the Health Sector

In order to address the country's various development challenges, the Government has developed the Vision 2030, which is a national long-term strategy document that lays down strategic interventions on a sector-by-sector basis. The country's national vision is to have attained by the year 2030: "A prosperous and industrialised Namibia, developed by her human resources, enjoying peace, harmony and political stability". It is obvious that a healthy population is both a contributor towards the attainment of this vision, as well as part of the vision itself. Undoubtedly therefore, health is a national priority for Namibia.

Vision 2030 specifically aims to improve the quality of life and life expectancy from 49 years to 61 years. The document states that "access to quality health care is an important component of the overall health system, and improved access facilitates overall development and enhances quality of life".

The NDP 3 – the country's third five-year strategic development plan covering the period 2008 to 2012 – identifies health as being crucial for the attainment of the country's long term vision, as articulated in Vision 2030. The Plan therefore includes a section that addresses health and the goal over the next five years is to provide "affordable and quality health services to all".

WHO's support to Namibia is geared towards the attainment of the objectives defined in Vision 2030 and NDP3, by supporting the national programmes that are implemented by the MoHSS and its partners. It contributes towards several NDP health indicators that are used to track progress in this sector, specifically those on measles vaccination, reducing under-five mortality, improving TB treatment success rates, increasing access to prevention of mother-to-child transmission of HIV (PMTCT) services and improving STI treatment, among others.

The second generation Country Cooperation Strategy document of the WHO, currently under development, will detail how the Organization's support dovetails into the national strategic documents.

3.2 National Health Policy Environment

The MoHSS is responsible for the development of national health policies and strategies, which are implemented through an integrated and decentralised health system that includes 13 Regional Management Teams and 34 District Health Teams. Civil society organizations have also increased their involvement in the implementation of health-related programmes by enhancing community-based interventions in education and sensitization, patient care and treatment.

As indicated earlier in this report, the focus of the Namibian public health care system is Primary Health Care (PHC). The Namibian Government launched the PHC approach for health service delivery shortly after attaining Independence. In 1992, a PHC policy was developed, mandating the MoHSS to undertake management and operational changes to facilitate the implementation of the PHC system. This led to the adoption of the decentralised operational structure described above, that empowered Regions to take responsibility for identifying and addressing their respective health needs. Following this, a National Health Policy was published in 1995. This policy emphasised a PHC approach.

A policy framework - "Towards achieving Health and Social Well-being for all Namibians" - was developed in 1998, which further defined overall goals of the health sector and emphasised the principles of equitable access, affordability and community involvement. These same concepts, values and principles are reflected in Vision 2030.

Since then, several national policies have been developed for various health aspects; for instance, occupational health, blood transfusion, HIV/AIDS and reproductive health among others. WHO has been instrumental in supporting the development of several of these policies as is indicated in Section 5 of this report.

3.3 Health Care System in Namibia

Health services in Namibia are provided through the public health sector and the faith-based organizations on one hand, and the private sector on the other. The majority of Namibians (85%) depend on the public health sector for health care services[22].

At the national level, health programmes are managed under the auspices of the MoHSS. The Ministry is currently planning a review of its organizational structure. However, as of December 2008, the Ministry was structured into functional units (six Directorates) that enable it to execute its mandate.

The MoHSS structure is as follows:
- Primary Health Care
- Special Programmes
- Developmental Social Welfare
- Tertiary Health Care and Clinical Support Services
- Policy, Planning and Human Resource Development
- Finance and Logistics
- 13 Regional Directorates

The management of public health programmes is decentralised and is under the responsibility of the 13 MoHSS Regional Health Directorates that cover the country's 34 districts.

The health facilities in Namibia are categorised into six classes: central referral hospital, intermediate hospitals, district hospitals, health centres, clinics and mobile clinics/outreach services. Serious health conditions are treated at the Central Referral Hospital in Windhoek and intermediate hospitals located in Oshakati, Rundu and Windhoek. The district hospitals and health centres offer secondary level care as well as primary care. Clinics and outreach services offer only primary care. In 2007, there were 30 district hospitals, 44 health centres and 265 clinics[23].

The public health system's activities are augmented by non-governmental and private sector institutions. The former include religious bodies and civil society organizations that play a significant role in terms of community-based interventions, for instance with regards to the roll out of the TB Directly Observed Treatment (TB-DOT) programme and community and home-based care (HBC) programmes for HIV positive people. In some instances, these organizations receive funding from the Government; in which cases planning and reporting would be conducted with and to the MoHSS.

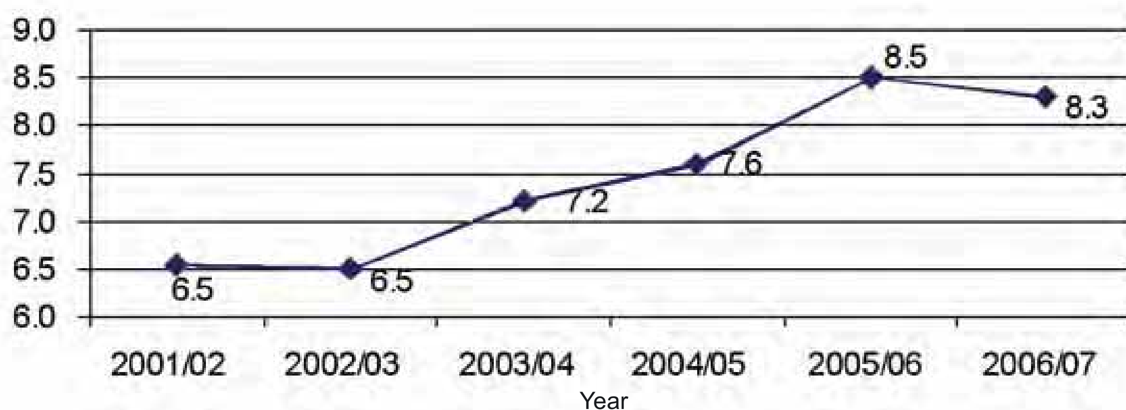
The private sector, which is regulated by the Hospital and Health Facilities Act of 1994, also plays an important role in the provision of health care services to Namibians. A total of 844 private health facilities were registered with the MoHSS in 2006. These comprised 13 hospitals, 75 primary care clinics, eight health centres, and 75 pharmacies. According to the 2008 NHA Report, 22% of the population that accessed health services in the period 2006/07, did so at private facilities.

3.4 Financial Allocations by Government and Key Development Partners

The key financial contributor towards development initiatives in the country is the Government of the Republic of Namibia. Government spending is provided for in the Medium Term Expenditure Framework (MTEF), which shows Government expenditure by sector. For the period 2006/07 to 2008/09, the Ministry of Finance has allocated 10% of the national budget to health, slightly lower than the 15% target set by the Abuja Health Ministers' Declaration[24]. A large proportion of this spending is dedicated to the provision of anti-retroviral therapy (ART) for HIV positive people, maintenance of health facilities and equipment, and the hiring of human resources for the health system.

Namibia is classified as a lower middle income country, a status which affects its access to Overseas Development Assistance (ODA). Budgetary contributions of ODA are minimal, standing at less than 1% of the national budget. Over the last few years, the country has seen the exit of several key development partners. Some of them were significant contributors towards health interventions, particularly the British and the Dutch development cooperation agencies. In spite of this, the country has managed to secure support from some other international development partners and thus increased assistance towards health expenditure.

Figure 3: Health expenditure as a percentage of GDP



Source: 2008 National Health Accounts Report, MoHSS

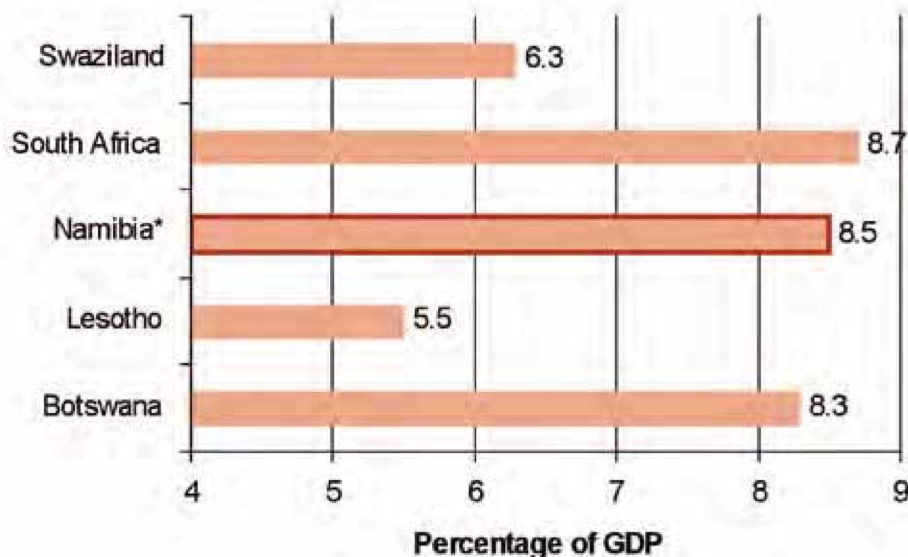
The key ODA contributors towards the health sector and its associated programmes include the following:

- The US *President's Emergency Plan for AIDS Relief (PEPFAR)* country programme for Namibia is the largest development partner programme sponsoring HIV/AIDS interventions. The programme commenced in 2004, when it provided US$24.5 million. In 2005, Namibia received US$42.5 million, in 2006, US$57.3 million and in 2007, US$91.2 million. The budget for the year 2008 is US$108.9 million. Support mainly goes towards health systems strengthening, behaviour change, prevention and treatment programmes, as well as HIV-related TB interventions. Most of the United States Government (USG) support towards HIV/AIDS and TB is financed through PEPFAR.

- The *Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)*: The largest grant is the Round 2 HIV/AIDS grant, amounting to approximately US$104 million. This supports the key strategies listed under the third Medium Term Plan for HIV/AIDS (MTP3), with the largest financial allocation going towards the ART programme. The country also won two TB grants under Rounds 2 and 5 amounting to US$18.5 million. The first TB grant aimed to strengthen the National TB Control Programme, while the second TB grant aimed to facilitate the expansion of the country's community-based interventions for TB. The two malaria grants were won under Rounds 2 and 6 worth US$20.6 million. The first grant aimed to strengthen the NVDCP and facilitate the roll-out of key malaria prevention strategies – the use of bed nets and household spraying. The second malaria grant is to assist the country to scale-up the two prevention strategies as well as facilitate the roll-out of the new treatment policy using Arthemeter-Lumefantrine.

- The *United States Agency for International Development (USAID)* and other United States Government (USG) partners (such as *Centers for Disease Control and Prevention* (CDC) and the Department of Defence) provide support to reproductive health programmes and health systems strengthening. In addition to implementing programmes under the PEPFAR programme, these institutions provide technical assistance that support national health interventions. The Centers for Disease Control and Prevention has been instrumental in supporting the National Blood Programme (NBPr), and more recently assisting the MoHSS to manage the emergence of Multi and Extensively Drug Resistance TB (M/XDR).

Figure 4: GDP percentage allocation towards health among SACU countries



Source: 2008 National Health Accounts Report, MoHSS

- The *German Technical Cooperation (GTZ)* and its affiliated agencies (*KFW, DED,* etc.) support HIV/AIDS initiatives through the Integrated HIV/AIDS Control Programme that provides cross-cutting HIV/AIDS support in the sectors they are involved in, that is, environment and tourism, promotion of the economy, land reform and transport.

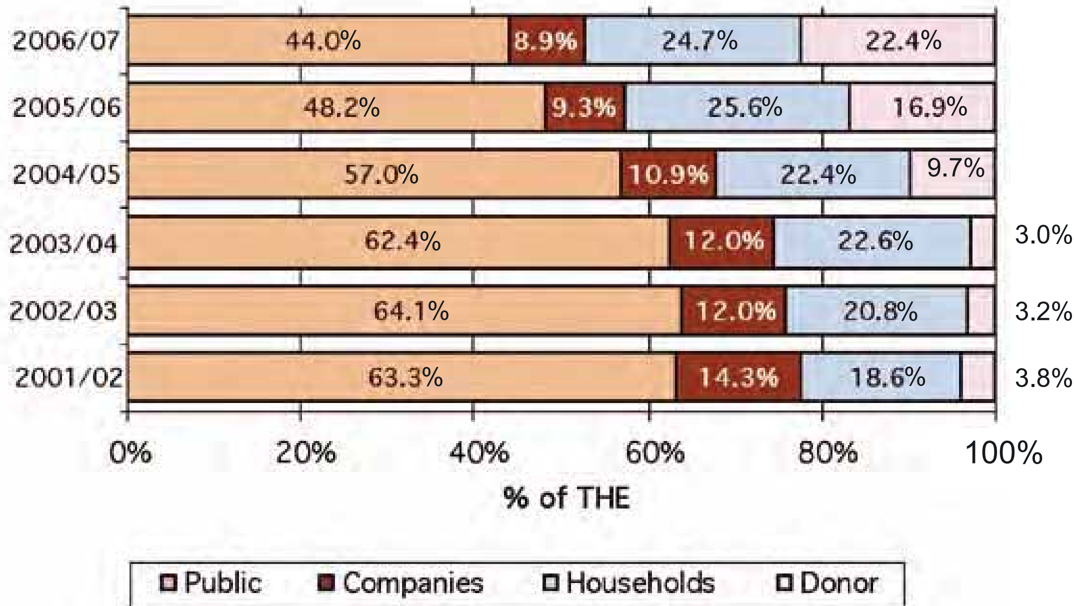
- The *European Union*, under the ninth European Development Fund, allocated Euro53 million for the period 2005 to 2008 towards rural development. The aim is to make significant investments in infrastructure development and incorporate HIV/AIDS interventions, gender and environmental management as cross-cutting issues.

- The *United Nations Children's Fund's (UNICEF)* largest intervention relates to improving young Namibians' life skills which incorporates HIV/AIDS, gender and cultural issues. Together with WHO and UNFPA, UNICEF supports HIV/AIDS and PHC interventions that target women and children. The organization also supports community capacity strengthening interventions for improved livelihoods that adopt child-centred approaches. UNICEF's financial allocation over the UNDAF period is US$25 million.

- The *United Nations Populations Fund (UNFPA)* supports the implementation of HIV/AIDS policies and strengthening of national capacity related to gender and reproductive health rights, which includes, working with key partners such as the relevant Government ministries responsible for health, gender and education. It also supports interventions to better monitor and respond to poverty needs, and the strengthening of PHC efforts amongst women and children. The allocated budget for these interventions is US$8.2 million.

- *WHO* mainly provides technical assistance by availing technical experts for the development of policies, guidelines and standards as well as training of health workers in order to strengthen the MoHSS' capacities for the successful delivery of programme interventions. Key support is provided to health systems strengthening, and various communicable and non-communicable disease prevention and control programmes. These include HIV/AIDS, TB, malaria, polio eradication initiative, immunization, epidemic preparedness and control among others. Catalytic resources to be channelled towards these interventions are scheduled to amount to US$10.6 million over the period 2006 to 2010.

Figure 5: Financial contribution towards Total Health Expenditure by funding source



Source: 2008 National Health Accounts Report, MoHSS

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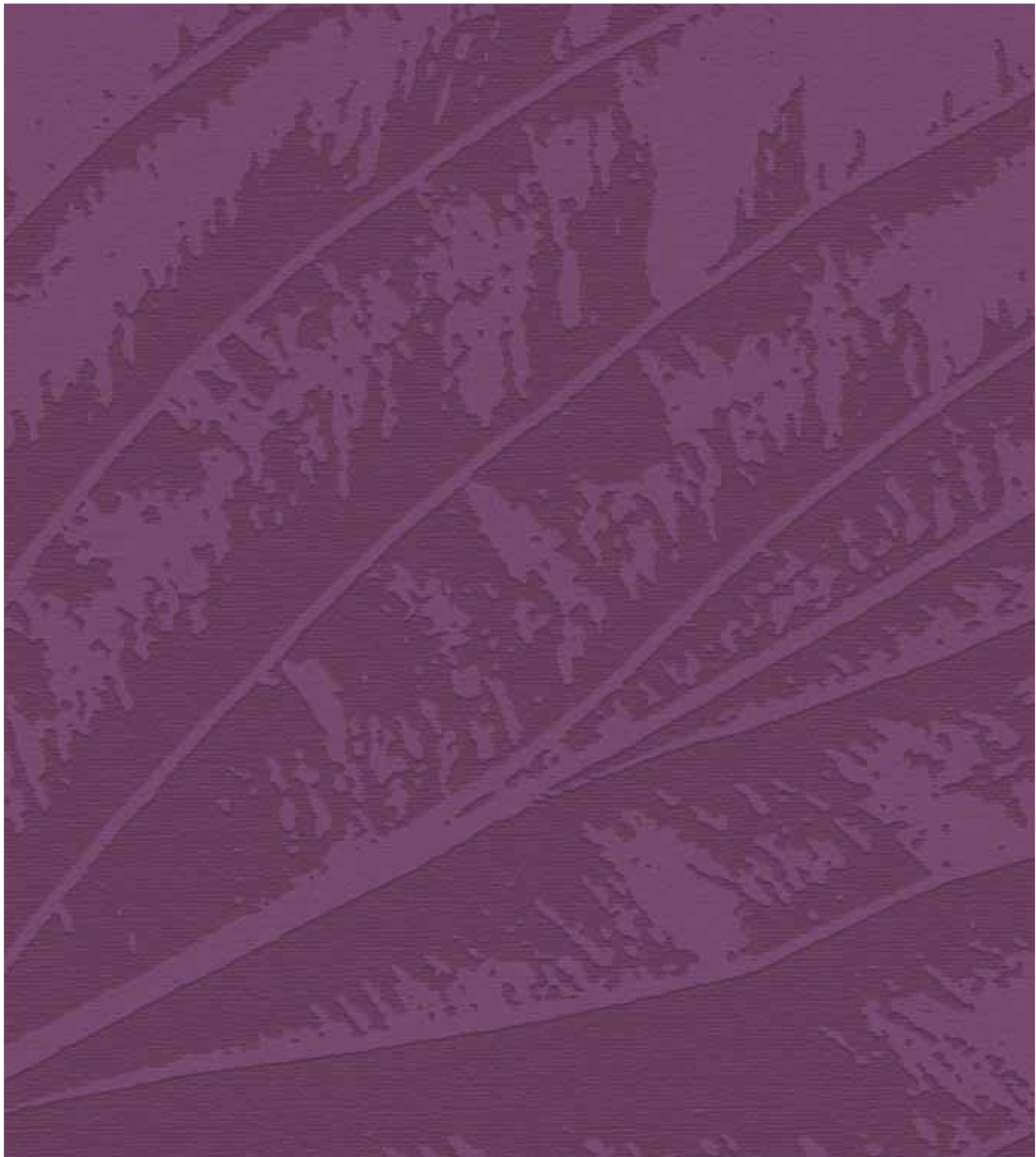
Section 4

WHO's Strategic Framework



Section 4

The Global Health Agenda as stated in the WHO's Eleventh General Programme of Work 2006-2015 includes seven priority areas[26]:

- **Investing in health to reduce poverty;**
- **Building individual and global health security;**
- **Promoting universal coverage, gender equality and health-related human rights;**
- **Tackling the determinants of health;**
- **Strengthening health systems and equitable access;**
- **Harnessing knowledge, science and technology; and**
- **Strengthening governance, leadership and accountability.**

WHO's Strategic Framework

4.1 WHO's Mandate and Priority Support Areas

Globally, WHO's mandate has been defined as follows[25]:

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

The WHO Global Health Agenda is also relevant to the WHO's Country Office strategic agenda for Namibia. These are the guiding principles for the Organization's operations within the country and WHO Namibia provides support to the MoHSS and other implementing partners in the context of the above-defined mandate and priority areas. These areas are typically addressed in a broad sense, although in some instances, specific interventions have been developed for some of the priority areas. As an example, the WHO Namibia's support towards the health systems review process, as well as the targeted support to the first ever HIV/AIDS Men Conference that was deliberately meant to strengthen leadership, participation and accountability in this area.

There are five strategic orientations for the African region, for the period 2005-2009:

- Strengthening WHO's support to countries;
- Strengthening and expanding partnerships for health;
- Strengthening health policies and systems;
- Promoting the scaling up of essential health interventions and;
- Enhancing response to the key determinants of health.

4.2 WHO Country Cooperation Strategy for Namibia

The next Country Cooperation Strategy (CCS) for WHO support to Namibia is under development. However, the 2008 interventions were aligned to the preceding CCS which covered the period 2004 to 2007. The CCS aimed to enable the WHO to use its comparative advantage to promote a strategic agenda that contributes to:

- Improved performance of the health system to provide quality health services that are efficient and equitable;
- Reduce the burden of major communicable and non-communicable diseases, especially among poor and marginalised populations; and
- Enhance health promotion to reduce the major risk factors.

The above elements guide and shape the operational framework within which the Country Office provided support to Namibia in 2008. These services are provided through six Units including the WHO Representative's Office, Disease Prevention and Control, HIV/AIDS Prevention, Treatment, Care and Support, Health Systems Development, Health Promotion, and Blood Safety.

NOTES:

Section 5

Progress in 2008

Section 5

"Steering health development towards improving the lives of the people requires informed decision-making and well-defined goals and strategies, focusing on tangible results."

Progress in 2008

WHO's support to the Namibia health sector for the prevention and control of communicable and non-communicable diseases, promotion of healthy lifestyles and health systems strengthening is predominantly channelled through the MoHSS. The Organization provides support for the implementation of various preventive and control interventions to the relevant Directorates.

The Directorate of Special Programmes (DSP) addresses HIV/AIDS, TB and malaria while maternal and child health (MCH), PMTCT, vaccine preventable diseases and non-communicable diseases are the PHC Directorate's responsibilities.

Support towards health systems strengthening (HSS) is provided through the Policy, Planning and Human Resource Development Directorate and the Tertiary Health Care and Clinical Support Services. The latter also encompasses the National Blood Programme.

5.1 Managing for Results: Health Systems Strengthening

The sustainable development of a nation is invariably a result of rational use of resources available to it. Steering health development towards improving the lives of the people requires informed decision-making and well-defined goals and strategies, focusing on tangible results. While Namibia has made demonstrable progress in making health services accessible, affordable and equitable, there are still considerable challenges towards improving the quality, effectiveness and efficiency of service delivery.

In 2000, WHO ranked Namibia at 189 out of 191 countries on health service efficiency noting that better quality of health outcomes could be achieved with the resources that were available to the system (WHO World Health Report, 2000 Report). The same report ranked Namibia at 66 out of 191 countries on health sector spending.

Cognizant of the challenges faced by the health system and the dangers of reversal in positive trends, WHO has called for the revitalization of PHC that goes beyond the perception of being a package of "interventions limited to poor people", to a basic strategy for the achievement of universal coverage and equity, responsive health system supported by appropriate national policies and with matching leadership that keeps pace with reforms.

A strong health care system is fundamental to the delivery of quality care to a nation's population. As such, the establishment of a solid national health system continues to be a priority for the Government of Namibia.

At global and regional level, WHO has provided guidance for nationwide integration and strengthening of health systems. In Namibia, the WHO Country Office has supported the MoHSS in the area of HSS by providing technical support, financing, supporting resource mobilization, providing catalytic and strategic support for the estabishment of the Medical School at the University of Namibia and facilitation of national and regional activities.

Highlights of specific interventions supported by WHO are presented below.

5.1.1 Health and Social Services Systems Review and Development of Strategic Plan

WHO, together with other partners, supported the MoHSS in undertaking the Health and Social Services Systems Review (HSSSR), which was completed in June 2008. This was the first exercise of this nature ever undertaken in the country's history. The review covered the Ministry's operational framework including organizational structures and functions, policies' coordination, human resources, service provision, infrastructure, support services, and financial planning.

As a member of both the Steering and Technical Committees, WHO provided support to the process, designed to ensure Government leadership and active participation of MoHSS staff, in order to facilitate capacity building. A framework was provided to develop the tools used for the review and training of the teams that undertook the field work.

Findings from the HSSSR constituted an evidence base for the development of a strategic plan which will guide MoHSS' interventions over the next five years. The MoHSS strategic plan provides a roadmap for the achievement of universal health care and service provision towards improved health outcomes.

5.1.2 National Health Accounts

Support was provided to the second estimation of National Health Accounts (NHA) for the financial years 2001/02 to 2006/07. This support included training of the core team members, data collection activities across the country, structuring and analyzing results.

The National Health Accounts Report provides information on distribution of funding and financial flows for the health care system from public, private and donor sources. The NHA is an important tool that provides evidence on resource allocations, health expenditure trends and assists national authorities in planning, allocation and disbursement of financial resources.

The current NHA report provides detailed information on the evolution of financing and health spending trends. It is recorded that the total health spending has doubled over the five year period of the study. The report also indicates that the share of public financing for health, the largest contributor to the health sector in Namibia, decreased from 63 to 44% of the Total Health Expenditure (THE) between 2001/02 and 2006/07. This is seen as a direct result of increased household expenditures on health (from 19% to 25%) and donor support (from 4% to 22%)[27].

5.1.3 Health, Poverty Reduction and Economic Development Project

A three-year collaborative project between the MoHSS, WHO and Government of Luxembourg on health, poverty reduction and economic development is currently being implemented. The proposal focuses on three identified aspects: **a.** development of pro-poor health policies, anchored in a sound health financing policy that will reduce the financial barriers to health services, and supporting the strengthening of national analytical and policy development capacities; **b.** the reinforcement and strengthening of national capacity for stewardship and donor coordination in MoHSS and National Planning Commission Secretariat (NPCS); and **c.** institutionalization of the system for tracking resource flows in the health system.

5.1.4 Stewardship and Partner Coordination

In furtherance of WHO's support for the strengthening of the stewardship role of the MoHSS, a dialogue has been initiated to provide assistance on partner coordination, harmonization and alignment, in line with the principles of the Paris Declaration and Accra Agenda for Action. A meeting between the Ministry and key partners in health in the country set the basis for the establishment of a mechanism for partner coordination, to be pursued in the years ahead.

5.1.5 Establishment of the School of Medicine at University of Namibia

Namibia faces tremendous human resources challenges, compounded by the inequitable distribution of health workers between the public and the private sector. In addition, skilled health workers are also scarce in the public health sector, taking into consideration the needs and the vastness of the country. According to the HSSSR, the national health worker capacity was of 3.0 health workers per 1,000 population, above the WHO benchmark. However, this represents in reality, a ration of 8.8 health workers per 1,000 population in the private sector, against 2.0 health workers per 1,000 population in the public sector.

To address this important challenge, the Government has embarked in the establishment of a School of Medicine, with support from WHO and other partners. WHO provided technical and financial support for the first feasibility study in 2003. This support continued over time and in 2008, WHO funded critical missions to finalise the processes towards establishing the School. A Steering Committee was put in place, and WHO is a member of the Technical Sub Committee, providing technical and strategic advice. The Technical Sub Committee was in charge of adopting the template of Curriculum consistent with international trends and standards; developing twining arrangements with regional Schools of Medicine; to prioritize the phasing of the implementation of the curriculum, among others.

5.1.6 MDG Progress Report

Namibia's development agenda is geared towards achieving the Millennium Development Goals. Working in partnership with development agencies, civil society organizations and other stakeholders, the Government of Namibia has been regularly monitoring its progress towards achievement of MDGs.

Health MDGs

Goal 4: To reduce child mortality;
Goal 5: To improve maternal health;
Goal 6: To combat HIV/AIDS, malaria, and other major diseases;

WHO supports the generation of reliable and timely data to assess progress on the health MDGs and other country and international goals, as well as to strengthen reporting mechanisms. WHO served on the Steering Committee of Government and UN agencies for the development of the second progress report on the achievement of the MDGs.

The eight Millennium Development Goals of the Millennium Declaration constitute a mutually reinforcing framework to improve overall human development. Three out of the eight goals, eight of the 16 targets and 18 of the 48 indicators relate directly to health. Health is also an important contributor to several other goals.

5.2 Maternal, Newborn and Child Health

The health status of mothers and children are a barometer of a country's health system and by extension its overall socio-economic development.

A wide range of measures exist across the life cycle from childhood, adolescence to reproductive age and beyond for women and their children to improve health, prevent and reduce health risks and increase survival. These are collectively referred to as maternal and child health care.

During the first decade after Independence, Namibia made tremendous progress in improving maternal and child health. Infant mortality was recorded at 103 per 1,000 live births and full immunization coverage at 26% before Independence (Primary Health Care Policy, 1990) compared to 38 per 1,000 and 65% respectively in 2000 (MoHSS Annual Report, 2005/6).

The gains made during the first decade after Independence have however started to show reversals (see Figure 6), due to a multitude of factors.

Looking at the current trends, Namibia is unlikely to achieve MDG 4 (reduction in under-five mortality by two-thirds by 2015) and MDG 5 (reduction in maternal deaths by 75% by 2015) unless concerted and scaled-up efforts are made by the Government and partners.

5.2.1 Maternal health

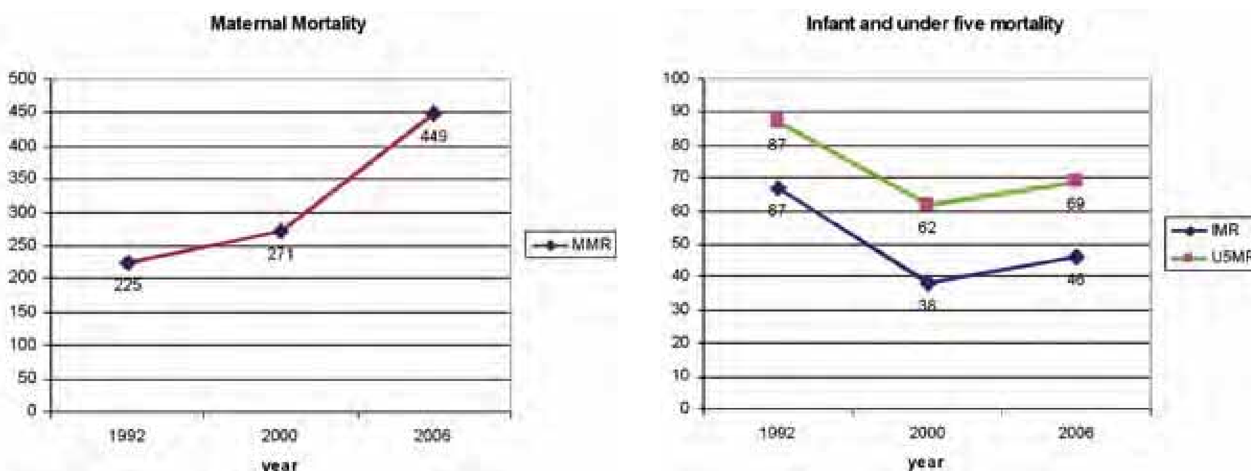
The Maternal Mortality Ratio (MMR) has increased to 449 deaths per 100,000 live births in 2006 from 271 deaths in 100,000 live births as reported in 2000[28]. The major causes of maternal death are severe eclampsia (33%), haemorrhage (25%), and obstructed/prolonged labour (25%). More recently, HIV/AIDS has emerged as the leading all-cause (both direct and indirect) of maternal mortality (37%) in health facilities[29].

The cumulative frequency distribution of maternal deaths during pregnancy and within postnatal period shows that a large proportion of maternal deaths occurred within the first four days after delivery[30]. These deaths, as childhood deaths, are largely preventable with currently available interventions.

Namibia has a robust health infrastructure and can mobilize the necessary resources to reverse these trends and commence a positive path that will ensure achievement of the maternal and child health related MDG goals.

Maternal health care is available for the vast majority of pregnant women in Namibia. Antenatal care from a health professional is available for 95% of pregnant women and 81% of births are delivered by a trained health professional[31]. This is far better than the situation in the Sub Saharan Africa where, in contrast, only 47% of deliveries occur in health facilities. While the proportion of deliveries attended by health workers in Namibia falls short of the targeted 88% for 2006, it is likely that the 2012 MDG target of 95% will be achieved.

Figure 6: Trends in maternal, infant and under-five mortality, 1992- 2006



Source: Namibia Demographic and Health Survey, 2006-07

However, the challenge is to ensure that the health workers are adequately skilled to assist pregnant women throughout pregnancy, during delivery and the post partum period. According to the EmOC needs assessment report of 2006, a significant proportion of health workers (both medical officers and midwives) lacked adequate knowledge and skills on the management of direct obstetric complications and nearly two thirds of direct obstetric complications remain untreated.

5.2.2 Child health

Both infant and under-five mortality rates are on a slight upward trend in Namibia. Between 2000 and 2006, the Infant Mortality Rate (IMR) increased from 38 to 46 deaths per 1,000 live births while the Under-five Mortality Rate (U5MR) increased from 62 to 69 deaths per 1,000 live births[32]. HIV/AIDS and malnutrition are reportedly responsible for this negative trend[33].

While these indicators remain much lower than those reported for the Eastern and Southern African region (IMR: 157 deaths per 1,000 births, U5MR: 131 per 1,000 births), and constitute a decrease from 1992 levels, they indicate stagnated progress towards achieving the MDG 2012 targets of 38 and 45 for U5MR and IMR respectively.

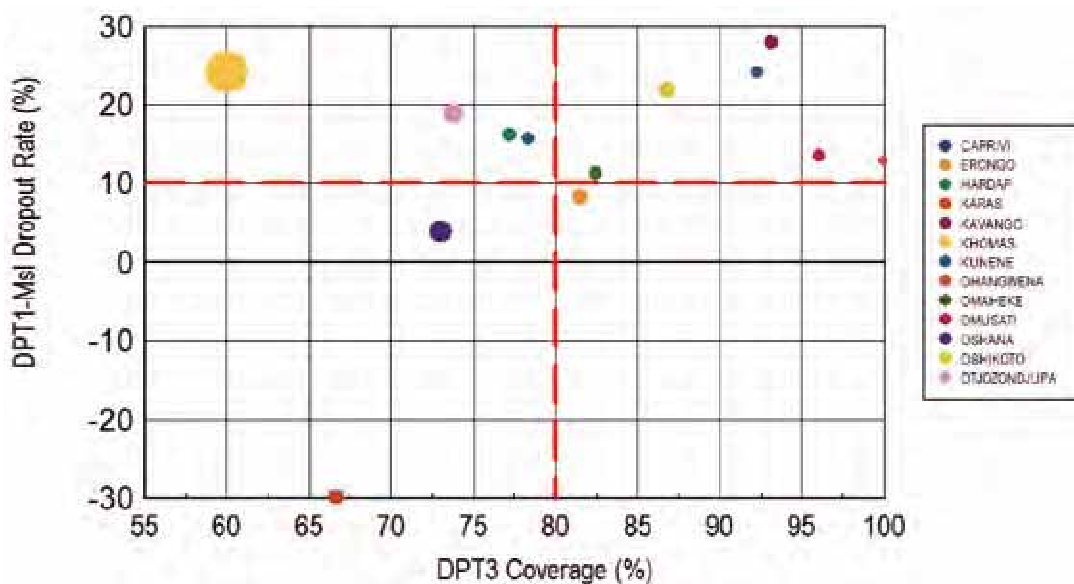
The prevalence of malnutrition among Namibian children is high and this is likely to have contributed to the stagnation in the reduction of childhood mortality. Three in ten children under five years of age are stunted and one in ten is severely stunted. Overall, 8% of children under five are wasted, 17% are underweight and 4% are severely underweight. There are regional disparities in malnutrition prevalence with six out of the 13 Regions having higher malnutrition than the national average. Malnutrition peaks at 12-23 months and declines as children approach their 5th birthday[34].

The major causes of child morbidity are diarrhoea (29%), acute respiratory infections (29%) and HIV/AIDS (8%) (MoHSS 2006-07 Health Information Systems). The same three conditions are the leading causes of child mortality (age 1 to under 5 years) with diarrhoea causing 35% of reported deaths and pneumonia and HIV/AIDS causing 24% and 8% of reported deaths respectively.

The high incidence of diarrhoea is likely due to poor sanitation (14% coverage in rural areas against a national coverage of 34%)[35] and hygiene practices especially in the populous northern Regions.

Over 90% of the children had at least four contacts with the health system during which they received vaccines to prevent common childhood diseases preventable by vaccination before their first birthday (NDHS, 2006-07), but only 69% of children aged 12-23 months are fully immunized.

Figure 7: DTP3 coverage by Region, 2008



Source: MOHSS/WHO

5.2.3 Roadmap for accelerating the reduction of maternal and newborn morbidity and mortality

The role of WHO in maternal and child health is providing quality technical advice and assistance, building capacity of national systems, catalyzing the adoption of technical strategies and innovative interventions, support towards research and development, policy and guidelines development, sharing information and advocacy.

In this regard, the development of a Roadmap for accelerating the reduction of maternal and newborn morbidity and mortality has been supported with evidence gathered from a national survey that assessed the coverage, access and utilization of maternal health services (Needs Assessment of Emergency Obstetric Care Services, MoHSS 2006). The Roadmap was further informed by the WHO generic Global Roadmap template. It outlines strategies, critical actions, stakeholder roles and accountabilities and costing towards the achievement of MDG 4 and 5. The Roadmap has been adopted by some Regions while others will need technical support for its operationalization.

To raise the profile of maternal and child health in the country, WHO's Assistant Director General for Family and Community Health, Ms Daisy Mafubelu visited Namibia and engaged in high level advocacy with senior Government policy makers on the need to invest adequate resources towards maternal and child health.

A National Conference on Maternal and Child Health has been slated for early 2009 to further raise the profile of maternal and child health and identify priority actions to be implemented by key stakeholders, to curb the current trend.

Other achievements specific to maternal and child health for the year under reference includes i) technical assistance in the documentation process towards Namibia being certified polio-free ii) support in monitoring the quality of the national immunization days iii) vaccine and cold chain assessment iv) strengthening the disease surveillance system, and v) strengthening routine immunization system.

5.2.4 Challenges to Maternal and Child Health

There is major under-funding for maternal and child health interventions, with more attention being given to HIV/AIDS, TB and malaria.

These three diseases, in addition to receiving the bulk of the funding, take on a larger share of the health workers' time and overburden the entire health system. As revealed by the recent NHA, investment in maternal and child health and family planning programmes decreased significantly from 44% to 3% between 2001/2 and 2006/7. This constitutes a worrisome trend and a threat to the achievement of the related MDGs.

Additional challenges are posed by the limited access of pregnant mothers to adequately skilled birth attendants, which compromise prevention and treatment of emergency and obstetric complications that can lead to death.

Child health is facing challenges related to malnutrition and limited access to immunization services in some regions and districts.

5.3 Blood Transfusion

Blood transfusion is a vital component of the health care delivery system of every country. It is the responsibility of the Government to ensure adequate, safe supplies of blood, blood products and services to meet the needs of all patients in a timely, cost -effective and efficient manner.

WHO advocates for Member States to promote national blood programmes based on voluntary non-remunerated donations, and to promulgate laws to govern their operations.

NAMBTS offices in Windhoek, Namibia

In 1994, the Regional Committee for Africa Resolution AFR/RC44/R12 urged Member States of the African region to take urgent steps to enact blood safety policies and mobilize resources for the development of the infrastructure of blood services in central and district hospitals.

The initiative to strengthen the National Blood Programme (NBPr) of Namibia was started in 2004 through a Cooperative Agreement between PEPFAR and WHO. The main aim of the project is to prevent the risk of transmission of HIV and other diseases through blood transfusion.

The Blood Safety Team is the core working group for the project and comprises representatives from the MoHSS, Blood Transfusion Service of Namibia (NAMBTS), the Namibia Institute of Pathology (NIP) and WHO.

WHO conducted a situation analysis in 2004 which revealed gaps in policy, legislation, organization, coordination and service delivery.

Table 1: Main players in blood transfusion

Institution	Role
Ministry of Health and Social Services	... is the Government body responsible for the stewardship and regulation of the National Blood Programme in the Republic of Namibia.
Namibia Blood Transfusion Service of Namibia	... has an obligation to ensure that safe products and related services are accessible to all patients in both the public and private sectors throughout Namibia.
Namibia Institute of Pathology	... plays an important role in providing hospital blood bank services to the medical community, using its comprehensive network of laboratories and trained staff.

The main areas of WHO's technical support provided in 2008 were in organizational and infrastructure development; the blood donor programme; laboratory testing and processing of donated blood; appropriate clinical use of blood and blood products; training and sustainability. The key activities supported by WHO in this area builds on support provided in previous years and are described below:

5.3.1 Organization and Infrastructure

As part of organizational and infrastructure development a series of activities were undertaken.

National Blood Policy and Implementation Plan

The NAMBTS is responsible for collecting, testing and supplying blood to all hospitals. The NBPr encompasses the NAMBTS, hospital blood banks (the majority of which are under NIP) and the MoHSS (both as the main user of the services in all Government hospitals and also the regulator of health services in Namibia).

The situation analysis at the inception of the collaborative project highlighted the need for a policy framework with the objective of defining the organizational, financial and legal measures relating to the establishment of an efficient, cost-effective and sustainable NBPr.

The resultant policy framework which was developed therefore, defines the measures that are to be taken to meet the transfusion requirements of the Namibian population through the provision of safe blood and related products and their appropriate use. The policy framework also needed legislative support. The various pieces of legislation were therefore consolidated into the current Blood Transfusion Bill to give the National Blood Policy legal effect. These instruments would afford the Government of the Republic of Namibia, through the MoHSS, a means of fulfilling its stewardship and regulatory role over all that participate in the NBPr to ensure adequate and safe blood supplies and appropriate clinical use of the national resource.

The legislation and the NBPr secure legal authority and ensure support for policy implementation, infrastructure development and resource mobilization at national and international levels. Equally, this strengthens the delegated responsibility and autonomy of the NAMBTS as a not-for-profit non-governmental organization. The policy further clarified the roles and responsibilities of all the health institutions involved in the blood transfusion chain - from blood donation under NAMBTS, hospital blood banks services under NIP in the majority of the hospitals, and clinical staff administering the transfusions, the majority of which are in Government hospitals.

Strategic Plan for the National Blood Policy Implementation

The Strategic Plan for the National Blood Policy Implementation 2007/8 to 2009/10, was launched in 2008. The plan illustrates the Government's commitment to the strengthening of the NBPr according to the objectives of the National Blood Policy. Implementation of the plan will strengthen the organization, management and coordination of all the stakeholders, formalize the working relationship between all stakeholders, and enable the development of national quality and information management systems towards sustainable and equitable service delivery.

Monitoring and Evaluation and Reporting Plan

Monitoring, evaluation and reporting (MER) tools are critical to assist the implementers of the Strategic Plan for the National Blood Policy Implementation 2007/8 to 2009/10, in measuring how successfully and efficiently the implementers effect the desired change in the programme during and after the project. The MER will strengthen the cooperation among the partners in the NBPr by providing particular information to stakeholders and donor partners.

The proposed MER plan is under review by the Blood Safety Team – the respective institutions that the team members represent are the main contributors and users of the MER information. The tools shall be used to provide implementers with timely information on the progress of the project activities against the timeframe. The tools will further assist in organizational learning and adaptive management during the implementation, determining allocation of resources, reporting to the local health authorities and stakeholders, and accounting to the funding partners.

An impact assessment at the end of the project will strengthen the case for continued funding where necessary. Upon ratification of the MER, implementation will follow through the provision of data collection facilities and staff training.

Memorandum of Understanding between MoHSS, NAMBTS and NIP

The regulation of blood services is formalized in the National Blood Policy, the Standards for the Practice of Blood Transfusion in Namibia, and the Blood Transfusion Bill. Due to the varying

important roles played by MoHSS, NAMBTS and NIP, there was a need to implement a coordinated national approach to service delivery if the objectives of the National Blood Policy are to be achieved.

The MoHSS, NAMBTS and NIP, based on an analysis of their respective resources and expertise, agreed to the procedures and conditions regarding the operations of the NBPr in Namibia in a Memorandum of Understanding (MoU). The MoU covers obligations of the three institutions in the provision of services, capacity building through training, quality management systems, clinical transfusion support services, management liaison and cost recovery to ensure financial viability and sustainability.

WHO provided technical support in the production of an electronic costing model, towards decisions aiming at sustaining the blood safety programme.

National Quality System

Quality management in the NBPr embraces every aspect of transfusion practice and applies to all activities of the programme. It includes the identification and selection of prospective blood donors, adequate collections of blood, and preparation of blood components, laboratory testing and ensuring the safest and most appropriate use of blood/blood components.

The Blood Transfusion Service of Namibia and NIP each has its own well developed quality management systems. However, there was need to integrate the two systems to establish the link between NAMBTS and the NIP hospital blood banks, so that the two use the same standard operating procedures to ensure national standards of practice.

The National Quality System is particularly important for the integration of the quality management systems, especially between NAMBTS and NIP, which share the continuum of service from the blood donor to the transfusion patient. The Blood Transfusion Service of Namibia collects, processes, tests and screens all donated blood and supplies the blood to all hospitals, the majority of which are served by NIP hospital blood banks. Patient safety and equity in national standards are assured through implementation of the requirements contained therein.

Formulation of the National Blood Programme Waste Management Guidelines

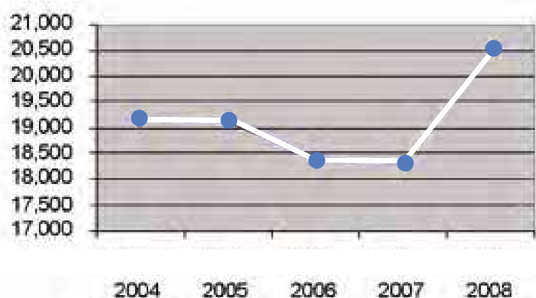
The situation analysis at district, intermediate and central hospitals showed that there were gaps in waste management at almost all the institutions handling blood transfusions. One of the responsibilities of the MoHSS in the National Blood Policy is to ensure appropriate bio-safety and waste management for the NBPr. The objective of the National Blood Programme Waste Management Guidelines is to outline the minimum acceptable measures that must be put in place by the generator, transporters and disposal/treatment facilities of Health Care Risk Waste (HCRW), in order to ensure proper waste management and minimize risk to public health and the environment.

The guidelines further outline the duties and responsibilities of the generators, transporters, treatment/disposal facilities and regulators involved in the management of HCRW to ensure appropriate management of blood transfusion waste at all transfusing institutions with provisions for improving record keeping and knowledge levels through training.

The existing legislative framework provides for registration of HCRW generators, transporters and treatment/disposal facilities.

WHO provided technical support in the formulation and consensus evaluation of the guidelines by representatives of medical institutions from the Regions.

Figure 8: Number of Blood units collected per year 2004 - 2008



Source: Blood Transfusion Reports, NAMBTS

Shortcomings in the available laboratory equipment were also identified in the situation analysis with examples of domestic refrigerators being used for everything in the laboratory including storage of blood and blood products.

The provision of effective and efficient blood storage, transport and cross-matching services within the hospital blood banks is dependant on the availability of suitable equipment that is properly validated and maintained, and on the availability of the appropriate materials required to carry out the stipulated procedures to ensure that minimum standards of practice are met.

In order to ensure the availability of such equipment and materials at each blood bank, WHO supported the drafting of the blood banks equipment needs analysis questionnaire. The questionnaire will help obtain an inventory which will be used to update the National Blood Programme Equipment Database, and to establish priorities for the provision of new and appropriate equipment.

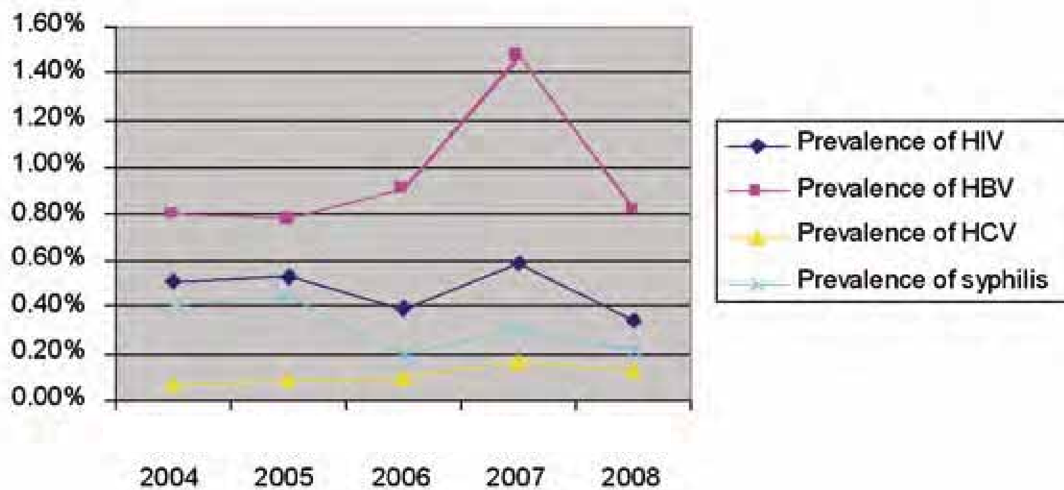
Ethics

Safe blood involves the blood donor, the NAMBTS, the hospital blood banks, the medical personnel who prescribe and administer transfusions and the recipient. All the partners in the chain have rights and responsibilities to ensure that blood transfusion remains a medical life saving act. These rights and responsibilities can be considered in civic, moral and ethical principles.

All levels in the blood transfusion process, from donation to transfusion, need a medical ethic to guide actions around safe blood to avoid frictions and tensions related to priorities, rights, responsibilities and costs. This calls for the recognition of basic values and principles related to harmonious relations between potential and actual blood donors and recipients. These basic ethical values and principles guide medical practice and are ensured by the Blood Transfusion Act and Regulations based on the National Blood Policy.

The National Blood Policy, the Guidelines for the Appropriate Clinical Use of Blood and Blood Products in Namibia (GACUB) and the legislation require the provision of ethics guidelines in the interest of all concerned. WHO supported the formulation of the draft guidelines which now await the consultative consensus process before adoption.

Figure 9: Sero prevalence of TTIs in donated blood, 2004 - 2008



Source: Blood Transfusion Reports, NAMBTS

5.3.2 Blood Donor Programme

Namibia has always had 100% voluntary non-remunerated blood donation which is one of the safest sources of blood. Increasing the volume of blood donations from regular blood donors further improves the safety margin because the donations have the lowest transfusion transmissible infection (TTI) prevalence. This is still necessary because it is not possible to assure 100% safety from TTIs because of the window period risk.

The sum total of the recruitment and retention strategies conducted during the year resulted in a 12% increase in blood collections in direct response to an increased demand from hospitals. The transfusion transmissible infection sero-prevalence maintained a downward trend despite the increase in donations possibly indicating an effective recruitment and selection process as well. Figures 8 and 9 illustrate the collections and seroprevalence from 2004 to 2008.

In order to strengthen the blood donor base, through recruitment and retention of those at low risk of TTIs, WHO supported and participated in the organization of the World Blood Donor Day in June 2008 at which 'honours boards' for donors with 150 and 200 donations were unveiled.

A Four Times a Year Winner Campaign was launched, encouraging donors to give blood every season (at least 4 times a year). Representatives from various organizations were also given certificates of appreciation for their role as contact persons during blood drives in their respective institutions.

The United Nations Blood Donation Challenge was launched on 24 October 2008 (UN Day) by the NAMBTS in collaboration with the MoHSS, WHO and other UN agencies. The purpose of the challenge was to boost blood collections at the Hidas Blood Donation Centre in Klein Windhoek and other institutions.

An additional objective of the challenge was to increase blood donations per day and consequently reduce the cost per unit and ensure sustainability of the fixed donor site. At the launch, 36 units of blood were donated by the UN staff. Media coverage further disseminated the 'thank you' messages to both current and prospective donors.

UN staff prepares to donate blood

The UN Resident Coordinator, Mr S. Nhongo and the Honourable Deputy Minister of Health and Social Services, Ms Petrina Haingura during World Blood Donor Day and UN Day celebrations in Namibia

Dr von Finckenstein, Director of NAMBTS, addressing UN staff

UN staff donating blood during UN Day

5.3.3 Appropriate Clinical Use of Blood and Blood Products

Blood transfusion is an important branch of therapeutic medicine which has contributed to the evolution of many medical disciplines. However, this life saving therapy is not without adverse effects including the risk of immunological reactions, transfusion transmissible infections, fluid overload as well as metabolic disorders.

A situation analysis on blood services and a nationwide study on the blood safety situation, suggests the need to improve blood transfusion practices in Namibia. The Guidelines on the Appropriate Clinical Use of Blood and Blood Products was developed as a response to the gaps identified and is part of a wider initiative to improve blood transfusion services.

The main objective of the GACUB is to encourage appropriate use and reduce unnecessary transfusions that expose patients to unnecessary risk on the one hand, and may waste blood on the other. Therefore, transfusion alternatives like crystalloids and colloids are also elaborated upon in these guidelines.

WHO has supported strategies to promote the appropriate use of blood and blood products and thus reduce unnecessary transfusions through training on the GACUB. Support was also provided to the review of the Namibian Standard Treatment Guidelines which includes a blood transfusion section.

Previously all hospitals had received two and a half days training on the GACUB. In 2008, the training continued at the request of the intermediate, central and one mission hospital. The main challenges at the intermediate and central hospitals are the absence of a 24-hour service and poor functionality of the hospital transfusion committees. The committees are still at infancy and need to be nurtured till they assume the reins of their full responsibilities in implementing the GACUB at the hospitals.

In order to strengthen the capacity at some of these hospitals a total of 57 doctors, four medical students and 128 nurses were trained at the Windhoek Central and Katutura Intermediate Hospitals in Windhoek. Onanjokwe, a mission hospital in the North of the country also mobilized 16 doctors, 19 nurses and one technologist for a half day training for each group to cover specific topics affecting the blood transfusion services at their hospital.

Permanent Secretary, MoHSS launches and hands over Blood Safety guidelines to WHO Representative, Dr Magda Robalo

5.3.4 Sustainability, Lessons Learnt and Way Forward

The infrastructure, organizational and legislative framework has been strengthened by the implementation of the National Blood Policy. The major challenges are to ensure adequate human resources and financial sustainability of the programme especially when the PEPFAR funding period comes to an end. The availability of laboratory staff should improve with the training programme at the Polytechnic of Namibia.
The lessons learnt since the inception of the programme in 2004 are that a consensus approach ensures ownership and sustainability of the programme under a policy framework that clearly states the roles and responsibilities of the various stakeholders in the NBPr from the NAMBTS, NIP, public and private hospitals, all under the stewardship of the MoHSS.

The advocacy and technical support role of the WHO motivates and supports implementation of change initiatives. Funding from PEPFAR and commitment from the MoHSS and involved stakeholders are enabling factors for all the interventions.

The way forward is to ensure that all the outstanding infrastructure and organizational improvements are implemented as much as possible in the fifth and last year of the current cooperative agreement with PEPFAR and also ensure long-term sustainability of the improvements attained to date.

A costing exercise scheduled for 2009 will advise on strategies to ensure financial sustainability. The main interventions documented above will all need effective implementation through appropriate capacity building and training which will certainly go beyond March 2010, when the current cooperative agreement with PEPFAR comes to an end.

5.4 Major Communicable Diseases

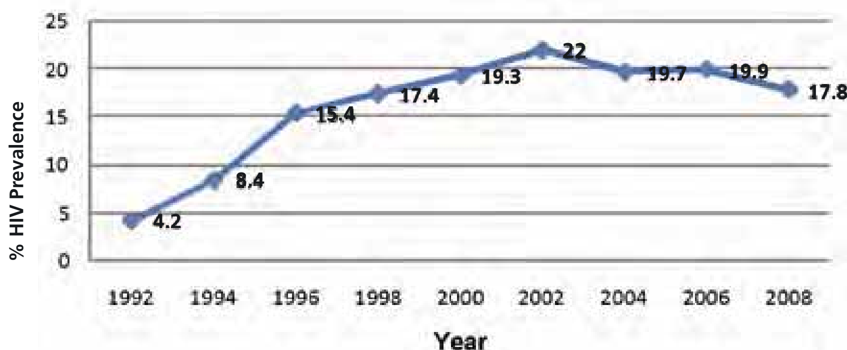
5.4.1 HIV/AIDS

Twenty-two years after the first AIDS case was diagnosed in 1986, HIV/AIDS remains a major threat to Namibia's socio-economic development. The country has a generalized epidemic, with HIV transmission occurring primarily through heterosexual means, and is ranked amongst the five highest affected countries. Following a rapid increase in the prevalence of HIV from an estimated 4.2% in 1992 to 22% in 2002, among women attending antenatal clinics, prevalence appears to have stabilized with the most recent National HIV Sentinel Survey (2008) reporting a rate of 17.8% prevalence.

HIV prevalence in women aged 15-24 years is used as a proxy for new infections. In this age group there has been a decline in prevalence between 2006 and 2008 from 14.2% to 10.6%[36].

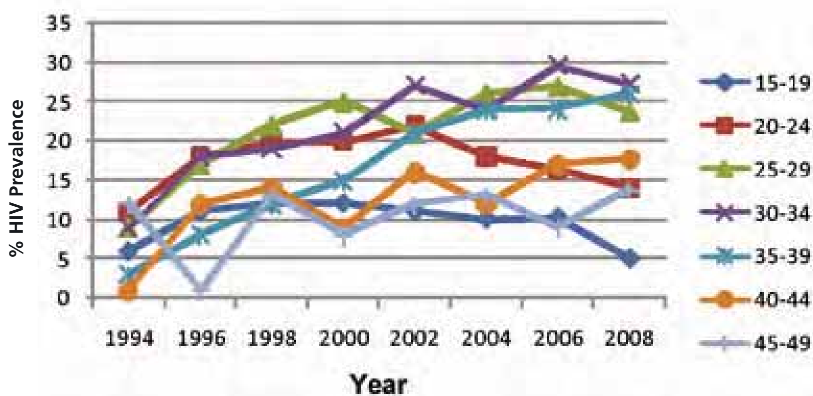
In terms of the two indicators that are being tracked as part of the MDG (Goal 6), prevalence has gone down from 10.2% in 2006 to 5.1% in 2008 for the age group 15-19 years, and from 26.9% to 23.8% for the age group 20-24 years. Therefore, in terms of the respective targets of 8% and 12%, the first has already been attained and now needs to be held stable at that rate or be reduced even further, while the target for the 20-24 year olds could be reached if the declining trend continues.

Figure 10: HIV prevalence in pregnant women, 1992-2008



Source: Report of the 2008 National Sentinel Survey

Figure 11: Trends of HIV prevalence by age group, 1994-2008



Source: Report of the 2008 National Sentinel Survey

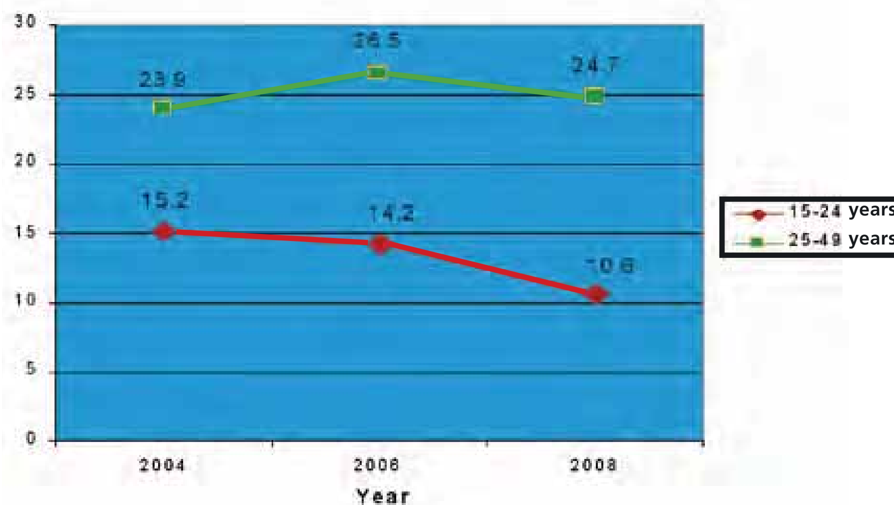
Prevalence is reported to be the same in rural and urban areas[37]. However, the disease is centred around geographic areas that have high numbers of mobile populations for instance border areas, as well as places with populations that take up temporary residence for economic activities such as mining, fishing, agriculture and tourism[38].

The current national response to HIV/AIDS in Namibia is guided by the Third Medium Term Plan on HIV/AIDS, 2004-2009 (MTP3). This document outlines national goals, objectives and priority interventions with respect to HIV/AIDS, and further provides a framework within which stakeholders operate. This is in keeping with the "3 Ones" approach that promotes the coordination of stakeholder activities and the use of common reporting framework, under a common strategy that ultimately enables a multi-sectoral response.

Key national achievements in the fight against HIV include the following:

- Provision of ART to a significant number of people in need of treatment. Currently over 50,000 people are on ART representing 68% coverage[39], which includes a 100% coverage rate for children, from a baseline of zero in 2003.
- Reduced numbers of HIV-related deaths from 9,200 in 2003 to 5,400 in 2007[40].
- Provision of a complete course of antiretroviral prophylaxis (PMTCT) to 70% of HIV positive pregnant women, also from a zero base in 2003. These services are provided through 238 of the country's 256 health facilities that offer ANC services[41].
- A decrease in the percentage of men who reported to have had sex with more than one partner in the preceding 12 months from 22% in 2000 to 16.1% in 2006[42].
- Increased distribution and use of condoms [43] - throughout the 13 Regions via a network that includes public, civil society and private sector organizations.
- Wide uptake of HIV testing and counselling services. The MoHSS reports that 300,000 people had received testing and counselling services in the country by 2008[44].

Figure 12: HIV Prevalence by youth and adult age groups and year



However, some challenges remain. The following are the major challenges to the HIV prevention, AIDS treatment, care and support efforts in the country:

- Insufficient focus on prevention activities.
- Wide spread stigma and discrimination against people living with HIV/AIDS.
- Insufficient and inadequate human resources capacity within the health sector.
- Limited interventions targeting high risk groups and vulnerable populations.
- Inadequate support programme on adherence.
- Weak monitoring and evaluation system, as well as coordination of the multi-sectoral programme and community based prevention, treatment, care and support programme in the presence of a strong ART programme.

Table 2: WHO support to the HIV/AIDS Programme in the context of the MTPIII

Component	Associated outcomes	WHO support in 2008
Enabling environment	Advocacy for behaviour change for reduced discrimination and stigma, and improved access to services and care • Sessions held with targeted groups	1. Contributed to the organization of the Male Conference
Prevention	80% reduction of STI cases by 2009 • Etiology study completed • STI guidelines disseminated Increased access to quality VCT services • Evaluate the VCT programme every two years Continued safety of blood transfusion and the rational use of these products • Strengthen capacity of NAMBTS *Activities related to development of a new prevention strategy that is still under consideration, and is therefore not part of the MTP3.	2. Funding and technical support for an etiological study on STI 3. Technical support for the revision of the national guidelines on the syndromic management of STI 4. Revision of the HIV Testing and Counselling guidelines to include Provider Initiated Testing and Counselling (PITC) 5. Support to National Blood Programme 6. Coordination of activities to promote and implement medical Male Circumcision
Improved treatment, care and support	Satisfactory laboratory capacity for monitoring HIV disease management and VCT quality • Feasibility study for ARV drug resistance monitoring completed	7. Implementation of HIV Drug Resistance monitoring and surveillance
Integrated and coordinated programme management at all levels	Obtaining resources for national, regional, sectoral and constituency management structures	8. Preparation of Global Fund Round 8 proposal

The key areas in which WHO provided support in 2008 are as follows:

Implementing the HIV Drug Resistance strategy

As part of the global efforts to prevent the emergence of HIV Drug Resistance (HIVDR) during the scale up of ART programmes, WHO began to support countries to assess the extent to which their ART programmes are functioning to optimize prevention of drug resistance. Recognizing that Namibia had undertaken a massive roll-out of ART services, and knowing that the emergence of drug resistance may be inevitable, WHO mobilized funds through the Spanish Government to support the development and implementation of an HIVDR strategy in the country. The goal of the strategy is to support ART programme practices, and country planning, to minimize the emergence of HIV drug resistance, and to restrict the extent to which resistance hampers the effectiveness of the limited ART regimens available, within the context of the national HIV prevention and treatment plan.

During 2008, WHO supported the development of a three-year plan to provide technical assistance and funding for the Namibia strategy. The plan is articulated around three key areas:

- Regular assessment of the HIV drug resistance "early warning" indicators in all ART clinics.
- Sentinel monitoring of HIV drug resistance emerging during treatment.
- HIV drug resistance transmission threshold surveys in selected geographic areas.

WHO Representative to Namibia, Dr Magda Robalo hands over the keys of a 4x4 vehicle to the Honourable Deputy Minister of Health and Social Services, Ms Petrina Haingura. The vehicle is donated in the context of the Spanish-funded WHO's support programme on HIV drug resistance. Mr Alberto Quintana, Head of the Spanish Cooperation in Namibia and Mr Kajihoro Kahuure, the Permanent Secretary, Ministry of Health and Social Services looks on.

Improving Sexually-transmitted Infection Control Services

The presence of an untreated STI (ulcerative or non-ulcerative) enhances both the acquisition and transmission of HIV. Thus, early diagnosis and treatment of STI has become an important HIV prevention strategy, both for people at risk, as well as in the general population.

To control the infections and offer treatment effectively, there is need for an easy mechanism to ensure early detection. However, the detection of some of the infections are made difficult by the fact that they are frequently asymptomatic and where there are symptoms, they are present in such a way that they are neither specific nor sensitive enough to allow an easy and cheap diagnosis. In an attempt to overcome these difficulties, WHO and partners developed patient management strategies based on the syndromic approach for use in resource constrained settings which Namibia has adopted.

Inherent in the STI syndromic management approach is the need for periodic STI surveys for both aetiological surveillance and the surveillance of antimicrobial resistance among major bacterial STIs. The current Namibia STI management guideline, developed in 1999, falls short of addressing the present organisms responsible for STI in the country. In 2008, WHO Namibia together with the MoHSS conducted an aetiological study of three key STI syndromes in the country and gonococcal antimicrobial susceptibility testing on gonococcal strains isolated from patients presenting with Urethral Discharge syndrome. A revision of the national guideline on syndromic management of STIs was also carried out.

The aetiological study showed that gonorrhoea is the most common agent responsible for male urethritis in Namibia. The antimicrobial susceptibility data revealed a marked prevalence of ciprofloxacin resistant gonorrhoea in the country. The study further revealed that, among women, vaginal discharge was most frequently due to bacterial vaginosis. The aetiological study also confirmed that herpes simplex type 2 virus now accounts for approximately half of all genital ulcers and is significantly associated with HIV infection.The bacterial aetiologies of genital ulceration, such as syphilis, granuloma inguinale and Lymphogranuloma venereum, were rarely detected during the study and no cases of chancroid were detected.

The findings are already being used to revise the national guidelines on syndromic management of STIs.

Increasing the uptake of HIV- Counselling and Testing

To date, Namibia has typically adopted a strategy of client-initiated testing and counselling – the traditional Voluntary Counselling and Testing - as the mainstay of the country's HIV testing and counselling strategy.

In spite of implementing this strategy over the past five years, and despite high levels of knowledge of the general populace about HIV/AIDS, the rate of acceptance of HIV testing and counselling is still very low. In order to increase the uptake of HIV testing and counselling in the country, Namibia has adopted the Provider-initiated testing and counselling (PITC) approach to be included in the country's overall HIV/AIDS strategy.

The Provider-initiated testing and counselling refers to HIV testing and counselling, which is recommended by health care providers to persons attending health care facilities as part of basic standard of medical care. The major purpose is to enable specific clinical decisions to be made that would not have been possible without knowledge of the person's status. In addition, the approach also aims to identify unsuspected HIV infection in persons attending health facilities. Health care providers are therefore encouraged to recommend HIV testing and counselling to patients even if they do not have obvious signs and symptoms related to HIV infection. In all circumstances, under the PITC approach, the testing and counselling is voluntary and all the ethics of informed consent, counselling and confidentiality must be strictly adhered to.

During 2008, WHO, in collaboration with the Clinton Foundation and the CDC, worked with MoHSS to revise the country's Testing and Counselling Guidelines to include the PITC approach. The aim is to increase the uptake of testing and counselling and also an early referral of the patient to services within or outside the health facilities in which the PITC service is provided.

Implementing a strategy to scale up medical male circumcision

Recent studies in sub-Saharan Africa have found that safe male circumcision can reduce a man's chance of becoming infected with HIV by approximately 60%. Three controlled trials were conducted randomly in which uncircumcised men were assigned to either receive circumcision or not, and then followed over time to see if one group had a higher rate of acquiring HIV. The risk reduction for circumcised men was about 60%, i.e., six of ten infections could have been prevented by circumcising men.

Dr Brian Pazvakavambwa, IST ESA, makes a presentation on medical male circumcision

Based on current estimates, the overall rate of male circumcision in Namibia is about 21% (NDHS 2006-07), although a wide variation exists between Regions. Following the announcement of the encouraging results of the studies on male circumcision referred to above by WHO and UNAIDS, Namibia adopted medical male circumcision as one of the strategies to prevent the transmission of HIV and included it as part of the comprehensive package for prevention of HIV transmission in the country.

In 2008, WHO worked with the MoHSS and other development partners to develop plans for the scale-up of medical male circumcision services. As a first step, a situation assessment was conducted with the aim of collecting data on male circumcision that will help to develop an evidence-based scale-up strategy.

In addition, a stakeholders' consultative meeting was also conducted where the findings of the situation assessment was presented for inputs and consensus from a broad range of stakeholders from across the country. One key outcome of this initial work is the development of a national policy on medical male circumcision and plan of work for scaling up implementation of medical male circumcision in the country.

The First National Conference on Male Involvement in HIV/AIDS

Namibia, with over 20 years programme experience on HIV/AIDS, had identified that most of the burden of the HIV/AIDS epidemic, whether in terms of disease or in first line care at the community or home level, was borne by the women.

The main challenge had become how to improve the involvement of the men. Thus in 2008, the MoHSS came up with plans to conduct the First National Conference on Male Involvement in HIV/AIDS with support from the WHO and other partners. The conference was called exclusively for the Namibian men. It was the first time that Namibian men came together to chart a plan on what they can contribute to combat the AIDS epidemic in the country.

The overall aim of the conference was to promote initiatives that respond to the needs of men as key players in the prevention of HIV transmission, with the expectation that this will enhance male involvement in the national response to the HIV/AIDS epidemic. It was attended by men from all sectors and from the highest level of Government and the political leadership.

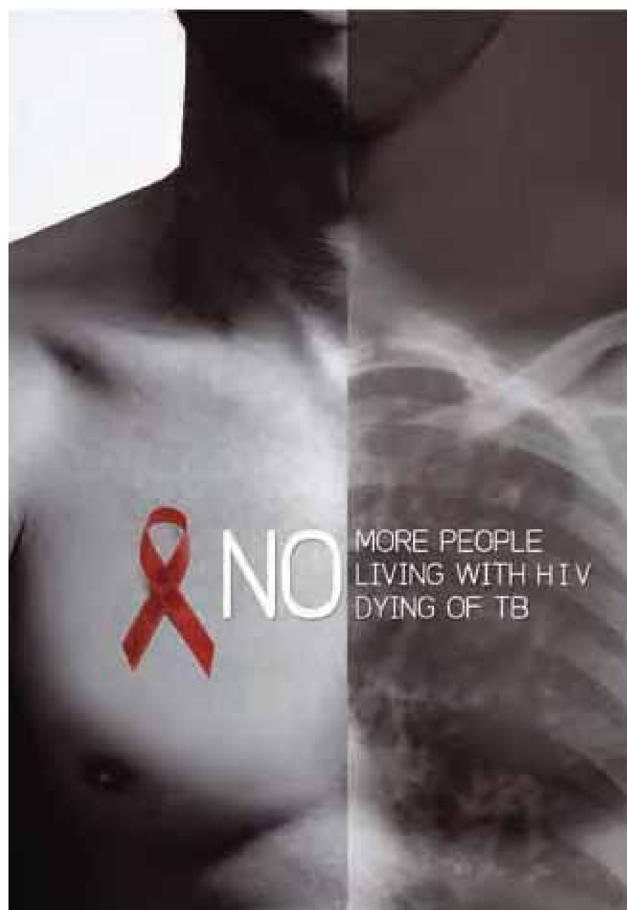
Some key outcomes of the conference included an identification and collation of sectoral and sub-group commitments for follow up and donors' commitment to support groups/organizations with plans to implement male involvement initiatives.

Global Fund Round 8 proposal development process

The Global Fund has been one of the largest financial sponsors of HIV, TB and malaria interventions in the country since 2005. The largest of the grants is the Round 2, which is also the only HIV grant sponsored by the Global Fund, worth US$104 million that comes to an end in 2009. Mobilization of additional resources for HIV programmes is therefore critical.

As a member of the country's Technical Coordinating Committee of the Global Fund Round 8 proposal development, the WHO provided technical assistance to the process of development of the country proposal.

In furtherance of its support to the process, WHO organized two Regional Missions to Namibia. The first mission supported the development of the log frame for the activities of the proposal and the second provided technical assistance for the finalization of the proposal before it was submitted to Global Fund headquarters. These missions were complemented by a WHO-led regional level UN inter-agency peer review of the proposal.



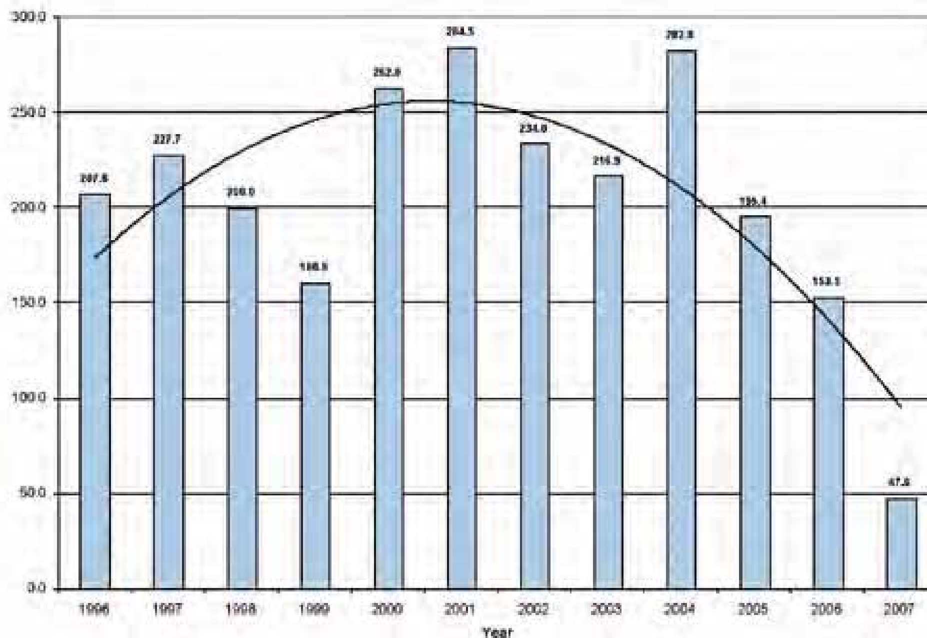
5.4.2 Malaria

Malaria is endemic in the north and the northern parts of the central Regions of the country, where 68% of the country's population lives. Although the malaria burden varies across the various Regions, it is generally a leading cause of morbidity and mortality in both children and adults. Approximately 400,000 cases and 1,000 deaths are reported annually[45].

Incidence rates of clinical malaria range from 618/1,000 in some districts in the northern part of the country to as low as less than 1/1,000 population per year in the southern part. In endemic areas, transmission occurs between the months of November and June which coincides with the rainy season, with peak transmission between the months of April and May. The most vulnerable populations are children under five years of age, pregnant women and persons with compromised immunity such as HIV-infected persons.

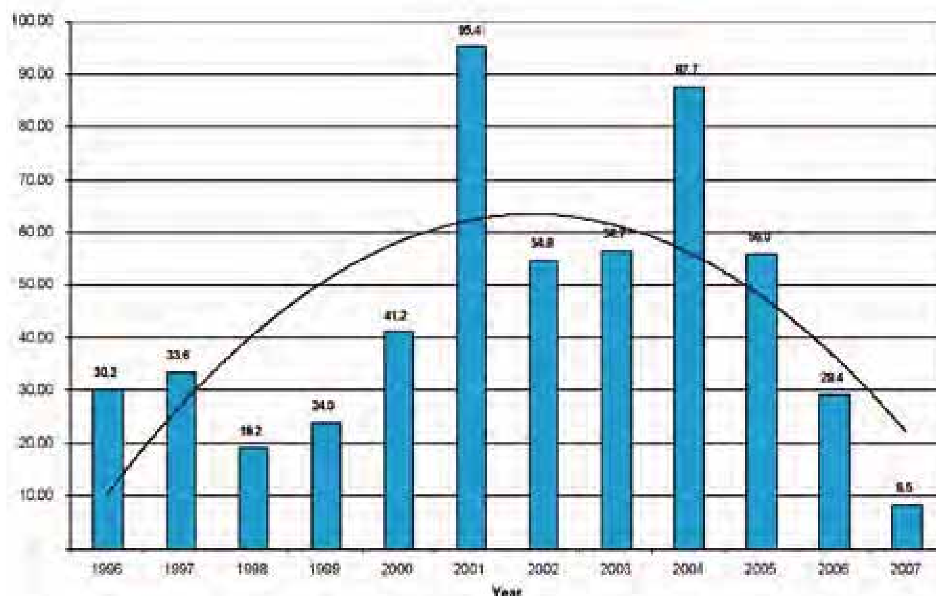
Significant strides have been made in malaria control since 2000, with cases dropping by 35% and 79% and deaths dropping by 41% and 82% in 2006 and 2007 respectively[46].

Figure 13: Annual malaria incidence rate per 1,000 population by year, 1996-2007



Source: National Vector-borne Disease Control Programme, Annual Report 2007/8

Figure 14: Annual malaria mortality rate per 100,000 population by year, 1996-2007



Source: National Vector-borne Disease Control Programme, Annual Report 2007/8

These declines are largely attributed to the implementation and scale-up of effective interventions such as wide distribution of insecticide-treated bed nets (ITNs) and wider coverage of indoor residual spraying (IRS).

In 2008, the National Vector-borne Disease Control Programme (NVDCP) distributed 153,422 bed nets to pregnant mothers and children under the age of five years in the nine malaria endemic Regions, giving a cumulative number of 333,422 bed nets distributed by the MoHSS between 2005 (when the ITN programme was introduced) and 2008.

The total number is much higher (577,500) if the ITNs contributed and distributed by other implementing partners, such as the Social Marketing Association (SMA), are included[47].

Twenty-five percent of all households own at least one mosquito net and 21% own at least one treated net. However, only 10.5% of under-five children and 8.8% of pregnant women were reported to have slept under ITN in the previous night (NDHS 2006-07) although the survey was conducted during the low malaria transmission period.

Bed net coverage is highest in households in the northern part of the country where malaria is endemic.

The IRS coverage has widened over the years and was recorded at 89% of targeted structures during 2007/08 spraying cycle, with 658,635 structures sprayed for the season. The insecticide DDT was chosen for use in Namibia because of its long residual effect and its cost-effectiveness. Spraying is provided free of charge to the population and is done on the basis of mapping of structures and residential properties. Each Region develops its own IRS operational plan and estimates of insecticide requirements.

Improved diagnosis and treatment have contributed significantly to the reduction of malaria-related mortality.

Specific interventions that have led to this are the introduction of Rapid Diagnostic Tests (RDTs) for diagnosis and the adoption of the artemisinin-based combination therapy, Artemether-Lumefantrine (ART-LUM) as the first line anti-malarial treatment.

The change in anti-malarial treatment policy was effected in 2005. To date, 827 health workers have been trained to ensure the successful roll-out of the new diagnosis and treatment policy. Namibia is now heading for elimination of malaria.

WHO provides most of its support to the malaria programme through the NVDCP. The NVDCP formulates and coordinates the national malaria response in Namibia.

Some of the major technical support provided during 2008 include:

- *Therapeutic efficacy study:* To establish a baseline therapeutic efficacy of the newly-introduced anti-malarial medicine, ART-LUM, a study was conducted at three sites in northern Namibia, i.e. Outapi, Rundu and Katima Mulilo. The Organization provided technical support for the training of three study teams from the above-mentioned sentinel sites. Two medical doctors, three nurses and three laboratory technologists were trained in March 2008 at the Rundu Hospital. The study was initiated at the three sites simultaneously, but insufficient number of patients for enrolment during the study period due to low transmission slowed down the pace of the study.

- *Training in vector control:* Twenty three Environmental Health Officers were trained in vector control and planning. This is an annual activity that has been supported by WHO since 2005 to improve vector control coverage and its quality. This sustained training support is believed to have contributed greatly to the successful coverage of IRS - up to 89% of all targeted households in malaria-prone areas.

- *Data management training:* WHO introduced the use of the global database for collection of key malaria indicators which had been identified as a major gap during a review of the malaria data reporting systems undertaken by the Global Fund for HIV/AIDS, TB and Malaria. A tool for collecting data on distribution of long-lasting treated nets (LLTNs) was also introduced. A training programme was held in Ondangwa for national, regional and district level staff in August 2008 and was attended by 26 health workers.

WHO, together with other partners, will provide the necessary support to address the following challenges faced by the NVDCP:

- Lack of technical expertise in epidemiology, parasitology and entomology needed in different areas of malaria control;
- Insufficient capacity for entomological surveillance;
- Need to further strengthen community-based malaria control activities, including community information, education and communication and distribution of ITNs through strengthened community-based health care structures and enhanced availability of field promoters;
- Limited coverage of ITNs for the general population;
- Inadequate transport for the malaria affected Regions and districts in order to be able to effectively conduct timely and comprehensive malaria spraying operations and other malaria control related activities; and
- Need to enhance cross-border activities with neighbouring countries and advocating for increased and coordinated malaria control activities in bordering provinces and Regions.

5.4.3 Tuberculosis

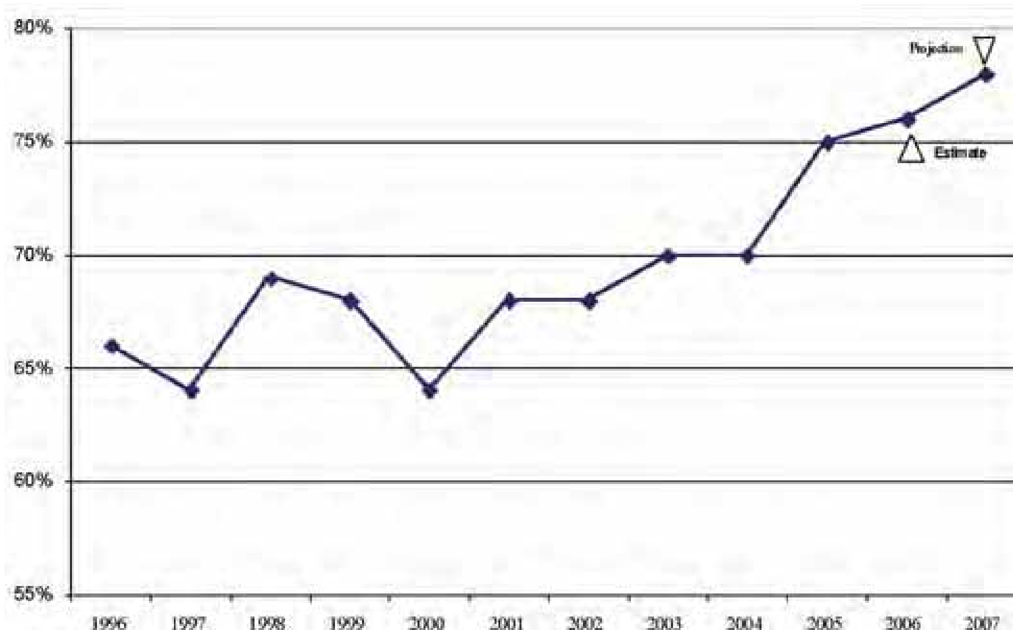
Namibia experiences one of the worst TB epidemics in recent years. According to the WHO Global TB Report 2008, Namibia is one of three countries with the highest case-notification rates (CNR) in the world; the two others being Lesotho and Swaziland. TB in Namibia has been associated with poverty and overcrowding and of course HIV/AIDS. The dramatic increase, observed over the last two decades, is likely to be the direct effect of the HIV epidemic. Approximately 60% of people with TB are co-infected with HIV.

Current TB prevalence is estimated to be 621 per 100,000 population, twice as high as the African regional average, but represents a decline from 2007 and 2000/03 estimates of 722/100,000 and 822/100,000 population respectively. Between 2005 and 2008, the CNR has declined by an average of 6.5%[48]. While prevalence is still unacceptably high, the decline suggests that TB control is improving and that the MDG 2012 target of less than 300 cases per 100,000 could be met[49].

The treatment success rate registered in the first three-quarters of 2007 was 83% which is close to the international target of 85%. This is largely due to decreased defaulter rates (5%). However, TB mortality for the same period was 10%, which is quite high.

The country faces additional threats due to the emergence of multi-drug resistant TB (MDR-TB) and extensively drug resistant TB (XDR-TB), a virtually untreatable form of tuberculosis. Two hundred and one confirmed MDR-TB cases were registered by October 2008[50].

Figure 15: Treatment results for new sputum smear positive cases, 1996-2007



Source: WHO Global TB Report 2008

The National TB Control Programme (NTCP) is responsible for coordinating the national response to TB in Namibia. The NTCP was established in 1991 and has strengthened its implementation activities significantly over the last few years. Namibia implements the NTCP according to the WHO recommended approaches, and is based on the "Global STOP TB strategy by 2015".

The NTCP adopted the Directly Observed TB Treatment – Short Course Strategy (DOTS) in 1995, following the strategy's launch by the WHO in 1993. The implementation of this strategy is driven by the civil society organizations that employ community workers who have a mandate to proactively identify TB cases, assist with treatment oversight as well as conduct general sensitisation and informative campaigns. The Community-based Directly Observed TB Treatment (CB-DOT) programme has reached nationwide coverage. This strategy has largely been funded by the Global Fund under Rounds 2 and 5, and USAID's Tuberculosis Control Assistance Program (TB CAP).

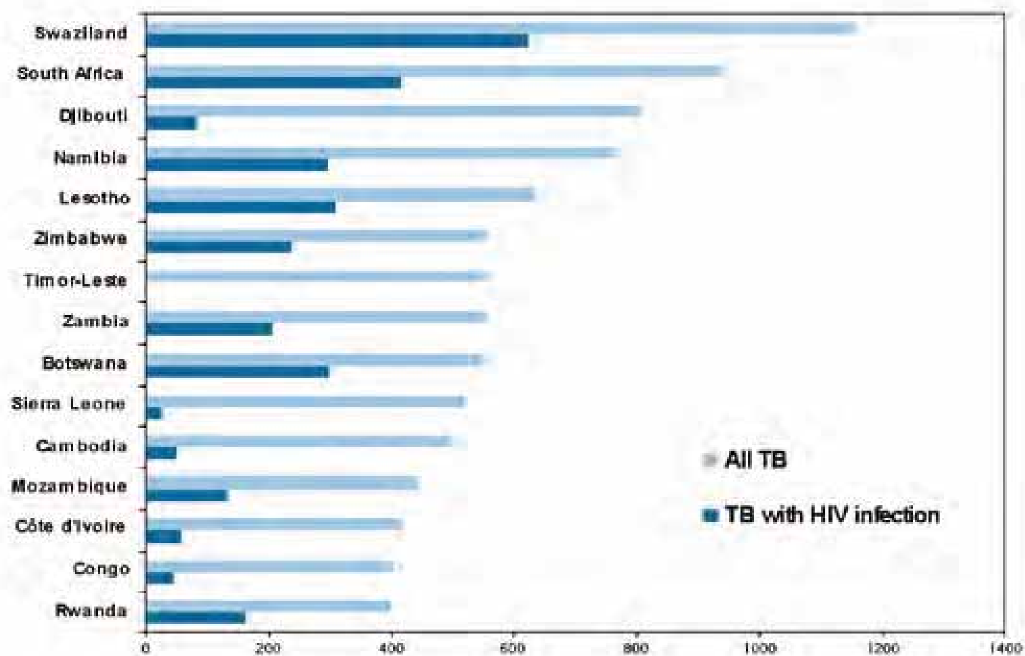
Support to the TB programme in 2008 mainly related to the provision of technical assistance to address the MDR-TB and XDR-TB challenge and undertake programme review. Some progress was made in developing strategies to identify and treat M/XDR. However, significant challenges remain.

As indicated above, in 2008, several cases of suspected MDR/XDR were reported. At the request of the MoHSS, an expert assessment of the MDR/XDR situation was conducted in April 2008. The objective of the expert's mission was to assist the country to adopt appropriate interventions aligned to WHO standards. The expert subsequently made recommendations in relation to the overall management of XDR-TB, and some specific tasks to be undertaken by the NTCP, NIP and MoHSS. On the management matter, it was recommended that the manuals and guidelines for MDR/XDR-TB be revised and the reporting system for MDR and XDR-TB improved. The expert mission also called for designing individualised regimens for XDR-TB and heavily poly resistant TB.

Technical support to lead the review of the MTP-I and development of MTP-II was provided. To this end, a preliminary meeting with the major objective of planning a comprehensive programme review is scheduled. The outputs of this meeting will form the basis for formulation of the next MTP.

In 2008, WHO played a role in convening a partnership forum for TB control which brought together all stakeholders. The partnership forum included MoHSS CDC, NIP, Global Fund-Namibia, KNCV, TB CAP and WHO. The meetings served as information sharing sessions and joint planning platforms to ensure more coordinated interventions among partners, during the early days of the XDR-TB emergence.

Figure 16: Countries with highest estimated TB incidence rates per capita and corresponding incidence rates of HIV-positive TB cases, 2006



Source: Global Tuberculosis Control 2008 Report, WHO

WORLD TB DAY 2008 COMMEMORATION

5.4.4 Vaccine preventable diseases

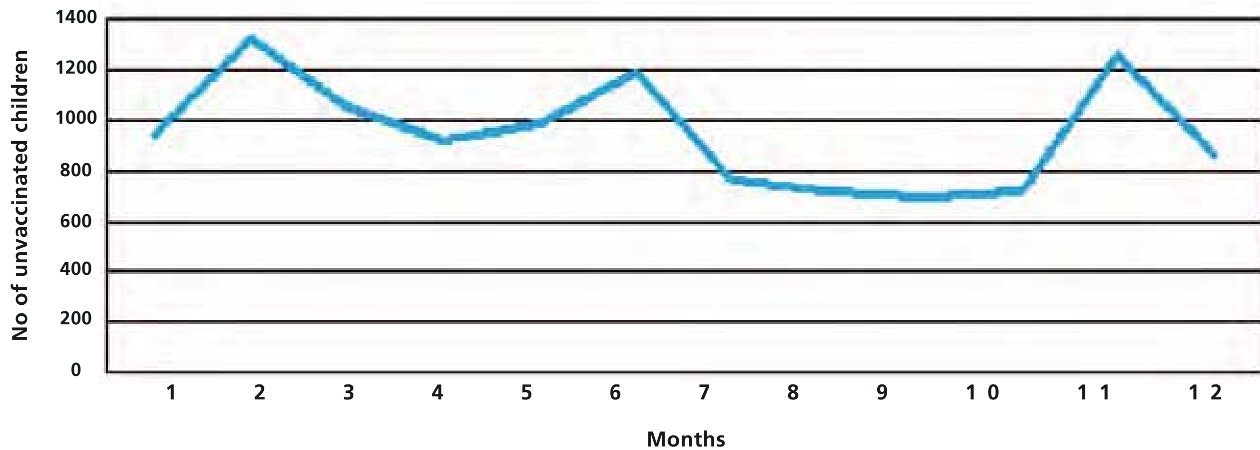
Vaccination coverage in Namibia has increased over the last five years. Full vaccination against the six vaccine-preventable diseases is achieved in 69% of children aged 12-23 months, with children living in urban areas somewhat more likely to be fully immunized than those in rural areas (72% versus 67%). By the same age, over 90% have received BCG and the first dose of DPT while coverage for the 3rd DPT dose and for polio is 83% and 79% respectively. A total of 84% of children received measles vaccine by age 23 months and only 2% of all children have not received any vaccination by 23 months of age.[51] While there is considerable variation in coverage by Region, overall these data indicate good progress towards achieving full immunization coverage and MDG 2012 targets.

Measles

WHO works with the NIP's measles laboratory to help maintain its accreditation status and provide quality support to the measles elimination effort. WHO provided some critical equipment to the laboratory and supplies all the reagents required for measles diagnosis. A three-day accreditation assessment of the NIP measles laboratory was conducted in 2008.

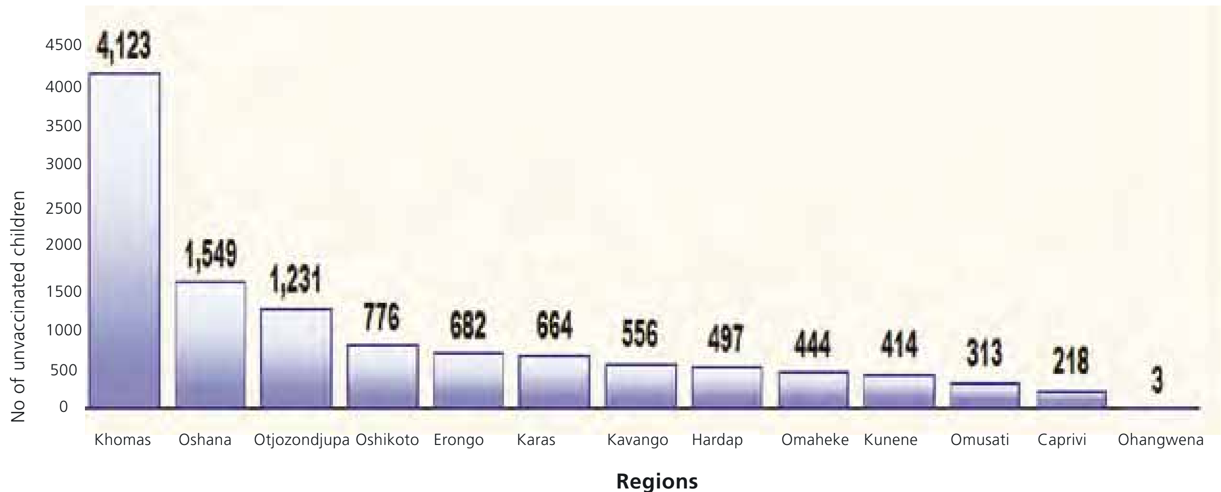
The assessment found that overall, the laboratory has one of the finest achievements in the network, especially in terms of accuracy and quality control. However, there is need to improve the timeliness in sending out results to the EPI programme, within seven days of the specimen being received at the laboratory.

Figure 17: Unvaccinated (DTP3) children by month, 2008



Source: MoHSS/ WHO

Figure 18: Unvaccinated children (DTP3) per Region, 2008



Source: MoHSS/WHO

Poliomyelitis

WHO has supported child immunization in Namibia for several years, primarily in the areas of surveillance and support towards the provision of immunization services and particularly with regards to polio eradication. This support has contributed to the overall good immunization coverage in the country and the country's increased surveillance capacity.

The last confirmed polio incidence in Namibia was reported in June 2006. A team of WHO experts, together with CDC, supported three Stop Transmission of Polio (STOP) teams in the supervision, monitoring and training of health personnel at district and regional levels and provided on-the-job training and feedback to the national programme.

Namibia was declared polio-free in October 2008 by the African Regional Certification Commission (ARCC) in its 10th Annual General Meeting held in Windhoek. WHO was thoroughly involved in the certification process, both at country and Regional levels. The team carrying out this verification exercise included representatives from the African Regional Certification Commission (ARCC), WHO/IST ESA and a country team that included the MoHSS.

Activities included review and verification of the country documentation for certification of polio-free status, review of the preparedness plan for importation of wild polio viruses into Namibia, stakeholder meetings and field visits to three hospitals in three districts in the Khomas and Otjiwarongo Regions and the NIP. Findings from the field were consistent with the country documentation.

Members of the ARCC, Minister of Health and Social Services and WHO Representative meet with former President Sam Nujoma

Family Photo of dignitaries at the opening of the 10th ARCC Annual General meeting

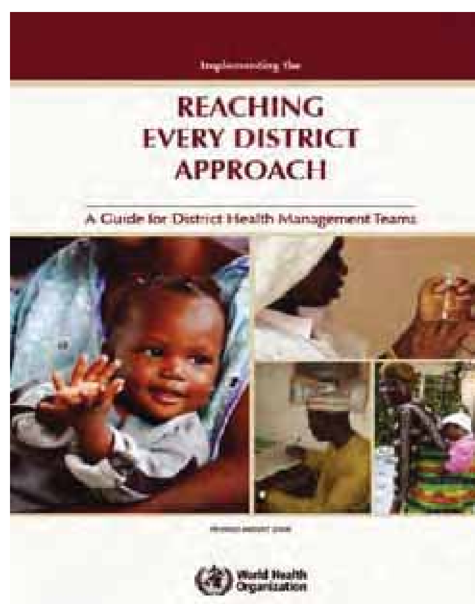
Further technical support provided during 2008, in the area of vaccine preventable diseases include:

- *Introduction of new vaccines:* WHO supported the development of a plan for introduction of new vaccines hepatitis B (HepB) and Haemophilus Influenza type B (Hib). These vaccines are to be rolled out and fully integrated into the routine immunization programme in 2009.

- *National Immunization Days:* WHO provided support in the preparation of district and regional micro-plans, implementation, monitoring and evaluation of the two rounds of the 2008 NIDs in June and July.

- *Vaccine management assessment:* Support was provided to conduct an assessment of vaccine management including: Vaccine Arrival Procedures, Vaccine Storage Temperatures, Cold Storage Capacity, Buildings, Cold Chain Equipment and Transport, Maintenance of Cold Chain Equipment and Transport, Stock Management, Effective Vaccine Delivery, Correct Diluents Use for Freeze Dried Vaccines, Effective Vaccine Vial Monitor Use, Multi Dose Vial Policy and Vaccine Wastage Control. The average score for the 11 indicators was 63%, below the 80% target. This implies that the vaccine management system needs to be improved, especially on stock management at sub-national and service delivery level, estimating needs, temperature monitoring and recording, and prevention of freezing, wastage and use of diluents as well as vaccine arrival procedures at national level. Regular supportive supervision is one of the key elements for improving vaccine management and needs to be strengthened.

- *Integrated Disease Surveillance:* In terms of surveillance, WHO has a dedicated staff member based in Oshakati, (EPI Surveillance Officer) who provides continuous technical support to the seven Regions along the border with Angola: Oshana, Omusati, Oshikoto, Kunene, Ohangwena, Kavango and Caprivi. In addition, with the support of three rounds of STOP Team members, supervisory visits were conducted in several health facilities in most of the Regions of the country. This helped to identify common gaps in disease surveillace and immunization service delivery. The STOP team members also assisted in improving the data management of vaccine preventable diseases.



STOP Team member conducting on the job training for nurses

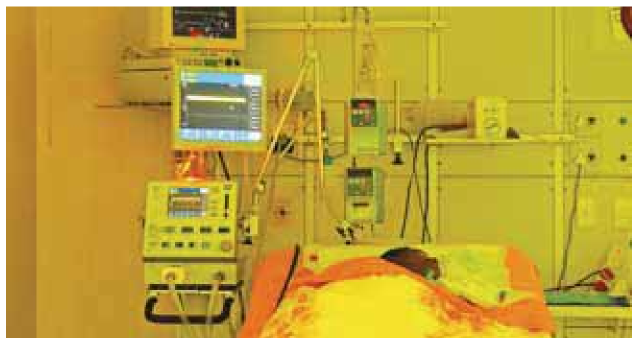
5.5 Non-communicable Diseases

Like other developing countries, Namibia may also be in epidemiological transition, given the indications that non-communicable diseases (NCD) are emerging as important causes of morbidity and mortality. However there is a scarcity of population-based data. According to data obtained from health facilities, hypertension and diabetes are rated as the first and second causes of NCD morbidity among adults. According to the Health and Social Services Systems Review Report, the proportion of deaths caused by hearth failure, hypertension and stroke increased from 5% in 2005 to 8% in 2007.

WHO has adopted an umbrella approach in the provision of its assistance to NCD control. The Organization's Country and Regional offices provided assistance to conduct the STEP survey. The survey comprises of three phases with the following objectives:

- Step I: Assess the risk factors associated with NCDs in the country (such as obesity);
- Step II: Assess the prevalence of risk factors identified in step I; and
- Step III: Conduct chemical studies relevant to the risk of NCDs e.g. blood glucose and lipid tests

In general, data on NCD is scarce and surveys and research in this area needs to be strengthened.



5.6 Emergency Preparedness and Response

At the beginning of 2008, Namibia experienced flooding in the northern and north-eastern parts of the country. More than 62,000 people in rural and urban areas were affected and lost their livelihood and belongings in variable degrees. About 4,000 people were relocated and sheltered at temporary camps. In March 2008, WHO carried out an assessment in the affected Regions on health-related issues.

As a consequence of inadequate availability of drinking water and poor sanitation, the country experienced a cholera outbreak. The first incidence was reported in February in Engela District, Ohangwena Region. By the end of March, 761 cases and three deaths were reported.

Technical support was provided for surveillance, data collection and analysis, and laboratory diagnosis as well as capacity building of health workers in managing the cholera outbreak.

5.7 Cross-border collaboration

Floods were experienced in other neighbouring countries as well, including Angola, Zimbabwe and Mozambique, which also experienced similar disease outbreaks. WHO offered its expertise to strengthen cross-border collaboration on emergency response.

Namibia and Angola started cross-border collaboration in 2002 when a Memorandum of Understanding was signed between the MoHSS and the Embassy of Angola in Windhoek. Several cross-border meetings have since been conducted. Although, the cross-border activities slowed down between 2004 and 2006, they were revived in 2006, with the support of WHO, following the Declaration of Oshakati that was adopted by the two sides in October 2006. Subsequently, the two countries were able to synchronize their National Immunization Day campaigns in 2007.

Cross-border meetings between Namibia and Angola were held twice a year in 2007 and 2008. Angola hosted the national level cross-border meeting with Namibia in November 2008, with technical and financial support from WHO. The areas of cross-border collaboration include disease surveillance, particularly for vaccine preventable diseases but in the future should be expanded to include HIV/AIDS, TB and malaria.

Oshikango border post

5.8 Advocacy, Partnership Building and Information Sharing

An important component of WHO's work is done through partnerships with other Government Ministries, donors, civil society organizations, the private sector, UN agencies and the community at large. During 2008, WHO embarked on various advocacy activities, built around the celebrations of the 60th Anniversary of the Organization.

WORLD HEALTH DAY 2008 COMMEMORATION FOCUS ON CLIMATE CHANGE

WORLD NO TOBACCO DAY 2008 TARGETS YOUTH

WHO's 60th Anniversary

In 2008, WHO celebrated its 60th anniversary. The Honourable Minister of Health and Social Services, Dr Richard N. Kamwi and the UN Resident Coordinator, Mr Simon Nhongo, together with the WHO Country Representative Dr Magda Robalo launched the celebrations at the UN House in Namibia.

As part of the 60th anniversary celebrations , a photo collection – spanning the 60 years of WHO – was exhibited around the world in 2008, including Namibia. The exhibit, based on the anniversary theme of "Our health, our future", tells the story of WHO and public health over the last 60 years. It featured key public health milestones including, but not limited to: the development of the first successful polio vaccine, the eradication of smallpox, primary health care, tobacco control and the revision of the International Health Regulations.

The exhibit also looked to the future covering themes such as protecting health from climate change, the future of primary health care and the use of information and communication technologies for better health outcomes.

The Namibia photo exhibition, organized in partnership with the MoHSS, was launched by the Honourable Minister of Finance, Ms Saara Kuugongelwa Amadhila, seen left in the photo below.

Launching of the World Health Report 2008

The World Health Report 2008, **Primary health care – now more than ever,** was launched in Namibia by the Honourable Minister of Health and Social Services, Dr Richard N Kamwi. This report critically assesses the way health care is organized, financed, and delivered in rich and poor countries around the world. It provides evidence on some of the challenges that prevent people around the world from enjoying good health to their fullest potential and points out the increasing inequalities within and between countries.

"The World Health Report sets out a way to tackle inequities and inefficiencies in health care, and its recommendations need to be heeded. A world that is greatly out of balance in matters of health is neither stable nor secure," said WHO Director-General Margaret Chan at the launch of the report in Almaty, Kazakhstan.

The Honourable Minister of Health and Social Services, Dr Richard Kamwi launches the 2008 World Health Report

The report commemorates the 30th anniversary of the Alma-Ata International Conference on Primary Health Care held in 1978, an event that was the first to put health equity on the international political agenda.

In the 2008 World Health Report, WHO proposes that countries should be guided by four broad, interlinked policy directions when making health system and health development decisions. These four represent the core primary health care principles:

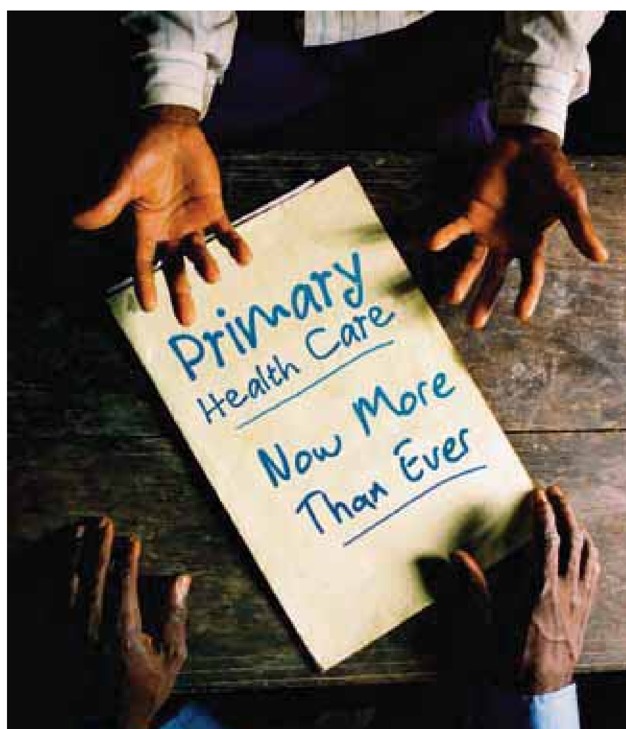
Universal coverage: For fair and efficient systems, all people must have access to health care according to need and regardless of ability to pay. If they do not have access, health inequities produce decades of differences in life expectancies not only between countries but within countries. These inequities raise risks, especially of disease outbreaks, for all. Providing coverage to all is a financial challenge, but most systems now rely on out-of-pocket payments which is the least fair and effective method. WHO recommends financial pooling and pre-payment, such as insurance schemes.

People-centred services: Health systems can be reoriented to better respond to people's needs through delivery points embedded in communities.

Healthy public policies: Biology alone does not explain many gaps in longevity. Much of what impacts health broadly lies outside the influence of the health sector. Ministries of trade, environment, education and others, all have their impact on health, and yet little attention is generally paid to decisions in these ministries that have health impacts. A "health in all policies" approach needs to be integrated broadly throughout governments.

Leadership: Existing health systems will not naturally gravitate towards more fair, efficient (those that work better) and effective (those that achieve their goals) models. So, rather than command and control, leadership has to negotiate and steer. All components of society – including those not traditionally involved in health – have to be engaged, including civil society, the private sector, communities and the business sector.

Health leaders need to ensure that vulnerable groups have a platform to express their needs and that these pleas are heeded. There is enormous potential to be tapped. In half of the world's countries, health issues are the greatest personal concern for a third of the population. Wise leadership requires knowledge of what works. Yet health systems research is an area that is often severely under-funded.



WHO Library Services

WHO Namibia maintains a Library Service in order to provide the Namibian citizens, in particular the health workers and other interested stakeholders, access to health, medical and development information resources. The Library provides comprehensive library and information services on WHO published information in print and other media.

The Library is serviced by a librarian who orientates users on WHO's collections and help them with information on how to use the library and its information resources. The Library also disseminates medical and health related literature to health and training institutions, professionals and partners organizations through a well established mailing list, on a regular basis.

The services of the Library will continue to be improved to avail the widest possible range of health and biomedical literature to potential users in a most cost-effective way.

INTERNATIONAL HEALTH REGULATIONS (2005)

EVERYBODY'S BUSINESS
STRENGTHENING HEALTH SYSTEMS TO IMPROVE HEALTH OUTCOMES

Why is giving special attention to adolescents important for achieving Millennium Development Goal 5?

AFRO News

GLOBAL MALARIA CONTROL AND ELIMINATION: report of a technical review

AFRO News
Africa Hosts Historic Conference on Primary Health Care and Health Systems to Renew Commitment to Health for All

A Strategic Framework for Malaria Prevention and Control During Pregnancy in the African Region

The Health of the People
The African Regional Health Report

5.9 Staff Development and Team Building

Gender equality training for WHO staff

The goal of gender equality is that "The Human Rights of women, girls, boys and men are equally promoted and protected." It is therefore everybody's responsibility and obligation to promote gender equality in order to create a just and balanced society where women and men, girls and boys enjoy opportunities and rights on an equal basis. In order to achieve this, programmes need to be designed that target women and girls, boys and men and also mainstream gender in all activities.

Gender equality is a principle that stipulates that all women and men are equal before and under the law. Women and men have equal dignity, worth of the person. And women and men have equal opportunities in economic, political, cultural and social life.

In order to strengthen streamlining of gender into WHO's work at country level, a training on gender issues was organized for WHO staff, and facilitated by the UNCT Gender Adviser. The training was an introduction to gender and gender equality and focused on the meaning, principles and related concepts of gender equality. The difference between gender and sex were explained and gender equality defined. It was emphasised that gender equality does not mean 'sameness' but rather equal enjoyment of rights, opportunities, socially valued goods, resources, rewards and benefits by females and males of all ages. Gender roles were also classified and explained. Protecting human rights and promoting gender equality must be seen as central in all aspects of society.

Staff retreat

The WHO Namibia staff went on a retreat from November 19 to 21, 2008. The objectives of the retreat were to strengthen performance through improved team work and better communications. Topics such as team effectiveness, trust, communication and conflict handling were developed through exercises, discussions and feed back questionnaires.

A team from the Ministry of Health and Social Services lead by the Honourable Minister, Dr Richard N. Kamwi joined the WHO retreat during a plenary session. The Honourable Minister delivered a keynote presentation on "Working together with WHO for better health", focusing on the various areas of support provided by WHO and the challenge ahead in the health sector.

WHO staff at the retreat

The following were noted as the participants' expectations at the retreat:

• Better team work
• A time together that can benefit all team members
• Help us to relieve stress
• Have fun and a good time together
• To lighten the load
• Be challenged to perform better
• Learn to respect one another
• Understand each other better
• Improve communication
• Better time management
• Get to know each other better
• Restore our high reputation as WHO
• Adapt to change
• Go back to the office as a new team

The Honourable Minister of Health and Social Services, Dr Richard Nchabi Kamwi addresses WHO staff at their retreat

WHO staff family photo with the Honourable Minister of Health and Social Services and other MoHSS staff

The WHO team in Namibia is able to work well together as a team, under a strong and yet flexible leadership.

Danie Botha, Facilitator, Free to Grow

NOTES:

Section 6 ● Conclusion

Section 6

Conclusion

"WHO remains committed to supporting Namibia in the provision of quality health services for all, as well as the attainment of the health MDGs."

Namibia continued to make steady progress in addressing national health issues over the course of 2008. As has been indicated in the previous sections of this report, even as it continues to face challenges related to the major communicable diseases, the country has been able to undertake some commendable responses. Several of these activities lay the groundwork for a more responsive and quality-oriented health care system. For instance, the undertaking of the Health and Social Services Systems Review and the subsequent development of the MoHSS Strategic Plan 2009-2013, both supported by WHO as a partner organization, should ensure that the public health system's challenges are addressed in a coordinated and comprehensive manner. The National Health Accounts Report, which was also published in 2008, shall further facilitate the process of planning, allocation and disbursement of financial resources going forward.

This was also the year for innovative and first time events, such as, the holding of the first-ever male conference on HIV/AIDS that saw the participation of men from a cross-section of sectors and industry. It was also the year when consideration was given towards innovative prevention interventions that include PITC and medical male circumcision. These are all proof of the country's commitments to mitigating the impact and effect of HIV/AIDS on the country. Similarly, the initiative to strengthen the blood transfusion programme contributes towards HIV prevention as well as the overall health care system. All these interventions give hope for the attainment of MDG 6.

However, there remain several challenges that need to be addressed. As has been indicated in Section 5.2, maternal and under-five mortality rates continue to be of growing concern, as current trends make it less likely for the country to attain MDGs 4 and 5. This is despite the fact that 81% of births in Namibia occur in health facilities. The National Conference on Maternal and Child Health that is planned for 2009 aims to identify priority actions in order to curb these trends. Raising the profile of maternal and child health and mobilization of additional resources for this important area shall continue to be a priority for WHO in Namibia.

Continued and sustained funding is also a challenge for other health aspects. More efforts and resources are necessary to continue interventions to reduce stigma, support high risk groups and vulnerable people, and to strengthen national monitoring and coordination systems. WHO shall therefore continue to offer its support in technical and financial resource mobilization.

Health aspects that receive less attention than others shall continue to be promoted, particularly the NCDs that are now reported to be on an increasing trend. WHO is already committed towards the full establishment of a database on NCDs which is necessary for the development of a national policy and strategy.

One of the more general challenges across the health sector is the limited human resource capacity to implement national health programmes. WHO shall continue to provide technical assistance in order to build human capacity at both management and technical levels. Additional support shall also be provided for regional interventions and cross-border activities, such as strengthening malaria control effort towards elimination in six SADC countries.

WHO remains committed to supporting Namibia in the provision of quality health services for all, as well as the attainment of the MDGs. We further appreciate the opportunity to serve Namibia, and the team looks forward to even stronger partnerships going forward.

NOTES:

Section 7 ● References

Section 7

References

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[2] National Demographic and Health Survey (NDHS), 2006-07, page 1.

[3] NDHS, 2006-07, page 2.

[4] http://hdrstats.undp.org/countries/country_fact_sheets/cty_fs_NAM.html

[5] Trends in Human Development and Human Poverty in Namibia, Human Development Report, 2007, page 7.

[6] NDHS, 2006-07, page 113. *The DHS however places a caveat on the figures and notes that "this figure should be viewed with caution because the number of female deaths that occurred during pregnancy, at delivery, or within two months of delivery is small (86). As a result the mortality estimates are subject to large sampling errors"*

[7] NDHS, 2006-07, page 100.

[8] NDHS, 2006-07, page 149.

[9] Third National Development Plan (NDP 3), page 210.

[10] Medium Term Expenditure Framework for 2008/2009 to 2010/2011, page 177.

[11] NDHS, 2006-07, page 3.

[12] African Economic Outlook Report, 2006/2007, page 407. *It quotes a gini-coefficient of 0.6, which is reported to be one of the worst in the world.*

[13] African Economic Outlook Report, 2006/2007, page 407. *Reported at 42%.*

[14] NDP 3, page 70. *This statistic is as per the broad definition of unemployment which includes unemployed people that are looking for work as well as those not looking for work but are available to work.*

[15] Central Bureau of Statistics, National Planning Commission, A review of poverty and inequality in Namibia, page 6. *This report applied a new methodology in the calibration of "severely poor" – the Cost of Basic Needs approach - that took monthly expenditures into consideration, as opposed to the old method that calculated household expenditures on food. The application of the CBN approach showed the component of severely poor people move from 3.9% to 13.8%.*

[16] Bank of Namibia, 2007 Annual Report, page 88.

[17] Bank of Namibia, 2007 Annual Report, page 97.

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[19] Reuters RSS Service, 10 Dec 2008: "Weaker exports to slow Namibia GDP growth: IMF"

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[31] NDHS, 2006-07, pages 115-6.

[32] NDHS, 2006-07, page 100.

[33] The Millennium Development Goals (MDG) Report, 2008, page 13.

[34] NDHS, 2006-07, pages 148-150.

[35] NDHS, 2006-07, page 19.

[36] Report on the National HIV Sentinel Survey, 2008, Ministry of Health and Social Services, page 16.

[37] Report on the National HIV Sentinel Survey, 2008, Ministry of Health and Social Services, page 13.

[38] Report on the National HIV Sentinel Survey, 2008, Ministry of Health and Social Services, page 18.

[39] Report on the National HIV Sentinel Survey, 2008, Ministry of Health and Social Services.

[40] Rolling Continuation Channel, HIV/AIDS Application document submitted to Global Fund to fight AIDS, Tuberculosis and Malaria.

[41] Rolling Continuation Channel, HIV/AIDS Application document submitted to Global Fund to fight AIDS, Tuberculosis and Malaria.

[42] NDHS, 2006-07, page 207.

[43] COMBI/ AFHS Survey, page 23: This study which covered three populous Regions in the north of Namibia found that two-thirds of sexually active men had used a condom in three consecutive previous occasions of sexual intercourse.

[44] Rolling Continuation Channel, HIV/AIDS Application document submitted to Global Fund to fight AIDS, Tuberculosis and Malaria.

[45] National Vector-borne Disease Control Programme, Annual Report 2007/08, page 1.

[46] National Vector-borne Disease Control Programme, Annual Report 2007/08, page 3.

[47] National Vector-borne Disease Control Programme, Annual Report 2007/08, page 6.

[48] KNCV Tuberculosis Foundation, Report on a visit to Namibia 17 – 28 November 2008, Report no. 4, page 5

[49] The MDG Report, 2008, page 59.

[50] KNCV Tuberculosis Foundation, Report on a visit to Namibia 17 – 28 November 2008, Report no. 4, page 21.

[51] NDHS, 2006-07, page 135.

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