

# COUNTRY COOPERATION STRATEGY III 2018-2022

*Accelerating Progress Towards Universal Health Coverage*



**WHO COUNTRY OFFICE, NAMIBIA**



**World Health  
Organization**

REGIONAL OFFICE FOR **Africa**

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**WORLD HEALTH ORGANIZATION  
REGIONAL OFFICE FOR AFRICA  
BRAZZAVILLE • 2019**

**Country Cooperation Strategy III 2018-2022: Accelerating Progress Towards Universal Health Coverage**

ISBN: 978-929031317-5

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Cataloguing-in-Publication (CIP) data. CIP data are available at <http://apps.who.int/iris>.

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Designed and printed by TIP Unit, WHO Regional Office for Africa, Brazzaville

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## ACRONYMS AND ABBREVIATIONS

AC	Assessed Contribution
AFHS	adolescent-friendly health services
AIDS	acquired immunodeficiency syndrome
ANC	antenatal care
ARCC	African Regional Certification Commission for Polio Eradication
ARI	acute respiratory infection
ART	antiretroviral therapy
ARV	antiretroviral medicines
BNLSS	Botswana, Namibia, Lesotho, South Africa and Swaziland
CCS	Country Cooperation Strategy
CHS	Catholic Health Services
CDC	Centers for Disease Control and Prevention (Atlanta)
CSO	civil society organization
DOTS	directly-observed treatment, short-course
DSP	Directorate of Special Programmes
EmONC	emergency obstetric and newborn care
EMT	Extended Management Team
EMTCT	Elimination of Mother-to-Child Transmission of HIV
EPI	Expanded Programme on Immunization
FAO	Food and Agriculture Organization of the United Nations
GDP	Gross Domestic Product
GFATM	Global Fund to Fight Aids, Tuberculosis and Malaria
GSM	Global Management System
GTZ	<i>Gesellschaft für Technische Zusammenarbeit</i> (German Technical Cooperation)
HAMU	HIV and AIDS Management Unit
HIV	human immunodeficiency virus
HRD	Human Resources Development
HSS	Health Systems Strengthening
ICT	Information and Communication Technology
IDSR	Integrated Disease Surveillance and Response
IHR	International Health Regulations
IMAAI	Integrated Management of Adolescent and Adult Illness

## WHO Country Cooperation Strategy III 2018–2022

IMCI	Integrated Management of Childhood Illness
IMNCI	Integrated Management of Newborn and Childhood Illnesses
IT	Information Technology
I-TECH	International Training and Education Centre on HIV
JICA	Japan International Cooperation Agency
JPO	Junior Programme Officer
KFW	<i>Kreditanstalt für Wiederaufbau</i> (Reconstruction Credit Institute)
MDG	Millennium Development Goal
MDR	multidrug resistance
MOHSS	Ministry of Health and Social Services
NANASO	Namibia Network of AIDS Service Organizations
NAPPA	Namibian Planned Parenthood Association
NASOMA	National Social Marketing Programme
NCD	noncommunicable disease
NDHS+	National Demographic and Health Survey Plus
NDP 3	National Development Plan 3
NGO	nongovernmental organization
NHA	National Health Accounts
NIP	Namibia Institute of Pathology
NPO	National Programme Officer
NVDCP	National Vector-borne Diseases Control Programme
OPM	Office of the Prime Minister
PEPFAR	President's Emergency Plan for Aids Relief
PHC	primary health care
PMTCT	Prevention of Mother-to-Child Transmission
PoE	Point of Entry
PSEMAS	Public Service Employee Medical Aid Scheme
SADC	Southern African Development Community
SMT	Senior Management Team
SOP	standard operating procedure
STI	sexually-transmitted infection
SWOT	strengths, weaknesses, opportunities and threats
TB	Tuberculosis
TIPC	Therapeutic Information and Pharmacovigilance Centre



## WHO Country Cooperation Strategy III 2018–2022

UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNAM	University of Namibia
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children’s Fund
UNV	United Nations Volunteers
USAID	United States Agency for International Development
VC	Voluntary Contribution
WCO	WHO Country Office
WHO	World Health Organization
WR	WHO Representative
XDR	extensive drug resistance

## EXECUTIVE SUMMARY

The Third Generation Country Cooperation Strategy (CCS III) outlines the strategic agenda adopted by the World Health Organization in Namibia over the five-year period 2019–2023. It is aligned to WHO’s Thirteenth General Programme of Work, 2019–2023 (GPW 13), the Sustainable Development Goals (SDGs), National Development Plan 5 (NDP5), National Health Strategic Plan (NHSP) and United Nations Partnership Framework (UNPAF) 2019–2023 for Namibia.

The CCS III takes into consideration the health and development situation in the country, including the political, social and macroeconomic context, health status and disease burden, health sector response and support by development partners as well as a review of previous WHO support through CCS II.

The Strategic Agenda in this third-generation Country Cooperation Strategy (CCS III) for Namibia focuses on three interconnected strategic priorities to ensure healthy lives and well-being for all people at all ages, and a fourth priority to enable WHO to fulfil its mandate:

**STRATEGIC PRIORITY 1: Advancing Universal Health Coverage (UHC)**

**STRATEGIC PRIORITY 2: Addressing Health Emergencies**

**STRATEGIC PRIORITY 3: Promoting Healthier Populations**

**STRATEGIC PRIORITY 4: Strengthening Leadership, Governance and Enabling Functions**

These priorities were identified through a rigorous process of national dialogue and consultation with the Government of Namibia, civil society, health development partners, academia and other stakeholders in the health sector. Each Strategic Priority in CCS III relates to a priority in WHO’s Thirteenth General Programme of Work, 2019–2023 (GPW 13). Specific interventions have been selected according to WHO’s unique role and capacity to complement the contributions of other players in the sector.

The first strategic priority (advancing UHC) focuses on the principles of access, equity, quality and sustainability. WHO will support the country’s efforts to achieve and sustain equitable access to quality health services for all through improved quality and scope of the essential health package, integration of services and targeting of key populations/marginalized groups.

The second strategic priority (addressing health emergencies) focuses on strengthening health security through the improvement of national preparedness, promoting adherence to the International Health Regulations (IHR, 2005), utilisation of the international framework for the monitoring and evaluation of IHR and enhancing collaboration with relevant partners and countries to prepare for and respond to public health emergencies.

The third strategic priority (promoting healthier populations) focuses on improving people’s health through the promotion of healthy lifestyles and reduction of risk factors.

The fourth strategic priority (strengthening leadership, governance and enabling functions) focuses on strengthening the internal capacity of the Country Office for generating,

interpreting and disseminating data, with attention to new and innovative processes and technologies.

These interventions support the country's National Health Strategic Plan (NHSP) 2017-2022, which is organized around three pillars: people's well-being, operational excellence and talent management.

## CHAPTER 1 • INTRODUCTION

This chapter sets out the policies underlying the role of the CCS in the wider landscape of health development.

### 1.1 WHO Policy Framework

WHO's vision (according to Article 1 of the WHO Constitution) and revised mission, strategic priorities and 'triple billion goals' are articulated in the Thirteenth General Programme of Work (GPW 13):

#### **VISION:**

A world in which **all** people attain the **highest** possible standard of health and well-being.

#### **MISSION:**

Promote health - keep the world safe - save the vulnerable.

#### **STRATEGIC PRIORITIES AND GOALS:**

Ensuring healthy lives and promoting well-being for all at all ages by:

- **Advancing universal health coverage**  
1 billion more people benefitting from universal health coverage
- **Addressing health emergencies**  
1 billion more people better protected from health emergencies
- **Promoting healthier populations**  
1 billion more people enjoying better health and well-being.

The GPW 13 signals three shifts in WHO's global strategy: stepping up leadership at all levels, driving public health impact in every country and strengthening WHO's normative work. (AFRO, 2015)

### 1.2 Country Context

The development of this Country Cooperation Strategy was timed to synchronize with the National Health Strategic Plan (NHSP) 2017–2022 and the UN Partnership Framework (UNPAF) for 2019–2023.

Based on a detailed analysis of the situation in Namibia and national priorities as articulated in the NHSP and during the national dialogue process, the WHO Country Office Namibia elected to concentrate its work in the next five years on the three strategic priorities of the GPW 13 and their (9) respective outcomes, as well as the corporate outcome on data and innovation.

### 1.3 CCS Development Renewal Process

The CCS process was led by the WHO Representative (WR) with support from consultants, Grow Training and Advisory Services, and the CCS Working Group, which was constituted of WCO staff, senior-level government officials in the Ministry of Health and Social Services (MoHSS), officials from UN agencies and other key stakeholders.

A total of 26 health partners participated in the process, including the MoHSS, other line ministries and agencies, parastatals and educational institutions, public sector organizations, CSOs and international development partners, including other UN agencies.

## CHAPTER 2 • HEALTH AND DEVELOPMENT SITUATION

This chapter provides a strategic overview of current and anticipated health and development issues that affect the achievement of Namibia’s health priorities.

### 2.1 Political, Social and Macroeconomic Context

After almost a century of colonial rule by Germany and illegal occupation by apartheid South Africa, and over twenty years of armed struggle, Namibia gained independence on 21 March 1990. Since then, the country has enjoyed peace and stability with a democratic government based on a multi-party electoral system, bicameral legislature and 14 administrative regions. Namibia is a Member State of the United Nations, the African Union, the Southern African Development Community and the Commonwealth of Nations.



Namibia’s gross domestic product (GDP) in 2016 was US\$ 13 429 million, ranking 126th out of 211 countries. The economy is expected to grow by upwards of 4% in coming years. The country’s key economic sectors are agriculture, fisheries, tourism and mining. Namibia’s erratic rainfall makes its agricultural sector precarious and droughts and floods dramatically affect crops and livestock. The economy is also vulnerable to the effects of economic crises, both globally and in the SADC region.

Poverty rates have declined significantly since independence but still stand at 27% in rural areas. The overall unemployment rate sits at around 29% and youth unemployment is as high as 43.4%. Although Namibia is ranked as a middle-income country, it has one of the most unequal distributions of income per capita in the world.

Namibia is one of the world’s most sparsely populated countries with a population of 2 458 800 (about 2.6 persons per km<sup>2</sup>), 66% of whom are under the age of 30. Regional population densities vary substantially, with almost two thirds of the population living in the four northern regions while less than one-tenth live in the south.

Figure 1: Population Pyramid



Source: Ministry of Health and Social Services; Namibia Statistics Agency, 2014

Namibia is mostly rural and only about four out of ten people live in urban areas although this number has been rising steadily due to rapid rural-urban migration. The country’s official language is English, and there are more than 11 indigenous languages with close to 50% of the population speaking a variant of the Oshiwambo group of languages.

## 2.2 Health Status

### HIV and AIDS, TB and Malaria

Namibia is one of the countries that are worst-affected by TB, and 9944 cases were reported in 2015. Multidrug resistance is a major problem. Ninety-two per cent of HIV-infected TB patients are on antiretroviral therapy (ART).

Namibia has one of the highest HIV/AIDS prevalence rates in the world. The estimated prevalence in 2016 among pregnant women was 17.2%. Recent data from the Namibia Population-based HIV Impact Assessment (NAMPHIA 2017) shows that the annual incidence of HIV among adults aged 15–64 is 0.36% and the prevalence rate within the same group is 12.6%. The incidence in young females aged 15–24 is three times higher than the national average. Namibia has reached or exceeded the UNAIDS 90-90-90 targets among women and also nationally, by attaining 86-96-91 among adults. The results also showed that 77% of all HIV-positive adults have achieved viral load suppression, surpassing the Joint United Nations Programme on HIV/AIDS (UNAIDS) target of 73% by 2020. Compared with the UNAIDS 2012 estimates, Namibia has reduced its adult HIV incidence rate by 50% in the past five years. The remarkable gains in the HIV response are the result of the Government’s commitment and ownership and the substantial support from the international and local development community. Successful strategies have included adopting a multisectoral, mainstreaming approach, making young people and key populations a key focus, decentralizing HIV services and implementing the 2013 WHO Treatment Guidelines.

There are a number of continuing challenges, including reduced funding for social and behaviour change communication (SBCC), lack of supplies and support for home-based carers and caregivers for orphans and vulnerable children (OVC) and the separation of HIV, TB and other services. Others are stigma and discrimination and other obstacles to access to services by key populations, and logistical challenges in the distribution of condoms and testing kits. Harmful social norms, values and culture, alcohol use, gender-based violence (GBV) and stigma continue to increase risk behaviours, particularly for young people.

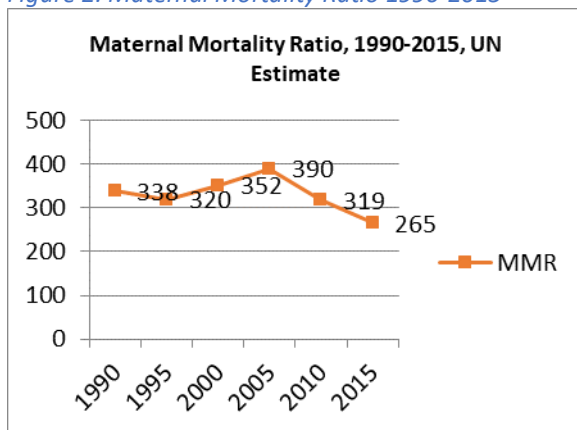
Namibia is in a malaria pre-elimination phase, with incidences dropping from 249.7 to 10.3 cases per 1000 population from 2002 to 2016. The malaria response is succeeding because of high-level political commitment, improved monitoring and tracing, sensitization campaigns, cross-border coordination and quick, effective response through the National Emergency Committee. The threat of losing acquired immunity and outbreaks due to repeats of the flooding experienced in 2016/2017 are ongoing challenges. The most at-risk groups are children under the age of five, pregnant women, people living in hard-to-reach areas, nomadic groups in the Kunene region and those who cross the border to and from Angola and Zambia.

### Neglected Tropical Diseases (NTDs)

The main NTDs endemic in Namibia are soil-transmitted helminths, schistosomiasis, trachoma, scabies, snake bite, rabies and leprosy. Namibia has reached elimination status for leprosy, but there is a need to systematize diagnosis and reporting.

### Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition

Figure 2: Maternal Mortality Ratio 1990-2015



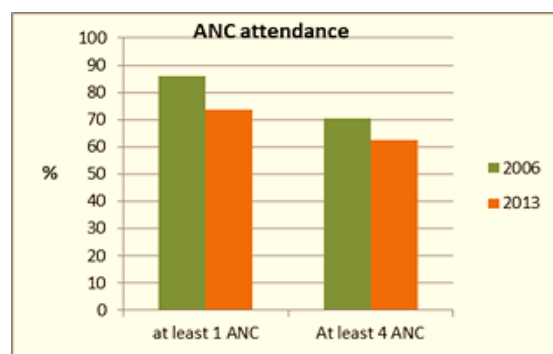
Source: UN's Maternal Mortality Estimation Inter-Agency Group report, 2016

Although the maternal mortality ratio (MMR) decreased dramatically between 1990 and 2015, the drop was not enough to achieve the MDG 5 target of less than 150 deaths per 100,000 live births. Moreover, with higher mortality in rural than urban areas and in low socio-economic than higher socio-economic groups, issues of equity are a serious concern. Most maternal deaths are related to low quality of emergency obstetric care (EmONC).



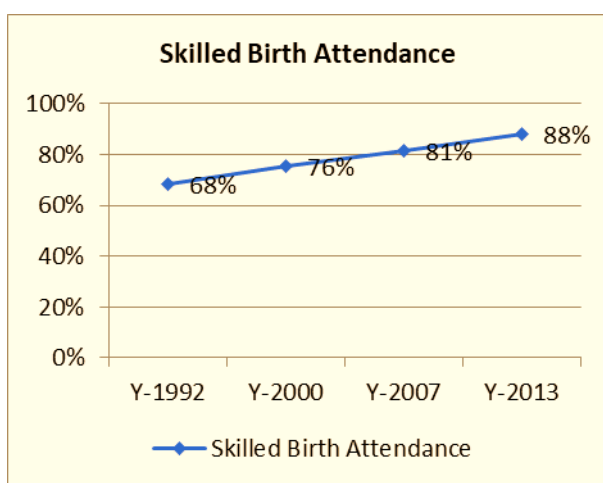
Despite the availability of free antenatal care (ANC) services in all health facilities, the proportion of women who received at least one ANC service dropped from 86% in 2006 to 73.6% in 2013. Similarly, HIV testing in pregnancy declined from 94% in 2009 to 79% in 2014.

Figure 3: ANC Attendance 2006-2013



Source: Ministry of Health and Social Services; Namibia Statistics Agency, 2014

Figure 4: Trends in Skilled Attendance at Birth 1990–2015

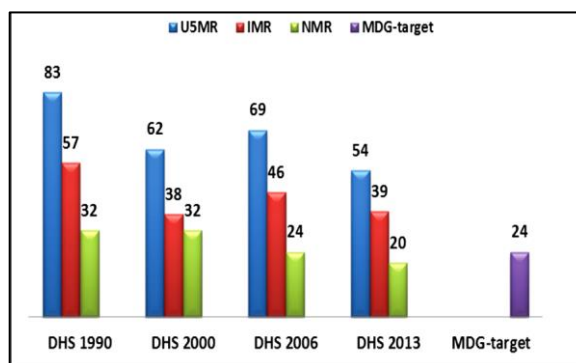


Source: Ministry of Health and Social Services; Namibia Statistics Agency, 2014

The proportion of women who deliver in health facilities remains high at 87%, and 88% of deliveries are attended by a skilled birth attendant. However, the quality of care in MNCH services is in serious need of improvement. Coverage of post-natal care (PNC) also needs to be expanded. In 2013, only 20% of newborns and 69% of mothers received PNC within the first two days of delivery.

Rates of infant and child mortality have decreased over time with infant deaths dropping from 57 to 39 per 1000 live births registered from 1992 to 2013. Under-five mortality decreased from 83 to 54 per 1000 live births from 1992 to 2013. The major reasons for under-five death include neonatal causes, pneumonia and diarrhoea, with malnutrition as an underlying factor.

Figure 5: Trends in Childhood Mortality 1990–2013

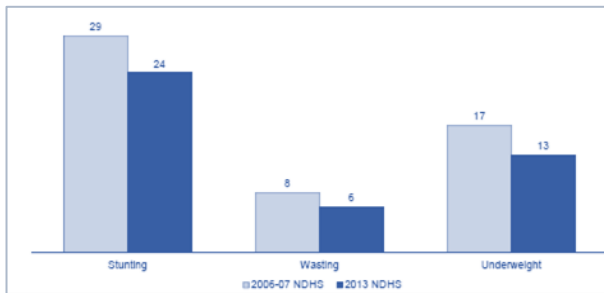


Source: Ministry of Health and Social Services; Namibia Statistics Agency, 2014

The neonatal mortality rate is 20 deaths per 1000 live births, accounting for 35% of under-five mortality. The proportion of fresh stillbirths in the country has generally declined during the same period. Large variations in the data indicate that equity is an issue.

The immunization of under-ones and routine immunization coverage stood at 88% in 2016/2017. Supplementary immunization campaigns were successfully conducted during measles outbreaks in specific regions. There have been no serious measles outbreaks since 2013 and with the introduction of the second dose of measles-containing vaccine in 2016, the country is on track to eliminate the disease by 2020.

Figure 6: Trends in Stunting, Wasting and Underweight 2006–2013



Source: Ministry of Health and Social Services; Namibia Statistics Agency, 2014

The prevalence of underweight, stunting, wasting and severe underweight has been on the decline but in 2013, underweight was still at 13.4%, stunting at 23.8% and wasting at 6.2%, with high regional variations. Namibia has made great strides in the promotion of breastfeeding, with the proportion of babies exclusively breastfed for the first six months rising from 23% in 2006 to 49% in 2013.

In response to the high rate of teenage pregnancy in most regions of the country and the vulnerability of young people (especially AGYW) to STIs, including HIV, there has been an increased focus on adolescent health. Adolescent-friendly health services (AFHS) have been rolled out in the country but an assessment showed that these are provided in only 19 of the 35 health districts and only 21% of health facilities have youth-friendly HIV-testing services. Counselling services for adolescents are also inadequate.

The Ministry of Education, Arts and Culture (MOEAC) is a key partner in the implementation of health initiatives targeting young people, including the Health Promoting Schools Initiative (HPSI) and School Health Programme. More disaggregated data and strategies targeting the partners of AGYW as well as the causes of vulnerability (such as poverty and unemployment) are needed.

Family planning and contraceptive services are available in all public health facilities across the country. However, there are limitations related to the mix of methods as well as supply issues. The unmet need for family planning is 12%.

Gender-based violence (GBV) is a prevalent social ill with 33% of married women having experienced some form of violence. This area is underserved: the number of facilities equipped to provide care and support to survivors is inadequate and the public are mostly unaware that they exist.

The gains recorded in the area of RMNCAH&N include an increase in the expenditure on reproductive health between 2008/2009 and 2012/2013 (from 10.3% to 38% of total health expenditure respectively), and on construction of maternal waiting homes. More funds were also spent on health promotion and immunization awareness through Maternal and Child Health Days, capacity building and the provision of vehicles and equipment for district health facilities. However, achieving equitable distribution of skilled staff remains a challenge.

### **Noncommunicable Diseases (NCDs) and Healthy Lifestyles**

Noncommunicable diseases like hypertension, diabetes and cancer are currently the leading cause of death in Namibia, accounting for 43% of all deaths. Based on current trends, by 2020 NCDs will account for 73% of deaths and 60% of the disease burden. High blood pressure, or hypertension, is a major risk factor for cardiovascular disease and is the leading cause of disability among adults in Namibia. Thirteen per cent of Namibians are either diabetic or pre-diabetic but only 3% are aware of their status and on average nearly 30% of diabetics are not taking medication. The risks of developing both hypertension and diabetes generally increase with age and obesity. The cancer incidence overall doubled between 2005 and 2014. The most common types of cancer in Namibia are prostate and Kaposi sarcoma among males and breast and cervical cancer among females.

Common risk factors for NCDs in Namibia include tobacco use, harmful use of alcohol, physical inactivity and unhealthy diet. The prevalence of tobacco use is 19% for men and 5% for women. Alcohol consumption is 10.8 L per person, which is one of the highest average rates of alcohol consumption in the African Region. The vast majority of Namibians (80% of women and 57% of men) are not physically active. Namibia adopted the regulations of the Tobacco Product Control Act No 1 in 2014 and has been implementing the recommendations of the Framework Convention on Tobacco Control. Sensitization campaigns have increased public awareness and NCD indicators have been added to the NDHS. However, there is still a lack of reliable, detailed data and support for addressing risk factors.

### **Mental Health, Injuries and Disability**

In Namibia, more women than men experience mental disorders or illnesses. One indication of the prevalence of mental health problems (and inadequacy of services) in Namibia is the suicide rate, which is extremely high at 22.1 per 100 000 population and young people are among those at risk. Only 18% of women and a very low 9% of men with mental health issues seek medical care. There are only two public psychiatric hospitals (in Windhoek and Oshakati) and very few psychotherapists/counsellors, especially in rural areas.

In 2013 Namibia was reported to have the highest per capita motor vehicle mortality rate in the world, with a total of 4076 crashes, 8890 injuries and 669 fatalities in 2015/2016. The youth are especially at risk. Efforts in recent years have had a positive impact and there was an 11% decrease in crashes between 2014 and 2016. However, Namibia lacks emergency medicine and trauma facilities and there is also a shortage of paramedics and ambulances. Multisectoral accident prevention strategies (such as road safety management), education, enforcement, engineering of roads and vehicles and emergency response are therefore a priority.

Disability is a concern in Namibia as the proportion of persons with disabilities is estimated at 5%. The most common disabilities are visual impairment among females and physical impairment of the lower limbs among males.

## Essential Demographic, Health and Socioeconomic Indicators

Table 1 below presents the most up-to-date demographic, health and socioeconomic indicators for Namibia as of the date of publication.

**Table 1: Essential Indicators**

WHO region	Africa
World Bank income group	Upper-middle income
<b>POPULATION (WHO, 2018)</b>	
Total population in thousands (2015)	Total: 2458.8
% Population under 15 (2015)	Total: 36.7%
% Population over 60 (2015)	Total: 5.5%
<b>SUSTAINABLE DEVELOPMENT GOALS (WHO, 2018)</b>	
Life expectancy at birth in years (2015)	Both sexes: 65.8 Male: 63.1 Female: 68.3
% births attended by skilled health workers (2013)	88.2%
<b>MORTALITY RATES (WHO, 2018)</b>	
Neonatal mortality rate per 1000 live births (2016)	17.8
Under-five mortality rate per 1000 live births (2016)	45.2
Maternal mortality ratio per 100 000 live births (2016)	265
% DTP3 immunization coverage among 1-year-olds (2016)	92%
<b>HEALTH PROFESSIONALS DISTRIBUTION (WHO, 2018)</b>	
Density of physicians per 1000 population (2007)	0.372
Density of nurses and midwives per 1000 population (2007)	2.76
<b>HEALTH EXPENDITURE (Ministry of Health and Social Services, 2017)</b>	
Total expenditure on health as % of GDP (2014)	8.93%
General government expenditure on health as % of total government expenditure (2014)	13.86%
Private expenditure on health as % of total health expenditure (2014)	30% <sup>1</sup>
<b>LITERACY RATE (Ministry of Health and Social Services; Namibia Statistics Agency, 2014)</b>	
Adult (15+) literacy rate (2013)	92%
<b>WATER AND SANITATION (Ministry of Health and Social Services; Namibia Statistics Agency, 2014)</b>	
Population using improved drinking water sources (%) (2013)	84%
Population using improved sanitation facilities (%) (2013)	33.8%
<b>DEMOGRAPHIC AND SOCIOECONOMIC INDEXES (WHO, 2018)</b>	
Poverty head count ratio at \$1.25 a day (PPP) (% of population) (2004)	31.9
Gender Inequality Index rank out of 148 countries (2014)	81
Human Development Index rank out of 186 countries (2014)	126

<sup>1</sup> GHO gives this figure as 40% (2014)

## 2.3 Health System Response

The Government of Namibia recognizes that health is a fundamental human right and for this reason, it is committed to achieving health for all Namibians.

### Health Governance

There are seven directorates at national level and fourteen Regional Health Directorates overseeing service delivery in thirty-five health districts. The MoHSS Strategic Plan identifies a need to focus on effective governance through capacity-building for improved leadership and management, acceleration of the decentralization process, evidence-based decision-making and better contract management.

### Health Policy and Legal Framework

The health sector is currently governed by the National Health Policy Framework 2010–2020 and a range of Acts, including the Public Health and National Environmental Health Act (2015), International Health Regulations (ratified 2007) and the Hospitals and Health Facilities Act (1994). Several policies are currently under review and a number of bills have been approved and are awaiting enactment. These include the Mental Health Bill and the Food and Safety Bill. The General Health Regulations (1969) and Regulations for the Control of Blood Transfusion Services (1962) also need to be updated.

### Health Services

The MoHSS takes a primary health care (PHC) approach to the delivery of health services, based on the four pillars of health promotion, disease prevention, curative services and rehabilitation services. The private sector is mainly concentrated in the urban areas.

There have been several improvements to service delivery since 2010, including the provision of more clinics and hospitals and introduction of new services, such as cardiac services in referral hospitals and nuclear medicine capabilities in the north. Patients are referred to private institutions in Namibia and South Africa for special investigations and procedures, such as MRI, dialysis, ophthalmic services and EEG. The MoHSS is in the process of decentralizing services, which will improve responsiveness. However, the quality of public services remains a concern and complaints of low quality of care are common, especially in rural areas.

### Health Resources

#### Human Resources for Health (HRH)

In 2017, the MoHSS staff establishment stood at 13 082 (of which 11 700 positions [89%] were filled). This represents an increase of 1812 positions from 2013. However, a shortage of human resources and their inequitable distribution have been a constant challenge for the Namibian health system while inadequate capacity continues to hamper effective implementation of programmes and plans. Although the supply of local health professionals

in priority areas has been increased through the establishment of the School of Medicine at the University of Namibia (UNAM) and other programmes at the Namibia University of Science and Technology (NUST), approvals are still pending for the Ministry’s staff establishment for the regional and district levels. There is a shortage of specialized personnel in areas such as oncology, surgery and mental health as well as a lack of specialists to manage teaching hospitals and provide supervision for trainees. The National Health Training Centre (NHTC) has been supplying nurses since 2014 but it is under-resourced and facing possible closure. An additional cadre - health extension workers (HEW) - has been trained but has not all been deployed.

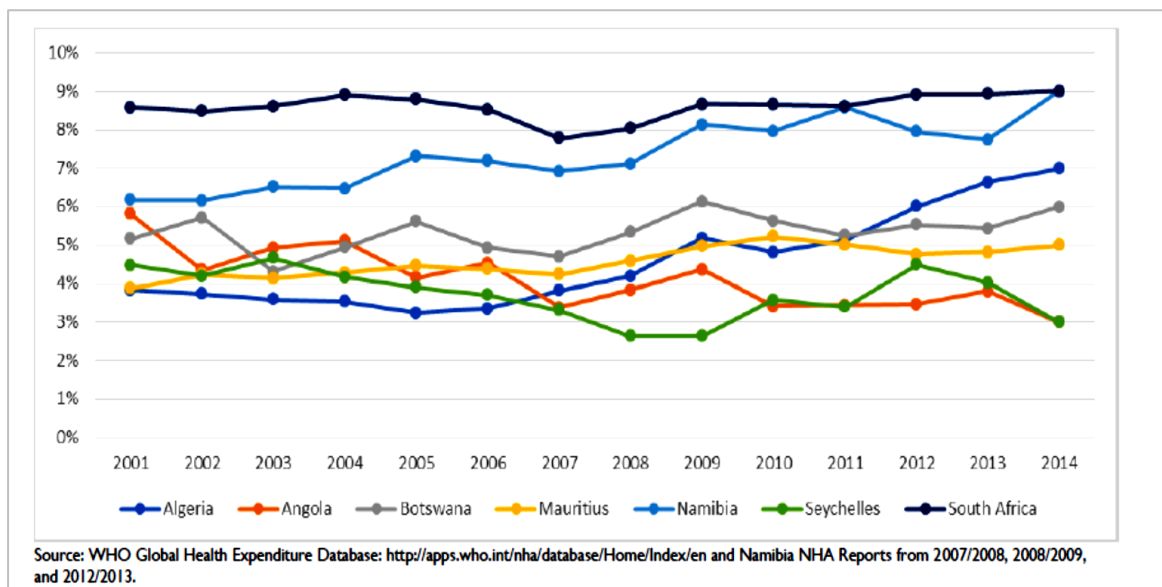
### Physical Facilities

Public health services are provided through 30 public district hospitals, 44 health centres, 269 clinics and 1150 outreach points across the country. Three intermediate hospitals and the National Referral Hospital provide support to the district hospitals. From 2012 to 2017, forty-one health facilities were constructed and 31 were upgraded. Despite these improvements, many facilities continue to experience serious challenges posed by ageing infrastructure and inadequate maintenance. There is also a shortage of properly equipped ambulances for emergency response and transportation of patients.

### Financial Resources

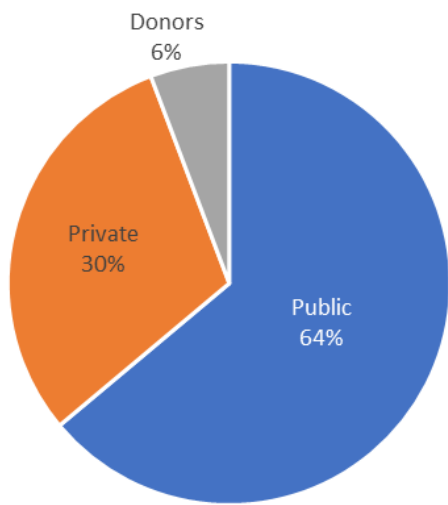
Health expenditure comprises 13% of the Government’s total spending, a higher level than in other countries in the region and close to the 15% target set by the Abuja Declaration.

Figure 7: Country Comparison of THE as a Percentage of GDP, 1995-2013



During the 2014/2015 financial year, the GRN contributed close to two thirds (64%) of total health spending. The private sector contributes 30% of THE in Namibia (comprising households at 10% and companies at 20%), which is slightly lower than the average (33%) for other countries in the region with similar GDP per capita.

Figure 8: THE by Financing Scheme



Source: Ministry of Health and Social Services, 2017

The General Government Financing Scheme accounts for more than half of health spending (51% of THE) and pools resources across the entire population, therefore spreading the risk. 15% is covered by the Public Service Employees Medical Aid Scheme (PSEMAS), with private medical aid funds pooling 21% (a considerable reduction from 30% in 2012/2013). Even so, there is very limited cross-subsidization between rich and poor and the fact that parallel health systems exist reflects the general wealth gap in the country. The 36% of THE that is spent on private health care caters for only 18% of the population, while the remaining 64% covers the other 82% of the population (mostly informal workers, the unemployed, and other vulnerable populations).

The Government’s record of good financial accountability has facilitated consistent support from major international donors. However, since Namibia was reclassified as an upper-middle-income country, donor funding has decreased significantly. Several funders have pulled out completely and those remaining, like the Global Fund, have drastically scaled back their assistance. In an unfavourable global economic climate and with health costs high, resources are not matching the burden of disease and this has adversely affected community-led health services, school health and HRH plans in particular. Namibia needs to develop innovative solutions to support community-led health programmes and build resilient and sustainable systems for health across all sectors.

**Programmes of Local and International Organizations**

Programmes focusing on HIV, TB and malaria receive critical financial and technical support from international development partners such as GFATM, PEPFAR, GIZ and JICA as well as UN agencies, including UNAIDS, FAO, WFP, UNFPA and WHO. Programme implementation involves local FBOs and civil society organizations (CSOs) under the stewardship of the MoHSS, with coordination and support from the Namibia Networks of AIDS Service Organisations (NANASO).

Health systems strengthening (HSS) is supported by organizations like Management Sciences for Health (MSH) and IntraHealth with financial support from USAID and CDC.

Other programmes focus on RMNCAH&N, SRH, adolescent health, environmental health, cancer, and emergency preparedness and response and they are carried out with multisectoral collaboration and support, including from various line ministries and international partners.

All government ministries and agencies are expected to integrate health programmes in their policies, under the oversight of the National Planning Commission (NPC) and facilitated by the ongoing Health in All Policies (HiAP) process, which was initiated in 2015.

## Health Information and Statistics

The health information system is fragmented, and this is a major obstacle to the provision of timely and accurate information for planning and implementation purposes. There are various bottlenecks in the system, including poor flow of information from the national level to the regional/district level and zero capacity for analysing and interpreting data at the regional/district level. In response, the Ministry has introduced a number of measures, including the introduction of the DHIS 2.

The Namibia Demographic and Health Survey (NDHS) is conducted every five years. Biennial HIV sentinel surveys are conducted countrywide to monitor the prevalence of HIV through the surveillance of pregnant women attending antenatal care. Data on communicable diseases are collected through integrated disease surveillance and response (IDSR).

Challenges in this area include maintaining capacity for IDSR and supplementing the existing data on NCDs, mental health, teenage pregnancies and adolescent health. The systems for health research in the country need to be strengthened.

## Medicines and Technologies

Although there have been serious challenges around procurement, including some stock-outs in recent years, the system is adjusting to the Procurement Act that was introduced on 1 April 2017. Mechanisms for the regular inventory and auditing of medical equipment and supplies have been established and the service level for pharmaceuticals and related medical supplies reached 80% in 2018. However, stakeholder trust must be re-established and management capacity at the Central Medical Stores and Pharmaceutical Services needs to be strengthened. Some of the gains that have been made in terms of medicines and technologies since 2010 include the strengthening of blood safety and the Namibia Blood Transfusion Services, progress towards the establishment of a National Public Health Institute, and improved provision of medical gas to health facilities. A Human Medicines Register and the Namibian Common Technical Document (CTD) were introduced and this has made new medicines more accessible to the people.

## 2.4 Cross-Cutting Issues

### Access for Marginalized Groups

The population groups that have particularly limited access to health services and are hard to reach with programme initiatives include women and girls, rural inhabitants, adolescents, marginalized indigenous communities (such as Ovahimba, San), the LGBTQI+ community, people with disabilities and people in correctional facilities.

Gender inequality is linked to disproportionately high levels of poverty and low-income status among Namibian women, their limited participation in political and economic institutions and high levels of gender-based violence (GBV). Namibia has pursued a policy of gender mainstreaming since 1995, under the leadership of the Ministry of Gender Equality and Child



Welfare, and the National Health Policy Framework 2010–2020 emphasizes the need to address gender issues in relation to access to health services.

However, to further improve access and equity, a number of challenges must be addressed, among them the lack of targeted services - especially for adolescents - logistical issues and the absence of e-Health records, which restricts where clients can access treatment. Continuing stigma and discrimination (including among health workers) hamper access for PLHIV, people with disabilities, mental health patients, the LGBTQI+ community, sex workers, and others. Laws against men who have sex with men (MSM) and sex workers (SWs) compound the obstacles to access for these groups.

National frameworks require all government ministries to integrate issues of gender, equity and human rights into public policies, strategies and operational planning. The Government of Namibia (GRN) acknowledges that “health and social well-being are fundamental human rights” and makes special mention of the protection of rights of PLHIV and mental health patients. In addition, the Harambee Plan identifies youth, young women in particular, as key target beneficiaries for development (as well as key implementing partners and participants), while the draft Health in All Policies (HiAP) strategy proposes four themes as entry points: Child Welfare; Women’s Well-being; Remote and Rural Services and Housing.

### **Social and Economic Determinants of Health**

The Harambee Prosperity Plan and the Fifth National Development Plan for 2017/2018–2021/2022 (NDP5) place emphasis on the need to use multisectoral approaches in addressing the social and economic determinants of health. The huge disparity between low- and high-income groups, together with high unemployment rates, is seen as the main cause of inequitable access to health services and inequitable distribution of human resources and facilities. Namibia’s high-income inequality poses a major challenge for equitable health service delivery. NDP5 aims to reduce income inequality, as measured by the Gini coefficient, from 0.57 (2016/2017) to 0.40 (2022), and the proportion of poor individuals and the severely poor from 18% and 11% in 2016/2017 to 10% and 5% respectively. Namibia’s Human Development Index (HDI) value for 2015 was 0.64 putting the country in the medium human development category and positioning it at 125 out of 188 countries/territories. This represents an increase of 10.7 per cent from 0.578 in 1990. (UNDP, 2016).

A number of intersectoral mechanisms have been established to address the social determinants of health, including the ongoing Health in All Policies (HiAP) process, which was initiated in 2015.

### **Universal Health Coverage**

Ensuring equitable access to health services is a primary goal of the Ministry of Health. This is reflected in its mission which is stated as being “to provide integrated, affordable, accessible, equitable, quality health and social welfare services that are responsive to the needs of the population” and in the Patient Charter, which promises “equity of access to public health and social care services” (MOHSS, 2010; Ministry of Health and Social Services, 2017). Similarly, the National Health Policy Framework pledges that “health and social welfare services will be affordable, and the principle of equity and fairness will underpin the commitment expressed

in this policy framework; special attention will be given to the needs of vulnerable groups”. In line with this intention, the MoHSS has begun laying the groundwork for establishing universal health coverage in the country.

### **Nutrition**

Namibia has adopted a multisectoral approach to nutrition since 2010, when the Namibia Alliance for Improved Nutrition (NAFIN) was established, with membership ranging from government ministries and CSOs to private businesses. In 2011, Namibia also joined the Scale Up Nutrition (SUN) Movement, which promotes the collaboration between civil society, the United Nations, donors, businesses and researchers across sectors for improved nutrition in countries. These initiatives help to support programmes that address malnutrition from a variety of perspectives, such as health, agriculture, social protection and education. However, both the School Health Programme, which includes nutrition education and the School Feeding Programme, which supplements the diets of at-risk school children face institutional and logistical challenges.

### **Environmental Health and Climate Change**

With industrialization on the increase and towns growing faster than ever before, the management of waste and pollution has become a serious concern. Climate change presents Namibia with an incentive to move towards low-carbon and climate-resilient development, a transition that must include the sectors of energy, transport, industrial production, agriculture, water and waste management.

The Ministry of Urban and Rural Development (MURD) oversees housing, an area that remains a major developmental challenge in Namibia. Low and lower-middle income earners are hardest hit by housing shortages. In 2016, nineteen per cent of households lived in improvised houses such as makeshift shelters built of waste materials. Efforts to provide housing have concentrated on urban centres, resulting in urban-rural imbalances.

Sanitation and water supply fall within the remit of the Ministry of Agriculture, Water and Forestry (MAWF). Over 3855 household and public sanitation facilities have been constructed in rural communities since 2013 (in all regions except Khomas), but low levels of access to improved sanitation still constitutes a serious public health problem in the country. Water scarcity also continues to seriously constrain efforts to achieve health, economic, environmental and social development objectives.

A Health Sector Plan of Action for Public Health Adaptation to Climate Change has been developed and the National Health Policy 2010-2020 has been revised to include updated strategies for environmental health.

### **Emergency Preparedness and Response**

Emergency preparedness and response (EPR) is a multisectoral effort, coordinated by the Office of the Prime Minister (OPM). The National Policy for Disaster Risk Management was

revised in 2017 and the multisectoral, all-hazard National Action Plan for Health Security (NAPHS) for Namibia was developed in the same year.

The status of implementation of the International Health Regulations (IHR) is updated annually. The core surveillance and response capacity requirements for IHR have not yet been met and the country's disease early warning system will also need to be strengthened. Laboratory facilities for Biosafety Level 3 are available in-country while Level 4 substances are sent to South Africa. The Government has identified and designated 12 points of entry (POEs) to assess cross-border spread of disease. Some legislation relating to POEs is in place but the regulations, standard operating procedures (SOPs), government instruments and resources that are required to facilitate IHR implementation at the designated POEs are lacking or out of date.

Namibia experienced several disease outbreaks in the period 2010–2017, including Crimean-Congo haemorrhagic fever in Gobabis and hepatitis E in Windhoek, both in 2017. These were quickly contained through the coordinated action of multiple partners, under the leadership of the MoHSS, and with the support of WHO.

## 2.5 Development Partners' Environment

This section provides an overview of the development partners' environment. A map of key partners, including their programmatic focus and budget, can be found in Annex A.

### 2.5.1 Partnership and Development Cooperation

Partner coordination in Namibia is governed by the Partnership Policy of 2005. The MoHSS plays a stewardship role in the health sector and has structures that coordinate the activities of health development partners at national and regional level. However, there are a number of coordination challenges, including inadequate private sector involvement, and the coordination of projects that require collaboration of other ministries (sanitation and the construction of maternity waiting homes, for example). A policy for Public-Private Partnerships (PPP) is in place and there is buy-in from the private sector, but there is no legal framework for implementation. MoHSS coordination, implementation, monitoring and evaluation of plans need to be strengthened overall.

In 2011, WHO initiated the Health Development Partners Forum (HDPF), which continues to meet every month. It aims to improve information sharing, coordination and collaboration in the provision of support to the MoHSS and to collectively address critical roadblocks.

### 2.5.2 Collaboration with the United Nations System at Country Level

#### Delivering as One

There are thirteen resident UN agencies in Namibia and seven non-resident agencies active in the country all collaborating according to the Delivering as One (DaO) strategy. This involves one budgetary framework, one leader (UN Resident Coordinator), one team, one office, one voice, and one programme framework (UN Partnership Framework) which is entirely aligned with national development plans and is based on the SDGs.

## Sustainable Development Goals

Another point of convergence is the country's commitment to achieving the 17 Sustainable Development Goals (SDGs). The SDGs are interconnected, meaning that the key to success in one may well involve tackling issues more commonly associated with another.

## Structure

**The UN Country Team (UNCT)**, under the leadership of the UN Resident Coordinator, is responsible for ensuring achievement of results and adherence to the **UN Partners Framework (UNPAF) Result Outcome**. The team is composed of the heads of all resident and non-resident UN agencies, funds and programmes and is the highest inter-agency coordination and joint decision-making body.

The **UN Programme Management Team (PMT)** provides internal oversight of the implementation of UNPAF 2019–2023 by monitoring the planning, implementation and reporting of the four **UN Results Groups (RGs)**. The PMT is supported by the **UN Communication Group** on matters related to communication and advocacy, and by the **Monitoring and Evaluation Group** to ensure that monitoring and evaluation of UNPAF 2019–2023 adheres to results-based management principles and standards.

The UNPAF is made operational through the Result Groups' **Annual Joint Work Plans (AWPs)**, which translate the UNPAF Outcomes into concrete, measurable and time-bound outputs; it includes a financing plan of identified resources from UN agencies, together with identified funding gaps for which resources need to be jointly mobilized.

The **Operations Management Team (OMT)** is an interagency team comprised of operations specialists from all United Nations agencies. The OMT is responsible for developing, implementing and monitoring the **Business Operations Strategy (BOS)**.

The **Joint UN Team on AIDS (JUTA)** is an interagency body comprising HIV/AIDS specialists and focal points. The role of JUTA is to develop the Joint UN Namibia Programme on HIV/AIDS and UN Cares for 2019–2023 in line with the 2017/2018–2021/2022 Namibia Strategic Framework on HIV/AIDS. It is chaired by the UNAIDS Country Director and reports directly to UNCT for decisions.

Other inter-agency groups include the **Gender Thematic Group** and **Emergency/Humanitarian Thematic Group**.

**WHO’s Role in the UN System**

WHO is the specialized agency for health, the authority on international health regulations, standards and guidelines, and the key technical advisor to the MoHSS with the broadest health mandate. The MoHSS relies on WHO’s technical assistance on a broad range of health issues. WHO supports the development of country proposals and negotiations for major grants from donor organizations and mobilizes resources for priority programmes.

WHO collaborates with other agencies on health through joint UN forums such as the JUTA, the Gender Thematic Group and the Emergency/Humanitarian Thematic Group and also through participation in external committees.

**UN Partnership Framework**

The UN Partnership Framework (UNPAF 2019–2023) is organized around four results areas:

*Figure 9: UNPAF Priorities and SDGs*



*Source: United Nations Country Team in Namibia and Government of the Republic of Namibia, 2018*

Technological innovation will be promoted throughout all priority areas and specific interventions will introduce innovative approaches and technology that promote sustainable use of natural resources at the community level; promote innovation for enterprise development and support digitization for public services delivery and data collection (e.g. e-Health, single registry, real-time data on GBV).

Outcome 2.1 under Pillar 2 (Social Transformation) is the key outcome focusing on health:

- By 2023, most vulnerable women, children, adolescents and young people in Namibia have access to and utilize quality integrated health care and nutrition services (UHC).

Programmes that fall under this outcome will target health-related issues that are outstanding (HIV, TB and poor sanitation) and emerging (NCDs and teenage pregnancy). The cross-cutting goals are to empower rights-holders and create an enabling environment for the most vulnerable to effectively utilize health care services and change their behaviour for healthy lives.

The UN will contribute towards this result through a number of key interventions, including support for the Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition Strategy (RMNCAH&N), strengthening the capacity of the health system to cope with health and nutrition emergencies and providing capacity building support for community health workers.

WHO's Country Cooperation Strategy (CCS) and the health dimension of the UNPAF are harmonized and mutually reinforcing.

### **UN Health Initiatives**

There are a number of UN-wide initiatives with a health component and these are detailed in Appendix B.

### **Resource Mobilization**

The first UN Resource Mobilization Strategy for Namibia was crafted in collaboration with GRN in 2017 with the aim of raising funds for each pillar, including Health. A Multi-Donor Trust Fund is administered by UNDP. All UN agencies worked together under the leadership of UNAIDS in 2017 to leverage US\$ 300 000 from UBRAF (Unified Budget, Results and Accountability Framework). WHO also mobilizes additional resources for joint programme implementation.

#### *2.5.3 Country Contributions to the Regional and Global Health Agenda*

Namibia has engaged in and led a number of interventions that have the potential to advance health regionally and globally, including the following:

- Highly successful roll-out of antiretroviral treatment (ART) through innovative strategies, such as practitioner-initiated HIV care and treatment (PIHCT) and household testing and counselling through volunteers.
- Commitment to domestic funding for health and leveraging of domestic resources in the HIV sector.
- Successful response to disease outbreaks through strong coordination with partners.
- Strengthened partnerships for health to enhance resource utilization and maximize impact.

- The Eliminate 8 Strategy, a trailblazing initiative for cross-border cooperation with the commitment of health ministers in eight countries across the southern African region, resulting in Namibia’s remarkable progress towards the elimination of malaria.
- Progressive policies and approach to learner pregnancy and the rights of pregnant teens to education, antenatal care, etc.
- The deployment of health extension workers as an effective approach to bridging service gaps at community level.
- Cost reductions in pharmaceutical stock management through the use of e-stock cards and basic technology to gather health data from the community.
- Centralized procurement system for medical products, which avoids the duplication of orders.

### 2.6 Review of WHO’s Cooperation over the Past CCS Cycle

An extensive review of the implementation of WHO’s second-generation Country Cooperation Strategy for Namibia (CCS II 2010–2015) was conducted with internal and external stakeholders to evaluate the extent to which plans were implemented and draw lessons for an improved process of planning and implementation in the third CCS. This section presents the conclusions from this process, highlighting the key achievements that WHO contributed to (alongside other partners), enabling factors and constraints, and unfinished agenda.

Overall, the areas in which the greatest efforts were made, and the most achievements registered were: combating priority communicable diseases and improving maternal, newborn, child and adolescent health. The areas where the agenda remains unfinished are health systems strengthening, combating NCDs and promoting a safer and healthier environment.

### **STRATEGIC PRIORITY 1: STRENGTHENING THE HEALTH SYSTEM**

#### **Key achievements:**

- Completion of baseline studies for universal health coverage (UHC)
- Institutionalization of National Health Accounts
- Strengthening of health information systems
- Resource mobilization
- Establishment/operationalization of Health Development Partners Forum (HDPF)

**Enabling factors:**

- GRN commitment to UHC
- Cooperation of partners
- Funding from EU and other donor agencies.

**Constraints:**

- Shortage, capacity gaps and high turnover of programme managers and service providers.
- Difficulties in obtaining timely data and reporting from the Ministry, partly due to fragmented and paper-based information systems.
- Inadequate accountability
- Cuts in the Ministry's budget since 2015/2016 which have led to limited investment in some priority areas, and halted restructuring and staff establishment plans.
- Capacity gaps at the WCO (with the loss of a dedicated technical officer for health systems strengthening).

**Unfinished agenda:**

- Support for the human resources development (HRD) strategy
- Strengthening of health information systems and implementation of eHealth
- Progress towards UHC
- Further strengthening of procurement capacity.

**STRATEGIC PRIORITY 2: COMBATING PRIORITY DISEASES**

**Key achievements:**

- **Surveillance and data collection:** e.g. HIV Sero-Sentinel Surveys (2012, 2014, 2016); Integrated Biological and Behavioural Surveillance Survey (IBBSS); national HIV/AIDS database.
- **Development of plans and guidelines:** e.g. HIV/AIDS National Strategic Frameworks (2010/2011–2014/2015 and 2017–2022); Adolescent Health Guidelines in the context of Young People Living with HIV/AIDS; Strategic Plan for the Elimination of Mother-to-Child Transmission of HIV (2012); Antiretroviral Treatment Guidelines (2013 and 2016); TB policy, plans and guidelines.
- **Health promotion days:** e.g. World AIDS Day and World TB Day
- **Malaria:** Successful response to outbreaks 2016/2017
- **TB:** Drug resistance studies and training and cross-border collaboration on TB
- **HIV:** Provider-initiated testing and counselling (PITC); voluntary medical male circumcision (VMMC); strengthening of NANASO's coordinating capacity
- **Measles:** Cross-border response to outbreaks 2012; provision of equipment and reagents to National Institute of Pathology (NIP) laboratory; Measles Vaccination Campaign Coverage Survey (2012); nationwide measles/rubella campaign 2016
- **Polio:** surveillance, monitoring and training



- **NCDs:** Inclusion of some NCD-related data in 2013 NDHS; National Multisectoral NCDs Strategy; development of National Tobacco Products Control Bill; adoption of Global Plan of Action for Road Safety 2011–2020; Cancer initiatives; School Health Programme.

**Enabling factors:**

- High commitment of GRN to a sustainable national response
- Partner collaboration and coordination.

**Constraints:**

- Lack of funding and focus for NCDs.

**Unfinished agenda:**

- NCD prevention and control
- Malaria elimination.

**STRATEGIC PRIORITY 3: IMPROVING MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH**

**Key achievements:**

- Programme for Accelerated Reduction of Maternal and Child Mortality (PARMaCM): Resource mobilization leading to the award of 10 million Euros from the European Union (EU) for construction/renovation of four maternity waiting homes; donation of ambulances and equipment; capacity building, review and assessment of programmes, and facilitation of Maternal and Child Health Days in several districts.
- Institutionalization of maternal and neonatal death surveillance and response.
- Progress towards integration of reproductive health into HIV/AIDS and adolescent health interventions.
- Adoption of Global Clinical Handbook for the Care of Women Subjected to Intimate Partner Violence and/or Sexual Violence.
- Introduction of new vaccines (pneumococcal conjugate vaccine, rotavirus vaccine, inactivated polio vaccine and hepatitis B birth dose vaccination)
- Nutrition policies, guidelines and capacity-building.

**Enabling factors:**

- High commitment of GRN to attaining MNCAH-related MDGs
- Partner collaboration and coordination
- Concerted advocacy

**Constraints:**

- Lack of funding at national level.

**Unfinished agenda:**

- Reduction of stunting, wasting and underweight rates – strengthening implementation of nutrition interventions at facility level, reduction of maternal and newborn mortality and stillbirth rates.
- Strengthening of adolescent-friendly health services.
- Interventions to address gender-based violence and harmful cultural practices.

**STRATEGIC PRIORITY 4: PROMOTING A SAFER AND HEALTHIER ENVIRONMENT**

**Key achievements:**

- Response to emergencies - floods in northern Namibia, 2011; disease outbreaks (malaria, 2016/2017; Crimea-Congo haemorrhagic fever and hepatitis E, 2017)
- Mobilization of funds from various partners, e.g. Government of Finland and Central Emergency Response Fund (CERF).
- Development of IHR Multisectoral All-Hazard National Action Plan for Health Security (NAPHS, 2017).
- Revision of IDSR Framework and Guidelines (2017)
- Inclusion of updated strategies for occupational health and safety in the National Health Policy 2010-2020.
- Implementation of policies on improved road safety and emergency medical services.
- Implementation of school hygiene initiatives.
- Cross-cutting health promotion activities, e.g. tobacco, maternal and child health, routine immunization, and Health Promoting Schools Initiative (HPSI).
- Development of health promotion frameworks, e.g. National Policy on Health Promotion (2012), Health Sector Plan of Action for Public Health Adaptation to Climate Change.

**Enabling factors:**

- Collaboration with other sectors.

**Constraints:**

- Lack of funding and prioritization of EPR at national level
- Inadequate funding for road safety.

**Unfinished agenda:**

- Resource allocation and capacity building for implementation of IHR 2005
- Improving water, sanitation and hygiene
- Monitoring of food quality, food safety
- Implementation of health promotion strategies.

## Internal Strengthening Plans

The second CCS took stock of the implications of implementation at country level and identified internal development needs. The extent to which these needs were met is outlined below:

### Key achievements:

- Mobilized additional financial resources to catalyse and complement national and partner efforts.
- Achieved effective teamwork through the integration of programme activities, teambuilding initiatives and consistently effective internal leadership.
- Increased understanding of WHO's role among partners (including its capacity to mobilize resources).
- Improved responsiveness to partner requests.
- Increased visibility through media engagements.
- Strengthened partner coordination, including UN 'Delivering as One'.

### Enabling factors:

- Global drive to focus on attaining the MDGs by 2015
- Adequate internal budget for implementation of plans with Partner cooperation (including MoHSS).
- Collaboration with other UN agencies in line with the Delivering as One principle.
- Access to a wider pool of experts available through AFRO and WHO Headquarters.

### Constraints:

- Loss of technical staff and lengthy process of appointment for WHO staff
- Lack of clarity of programme ownership and roles within UN joint programmes.

### Unfinished agenda:

- Promote WHO's role and provide health information directly to individual CSOs and health educational institutions
- Develop more direct ties with other line ministries that have important roles to play in executing the health agenda
- Closer collaboration with the National Planning Commission (NPC) to further increase health leadership role.

## CCS Development and Use

The highly participatory process of developing CCS II enabled all staff at the WCO to engage with the goals of the Organization and value individual roles. The document itself has served as a basis for the preparation of workplans and has informed other documents, including the MoHSS National Health Strategic Plan and AFRO priorities. Alignment with the MDGs, UNDAF

and MoHSS Strategic Plan made CCS II a powerful tool for orienting new staff, briefing partners and mobilizing resources. However, the absence of a specific monitoring and evaluation plan meant that more emphasis was placed on biennial workplans in guiding activities, though these plans are derived partly from the CCS.

In order to optimize the value of this third Country Cooperation Strategy, regular reference to CCS III will be made in staff meetings, partner forums and documents; mid-term and end-term evaluations will be conducted in line with Chapter 5; periodic reviews will be conducted together with MoHSS to establish accountability, and the monitoring and evaluation process will be aligned with the MoHSS monitoring and evaluation system for consolidated reporting.

## CHAPTER 3 • THE STRATEGIC AGENDA FOR WHO COOPERATION 2018–2022

This chapter sets out the medium-term priorities and focus areas on which WHO will concentrate the majority of its resources over the new CCS cycle (2018–2022).

The Strategic Agenda supports the National Health Strategic Plan and is fully aligned with the health-related SDGs (see Appendix C) and the WHO Thirteenth General Programme of Work, 2019–2023 (GPW 13). It is therefore geared towards achieving three interconnected strategic priorities to ensure healthy lives and well-being for all people at all ages:

- (a) advancing universal health coverage,
- (b) addressing health emergencies, and
- (c) promoting healthier populations.

The national priorities were identified by a rigorous process of national dialogue and consultation with the Government of Namibia, civil society, health development partners, academia and other stakeholders in the health sector. The analysis of the country’s health and development situation presented in Chapter 2 was also taken on board and due account taken of lessons learned from the previous CCS cycle and WHO’s financial and human resource capacity.

Each strategic priority relates to a priority in WHO’s Thirteenth General Programme of Work (GPW 13). The selected outcomes and focus areas will guide the expected interventions required to achieve the priority.

*Table 2: Strategic Priorities, Outcomes and Focus Areas 2018–2022*

STRATEGIC PRIORITY (AND TARGET)	OUTCOME	FOCUS AREAS
1. Health Coverage (More people with health coverage)	1.1 Improved access to quality essential health services	1.1.1 Health systems strengthening 1.1.2 Reproductive, maternal, neonatal, child and adolescent health and nutrition 1.1.3 Communicable and non-communicable diseases.
	1.2 Reduced number of people suffering financial hardship	1.2.1 Health financing 1.2.2 Effective partner coordination 1.2.3 Mobilization and management of resources
	1.3 Improved availability of essential medicines, vaccines, diagnostics and devices for PHC	1.3.1 Procurement and supply of essential medical products

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STRATEGIC PRIORITY (AND TARGET)	OUTCOME	FOCUS AREAS
		1.3.2 Provision of essential equipment
2. Addressing Health Emergencies (More people made safer)	2.1 Country health emergency preparedness strengthened	2.1.1 Implementation of IHR (2005)
	2.2 Emergence of high-threat infectious hazards prevented	2.2.1 Integrated disease surveillance and response (IDSR) and IHR (2005)
	2.3 Health emergencies rapidly detected and responded to	2.3.1 Institutional strengthening 2.3.2 International classification of diseases (ICD)
3. Promoting Healthier Populations (More people's lives/health improved)	3.1 Determinants of health addressed leaving no one behind	3.1.1 Nutrition 3.1.2 Environmental health 3.1.3 Sexual and reproductive health (SRH)
	3.2 Reduced risk factors through multisectoral approaches	3.2.1 Physical activity 3.2.2 Diet 3.2.3 Substance abuse
	3.3 Health promotion in all policies and settings	3.3.1 Health in All Policies (HiAP) 3.3.2 Noncommunicable diseases (NCDs) and conditions
4. Strengthening Leadership, Governance and Enabling Functions	4.1 Strengthened data and innovation	4.1.1 Research 4.1.2 Health information systems 4.1.3 Monitoring and evaluation

Achieving each priority is the joint responsibility of GRN, WHO, development partners and other stakeholders in the health sector. WHO will contribute according to its core functions and comparative advantage in the Namibian health development sector.

The six core functions articulated in the Thirteenth General Programme of Work remain a sound basis for describing the nature of WHO's work. They are:

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

6. Monitoring the health situation and assessing health trends.

Following is a description of the background for each strategic priority and outcome, and the focus areas for WHO's plans in the new Strategic Agenda.

## **Strategic Priority 1: Advancing Universal Health Coverage (UHC)**

### **Target: More people with health coverage**

In line with the principles set out in WHO's Constitution, this priority focuses on strengthening health systems to progress towards universal health coverage (UHC). WHO's work on UHC will be fully aligned with SDG target 3.8 which focuses on achieving UHC, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

The essence of UHC is a strong and resilient people-centred health system with primary care as its foundation and community-based services, health promotion and disease prevention as its key components. This is to ensure that all people and communities have access to and can use the promotive, preventive, curative, rehabilitative and palliative health services that are appropriate to their needs and are of sufficient quality to be effective while not exposing the user to financial hardship.

This priority area focuses on the principles of access, equity, quality and sustainability. WHO will support the country's efforts to achieve and sustain equitable access to quality health services for all through improved quality and scope of the essential health package, and by integrating services and targeting key populations/marginalized groups.<sup>2</sup>

WHO's support in this priority area seeks to help the country achieve the following three outcomes:

### **Outcome 1.1: Improved access to quality essential health services**

WHO will support improved access to quality essential health services by focusing on the following three areas:

#### **Focus Area 1.1.1: Health Systems Strengthening (HSS)**

- Strengthened governance, leadership and coordination in the health sector
- Finalization of legislative frameworks, such as the law on blood and blood products
- Strengthened human resources for health (HRH), including establishment of National Health Workforce Accounts and development of HRH Strategy
- Generation of new data or utilization of existing evidence to make investment case where needed and advocate for sustainable financing for health

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<sup>2</sup> Key populations/marginalized groups include: women (especially AGYW), adolescents and young people, remote communities, MSM (including correctional facility populations), sex workers, people with disabilities, marginalized ethnic groups, LGBTQI.

- Strengthened coordination and integration of support and interventions to address communicable diseases
- Strengthened supply management to ensure adequate diagnostics, medicines and supplies for the prevention and management of CDs at all points
- Strengthened IDSR system to address CDs (including neglected tropical diseases and vaccine-preventable diseases) especially those targeted for eradication and elimination
- Monitoring/tracking health outputs and outcomes
- Drug resistance monitoring and provision of guidance for action.

**Focus Area 1.1.2: Reproductive, Maternal, Neonatal, Child and Adolescent Health and Nutrition (RMNCAH&N)**

- Advocacy for more funds to be allocated for maternal health
- Improved coverage and quality of maternity and newborn care services, including antenatal care (ANC), emergency obstetric care (EmONC), elimination of mother-to-child transmission of HIV (EMTCT)
- Scaling-up of integration of SRH and HIV/AIDS services
- Implementation of the Regional Adolescent Flagship Programme to expand coverage of adolescent-friendly SRH services,
- Integrated school health programme including review of School Health Policy Training of health workers on new family planning curriculum with a focus on long-acting reversible contraceptive methods, timely maternal and peri-neonatal death reviews
- Strengthened health sector response to violence against women and children
- Regular review and update of guidance for managing sick children
- Introduction and scaling-up of Care for Child Development
- Improved quality of care for children in referral facilities.

**Focus Area 1.1.3: Communicable and Noncommunicable Diseases (CDs and NCDs)**

- Ongoing revision of national guidelines for disease control in accordance with global WHO guidance
- Finalization/updating of guidelines for Expanded Programme on Immunization (EPI) and the Integrated Disease Surveillance and Response (IDSR) Guidelines.
- Improved quality, coverage and access to services for the prevention, treatment and care of HIV, TB and malaria
- Integration of HIV and TB services
- Drug resistance, including TB drug resistance (MDR and XDR), and antimicrobial resistance
- Management of schistosomiasis and other neglected tropical diseases
- Equitable access to public services for the prevention, treatment and care of non-communicable diseases (NCDs)
- Advocacy for mobilization and equitable distribution of resources for NCDs, including skilled personnel.



## **Outcome 1.2: Reduced number of people suffering financial hardship**

Protecting people against the impoverishing effect of health payments is a cornerstone of UHC and will help prevent poverty in Namibia. Using sustainable strategies for health financing and resource management will make services affordable for everyone and provide effective financial protection. These strategies will include increasing the level of health financing by Government and other stakeholders, implementing cost-efficiencies and improved resource management, introducing pre-payments for the poor and those working in the informal sector and improving coordination of health development assistance.

WHO will provide support for this outcome with a focus on the following three areas:

### **Focus Area 1.2.1: Health Financing**

- Enhancing the effectiveness of the National Committee in relation to health financing and financial protection within the context of universal health coverage.

### **Focus Area 1.2.2: Effective Partner Coordination**

- Strengthened stewardship role of the MoHSS
- Establishment and institutionalization of the health sector coordination mechanism, bringing together all key stakeholders for improved harmonization and alignment within the sector.

### **Focus Area 1.2.3: Mobilization and management of resources**

- Mobilization of resources for specific programmatic areas, such as RMNCAH&N, NCDs, PHC and health promotion.

## **Outcome 1.3: Improved availability of essential medicines, vaccines, diagnostics and devices for primary health care**

Making essential medical products more available contributes to greater access to quality essential health services, which is dealt with in Outcome 1.1. Efforts in this area involve aspects of health systems strengthening, such as improving procurement and distribution systems, and better mobilization and management of products.

WHO's support for this outcome will focus on the following two areas:

### **Focus area 1.3.1: Procurement and Supply of Essential Medical Products**

- Provision of guidance and standards for procurement and supply of essential medicines, vaccines and diagnostics (e.g. HIV testing kits)
- Collaboration with other partners providing key support to Ministry for strengthened procurement, logistics and supply management.

### **Focus area 1.3.2: Provision of Essential Equipment**

- Standard setting
- Resource mobilization for provision of essential equipment.

## **Strategic Priority 2: Addressing Health Emergencies**

### **Target: More people made safer**

This priority area focuses on strengthening health security by improving national preparedness, promoting adherence to the International Health Regulations (IHR), utilizing the international framework for the monitoring and evaluation of IHR and enhancing collaboration with relevant partners and countries to prepare for and respond to public health emergencies.

WHO's support in this priority area will help the country achieve the following three outcomes:

### **Outcome 2.1: Country health emergency preparedness strengthened**

Namibia's capacity for emergency preparedness involves action by a large number of ministries and partners, and is coordinated by the Directorate of Disaster Risk Management at the Office of the Prime Minister (OPM). Some progress has been made in the area of policy and planning but the country has not yet met the core requirements for the implementation of the International Health Regulations (IHR) that guide emergency preparedness and response.

WHO's support for this outcome will focus on the following area:

#### **Focus Area 2.1.1: Implementation of IHR**

- Assistance with donor mapping, costing and budgeting for All-Hazards National Action Plan for Health Security (NAPHS)
- Strengthened disease early warning system and biosafety assessments
- Implementation of national risk assessments
- Stockpiling for biological, chemical and radiological events
- Development and testing of risk communication plan
- Strengthened designated points of entry (PoEs).

### **Outcome 2.2: Emergence of high-threat infectious hazards prevented**

Globally, WHO is working closely with partners to implement the research and development blueprint for action to prevent epidemics, which aims to reduce delays between the detection of an outbreak and the deployment of effective medical interventions, thus saving lives and minimizing socioeconomic disruption. Bringing research into the mainstream of the WHO response is successfully reducing the time needed for products to reach those who need them.

WHO will continue to be Namibia's first port of call in the event of any outbreaks of infectious diseases, leveraging its global technical resources and coordination capacity, such as the

Emerging Diseases Clinical Assessment and Response Network and International Coordinating Group (ICG) mechanism.

WHO will focus its support for this outcome on one area:

**Focus Area 2.2.1: Integrated Disease Surveillance and Response (IDSR)**

- Strengthen surveillance capacity for early detection and response to disease outbreaks
- Limit the spread and rapidly contain the risk of emerging and re-emerging epidemics through deployment of vaccines and dissemination of information.

**Outcome 2.3: Health emergencies rapidly detected and responded to**

Namibia is historically vulnerable to alternating floods and droughts, especially in the northern regions, and they increase both the risk of malaria outbreaks and food insecurity due to loss of crops and livestock. In recent years, instances of Crimea-Congo haemorrhagic fever and hepatitis E in the central regions have underscored the importance of early warning and response systems.

WHO's support for this outcome will focus on the following two areas:

**Focus Area 2.3.1: Institutional Strengthening**

- Establishment of the Namibia Institute of Public Health (NIPH) to expand Namibia's capacity for early detection and response to health emergencies.

**Focus Area 2.3.2: International Classification of Diseases (ICD)**

- Complete transition from the International Classification of Diseases 9th Revision (ICD-9) to ICD 10/11.

**Strategic Priority 3: Promoting Healthier Populations**

**Target: More people's lives/health improved**

This priority area focuses on improving people's health by promoting healthy lifestyles and reducing risk factors.

WHO's support in this priority area will aim to assist the country to achieve the following three outcomes:

**Outcome 3.1: Determinants of health addressed leaving no one behind**

Many factors combine to affect the health of individuals and communities. The determinants of health include: the social and economic environment (cultural norms, social support networks, level of income, education, employment, etc.); the physical environment (e.g. housing, water, sanitation, working conditions) as well as individual characteristics. Individual genetics, gender, personal behaviour and coping skills (such as balanced diet, keeping active,

smoking, drinking and how we deal with life's stresses and challenges) all have an impact on health.

Environmental health is a challenge in Namibia, especially in rural areas and in informal settlements that lack basic services. Inadequate housing, hygiene, water and sanitation create conditions which increase the risk of transmission of communicable diseases like TB, diarrhoea and hepatitis E. Environmental programmes span several sectors and close cooperation is therefore required between the various line ministries and their partners in the development and private sectors.

WHO's support for this outcome will focus on the following three areas:

#### **Focus Area 3.1.1: Nutrition**

- Preventing and managing malnutrition, particularly in infants and young children
- Evidence-based health promotion and health education programmes at different levels of service delivery
- Preventive services, growth promotion and counselling and complementary feeding
- Strengthened nutrition counselling within the MCH service
- Strengthened Baby-Friendly Hospital Initiative
- Finalization and implementation of regulations on Code of Breastmilk Substitutes
- Participation in multisectoral efforts to address food security and food fortification
- Enhanced capacity to monitor food quality and ensure food safety.

#### **Focus Area 3.1.2: Environmental Health**

- Strengthened partner coordination
- Capacity building
- Implementation of standards and guidelines
- Communication and social mobilization support across programmes
- Strengthened capacity to monitor drinking water quality and sanitation.

#### **Focus Area 3.1.3: Sexual and Reproductive Health (SRH)**

- Harmful cultural practices (such as child, early and forced marriages) and socio-economic conditions that make Namibian young women and girls vulnerable to sexually transmitted diseases
- School health initiatives (including the review of School Health Policy).

### **Outcome 3.2: Reduced risk factors through multisectoral approaches**

The major noncommunicable diseases that are responsible for a significant proportion of morbidity and mortality share similar risk factors. These include the use of tobacco products, harmful use of alcohol, lack of physical activity and unhealthy diets. As these underlying determinants of noncommunicable diseases lie outside the health sector, WHO aims to employ strategies that will involve both public and private actors from multiple sectors,

including sectors such as agriculture, finance, trade, transport, urban planning, education, youth and sport.

WHO's support for this outcome will focus on the following three areas:

#### Focus Area 3.2.1: Physical Activity

- Developing policies on physical activity
- Creating awareness on the health benefits of physical activity; targeting different groups and settings, including schools, workplaces and the community at large
- Advocacy for policy and regulation for improved urban design that is conducive to physical activity.

#### Focus Area 3.2.2: Promotion of Healthy Diets

- Promoting healthy diets in all age groups
- Health promotion and advocacy strategies aimed at increasing consumption of fruits and vegetables, limiting the intake of free sugars and salt (sodium)
- Health education programmes to help the population achieve energy balance and healthy weight.

#### Focus Area 3.2.3: Substance Abuse

- Strengthening of tobacco control measures through capacity development programmes, advocacy and generation of evidence of efficiency and compliance
- Advocacy for adoption of an optional protocol to minimize illicit trade in tobacco products
- Drafting and implementation of tobacco cessation programme
- Implementation of strategies to increase levels of awareness on risks associated with tobacco use and second-hand smoking in various settings, including schools and communities
- Creation and strengthening of a strong policy and legal environment for prevention of alcohol abuse
- Evidence generation on prevalence and risk factors for alcohol abuse.

### Outcome 3.3: Health promotion in all policies and settings

Namibia is witnessing an alarming rise in noncommunicable diseases (NCDs) such as cancer, diabetes, hypertension and cardiovascular disease. In addition, noncommunicable conditions, such as mental illness, injuries and disability require greater attention.

Health promotion is the process of enabling people to increase control over and improve their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions that are designed to benefit and protect individual people's health and quality of life by addressing and preventing the root causes of ill health. The three key elements of health promotion are: good governance for health, health literacy and healthy cities.

WHO's support for this outcome will focus on the following two areas:

**Focus Area 3.3.1: Health in All Policies (HiAP)**

- Finalization of Health Promotion Implementation Strategy and Health in All Policies (HiAP) Strategy
- Capacity development for health promotion across sectors.

**Focus Area 3.3.2: Noncommunicable diseases (NCDs) and conditions**

- Advocacy for greater prioritization of NCDs
- Establishment of a high-level multisectoral coordination body to lead the NCD response
- Mobilization of more resources for strengthening promotion of healthy lifestyles.

**Focus Area 3.3.3: Mental illness, injuries and disability, suicide prevention**

- Developing and strengthening of national policies, strategies and action plans on mental health
- Developing capacity at primary health care level to enable provision of non-specialized interventions in mental health care
- Implementation of National Decade of Action on Road Safety
- Developing and implementing the second National Suicide Prevention Strategy
- Strengthening the School Health Programme to include suicide prevention approaches.

**Strategic Priority 4: Strengthening Leadership, Governance and Enabling Functions**

This priority area focuses on strengthening the internal capacity of the WHO Country Office for generating, interpreting and disseminating data, with attention to new and innovative processes and technologies.

**Outcome 4.1: Strengthened data and innovation**

WHO support for this outcome will focus on the following areas:

**Focus Area 4.1.1: Research**

- Support for operational research, including capacity building
- Facilitating and building linkages between the universities and the MoHSS to support operational research
- Support framework linking evidence to policy and action.

**Focus Area 4.1.1: Health Information Systems**

- Support for health information systems strengthening, focusing on building capacity of national data managers and users to strengthen and streamline health information systems integration into the DHIS 2
- Advocacy and support for health observatory system to allow access to data
- Advocacy and support for relevant platforms to disseminate information (websites, etc.).

**Focus Area 4.1.1: Monitoring and Evaluation**

- Integrated monitoring of access to and utilization of health services
- Monitoring coverage and evaluation of outcomes and impact of interventions
- Support for the conduct of National Health Accounts and other mechanisms to track health system inputs
- Support systems to monitor the quality of care, especially in private facilities.

## CHAPTER 4 • IMPLEMENTING THE STRATEGIC AGENDA: IMPLICATIONS FOR THE SECRETARIAT

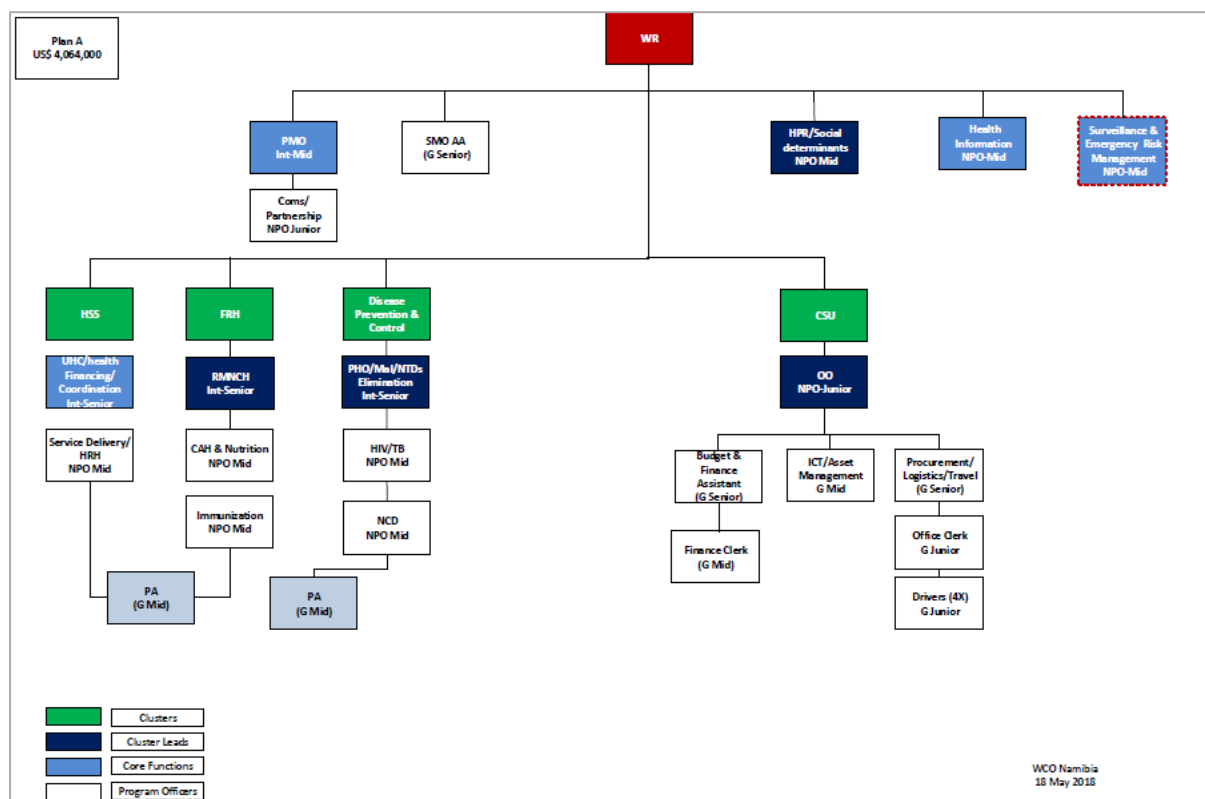
This chapter sets out the implications of the new Strategic Agenda for the Country Office in terms of sustaining effective and efficient operations at all levels. Internal strengthening plans will focus on: Structure and Human Resources; Funding; Internal and External Coordination; Procurement; and Information and Communication Technology (ICT).

### Structure and Human Resources

Although there has not been a substantive change in focus areas, the Strategic Agenda for CCS III (Chapter 3) represents a shift towards a more integrated focus on universal health coverage. A new structure for the country team has been proposed to reflect this shift, and to concentrate more resources on areas like health systems strengthening and NCDs where the Office was not able to provide adequate support in the previous planning cycle (see organogram below).

Given approval from the Regional Office, the technical teams will focus attention on Health Systems Strengthening/Universal Health Coverage/Health Financing, Family and Reproductive Health, and Disease Prevention and Control (Strategic Priority 1); Surveillance and Emergency Risk Management (Strategic Priority 2); Health Promotion/Social Determinants of Health (Strategic Priority 3) and Health Information (Strategic Priority 4).

Figure 10: WCO Organogram 2018–2022





National Programme Officer (NPO) positions usually require the recruitment of international staff due to the low availability of public health specialists and medical doctors in-country. This results in more than 80% of allocated resources going towards salaries leaving very little for promoting WHO's presence and activities. The Secretariat therefore needs to explore strategies for mobilizing funds for its activities, filling posts with UN volunteers (UNVs) and Junior Programme Officers (JPOs), for example, and advocating for higher budget allocations.

The WCO will make recommendations to the Regional Office to strengthen expertise in priority areas (health systems strengthening, family and reproductive health, disease prevention and control), cross-cutting functions (e.g. administrative support) and enabling functions (e.g. communication, planning and resource mobilization).

Other plans for improving capacity in the Office include the introduction of a standardized induction programme for new staff and the establishment of a staff development fund.

### Funding

The WCO has mobilized 25% of the US\$ 9.4 million needed to implement its 2018–2019 biennial plan of which US\$ 1.6 million is derived from WHO voluntary contributions. Other donations have been made by the United Nations Environment Programme (UNEP), the US Centers for Disease Control (CDC) and USAID. The Office intends to mobilize the remaining funds through effective donor engagement.

In addition to maintaining regular communication with current donors, the WCO will develop a resource mobilization strategy based on a donor mapping exercise to identify common priorities. Bilateral meetings will then be held with representatives of potential donors present in the country. The Office will roll out consistent communication materials, including monthly and mid-year reports and engage the media to increase the visibility of WHO Namibia among the public.

The Secretariat will also explore the options of joint proposals with WHO Headquarters and the Regional Office for Africa and consider resources from other countries so as to take advantage of South-South and triangular cooperation opportunities.

### Internal Coordination

Strong team dynamics and leadership were identified as significant enablers for the results achieved by the WCO over the past seven years and continuing efforts will need to be made to sustain these. Attention also needs to be paid to staff's wellness, particularly in terms of establishing a work culture that promotes a healthy work-life balance.

Priorities for internal coordination include improving the technical and administrative platform for information sharing. In addition, different focal persons will be designated to share specific information in an effort to reduce information overload.

In order to further augment internal planning and coordination, a Senior Management Team (SMT) will be established for decision-making and monitoring of progress, and an Extended Management Team (EMT) will be set up to promote collaboration between teams.

## External Coordination

WHO initiated the Health Development Partners Forum (HDPF) in response to the need for better coordination of programmes and actors in the health sector. Building on this promising foundation, the WCO now intends to streamline its membership and terms of reference to focus them more sharply on coordinating partner support (as opposed to the broader health sector coordinating forum).

As mentioned under 'Funding' above, there is also a need to give greater publicity to WHO activities in the country for enhanced visibility and resource mobilization. Accordingly, WHO will seek to strengthen its working relationship with civil society organizations (CSOs) especially with a view to supporting community engagement and surveillance.

The establishment of the Medical School at the University of Namibia presents a great opportunity for improved human resources for health in the country. WHO will increase its collaboration with the School, focusing on strengthening operational research and the use of research findings by implementing partners, research project appraisals and ethical clearance and the establishment of a Human Resources Observatory.

## Procurement

The Office will request a practical procurement training from AFRO to equip the Procurement Committee to evaluate big tenders.

In order to address other challenges affecting recruitment, travel, logistics, compliance and procurement, the Office proposes a number of standard operating procedures (SOPs), such as requiring:

- Invitations from AFRO to be extended three months in advance
- All procurement/meetings for end of biennium to be planned by third quarter
- Advanced notice of changes in processing purchase orders.

Other improvements are needed in terms of timely planning and tracking of correspondence.

## Information and Communication Technology (ICT)

The Office proposes the following improvements to AFRO ICT systems:

- Enhancing the MyService system to facilitate the closing of requisitions
- Testing connections to WebEx Meetings hosted by AFRO several hours in advance
- Allocating additional funds to refurbish old infrastructure (servers and cabling).

## CHAPTER 5 • MONITORING AND EVALUATION OF THE CCS

This chapter outlines how the CCS will be monitored and evaluated during implementation and at the end of the CCS cycle. It sets out the steps within the process as well as the overarching Country Results Framework to guide the process.

### 5.1 CCS Monitoring and Evaluation

The WCO will monitor and evaluate the CCS under the leadership of the WR, with the support of the Regional Office and Headquarters, and with the full participation of, and in coordination with the MoHSS, health-related ministries, national stakeholders and other partners that participated in the formulation of the CCS.

Regular monitoring of the CCS will be conducted during implementation in alignment with the biennial workplan process in 2019 and 2021. The mid-term and end-term evaluations will be conducted alongside the mid-term review of the NHSP and UNPAF.

### 5.2 Country Results Framework

The Country Results Framework sets out the targets and indicators based on the GPW 13 Planning and Budgeting Framework, the UNPAF and the National Health Sector Strategic Plan (NHSSP). These will link the CCS to the outcomes and impact achieved at country level.

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Table 3: Impact Framework at Country Level (Country Results Framework)

INDICATORS	BASELINE	TARGET	DISAGGREGATION FACTORS	INDICATOR ALIGNMENT
<b>STRATEGIC PRIORITY 1: Advancing universal health coverage (UHC)</b>				
Human Resources for health per 1 000 population	3.6	4.45	Geo/Private, public	GPW, NHSP
Maternal mortality ratio	265	200	Age Geo/Socioeconomic status	GPW, UNDAF, NHSP
Neonatal Mortality Rate	39/1000	20 /1000	Geo/Socioeconomic status	GPW, UNDAF, NHSP
Percentage of women of reproductive age (15-49) who have their need for family planning satisfied with modern methods	80%	90%	Age Geo/Socioeconomic status	GPW, UNDAF, NHSP
Measles vaccination coverage	79%	90%	Geo/Socioeconomic status	GPW, NHSP
Malaria deaths	120	50%	Age Geo/Socioeconomic status	GPW, NHSP
New HIV infections	4.3/1000	0.9/1000	Age Geo/Socioeconomic status	GPW, UNDAF, NHSP
Treatment coverage of RR-TB	60%	71%	Age Geo/Socioeconomic status	GPW, NHSP
Premature NCD-related mortality	43%	35%	Age Geo/Socioeconomic status	GPW, UNDAF, NHSP
Percent of people suffering financial hardship in accessing health services	<1%	<1%	Age Geo/Socioeconomic status	GPW, UNDAF, NHSP
<b>STRATEGIC PRIORITY 2: Addressing health emergencies</b>				
Proportion of core surveillance and response capacity requirements for IHR are met.	<10%	50% increase	Age Geo /Socioeconomic status	GPW, NHSP
Proportion of suspected outbreaks investigated in time and contained.	67%	100%	Age Geo /Socioeconomic status	GPW, NHSP
<b>STRATEGIC PRIORITY 3: Promoting healthier populations</b>				
Percentage of stunted children under 5	24%	14%	Geo /Socioeconomic status	GPW, UNDAF, NHSP
Access to safe drinking water - % of households used improved sources of water	Urban 98.3%	Urban 100%	Age Geo /Socioeconomic status	GPW, UNDAF,

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INDICATORS	BASELINE	TARGET	DISAGGREGATION FACTORS	INDICATOR ALIGNMENT
	Rural 84%	Rural 95 %		
Access to safe sanitation: households use improved toilet facilities not shared with other households	Urban 77% Rural 28%	Urban 87% Rural 40%	Geo /Socioeconomic status	GPW, UNDAF,
Tobacco use in men (15-49 yrs.)	19%		Age Geo /Socioeconomic status	GPW, NHSP
Suicide mortality rate	22.1 per 100 000		Age Geo /Socioeconomic status	GPW, , NHSP
Prevalence of obesity in women (35-64 yrs.)	32%			GPW, , NHSP

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### Appendix A: Partner Map

Name of agency	Role	Health-related SDG targets	Major programmatic area of support within country	Net contribution (US\$ in millions)
PEPFAR	Funding HIV response through MoHSS and implementing partners	3.1 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.	HIV	<b>2018:</b> 72.3 <b>2019:</b> 71.6
GFATM	Funding HIV, TB and malaria response through MoHSS and civil society partners	3.2 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.	HIV, TB, Malaria	<b>2018–2020:</b> 38.1
UNICEF	Cooperation with the GRN to accelerate realization of rights of children and women through national systems, to ensure that the most vulnerable people in Namibia have equitable access to high-quality services	3.3 By 2030, end preventable deaths of new-borns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births. 3.4 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases. 3.5 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.	HSS, Maternal and Child Health, PMTCT and ALHIV, WASH, ECD	<b>2018:</b> 2.2
WHO	Technical assistance to GRN and partners to improve health outcomes as captured in national development plans	<b>All</b>	EPI and surveillance, HIV TB, Viral hepatitis, Malaria NCDs, HSS	<b>2018:</b> 0.7
UNFPA	Supporting GRN to expand the possibilities for women and young people to lead healthy and productive lives	3.6 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.	Adolescent SRH Family planning	<b>2018:</b> 0.8
UNAIDS	Technical assistance for the GRN's HIV response, including support to CSOs	3.7 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.	HIV	<b>2018:</b> 0.5
WFP	Technical assistance to GRN through MOEAC and MOPESW to ensure food security	<b>SDG 2:</b> Zero hunger - Addressing the causes and consequences of all forms of malnutrition	Food security (Zero Hunger Programme; School Feeding Programme)	Budget pending finalisation of SCOPE project

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### Appendix B: UN-Wide Health Initiatives

Initiative	Specific outputs	Status
UNPAF 2019-23	Outcome 2.1: By 2023, most vulnerable women, children, adolescents and young people in Namibia have access to and utilize quality integrated health care and nutrition services (UHC)	Developed 2018
Joint UN Team on HIV/AIDS (JUTA)	To reduce new HIV infections and AIDS-related mortality by 75% by 2022 from 2015 levels and move towards ending AIDS as a public health threat by 2030	Functional
Joint UN Programme on Disaster Risk Management	Key strategic interventions under the environmental sustainability priority area of the UNPAF	
Joint UN Programme on Gender	To promote gender equality and equity	Planned in new UNPAF
Joint UN Programme on Youth	Support youth empowerment through: <ul style="list-style-type: none"> <li>• enhancing youth employment</li> <li>• promoting sexual and reproductive rights of the youth</li> <li>• developing youth skills and vocational training</li> </ul>	Planned in new UNPAF

## WHO Country Cooperation Strategy III 2018–2022

### Appendix C: Alignment of Strategic Agenda with National and International Priorities

The table below maps the alignment of the CCS III Strategic Agenda with the pillars of the NHSP, health-Related SDGs and UNPAF Health Outcomes.

Strategic Priority	Outcomes	NHSP Pillars	Health-Related SDGs	UNPAF Health Outcome 2.1
1. Advancing Health Coverage (More people with health coverage)	1.1 Improved access to quality essential health services	<ul style="list-style-type: none"> <li>• People Wellbeing</li> <li>• Operational Excellence</li> <li>• Talent Management</li> </ul>	<ul style="list-style-type: none"> <li>• Maternal mortality)</li> <li>• Neonatal and U5 mortality</li> <li>• Communicable Diseases (CDs)</li> <li>• Non-communicable diseases (NCD)</li> <li>• Sexual and Reproductive Health (SRH)</li> <li>• Universal Health Coverage (UHC)</li> </ul>	<ul style="list-style-type: none"> <li>Scaling-up of food and nutrition interventions</li> <li>Improved routine immunization coverage</li> <li>Support RMNCAH&amp;N Strategy</li> <li>Synchronize and strengthen the management of health information systems</li> <li>Support design and implementation of promotive and preventive health care services</li> </ul>
	1.2 Reduced number of people suffering financial hardship	<ul style="list-style-type: none"> <li>• Operational Excellence</li> </ul>	<ul style="list-style-type: none"> <li>• Health financing and HRH in developing countries</li> <li>• (UHC)</li> </ul>	<ul style="list-style-type: none"> <li>Contribute to development of a health financing strategy and financial protection</li> </ul>
	1.3 Improved availability of essential medicines, vaccines, diagnostics and devices for PHC	<ul style="list-style-type: none"> <li>• Operational Excellence</li> </ul>	<ul style="list-style-type: none"> <li>• Vaccines and medicines for CDs and NCDs in developing countries</li> <li>• UHC</li> </ul>	<ul style="list-style-type: none"> <li>Strengthened management system for supply of medicines, vaccines and commodities supply</li> </ul>
2. Health Emergencies (More people made safer)	2.1 Country health emergency preparedness strengthened	<ul style="list-style-type: none"> <li>• Operational Excellence</li> <li>• Talent Management</li> </ul>	<ul style="list-style-type: none"> <li>• Early warning and risk reduction</li> </ul>	<ul style="list-style-type: none"> <li>Strengthened capacity to cope with health and nutrition emergencies</li> <li>Improved routine immunization coverage</li> </ul>
	2.2 Emergence of high-threat infectious hazards prevented	<ul style="list-style-type: none"> <li>• Operational Excellence</li> </ul>	<ul style="list-style-type: none"> <li>• Early warning and risk reduction</li> <li>• Vaccines and medicines for CDs and NCDs in developing countries</li> <li>• Hazards</li> </ul>	
	2.3 Health emergencies rapidly detected and responded to	<ul style="list-style-type: none"> <li>• Operational Excellence</li> </ul>	<ul style="list-style-type: none"> <li>• Early warning and risk reduction</li> </ul>	



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Strategic Priority	Outcomes	NHSP Pillars	Health-Related SDGs	UNPAF Health Outcome 2.1
3. Health Priorities  (More people's lives/health improved)	3.1 Determinants of health addressed leaving no one behind	<ul style="list-style-type: none"> <li>• People Wellbeing</li> </ul>	<ul style="list-style-type: none"> <li>• Hazards</li> </ul>	Support capacity building of health workers and community health workers  Support design and implementation of promotive and preventive health care services
	3.2 Reduced risk factors through multi-sectoral approaches	<ul style="list-style-type: none"> <li>• Operational Excellence</li> </ul>	<ul style="list-style-type: none"> <li>• Tobacco Control</li> <li>• Substance abuse</li> </ul>	
	3.3 Health promotion in all policies and settings	<ul style="list-style-type: none"> <li>• Operational Excellence</li> </ul>	<ul style="list-style-type: none"> <li>• NCDs</li> <li>• Road traffic accidents</li> <li>• SRH</li> </ul>	
4. Leadership, Governance and Enabling Functions	4.1 Strengthened data and innovation	<ul style="list-style-type: none"> <li>• Operational Excellence</li> </ul>		Synchronize and strengthen the management of health information systems

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