

Biennial Report 2014/2015



**World Health
Organization**

NAMIBIA

The World Health Organization – Making a Difference in Namibia.





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Text editing and adaptation: William Hofmeyr
Layout and design: Imagine Design

Foreword

Hon. Dr Bernard Haufiku, Minister of Health and Social Services

It is a great pleasure and privilege for me as the Minister of Health and Social Services to write the Foreword to the World Health Organization (WHO) Namibia Biennial Report. Having only filled the “giant shoes” of my predecessor in this role, Honourable Dr Richard Kamwi, in March 2015, I realise that my work is only beginning. Reviewing WHO Namibia’s projects of the last two years, I am filled with pride to know that many of them have been implemented together with my Ministry and staff. Clearly, WHO Namibia and the Ministry of Health and Social Services (MoHSS) make a formidable team when it comes to combating diseases.

Namibia is a nation that is making great strides in development and improving the quality of life of its citizens, whatever their socioeconomic background. However, we at the MoHSS are acutely aware that the facts and figures simply do not lie: providing quality healthcare throughout Namibia is a daunting task, and there are many challenges that must be faced. Our ministry has been tasked with achieving Millennium Development Goals and nationally and internationally agreed upon targets. It is imperative that we know where we stand when it comes to healthcare and what we need to do to strengthen our health systems. Reducing infant mortality and improving maternal and child healthcare have become a primary focus for the MoHSS and our esteemed partners.

The National Health Accounts (NHA) study was conducted to provide a comprehensive assessment of health spending and the use of both private and public financial resources in the health sector in Namibia. It supports our Ministry as well as other stakeholders like WHO Namibia in guiding strategic planning and dialogue to inform decision making for health and social service

Foreword by:
**Hon. Dr
Bernhard
Haufiku**



delivery. Research conducted in this regard has thrown light on certain issues. At 13 percent, Namibia’s health spending as a percentage of its total spending is higher than that of all of our neighbouring countries, and just shy of the Abuja Declaration target of 15 percent, something we can be justly proud of. With increased spending on primary care and prevention, we can help improve the quality of life of the population and reduce the costs of care in the future. This is why we also need to shift attention and funding to non-communicable diseases (NCDs). We have hitherto been focused on lowering the rates of communicable disease like HIV/AIDS, tuberculosis (TB), cholera, malaria and even the Ebola virus when it was a potential threat, but the threat posed by NCDs is also very worrisome. The rising rates of NCDs such as cardiovascular disease, diabetes, cancer and chronic respiratory disease are of grave concern, and need to be addressed by all healthcare stakeholders. Health expenditure on NCDs – only five percent of total health expenditure – is inadequate. If not addressed, the growing burden of NCDs will have serious economic consequences, as Namibians who suffer from these diseases work less, and are less productive even when they do work. This loss of productivity has the potential to severely

constrain the growth of Namibia as a nation, making it harder for our country to achieve our Vision 2030 goals.

WHO Namibia and the MoHSS have worked hand in hand on many projects over the past few years, all geared towards addressing the infrastructural needs of Namibia's health systems and improving the lives and health of our people. This report covers numerous important cooperative projects, like the opening of the first maternity waiting home constructed through the Programme for Accelerating the Reduction of Maternal and Child Mortality. Together with WHO Namibia and the European Union (EU), the MoHSS is set to open several more waiting homes in centres that serve remote rural regions of Namibia, thereby significantly improving maternal and child healthcare. The annual World Health Day activities that WHO Namibia organises to highlight diseases such as HIV/AIDS, TB, cholera and malaria are all carried out together with our ministry, as well as other stakeholders.

In the first few months of being the Minister of Health and Social Services, I have already had the pleasure of witnessing the work of WHO Namibia staff at first hand, and I am deeply impressed by their skill, knowledge and dedication to healthcare, and to the wellbeing of all Namibians. Through their projects and collaboration at all levels, WHO professionals are a catalyst for change and a source of inspiration and hope. We are proud of our partnership in many of the programmes mentioned in this report, and believe that together, we are a formidable team. On behalf of myself, the MoHSS, and the Namibian people, I would like to take this opportunity to thank the WHO Representative in Namibia, Professor Dr Quazi Monirul Islam, and his staff for their hard work and dedication to healthcare in Namibia.



Dr Bernard Haufiku
Minister of Health and Social Services

Prof. Dr Quazi Monirul Islam, WHO Representative in Namibia

Foreword by:
**Prof. Dr Quazi
Monirul Islam**



First of all, I would like to thank you for taking the time to read WHO Namibia's Biennial Report, covering 2014 and 2015. With its dedicated, competent staff members, WHO Namibia is fully committed to bringing good health to the people of Namibia, and does so on a daily basis through the programmes, policies and projects that it has in place. It is my great honour to head this team of excellent professionals.

Prof Dr Quazi Monirul Islam

The disparity in Namibians' income levels and quality of life brings with it many challenges in the field of healthcare. These come in various forms, and it is often women and children that suffer most. Namibia still lags behind regarding the achievement of Millennium Development Goals 4 and 5: the reduction of child mortality by two-thirds, and of maternal mortality by three-quarters by 2015, from the levels in 1990. The Namibian Government, together with the former First Lady, Madam Penehupifo Pohamba, has shown steadfast commitment to providing for good maternal and child healthcare, which is essential for the sustainable development of the nation. Maternal and child health is very high on the nation's agenda, and therefore also on that of WHO Namibia.

With the support of Madam Pohamba, the Patron of Maternal and Child Health in Namibia, the MoHSS, WHO Namibia and the EU Delegation to Namibia designed and are currently implementing the Programme for Accelerating the Reduction of Maternal and Child Mortality (PARMaCM). Studies have revealed the importance of maternity waiting homes for bridging the geographic gap for poor and disadvantaged women from rural areas, and improving their access to emergency obstetric and neonatal care services. The first of these homes, the Joshua Hanyango Maternity Waiting Home, was opened in Okongo on 3 March 2015 – something of which all partners involved can be justly proud.

Through collaborative projects with our esteemed partners like the MoHSS, the Namibian Red Cross, CDC, NAPA, UNAM, the EU and many local and regional stakeholders, WHO Namibia is involved in a wide spectrum of activities that are collectively bringing about progress towards the ultimate goal of universal access to quality healthcare, and zero preventable deaths from infections and outbreaks of disease.

I must applaud the MoHSS for the significant progress made in reducing the burden of tuberculosis (TB) in the country. This has been demonstrated by a consistent decline in the number of TB cases, and the maintaining of a treatment success rate of around 85% over the past few years. While striving to eradicate the disease itself, it is important that we continue with education and advocacy aimed at combating the social stigma that is still attached to TB. This stigma needs to be overcome, if the disease is to be totally eradicated.

To ensure successful adaptation of the Global Strategy, WHO Namibia will continue to provide the required technical support in critical programme areas and to monitor the implementation of key interventions. We will continue with our surveillance programmes in all regions, with training and educating local healthcare workers, nurses and doctors, and with providing equipment when and where possible. We will continue to advocate for the adoption of a healthy lifestyle, but the responsibility for this lies with each individual as well. Basic hygiene practices like washing hands are the foundation of good health. Not smoking is also a major positive lifestyle choice. WHO Namibia celebrates World No Tobacco Day each year at the end of May, highlighting the need to rid countries of tobacco. In 2015, the theme was "Stop illicit trade of tobacco products." Despite the increasing pressure being exerted by the tobacco industry, we are making good progress in Namibia. The implementation of the Tobacco Products Control Act in 2014 is evidence of the determination of the Namibian Government to improve the health of its citizens, and a landmark in the history of tobacco control in Africa, and the world.

WHO Namibia's strategic, policy and programmatic guidance within the health sector takes many forms, as this report illustrates. However, it is only a snapshot of the full array of activities that we undertake to help strengthen the health system and improve holistic wellbeing in Namibia.

Please join me, my staff and our health development partners in supporting the MoHSS in its reform agenda to strengthen the health system and deliver improved health outcomes for all Namibians, throughout the "Land of the Brave".



Prof. Dr Quazi Monirul Islam
WHO Representative in Namibia

Acronyms and Initialisms

ART	antiretroviral therapy	NGO	non-governmental organisation
AVW	African Vaccination Week	NHA	National Health Accounts
CCS	Country Cooperation Strategy	PARMaCM	Programme for Accelerating the Reduction of Maternal and Child Mortality in Namibia
CDC	Centres for Disease Control and Prevention	PLHIV	People Living with HIV/AIDS
ECD	Early Childhood Development	PMTCT	prevention of mother-to-child transmission
EPI	Expanded Programme on Immunization	SRH	sexual and reproductive health
EU	European Union	TB	tuberculosis
EVD	Ebola virus disease	THE	Total Health Expenditure
EVMA	Effective Vaccine Management Assessment	TWG	Technical Working Group
FP	field promoter	U5MR	Under-5 Mortality Rate
GRN	Government of the Republic of Namibia	UHC	Universal Health Coverage
HEW	health extension worker	UHCAN	Universal Health Coverage Advisory Committee of Namibia
HRH	Human Resources for Health	UN	United Nations
IHR	International Health Regulations	UNICEF	United Nations Children's Fund
IMNCI	Integrated Management of Neonatal and Childhood Illness	UNPAF	United Nations Development Partnership Framework
MCHW	Maternal and Child Health Week	WBDD	World Blood Donor Day
MDG	Millennium Development Goal	WHA	World Health Assembly
MoHSS	Ministry of Health and Social Services	WHO	World Health Organisation
RMNCH	Reproductive, Maternal, Newborn and Child Health	WMD	World Malaria Day
MPNDR	Maternal and Perinatal Death Review	WTBD	World TB Day
MWH	Maternity Waiting Home		
NCD	non-communicable disease		

OUR FOCUS



**CAPACITY
BUILDING**



**WOMAN AND
CHILDREN'S
HEALTH**



**HIV/AIDS, MALARIA,
TB, MALARIA AND
INFECTIOUS DISEASES**



**UNIVERSAL
HEALTH
COVERAGE**



**NON-COMMUNICABLE
DISEASE**



**MONITORING
PROGRESS**

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chapter 1

Introduction

The general mission of the World Health Organization (WHO) is “**the attainment of the highest possible level of health by all people**”. In pursuit of this goal, the WHO undertakes important, holistically structured projects and programmes all around the world, with a view to strengthening the healthcare systems of the countries where it works.

In Namibia, the WHO’s mission is to serve as an essential and strategic partner with the Government of the Republic of Namibia (GRN) and other stakeholders/development partners. In order to fulfil its mandate of improving health outcomes for Namibians, WHO Namibia strives for the achievement of the national vision and goals, as captured in national development plans.

The **Fourth National Development Plan (NDP4)**, which is currently being implemented, stipulates that by 2017, all Namibians should have access to a quality health system in terms of prevention, cure and rehabilitation; Namibia’s **National Health Policy Framework 2010 – 2020** aims for “a healthy nation which is free of diseases of poverty”; and Namibia’s Vision 2030 states: “Health is a very important vision for Namibia. We will achieve our goal of eliminating the main causes of physical ill health, as well as mental and social ailments.

This will ensure the attainment of health and social well-being of all Namibians, which will enable them to lead an economically and socially productive life. We continue to be guided by our health principles that are based on equity of services, accessibility, affordability, sustainability, inter-sectoral collaboration and community involvement.” WHO Namibia wholeheartedly embraces and supports these aims.



Namibia Fact Sheet

825 615 km², divided into 14 regions

Population: 2.3 million (36% under 15; 45% urban)

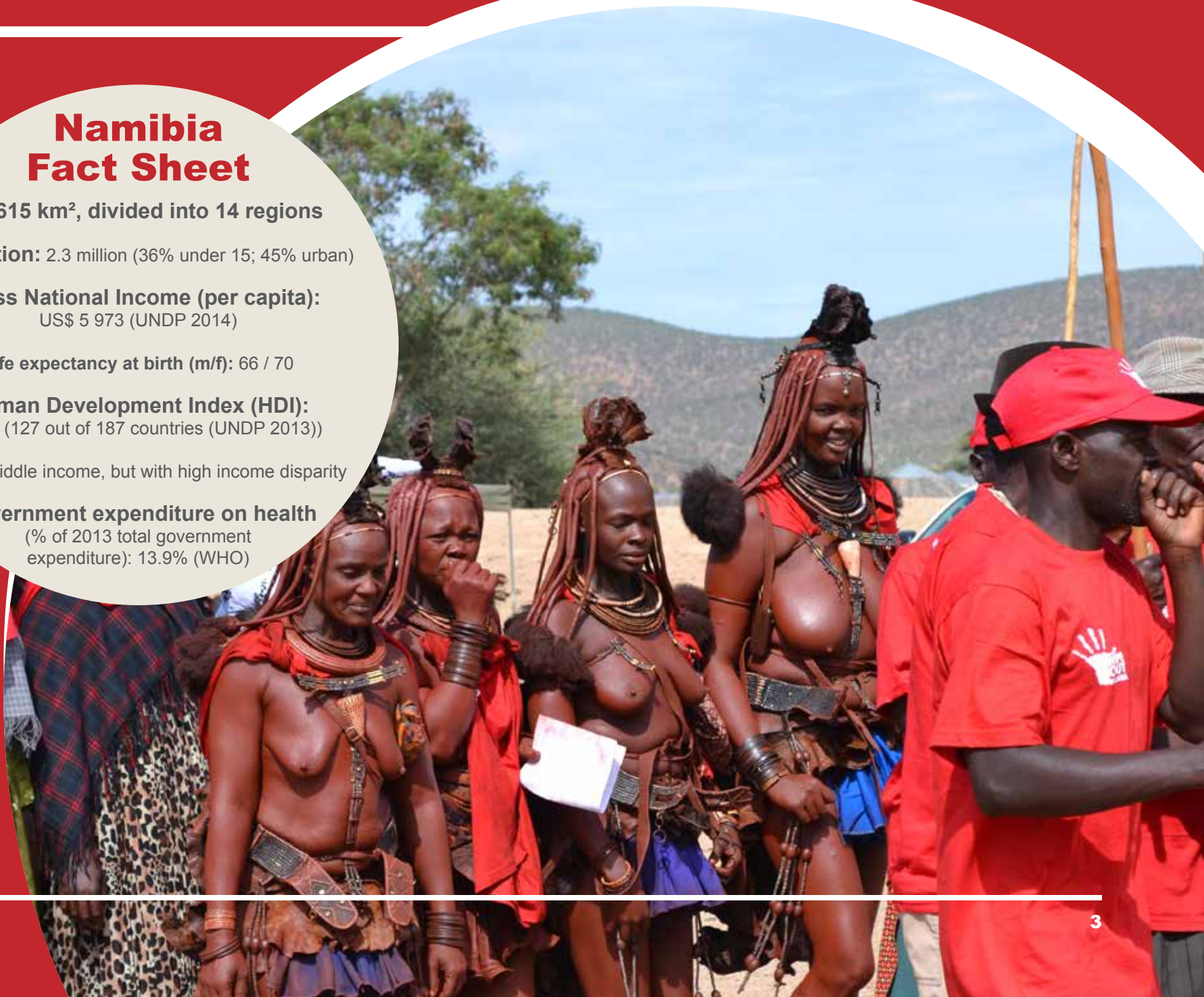
Gross National Income (per capita):
US\$ 5 973 (UNDP 2014)

Life expectancy at birth (m/f): 66 / 70

Human Development Index (HDI):
0.608 (127 out of 187 countries (UNDP 2013))

Upper-middle income, but with high income disparity

Government expenditure on health
(% of 2013 total government
expenditure): 13.9% (WHO)



1.1 WHO'S KEY PARTNER IN NAMIBIA: MINISTRY OF HEALTH AND SOCIAL SERVICES

WHO Namibia's key partner is the Ministry of Health and Social Services (MoHSS). The MoHSS derives its mandate from Article 95 of the Namibian Constitution, which requires the state to maintain the welfare – both physical and social – of the Namibian people. The MoHSS is therefore responsible for ensuring that all people throughout the country, including marginalised and vulnerable members of society, have access to quality, integrated and affordable healthcare and social services.

From a healthcare perspective, the challenges faced in Namibia are complex. With its wealth of expertise, WHO Namibia is ideally placed to work together with the MoHSS. In addition, Namibia collaborates with other partners in the broader health sector – communities, civil society, the private sector, bilateral and multilateral donors, and other United Nations (UN) organizations, always focusing on outcomes that have positive impacts on the lives of the people who need them most.

Success should be measured in practical outcomes. This basic principle informs WHO Namibia's operations. WHO Namibia can be seen as a "knowledge partner" in the country, sharing a common mission and vision with local partners, stakeholders and organizations, and complementing their skills and capacity, to achieve the best possible results. It doesn't have its own extensive infrastructure, but it is in a position to offer critical expertise, technical support, and advocacy guidance. In addition, it has assisted in the shaping of the health research agenda, the setting of norms and standards, the articulation of evidence-based policy options, the monitoring and assessment of health trends in the country, and the targeted provision of equipment and supplies.

1.2 WHO NAMIBIA'S MEDIUM-TERM GOALS: CCS AND UNPAF

WHO Namibia's work is conducted in accordance with Namibia's second **Country Cooperation Strategy (CCS)** 2010 – 2015. The CCS sets out the key health priorities for collaboration between the WHO and Namibia, in accordance with the WHO's own global mission statement. The CCS identifies four strategic priority areas:

- strengthening the health system;
- combating priority diseases;
- improving maternal, newborn, child and adolescent health; and
- promoting a safer and healthier environment.

The **United Nations Development Partnership Framework (UNPAF)** for Namibia, covering the period 2014 – 2018, is the third strategic programme framework prepared by the GRN and the UN System in Namibia. It is built on four pillars: Institutional Environment; Education and Skills; Health; and Reduction of Extreme Poverty. UNPAF's Health pillar guides WHO Namibia's work in terms of programme planning and resource allocation. Following on the 2010 – 2015 CCS, it identifies WHO Namibia's focus areas as being strengthening health systems; combating priority diseases; and addressing the socio-economic determinants of health.

Millennium Development Goals

The Millennium Development Goals (MDGs) are the world's time-bound and quantified targets for addressing extreme poverty in its many manifestations. A total of 189 countries, including Namibia, endorsed the MDGs. MDG 1 ("Eradicate extreme hunger and poverty") underlies all the other MDGs; WHO Namibia's work is directed primarily at MDG 4 (improving child health), MDG 5 (improving maternal health) and MDG 6 (combating priority diseases).

In Namibia, the WHO's activities collectively support the provision of essential healthcare programmes which are based on scientifically sound and socially acceptable standards. WHO Namibia contributes to health promotion, the prevention of diseases, and the rehabilitation of those who are in need – often members of isolated rural communities.

This report outlines the WHO's activities with its Namibian partners and stakeholders during 2014 and 2015. It will clearly emerge that significant progress has been made in improving the rightful access of every Namibian to timely quality healthcare services.



1.3 THE WHO NAMIBIA TEAM

Prof Monirul Islam	WHO Representative in Namibia
Dr Desta Tiruneh	Disease, Prevention and Control Officer
Dr Mary A. Brantuo	Child and Adolescent Health Officer
Dr Tomas Zapata	PARMaCM Project Coordinator
Dr Sirak Bantiewalu	Maternal and Child Health Officer
Ms Roselina De Wee	NPO/EPI Surveillance Officer
Mr Petrus Mhata	Surveillance Officer
Ms Gesine Knolle	Advocacy and Communication Officer
Ms Celia Kaunatjike	Health Promotion Officer
Ms Mary Masule	Operations Assistant
Ms Margret Mutirua	Logistics, Procurement and Travel Assistant
Ms Karin Mvula	Project Assistant (PARMaCM)
Ms Wendy Mutabelezi	Finance Assistant
Ms Irma Naanda	Personal Assistant to the Representative
Mr Japhet Nashipili	ICT Assistant
Mr Nicky Narib	EPI Driver
Mr David Kavari	EPI Driver
Mr Lasarus Tjitjai	Senior Driver
Ms Cathrin Fish	Senior Secretary

chapter 2

Maternal, Newborn and Child Health

It is the duty of every society to care for its most vulnerable citizens, and more often than not, these are the mothers and their children. Proper care during pregnancy is important for the health of the mother and the development of her unborn baby. This period forms a critical link in the continuum of care, and is therefore the appropriate time to encourage mothers-to-be to adopt a healthy lifestyle and develop parenting skills. Several life-saving interventions have been promoted by WHO Namibia in the area of Reproductive, Maternal, Newborn and Child Health (RMNCH) through the development of strategic documents and guidelines, the provision of training, medical equipment, ambulances and vehicles to improve supervision and monitoring, and the construction of Maternity Waiting Homes.

“We as Namibians owe it to ourselves and this great nation to look after each and every one of us ... especially after our mothers and children.”

Former First Lady of the Republic of Namibia, Madam Penhupifo Pohamba

Picture right: Madam Penhupifo Pohamba together with the WHO Representative in Namibia, Dr Monir Islam, during the inauguration of the Maternity Waiting Home in Okongo

2.1 IMPLEMENTING POLICIES AND PLANS

MDG 4 and MDG 5 are specifically focused on the reduction of child mortality, and on improving maternal health. The national Maternal and Newborn Health Roadmap (2010 – 2014) for Namibia was developed in 2010 to accelerate the reduction of maternal and neonatal morbidity and mortality, with the ultimate goal of achieving these MDGs. The main objectives of the roadmap were to increase utilization of and access to quality maternal, neonatal, and adolescent health services in Namibia, and thereby accelerate the reduction of maternal and child morbidity and mortality, with a view to the achievement of MDGs 4 and 5.



Millennium Development Goals

MDG4: “Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate”

MDG 5: “Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio.”

“Achieve, by 2015, universal access to reproductive health”



With the expertise of WHO Namibia, an assessment of the implementation of the national road map and other related strategic plans for the period 2010 – 2014 was carried out during the period under review.

It was found that conditions in Namibia are suitable for the implementation of interventions that have significant impact on maternal, newborn and child survival. It was also determined that a number of policies, guidelines and RMNCH services are available free of charge for women, mothers and their newborn babies. However, the roadmap review highlighted some **concerns that affect RMNCH service delivery in Namibia:**

- wide disparities in geographic access and coverage of RMNCH services and interventions;
- inadequate quality of RMNCH services despite high access to facility care;
- critical skills shortages in clinical and managerial staff at all levels;
- a health information system which is not comprehensive, with problems related to the quality, harmonization and usage of data for decision making;
- the absence of a comprehensive strategic plan and monitoring framework for addressing all sexual and reproductive health (SRH) issues, including family planning, abortion care, sexually transmitted infections, reproductive cancers, gender-based violence and adolescent SRH; and
- the unavailability of service delivery guidelines for cervical cancer, sexual violence, post-abortion care and adolescent SRH services, in spite of the policy being in place.

The key recommendations were to:

- address equity issues through the decentralization of services and task sharing;
- build human resources capacity in terms of clinical and managerial skills;
- develop a comprehensive SRH Strategic Plan and service delivery guidelines by incorporating all key RMNCH interventions suggested in the roadmap;
- institutionalize quality of care improvement processes at all levels of the health system, including standardized quality care indicators for RMNCH; and
- strengthen the Health Management Information System (HMIS) and data usage for decision making.

WHO Namibia started working with the MoHSS and partners in addressing the above recommendations in order to further improve the health and survival of mothers, newborns and children. WHO Namibia's work plan for 2016/17 will continue to address these issues.

2.2 KEY WHO NAMIBIA MATERNAL HEALTH INTERVENTIONS

WHO Namibia is well aware of the urgent need to enhance the capacity of health institutions to provide timely, quality, people-centred RMNCH services. This can best be achieved by ensuring adequate staffing, the training of service providers in life-saving skills, the provision of essential supplies and equipment, and improved documentation and monitoring of progress. In 2014 and 2015, substantive progress was made by WHO Namibia together with partners and stakeholders in building national capacity in this regard.

Programme for Accelerating the Reduction in Maternal and Child Mortality

WHO Namibia supported the MoHSS and local stakeholders in their drive to improve maternal and newborn health through an EU-funded project known as the Programme for Accelerating the Reduction of Maternal and Child Mortality (PARMaCM). This programme supports activities aimed at sensitizing expectant mothers and their families and communities, and raises awareness of the three key reasons for delays that put both mothers and their (unborn) babies at risk: poor health-seeking behaviour; a lack of transportation to health facilities; and in some cases, the inadequate quality of services at the facilities themselves. WHO Namibia provided technical assistance and expertise to address these three key concerns, resulting in significant improvement in maternal and child health and survival.

For a variety of reasons, approximately 25% of expectant mothers do not visit doctors, healthcare facilities or even midwives when pregnant, which results in potentially dangerous delays in accessing healthcare for both the mother and her unborn child. Around 10% to 15% of deliveries in Namibia take place at home, without adequate and timely critical maternity care. Despite an

impressive healthcare system, people in rural areas can't access maternity care services on time due to their remoteness and, once the decision has been made to seek out healthcare, the lack of transport. Without access to any public transport, impoverished pregnant women from rural communities often have to travel substantial distances to reach the centres by whatever means they can arrange – as often as not, a lengthy walk to reach the main road, then hopefully a lift from a passing car or donkey cart – whatever is available.

It is understandable that such trips are often put off, and only undertaken once a problem is encountered, or labour sets in. The upshot of such delays can be catastrophic. Some set out and give birth along the way if they have left it too late. Others may arrive when complications have set in, when it is too late to save the baby or the mother. Once the mother reaches the facility, there is still no guarantee that she will receive timely quality care because of uncertainties related to the availability of a doctor, midwife or nurse, and of the necessary medicines or equipment. Further delays may therefore be encountered while accessing the right medical attention.

With support from the EU, WHO Namibia undertook various actions to improve the situation during 2014/15, as described below.

Maternal and Peri/Neonatal Death Review

A national Maternal and Peri/Neonatal Death Review (MPNDR) system was instituted in 2010 within health facilities. During 2014/15, WHO Namibia actively supported the MoHSS in the strengthening of RMNCH-related health services. This included capacity building for the service providers and their managers in maintaining the MPNDR system.

The first report for the period April 2010 to March 2012 documented 63 maternal and 341 perinatal/neonatal deaths. Of the maternal deaths, 60% were caused by haemorrhaging, with other contributing factors being sepsis, hypertensive disorders, and infections, especially HIV/AIDS, which contributed to 27% of all maternal deaths. In 13% of cases, poor record keeping resulted in the causes of deaths not being known.

As member of the national MPNDR committee, WHO Namibia has been

supporting the MoHSS's efforts in reporting and reviewing maternal and perinatal/neonatal deaths, disseminating information, and coordinating the national response. It has done so by providing technical support for the review process and capacity building training to improve the quality of maternity and neonatal services in the country, and supplying ambulances, medical equipment and supplies.

Maternity Waiting Homes

As it was found that there was an urgent need to strengthen delivery and neonatal care facilities in order to improve maternal and neonatal outcomes and prevent yet more stillbirths, WHO Namibia became involved in the development of Maternity Waiting Homes (MWHs), which bridge the geographical gap for women living far from health facilities. The MWHs are located next to the health facilities in the region, making it very easy for the expectant mothers to receive the antenatal, delivery and neonatal care they so desperately want and need.

On 12 March 2014, the First Lady of the Republic of Namibia, Madam Penehupifo Pohamba, officiated at the ground-breaking ceremony for the construction of the MWH in Okongo, Ohangwena Region, and on 3 March 2015, at an occasion attended by the MoHSS, the EU and WHO Namibia, she inaugurated the home. Three more MWHs are at different phases of construction, while the fifth one has been delayed until the land can be acquired. WHO Namibia provided most of the essential supplies such as beds, cookers, cooking utensils and fridges. Until the end of 2017, the programme will be funded by the EU, and implemented by the MoHSS and WHO Namibia. It is envisaged that by 2017, PARMaCM will have completed five MWHs (one with funding directly from WHO Namibia), in Okongo, Gobabis, Katima Mulilo, Opuwo and Outapi. The MWHs will be managed by regional councils and local constituencies.

Each MWH has dormitories which can house up to 80 women, a kitchen, a dining hall, a meeting area, showers and ablutions, and a herb and vegetable garden. Women receive all the antenatal care they need and are properly monitored, so that any problems can be addressed immediately, and that the women can be taken to the maternity wards at the nearest hospital in good time. MWHs also provide opportunity for health promotion activities on topics such as exclusive breastfeeding, family planning, newborn care, and immunization.

WHO Namibia 2014/15 support through PARMaCM

- N\$28 million on medical equipment in order to upgrade maternity care services and improve quality of services
- 27 nurses and midwives trained on the use of the equipment
- Doctors trained on emergency obstetric surgery, anaesthesia and the use of sonar equipment
- 220 health providers including doctors and nurses trained in emergency obstetric and neonatal care and life-saving skills
- 61 nurses trained on focus ante-natal care
- 34 facilities supplied with cold chain equipment for vaccination and immunization
- 9 ambulances and 6 utility vehicles donated to the PARMaCM Focus Districts and the respective referral facilities for addressing problems of transportation and supervision
- 818 health extension workers trained in identifying pregnant women in their respective areas and promoting timely access to maternity facilities

A further aspect of WHO Namibia support was to communicate the existence and importance of the PARMaCM MWHs in Namibia to the relevant stakeholders, including pregnant women. One of the ways in which WHO Namibia and its partners were able to do this was through a professionally scripted and filmed documentary, *Hope for the Future*. The documentary featured footage captured during a two-week trip to Okongo and Opuwo, and included interviews with the former MoHSS Minister, Hon. Dr Kamwi, the former EU Ambassador, Mr Raul Fuentes Milani, and the WHO Representative in Namibia, Dr Monir Islam. Two hundred copies of the documentary were recorded on USB flash drives for wider distribution. *Hope for the Future* was launched at the cinema of the Franco-Namibian Cultural Centre, with high level guests, including the former First Lady and the MoHSS Minister, in attendance. The film was shown by the National Broadcasting Corporation on primetime television. An information brochure, "Maternity Waiting Homes in Namibia: Hope for the Future" was also developed and distributed. Both the film and the brochure were distributed among EU Members of Parliament, who highly valued them.

2.3

KEY WHO NAMIBIA MATERNAL HEALTH INTERVENTIONS

Neonatal, Infant and Under-5 Mortality Rates

Namibia is a young country, with children under 14 years of age making up approximately 38% of the total population. It is a young country with a great future, should conditions be met to ensure that children can grow up in an environment where they will be healthy, safe, well-nourished, and educated. It is vital for the growth of Namibia and the general well-being of all Namibians that the infant mortality rate – currently far too high at 39 per 1 000 births – be reduced.

Children dying from conditions that are preventable or treatable has a devastating impact on families and communities. Nevertheless, children in Namibia are still challenged by such conditions, and the infant mortality rate is high. Following Namibia's Independence in 1990, a reduction in the Under-5 Mortality Rate (U5MR) was achieved. However, the U5MR is rising again, and currently stands at 54 per 1 000 live births. The mortality rates for infants and newborns in Namibia therefore remain alarming, and Namibia did not reach the MDG 4 goal of reducing under-five mortality to 24 deaths per 1 000 live births by December 2015.



Neonatal conditions (prematurity, low birth weight, asphyxia, and septicaemia), pneumonia, diarrhoea, and malnutrition are the most common causes of sickness and death in under-5 children in Namibia. Malnutrition is an underlying condition in many childhood illnesses. The Demographic and Health Survey 2013 indicates that approximately 24% of children under the age of five are short in height for their age (stunted), and that 13% are underweight. Children in the rural areas and those from the lowest wealth quintile are at a higher risk of being malnourished. The exclusive breastfeeding rate in infants under six months increased from 23% in 2007 to 49% in 2014. Although Namibia has made progress in this regard, more still needs to be done. Nutrition and other proven high-impact and affordable interventions, when implemented to scale in an integrated manner, can prevent over 60% of under-5 mortality.

WHO Namibia goes to great lengths together with its local partners to improve child survival. WHO provided support in developing the Child Survival Strategy for 2014 – 2018. The GRN is implementing the Child Survival Strategy, with essential technical support being provided by WHO Namibia. The goal of the strategy is to contribute towards the reduction of under-five mortality, and attaining the longer term goal set out during the 2013 Regional Child Survival Forum held in Addis Ababa, of 20 deaths per 1 000 births by 2035.

Child Survival Strategy targets for reducing mortality rates in Namibia

- U5MR (per 1 000 births) down to 24 by 2015 (MDG 4, which was not attained)
- U5MR down to 24 by 2018
- U5MR down to 20 by 2035
- Infant mortality rate (per 1 000 births) down to 18 by 2018 (from 39 in 2013)
- Neonatal mortality rate (per 1 000 births) down to 10 by 2018 (from 20 in 2013)

A national Maternal and Peri/Neonatal Death Review (MPNDR) system was instituted in 2010 within health facilities. During 2014/15, WHO Namibia actively supported the MoHSS in the strengthening of RMNCH-related health services. This included capacity building for the service providers and their managers in maintaining the MPNDR system.

WHO Namibia has played an active and life-saving role in providing support for a number of key child survival interventions. These include:

- exclusive breastfeeding;
- appropriate complementary feeding;
- hand washing;
- sanitation and appropriate disposal of faeces;
- recognition of signs of illness and timely care seeking;
- home care during illness;
- provision and promotion of insecticide-treated bed nets;
- immunization;
- micronutrient supplementation;
- assessment of nutritional status and feeding counselling;
- integrated management of diarrhoea, pneumonia, fever (malaria and measles), and uncomplicated severe acute malnutrition;
- identification, referral and management of children with severe illness;
- identification, referral and management of children with severe complicated malnutrition;
- prevention of mother-to-child transmission (PMTCT) of HIV;
- management and care of HIV-exposed or infected children; and
- management and care of TB-exposed or infected children.

Achievements

Available evidence for improved infant and young child feeding

WHO supported the conducting of an assessment of infant and young child feeding practices. This was the first of its kind in Namibia, and the findings will be used to inform decisions relating to the development and delivery of improved nutrition programmes for the country. The assessment was undertaken in recognition of the fact that very little was known about how and what children are being fed, and what the barriers and facilitators to breastfeeding are. The findings from the study showed major gaps in the caregiver practices for infant and young child feeding. It was found that only 70 percent of infants are started on breast milk within an hour of delivery. Also, infants from two to

three months of age are being given water and other milk feeds, contrary to the recommendation on exclusive breastfeeding. Caregivers were of the belief that breast milk only was not adequate for the infant in the first six months of life. The study also brought to the fore the limited knowledge of caregivers on feeding sick infants and young children. The findings from this assessment will guide the development of strategies and materials on breastfeeding and complementary feeding in 2016/17.

Strengthened growth monitoring and counselling

Regular monitoring of the growth of children involves weighing them, taking their heights, and measuring the circumference of their mid-upper arms. This takes place through the clinics and immunization visits, and during Child Health Week. Since 2013, WHO Namibia and its PARMaCM partners have supported growth monitoring and counselling, thereby contributing to reducing malnutrition in children. WHO supported the development of guidelines which are utilised within the community and at clinics, health centres and hospitals, as well as during Maternal and Child Health Weeks, where growth assessment is conducted. Children with moderate acute malnutrition, and those with severe acute malnutrition without medical complications, are managed at the primary healthcare level and at home, with high energy, vitamin- and mineral-rich ready-to-use therapeutic feeds.

Strengthening the legal environment and national capacity for implementation of the International Code of the Marketing of Breast Milk Substitutes

The International Code on the Marketing of Breast Milk Substitutes regulates the marketing of breast milk substitutes, feeding bottles and teats. It aims to shield breastfeeding from commercial promotion that affects mothers, health workers and healthcare systems. The Code and its resolutions also contain specific provisions and recommendations relating to the labelling of infant formula and other breast milk substitutes.

Through the PARMACM project, WHO Namibia supported the strengthening of the legal environment for implementation of the International Code for the Marketing of Breast Milk Substitutes in Namibia. The GRN passed into law the **Public and Environmental Health Act** (Act No. 1 of 2015), which incorporates a number of provisions of the International Code. However, there was still a need for additional legal framework and regulations, and for a monitoring mechanism to support implementation.

Following the adoption of the Public and Environmental Health Act, a national training campaign to build in-country capacity on the Code was conducted in March 2015. This training was designed to create awareness on the importance of the Code, and to begin to build a critical mass in the country to support the drafting of the appropriate legal framework and regulations. This was followed by the drafting of the Regulations Relating to Infant and Young Child Nutrition, to be adopted under Part 8, Section 50 of the **Public and Environmental Health Act**. Following this initial course, several further training campaigns were conducted, for over 130 officers from the health and other sectors. This has enhanced their capacity to support the national implementation of the Code in Namibia.

Strengthening community child health services through the Health Extension Programme

The Health Extension Programme in Namibia is a part of primary health care that aims to deliver family and community-centred promotive, preventive, rehabilitative and basic curative services. The Health Extension Programme is designed to ensure access to equitable health services for all Namibians, and particularly those living in the remote parts of the country. PARMaCM supported the training of **818 health extension workers** (HEWs) from 10 regions in the country. The HEWs completed their training and have been deployed in their respective communities. In addition, **166 HEWs** in Kunene Region were given refresher training to improve their data collection and reporting. These HEW have been deployed in the communities, and are contributing to efforts to educate the community on personal hygiene and handwashing, sanitation, early care seeking, and home care during illness.

Integrated management of childhood illness

WHO Namibia provided support for the national adaptation of the **Integrated Management of Neonatal and Childhood Illness** (IMNCI) Computerised Adaptation and Training Tool. The adaptation of this tool facilitated the roll out of IMNCI implementation in the country. A total of 208 health workers have now been trained using the tool, from all of Namibia's fourteen regions. This training has enabled the health workers at first level facilities to manage, in an integrated manner, children with diarrhoea, pneumonia, fever (malaria and measles), and uncomplicated severe acute malnutrition; and to refer severe cases to the hospitals.

Maternal and Child Health Week

Maternal and Child Health Week (MCHW) is held every year in November to increase the uptake of interventions such as de-worming and the administering of supplements such as Vitamin A, and immunisation. Throughout 2014 and 2015, WHO Namibia supported the preparation for and conducting of MCHW. During MCHW in 2014, over 200 000 additional children were reached through a variety of interventions. Approximately 9 000 children from 11 to 59 months who were due were given measles immunisation, and close to 230 000 children were given Vitamin A supplementation, and Albendazole for deworming.

In 2015, the total additional number of children reached during MCHW exceeded 350 000. Vitamin A was given to 269 395 children below the age of five years, and Albendazole to 232 824. A total of 329 954 under-five children were screened by measurement of MUAC (mid-upper arm circumference); of these, 324 097 were reported in green (with normal nutritional status), 4 984 in yellow (moderately malnourished), and 873 in red (severely malnourished).

2.4 EARLY CHILDHOOD DEVELOPMENT

The National Policy on Early Child Development

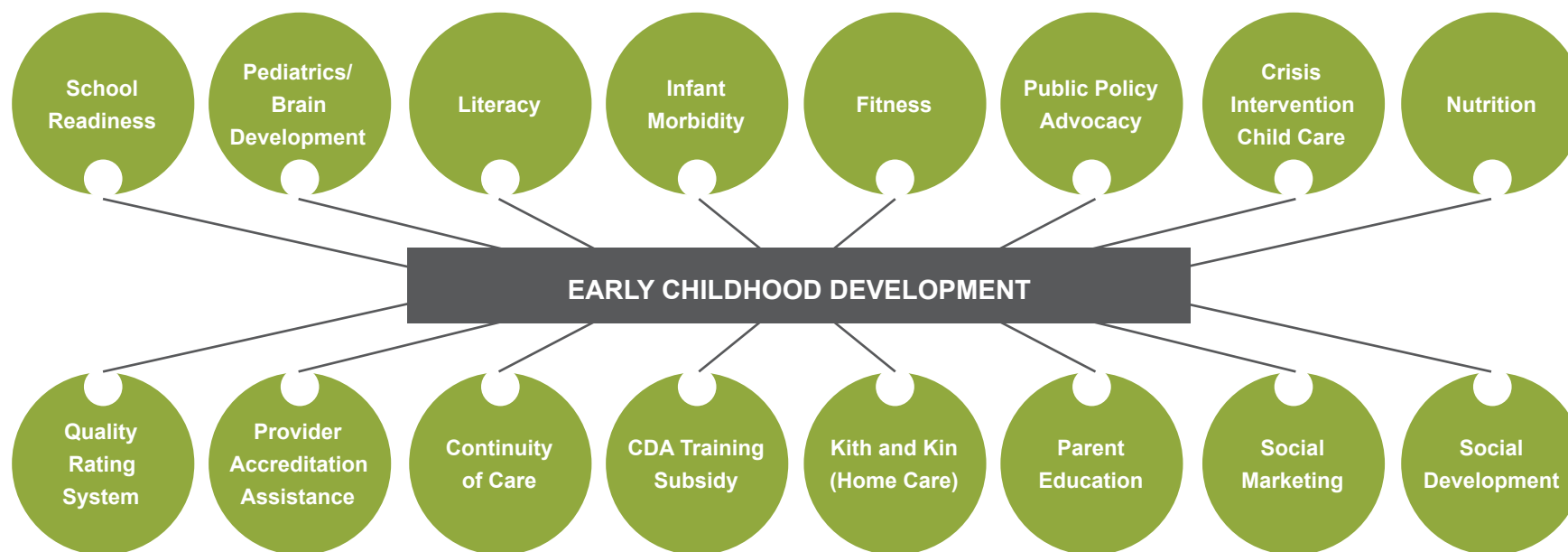
Namibia is a young country, with children under 14 years of age making up approximately 38% of the total population. It is a young country with a great future, should conditions be met to ensure that children can grow up in an environment where they will be healthy, safe, well-nourished, and educated. It is vital for the growth of Namibia and the general well-being of all Namibians that the infant mortality rate – currently far too high at 39 per 1 000 births – be reduced.

The National Policy on Early Child Development addresses the needs of Namibian children from birth to eight years of age. It promotes the holistic development of the child, which is to say that it deals in an integrated manner with the child's health, nutrition, cognitive and socio-emotional needs (including the need for protection, food, healthcare, affection, interaction and stimulation), and security provided through consistency and predictability.

The Policy establishes a supportive framework of actors at many levels to work with communities in the development of appropriate Early Childhood Development (ECD) programmes. The creation of ECD programmes begins with the parents and the community, supported by a community activator, community liaison officer and/or non-governmental organisation (NGO). The aim is therefore to strengthen the decision-making capacity at local level with regards to the design of sustainable ECD support (such as parent education and home-, community- or centre-based programmes), and to ensure that all young children and their families, especially those in rural areas and those living in difficult circumstances, are able to access the support.

Target Population: Children from Birth to Eight Years Old

Source: www.childhoodstudies.blogspot.com



During a two-day symposium held in January 2015, experts in the fields of education, health and nutrition gathered in Windhoek to discuss ways of strengthening ECD in Namibia. Training on the implementation of ECD programmes and principles was offered to individuals who work with children and/or parents; early childhood workers; community liaison officers of the Ministry of Regional and Local Government and Housing; and community activists.

The role of wider community: The National ECD Policy holds that development and learning occur continuously as a result of children interacting with people and objects in their environments. It states that ECD programmes should be developed in collaboration with the community, so that they are better able to define their own needs and develop their own resources, as this will enhance the likelihood of decisions being implemented and programmes being maintained once initial external support is withdrawn.

For these reasons, the Policy supports:

- building local capacity to identify needs and seek solutions;
- creating ownership and accountability;
- encouraging unity and strength within the community; and
- empowering people to make decisions in relation to all aspects of their lives.

Achievements

Available evidence for ECD

WHO Namibia supported a study on Infant and Young Child Feeding Practices, which also assessed knowledge about ECD with respect to play, early stimulation and childcare practices in Namibia. The results showed that participation in organised early learning activities is low, especially in rural areas. These results will guide the planning of early childhood interventions in the country.

WORLD HEALTH ORGANIZATION NAMIBIA STAFF



chapter 3

Combating Priority Diseases: Malaria, TB and HIV/AIDS

Improving peoples' lives, regardless of their background or socio-economic status or where they live, is in essence what the WHO sets out to achieve in countries all around the world, and Namibia is no exception. The ultimate goal of WHO Namibia and the MoHSS is to prevent, control and/or eradicate communicable diseases. A significant part of WHO Namibia's work consists of preventing and/or controlling disease outbreaks.

Malaria, TB and HIV/AIDS are regarded as priority diseases owing to their nature and impact on society, and it is therefore understandable that MDG 6 is solely focused on combating these diseases.

In 2014 and 2015, WHO Namibia continued to support programmes in combating these priority diseases in collaboration with other stakeholders. WHO Namibia provided support in developing/revising normative documents such as policies, plans and guidelines through promoting partnerships.

3.1 MALARIA

Rolling back malaria is critically important, and although there has been a slight upturn in the number of cases reported, particularly in the northern regions, the general trend over recent years has been for far fewer malaria cases being reported in Namibia than has been the case in the past. Nevertheless, complacency could wipe out all the gains that have been made so far, and ultimately cost lives. It is therefore essential that all stakeholders remain ever-vigilant.



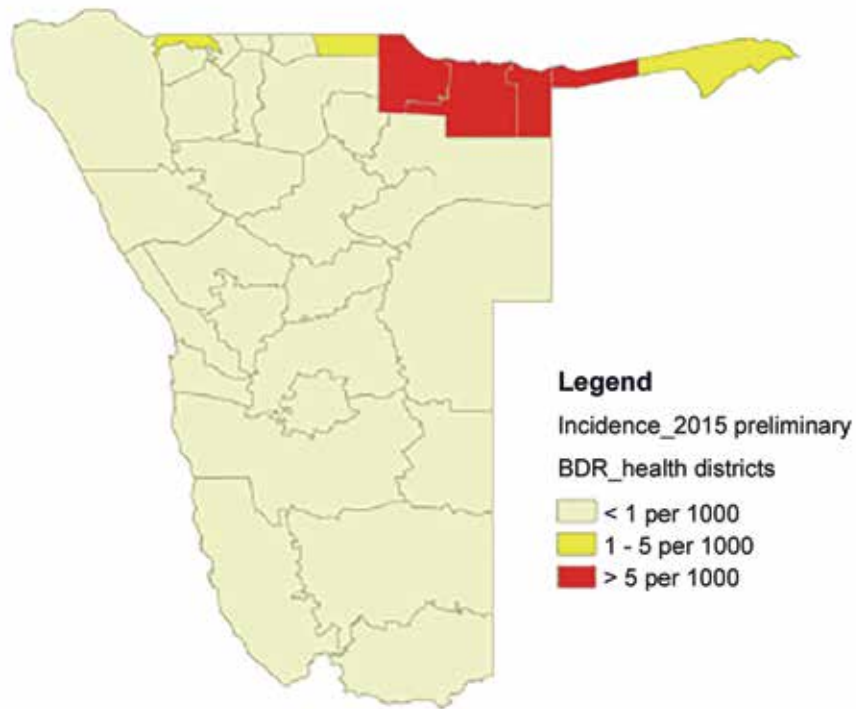
Millennium Development Goals

MDG6: “Have halted by 2015 and begun to reverse the spread of HIV/AIDS”

“Achieve, by 2010, universal access to **treatment for HIV/AIDS** for all those who need it”

“Have halted by 2015 and begun to reverse the incidence of **malaria and other major diseases**”





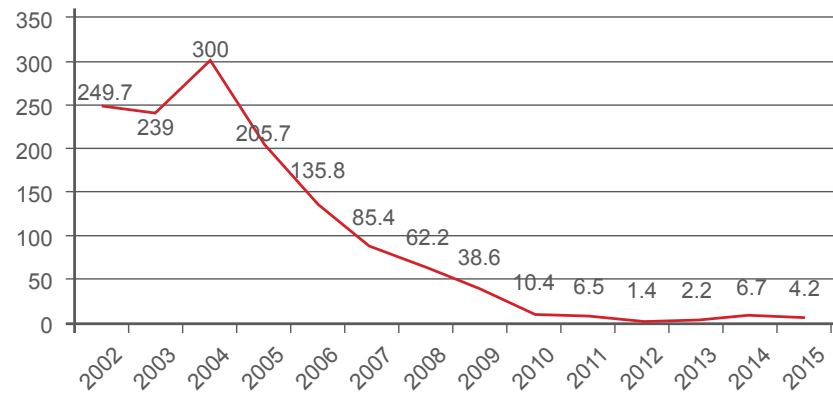
Incidence of malaria in Namibia by district in 2015

Malaria milestones

Between 2001 and 2014, Namibia achieved three great milestones:

- malaria incidence dropped from 403/1 000 to 6.7/1 000;
- malaria mortality reduced from 96/100 00 to 5.6/100 000; and
- more districts transitioned to low malaria incidence: the number of districts reporting fewer than 1/1 000 malaria cases increased from under 10, to 25.

Trends in malaria incidence in Namibia per 1000 population, 2002 - 2015



These great achievements have not gone unnoticed, and in 2014 Namibia received the African Leaders Malaria Alliance award.



Combating malaria in Namibia

Invest in the Future: Defeat Malaria was a three-year theme chosen in 2013 by health partners in the struggle to achieve the MDG 6 target reduction in the global malaria burden for 2015. The decline in malaria deaths that has been achieved has also contributed to the progress made in achieving the MDG 4 target of reducing the U5MR rate by two-thirds between 1990 and 2015, and to achieving MDG5.

WHO Namibia has been very active in supporting GRN efforts over the past five years aimed at eliminating malaria. There is good reason to be optimistic that this goal will be attained in Namibia. It should be noted, however, that this also leaves the population exposed to risks of severe malaria and death due to the loss of natural protective immunity.

On the other hand, with fewer and fewer cases being reported and a dramatic drop in the number of deaths, both health workers and communities might become complacent and lose the capacity they have developed over time to prevent and manage the disease. It is important that vigilance be maintained. The GRN is responsible for ensuring that this capacity is maintained at all levels, so that Namibia can become malaria-free. Through regular programme reviews and surveillance, WHO Namibia monitored progress and worked with the programme by taking actions when and where needed. WHO Namibia also supported the training of health programme managers and healthcare providers, including environmental health professionals, in an effort to strengthen programme capacity for malaria elimination.

In Namibia, malaria cases are mainly reported in the northern regions of the country, and some parts of the central regions. Most of the northern regions border areas of Angola and Zambia, where malaria is highly endemic. These regions are therefore exposed to seasonal surges of malaria due to the high influx of people from these neighbouring countries. As a result, Kavango East, Kavango West and Zambezi regions in the north-east of the country reported the highest numbers of malaria cases during 2014 and 2015 following the rainy season (between January and May).

Malaria is considered to be endemic in 21 of the 34 health districts in Namibia. WHO Namibia is focusing its attention on interventions throughout the northern areas of the country, with a view to controlling the situation and preventing further outbreaks by strengthening overall programme capacity and supporting cross-border collaborations.

Elimination Eight (E8)

In 2009, the Southern Africa Development Community (SADC) noted a significant reduction in malaria morbidity and mortality in Botswana, Namibia, South Africa and Swaziland, and identified these countries as having potential for malaria elimination. Following this, these four countries, together with their close neighbours (Angola, Mozambique, Zambia and Zimbabwe) formed a collaborative initiative which is known as **Elimination Eight**, or **E8**. The aim of the E8 initiative is to strengthen cross-border malaria control activities, as a catalyst for eliminating malaria in the four frontline southern Africa countries, and to expand the malaria-free zone in the sub-region into the four second-line countries. In collaboration with other partners, WHO Namibia has been involved in the drafting of the resolution of E8 countries, and provided technical guidance and advice to the E8 initiative in 2014 and 2015.

Malaria resurgence threats

Cross-border traffic of people between Namibia and its neighbours means that malaria parasites travel the same way. This is an important challenge that must be addressed. WHO Namibia has been assisting the GRN to curb the spread of malaria by sponsoring cross-border collaborative consultations between Angola and Namibia. While Namibia is making an effort to stamp out malaria at home, the free movement of people between countries has the potential to allow the disease to flare up from time to time, unless appropriate measures are put in place. There is a need for high-level advocacy and collaborative efforts between Namibia and its neighbours, particularly Angola and Zambia. As part of this endeavour, in 2014 and 2015 WHO Namibia facilitated cross-border workshops with Angola that helped to chart practical actions to effectively control malaria and other communicable diseases across the common border.

The spread of the disease through cross-border movement, and resurgence due to complacency following the sharp drop in cases, have brought about a renewed sense of urgency within WHO Namibia and its partners. WHO Namibia has been instrumental in facilitating meetings and engaging health workers, ministry officials and other stakeholders at all levels.

Malaria programme desk review

The MoHSS National Vector-borne Control Diseases Programme organized a thematic desk review workshop between 24 and 28 February 2014 in Okahandja, Otjozondjupa Region. Funding came from WHO Namibia and its local, regional and international partners for an essential workshop to gauge where Namibia stands regarding efforts aimed at the elimination of malaria.

Training workshop on malaria elimination

A training workshop aimed at building capacity and knowledge amongst the people who are working towards malaria elimination was facilitated by WHO Namibia from 9 to 18 June 2014 in Zimbabwe. Issues and challenges that have hampered surveillance in the past were discussed, and a plan of action was developed to ensure that these would be rectified. The substantial store of knowledge that the WHO has in combating malaria around the world allowed the programme staff to be equipped with the necessary knowledge for planning and implementing programme interventions aimed at malaria elimination.

Cross-border meeting between Namibia and Angola

A regional consultative cross-border meeting was held between Kavango East and Kavango West regions of Namibia and Cuando Cubango Province of Angola in May 2015. For details, see Section 4.2 (Cross-border Collaboration) below.

World Malaria Day

On 25 April every year, World Malaria Day (WMD) is commemorated all around the world. WMD allowed WHO Namibia and local, regional and governmental partners and stakeholders in Namibia to raise public awareness and sensitize Namibians to the need for continued vigilance.

WHO Namibia's WMD involvement includes community-based activities that educate participants about malaria prevention and treatment in areas where it is endemic. The focus is on the three key areas: reducing transmission using indoor residual spraying and insecticide-treated bed nets; early diagnosis and effective treatment; and strengthening malaria surveillance systems.

WMD was celebrated in Ohangwena Region in 2014, and in Kunene Region in 2015.



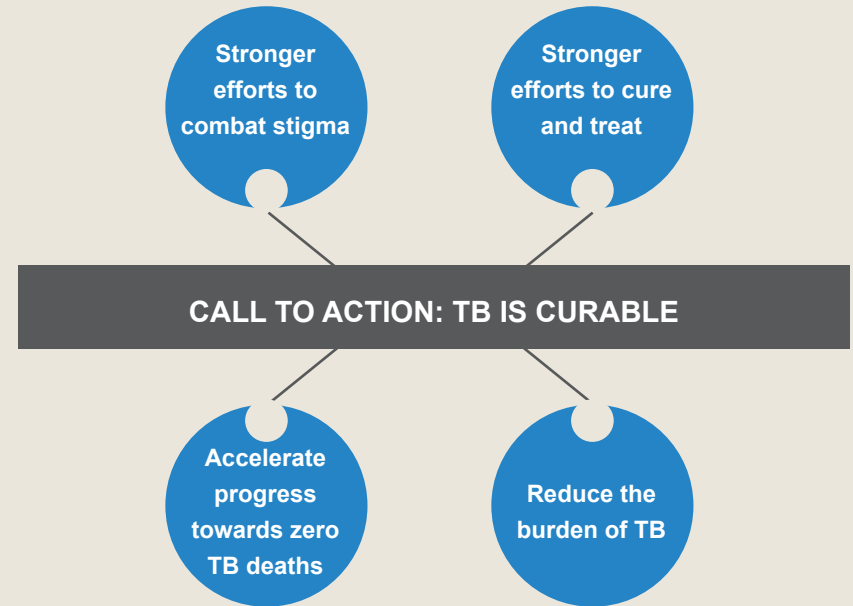
Celebrating World Malaria Day, 2014

Namibia can eliminate malaria, but doing so will require increasing investment, and the available funds for critical activities are never sufficient. WHO Namibia has therefore been advocating for increased funding for malaria control and elimination, so that programme coverage can be expanded in order to meet international targets. WHO Namibia provided technical support in the development and implementation of Global Fund-supported activities relating to malaria. WHO Namibia and its partners are determined to ensure that Namibia achieves its goal of malaria elimination as planned.

3.2 TUBERCULOSIS

In 2000, Namibia committed to attaining the MDG targets for 2015. Although Namibia is on track for reaching its targets for some MDGs, continued action is needed to achieve the target for MDG 6, namely achieving a 90% TB treatment success rate.

Tuberculosis remains a major public health problem in Namibia, with significant variations in burdens of disease and programme performance among different regions. The performance challenges in some regions require immediate and continued attention to enable the country move forward in achieving the set programme targets. To maintain the 2014 treatment success rate of 90% and achieve a consistent decline in the number of TB cases will require that the MoHSS intensify its effort, with the support of partners. The programme has updated its Medium-Term Plan II, which is now aligned with NDP 4 and has been developed with due consideration for the WHO Global End TB Strategy.



TB prevention, care and control after 2015

In May 2014, the World Health Assembly (WHA) passed the Global TB Strategy, approving ambitious targets to end the global TB epidemic (targets relative to 2015):

- 95% reduction in TB deaths by 2035
- 90% reduction in the tuberculosis incidence rate by 2035

The Global TB Strategy calls on governments and partners to adapt and implement the strategy with high-level commitment and financing, with special focus on the provision of services to highly vulnerable populations with poor access to healthcare. The strategy stresses the need to involve partners within and outside the health sector. WHO has supported the MoHSS through 2014 and 2015 in adapting and operationalizing the strategy, monitoring its implementation, and evaluating progress towards the interim 2020, 2025 and 2030 milestones, and the 2035 targets.

WHO Namibia interventions and activities to combat TB included those outlined below.

Monitoring Programme Implementation

WHO Namibia participated in the regional supervisory support visits in November 2014 in Otjozondjupa Region. The support visit covered all four districts (Okahandja, Okakarara, Grootfontein and Otjiwarongo). The team comprised officials from the MoHSS's TB and HIV programmes, WHO Namibia, and other partner organizations. The supervisory visit helped to determine the strengths and weakness of TB and HIV/AIDS services delivery, and provided guidance and advice on addressing the shortcomings at health facility, district and regional levels.

Regional cross-border meeting between Namibia and Angola

A regional cross-border meeting between Namibia and Angola was held in Ondangwa in March 2014. For details, see Section 4.2 (Cross-border Collaboration) below.

TB Drug Resistance Survey

The National TB and Leprosy Programme initiated the TB Drug Resistance Survey in 2014. The survey was supported and guided by a technical working group which included WHO Namibia. WHO Head Quarters provided technical guidance regarding protocol development, monitoring of progress, and data analysis. In 2015, a team of three technical staff from WHO, Centres for Disease Control and Prevention (CDC) and the MoHSS were trained in the analysis of TB Drug Resistance Survey data by the WHO TB programme in HQ.

Over the years, WHO Namibia, along with other partners, has provided support in building a critical mass of technical and managerial staff within the MoHSS in various programme areas. This critical mass now enables the MoHSS to carry out important programme activities. The National TB and Leprosy Programme was therefore able to undertake the following activities:

- training of nurses and trainers, who in turn trained other healthcare providers in the regions where TB is most prevalent; this training included how to diagnose TB in patients of all ages;
- field promoters (FPs) at Nau Aib Clinic were trained in the use of Electronic TB Register equipment, allowing for better record keeping;

- continued education, training and technical support were extended to the FPs, ensuring that they could educate, inform and advocate on this subject in the different regions of Namibia; it was found that they were quite knowledgeable about TB;
- improvements made during 2014 and 2015 in the regions to facilitate communication with the Namibia Institute of Pathology regarding laboratory results, and the expediting of the process;
- the designing of weekly and monthly “to-do plans” for FPs to serve as a checklist for work commitments and basic tasks, for example health talks, school meetings, contacts and tracing;
- training during 2014 and 2015 of staff working in the TB clinics who had not previously been trained ;
- the recruitment of FPs for clinics without FPs, so that even the most rural areas in Namibia can have people to turn to for information about combating TB; and
- the establishment of contact investigation processes where TB flared up in the northern regions of Namibia to better monitor and investigate if family, schools, hostels, hospitals and/or prisoners had been exposed.

World TB Day

World TB Day (WTBD) is commemorated on March 24 each year to highlight successes and challenges in fighting TB, and what needs to be done to significantly reduce the burden of this treatable disease. Young children, in particular, are highly susceptible to TB, but it can be hard to diagnose the disease at this age. People should be made aware of the fact that a cough that lasts for two weeks or more is not always “just a cough”, but is likely to be due to TB. TB in a child is recognized as a sentinel event, and demonstrates the challenge of ongoing transmission and missed opportunities for prevention. More than one million children contracted TB in 2010 globally, which clearly demonstrates that more needs to be done.

“Reach the 3 Million”: Approximately nine million people each year get sick with TB, but about a third of them are “missed” by public health systems. The theme highlights the need to reach those who fall through the cracks, and are not diagnosed. WTBD is observed annually as a key awareness activity in Namibia. The event is usually presided over by the Minister of Health and Social Services, which demonstrates the importance the GRN attaches to TB control in the country.



**EVERY YEAR
9 MILLION PEOPLE
GET SICK WITH TB.**

**3 MILLION DON'T GET
THE CARE THEY NEED.
HELP US TO REACH THEM.**

**REACH THE
3 MILLION.**
FIND. TREAT. CURE TB.

WORLD TB DAY 24 MARCH 2015

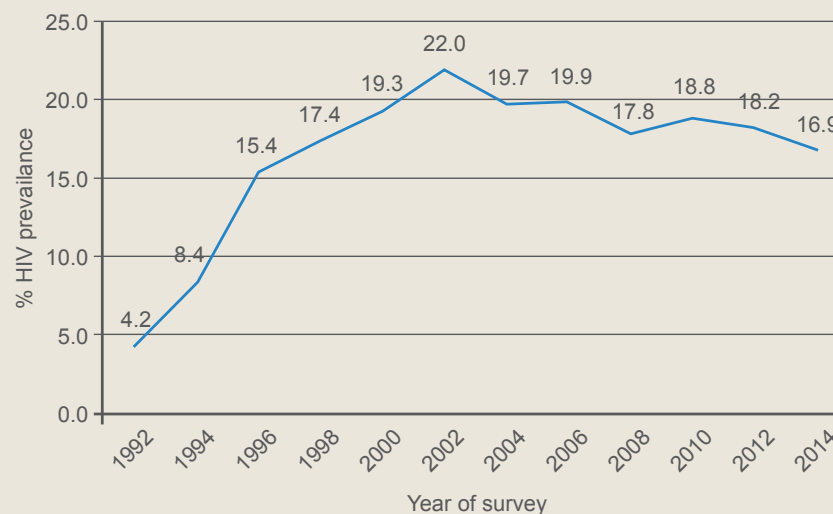


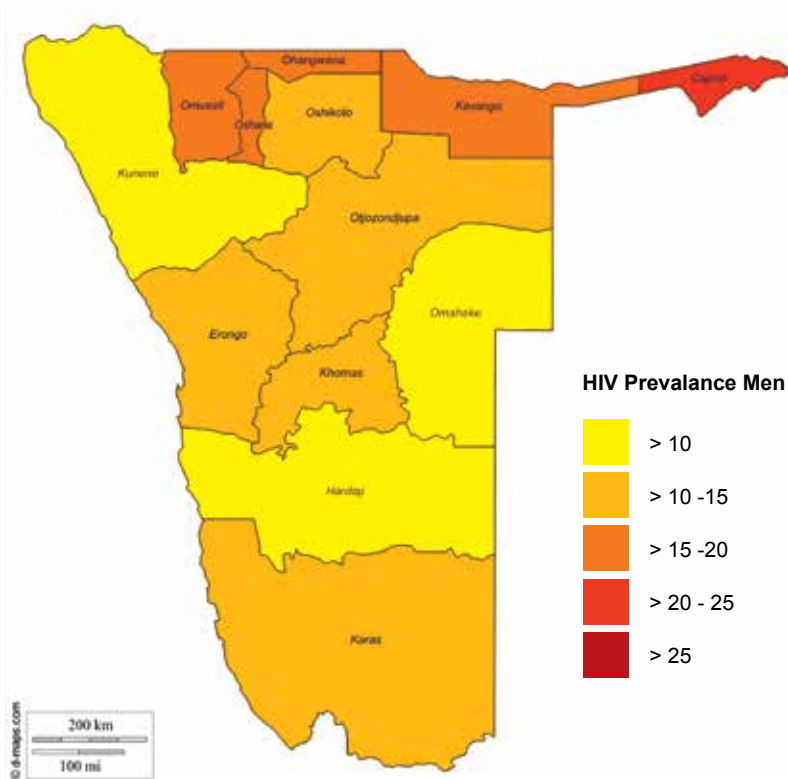
Hon. Dr. Richard Kamwi at World TB Day in 2014

Important achievements in Namibia in combating TB

- 9 882 TB cases were notified in 2014, down from 10 610 in 2013, and 12 625 in 2010.
- TB/HIV co-infection dropped from 59% to 44% between 2008 and 2014.
- Antiretroviral therapy (ART) coverage among TB/HIV co-infection cases reached 84%, up from 80% in 2013.
- Multidrug-resistant TB cases decreased from 214 in 2010 to 137 in 2014.
- Extensively drug-resistant TB cases declined from 20 to 6 cases between 2008 and 2014.
- 92% of TB cases know their HIV status.

3.3 HIV/AIDS



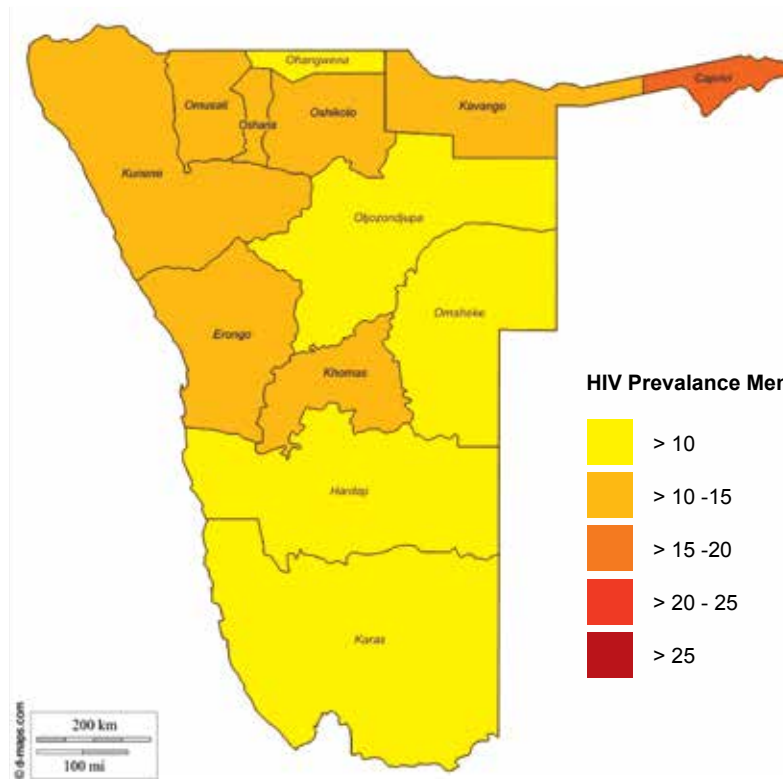


Overall HIV prevalence among pregnant women receiving antenatal care, National HIV Sentinel Survey 1992 – 2014

HIV prevalence among women age 15 – 49 by region (%)

Despite the high associated burden, Namibia has made significant strides in achieving critical milestones in the delivery of HIV/AIDS services to its population over the past decade. This is evidenced by the stabilizing of the overall HIV prevalence rate since 2004, a declining HIV infection rate among the younger age groups, particularly those in the 15 – 19-year-old age group, and a declining rate of mother-to-child transmission of HIV.

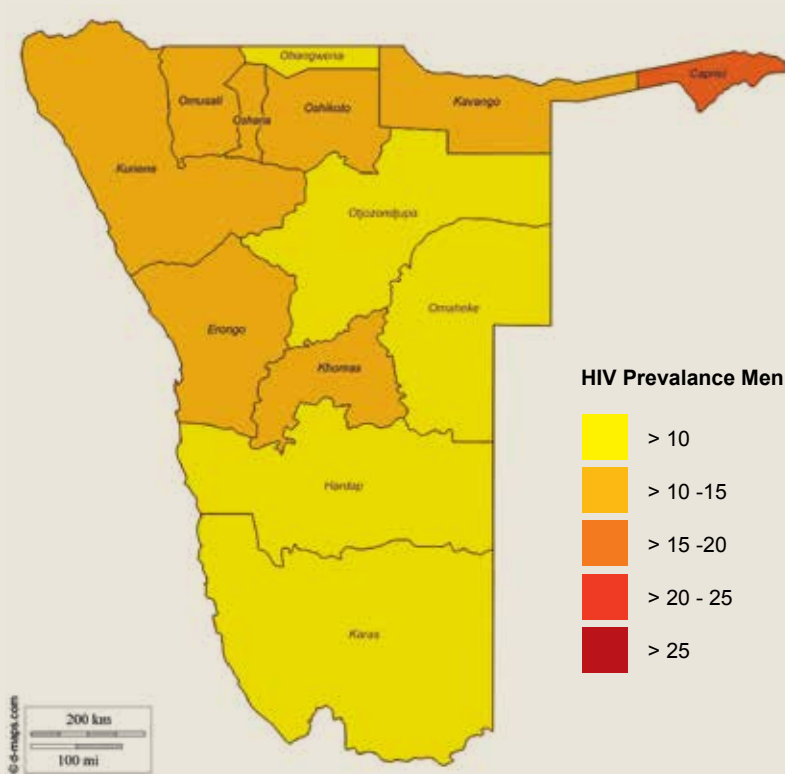
Together with other partners, WHO Namibia has worked closely with the MoHSS in combating the HIV epidemic. In both 2014 and 2015, WHO Namibia rendered support in the various HIV programme areas.



HIV prevalence by region (%)

Near-universal ARV coverage

Access to ARVs in Namibia more than doubled between 2009 and 2014, with the numbers being reached with treatment services up from 64 737 to 131 172. ART coverage stood at 83% in 2014 despite the expansion in the eligible population following revision of the ARV treatment guidelines in 2014. The impact of the epidemic is greater on the health, livelihoods and economic prospects of the poorest members of Namibian society. The country has a generalized mature epidemic, with HIV being primarily transmitted through heterosexual sex. Ongoing HIV campaigning and education therefore continued unabated during 2014 and 2015.



HIV prevalence among men age 15 – 49 by region (%)

The 2014 HIV Sero-Sentinel Survey

Together with other partners, WHO Namibia provided technical support during the planning and preparation of the 2014 HIV Sero-Sentinel Survey. This survey, which reflects HIV prevalence amongst pregnant women attending antenatal clinics, has been conducted every two years since 1992 by the MoHSS in selected sentinel health facilities.



The general objectives set by the MoHSS in 2014 were to:

- estimate the national prevalence of HIV infection in pregnant women aged 15 – 49 years;
- identify geographic and socio-demographic characteristics associated with higher prevalence; and
- monitor HIV prevalence trends over time.

The data reveal what is actually happening on the ground, and are used to estimate HIV prevalence in the general population for programming purposes. The results contained in the Sentinel Survey have been the main source of strategic information for gauging the trend of the HIV epidemic in the country.

Quality ARV treatment

Namibia has made remarkable progress in rolling out ART. The number of those in need of treatment continued to increase due to revised guidelines, and stood at an estimated 158 000 by 2015/16. One of the major interventions in the HIV/AIDS response is the provision of quality ARV treatment services to people living with HIV/AIDS (PLHIV). This is guided by the ARV Treatment Guidelines, which are regularly updated by the MoHSS and aligned with the WHO's Consolidated Guidelines on ARV Treatment. The ARV Treatment Guidelines were revised in 2013 with the assistance of WHO Namibia and other partners, and launched in March 2014.

The guidelines support Namibia in expanding ARV treatment services to a larger population of PLHIV, such as those with CD4 counts of less than 500, discordant couples, all pregnant and breastfeeding women (life-long treatment), all HIV-positive children below 15 years, and all patients with active TB. Evidence indicates that earlier ART will help people with HIV to live longer, healthier lives, and substantially reduce the risk of transmitting HIV to others. WHO has based its recommendation on evidence that treating people with HIV earlier, with safe, affordable, and easier-to-manage medicines, can both keep them healthy and lower the amount of virus in the blood, which reduces the risk of passing it on to someone else.

WHO Namibia continued to provide support in 2014 and 2015 in the development of an operational plan for the implementation of the revised ARV Treatment Guidelines. In order to expedite the implementation of the new guidelines on increased access to ART by all eligible population groups, there was nationwide engagement of stakeholders working in various programme areas in the provision of HIV/AIDS services.

WHO Namibia is an important partner in the HIV/AIDS national response, and continues to play an important role in various coordination groups, including, but not limited to the National AIDS Executive Committee, the Global Fund Country Coordination Mechanism, the Joint United Nations Task-team on AIDS, and various technical advisory committees. WHO Namibia consistently helps in combating HIV/AIDS in Namibia through support in the form of resources, knowledge, expertise and financial backing.

PMTCT and ART guidelines implemented in 2014 and 2015

The guidelines for the prevention of PMTCT of HIV were reviewed in the light of the ARV Treatment Guidelines, which stemmed from WHO recommendations. WHO Namibia participated in the review of the draft guidelines in a workshop organized by the MoHSS in February 2015. The workshop discussed the operational aspects of the PMTCT services, and proposed measures that should be adopted to successfully roll them out. The development of the guidelines was supported by WHO Namibia and other technical partners, such as the CDC and IntraHealth.

World AIDS Day

World AIDS Day, observed annually on 1 December, remains one of the most powerful tools that the MoHSS and WHO Namibia use to keep the need for ongoing combating of HIV/AIDS in the spotlight. Education and sensitisation remain vital tools for curbing the spread of HIV/AIDS amongst the most susceptible. This ranges from ongoing public information campaigns, the distribution of condoms, advocating male circumcision and, in particular, unrelenting education of children, pupils and students. Targeted education, for example through training-of-trainers workshops, is a further method that is employed.



WORLD AIDS DAY 2014

Achievements

The overall HIV prevalence rate of 16.9% in 2014 represents a slight decline from 18.2% in 2012. Results from the 2014 National HIV Sentinel Survey suggest that Namibia's epidemic remains in a period of stabilization, with slow, yet sustained decreases in HIV prevalence among pregnant women since 2002. From 2012 to 2014, a decrease in the HIV prevalence was observed at 23 sites (66%). An increase in the HIV prevalence between 2012 and 2014 was also observed in some sites, with the greatest increases being observed in Usakos (12.2% to 21.9%), Katutura (14.4% to 19.6%), and Okahao (16.3% to 20.6%).

By age group, HIV prevalence was observed to be highest among women aged 40 – 44 years (30.6%) and women aged 35 – 39 years (30.3%). HIV prevalence was lowest among women aged 15 – 19 years (5.8%) and women aged 20 – 24 years (9.8%). In 2014, the lowest HIV prevalence among women aged 15 – 24 years was observed in Opuwo (0.0%), followed by Omaruru (1.3%), while the highest HIV prevalence among women aged 15 – 24 years was observed in Katima Mulilo (24.3%) and Engela (14.3%). In 13 out of 35 sites (37%), more than one quarter of the women within the older age groups (25 – 49 years) were HIV-positive. WHO's work in 2016/17 will take the form of interventions focused on those areas where HIV prevalence remains high.



chapter 4

Surveillance and Disease Prevention

WHO Namibia has been active and ambitious regarding the implementation of the surveillance activities which are essential for the prevention and control of communicable diseases, and the provision of immunisation. Together with the MoHSS and relevant partners, the organization has given training to build national and regional technical and managerial capacities for surveillance and the prevention and control of vaccine-preventable diseases. This has been a catalyst for achieving WHO and MoHSS goals set out in the CCS for the eradication and elimination of communicable diseases.



4.1 STRENGTHENING HEALTH SECURITY BY IMPLEMENTING THE INTERNATIONAL HEALTH REGULATIONS

In today's connected world, health security is a global issue. We must all protect ourselves and each other from threats like infectious diseases and chemical and radiological events. This is why 196 countries endorsed the International Health Regulations (IHR) 2005, which entered into force in 2007, and agreed to work together to prevent public health crises, and to respond to them when they do arise.

WHO Namibia is supporting the GRN in building the core capacities necessary for IHR implementation. However, Namibia still needs time to build those capacities and requested an extension of time for full implementation of IHR. WHO extended the target deadline for full implementation till June 2016.

Through the IHR, WHO keeps countries informed about public health risks, and works with partners to help countries build capacity to detect, report and respond to public health events. The aim of the IHR is to help the international community respond to acute public health risks that have the potential to cross borders and threaten people throughout the world.

Vaccination

“Although the coverage of above 80% is reported at national level, seven out of 35 districts could not achieve the expected **80% immunization** coverage in all vaccines. It is estimated that **17 632 children have not received the recommended measles vaccination** for their age, and that is a huge concern. The country still experiences sporadic **outbreaks of measles**, which is an indication that all our children are not fully vaccinated.”



WHO Namibia activities with the MoHSS for implementing the IHR

- Advocacy and sensitization on the purpose, scope, principles, implementation and deadlines for the implementation of the IHR core capacities 2005
- Monitoring and reporting on progress with IHR implementation
- Reporting to and consulting the WHO
- Providing updates on IHR 2015 and supporting the country with regards to preparedness for international event detection, joint assessment and response
- Participation in the Public Health Emergencies of International Concern
- Strengthening of national surveillance and response capacities
- Increasing of public health security at ports of entry (airports, seaports and ground crossings)
- Providing guidance on screening for travellers, including development of screening forms and standard operating procedures; development/ dissemination of information leaflets and other IHR related documents/ information at points of entry

WHO Namibia is working closely with Namibian partners in implementing the IHR. The 2014 Ebola outbreak in three African countries far away from Namibia was a prime example of the need for the IHR, and how the WHO facilitates the global action plan to prevent a wide-scale outbreak. WHO Namibia carried out an effective campaign, including preparedness for the detection, assessment, reporting and responding to any Ebola virus disease (EVD); training for health workers on the use of personal protective equipment and related infection prevention and control procedures. WHO Namibia furthermore supported the MoHSS with finalizing its EVD Preparedness and Response Plan, for the country to use in case of an actual outbreak, which thankfully never occurred.

With rigorous implementation of the IHR around the world, outbreaks of communicable diseases can be stopped in their tracks. When the threat of the Ebola virus emerged, the MoHSS was responsible for taking primary action to proactively secure the safety of Namibian residents and visitors. With technical support from WHO Namibia specialists, the MoHSS managed to take all the right steps and followed the IHR guidelines for dealing with a potential Ebola outbreak.

Right: Demonstration of the use of personal protective equipment for EVD





4.2 CROSS-BORDER COLLABORATION

The various regions in Namibia face particular challenges for disease surveillance and patient care. One of these is the cross-border traffic of people, especially to and from Angola and Zambia, which has been shown to burden the existing healthcare systems of WHO Namibia, the MoHSS, and their counterparts across the borders. Concerned parties remain in constant dialogue on how to resolve these problems. WHO Namibia serves as an important advisor, especially to politicians, in trying to establish ground rules and workable solutions to address the ongoing situation. During 2014 and 2015, WHO Namibia was instrumental in drafting recommendations and resolutions based on their proven track record and experience in dealing with similar cross-border challenges in other countries.

Regional cross-border meeting between Kavango East and Kavango West regions of Namibia and Cuando Cubango Province of Angola, 11 – 13 May 2015

Major challenges are hampering the effective implementation of preventive and control measures against epidemic-prone diseases like malaria, especially across borders. A regional cross-border meeting was therefore held between Angola and Namibia, facilitated by a WHO Namibia specialist, to discuss and reach consensus on combating priority public health problems such as malaria, TB, HIV/AIDS and vaccine-preventable diseases. Proper communication at the Angola – Namibia border and information sharing with and between health facilities, community health workers and volunteers at all levels were found to be essential. The importance of basic information sharing on the quality and availability of services (such as vaccination) on both sides of the border was articulated. During the meeting, challenges were identified, and indicators and tools were developed to assist in the tracking of malaria and other priority surveillance diseases.

These activities, together with the practical implementation of certain activities in the affected regions, are the only way in which WHO Namibia and its partners can be successful in eliminating malaria and other priority surveillance diseases. Over the last two years, activities have therefore continued, often in areas where there haven't been many malaria cases and other vaccine-preventable diseases. This has been done to ensure that Namibia ultimately brings its malaria infections and deaths down to zero.

Regional cross-border meeting between Namibia and Angola in Ondangwa, March 2014

This meeting was held in Ondangwa to discuss measures surrounding control measures for TB and other communicable diseases that had not previously been implemented, in spite of their having been recommended. These measures were wide-ranging, and covered aspects such as cross-border traffic, poor TB and HIV/AIDS control and contact tracing and follow-up for priority surveillance cases along the border areas, and how to deal with Angolan citizens suffering from TB. The Namibian proposal to open up a Direct Observation Treatment Centre at Santa Clara was also discussed.

The meeting discussed at length the levying of high payments on Angolan patients, and the fact that this deterred them from accessing treatment. The meeting suggested that the MoHSS should make a final decision on the possible exemption or lowering of treatment fees for foreigners.

4.3 SURVEILLANCE ACTIVITIES

Surveillance is the continuous systematic collection, analysis, and interpretation of outcome-specific data for use in planning, implementing and evaluating public health policies and practices. A communicable disease surveillance system serves as an early warning of potential threats to public health. In Namibia, all surveillance is carried out in accordance with WHO standards and guidelines.

The data are used to:

- evaluate the effectiveness of control and preventive health measures;
- monitor changes in infectious agents, e.g. trends in the development of antimicrobial resistance;
- support health planning and the allocation of appropriate resources within the healthcare system;
- identify high risk populations or areas for targeted interventions; and
- provide a valuable archive of disease activity for future reference.

Like many other countries, Namibia has developed surveillance activities for communicable diseases in order to monitor diseases with a high burden, detect outbreaks of epidemic-prone disease, and monitor progress towards national or international control/eradication targets. **Measles, TB, malaria and neonatal tetanus** elimination are essential goals for WHO Namibia and the MoHSS. The surveillance activities are maintained at the highest standard in each region and district in Namibia, and are rigorously enforced, checked and improved on by WHO Namibia. These surveillance activities fall under the umbrella of Epidemiological Surveillance, which deals with diseases which are prone to spread if there is an outbreak, or if “at-risk” people are not vaccinated.

WHO Namibia, the MoHSS and partners have managed to have a significant impact in the controlling of communicable diseases, and in so doing, have

saved many lives. Measurable results and improvements were achieved through practical surveillance and the constant monitoring of processes and activities. This was made possible by giving HEWs the necessary training and tools to conduct proper surveillance and advocacy.

WHO Namibia experts carried out close to **40 field and site visits** to support immunisation and surveillance activities for vaccine-preventable and other priority surveillance diseases during 2014 – 2015.

HEWs in rural areas have been trained to look out for specific symptoms of diseases, and to know what immediate action to take to ensure that outbreaks of measles, cholera, TB or even EVD are contained. In 2014 and 2015, WHO Namibia continued all aspects of its surveillance work, and its experts provided technical assistance to help improve health in all regions of Namibia. All of the field visits made by WHO Namibia, often with local and regional partners, were geared towards strengthening the surveillance system for improved disease prevention and control.

4.4 SURVEILLANCE ACTIVITIES

MoHSS and WHO Namibia activities in response to the Ebola outbreak

- All the relevant stakeholders and the community at large were sensitized. A special team of doctors and healthcare staff from national, regional and district levels were trained to deal with a potential outbreak.
- Screening points were set up at all border crossings and equipped to monitor all travellers entering and leaving the country from EVD-affected countries. Regular updates were given in all media to inform the public of steps taken by the MoHSS, with the assistance of WHO Namibia.
- A National Ebola Preparedness and Response Plan was developed by WHO Namibia together with the MoHSS and other stakeholders, and is in use.
- WHO Namibia regularly briefed all development partners, including UN agencies and diplomatic missions, and provided them with regular updates on the epidemic.

How to prevent EBOLA?

Do not touch an infected person and their body fluids:



What to do if you suspect EBOLA?

If you are in contact with a person known or suspected to have EBOLA:



- Call your medical centre and tell them about your illness immediately
- Keep away from others so they do not get sick
- Be especially careful of your vomit and diarrhoea
- Listen to the doctor or nurse
- You may be sent to a special hospital
- Do not stay at home

Illustrations with courtesy of
International
SOS

Contact details:

For more information, contact
World Health Organization Namibia Country Office:
Tel: +264 (0)61 255 121 | 255 191
Email: registry@na.afro.int



EBOLA is preventable!

Everything you need to know about the EBOLA VIRUS DISEASE



What is the EBOLA Virus Disease?

- The Ebola Virus Disease is highly infectious and often leads to death.
- The disease comes from fruit bats, monkeys, gorillas and chimpanzees.
- People can be infected either through these animals or by coming in contact with infected people with Ebola symptoms.



EBOLA symptoms

Beware of the following symptoms:



Symptoms can start within **2 to 21 days** of contact with an infected person or dead body.

EBOLA. How does it spread?

Infected people showing signs and symptoms can spread the Ebola virus to others. People in direct contact with sick people are at highest risk:



Dead bodies can also spread the disease. **BE CAREFUL!**
DO NOT wash, touch or kiss dead bodies
DO NOT wash hands in the same bucket as others who have touched the dead body.

Measles and cholera outbreaks

In 2014, Namibia suffered an outbreak of measles, in spite of its being preventable through immunization. One of the greatest problems when combating such an outbreak is the fact that many Namibians are not vaccinated. If half of the population in a region is not vaccinated, it brings with it challenges that have to be overcome. With WHO Namibia's expertise, the outbreak was contained through surveillance, vigilance, education and the implementation of emergency vaccination activities.

Following detection of the 2014 measles outbreak, an Emergency and Preparedness Committee meeting took place to discuss how to counter the outbreak. WHO Namibia and the MoHSS embarked on a campaign to educate and inform Namibians of all ages about measles. A successful measles vaccination campaign was conducted in Outapi District. In August 2014, awareness campaigns were organized and carried out in the affected regions and in villages along the Angola – Namibia border, targeting the population from six months to 20 years.

Cholera is another example of a disease which is preventable and curable, but which remains a problem for parts of the Namibian population, especially in rural areas. Outbreaks, although not common, do happen from time to time in Namibia. Towards the end of 2013 and early in 2014, an outbreak occurred which required an immediate, decisive response. Acknowledging an outbreak that affected various regions and commencing at once with surveillance allowed WHO Namibia and its partners to implement emergency programmes to combat the outbreak.

Details of the cholera outbreak

In November 2013, a cholera outbreak was detected, mainly confined to the northern regions, including Kunene and Omusati regions, with a combined total of 518 cases and 17 fatalities recorded nationally. On 11 February 2014 the first recorded cases of cholera occurred in the capital, Windhoek. This was the first outbreak of cholera ever recorded in Windhoek. The MoHSS and the Khomas Regional Council led the response. The National Health Emergency Management Committee initially met on 13 February so that decisive action could be taken. Stakeholders were concerned about the presence of cholera in Katutura, in the urban environment of Windhoek. Containing the outbreak

was essential, and the MoHSS, together with WHO Namibia's experts, took the necessary steps, which included a fully-fledged media campaign to sensitize and educate the population on the subject of cholera and preventing it from spreading. A total of 70 suspected cases (five confirmed) and two deaths (CFR 2.9%) were reported in this outbreak. The last patient to be admitted was discharged on 26 April 2014. No region in Namibia besides Khomas reported cholera during 2014 and 2015.

MoHSS health partners' measures to contain the outbreak

Health partners (WHO, UNICEF, CDC, and the Red Cross) met regularly to formulate and guide a coordinated response that entailed capacity building, active surveillance, case management, and social mobilization. Measures adopted included the following:

- oral rehydration solution sachets were provided;
- one cholera treatment centre was built to isolate and treat new cases;
- beds and tents were provided;
- public health campaigns promoting good hygiene and sanitation practices were conducted through the targeted use of integrated education and communication; and
- hygiene promoters were trained on hygiene, water purification and the use of oral rehydration solution sachets provided in the affected areas.



How to make oral rehydration solution (ORS)

- ① Wash your hands with soap and treated water.



- ② Wash container and stirring utensil with soap and treated water.



- ③ Put 1 liter of treated water in the clean container. Put ORS powder in the water.



Stir the solution with the clean utensil.



How to use oral rehydration solution (ORS)

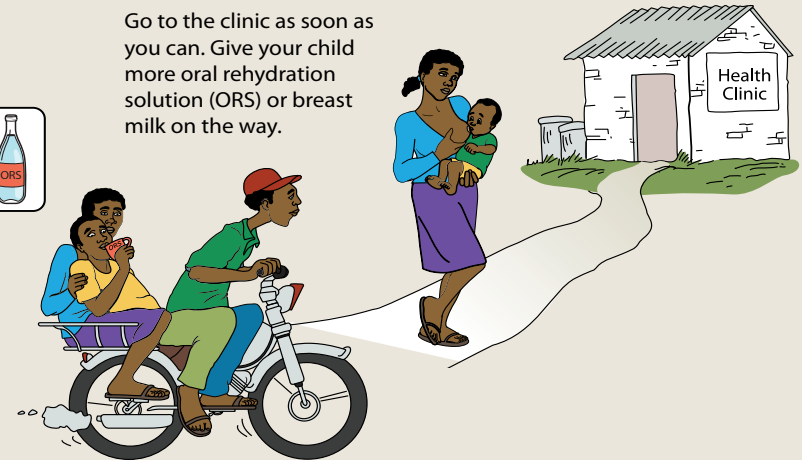
Give ½ liter of ORS each day to babies and toddlers who have diarrhea.



Give 1 liter of ORS each day to children who have vomiting or diarrhea.



Go to the clinic as soon as you can. Give your child more oral rehydration solution (ORS) or breast milk on the way.



Give 3 liters of ORS each day to adults who have vomiting or diarrhea.



Go to the clinic as soon as you can. Drink more oral rehydration (ORS) on the way.



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4.5 IMMUNIZATION ACTIVITIES

Expanded Programme on Immunization

Through WHO Namibia, MoHSS and partner collaboration, substantial progress was made with the implementation of the Expanded Programme on Immunization (EPI) in Namibia during 2014 and 2015. Results were achieved through continuous training, supporting of key interventions, and team work. The hope is that the introduction of relevant new vaccines and the improved immunization coverage will increase the protection of children from vaccine-preventable diseases, and eventually contribute to the attainment of MDG 4.

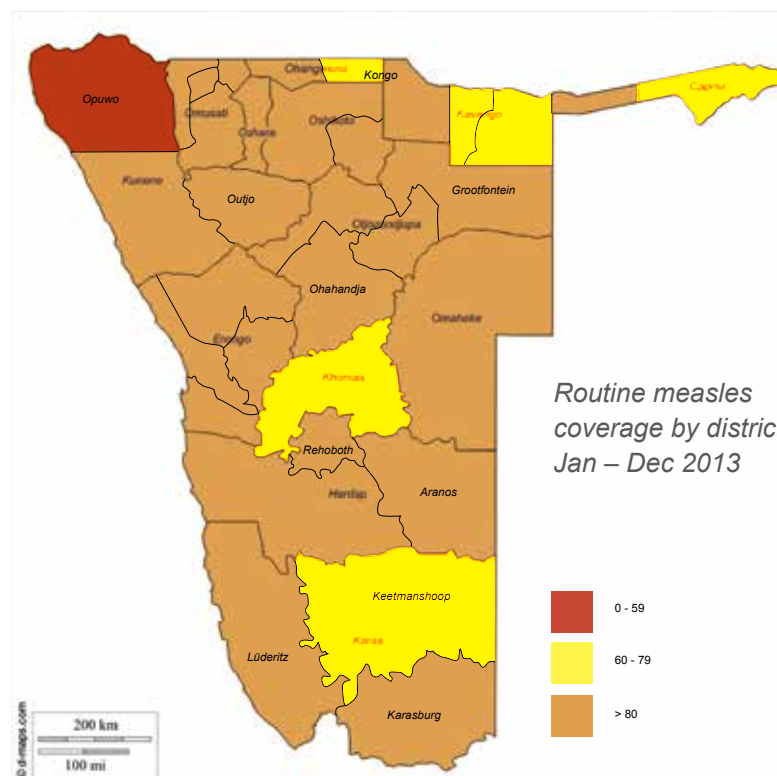
In the period under review, WHO Namibia trained health workers in various aspects of the EPI. Regional and district EPI officers were trained, who in turn conducted training at health facilities with the introduction of new vaccines. Training in vaccine management was also carried out at district and regional levels to ensure that health workers were up to date with the different elements pertaining to vaccine management, including stock management.

The EPI made substantial progress over the course of 2014 and 2015. The country implemented its first nationwide Maternal and Child Health Week in November 2013, and repeated the exercise in November 2014. Namibia also observed African Vaccination Week (AVW) for the first time in May 2014, and again in April 2015. Through these interventions, WHO Namibia and its partners highlighted the need for parents and caregivers to take their children for routine vaccinations and check-ups, and to benefit from free routine immunization.

These activities, implemented with constant support from WHO Namibia's experts, resulted in coverage improving from 84% in 2012 to 88% in 2014 for Penta3/OPV3. A similar improvement was noted in the coverage of measles, up to 83% for the first time in the history of the programme. During 2014 and 2015, WHO Namibia operated easily and met set targets in certain well-performing regions. However, some districts and regions are still not reaching their set targets, which can pose a health risk for the children and the general population living there. In addition, defining and reaching the target populations in some of the districts remains a challenge, as recent census data and programme estimates do not correspond.

WHO measles immunization target for Namibia: 90% coverage by the end of 2015

- All the relevant stakeholders and the community at large were sensitized. A special team of doctors and healthcare staff from national, regional and district levels were trained to deal with a potential outbreak.
- Screening points were set up at all border crossings and equipped to monitor all travellers entering and leaving the country from EVD-affected countries. Regular updates were given in all media to inform the public of steps taken by the MoHSS, with the assistance of WHO Namibia.
- A National Ebola Preparedness and Response Plan was developed by WHO Namibia together with the MoHSS and other stakeholders, and is in use.
- WHO Namibia regularly briefed all development partners, including UN agencies and diplomatic missions, and provided them with regular updates on the epidemic.

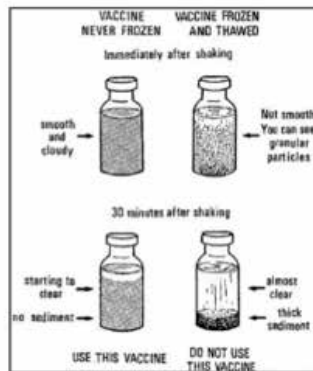




Handing over of cold chain vaccination equipment to the former MoHSS Minister, Dr Riichard Kamwi

How does the cold chain affect the potency of vaccines?

- Developing countries without proper or reliable access to electrical power face many adversities to keep the cold chain unbroken
- When vaccines get too hot or freeze they **become inactive or lose their potency**



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Polio Endgame

Another important milestone in the programme is the **Polio Endgame**, with the introduction of the affordable Inactivated Poliovirus Vaccine into Namibia's routine immunization programme. The **Global Polio Eradication** programme developed various standard operating procedures, and these were implemented in Namibia as part of the Polio Endgame strategy during 2014 and 2015. Capacity building, training and switch planning workshops were organized with the local partners and stakeholders under the leadership of WHO Namibia, leading to great progress in polio eradication over the last two years. The draft switch plan is also ready for endorsement.



A child being vaccinated at a Health Centre



Children and their parents waiting for vaccinations in Omaheke Region



African Vaccination Week

From 19 – 23 May in 2014, Namibia joined other countries around the world to commemorate and raise public awareness by celebrating AVW. It commenced with advocacy on the benefits of vaccination and the conducting of catch-up vaccination activities. The theme for 2014's commemoration, **“Vaccination, a shared responsibility”**, focused on the need for increased community involvement. WHO Namibia believes implicitly in the effectiveness of grassroots-level sensitization to achieve its goals. WHO Namibia personnel often travel to venues across the country – in regional centres, villages and remote settlements – and the resultant visibility and face-to-face interaction of the personnel motivates individuals to take on the responsibility for having themselves and their families vaccinated.

During the five-day AVW programme, immunization services were provided to children in all regions of Namibia. Vaccination, and ultimately immunization, improves children's health, and will prevent common childhood diseases in the future. AVW complements the efforts of the MoHSS to accelerate Namibia's attainment of MDG 4, namely reducing child mortality by two-thirds from 1990 levels by 2015. At the launch of AVW, WHO Namibia and its PARMaCM partners handed over the following cold chain equipment:

- 45 MK 304 Icelined refrigerators;
- 50 MK 204 Icelined refrigerators;
- 37 MF 314 vaccine/ice pack freezers;
- 680 vaccine carriers; and
- 339 fridge tags.

Supportive mission to Omaheke Region during AVW

During AVW, WHO Namibia sent a team to Omaheke Region to document the implementation of AVW activities. Their objective was to provide technical support in using the supervision checklist, and to ensure smooth implementation in terms of overall planning and coordination, social mobilization, logistics and supplies, injection safety, and waste management practices. During their three-day field visit, WHO Namibia staff also guided the Namibia Broadcasting Corporation television crew who were making a documentary on health and immunization. During this time, they interviewed medical and health staff, mothers, and caretakers for the health programme In Focus 2030, which was aired in June 2014. The implementation of AVW provided a perfect opportunity for the television crew to accompany the WHO monitoring team and to collect information and material for the documentary.

It was found that the region (which has only a single district) had responded very positively to AVW, and that there were complete micro-plans and maps identifying high-risk areas such as remote villages and nomadic San populations. At the health facilities visited, copies of excellent hand-drawn maps were available, showing important information (PLHIV, TB patients, health facilities, etc.). It was also found that outreach and mobile teams had been deployed to reach every community, and that there had been effective social mobilisation. Information about AVW had been communicated to mothers and other community members via local language radio programmes and during church services. The district also had a team responsible for social mobilization which had conducted community mobilization using megaphones. Posters promoting AVW had been printed and distributed.

AVW proved to be the perfect opportunity to sensitize all the relevant stakeholders regarding vaccination and immunization, especially with regards to the effect and impact of immunization on children, as well as on maternal health. Through careful planning, clearly formulated objectives and flawless execution, the celebration of Namibia's first vaccination week was a major success.

chapter 5

Non-communicable Diseases

Non-communicable diseases (NCDs) are medical conditions or diseases that are non-transmissible, chronic and related to lifestyle or behavioural factors. NCDs are the leading health and development challenge of the 21st century, in terms of their negative impact both on the health and socio-economic development of populations.

The four main types of NCDs are cardiovascular diseases (like heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma), and diabetes. Road traffic accidents, injuries stemming from violence, and mental health conditions also belong to the group of NCDs.



Globally, NCDs kill 38 million people each year, which is nearly two-thirds of all deaths. The four groups of diseases account for 82% of all NCD deaths: cardiovascular diseases contribute to 17.5 million deaths, followed by cancers (8.2 million), respiratory diseases (4 million), and diabetes (1.5 million). Almost three quarters of NCD deaths (28 million) occur in low- and middle-income countries.

NCDs are attributed to four common shared behavioural risk factors: tobacco use; physical inactivity; the harmful use of alcohol; and unhealthy diets. All of these increase the risk of dying from NCDs. Tobacco accounts for approximately 6 million deaths annually, harmful drinking for 3.3 million, insufficient physical activity for 3.2 million, and excessive salt/sodium intake for 1.7 million.

The progress made in the fight against major communicable diseases will be threatened if countries are obliged to devote their limited resources to take care of serious consequences of NCDs. Targets have therefore been set by the WHO to address the rise of NCDs.

In 2013, the WHA agreed on nine voluntary NCD targets to be attained by 2025 against a 2010 baseline:

Main types:

Cardiovascular diseases, cancers, chronic respiratory diseases, diabetes










Risk factors:

Tobacco use, lack of exercise, excessive alcohol consumption, an unhealthy diet

Responsible for:

Almost two-thirds of all deaths worldwide, and three-quarters of NCD deaths in low- and middle-income countries



- 1  A 25% relative reduction in the risk of premature mortality from cardiovascular disease, cancer, diabetes or chronic respiratory diseases
- 2  At least a 10% relative reduction in the harmful use of alcohol
- 3  A 10% relative reduction in the prevalence of insufficient physical activity
- 4  A 30% relative reduction in the mean population intake of salt/sodium
- 5  A 30% relative reduction in the prevalence of current tobacco use
- 6  A 25% relative reduction in the prevalence of raised blood pressure
- 7  Halting the increase in diabetes and obesity
- 8  At least 50% of eligible people receiving drug therapy and counselling to prevent heart attacks and strokes
- 9  An 80% availability of affordable basic technologies and essential medicines, including generics, required to treat NCDs

Prevention and Control of NCDs in Namibia

The current situation in Namibia

- Of people aged 35 – 64, 44 percent of women and 45 percent of men have elevated blood pressure or are currently taking medicine to lower their blood pressure.
- Forty-nine percent of women and 61 percent of men are not aware that they have elevated blood pressure.
- Forty-three percent of women and 34 percent of men with hypertension are taking medication for their condition.
- Only 29 percent of women and 20 percent of men with hypertension are taking medication and have their blood pressure under control.
- Six percent of women and seven percent of men are diabetic (that is, they have elevated fasting plasma glucose values or report that they are taking diabetes medication). An additional seven percent of women and six percent of men are pre-diabetic.
- Sixty-seven percent of women and 74 percent of men with diabetes are taking medication to lower their blood glucose.
- Women and men with a higher-than-normal body mass index (25.0 or higher) are more likely to have elevated blood pressure and elevated fasting blood glucose.

Tackling NCDs is the next big public health challenge in Namibia. There is concern about the rise in preventable diseases which are lifestyle-related. NCDs threaten Namibia's progress towards the UN MDGs and the post-2015 development agenda. Poverty is closely linked with NCDs, which in turn have the potential to impede poverty reduction initiatives in countries like Namibia, particularly by increasing the potentially catastrophic household costs associated with healthcare.

To reduce the impact of NCDs on individuals and society, a comprehensive approach is needed that requires all sectors, including health, trade, finance, foreign affairs, education, agriculture and planning, to work together to reduce the risks associated with NCDs, and to promote interventions aimed at controlling and even eliminating them.

WHO Namibia will therefore pursue the attainment of the global NCD targets as an essential part of its post-2015 agenda by supporting the country's efforts

to reduce the burden of NCDs. WHO Namibia is working with the MoHSS to implement NCD preventive and control measures in all the 14 regional health directorates in the country.

WHO Namibia provided evidence-based policy support in working with the GRN in developing a national multi-sectoral NCD strategy and implementation plan and protocol for the second national NCDs Survey, which will help to generate up-to-date data on the burden of NCDs and their risk factors, including biochemical profiles.

The following are some of the activities that WHO Namibia will be undertaking to combat NCDs in the coming years:

- applying evidence-based information to policy and practice;
- developing policies that promote public health and healthy lifestyles;
- individual and community empowerment;
- partnerships and inter-sectoral action;
- capacity building for health promotion;
- advocacy, communication and social mobilisation;
- mainstreaming health promotion and assisting with institutional arrangements for the coordination and management of health promotion;
- provision of initial financial resources for health promotion; and
- monitoring, evaluation and reporting.

Together with its partners, stakeholders and the general population of Namibia, WHO Namibia will be fully committed to these actions in the coming years, as the threat to the health of Namibians posed by NCDs grows.

Tobacco control

The WHO **Framework Convention on Tobacco Control** is an international treaty that entered into force in 2005, and has been endorsed by 178 countries, including Namibia. It is imperative for global health and therefore for Namibia that its citizens stop smoking. This is why the international community negotiated and adopted the framework in November 2012. However, because of the extensive and powerful lobby that challenges anti-tobacco legislation, WHO Namibia has had to actively support GRN ministries to get the **Tobacco Products Control Act** (No. 1 of 2010) ratified and implemented.



WHO Namibia has assisted the GRN, and in particular the MoHSS, to achieve this major milestone in the history of tobacco control in Namibia. The country, its leaders and the Namibian people deserve to be congratulated, encouraged and constantly supported in their fight to curb the use of tobacco. WHO Namibia provided policy guidance and technical support in the development



of regulations for implementing the Tobacco Products Control Act, and was delighted at the promulgation of the Regulations (Government Notice No. 35 of 2014). This had the effect of banning smoking in public places and requiring health warnings and pictures showing the adverse health effects of smoking on all tobacco products – a significant achievement for Namibia, and a landmark in the history of tobacco control in Africa, and the world.

Namibia has made significant strides towards reducing the burden imposed by tobacco on its population. To counteract the various tactics of the tobacco industry aimed at increasing the use of tobacco products, the country has to join the fight against the illicit trade in tobacco products. Ratification of the **Protocol to Eliminate Illicit Trade in Tobacco Products** is a necessary step in countering the adverse impacts highlighted above. Forty countries must ratify or accede to this protocol for it to become international law.

Commitment on the part of all potential stakeholders in Namibia to eradicating the use of tobacco products will mean that Namibia will continue to move in the right direction, thereby improving Namibians' health and reducing the economic

burden tobacco use entails. Different themes informed the work of WHO Namibia in connection with reducing tobacco use in the country. WHO Namibia's active involvement in reducing the burden of tobacco in Namibia included participation in the annual World No Tobacco Day (31 May). Each year, World No Tobacco Day has a different theme. In 2014 the theme was "Raise taxes on tobacco" and in 2015, "Stop illicit trade of tobacco products".

Stakeholders' meeting on the Tobacco Products Control Act and Regulations

WHO Namibia provided guidance and financial support for the stakeholders' meeting held on 13 – 14 March 2014, following the signing of the Tobacco Control Regulations by the MoHSS. The aim of the meeting was to introduce key law enforcement agencies and Tobacco Control Committee members to the stipulations contained in the 2010 Act and the 2014 Regulations. At the official opening ceremony, the MoHSS Minister, Hon. Richard Kamwi, handed over official letters of appointment to the Committee Members and regional and district law enforcement agents. Currently, the MoHSS is busy introducing the Regulations to regional law enforcement bodies and the public, to ensure their successful implementation.

Reduction of road traffic accidents, injuries and fatalities

The African region has the highest road traffic fatality rate (26.6 per 100 000 population versus 17.4 per 100 000 for the world) despite having the smallest proportion of registered vehicles in the world (2%). While some countries (79 of 194) have seen a reduction in road traffic deaths since 2010, only five of these are in Africa. Namibia reports around 550 deaths every year from road traffic accidents – about 24 per 100 000 population (lower than the regional rate). Much more needs to be done in the following areas:

- road user behaviour, infrastructure and vehicle design should improve;
- speeds on urban roads should be set at 50 kph;
- seat belt laws should cover all passengers, not just those in the front seats, and all children should be transported in appropriate child restraints;
- roads should be built to 3-star levels; and
- vehicles should meet the criteria set by the UN World Forum on the Harmonization of Vehicle Standards.

More should be done for the injured patient attending hospital facilities. At a very minimum:

- there should be an emergency access telephone number;
- doctors and nurses should be appropriately trained to deal with major road traffic trauma; and
- appropriate data should be collected in hospitals to optimise care and prevention.

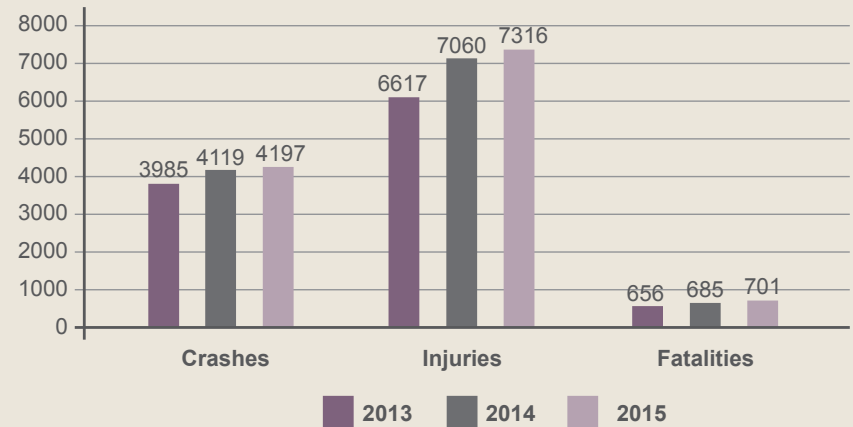


MVA Fund Crash Statistics Report (2013 to 2015)

Between 2013 and 2015, crashes, injuries and fatalities on Namibian roads all increased:

- from 2013 to 2014, crashes increased by 3%, injuries by 7%, and fatalities by 4%;
- from 2014 to 2015, crashes increased by 2%, injuries by 4% and fatalities by 2%.

Comparative crash statistics: 2013 - 2015



WHO Namibia activities during 2014 – 2015 regarding road traffic accidents included:-

- support for newspaper, television and radio campaigns creating awareness before the festive season on safe and alcohol-free driving;
- advocacy with high ranking police officials and traffic police on implementing existing sound traffic laws and regulations;
- provision of financial support to the Motor Vehicle Association to train 140 traffic police officers on first aid and initial critical care, as they are the first responders to any accident; and
- support for the Namibia Surgical Society in building capacities in trauma surgery through training.

Addressing gender-based and other violence

Globally, violence, in particular against women and children, shatters lives. It not only entails negative physical and mental health consequences, but also seriously hampers social and economic development. Over the past years, Namibia has scaled-up its efforts aimed at strengthening services for survivors of violence, in particular gender-based violence. While the establishment of services is of the utmost importance, we strongly welcome the explicit focus

on prevention in the global plan of action, and recognize the importance of addressing the root causes of violence, which are often already deeply ingrained in childhood. To enhance its response, in 2012 Namibia launched a National Action Plan on Gender-Based Violence 2012 – 2016, for which WHO Namibia provided policy and strategic support.

The 2004 Namibia School-based Student Health Survey, which was conducted with the support of WHO Namibia, found that one-fifth (20%) of all the students (both male and female) surveyed had been physically forced to have sexual intercourse.

WHA Resolution 67.15 on “Strengthening the role of the health systems in addressing violence, in particular against women and girls and against children” is timely, as the National Action Plan will be evaluated in 2016. We will in particular take into consideration the links between violence against children and violence against women, and welcome the fact that the plan explicitly addresses crosscutting issues relevant to all forms of violence. Namibia strongly supports WHA Resolution 67.15 as it recognises and endorses the Global Plan of Action, and will continue to work to support this effort.

Prevention, diagnosis and management of cancers

The Cancer Registry in Namibia is housed in the Cancer Association of Namibia Head Office. The registry receives data from both public and private health facilities in the country, but mostly from the Cancer Treatment Centre in Windhoek Central Hospital. According to Cancer Registry data, cancer cases have been on the rise since 2006, when a total of 1 625 cases were detected, compared to 3 092 recorded in 2012. In 2012, 458 cases of breast cancer were recorded, almost double the 229 recorded in 2006. Breast cancer is the most common cancer in Namibia; in second place is skin cancer, followed by Kaposi’s Sarcoma, prostate cancer, and cervical cancer. Cervical cancer cases stood at 125 in 2006, and 266 in 2012, while 136 cases of prostate cancer recorded in 2006, and 311 in 2012. There were 156 cases of Kaposi’s sarcoma (mostly diagnosed in men) in 2006; the number of cases rose to 214 in 2012. This is a cancer that develops from the cells that line lymph or blood vessels. It usually appears as tumours on the skin or on mucosal surfaces such as inside the mouth. Tumours can also develop in other parts of the body, such as in the lymph nodes or digestive tract. Most cases are associated with HIV/AIDS.

WHO provided support and was actively involved in organizing the African First Ladies Forum for the Prevention and Management of Breast, Cervical and Prostrate Cancer, held in Windhoek in 2014. The President of Namibia and the WHO’s Director General attended the forum. Namibia is working with the GRN and its partners in the prevention, early diagnosis and management of cancers. Some of the key cancer prevention guidelines are to:

- avoid tobacco use;
- get immunized for hepatitis B
- eat a healthy, low-salt diet;
- exercise regularly;
- reduce alcohol consumption;
- reduce environmental risks, especially sun exposure;
- treat infections as soon as they become apparent;
- get regular screenings e.g. for breast, cervical and colorectal cancer; and
- introduce HPV vaccination.

Mental health

There is a lack of awareness about mental illness, and an effective campaign is needed to curb discrimination against people with mental illness. More than 50 000 new psychiatric patients visited various healthcare facilities between 2008 and 2013. The country is also experiencing a general shortage of mental health facilities. Mental health is a part of the primary health care system. Actual treatment of severe mental disorders is not available at the primary level. Treatment is generally available at the hospital level, but follow-up on discharged psychiatric patients is done in all healthcare facilities. All district hospitals have emergency mental health services as part of their outpatient services. These hospitals have no specialised staff, although a limited range of psychotropic medications is available at some of the hospitals and clinics. The MoHSS has formulated plans to improve mental healthcare in Namibia by 2018.

Mental health services are provided in accordance with the South African Mental Health Act (No. 18 of 1973). This is in spite of the fact that this Act has been amended in South Africa. Namibia is therefore using outdated legislation. WHO Namibia conducted a technical review for a new Bill on mental health,



which the GRN aims to table in parliament during 2016. This is an essential element of reform that is needed as an element of the implementation of the Mental Health Policy.

Some NGOs concern themselves with mental health in the country, focusing mainly on advocacy, promotion, prevention and rehabilitation. In Windhoek, the German Evangelical Lutheran Church provides one accommodation facility for psychiatric patients who do not have a family to take care of them.

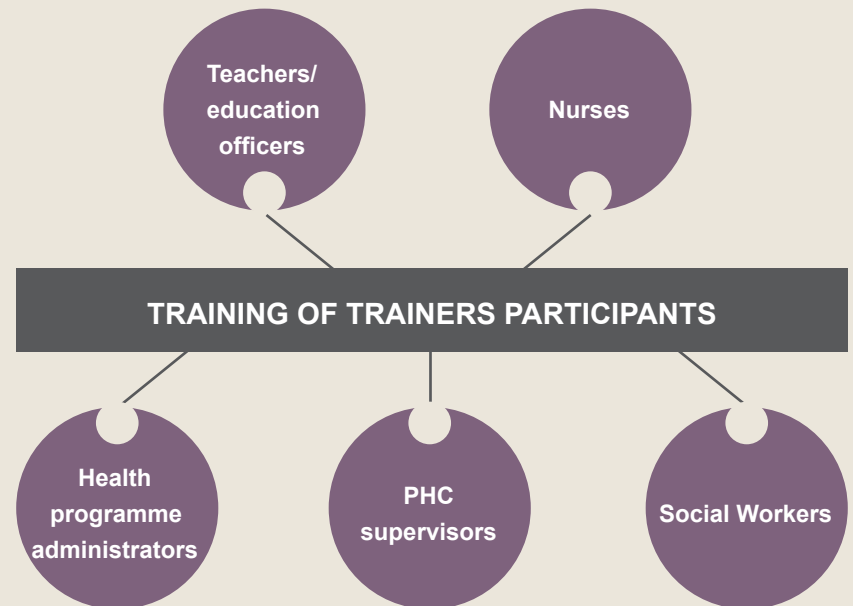
The **Health Information System** was revised in 2000, and a new system was introduced in 2001. The analyses are based on the records of outpatients who attended clinics, health centres and hospital outpatient departments. Information on inpatients is also available. The facility-based information system contains data on all public health sectors and services, including mission healthcare facilities.

WHO Namibia provided policy, strategy and financial support for the Mental Health Association of Namibia. The objectives of the Association include raising awareness of the countrywide mental health problem and training professionals

and family/community members in mental health issues. WHO Namibia contributed to the Association's efforts at establishing community support groups for patients and their families. Over 50 such groups were established in Windhoek. The support further strengthened the Association's administrative capacity by securing office equipment and affiliation with regional and national bodies.

School health

The MoHSS and the Ministry of Education conducted two training-of-trainers workshops aimed at strengthening and scaling up the school health programme in the country. In March 2015, two workshops were held in Tsumeb (Oshikoto Region) and Okahandja (Otjozondjupa Region). The training-of-trainers workshops were the culmination of a process that started with the drafting of an integrated school health manual that was pre-tested in Swakopmund (Erongo Region) in October 2014. The manual was enriched by contributions from members of the National Task Force on School Health, which included WHO Namibia and its health experts.



chapter 6

The Health System

6.1 THE BURDEN OF DISEASE

It is vital that a nation knows what is required for its people when it comes to healthcare. Together with the Institute of Health Metrics and Evaluation, WHO Namibia conducted a “burden of disease” study in Namibia. Through this study, the MoHSS and WHO Namibia together informed the Universal Health Coverage Advisory Committee of Namibia (UHCAN) Technical Working Group (TWG) about the appropriate package of services that should be included in Namibia, in order to achieve universal health coverage. A scoping mission was conducted by the Institute of Health Metrics and Evaluation in March 2015 to engage with GRN stakeholders from the MoHSS, the Social Security Commission, and the National Statistics Agency.



IHME
Institute for Health Metrics
and Evaluation

Findings of the Global Burden of Disease Study for Namibia

- Highest burden of disease in 2013: **HIV** (ranked 12th in 1990)
- Second highest burden: **lower respiratory infections** (mostly affecting children)
- Third highest burden: **cerebro-vascular disease** (ranked 5th in 1990)
- Fourth highest burden: **ischemic heart disease** (indicating clearly that NCDs are on the increase in Namibia)
- Fifth highest burden: **TB**
- Sixth highest burden: **diarrhoeal diseases** (ranked 2nd in 1990)
- Seventh and eighth highest burdens: **diabetes** and **obstructive pulmonary diseases** (both also NCDs)

There has been a significant increase in the HIV burden of disease, which now constitutes 28% of the total burden of disease in Namibia. At the same time, there is an epidemiological transition from communicable diseases to non-communicable diseases (NCDs) in Namibia.

**Basic
healthcare
for remote rural
communities**

1 200 health extension
workers trained by end-
December 2015, now
providing basic healthcare
and counselling in their
own communities



6.2 STRENGTHENING THE NAMIBIAN HEALTHCARE SYSTEM

Health is not a stand-alone concept, and cannot be dealt with in isolation, since it touches the entire fabric of a country. There are social, environmental, economic and nutritional factors that have an impact on health, and there is also the need for proper sanitation, healthy lifestyles, and security for people. Although communicable diseases are still prevalent in Namibia, they are on the decline. Non-communicable diseases like cancer, diabetes and hypertension, on the other hand, are becoming more common. Namibia is therefore in a transitional phase with respect to dealing with public health, with the focus moving away from emergency responses, to NCDs.

WHO Namibia and the MoHSS are now looking into the strengthening of the healthcare system and the integration of disease-specific programmes into mainstream health services. This presents a whole new range of challenges for Namibia, its healthcare professionals, and WHO Namibia.

WHO Namibia partners with relevant local, regional and international organizations and institutions to ensure that health services are delivered in accordance with the principles of primary healthcare, namely:

- **universal coverage reforms:** reducing exclusion and social disparities in health;
- **service delivery reforms:** organizing health services around people's needs and expectations;
- **sustainable human resource planning;**
- **management of essential medicines and supplies;**
- **public policy reforms:** integrating health into all sectors;
- **leadership reforms:** pursuing collaborative models of policy dialogue; and
- **increasing stakeholder participation.**

WHO Namibia and other local partners, including other UN agencies, are fully committed to implementing these interventions consistently and without delay in all 14 regions of the country. This places a great deal of pressure on a healthcare system that is already stretched to capacity, and which is always in need of additional funding. The investment in healthcare in a country is never

enough, but it should minimally be sufficient to protect the most vulnerable members of society.

Integration of health services in public healthcare

WHO Namibia provided technical support to the MoHSS to implement the new integrated model of health services in public healthcare in Namibia. Seven pilot clinics in the country are implementing this model, and they were evaluated at the end of 2015.

Pilot health facilities



- | | |
|------------------------|-----------------------|
| 1 Hakahana (Windhoek) | 5 Nau Aib (Okahandja) |
| 2 Khomasdal (Windhoek) | 6 Okankolo (Oshikoto) |
| 3 NAPPA (Windhoek) | 7 Kanono (Zambezi) |
| 4 Epako (Gobabis) | |

WHO Namibia also organized a study visit to the Epako clinic in Gobabis with the Regional Director of Hardap Region, Dr. Pumwe, and his team to learn how Epako is implementing the new model to integrate health services in primary healthcare. WHO Namibia will support Hardap to start integrating health services in Mariental and Rehoboth.

The success of these pilot projects was much appreciated by the GRN and development partners, and WHO Namibia is working with the MoHSS to roll out integrated people-centred healthcare services throughout the country.

6.3 THE HEALTH EXTENSION WORKERS PROGRAMME

One of the solutions to the lack of healthcare workers, medical facilities and access to doctors, especially in rural areas, has been the introduction of a Health Extension Workers Programme, which trains and empowers HEWs with knowledge and skills, enabling them to make a difference in their own communities.



An HEW out in the field checking on a mother and child

WHO Namibia believes that primary healthcare is a basic human right, and that it must be brought to rural communities. This can only be accomplished through the use of HEWs.

In Namibia, the HEW programme commenced with a pilot programme in 2012. This was followed by the first multi-regional HEW training of 500 Namibians in 2013 – 2014. For the 2014 – 2015 HEW training cycle, about 900 trainees were recruited from 10 regions. The current group of trainees will bring the total number of HEWs to 1 200.

The HEWs are not doctors or nurses, but they address the critical shortage of human resources, particularly in rural areas. HEWs are the eyes and ears of the healthcare system, linking communities with facilities. They are improving the health and survival of people by promoting health, preventing disease and injuries, providing first aid for simple illnesses, making referrals, and monitoring unusual health events and disease outbreaks so that appropriate investigation and management can follow. As far as possible, they will work in their own villages. This arrangement helps to ensure that there is a close relationship between HEWs and the communities they serve.

Six HEW training modules

- Community mobilisation, mapping and the household census, behaviour change and facilitation
- First aid
- Community-based maternal and newborn care
- Community-based integrated child health
- HIV and AIDS, TB and malaria
- Social welfare and disabilities

1 200 health extension workers trained by end-December 2015 in Namibia, with a graduation ceremony held in Omusati Region in April 2015.

WHO Namibia joined hands with the MoHSS to make the HEW programme a reality in Namibia, and will continue to provide support to ensure that it is strengthened to deliver the positive health outcomes that are so sorely needed. Along with the MoHSS, WHO Namibia will monitor the HEW's performance, and ascertain further training needs. The implementation of the HEW programme is a journey towards improving the health of each and every Namibian, and WHO Namibia is proud to be supporting it.

6.4 NATIONAL HEALTH ACCOUNTS

Many of WHO Namibia's activities are related to measuring, researching and planning ahead. Decisions on where resources should be targeted and which health sectors deserve the most attention can only be made if all the relevant facts and figures are available, and are analysed and interpreted. Research and statistics constitute the foundation for establishing good health systems for Namibia.

Namibian public health was researched and tracked through the **Namibia Health Resource Tracking Exercise** (usually referred to as the **National Health Accounts** (NHA)) for the 2012/13 financial year, and the results were released by the MoHSS Minister, Hon. Dr Bernard Haufiku, on 15 July 2015.

The WHO Representative in Namibia, Dr Monir Islam, presented the keynote speech with the publication of the findings. He noted that:

... the results of the National Health Accounts 2012/13 exercise highlight the strong commitment of the Namibian Government to financing the general healthcare of the population and the national HIV response. The commitment is commendable and should be maintained, as it will be a key strength in Namibia's efforts toward achieving Universal Health Coverage.

The sound estimates of health expenditure contained in the NHA are vital for strengthening health systems in Namibia. They give stakeholders information on the value of healthcare goods and services purchased, existing patterns in financing, and the provision and consumption of healthcare resources. The work of WHO Namibia and its local partners is largely based on these findings. WHO Namibia has been fully involved in conducting the NHA exercise since its inception phase in March 2014. WHO Namibia provided technical support to train MoHSS staff on such exercises, helped design the protocol for the study, and recruited the enumerators. WHO Namibia's specialists also assisted by collecting data in the field, introducing the data to the **National Health Accounts Production Tool**, analysing the data, and writing the final report. Data from the NHA will guide WHO Namibia, the MoHSS, national policymakers, donors and stakeholders in their strategic planning, and allow them to make informed decisions for health and social service delivery in the future.

Some findings of Namibia's National Health Accounts

- Total Health Expenditure (THE) in Namibia is N\$ 9.2 billion (9% of GDP).
- The GRN finances 54% of THE; the private sector 38%; and donors 8%.
- THE per-capita expenditure is N\$4 294.
- GRN health expenditure is 13% of its total budget expenditure.
- Out-of-pocket payments have increased in Namibia from 6% in 2009 to 11% in the 2012/2013 NHA.
- HIV accounts for 13% of THE.
- Non-communicable diseases spending is only 5% of THE.
- 44% of THE goes to paying for healthcare, as only 19% of the population is covered by some form of medical aid.



Health Accounts Final Report 2015

The following areas were researched in the Health Accounts Final Report 2015:

- identification of alternative sources of health financing to sustain domestic financing;
- the increase in government health expenditure to achieve the Abuja target of 15% of public expenditure;
- the increase in HIV/AIDS expenditure to respond to the high burden of the disease;
- the re-allocation of funds on primary care in order to improve quality, accessibility, and efficiency;
- the shift of attention and funding to NCDs;
- the improvement in financing equity, and in access to health services; and
- the identification of ways to improve efficiency within the public and private health sectors.

Stakeholders involved in the Namibia Health Resource Tracking Exercise



chapter 7

WHO Namibia's Future Vision: Universal Health Coverage

As noted in the introduction to this WHO Namibia Biennial Report, the general mission of the WHO is “the attainment of the highest possible level of health by all people”. WHO Namibia’s substantial contributions to the provision of quality healthcare for all in Namibia have been outlined in the report. It is important, however, that we recognise some sobering facts:

- only 15% – 16% of the Namibian population are covered by a medical aid scheme; and
- less than half of the formal sector work force have medical scheme coverage.

This low level of health coverage results in a high burden of health costs that must be borne by the GRN, adversely affecting the sustainability of healthcare financing and universal access in Namibia. **Universal Health Coverage (UHC)** is therefore vital for truly attaining “the highest possible level of health by all people”, but it is still far from being achieved.



WHO Namibia's Future Vision: Universal Health Coverage

**“Universal Health Coverage is the
single most powerful concept
public health has to offer.”**

Dr Margaret Chan,
Director-General
of the WHO



Activities directed towards achieving UHC, which will continue in the future

- WHO Namibia is a member of the steering committee and the advisory group formulating policy and strategies for policy decisions on UHC in Namibia. This activity is financially supported by the African Development Bank.
- WHO Namibia hosted intensive five-day courses on UHC in 2014 and 2015, emphasizing its commitment to the training and education of local partners and stakeholders on the need for UHC to create a critical mass. Participants were from Spain, Sudan, Angola, Mozambique and Namibia.
- Work groups and task forces were created by WHO Namibia and its partners to facilitate ongoing training of healthcare workers on integrated health management, as well as on the proper and efficient distribution of available resources. In June 2014, a three-day workshop on this subject was held, and more are planned for the future.
- Technical working groups offered education and training to ensure the availability of equitable, integrated, people-centred health services at affordable rates, and access to affordable, safe and effective medicines and health technologies.
- WHO Namibia assisted with the strengthening of Namibian health information systems in order to provide information and evidence on health-related matters, to enable the formulation of evidence-based policy.

During 2014 and 2105, with a view to securing a better future for healthcare in Namibia, the need for the following studies was identified:

- **a health financing review:** to conduct an analysis of health spending, current revenue collection, resource allocation, efficiency, budgets and allocations;
- **a burden of disease study:** to measure the impact of health problems in terms of financial cost, mortality, morbidity, or other indicators;
- **a performance of the health system review:** to determine and evaluate the current capacity of the existing health system, and to assess the quality and equity of health services provided through the public and private sectors;
- **a unit cost of health services study:** to determine the total expenditure on health services as a basis for establishing the total funding requirements for the achievement of UHC; and

- **a feasibility study:** to combine the current contextual information on the Namibian health system, financing mechanisms, and demands in terms of the health burden and system capacity, and to evaluate the feasibility of various proposed health systems.



The **Universal Health Coverage Advisory Committee of Namibia (UHCAN)** was established as a sub-committee of the Social Security Commission Board, with the objective of providing advice and guidance to the MoHSS, to which it is primarily accountable, on the development of systems and policies for UHC in Namibia. WHO Namibia provided technical support to the UHCAN.

One of the goals of the UHCAN is to have a comprehensive understanding of the current healthcare situation in Namibia, through the UHCAN TWG. WHO Namibia, represented by the PARMaCM Project Coordinator, Dr Tomas Zapata, provides focused technical support and expertise. For example, WHO Namibia has supported the Social Security Commission in developing a checklist for a study tour to Thailand, Mexico, Germany and Ghana to learn how these countries have achieved UHC. WHO participated in the International Conference on Social Protection that took place in Windhoek in June 2015.

Human resources for health

In May 2014, the 67th World Health Assembly tasked the WHO Director-General with developing a new Global Strategy on Human Resources for Health (HRH), to be considered by the 69th World Health Assembly in May 2016. This strategy represents a critical component of the WHO strategic vision towards UHC in the framework of the post-2015 health development agenda. As part of this drive, WHO Namibia advocated for the establishment of the HRH TWG under the leadership of the MoHSS.

During the first trimester of 2015, the TWG was created and the terms of reference were developed. The main objective of the TWG is to keep the HRH situational analysis updated, to develop the HRH policy, and to develop the National Strategy on HRH.

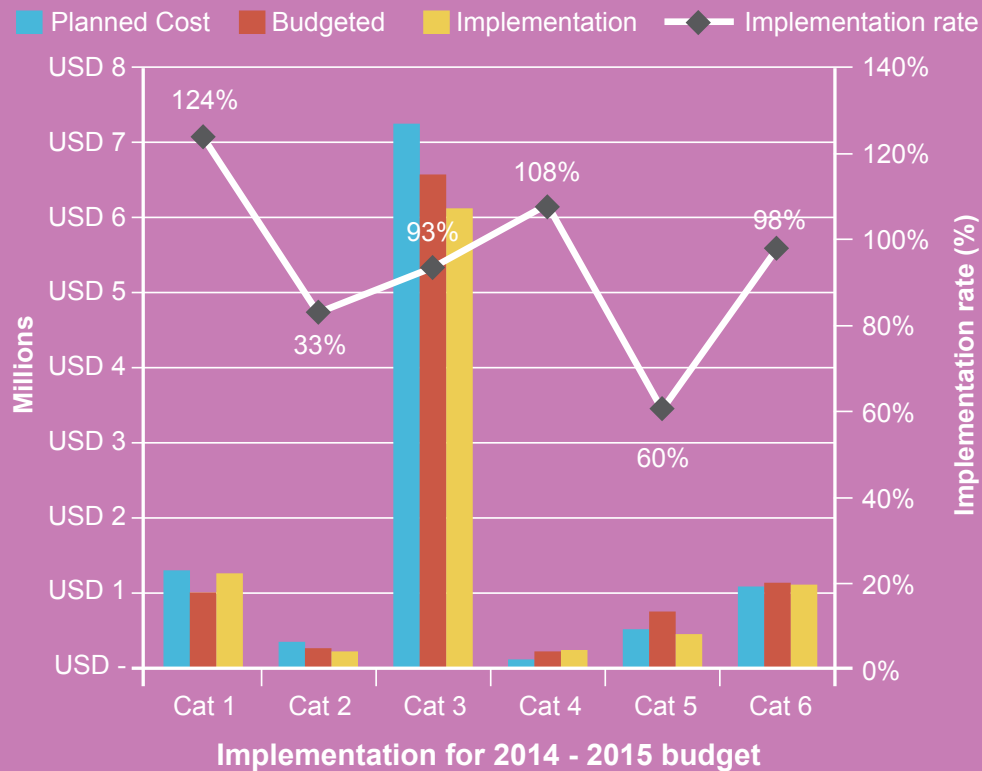
The MoHSS and WHO Namibia also participated in the pan-African consultative meeting for the Global Strategy on Human Resources for Health in Ghana. As part of the strategy, WHO Namibia will develop the National Health Workforce Accounts in Namibia.

In 2014 and 2015, WHO Namibia dedicated a great deal of time, expertise and resources to assisting the GRN in developing, implementing and monitoring sound national health policies, strategies and plans. Through research and the analysis of data, WHO Namibia developed more effective and efficient ways of implementing and integrating health systems and policies in Namibia. It will continue to support the GRN, specifically the MoHSS, in the years to come with the strengthening of health systems, so that UHC can become a reality in Namibia.



chapter 8

Financial Implementation



“Working as a team of dedicated staff, professional and general, and thanks to timely excellent support from IST and regional office, WHO Namibia office achieved its objectives of 2014/15 workplan. Workplan was completed on time and with quality and satisfactions of the government and development partners. The financial implementation of the 2014/15 was 94%”

chapter 9

Conclusion and Thanks

The individual activities undertaken by WHO Namibia are focused on specific, limited targets, but they are part of a larger, holistically conceived strategy. WHO Namibia is proud to be a key partner of the Namibian people in this endeavour, which is fundamental to giving meaning to the freedom won by Namibians on Independence.

WHO Namibia has very dedicated and committed staff members working as a team, and would like to extend its thanks for constructive cooperation during 2014 and 2015 to all GRN staff and officials, particularly in the MoHSS, and to all partner organisations who share its commitment to attaining “the highest possible level of health by all people”.





World Health
Organization

NAMIBIA



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