



World Health Organization



NAMIBIA Biennial Report 2018 – 2019



PROMOTE HEALTH, KEEP NAMIBIA SAFE, AND SERVE THE VULNERABLE.





World Health
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NAMIBIA

Biennial Report 2018 – 2019

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ACRONYMS AND INITIALISMS

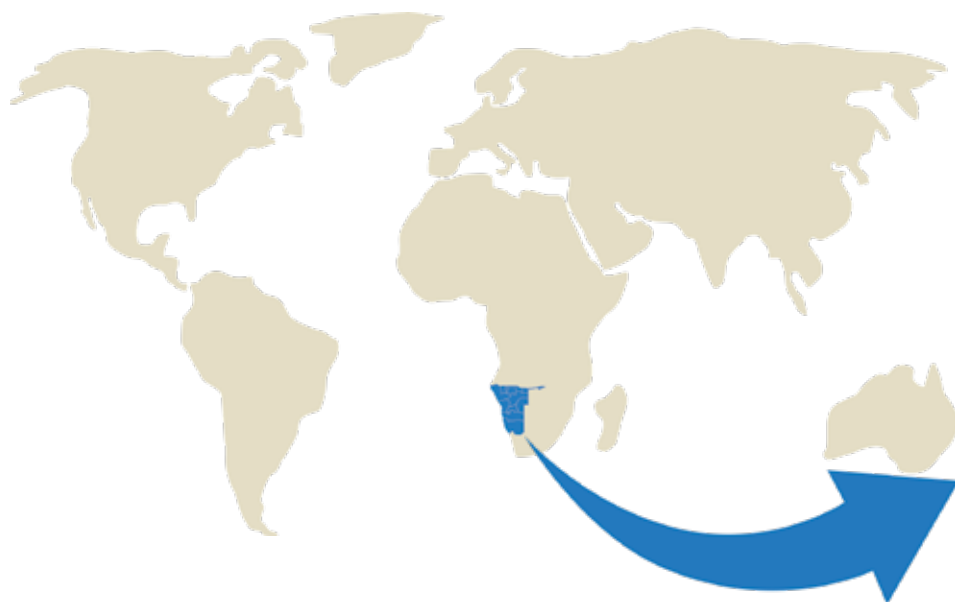


AFROII	Integrated Vector Management Project
ART	antiretroviral therapy
CCHF	Crimean-Congo haemorrhagic fever
ECD	early childhood development
EPI	Expanded Programme on Immunisation
HEV	hepatitis E virus
HRH	Human Resources for Health
ICD	International Statistical Classification of Diseases and Related Health Problems
IHR	International Health Regulations
MoHSS	Ministry of Health and Social Services
RMNCH	Reproductive, Maternal, Newborn and Child Health
MEC	Medical Eligibility Criteria
MWH	maternity waiting home
NCD	non-communicable disease
NEMlist	Namibia Essential Medicines list
NTDs	neglected tropical diseases
PARMaCM	Programme for Accelerating the Reduction of Maternal and Child Mortality in Namibia
PEN	Package of Essential NCD Interventions
SDGs	Sustainable Development Goals
TB	tuberculosis
UHC	Universal Health Coverage
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNPAF	United Nations Partnership Framework
USG	United States Government
WASH	Water, Sanitation and Hygiene Standards
WHO	World Health Organization
WHO-Namibia	WHO Country Office in Namibia

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FOREWORD

As the World Health Organization (WHO) Representative to Namibia, it is again my profound pleasure and honour to thank all the staff of the WHO Country Office (WHO-Namibia) for their continued dedication, often under considerable stress, during the 2018/2019 biennium. Equally well, I must thank all our partners and key stakeholders, especially the Ministry of Health and Social Services (MoHSS) and in particular the former Minister, Honourable Dr Bernard Haufiku, and the new Minister, who assumed the leadership role in December 2018, Hon. Doctor Kalumbi Shangula. We appreciate the continuity in cooperation which has allowed us together to continue making significant strides towards achieving the highest possible standard of health for all Namibians.

Although the Programme for Accelerating the Reduction in Maternal and Child Mortality (PARMaCM) has now run its course, we will strive to maintain and build on its achievements to ensure that mothers receive the best possible ante- and postnatal care, and that children get the best possible start in life. In this regard, during the review period, two more MWHs were completed and launched, and began to operate in Opuwo and Gobabis, improving the access of pregnant women in the respective districts to skilled antenatal care and birth attendance.

As always, child health has been a primary focus area. The past biennium saw the roll out of the integrated management of childhood illness approach, with WHO-Namibia providing generic training materials and guidance to facilitate the review of capacity building training materials for health providers. National immunisation coverage through the Expanded Programme on Immunisation has also continued to expand.

The Brief Behavioural Motivational Intervention (BBMI) programme was also introduced during the biennium. Namibia has one of the highest alcohol consumption rates in the world, and the associated burden of disease is a problem that must be addressed. Under the BBMI, WHO-Namibia assisted with the training of social workers to enable them to help clients to wrest control of their lives away from alcohol and other drugs.

The outbreak of hepatitis E virus is a serious health crisis that has not yet been contained. By October 2019, 6527 cases had been reported, with 55 deaths. Together with health development partners, WHO-Namibia developed a response plan and supported the MoHSS with its implementation, leading to a gradual decrease in new cases and deaths.

WHO-Namibia will continue to focus on the strategic priorities identified in the Third Country Cooperation Strategy for 2017 – 2022, namely strengthening the health system; combatting priority diseases; improving maternal, newborn, child and adolescent health; and promoting a safer and healthier environment, with particular emphasis on Universal Health Coverage (UHC) as outlined in the interconnected “triple billion” goals of the WHO 13th General Programme of Work.

The statistics relating to programmes and interventions which appear in this report tell only part of the story. The real impact of WHO-Namibia interventions, we believe, can best be seen in the lives of the beneficiaries – the people of Namibia, and particularly those in resource-poor rural areas – who as a result of MoHSS interventions enjoy access to improved health care. Photographs and supporting text in this report tell the stories of beneficiaries of four programmes: Maternity Waiting Homes; the Expanded Programme on Immunisation; the Brief Behavioural Motivation Intervention; and the Health Promoting School Initiative. WHO-Namibia is proud to support the MoHSS in pursuit of these goals, and grateful for the invaluable support of our partners in this quest.



Dr Charles Sagoe-Moses, WHO Representative to Namibia



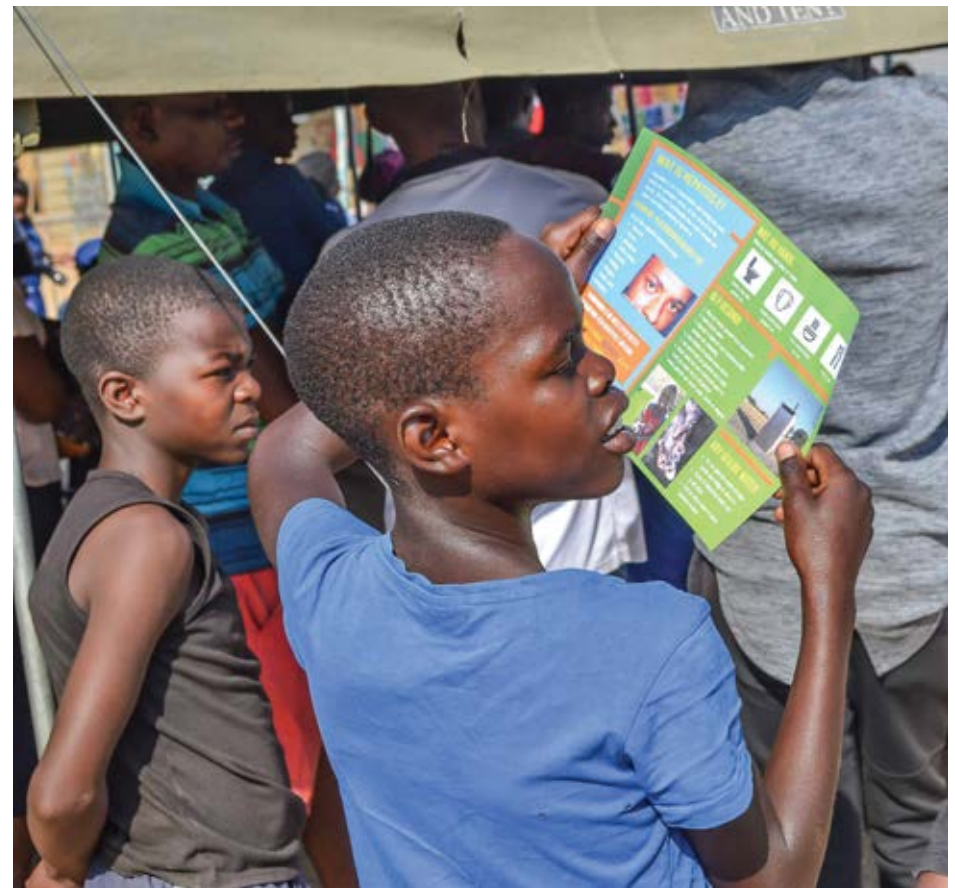
EXECUTIVE SUMMARY

The mission of the World Health Organization (WHO) in Namibia is the attainment of the highest possible level of health by all people. It strives to do this by supporting and cooperating with its strategic partners, including the Ministry of Health and Social Services (MoHSS), United Nations (UN) agencies, development partners and other stakeholders. The WHO Country Office (WHO-Namibia) provides leadership in five operational areas:

- promoting health through the life course;
- communicable and non-communicable diseases;
- surveillance and disease prevention;
- strengthening health systems; and
- health security and emergencies.

WHO-Namibia utilised 95% of its biennium budget for the implementation of programmes. The key achievements during the reporting period are summarised below.

- With WHO-Namibia technical support and EU funding, Namibia's capacity for the delivery of quality reproductive, maternal, newborn, child and adolescent health care has improved.
- Two new maternity waiting homes, in Opuwo and Gobabis, were opened and are fully functioning.
- Immunisation coverage of children <1 year improved from 88% in 2017 to 90% in 2018.
- Over the course of the biennium, a total of US\$29.6 million was disbursed from the HIV/TB Global Fund, bringing the cumulative total since 2001 to US\$334.1 million.
- On 21 August 2019, three years had passed since the last wild polio virus had been detected in Africa.
- WHO-Namibia co-hosted the meetings of the United Nations Partnership Framework (UNPAF) 2019 – 2023 Health Sub-Pillar, in order to engage health stakeholders regarding the UNPAF 2019 – 2023 Health Sub-Pillar workplan.
- WHO-Namibia technical and financial support extended to projects and activities including:



- ▶ the development of the national Antenatal Care (ANC) for a Positive Pregnancy Experience Guideline;
- ▶ the updating of the Namibian Family Planning Medical Eligibility Criteria (MEC) Wheel and the national Family Planning Guideline;
- ▶ technical advice and generic distance education training materials on the integrated management of childhood illnesses;
- ▶ the development of the costed Third Medium Term Strategic Plan for Tuberculosis and Leprosy 2017/18 – 2021/22;
- ▶ the reviewing and updating of the national Integrated Vector Management Strategy, the Insecticide Resistance Monitoring Plan, and the Malaria Social and Behaviour Change Communication Strategy;
- ▶ the implementation of the Integrated Supportive EPI and Surveillance Supervision tool of AFROII on the Open Data Kit platform in 11 regions and 28 districts in 2019, resulting in the country meeting the detection rate target of 2/100 000 children under 15 years;
- ▶ the revision of the National Antiretroviral Therapy (ART) Guidelines so that they align with the current WHO recommendations released in December 2018;
- ▶ the development of the national Neglected Tropical Diseases Elimination Master Plan, which addresses the burden of the five confirmed Namibian NTDs (schistosomiasis (snail fever/bilharzia), soil-transmitted helminths, scabies, snake bites, and rabies);
- ▶ the provision of deworming medication for schistosomiasis (bilharzia) and soil-transmitted helminths (worms) to over 158 600 school children in six endemic regions;
- ▶ the development of the national Package of Essential NCDs (Non-Communicable Diseases) Interventions (PEN) guideline to improve the care of non-communicable diseases in primary health care facilities, and the training-of-trainers training of 27 health workers which was further rolled out through the training of over 80 health providers;
- ▶ the production of the 6th round of the National Health Accounts, which was launched in early 2019;
- ▶ the revision of the standard treatment guidelines and the Namibia Essential Medicines list (NEMlist) and (with the United States Agency for International Development (USAID) and IntraHealth) the development of the MoHSS Human Resources for Health strategic plan, covering a ten-year period, with a five-year implementation strategy;
- ▶ the combatting of the ongoing hepatitis E virus (HEV) outbreak;
- ▶ the drafting the 2nd National Suicide Prevention Strategy, and participation in World Suicide Prevention Day and World Mental Health Day events;
- ▶ the introduction and strengthening of the Brief Behavioural Motivational Intervention (BBMI) programme for alcohol and drug abuse in four regions; and
- ▶ the Health Promoting School Initiative, which encourages adherence to specific criteria for Water, Sanitation and Hygiene Standards (WASH), health promotion, the physical environment, and nutrition, in Omaheke and Kunene regions.



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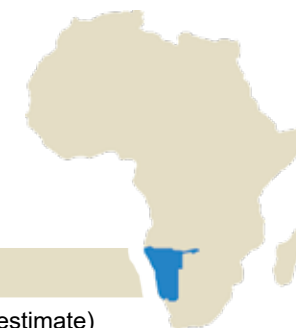
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HEALTH PROFILE OF NAMIBIA

COMPARED WITH THE REST OF AFRICA



INDICATOR	NAMIBIA	REST OF AFRICA	UNIT OF MEASUREMENT
Maternal mortality rate (2017 United Nations (UN) estimate)	195 ¹	542 ²	Deaths per 100 000 live births (2017 UN estimate)
Neonatal mortality rate (2017) ³	18 ⁴	27 ⁵	Deaths before 28 days per 1 000 births
Under-5 mortality rate (2018) ⁶	44 ⁷	74 ⁸	Deaths per 1 000 live births
Total fertility rate	3.6 ⁹	5 ¹⁰	Births per woman
Antenatal care (4 or more visits)	63% ¹¹	75% ¹²	Women visiting hospital/clinic at least 4 times during pregnancy
Institutional deliveries	88% ¹³	48% ¹⁴	Births attended by skilled health personnel
Contraceptive prevalence rates	50% ¹⁵	27% ¹⁶	Use of contraceptives amongst women of child-bearing age
Penta3 coverage (routine)	88% ¹⁷	72% ¹⁸	Children vaccinated with penta 3
HIV/AIDS prevalence (2017) ¹⁹	12.6% ²⁰ (males: 9.3%; females: 15.7%)	3.9 ²¹	Prevalence of HIV among adults aged 15 to 64
Tuberculosis (TB) prevalence ²²	524 (Uncertainty interval: 375 – 697) ²³	231 ²⁴	TB prevalence per 100 000 population
Children under-5 stunted ²⁵	22.7% ²⁶	33.1 ²⁷	Children under-5 with below-expected development
Prevention of HIV mother-to-child transmission coverage (2018) ²⁸	>95% ²⁹	85% ³⁰	Estimated pregnant women living with HIV who received antiretroviral medicine for preventing mother-to-child transmission
Mortality due to non-communicable diseases (NCDs)	41% (WHO 2016 estimate) ³¹		Mortality resulting from the four major NCDs as % of all mortalities
Malaria incidence (2018)	14.8		Incidence of malaria per 1 000 population
Health workforce ³²	36.0 (2015) ³³	12.79 (2014) ³⁴	Number per 10 000 population

[SOURCES](#) ▶

HEALTH PROFILE SOURCES

- 1 **Internationally comparable MMR estimates by the Maternal Mortality Estimation Inter-Agency Group (MMEIG)**, WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division
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- 3 **World Health Statistics 2019**, https://www.who.int/gho/publications/world_health_statistics/2019/en/
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- 17 **Namibia Health Information System 2018**
- 18 **The African Regional Health Report 2014**, WHO
- 19 **Namibia Population-based HIV Impact Assessment**; and **WHO Global Health Observatory**, <https://apps.who.int/gho/data>
- 20 **Namibia Population-based HIV Impact Assessment**
- 21 **WHO Global Health Observatory**, <https://apps.who.int/gho/data>
- 22 **Global Tuberculosis Report 2019**, <https://www.who.int/tb/global-report-2019>
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- 31 <https://data.worldbank.org/indicator/SH.DTH.NCOM.ZS>
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- 33 Ibid.
- 34 **WHO Global Health Observatory**



MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH AND NUTRITION

Key achievements

- Two more Maternity Waiting Homes (MWHs) are opened.
- The Namibian Family Planning Medical Eligibility Criteria (MEC) Wheel was updated and 1 500 copies were printed; and the national family planning guideline was also updated.
- The national Antenatal Care (ANC) guideline for a positive pregnancy experience was developed.
- The distance integrated management of childhood illness approach was rolled out in one region.
- The nurturing care framework guiding the implementation of early childhood interventions was incorporated into the training of edu-carers (Basic Course for Early Childhood Edu-carers).
- Orientation on Adolescent Job Aid is rolled out in the regions.
- Immunisation coverage of children <1 year reached 90%.
- Policy dialogue to address health in ageing populations was initiated.

Challenges

- The quality of maternal, newborn and child health services in health facilities needs to be improved.
- Access of adolescents to health care services is limited.
- Distances to health facilities remain a challenge for rural women.
- Hepatitis E virus was responsible for 16% of maternal deaths recorded during the period April 2018 to March 2019.



1.1 Maternal, newborn and sexual reproductive health

Several studies have revealed the importance of maternity waiting homes (MWHs) in bridging the geographic gap for the poor and disadvantaged women from rural areas and improving access to emergency obstetric and neonatal care services when they are needed. During the review period, two more MWHs were completed and launched, and began to operate in Opuwo and Gobabis, improving the access of pregnant women in the respective districts to skilled antenatal care and birth attendance. These homes were constructed through the support of WHO-Namibia as part of the European Union-funded Programme for Accelerating the Reduction of Maternal and Child Mortality (PARMaCM). The MWH in Gobabis was named after the Former First Lady of the Republic of Namibia, Madame Penehupifo Pohamba, who jointly launched the home with the Hon. Minister of Health and Social Services (represented by the Deputy Permanent Secretary), the Governor of Omaheke Region, and representatives from the European Union and WHO-Namibia. The Madame Pohamba – Omaheke MWH is currently functioning and can accommodate up to 40 pregnant women.

The MWH in Opuwo was jointly launched by the former Minister of Health and Social Services, Hon. Dr Bernard Haufiku, and the Governor of Kunene Region, Hon. Marius Sikunawa Tuyoleni Sheya, together with the Ambassador of the Delegation of the European Union to Namibia, H.E. Jana Hybaskova, and the WHO Representative in Namibia, Dr Charles Sagoe-Moses. The home was named the Kazetjindire Angelika Muharukua Maternity Waiting Home after the late Governor of the Region, who was very supportive of the process.

WHO supported the adaptation of the *2016 WHO Antenatal Care Guideline for a Positive Pregnancy Experience*, which aims to provide pregnant women with respectful, individualised, person-centred care at each of the eight contacts, and to ensure that each contact delivers effective, integrated clinical practices and information.

WHO supported the preservice EmONC (Emergency Obstetric and Newborn Care) training of 65 University of Namibia final year midwifery students in order to strengthen their skills in providing quality maternity and newborn care services to the community once they have been deployed.



Through its representation on the national committee, WHO-Namibia provided technical support for the revision of the *National Guidelines for the Review and Response to Maternal Deaths, Near Misses, Still Births and Neonatal Death* and the development of the maternal death and near-miss report for the period April 2018 – March 2019. Support was also provided during the design of the maternal and newborn quality of care collaborative that is aimed at implementing key maternity care interventions in selected initial implementing regions, to be subsequently rolled out based on learning from best practices.

As part of the preparations in anticipation of the release of the results of ECHO (the Evidence for Contraceptive Options and HIV Outcomes Trial), the national Family Planning Technical Working Group and coordination with the HIV programme were strengthened, and a communication strategy and a workplan to strengthen family planning programming were developed and are being implemented.

Support was provided for the updating and finalisation of the Namibian Family Planning MEC Wheel and the national Family Planning Guideline which were aligned with the 2015/2016 WHO recommendations and the 2018 Family Planning Global Handbook. One-thousand-five-hundred (1 500) copies of the MEC Wheel were printed, and support was provided for the organisation of the national Family Planning Trainers of Trainers training, where 22 national trainers were trained in family planning counselling and the insertion of long-acting contraceptives. These evidence-based guidelines and training sessions will strengthen the programme and improve access to and the quality of family planning services.

Maternity Waiting Homes: Safe havens

Following the opening of a maternity waiting home (MWH) in Okongo in 2014, new MWHs have been opened in Gobabis and Opuwo, both in 2018. The MWHs provide a safe haven for expectant women in the weeks prior to their confinements. This is particularly important for women in rural areas or isolated villages, who have no means of transport at short notice to maternity hospitals. The MWHs are situated close to maternity hospitals, making it possible for the women to receive appropriate antenatal care and counselling.

The caretaker of the Lady Pohamba – Omaheke MWH, Ms Mita Kangue, explained that the facility falls under the Gobabis Municipality, which waives water and electricity charges. Up to 20 expectant mothers can be accommodated. The women are usually referred to the MWH by clinics or health workers from places like Talismanus, Aminuis, Epukiro, and Buitepos. Nurses visit the MWH to give antenatal care and to follow up on how pregnancies are progressing. Primary healthcare information is given, and birth plans are discussed with the women.

All MWHs have sleeping, cooking, and laundry facilities, consulting rooms and emergency delivery areas.

Ms Dina Anton is on standby to offer traditional birth assistance where the need arises because of language constraints or cultural preferences.

The MWHs thus provide much-needed services to the communities they serve, and in the Kazetjindire A. Muharukua MWH in Opuwo, this is reciprocated by two volunteer cleaners, who work fulltime without expecting any payment for their services.

As the women at the Kazetjindire A. Muharukua MWH await the arrivals of their babies, they know that they are benefitting from expert antenatal care, and that they will be taken to the maternity wing of the hospital when the time comes, thus avoiding the substantial risks associated with homebirths. This is particularly important in the vast and sparsely populated Kunene Region, where the widely scattered settlements may be far away from any roads, transport links are non-existent, and communities may move from place to place in response to fickle localised weather patterns.

Many before the current residents have already given birth, returning to their homes with healthy babies who have received their first immunisations. As importantly, they are armed with the knowledge they have gained about childcare and nutrition. One such woman is Ms Reree Tjijomba, who lives at the village of Omitumbirua (“the place where livestock grazes”), some 35 kilometres to the east of Opuwo.

She lives together with the matriarch, “Ouma” (Grandma) Rebecca, who founded the village many years ago, her three children (her daughter Kaiku, and her sons Tjinouvaia and the youngest, baby Oweza) and the extended family.

Now a year and five months old, Oweza appears to be healthy – he was given a good start by being breastfed for six months and has now been safely weaned onto soft porridge and omaere (traditional soured milk). ►



1. New MWHs in Gobabis and Opuwo

2. Magritta Kanguvi, Senior Health Programme Officer for Family Health in Omaheke Region, with the caretaker of the Lady Pohamba – Omaheke Maternity Waiting Home in the emergency delivery room



3. Batemwe Maihama from Talismanus, and Rebecca Okeriko from Aminuis preparing for the births of their babies at the Lady Pohamba MWH



4. Like her volunteer cleaner colleague Uaepanavjo Tjipepa, Elsie Vaanisa Tjimuhiva is happy to offer her services at the Kazetjindire A. Muharukua MWH in Opuwo, as this allows her to support the community.



5. Ladies in waiting: Ngate van der Merwe, Sabina Kapanga, Zahangoxita Musutua and Ngutjiua Hepute



6. Elsie Uaepanavjo Tjipepa and Vaanisa Jjimuhiva (volunteer cleaners), Jogbeth Karutjaiva (Chief Health Programme Officer for Family Health in Kunene Region), Uandia Tjiuonyoye, Julia Hepute (caretaker of the Kazetjindire A. Muharukua MWH), Zahangoxita Musutua and Ngutjiua Hepute

Prior to the births of her first two children, Reree, who was determined to give birth in the hospital, was at the mercy of relatives in Opuwo for space to set up a tent in their yard to wait for labour to commence. On both occasions, this was during the rainy season: she suffered a great deal in her condition, and also felt uncomfortable in another woman's house.

Fortunately, this time round, she could go to the MWH in Opuwo, where she stayed for a month before Oweza's birth. She found it extremely helpful, especially because nurses would visit them to discuss how to deal with the pregnancy, and what to expect

on the day of delivery. They counselled her on the need and reasons for immunisation and a number of issues related to maternity and childcare – information which she has also been able to apply to her older children, who are now already in school. She now knows how to identify early symptoms of various illnesses, and how to look out for signs of malnutrition, especially vitamin A deficiency. She has since regularly taken all her children to Orumana Clinic, which is only four kilometres away from the home, for follow-up care. She expressed gratitude for the assistance and services she has received from the MoHSS, since they have improved the quality of life for her and her family.



7. Ngate van der Merwe, Uandia Tjiuonyoye, Zahangoxita Musutua, Ngutjiua Hepute and Sabina Kapanga



8. Village scenes: a herd of goats being driven to a nearby waterpoint; a house-proud villager; a young man with dreams in his eyes; children at play



9. Reree Tjjomba with her youngest child, Oweza



10. The past and the future: Ouma Rebecca and her granddaughter



11. Uandia Tjiuonyoye and Sabina Kapanga preparing a meal in the kitchen of the Kazetjindire A. Muharukua MWH



12. Before the MWHs were opened, it was not uncommon for pregnant women to camp out with no protection in centres like Opuwo and Okongo prior to the births of their babies



13. Jogbeth Karutjaiva of the Family Health Division in Kunene Region with Reree Tjjomba and baby Oweza, surrounded by Ouma Rebecca and her caring family

1.2 Child health

The integrated management of childhood illness strategy is an integrated approach to child health that focuses on the well-being of the whole child, and has been implemented in Namibia since 1999. WHO strengthened the capacity of health providers in this approach by providing generic training materials, and guidance to facilitate the review of capacity building training materials for health providers. The goal of the training is ultimately to increase the access of children to quality child survival interventions. WHO-Namibia provided technical advice and generic distance education training materials on the integrated management of childhood illnesses, and also supported the adaptation training prior to the roll out in Kavango East and Kavango West regions that took place during 2019.

Early childhood development (ECD) encompasses physical, socio-emotional, cognitive and motor development from birth to eight years of age. The early years are critical, because this is the period in life when the brain develops most rapidly and has a high capacity for change, and the foundation is laid for health and wellbeing throughout life.

Nurturing care:

- is provided in a stable environment;
- is sensitive to children's health and nutritional needs;
- provides protection from threats;
- provides opportunities for early learning; and
- encourages interactions that are responsive, emotionally supportive and developmentally stimulating.

Nurturing care is at the heart of children's potential to develop. The WHO, UNICEF and our other partners have developed a Nurturing Care Framework to guide countries in addressing ECD. This framework has been incorporated into the Basic Course for Early Childhood Edu-carers training that is being rolled out in the regions. This activity was conducted jointly with UNICEF and the MoHSS, the Ministry of Education, Arts and Culture, and the Ministry of Gender Equality and Child Welfare. The WHO also provided material on Care for Child Development for incorporation in the integrated training package for edu-carers of children under-five.



The development of the integrated training package took place with additional support from UNICEF. These training courses are designed to build the capacity of health providers to enable them to increase the access of children to survival interventions.

The *WHO Pocket Book of Hospital Care for Children* is intended to guide the practice of doctors, nurses and other health workers in order to improve the quality of care that young children receive at the first-level referral hospitals. It presents up-to-date, evidence-based clinical guidelines and recommendations approved by WHO-Namibia, and focuses on the management of the major causes of childhood deaths in most developing countries. The WHO supported the distribution of the pocket book to 40 interns to strengthen their knowledge and skills in the provision of paediatric care.



With the support of WHO-Namibia and through the implementation of African Vaccination Week and Maternal and Child Health days, immunisation coverage of children <1 year improved from 88% in 2017 to 90% in 2018. A parent's guide on routine immunisation was also produced, printed and distributed in all regions and districts of the country.

Expanded Programme on Immunisation: A helping hand from the start

At a time when entirely preventable diseases like measles are on the rise in many countries, it is heartening that immunisation coverage in Namibia – while still less than complete – is improving every year. The message must be heard by all parents that having their babies immunised is essential for ensuring their good health.

Like most babies in Namibia, Aletta Hoxobes is benefitting from the Comprehensive Immunisation Campaign run by the MoHSS, with support from the WHO. Because her mother has made sure that she has received the full schedule of immunisations, she will be protected from a host of serious diseases.

Meet Amen Tjiho and his mother, Victoria Tjiho (nee Tjizera). Amen may not realise it yet, but he is fortunate to be benefitting from significant advantages in life.

Amen lives with his mother and father in Roadcamp (part of the Epako suburb in Gobabis). Victoria has fully utilised all the integrated health services related to mother- and childcare (HIV counselling/pap smears/ante- and postnatal health care and family planning). And crucially, from the start, his parents have made sure that Amen has received the full schedule of immunisations.

Things could easily have been different for Amen, however, because his umbilical cord was wrapped around his neck, and without medical intervention, he would probably

not have survived childbirth. Because of regular health consultations at the clinic, Victoria's pregnancy complications were identified timeously, and she was taken to hospital for an emergency caesarean. After Amen's birth, she stayed in hospital for two days, and after being discharged, she went to her mother's house for the first three months to recover. When she was strong enough, she went back home to her supportive husband, Costa.

Victoria is most thankful for the useful advice and information she has received at the clinic and maternity hospital. She also proudly refers to Amen's blue health passport which is fully up to date with his record of visits to the clinic, and medication received at the clinic's dispensary. Amen stays healthy because his mom follows all the advice in the blue passport about how to care for him: what he should eat, how to look out for illness, and when and why he should go for immunization.

Amen is still an only child – his parents want to wait a while before having another. When they do, however, Amen's brother or sister will be born into a family that is taking full advantage of all the family health care services that are available, and will be given the best chance in life.

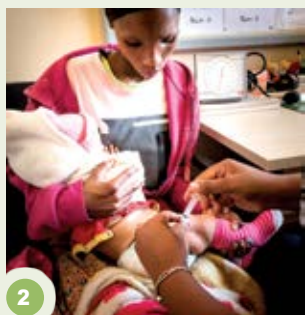
So be it.



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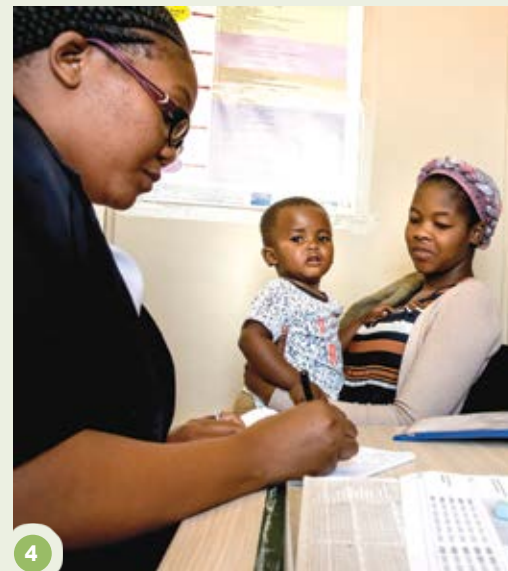


3



2

1. A helping hand from the start for Aletta Hoxobes
2. Aletta Hoxobes is held by her mother, Erika, while being immunised
3. Comprehensive record keeping is essential for ensuring that children receive all the immunisations they need
4. An apprehensive young Mindo Garureb with his mother Maria Garures, while Sister Mokhatu completes the paperwork
5. Victoria Tjiho with her son, Amen, and his health passport
6. Magritta Kanguvi, Senior Health Programme Officer for Family Health in Omaheke Region, checking Amen's health passport with his mother, Victoria Tjiho
7. Amen Tjiho at home with his mother, Victoria



4



5



6



7

IMMUNISATION SUCCESS STORY: EPAKO CLINIC

Omaheke Region has achieved the highest overall immunisation coverage of all 14 regions in the country. Epako Clinic in Gobabis is one of the thirteen clinics in Omaheke Region. It serves a total population of almost 32 000, of whom almost 1 000 are under one year old. The Gobabis District outreach team operates from Epako Clinic, covering settlement posts such as Drimiopsis and Tjaka and a total of 43 outreach points.

The outreach team plays a major role in increasing immunisation coverage. They organise “accelerating days” twice yearly, concentrating on:

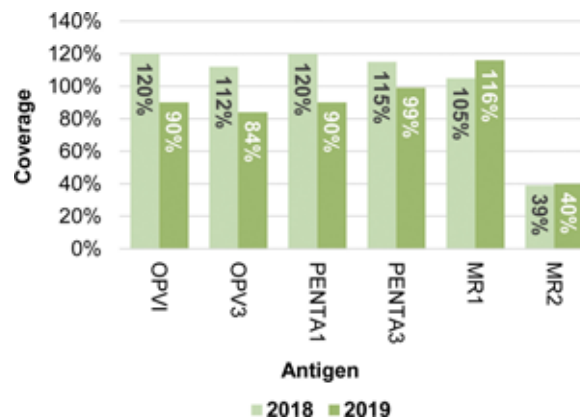
- health promotion; and
- maternal and child health services (antenatal care, post-natal care, immunisation, growth monitoring, nutrition assessment, vitamin A supplementation, deworming).

Immunisation campaigns are also run during African Vaccination Week and on Maternal and Child Health days. Over 100% coverage has been achieved for most antigens.

Informing the community about campaigns is essential. To achieve this, WHO-Namibia, political and traditional leaders, other line ministries, the private sector, faith-based organisations and news media are all involved, and a Music DVD was produced.

Community health workers do an excellent job of bridging the gap between health facilities and communities, and the Omaheke Regional Health Directorate deemed it necessary to recruit some in Epako to cover the ever-growing informal settlement areas. They raise awareness of emergencies such as the hepatitis E outbreak in January 2019, and actively seek out un- and under-immunised children, who are referred to Epako Clinic for catch-up immunisation.

Figure 1: Epako Clinic EPI performance Jan – Sept 2018, 2019



1.3 Adolescent health

The goal of the WHO Regional Adolescent Health Flagship Programme is to empower adolescents to make healthy choices and to provide an environment that can offer such healthy options and health services for all. The programme therefore guides and supports countries and partners in the implementation of effective, evidence-based interventions to improve the health and well-being of adolescents. As part of the Adolescent Health Flagship Programme in Namibia, WHO-Namibia provided technical and financial assistance for the training of 35 pre-service lecturers from all five nursing training institutions, who improved their knowledge and skills relating to the inclusion of adolescent health issues in the curriculum, and in their teaching.

WHO-Namibia supported the printing of a further 1 000 copies of the *Adolescent and Young People Job Aid*, a WHO generic tool which has been adapted for use in Namibia. These copies will be distributed to the tertiary institutions to strengthen the teaching of adolescent health in pre-service education. Discussions are underway to support the development of a national action plan for better coordination of adolescent health interventions.

Over 200 health professionals were brought up to date on developments in reproductive, maternal and adolescent health, including on the use of the Adolescent and Young People Job Aid at the first Namibia Women's Health Conference.

Additional support was provided for two youth groups – African Youth Alliance for Namibia (AfriYAN) and Her Voice Fund – to train adolescents to accelerate their participation and engagement in adolescent health programming. This was done in partnership with the Students Representative Council of the University of Namibia.

As populations around the world are rapidly ageing, comprehensive public health action on population ageing is urgently needed. The WHO, through the *Global strategy and action plan on ageing and health for 2016 – 2020*, outlines key actions for countries to address this. WHO-Namibia facilitated a Policy Dialogue on Ageing to increase attention and focus on the health of the ageing population, and to strengthen coordination of activities to address their health.

1.4 Nutrition

Nutrition is a critical part of health and development. Better nutrition is related to improved infant, child and maternal health, stronger immune systems, safer pregnancy and childbirth, a lower risk of non-communicable diseases (such as diabetes and cardiovascular disease), and increased longevity.

WHO-Namibia provided technical assistance to help the country to address all forms of malnutrition to support health and wellbeing for all, at all ages. This included technical support for the revision of the Baby Friendly Hospital Guidelines, which is expected to improve breastfeeding practices in the facilities and the nutritional status of children under-five. Support was also provided to finalise the National Food and Nutrition Policy and Implementation Plan, which will guide the national coordination and implementation of programmes and activities aimed at improving the nutrition status of the people.



CHAPTER 2

COMBATTING PRIORITY DISEASES (communicable and non-communicable)

Key achievements

- Dolutegravir-based antiretroviral therapy for HIV was introduced.
- The Namibia National Strategy for HIV Drug Resistance (HIVDR) Prevention, Monitoring and Response 2018 – 2023 was completed.
- Paediatric HIV Treatment and Care Strategy was launched.
- The Road Map for the Elimination of Mother to Child Transmission of HIV and Syphilis was completed and rolled out.
- The Third Medium Term Strategic Plan for Tuberculosis and Leprosy 2017/18 – 2021/22 was launched, implemented and reviewed at mid-term.
- Malaria incidence in 2018 decreased by 46% from 2017.
- 21 August 2019 marked three years since the last detected case of polio in Africa.
- Since the introduction of the measles and rubella vaccine, there has been a substantial decrease in both measles and rubella cases. In 2019, only three confirmed cases of measles and eight of rubella were reported in Namibia.

Challenges

- Despite high ART coverage, viral load suppression is low in children and adolescents.
- The malaria elimination programme still faces budgetary and capacity challenges, and the emergence of insecticide resistance.



2.1 Communicable diseases

Addressing HIV and viral hepatitis

People living with HIV in Namibia have access to the best current treatments for HIV through WHO support. The National Antiretroviral Therapy (ART) Guidelines were revised so that they align with the current WHO recommendations released in December 2018. The preferred first-line regimen for people living with HIV initiating ART is based on dolutegravir, used in combination with other drugs. It is more effective in suppressing the HIV virus and improving the immune response, and is also less prone to becoming ineffective due to the virus developing resistance. The guideline was launched in August 2019, and roll out commenced in October 2019.

The WHO/UN provided technical and financial support for the development of an eMTCT (elimination of mother-to-child transmission) Road Map. This sets yearly targets to be achieved on the pathway to elimination of mother-to-child transmission, with the goal of reaching “Gold Tier” status by 2023.

The WHO supported the MoHSS in the development of the Namibia National Strategy for HIV Drug Resistance Prevention, Monitoring and Response 2018 – 2023, based on the Global Action Plan on HIVDR 2017 – 2021, which is aligned with the WHO’s Global Action Plan on Antimicrobial Resistance and the Global Health Sector Strategy on HIV (2016 – 2021). The strategy aims to prevent HIVDR from undermining accomplishment of the national HIV and AIDS response goal, namely to reduce new HIV infections and AIDS-related mortality by 75% by 2022 from 2015 levels, and move towards ending AIDS as a public health threat by 2030. The National HIVDR strategy for 2018 – 2023 is intended as a guide for the HIVDR-prevention efforts to be implemented in Namibia, and specifies actions that will require the participation and commitment of all stakeholders.

WHO-Namibia supported the conducting of a baseline assessment and the development of a strategy for viral hepatitis programming in the country. The baseline assessment found that although studies have shown a high national prevalence (approximately 9–11%) of Hepatitis B in the country, there is limited focus on and attention to the disease. The strategic plan is therefore to guide programming, particularly by increasing access to treatment, raising awareness of the disease, and having a coordinated national response to meet the regional and global targets for elimination of hepatitis B and C by 2030. Addressing viral hepatitis is crucial to the control of HIV in Namibia due to the high prevalence of hepatitis B/HIV co-infection in the country (13.6%), as well as the opportunities presented for creating linkages and integrating responses.



To accelerate the response and address the critical gaps remaining in scaling up Paediatric ART, the Paediatric HIV Treatment and Care Strategy was launched as part of celebrations to commemorate World AIDS Day, 2019. This strategy is in line with the Start Free – AIDS Free – Stay Free collaborative framework aimed at ending AIDS among children, adolescents and young women by 2020. This is critical for Namibia in the light of NAMPHIA (the Namibia Population-based HIV Impact Assessment)

results, which show that although ART coverage is high throughout the population, while viral load suppression is remarkable in adults, it is less so in children and adolescents. The strategy will therefore strengthen efforts that maintain high ART coverage and ensure high rates of viral load suppression among children and adolescents. The strategy was developed with WHO support.

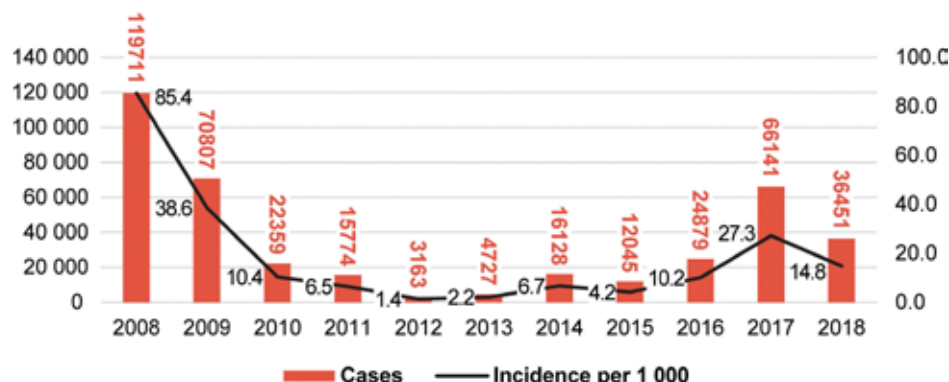


Malaria

Malaria in Namibia is seasonal and unstable with focal and cyclic epidemics, especially in the north-east of the country. Malaria incidence declined from 85.4 cases per 1 000 population in 2008 to the lowest recorded rate of 1.4 cases per 1 000 population in 2012. Thereafter, there was a steady increase up to a peak of 27.3 per 1 000 in 2017, before the incidence declined by 46% in 2018 to stand at 14.8 cases per 1 000. Insufficient funding, a shortage of human resources, the emergence of insecticide resistance resulting in an increase in the required insecticide budget, and poor data quality and reporting are some of the challenges for the malaria elimination programme.



Figure 1: Malaria cases and incidence 2008 – 2018



Technical support was provided to the malaria control programme for strengthening its efforts in the vector mapping and insecticide resistance monitoring activities through capacity building of its staff on insecticide resistance testing and vector surveillance, reviewing of the national vector control guidelines and tools; and identification of gaps for revision/updating. In addition, support was provided for the reviewing and updating of the national Integrated Vector Management Strategy, the Insecticide Resistance Monitoring Plan, and the Malaria Social and Behaviour Change Communication Strategy. These evidence-based strategic documents and the related training will strengthen the capacity of the national programme in its efforts aimed at the elimination of malaria by 2022. WHO-Namibia furthermore seconded a STOP Malaria Pilot Programme fellow to the MoHSS to provide support in the implementation of malaria elimination at sub-national level, and particularly to strengthen surveillance as an intervention. This is a two-year programme, and Namibia is one of the four countries globally to receive such support. The STOP malaria fellow was posted in Rundu from September 2019 to support malaria surveillance activities in Kavango East and Kavango West regions.



Despite challenges, good progress was made in controlling malaria.

The implementation of the Integrated Vector Management Project (AFROII) LARVICIDING DEMONSTRATION PROJECT in collaboration with the National Vector Borne Disease Control Programme of the MoHSS started in six malaria-endemic districts and 12 study sites after the National Project Coordinator came on board and approval was granted by the MoHSS Research Unit. Thirty-six community members from the 12 study sites and six MoHSS district coordinators were identified and trained. Baseline data were collected and larval habitat mapping and larval sampling are currently ongoing to determine the baseline for the project. To date, 341 larval habitats have been mapped and preparations are ongoing to start the 2020 winter larviciding intervention using *Bacillus thuringiensis israelensis* in 2020.

Tuberculosis

Namibia is considered one of the 30 high tuberculosis (TB) burden countries globally, with an estimated TB incidence of 524/100 000 population as at 2018 (down from 892 in 2010). Although the country has seen a decline in the new cases over the years, there is a need to accelerate the progress in line with the WHO End TB Strategy, which aims to reduce deaths by 95% and cut new cases by 90% between 2015 and 2035, with interim targets set for 2025 and 2030. As the lead technical agency, WHO-Namibia provided guidance for the development of the costed Third Medium Term Strategic Plan for Tuberculosis and Leprosy 2017/18 – 2021/22, and a number of supportive visits and reviews, including the mid-term review of the strategy to ascertain the level of implementation and address identified gaps. WHO-Namibia also supported the conducting of the TB prevalence study to provide more accurate estimates of the burden of the disease in the country.



World TB Day was commemorated on 28 March 2019 in Oshakati, Oshana Region, on the theme, “It’s Time”. The Deputy Minister of Health and Social Services, Hon. Julieta Kavetuna, officiated at the event and was the keynote speaker. WHO-Namibia participated in the event, which was an opportunity to raise awareness while reflecting on both the advances that have been made in recent years and on what remains to be done to end the scourge of TB in Africa, and around the world.

Poliomyelitis and other diseases under surveillance

It was cause for celebration throughout Africa on 21 August 2019 when three years had passed since the last wild polio virus had been detected in the WHO African Region. Namibia is well on track in the quest to eradicate polio, and has attained all targets in this regard. To further strengthen polio surveillance, WHO-Namibia, with the support of WHO/AFRO, procured 51 mobile devices for surveillance focal persons at all levels. These devices are being used for real-time data reporting. Using the Integrated Supportive EPI and Surveillance Supervision tool of WHO/AFRO on the Open Data Kit platform, WHO-Namibia provided technical and financial support to 11 regions and 28 districts in 2019. The outcome of these activities was improved case detection and notification, which directly contributed to the country meeting the detection rate of 2/100 000 children under 15 years. On-the-job training was provided on vaccine-preventable diseases, with focus on polio (acute flaccid paralysis) and vaccine management.



Neglected tropical diseases

The global Elimination of Neglected Tropical Diseases initiative was ratified by all affected UN member states, including Namibia, where five neglected tropical diseases (NTDs) are confirmed to be endemic. These are schistosomiasis (snail fever/bilharzia), soil-transmitted helminths, scabies, snake bites and rabies; in addition, evidence of trachoma has been detected in 2019 in some remote communities whose access to health services is limited.

WHO-Namibia provided technical and financial support for the drafting of the national NTDs Elimination Master Plan, which addresses the burden of the five confirmed Namibian NTDs. Capacity building training was conducted for seven MoHSS staff on two NTDs tools: the Tool for Integrated Planning and Costing, and the Country Integrated NTDs Database. This was done to strengthen effective data storage, data sharing, data management and reporting at the country level.

Schistosomiasis and soil transmitted helminths are endemic in nine northern and central regions of Namibia. The prevention and control of these worms requires improvements in hygiene, water supply and sanitation, and regular mass administration of deworming medicines, particularly targeting school children. It is estimated that treating school-age children could reduce the total burden of disease due to intestinal worm infections by 70% in the community as a whole.



A mass deworming campaign against schistosomiasis and soil transmitted infestations was conducted in May 2019. WHO-Namibia provided the medicines (albendazole and praziquantel tablets) and technical, financial and logistical support for the campaign, and trained 41 health care providers on deworming. School children aged five years and above from 436 schools in six regions (Zambezi, Kavango East, Kavango West, Ohangwena, Omusati and Otjozondjupa) were targeted. Out of the 251 908 school children enrolled in the six regions, a total of 158 614 were dewormed (133 894 received both albendazole and praziquantel, while 24 720 received only albendazole), giving a deworming campaign coverage of 64%.

Trachoma is an infectious eye disease caused by the bacterium *Chlamydia trachomatis*. The disease progresses through trachomatous follicular inflammation of the eye lids, scarring, then trichiasis, and if not treated leads to corneal opacity and eventual blindness. Trachoma causes blindness in poor rural communities. In Namibia, there was limited information on whether it is found in the more remote, disadvantaged populations such as the San, Ovahimba and Ovazemba in Kunene and Zambezi regions. WHO-Namibia supported a preliminary investigation to establish the endemicity of trachoma by conducting field visits to suspected endemic sites in the Zambezi, Ohangwena and Kunene regions in July 2019. Over 800 adults and children were screened; a few cases of adults with evidence of scarring and children with active trachoma were identified in Zambezi and Kunene regions, which pointed to the need for population-based trachoma assessment. A trachoma mapping survey will be conducted in early 2020 in order to determine whether prevalence estimates exceed those felt to represent a public health problem.



Poor eyesight and blindness are more common in older people.



2.2 Non-communicable diseases

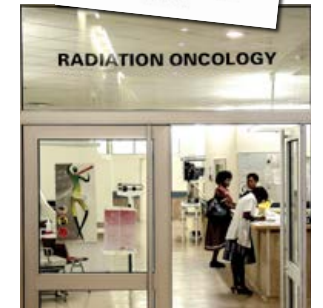
WHO-Namibia provided technical and financial support that included the printing of 2 000 copies of the *National Multisectoral Strategic Plan For Prevention and Control of Non-Communicable Diseases (NCDs) in Namibia 2017/18 – 2021/22*, which was jointly launched by the Prime Minister and the Minister of Health and Social Services in August 2018 to streamline the systematic implementation of measures aimed at preventing and controlling NCDs in Namibia.

More than one in five Namibians will die of an NCD between age 30 and 70.

WHO-Namibia supported the development of the national Package of Essential NCD Interventions (PEN) guideline to improve the care of non-communicable disease services in primary health care facilities. WHO-Namibia also supported the training-of-trainers training of 27 health workers (seven doctors and 20 nurses) on the PEN guideline, which enabled the MoHSS and partners to roll out the training in three regions, with a total of 82 health workers trained on how to implement the guideline in their facilities.



WHO-Namibia co-hosted a health education session on healthy lifestyles with UN Cares for the UN staff. The aim of the event was to present the findings of an early health assessment which reflected a high level of risk factors amongst the UN staff. WHO-Namibia facilitated the session on mitigating the risk factors and stressed the importance of adherence to treatments where needed.



Measuring blood pressure





CHAPTER 3

HEALTH SYSTEM STRENGTHENING

Key achievements

- WHO-Namibia co-hosted the meetings of the United Nations Development Partnership Framework (UNPAF) 2019 – 2023 Health Sub-Pillar.
- Health sector coordination mechanisms were strengthened with the conducting of the 1st and 2nd National Health Assemblies.
- The Human Resources for Health strategic plan was introduced as a guiding tool for multi-sectoral health workforce interventions.
- National Health Accounts (NHA) were institutionalised and annual reports were produced to guide the health financing policies.
- The E-Health Strategy was developed and validated.
- The 3rd-generation Country Cooperation Strategy was finalised and disseminated.

Challenges

- There is a need to address efficiency gains and maximise resources in the health sector.



WHO-Namibia is supporting the MoHSS to strengthen health sector coordination to ensure that all resources, including financial resources, are optimally put to use, sustainably mobilised, effectively coordinated, equitably distributed, and efficiently utilised in accordance with the government's policies and guidelines and in line with the Paris Declaration and the Accra Agenda for Action. In partnership with the UN agencies, WHO-Namibia supported a team from the MoHSS, the National Planning Commission and the United Nations to visit Ghana to observe and learn lessons from the implementation of sector-wide approaches in health (known as SWAp), and policies for donor coordination. The visit focused on the planning and budgeting processes, health sector coordination mechanisms, and monitoring and evaluation at all levels of the health system. Following the visit, the MoHSS launched the *Ministry of Health and Social Services Strategic Plan 2017/2018 – 2021/2022* and hosted the inaugural National Health Assembly to take stock of the achievements of the past year and coordinate the health interventions of partners in the country. Monthly Health Development Partners' Fora were also held under the leadership of WHO-Namibia. Through these meetings, WHO-Namibia coordinated the development partners' contribution to the National Health Strategic Plan.

With the MoHSS, WHO-Namibia co-hosted the meetings of the United Nations Development Partnership Framework (UNPAF) 2019 – 2023 Health Sub-Pillar. The purpose of these meetings was to engage health stakeholders regarding the UNPAF 2019 – 2023 Health Sub-Pillar workplan, and to serve as a platform for health stakeholders to continuously engage each other on the coordination and tracking of implementation.

Namibia has institutionalised the National Health Accounts and produces annual reports to guide health financing policies. The Minister of Health and Social Services, Hon. Dr. Kalumbi Shangula, launched the 6th round of National Health Accounts in early 2019. The report reflects results of the Health Accounts for two consecutive years, 2015/16 and 2016/17. Namibia used a combined methodology incorporating standard Health Accounts methods and the National AIDS

Spending Assessment estimations. Together with two other UN agencies (the Joint United Nations Programme on HIV and AIDS and the United Nations Population Fund (UNFPA)) and the United States Government (USG) partners, WHO-Namibia provided technical support for the production of the report. The National Health Accounts report will contribute to tracking resource flow and advocate for a more equitable distribution of resources in addressing Universal Health Coverage (UHC).



With support from WHO-Namibia and the United States Agency for International Development (USAID) and IntraHealth, the MoHSS contributed to the development of the Human Resources for Health (HRH) strategic plan. The HRH strategic plan would serve as a guiding tool for multi-sectoral health workforce interventions in support of efforts to achieve Sustainable Development Goal 3, Vision 2030, NDP5 (5th National Development Plan), the National Health Policy Framework 2010–2020, and the MoHSS Strategic Plan, 2017/18 – 2021/22. The HRH strategic plan covers a ten-year period and includes a five-year implementation strategy. The strategic plan includes four key strategic objectives, namely:

- align health workforce production capacity and quality to match population health needs and economic demand;
- optimise the health workforce recruitment, distribution, retention and utilisation in the public sector towards achieving UHC;
- improve efficiency in health workforce management to catalyse health systems performance; and
- increase investment in health workforce information, evidence generation and use for decision making.

Access to safe, effective and quality medicines and vaccines for all is one of the targets of the Sustainable Development Goals, and is critical for achieving UHC. To improve access to essential medicines in the country, WHO-Namibia, in collaboration with UNICEF, UNFPA and USG-supported agencies, provided assistance for the drafting of a concept note to enable the MoHSS to engage in pooled procurement processes, using global drug facilities in order to improve the supply of medicines. This will result in efficiency gains, as well as greater reliability in the supply and quality of essential medicines. WHO-Namibia also supported the printing of the *Anti-microbial Resistance Plan* for Namibia.

WHO-Namibia supported the revision of the standard treatment guidelines and the Namibia Essential Medicines list (NEMlist), to ensure concurrence between the two documents and the inclusion of the essential medicines most commonly used to treat the majority of the most frequently presented illnesses in the country. The standard treatment guidelines and NEMlist are key to ensuring access to essential medicines and addressing UHC.

The International Statistical Classification of Diseases and Related Health Problems (ICD) is the bedrock for health statistics. It maps the human condition from birth to death: any injury or disease we encounter in life – and anything we might die of – is coded. It captures factors influencing health, or external causes of mortality and morbidity, providing a holistic look at every aspect of life that can affect health. These health statistics form the basis for almost every decision made in health care today – understanding what people get sick from, and what eventually kills them, is at the core of mapping disease trends and epidemics, deciding how to programme health services, allocate health care spending, and invest in research and development. The WHO released ICD-11 in 2018 for adoption by member states in 2022. To facilitate this, WHO strengthened the capacity of national health managers in the ICD-11 coding. This resulted in the harmonisation of data from the Civil Registration system and the Health Information system and the generation of evidence to guide policy and action. This has been utilised for data analysis and subsequently for the production of the first cause-of-death report for Namibia.

The use of digital technologies, including e-health, has become a salient feature of the gathering of health data. Both routine and innovative forms of information and communications technology are now employed to address health needs. The World Health Assembly Resolution on Digital Health adopted in May 2018 demonstrated a collective recognition of the value of digital technologies to contribute to advancing UHC and other health aims of the SDGs. In line with this, WHO-Namibia is supporting the MoHSS in the development of an e-Health System Implementation Strategy. This involves a paradigm shift in the way information is collected, communicated and used across the health facilities.



It is a shift from reliance on human memory and manual analogue tools such as paper, to an environment where patients/clients, health care providers and health care managers can reliably and securely access and share health information in real time, across geographic and health sector boundaries. A draft strategy has been developed and implementation is expected in 2020.



WHO-Namibia has finalised the 3rd-generation Country Cooperation Strategy. The development of this Country Cooperation Strategy was timed to synchronise with the MoHSS Strategic Plan 2017/18 – 2021/22 and UNPAF for 2019 – 2023. Based on a detailed analysis of the situation in Namibia and national priorities as articulated in the Strategic Plan, and the national dialogue process, WHO-Namibia will be focusing work over the next five years on the three strategic priorities of the WHO 13th General Programme of Work and its nine respective outcomes, as well as the corporate outcome on data and innovation.



The "tippy tap": an effective means of maintaining hand hygiene where water is scarce

CHAPTER
4

HEALTH EMERGENCIES

Key achievements

- An outbreak of Crimean-Congo haemorrhagic fever was contained.
- A multi-sectoral costed response plan was developed for the outbreak of hepatitis E virus (HEV).
- Laboratory diagnostic support, including reagents, was procured for rapid testing for HEV; 24 epidemiologists were trained and deployed for the HEV response.
- Coordination and partnerships with relevant agencies (both local and cross-border) were strengthened.
- The National Action Plan for Health Security was finalised and endorsed by the government, and is ready for launch.

Challenges

- The HEV outbreak has become protracted and is ongoing.
- Anthrax outbreaks were reported in Kunene and Zambezi regions during 2018 and 2019.
- The economic downturn and staff constraints at government and WHO-Namibia levels are major concerns.



H.E. President Hage Geingob leading the presidential clean-up campaign to combat the hepatitis E virus

4.1 Crimean-Congo haemorrhagic fever

WHO-Namibia supported the response to the Crimean-Congo haemorrhagic fever (CCHF) outbreak in Karas Region, where an index case was confirmed on 31 March 2018 and passed away on 3 April 2018. There has not been another confirmed case. All 37 contacts for this case were followed up and monitored for 14 days from the most recent exposure, and none developed signs and symptoms of CCHF. The results of the only one suspected case came out negative for CCHF and no other new case was reported in this region or elsewhere in Namibia during 2018. The MoHSS worked together with stakeholders, through the Regional Health Emergency Management Committee, to ensure the smooth coordination of interventions.

During 2019, a total of two cases of CCHF were reported in Oshikoto and neither of them was fatal. The Omusati case lives in Angola and cross-border alert systems and joint outbreak investigations were conducted. There were no other additional cases and the outbreaks were successfully contained.

4.2 Hepatitis E virus

WHO-Namibia continued to provide technical support to combat the ongoing HEV outbreak, which was declared in Windhoek district in December 2017. A total of 10 regions (out of 14 regions in the country) continue to be haunted by this outbreak, with about 65% of reported cases occurring in Khomas Region. Cases are reported mainly from informal settlements such as Havana and Goreangab in Windhoek, Democratic Resettlement Community in Swakopmund, and similar settings in other regions where access to safe water, proper sanitation and personal/environmental hygiene is limited. Most cases from less affected regions have a travel history to the abovementioned informal settlements in Windhoek or Swakopmund.

In a teleconference involving all three levels of the WHO conducted in August 2018, the event was assessed at Grade 1. The WHO Regional Office in Africa provided the required support of US\$195 000, including an epidemiologist (consultant) and risk communication expert to support the country in bringing the outbreak under control. A costed response plan was developed with the involvement of other health development partners, including the United Nations Development Programme (UNDP), UNICEF, the Centers for Disease Control and Prevention, and line-ministries, for improved coordination.

As of 17 November 2019, a cumulative total of 6 746 HEV cases had been reported, with 56 deaths (a case fatality rate of 0.8%), of which 24 (42%) were maternal deaths, since the outbreak was declared in December 2017.

Khomas Region remains the most affected region, accounting for 4 202 (62%) of the confirmed cases, followed by Erongo Region with 1 530 cases (23%) since the outbreak began. The remaining regions collectively account for 15% of the reported cases. Of the total HEV cases, 50 (0.7%) are Angolan residents.



The majority (73%) of cases are among those in the age group 20 – 39, while the lowest proportion are children under 1 year (0.1%). Males (60%) are more affected than females (40%).

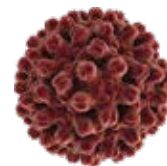
WHO-Namibia supported the MoHSS in conducting a rapid assessment of the HEV outbreak response in 2018 and continued to conduct Integrated HEV Support Supervision visits to affected regions. The findings and recommendations, which have been shared with MoHSS management, are being used to improve required interventions for stopping the outbreak.

WHO-Namibia furthermore supported the procurement of point-of-care reagents for testing for HEV IgM antigens and for confirmatory tests in the local national laboratory, and for rapid diagnostic testing for surveillance in smaller facilities.

Twenty-four epidemiologists were trained and deployed to all districts to respond to the HEV outbreak. Cross-border collaboration meetings between HEV-affected regions of Namibia and Angola were conducted in May 2019 and November 2019, and alert notifications between Namibia and Angola are taking place.

WHO furthermore supported the development of the Incident Management System and the terms of reference of the Incident Manager, in addition to building capacity and strengthening the reporting systems at the National Public Health Emergency Operation Centre.

WHO-Namibia continues to provide technical support for the country to consider using HEV vaccine for vulnerable groups, in particular pregnant women, during this protracted outbreak. The protocol is still being finalised, with technical oversight from WHO/HQ/AFRO.



In September 2019, the Namibian government agreed to introduce the Community-led Total Sanitation project in Windhoek, in collaboration with the government of Japan, UNICEF, the City of Windhoek and partners. It is hoped that in combination with other interventions, this will assist in bringing about a decline in HEV cases.

CHAPTER
5

HEALTH PROMOTION AND SOCIAL DETERMINANTS OF HEALTH

Key achievements

- The 2nd National Suicide Prevention Strategy was drafted.
- A clinical handbook for women subjected to intimate partner and/or sexual violence was launched, and training was given to more than 100 health care providers.
- The Brief Behavioural Motivational Intervention (BBMI) programme for alcohol and drug abuse was introduced in four regions.
- An internal and external assessment of all 45 schools participating in the Health Promoting School Initiative in Omaheke Region was conducted.
- An implementation strategy on Health in All Policies was nearing finalisation by the end of the biennium.

Challenges

- Suicide is the second leading cause of death in the 15 – 29-year age group globally, and accounts for 1.4% of all deaths worldwide.
- Despite WHO-Namibia efforts, approval was given for the development of a tobacco plantation.
- A quarter of women experience intimate partner and/or sexual violence.



5.1 Mental health promotion and suicide prevention

According to the WHO Mental Health Atlas 2017, the burden of mental health disorders in Namibia is 2 838.71 per 100 000 population, and the suicide rate is estimated at 8.7 per 100 000 population. This is against a backdrop of the limited availability of psychiatrists and child psychiatrists of .37 and .04 per 100 000 population respectively, and only one public mental health centre. Mental health promotion and suicide prevention are therefore critical to minimise the burden on the health care system.

During the biennium, WHO-Namibia supported the government through the MoHSS and partners by:

- contributing towards the strengthening of the national coordination mechanism for suicide prevention with a multi-sectoral representation for government ministries, the private sector, tertiary institutions, media and civil society organisations;
- drafting Namibia's 2nd National Suicide Prevention Strategy;
- partnering with tertiary institutions for mental health promotion activities on two main campuses in Windhoek;
- supporting awareness creation activities in different settings in all 14 regions targeting school learners, corporate company personnel, communities and the general public;
- increasing engagement of the media through World Suicide Prevention Day and World Mental Health Day with interviews, and the placement of communication materials on mental health promotion and suicide prevention in electronic, print and social media platforms; and
- hosting a special public lecture for development partners, government agencies, the media and tertiary institutions on suicide prevention at which the MoHSS launched the *National study on the prevalence of and interventions in relation to suicide in Namibia*.



Mental Health Day 2018 poster



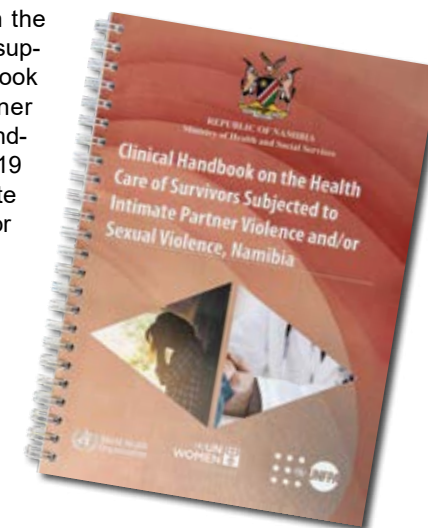
Manny Kandji and René Adams, MoHSS social workers

5.2 Intimate partner and/or sexual violence

There is a need for strengthening of the capacity of the health sector to respond to women and girls being subjected to intimate partner violence and/or sexual violence.

Globally, and in Namibia, one in four women have experience physical and/or sexual violence at the hands of their partner at some time in their lives. For the majority of women violence starts at an early age and continues through their adult life. Women subjected to intimate partner violence report increased violence during pregnancy.

WHO-Namibia has been working with the MoHSS in partnership with UNFPA to support the adaptation of a clinical handbook for women subjected to intimate partner violence and/or sexual violence. The handbook was approved and launched in 2019 and will serve as a catalyst to advocate for comprehensive, quality health care for this vulnerable group.



Following the launch of the handbook, WHO-Namibia supported the MoHSS by:

- training 35 trainers from Khomas, Zambezi, Oshikoto, Omaheke, Hardap and Erongo regions, as well as representatives from the national and regional health training centres. Participants were selected from specific health facilities targeted for the rollout of the implementation of the handbook, and will in turn support training sessions at their respective facilities and elsewhere. In due course, the training will be incorporated into the in-service training schedule of the MoHSS Health Training Centre to ensure sustainability; and
- offering subsequent training sessions for Omaheke and Oshikoto regions, reaching 70 health care providers from major health facilities in the two regions.

5.3 Tobacco control activities

The Namibia Demographic Health Survey (2013) reports the use of tobacco for 15 – 49 years old male at 20.1%, and for females at 5.1. According to the WHO report on the global tobacco epidemic, 2019, smoking of any tobacco product (usually cigarettes) is relatively high for both sexes for those aged 15 years or more (31.1%). The Global School-Based Student Health Survey of 2013 for Namibia also reported a relatively high prevalence rate for tobacco use for adolescents aged 13 – 15 years old for both sexes (11.2%).

WHO-Namibia support during this biennium included the provision of high-level technical support to help the Minister of Health and Social Services make a case against a then-proposed tobacco plantation in Zambezi Region. The Regional Hub on Tobacco Control based in Uganda sent two senior technical officers, one with an economic background and the other a lawyer. They were accorded an opportunity to make a presentation in Cabinet in the presence of the Head of State and Cabinet ministers. This resulted in the decision regarding the tobacco plantation being deferred to a committee for further deliberation. Subsequent to this, presentations were made to different lobby groups and activists in partnership with the MoHSS with the aim of creating awareness on the risks of the plantation and providing factual information which can be used for further advocacy. Unfortunately, despite these efforts, the government approved the plantation.

The MoHSS conducted community mobilisation in the affected communities meeting with the regional governor, regional councillors, traditional leaders and prominent community members, sharing the same presentation on the risks of tobacco use and the plantation.

World No Tobacco Day was used as a platform to increase awareness on the risks associated with tobacco use with outreaches in all 14 regions to schools, various traditional authorities and the general public.

5.4 Reduction in the harmful use of alcohol

Namibians aged 15 years and older drink an average of 32.4 litres of pure alcohol per capita per annum, making Namibia amongst the high alcohol consumption countries in the AFRO region. Heavy episodic drinking is also worrying, especially amongst males, with 71.6% of males 15 years and older and 74.1% of 15 – 19 years old having drunk at least 60 grams or more of pure alcohol on one occasion during the 30 days preceding the survey.

WHO-Namibia support aimed at the reduction of harmful use of alcohol included the introduction and strengthening of the Brief Behavioural Motivational Intervention (BBMI) programme for alcohol and drug abuse in four regions. The programme was rolled out in health facilities in Kavango Region and introduced in Zambezi, Kunene and Oshikoto regions. With support from other partners, the MoHSS expanded the programme to two more regions, namely Hardap and Karas.

Namibia is participating in a global study to determine the prenatal risk factors of foetal alcohol syndrome disorders. The Ministry of Education, Arts and Culture is leading the data collection process in the country together with the Ministry of Health and Social Services. Data collection is envisaged to be completed in 2020.



Brief Behavioural Motivational Intervention

The Brief Behavioural Motivational Intervention (BBMI) programme for alcohol and drug abuse was introduced in May 2019. The Chief Social Worker at Rundu Hospital, Ms Angeleni Kangayi explained that it is vitally important to identify early patterns of abuse. Counselling is given by social workers at the clinic on the hospital grounds, while outpatient treatment is given by doctors and nurses, but it remains a troubling and often devastating problem in both rural and urban communities. The WHO awareness programme has brought about a reduction in alcohol abuse in urban communities, and needs to be rolled out to the rural areas in which the WHO is active.

The BBMI team in Rundu is comprised of Ms Kangayi; a registered social worker, Ms Aurelia Mukundu; Dr Limonta Lazara from the Environmental Health Department; and a student social work intern from UNAM, Ms Wendy Nyangana.



Aurelia Mukundu (social worker) and Wendy Nyangana (social work intern)



Dr Limonta Lazara and Angeleni Kangayi

People are referred to the BBMI team by doctors and nurses offering outpatient health services. Depending on the outcome of an assessment, blood samples can be taken to ascertain alcohol levels, and in severe cases patients can be admitted to hospital. In some cases, it is family members who bring people in to be assessed. Clients are also brought in by police, especially if violence has been involved. Social workers can also make visits to patients in their homes, although the limited staff numbers and transport make this difficult.

The most common forms of substance abuse involve alcohol, dagga (marijuana), and other drugs. The problem is aggravated by Rundu being on the border with Angola, and the fact that law enforcement agencies only undertake occasional, random operations aimed at limiting the availability of drugs.

Consultations are preferably conducted in the client's mother tongue. The team determines what substance was used (whether it was commercial or traditional); how often and how recently it was taken, and the quantity involved; and relevant home circumstances, such as whether other family members or friends are also taking the substance.

There is both individual counselling and family therapy. The WHO has supported the roll out of the BBMI, for example by providing funding to pay for MHSS officers' subsistence and travel expenses to go to assist with BBMI roll out in Zambezi Region; supporting the outreach programme and a promotional campaign; and awareness-raising in communities.

The BBMI team works with nurses in primary health care, community and traditional healers, village councils and faith-based organisations like churches. Communities are increasingly aware of BBMI services, and have invited BBMI team members to come and address them. A recent awareness campaign took the form of a music competition with the theme "Fight Alcohol Through Music".

Preparations are underway for a WHO educational CD on Teenagers Against Drug Abuse. This is a school project for learners and teachers to take ownership of healthy lifestyles without alcohol targeting learners from 10 to 19 years old. Awareness raising even extends to the kindergarten level, where children are given advice on what they should do in the presence of abuse.

Dr Limonta Lazara explains that the first diagnosis is done by looking at the eyes to see if they are bloodshot, or yellow/jaundiced; observing how the client/patient responds to questions about drugs and alcohol; smelling if they have alcohol on their breath; shaking hands to assess withdrawal; determining if other medication has been taken, or if any other ailment is present; determining when last they took the substance that was used/abused; and building confidence and getting the client/patient to unlock and tell the story. Most of the time family members or teachers come forward to inform about suspicions and concerns, and issues like irrational behaviour, being excessively noisy, or constantly joking and laughing for no apparent reason. The problem is far more prevalent and serious amongst males, especially where physical strength and aggression are combined.

It is clear that there is an absence of vocational development opportunities for recovering patients. Dr Lazara and staff would love to have a skills development programme at the hospital. The BBMI programme does have links to the Ministry of Agriculture, Water and Forestry and puts some patients in touch with the Mashari gardening training centre.



Alcohol is the biggest single problem, typically traditional or commercial beer, and especially when combined with marijuana use. Amongst youths, three-quarters of problems relate to alcohol and marijuana. Amongst the adult population, they are often related to traditional types of alcohol like *kasipembe*, which is made from manketti nuts (*mongongo*), *katokere* (mahangu), *ondevere* (sorghum). The use of this strong spirit diagnosed through brown spots in the eyes. Because its production is unregulated, it may contain all kinds of dangerous additives – even battery acid. The sharing of drinking containers can also spread TB. Amongst school learners, sniffing petrol, using “hubbly bubbles”, and consuming cough syrup are also problems. One case of heroin use has been detected, probably mixed with mandrax.



Chief Medical Officer of the Kavango Health Directorate, Dr Abiola Adesina, describes the BBMI as a “flagship programme”

Case study 1: A son making excellent progress

The mother of two boys and four girls brought her eldest son to the clinic 13 months ago. He was introduced to marijuana by the neighbours when he was fifteen years old, in Grade 9. They gave it to him because they were amused at his “funny” behaviour. He failed at school, and stayed at home, exhibiting signs of mental instability, retardation, and psychotic behaviour, being aggressive and laughing incessantly. Since then, he has been a model patient, and has not gone back to drinking or smoking. He has attended regular appointments (first weekly and later, monthly). He was given medication to control the situation (haloperidol is still being used twice daily) but the patient cooperating and willing to stop abuse and to abstain.

The mother’s younger son is also receiving treatment, although he tends to be a bit more reluctant in following up with appointments. He started using drugs in Grade 7, but she only discovered it when he was in Grade 9 upon returning from the farm where she had been to collect food for the family. He was in a private school but dropped out and always used to hang out at the service station. Because of his aggressive behaviour, it took police intervention to get him away from there and to have him admitted for treatment. He is also now home, sleeping most of the time because of medication. She is happy that he has put on weight

Her sons are now mainly at home all the time. She says that the oldest is helpful around the house and helps with collecting firewood, cooking and running errands like shopping. The son expresses the desire to study further, and admits that he doesn’t want to do nothing. He also likes drawing and would like to “make things”.

The mother is deeply thankful to the social workers at the hospital and for the BMI interventions because she has seen a vast improvement in the quality of life for herself, her family and especially for her two boys. She is now happy and has peace of mind. She says that the two boys were never at home but are now with her and not hanging out with friends. The hospital has also motivated why she should be receiving mental disability grants for the two.

Case study 2: A son making progress, but still battling problems

The client was twice admitted to hospital suffering from severe abdominal pains and hallucinations. After his second discharge, he was taken into the BBMI programme. The boy had apparently started with substance abuse in 2012 when he was in Grade 7. His family informed, but the mother was initially in denial.

His medication was adapted to get the correct dosage based on blood analysis. According to his mother, he has improved since the intervention. She is thankful that his aggressive behaviour has changed, and that has been staying at home rather than hanging out in strange places. However, he still does not have the strength to help her with chores, and appears to be depressed.



A mother and her son, who is receiving counselling from Aurelia Mukundu and Dr Limonta Lazara



Confronting problems in life through the BBMI



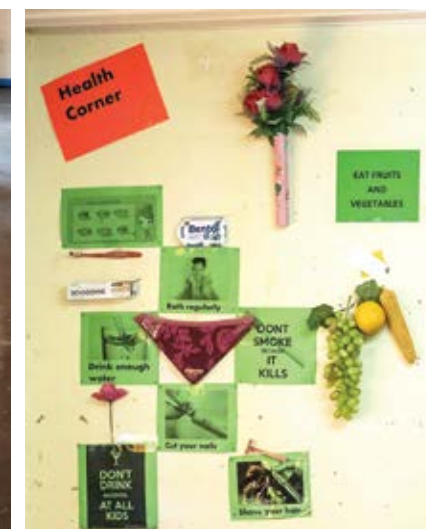
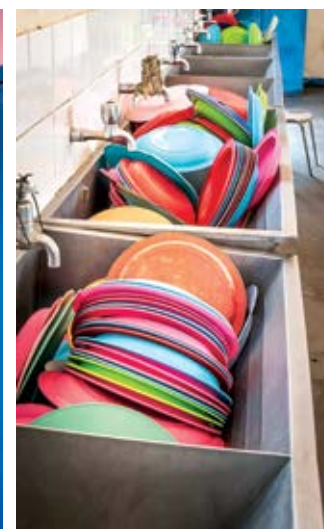
Concern on the faces of Aurelia Mukundu and Dr Limonta Lazara

5.5 Initiatives and policies

Health Promoting School Initiative

Omaheke Region conducted an internal and external assessment of all their 45 participating schools as part of an annual process to motivate schools to maintain their grading. Health Promoting schools have been graded in three categories: gold, silver and bronze levels, and in exceptional cases, platinum level. Each school in Omaheke Region fights to maintain or improve their grading level by adhering to specific criteria for Water, Sanitation and Hygiene Standards (WASH), health promotion, the physical environment, and nutrition.

Kunene Region selected 10 schools in the Opuwo and Otavi health districts with the aim of introducing the Health Promoting School Initiative in the region. An internal assessment was conducted by the region and a follow-up assessment at the national level. These assessments serve as a baseline against specific indicators. The reports were presented to the school management in order to improve the school environment and make it conducive for health promotion and learning. For the schools in Kunene Region, the teams concluded that the schools were still far below the bronze level and may need a year or more to work on the recommendations to improve the overall school environment.



Health Promoting School Initiative

What is a “good education”? This question might appear to be simple – surely it means being well taught in subjects like Mathematics, Biology and Science, and in arts and languages? But while these subjects are of course important, there is a more holistic, rounded way of looking at the question, which focuses on the values, self-discipline, integrity and respect – for self and others – that learners develop.

In the context of health, these values are the goals of the MoHSS’s Health Promoting School Initiative / Integrated Health Programme, which is being supported by the WHO. The programme has four main components:

- safe water and sanitation (linked to environmental studies);
- school policies;
- skills-based education (addressing issues like the use of drugs/alcohol, bullying, teenage pregnancy etc.); and
- health and nutrition services.

Schools are assessed on numerous indicators under these headings, and depending on their performance, are awarded bronze, silver or gold certificates, or in exceptional cases, a platinum certificate. One of the requirements for a gold award is that the school has a sister school which it assists with raising standards. The assessments are



1. Magritta Kanguvi, Senior Health Programme Officer for Family Health in Omaheke Region, inspecting facilities at Wennie du Plessis High School in Gobabis



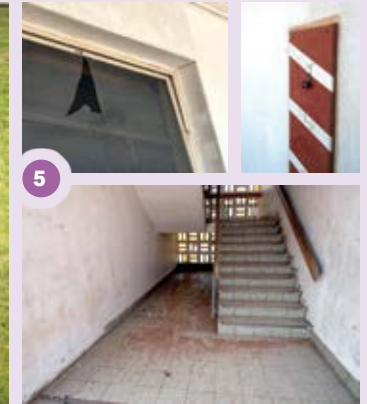
2. A Health Promoting School Initiative assessment sheet



3. Learners should always have access to cool, clean drinking water.



4. The assessment covers both positive features like well-kept school grounds ...
5. ... and problems with maintenance and repairs.



comprehensive and uncompromising: both good and bad are noted and considered when deciding if a school stays at its current level, drops a level, or goes up a level.

Assessments are made by speaking to teachers and learners to establish how well they understand important health issues. The themes and focus are appropriate to age groups: at the lower primary level, for example, personal hygiene is discussed; at secondary schools, issues such as HIV and teenage pregnancies are also dealt with. Facilities are checked to see if soap, toilet paper and running water are available in the toilets, if girls have access to sanitary napkins, if drinking fountains are operational, and if sick bay facilities are in good order, with appropriate medication available. The premises are also inspected to detect possible littering or vandalism, and the working status of safety equipment.

The biggest challenge Ms Magritta Kanguvi faces is to get “buy in and ownership” from school principals, focus teachers and students. Ideally, a school will have health policies which are known by the students, and operational clubs where relevant themes are dealt with.

A shining example of a school that has embraced the Health Promoting School Initiative is, this is the biggest school and hostel in the region, accommodating 1 096 students.

When Ms Nono (as she is fondly referred to) arrived there, the school, which had been built in 1962, was dilapidated and had inadequate facilities, especially in terms of ablutions, with only three toilets for boys, and eight for girls. She and her team – she often emphasises the importance of teamwork – have developed a school which is now a national achiever in academics, sport and culture. She firmly believes that a beautiful environment develops the “frame of mind” that brings about a balance between mental, physical and spiritual health, and that this spreads to the parents and community through the learners and teachers. ▶

She explains that the school has benefited vastly from participating in the Integrated Health Programme's graded system. By following the advice given through ongoing external assessment by the MOHSS staff, the school has been able to set and achieve all the goals associated with the Bronze, Silver and Gold levels. With the establishment of a health committee (of which the head girl and head boy are members), the school has now fully implemented all requirements relating to safe water and sanitation, school policies, age-related health issues incorporated in skills-based education, and the successful offering of health and nutrition services.

C. Ngatjizeko Primary School achieved the Health Promoting School Initiative Gold Award in 2016. One of the requirements for this award was that they assisted their "sister schools", Usiel Ndjavera PS and Morukutu PS, to achieve higher levels. Ms Nono gives full credit to the designated MoHSS official, Ms Emgard Kaune, and her team who have assisted the school with frank assessments and invaluable advice through the years.

In turn, the MOHSS is so impressed with the achievements of this school that it has introduced a special Platinum Award and conferred it on C. Ngatjizeko PS – the first school in the country to be honoured in this way. This bears the stamp of best practice and great teamwork between the school, the MoHSS and the Ministry of Education, Arts and Culture, with the support of the WHO.



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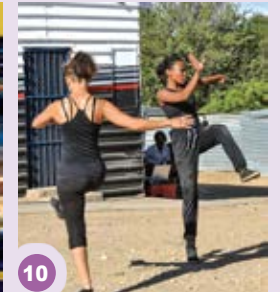
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6. The principal of C. Ngatjizeko Primary School, Ms Nono Katjingsiua, with a mural of the school's founder
7. Excellence attracting attention:
Ms Selma Gqwede (Chief Inspector of Education, MEAC);
Ms Nono Katjingsiua (Principal, C. Ngatjizeko PS);
Ms Emgard Kaune (member of the Integrated Regional School Health Committee);
Ms Claudia Kahuikee (Hostel Matron);
Ms Cornelia Kandetu (Environmental Health Inspector);
and Ms Emma Shilongo (Regional School Counsellor),
together with Grade 2 learners



11

8. The school is an integral part of the community.
9. A few minutes of physical exercise ...
10. ... are followed by washing hands at the water tanks before entering the classrooms.
11. A culture of care: spotlessly clean ablutions
12. A well organised, hygienic cold room and pantry



12





13



13



17



18



- 13. A kitchen and dining room filled with good food and good cheer
- 14. Beautifully illustrated health and safety displays in every classroom
- 15. Functional drinking fountains throughout the school grounds
- 16. The school's own vegetable garden
- 17. Dedicated gardeners
- 18. The school's Health Charter and messages of mutual respect displayed throughout the school
- 19. A sense of humour to put a smile on your face
- 20. Retired registered nurse Emgard Kaune, who is a member of the Integrated Regional School Health Committee, discussing health issues with learners at C. Ngatjizeko PS
- 21. Learners at C. Ngatjizeko PS discussing the importance of personal hygiene
- 22. Recipient of the "Namibia School Health Initiative Health Promoting School Gold Award 2016"



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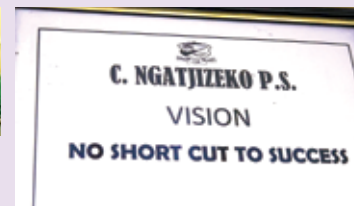
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Windhoek has long been rated one of the top 10 cleanest cities in Africa.



Healthy Cities Initiative

WHO-Namibia supported the strengthening of the City of Windhoek Healthy Cities Committee by helping to review its terms of reference. The committee meets at least twice annually. Under its mandate various health promotion activities are conducted in different parts of the city. As part of the Healthy Cities Initiatives, the Windhoek Municipality, with WHO-Namibia and UNICEF support, have been hosting an annual hygiene week as a response to the current HEV outbreak. During this week, vendors in informal settlements are judged for hygiene promotion and this culminates in a prize giving ceremony during Global Handwashing Day. The committee has also engaged the City's management and political leadership to address the sanitation and water supply needs in the informal settlements as a long-term solution to the current HEV outbreak.

Health in All Policies

WHO-Namibia has been working with the MoHSS to finalise an implementation strategy on Health in All Policies which will allow for the adoption of a whole-government approach to health. The strategy is near finalisation and will be facilitated by the Office of the Prime Minister and the National Planning Commission, with secretarial support from the MoHSS.

WHO-Namibia also supported the MoHSS with the documentation of the country's activities related to intersectoral action in addressing the social determinants of health.

5.6 Risk communication interventions

In order to respond to the HEV outbreak, WHO-Namibia:

- revitalised the Social Mobilisation and Risk Communication sub-committee;
- signed Letters of Agreement with the Red Cross Society and the Swakopmund Municipality to train community health workers;
- developed a three-day training guide for community volunteers which was used to train volunteers on an integrated approach to community engagement, WASH and community surveillance;
- trained 24 community health workers for the Swakopmund Municipality and 35 Red Cross volunteers (the volunteers are deployed in the Havana, Goreagab and DRC settlements in Windhoek and Swakopmund and 10 communities in Omusati Region to complement the work of the community health workers under the MoHSS; the additional volunteers have reached households, individuals and shebeens with hygiene promotion messages); and
- reprinted a number of health education materials and distributed these widely through community health workers and the community volunteers.



WHO/Red Cross training of volunteers in community mobilisation and sanitation

5.7 Commemoration of health days

World Health Day



African Vaccination Week



AFRICAN VACCINATION
WEEK 2018
Vaccines work, Do your part!



World TB Day



World TB Day



World Malaria Day



World No Tobacco Day



SADC Malaria Day



World Blood Donor Day



World Hepatitis Day

From speeches and flyers to hand-washing stations and the inauguration of new toilet facilities, the message was clear, that good sanitation is the key to beating hepatitis

Global Road Safety Week



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1. Driving conditions on Namibian roads can be hazardous
2. The General Manager of the Automobile Association of Namibia, Ms Hileni Tjivikua, signing a road safety pledge
3. Hon. John Mutorwa signing the road safety pledge
4. Dr Charles Sagoe-Moses visiting the Minister of Transport, Hon. John Mutorwa, during Global Road Safety Week to affirm WHO-Namibia's commitment to road safety



World Mental Health Day and World Suicide Prevention Day



WHO-Namibia and partners releasing the *National study on the prevalence of and interventions in relation to suicide in Namibia*

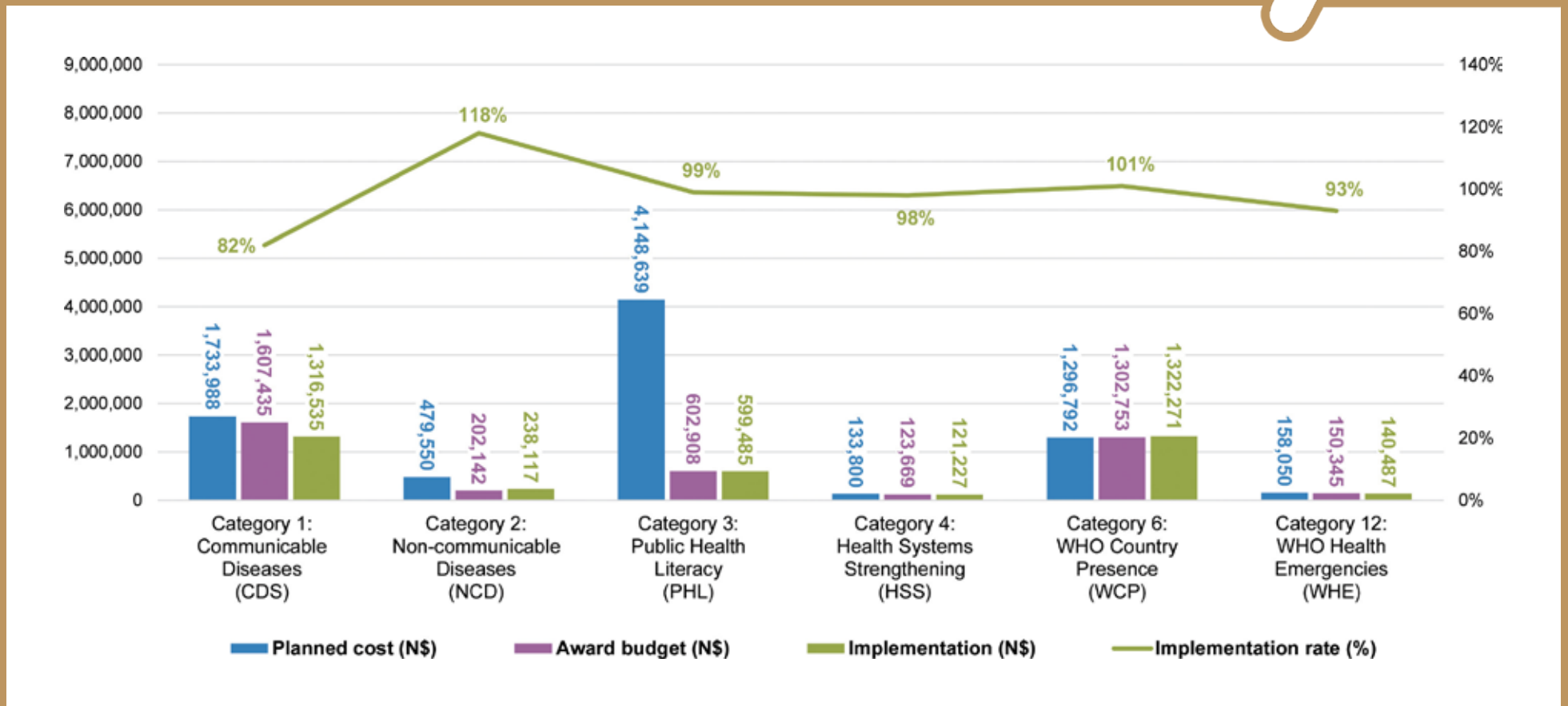
Public lectures

WHO has introduced public lectures on contemporary health issues as a way of engaging stakeholders and providing updated information on health priorities.



CHAPTER
6

RESOURCE ALLOCATION



CHAPTER 7

CHALLENGES AND CONCLUSION

Challenges

Donor support continues to be difficult to come by, which may have hampered the effective implementation of the country work plan. The difficulty experienced in securing funding is in part a consequence of Namibia's ranking as an upper-middle income country, despite the country's heavily skewed income distribution. This situation has been exacerbated by the country's worsening economic performance, which has restricted budgetary allocations to MoHSS programmes. Furthermore, staff turnover at the MoHSS remains high, necessitating costly and time-consuming training of newly recruited staff.

The heavy workload experienced by both WHO-Namibia and MoHSS staff has stretched capacity to the limit, particularly when health emergencies such as the HEV and CCHF outbreaks have required urgent and undivided attention.

Conclusion

WHO-Namibia remains committed to working with the Government of the Republic of Namibia and our partners to ensure the attainment of the highest possible level of health by all people. In collaboration with key stakeholders, WHO-Namibia contributed towards ensuring healthy lives and promoted the wellbeing of the people of Namibia, particularly those who are the most vulnerable.

While there have been improvements in areas such as immunisation coverage and maternal and child health, we cannot afford to be complacent. Our focus must be on consolidating the gains that have been made, and on responding timeously to new challenges as they arise. WHO-Namibia will continue to provide high-quality technical support to the MoHSS within the framework of the third generation of the CCS.





World Health
Organization

NAMIBIA Biennial Report
2018 – 2019