World Health Organization

Country Cooperation Strategy at a glance

Namibia

http://www.who.int/countries/en/

WHO region	Africa
World Bank income group	Upper-middle-income
Child health	
Infants exclusively breastfed for the first six months of life (%) (DHS 2013)	49
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%) (2015)	92
Demographic and socioeconomic statistics	
Life expectancy at birth (years) (2015)	63.1 (Male) 68.3 (Female) 65.8 (Both sexes)
Population (in thousands) total (2015)	2458.8
% Population under 15 (2015)	36.7
% Population over 60 (2015)	5.5
Poverty headcount ratio at $1.25 a day (PPP) (% of population) (2009)	23.54
Literacy rate among adults aged >= 15 years (%) (2007-2012)	89
Gender Inequality Index rank (2014)	81
Human Development Index rank (2014)	126
Health systems	
Total expenditure on health as a percentage of gross domestic product (2014)	8.93
Private expenditure on health as a percentage of total expenditure on health (2014)	40.00
General government expenditure on health as a percentage of total government expenditure (2014)	13.86
Physicians density (per 1000 population) (2007)	0.374
Nursing and midwifery personnel density (per 1000 population) (2010)	3.51
Mortality and global health estimates	
Neonatal mortality rate (per 1000 live births) (2015)	15.9 [11.5-24.5]
Under-five mortality rate (probability of dying by age 5 per 1000 live births) (2015)	45.4 [33.0-63.0]
Maternal mortality ratio (per 100 000 live births) (2015)	265 [172 - 423]
Births attended by skilled health personnel (%) (2013)	88.2
Public health and environment	
Population using improved drinking water sources (%) (2015)	91.0 (Total) 98.2 (Urban) 84.6 (Rural)
Population using improved sanitation facilities (%) (2015)	54.5 (Urban) 16.8 (Rural) 34.4 (Total)

Sources of data:
Global Health Observatory May 2016
http://apps.who.int/gho/data/node.cco

HEALTH SITUATION

The health status of Namibia has been heavily impacted by the HIV/AIDS epidemic and negatively affected by the country's unequal socioeconomic development. The 2001 Population and Housing Census showed a dramatic drop in life expectancy in Namibia since the previous census in 1991 – from 59 to 48 for men, and 63 to 50 for women. The drop was mainly due to the HIV epidemic. As a result of the concerted HIV response and other health initiatives, Namibia has already exceeded its 2013 target as set by National Development Plan III (NDP3) achieving an estimated life expectancy of 66 and 68 years for men and women respectively.

The Ministry of Health and Social Services has prioritized the implementation of three health Millennium Development Goals, namely goals 4, 5, and 6: to reduce child mortality, improve maternal health, and combat HIV/AIDS, malaria and other diseases, respectively.

Namibia is ranked 52nd in the world for under-five mortality, which has decreased between 1990 and 2015 from 73 to 45 deaths per 1000 population. Despite this decrease, Namibia did not meet either the under-five or infant mortality targets for the Millennium Development Goals.

The HIV prevalence dropped from 22% in 2002 to 17.2% in 2016. Data show that the HIV prevalence is decreasing in younger age groups (15–19 and 20–24), while prevalence in the older age groups appears to be increasing. At the end of June 2016, 149,829 adults and 9,666 children were receiving ART, representing 79% coverage of people eligible for treatment. This high coverage is among the highest in the African region and does not include patients being treated in the private sector.

TB remains a serious concern in Namibia, which has one of the highest case notification rates in the world. The emergence of multidrug-resistant TB and the growing problem of extensively drug-resistant TB pose new challenges to improve the capacity for the management of identified cases, infection control in health facilities and strengthened surveillance and reporting.

The malaria mortality rate declined drastically from 96.5 per 100,000 population in 2000 to 1.5 per 100,000 population in 2012 and an increase in the number of cases has been observed since 2014. The country is among four southern African countries aiming to achieve malaria elimination by 2020.

Namibia is signatory to the WHO FCTC and has enacted a tobacco control legislation, and has enforced tobacco control measures starting 1 April 2014. It has also developed a comprehensive five-year plan for the implementation of IHR 2005, which is yet to be implemented fully.

HEALTH POLICIES AND SYSTEMS

The Health sector strategy is guided by Vision 2030, which is long-term development vision, for the country. Vision 2030 aims at transforming Namibia into an industrialised nation and reverse a colonial legacy of high income inequality and poverty. The2016/17, is an attempt to translate Vision 2030 objectives into concrete policies and actions. More specifically, the plan seeks to achieve the medium term objectives of High and economic sustained growth, employment creation, and increased income equality.

Namibia is a signatory of the WHO-FCTC and has promulgated a Tobacco Control Act in 2010, which led to the Tobacco Control legislation in March 2014 and enforcement in April 2014. The country has achieved a polio free status in 2008 and has maintained this to date.

The public health sector is structured in a three-tier hierarchy with central, regional and district levels. The central level has devolved authority to 14 Health Regional Directorates and 34 districts. Churches and NGOs play a significant role in protecting and promoting the health and social welfare of the Namibian people. Many of the NGOs are involved in the delivery of community-based health care.

The private sector is regulated by the Hospital and Health Facilities Act of 1994 (Act No. 36). The private sector facilities are licensed to provide health services to all patients and they complement the services of the public sector. The Namibian health system receives contributions from government, donors and their implementing agencies, and households through private insurance and out-of-pocket payments. The public and private not-for-profit healthcare system serves 85% of the Namibian population and is accessed by the lower income population. The private for-profit healthcare system serves the remaining 15% of the population, consisting of the middle and high income groups. Access to care is an issue for a large number of Namibians with over 40% of the population living further than 5km from a health facility.

COOPERATION FOR HEALTH

The United Nations Development Partnership Framework (UNPAF) covering the period 2014-2018 is the third strategic programme framework developed by the Government of the Republic of Namibia (GRN) and the United Nations (UN) system in Namibia, describes the collective response of the UN to priority national development challenges. This strategic partnership and resource planning driving the programmes through which the UN Country Team System supports Namibia in implementing the 4th National Development Plan (NDP 4) and the realization of its development goal as stipulated in Vision 2030. The UNPAF contains four pillars, i.e. Institutional Environment, Education and Skills, Health, and Reducing Extreme Poverty. There are relatively few bilateral and other non-state actors working in the country with whom WHO works. Currently the largest contributors among the donors and their implementing agencies in the health sector are the President's Emergency Plan for Aids Relief (PEPFAR), GFATM, UN agencies, European Union, German Technical Cooperation (GTZ), the Finnish Government, Synergos and few others.

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Country Cooperation Strategy *at a glance*

WHO COUNTRY COOPERATION STRATEGIC AGENDA (2010–2015)	
Strategic Priorities	**Main Focus Areas for WHO Cooperation**
STRATEGIC PRIORITY 1: Strengthening the health system	• ***Governance:*** Facilitate the use of evidence; Strengthen the stewardship and policy dialogue; Foster strategic partnerships; Enhance the generation and strategic use of information • ***Human resource development:*** Enhance capacity for human resources development; Maximize potential of existing health workforce; Monitor the recruitment, management, deployment and availability of health workforce • ***Health financing:*** Strengthen equitable, evidence and results-based resource allocation; Promote sustainable financing and social protection; Institutionalize the National Health Accounts; Strengthen the capacity for resource mobilization; • ***Health information systems:*** Harmonize, rationalize and integrate the existing multiple health information systems; Promote the production, analysis, dissemination of reliable and health information for policy and decision-making; Build capacity for operational and health systems research • ***Medical products, vaccines & technologies:*** Strengthen capacity for development of policies, legislation, regulation and strategies; Strengthen procurement capacity and access to and quality, safety, access and use of medical products, vaccines and technologies; Explore introduction of eHealth • ***Service delivery:*** Strengthen referral systems and programme linkages; Promote linkages between facilities and communities; Improve quality of health services; Strengthen capacity to achieve universal access to priority health interventions
STRATEGIC PRIORITY 2: Combating priority diseases	• ***HIV/AIDS and TB:*** Enhance capacity for strategic planning, surveillance, monitoring and evaluation; Strengthen capacity to scale up priority interventions • ***Diseases targeted for elimination/eradication:*** Enhance capacity for malaria elimination; Strengthen capacity to sustain the achievements made towards elimination of measles and neonatal tetanus and eradication of polio • ***Non-communicable diseases and conditions:*** Strengthen surveillance, monitoring and research; Influence policy formulation, legislation and support planning for NCDs; Promote healthy lifestyles and primary prevention
STRATEGIC PRIORITY 3: Improving maternal, newborn, child and adolescent health	• ***Emergency obstetric care***: Enhance quality of focused antenatal care; Strengthen the capacity to provide quality and equitable emergency obstetric and new-born care services; Promote availability of emergency obstetric care services at all levels • ***Maternal and neonatal death reviews:*** Institutionalize maternal and neonatal death reviews; • ***Integration of reproductive health and HIV/AIDS:*** Strengthen capacity to deliver integrated services and interventions at all levels; Promote the harmonization of tools and guidelines • ***Immunization***: Improve immunization services; Advocate for the introduction of new vaccines and technologies • ***Child nutrition and IMNCI:*** Advocate for a strategic plan on nutrition; Promote exclusive breastfeeding and adequate infant and young child feeding; Strengthen capacity to manage malnutrition and nutritional deficiencies; Promote the scaling up of IMNCI • ***Adolescent health:*** Advocate for and support adolescent-friendly health services; Promote school health programmes
STRATEGIC PRIORITY 4: Promoting a safer and healthier environment	• ***Emergency preparedness, risk reduction and response:*** Enhance capacity for disaster risk assessment, reduction, preparedness, response and early recovery and strengthen health emergency coordination mechanisms at all levels; IHR (2005); Build core capacity for IHR (2005) requirements and harmonize IDSR framework with IHR (2005) • ***Environmental health:*** Influence public policies to improve road safety***;*** Enhance capacity to monitor food quality and ensure food safety***;*** Strengthen capacity to monitor drinking water quality and sanitation; Advocate for improved occupational health policies and service delivery • ***Health Promotion:*** Advocate for multi-sectoral involvement in promoting healthy lifestyles***;*** Promote communities' and individuals' responsibility for own health***;*** Disseminate information, evidence and best practices; and advocate for action on social determinants of health

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