[Annual Report 2011]

World Health Organization
Namibia

Annual Report 2011

World Health Organization
Namibia

Copies of this publication may be obtained from the WHO Country Office in Namibia:
UN House, 2nd floor
38 Stein Street
P. O. Box 3444, Windhoek
Namibia
Tel: +264 -61-255-121; Fax: +264-61-204-6202
Email: registry@na.afro.who.int

Photo Credits: WHO Country Office, Namibia, unless otherwise stated.

Printed in Namibia: John Meinert Printing, 2012
Design & Layout: brownpaperbag, 2012

Contents

List of Tables

List of Figures

ADH	Adolescent Health
AFP	Acute Flaccid Paralysis
AHO	African Health Observatory
AIDS	Acquired Immune Deficiency Syndrome
AMR	Antimicrobial Resistance
APHEF	African Public Health Emergency Fund
ART	Antiretroviral Therapy
ARV	Antiretroviral medicine
AU	African Union
BMGF	Bill and Melinda Gates Foundation
BMI	Body Mass Index
CBS	Community-Based Surveillance
CCM	Country Coordination Mechanism
CCS	Country Cooperation Strategy
CDC	Centers for Disease Control and Prevention
CERF	Central Emergency Response Fund
CESTAS	Centro di Educazione Sanitaria e Tecnologie Appropriate Sanitarie
CHAI	Clinton Health Access Initiative
CHPP	Country Health Policy Process
CNR	TB Case Notification Rate
CoW	City of Windhoek
CPD	Continuous Professional Development
CPT	Chemoprophylaxis Therapy
DAPP	Development Aid from People to People
DHS	Demographic and Health Survey
DPC	Disease Prevention and Control
DRC	Democratic Republic of Congo
DR TB	Drug Resistant Tuberculosis
ECA	United Nations Economic & Social Council, Economic Commission for Africa
EDHP	Essential District Health Package
EDT	Electronic Dispensing Tool
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and Newborn Care
EMOP	Emergency Management Operational Procedure
e-MTCT	Elimination of Mother to Child Transmission of HIV
EoI	Expression of Interest
EPI	Expanded Programme on Immunization
EPMS	Electronic Patient Monitoring System
EU	European Union
EWIs	Early Warning Indicators
FBO	Faith Based Organization
GDP	Gross Domestic Product
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GIVS	Global Immunization Vision and Strategy
GNI	Gross National Income
GR	Geographical Reconnaissance
GSHS	Global School-Based Health Survey
GSK	Glaxo Smith Kline
HCP	Healthy Cities Project
HDPG	Health Development Partners Group
HIFTAC	Namibia National Health Insurance and Finance Technical Advisory Committee
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HIV DR	HIV Drug Resistance
HPCN	Health Professions Council of Namibia
IAEA	International Atomic Energy Agency
IAP	Integrated Action Plan (on TB and Leprosy)
IATC	Inter-Agency Technical Committee
IC	Infection Control
ICF	Intensified TB Case Finding
IDSR	Integrated Disease Surveillance and Response
IEC	Information, Education, Communication
IHR	International Health Regulations
IMNCI	Integrated Management of Newborn and Childhood Illnesses
IND	International Nurses Day
IPT	Isoniazid Preventive Treatment
IRS	Indoor Residual Spraying
IST/ESA	WHO Inter-Country Support Team for East and Southern Africa
IST/HPR	WHO Inter-Country Support Team for Health Promotion
IST/HSS	WHO Inter-Country Support Team for Health Systems Strengthening
IST/IVD	WHO Inter-Country Support Team for Immunization & Vaccine Development
IST/MAL	WHO Inter-Country Support Team for Malaria
ITNs	Insecticide Treated Nets
KNCV	Koninklijke Nederlandse Chemische Vereniging (Royal Dutch Chemical Association)
JNAOB	Joint National Assessment Organizing Body
JUTA	Joint United Nations Team on HIV/AIDS
LSS	Life Saving Skills
LTFU	Lost to Follow-Up

MAN	Medical Association of Namibia
MC	Male Circumcision
MCH	Maternal and Child Health
MDR TB	Multi Drug-Resistant Tuberculosis
M&E	Monitoring and Evaluation
MIS	Malaria Indicator Survey
MMR	Maternal Mortality Ratio
MoHSS	Ministry of Health and Social Services
MoU	Memorandum of Understanding
MPR	Malaria Programme Review
MSH	Management Sciences for Health
MTCT	Mother–To-Child Transmission of HIV
MVA	Motor Vehicle Accident Fund
MWH	Maternity Waiting Homes
NaCCATuM	Namibia Coordinating Committee for AIDS, Tuberculosis and Malaria
NAEC	National AIDS Executive Committee
NAFIN	Namibia Alliance for Improved Nutrition
NAMPOST	Namibia Postal Services
NAPPA	Namibia Planned Parenthood Association
NCD	Noncommunicable Diseases
NDF	Namibia Defence Force
NDHS	Namibia Demographic and Health Survey
NDP3	National Development Plan 3
NDRMP	National Disaster Risk Management Plan
NGO	Non-Governmental Organization
NHFC	Namibia Health Facility Census
NICD	National Institute of Communicable Diseases (South Africa)
NID	National Immunization Day
NIP	Namibia Institute of Pathology
NLA	Nutrition Landscape Analysis
NMPNDR	National Maternal, Peri and Neonatal Death Review Committee
NMR	Neonatal Mortality Rate
NRCS	Namibian Red Cross Society
NRSC	National Road Safety Council
NTLP	National Tuberculosis and Leprosy Programme
NVDCP	National Vector-borne Diseases Control Programme
OPV	Oral Polio Vaccine
PARMaC	Programme for Accelerating the Reduction of Maternal and Child Mortality
PDA	Personal Digital Assistant
PEP	Post Exposure Prophylaxis
PHC	Primary Health Care
PHEIC	Public Health Event of International Concern
PLHIV	People living with HIV/AIDS
PMDR–TB	Programmatic Management of Drug Resistant TB
PMO	Principal Medical Officer
PMTCT	Prevention of Mother–To-Child Transmission of HIV
PTI	Patient Tracing Intensification
RBM	Roll Back Malaria Partnership
RD	Regional Director
RDT	Rapid Diagnostic Test
RED	Reach Every District
SADC	Southern Africa Development Community
SAMEST	Southern Africa Malaria Elimination Support Team
SARN	Southern Africa Roll Back Malaria Partnership Network
SDH	Social Determinants of Health
SFH	Society for Family Health
SSC	Social Security Commission
STI	Sexually Transmitted Infections
STOP	Stop Transmission Of Polio
TAG	Polio Technical Advisory Group
TB	Tuberculosis
THE	Total Health Expenditure
TKMI	TransKunene Malaria Initiative
U5MR	Under- five Mortality Rate
UN	United Nations
UNAM	University of Namibia
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
WBW	World Breastfeeding Week
WCH	Windhoek Central Hospital
WCO	World Health Organization Country Office
WHD	World Health Day
WHO	World Health Organization
WHO AFRO	World Health Organization Regional Office for Africa
WHS	World Health Survey
XRD-TB	Extensively Drug-Resistant Tuberculosis

Acknowledgements

We would like to thank all those who contributed to the work of the World Health Organization (WHO) in Namibia in 2011, particularly the Honourable Minister of Health and Social Services (MoHSS) and his team at national, regional and district level, other line ministries and Government departments, UN agencies, donors, civil society organizations, private sector and other partners.

We would also like to express our gratitude to WHO Headquarters, Regional Office for Africa and the East and Southern Africa Inter-Country Support (IST ESA) Team for their continued support. The hard work of the Professional and General Service Staff of the WHO Country Office is commendable! Their dedication, teamwork and commitment made it possible to maintain and even increase the level of technical support narrated in this progress report.

Finally, we would like to sincerely acknowledge the contribution of all the Professional Staff of the WHO Country Office in putting this report together and that of General Service Staff in facilitating administrative processes for its design, printing and distribution.

There is no doubt that road traffic fatalities are on the increase in Namibia. Available data shows an upwards trend in mortality between 2009 and 2010. The majority of these deaths are preventable. In addition to the loss of lives, hundreds more are left disabled and thrown into a spiral of physical and financial dependency. Individually and collectively, we should do more, much more, to bring this tragedy to an end.

Dr Magda Robalo Correia e Silva
WHO Representative

You will read in this report that Noncommunicable diseases and their risk factors are also on the increase globally and in Namibia. For example, the health information system is capturing increasing cases of diabetes. Although data is not recent or even completely non-existent, available estimates indicate that risky behaviours and factors such as excess drinking, smoking and obesity are prevalent at alarming levels. Here again, prevention is the mainstay.

These two important issues have deserved global and local attention over the course of this year. At the global and national level, the Decade of Action for Road Safety 2011-2020 was launched in May 2011. The Decade of Action and its Global and National Plan calls for a collective and synergistic effort between governments, private sector, civil society, international agencies and other stakeholders, including road users, to curb the toll of death and disability caused by road traffic accidents.

The United Nations High-level Meeting of the General Assembly on Noncommunicable Disease Prevention and Control held in New York in September 2011 was attended by His Excellency the President of the Republic of Namibia, Dr Hifikepunye Pohamba who expressed his commitment and determination to fight the emerging epidemic of noncommunicable diseases in his country. The resolution and political declaration adopted at the summit acknowledges the developmental impact of these diseases, if not tackled through a whole-of government and whole-of society efforts.

As we roll up our sleeves to "Getting to zero" in our response to the HIV/AIDS pandemic, to engage in malaria pre-elimination activities and strengthen health systems to improve service delivery and reduce maternal and child mortality, we also need to adjust our gears to halt suffering, death and disability caused by noncommunicable diseases and road traffic accidents.

Disease, death and disability from these causes are largely preventable. We need to adopt healthy lifestyles, adhere to road traffic rules and lead by example as citizens, as parents, educators and leaders. Only and only then, we will be able to win this battle.

This progress report is articulated around the four strategic priority areas of the WHO Country Cooperation Strategy (CCS) with Namibia, 2010-2015. It highlights some of the normative and policy guidance as well as strategic, technical, programmatic and operational support provided by WHO to the Government of the Republic of Namibia and areas of collaboration with our valued partners in 2011, to improve health outcomes, contribute to the achievement of Millennium Development Goals (MDGs) and other internationally and nationally agreed goals and targets.

Strengthening Health Systems

WHO supported the restructuring process of the Ministry of Health and Social Services (MoHSS) which included the development of the Essential District Health Package (EDHP) and revision of national, regional and district management structures. The restructuring process advocates for the improved availability of human and financial resources at all service delivery levels, particularly the district level.

As part of development of United Nations Development Assistance Framework (UNDAF) 2013-2017, WHO participated and supported the Country Analysis exercise undertaken by the UN Country Team (UNCT) in Namibia. The Country Analysis process was framed around national development plans and policies. Specific attention was paid to the outcomes of the Mid-Term Review of the NDP3, Namibia's 3rd MDG Report, and the 2010 Universal Periodic Review of Human Rights. The UNDAF 2013-2017 will provide a set of core development objectives for UN cooperation and prioritization, to address equitable access to quality social services, employment generation, comprehensive social protection systems, human resource development and systems strengthening, management of public affairs and social accountability, natural resource management and disaster risk management, among others.

WHO supported developing a Human Resource for Health (HRH) situation analysis, policy and strategic plan, to ensure availability of sufficient health workers according to the country's rising health needs and based on the current stock of workers, from those expected to join through education or recruitment, and those expected to leave the system through retirement or attrition.

Following a 2010 assessment of medical gas (particularly oxygen) systems and supply in Namibia, the WCO supported the implementation of the recommendations of the assessment. These recommendations included the development of plans for, the preventive maintenance programme; quality assurance programme to prevent production and supply of sub-standard medical gas products for hospital use; as well as the development of a system for managing and monitoring the medical gas system by the MoHSS to ensure delivery of quality medical gas products.

Combating Priority Diseases

WHO supported a Human Immunodeficiency Virus Drug Resistance (HIVDR) Adherence Measures Study aimed at assessing patients' knowledge of their Antiretroviral (ARV) medicines, the social characteristics of patients (e.g. distance from Antiretroviral Therapy (ART) clinic, household income) and their impact on the patients' treatment response as measured by routine viral load.

WHO provided support in the development and revision of the Global Fund Round 10 Tuberculosis (TB) Proposal based on the Global Fund 2nd Round Technical Review Panel requirements. The proposal was approved with a total budget of over 32 USD million spanning a five-year period.

WCO facilitated the revision of the national malaria policy. The revision of the policy was necessitated by the country's decision to achieve malaria pre-elimination by 2016 and elimination by 2020. The major areas that were amended included surveillance, criteria for malaria diagnosis and management at different levels and the application of vector control interventions in different malaria transmission zones.

The MoHSS with support from WHO and the Novo-Nordisk Company developed a Noncommunicable disease (NCD) strategy to stem the rise of this epidemic in the country.

Maternal, Newborn, Child and Adolescent Health

As part of continuing efforts to build the capacity of health staff to deliver quality services to rural and disadvantaged women and newborns in Namibia, WHO supported training of 64 health workers, including nurses and midwives on Life Saving Skills in Emergency Obstetric and Newborn care (LSS/EmONC).

One of the strategies to remove geographical barriers to access to basic and comprehensive EmONC in Namibia is through the establishment/construction of Maternity Waiting Homes (MWH). To this end, WHO supported the MoHSS in conducting an assessment of MWHs to ascertain their impact towards improving access and quality of services to pregnant women and newborns.

WHO provided extensive technical support to Namibia's 15th National Immunization Days (NID) campaign. More specifically, technical support was provided to the Expanded Programme on Immunization (EPI), micro-planning, logistics procurement, development and implementation of a communication and social mobilization strategy to inform the public about the importance of the NID. The campaign reached 298,029 children (95% coverage) in Round One and 303,396 children (97% coverage) in Round Two.

Promoting a Safer and Healthier Environment

Namibia experienced another episode of recurrent floods. The 2011 floods began earlier than usual. with increasing magnitude. More than 130,000 people were affected by the floods in six northern regions and as many as 40 health clinics and 180 outreach health points were rendered inaccessible. WHO swiftly deployed technical experts to assist the Government with rapid health assessments, disease surveillance and control, emergency response and recovery plans, and other interventions. No disease outbreaks were experienced during the flood period.

Ahead of the rainy season, WHO handed over emergency medical supplies to the MoHSS. The medical supplies consisted of emergency health kits and medical supplies for diarrhoeal diseases and water testing kits. The WHO consignment was part of prepositioning of emergency medicines and supplies to enhance emergency preparedness and response capacity of the MoHSS.

The MoHSS was supported to revise the existing Integrated Disease Surveillance and Response (IDSR) technical guidelines. The purpose of the revision was to update existing information, include emerging and other priority diseases, conditions and public health events that were not addressed in the old guidelines. Additionally, comprehensive disease surveillance aspects of the International Health Regulations (IHR) 2005 were incorporated in the guidelines.


cation
Disability
Communication
Information
Nutrition
AIDS
Children
Hunger
Statistics
Immunizat
Health Partner
Developm
International Health Regula
United Nat
Millennium Development

Section 1

Introduction

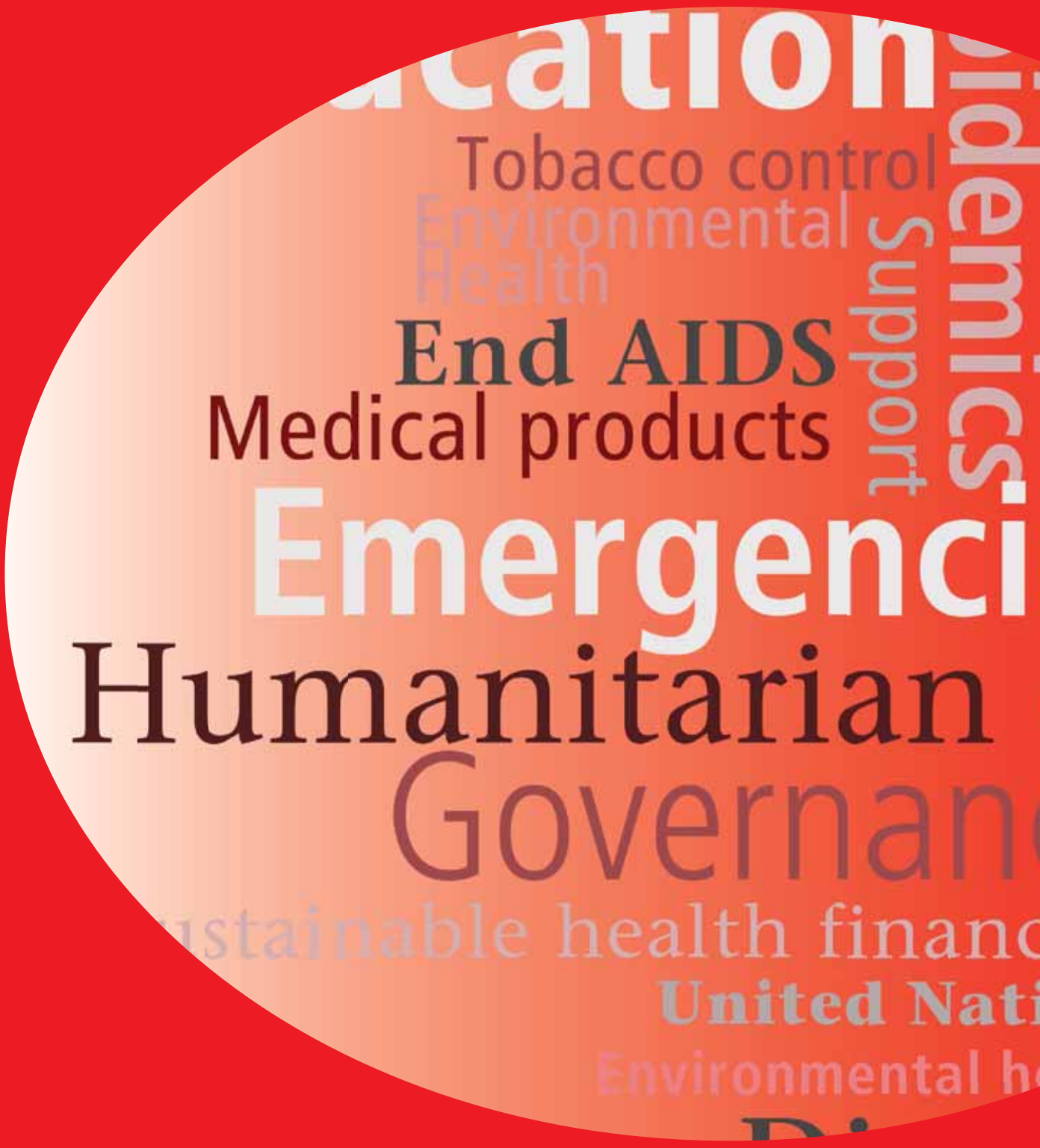
1. INTRODUCTION

2011 marked the second year of implementation of the World Health Organization's (WHO) Country Co-operation Strategy (CCS) with Namibia, 2010-2015 and the 2010-2011 Programme Budget period.

WHO Namibia continued to support the Ministry of Health and Social Services (MoHSS) to strengthen national capacity for the delivery of essential health services for better health outcomes for its people. Interventions addressed health promotion, disease prevention, treatment, control, elimination and eradication; provision of evidence-based tools and normative guidance for policy decisions; advocacy, dissemination of information, surveillance, monitoring and evaluation.

This report provides an overview of Namibia's health situation and highlights progress and achievements as well as challenges in the four strategic priorities outlined in the CCS namely:

- Strengthening the Health System;
- Combating Priority Diseases;
- Improving Maternal, Newborn, Child and Adolescent Health, and
- Promoting a Safer and Healthier Environment.


Tobacco control
Environmental
Health
End AIDS
Medical products
Emergenci
Humanitarian
Governan
ustainable health financ
United Nati
Environmental h

Section 2

Background

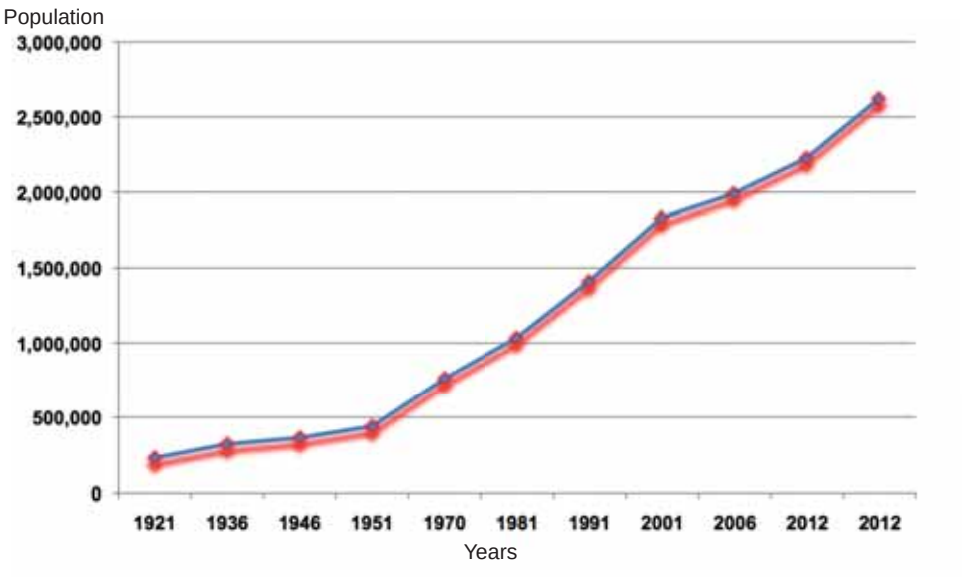
Namibia has a young population, with about 40% of people aged fifteen years and below and 54% aged 15 to 59 years old.

The government of Namibia invests about 7% of its gross domestic product on health.

2. BACKGROUND

2.1 Namibia Social and Demographic Characteristics

Figure 1: Namibia's population estimates and projections



Source: National Planning Commission, Central Bureau of Statistics, 2010

Between 1921 and 2001, the Namibian population grew more than eight times, from 229,000 to 1,830,330 people. It is estimated that by 2021, the country will have over 2,500,000 inhabitants. The Central Bureau of Statistics estimates that the population growth was about 3% during the second half of the 20th century and declined to about 2% by 2010. The population growth is mostly attributed to two key factors: improved medical care and immigration. The slowing in population growth rate is estimated to be caused by a reduction in fertility rates, which in turn is due to improved levels of education among young women and their increased participation in economic development.

Namibia has a relatively young population, with about 40% of people aged fifteen years and below and 54% aged 15 to 59 years old. Most of the latter group live in urban areas, with a significant number in informal settlements. Women and children constitute more than 70% of Namibia's population. These demographic dynamics pose specific health challenges that require swift and effective adaptation and response by the health system.

As in many other countries, rapid urbanisation is occurring, particularly in informal and low income housing areas. It is estimated that the urban population growth rate has been around 4% to 5% over the past decades and population density can reach up to 50,000 people per square kilometre in these areas, as opposed to the national average of 2.7 people per square kilometre. Lack of fertile soil and

water are the main reasons for low population density in most parts of the country. According to the 2001 census, there are more women than men in the northern regions, except in Kunene; while in central and southern regions particularly in Erongo in Khomas regions, there are more men than women, probably related to predominantly male employment in farms and mines.

By 2006, around 13% of homes in Namibia were improvised informal shacks and this proportion may have significantly increased as rural-urban migration continues to grow. Sixty four percent of the population were estimated to live in rural areas in 2006 and 43% of households were female headed. The literacy rate of people older than fifteen years is estimated at 85%. About 50% of households had no toilet facility, as estimated by the 2006 Namibia Inter-censal Demographic Survey.

The Namibian population is very mobile, due to related work migration in farms, mines, ports, etc. The port of Walvis Bay has also created transport corridors with neighbouring countries.

Namibia is ranked as an upper-middle income country since 2008, with a Gross National Income (GNI) per capita estimated at US$4,200. However, it has one of the greatest income inequalities in the world and high unemployment rates, estimated at 52% in 2008. Unemployment is higher in rural areas and among females. Disaggregated data reveals that unemployment among young people aged 20 to 24 years is as high as 68% (73% among females and 62% among males). It is estimated that 28% of Namibian households are poor and 14% severely poor.

2.2 Health Situation in Namibia

The Government of Namibia invests about 7% of its Gross Domestic Product (GDP) on health. The Total Health Expenditure per capita (THE) was estimated at US$268 in 2008/09, up from US$259 in 2007/08. The Namibian health care system is pluralistic, constituted by a public sector, private for profit and not-for-profit sectors. The public sector is the major financier of the health system, contributing 54% of the THE, followed by donors (22% of THE), private companies and households (12.2% of THE each).

The system has chronic shortage and misdistribution of its health workforce, rendering access to health care a challenge, particularly in rural and remote areas. Although aggregated figures establish the national average at around 3 health workers per 1,000 population, the majority of the workforce is employed by the private sector and are based in urban and semi-urban areas. Therefore, the public sector has inadequate health workers to deliver quality health services to the population. As a consequence, existing health workers have heavy workloads, which compromises the quality of services provided. Furthermore, there is suboptimal integration of services, which aggravates the burden on health workers, compromises continuum of care to patients, increases the cost of service provision and time spent by patients to access health care.

Namibia is in an epidemiological transition, facing a high burden of communicable diseases, mainly HIV/AIDS and Tuberculosis (TB) and an increasing prevalence of Noncommunicable diseases (NCD).

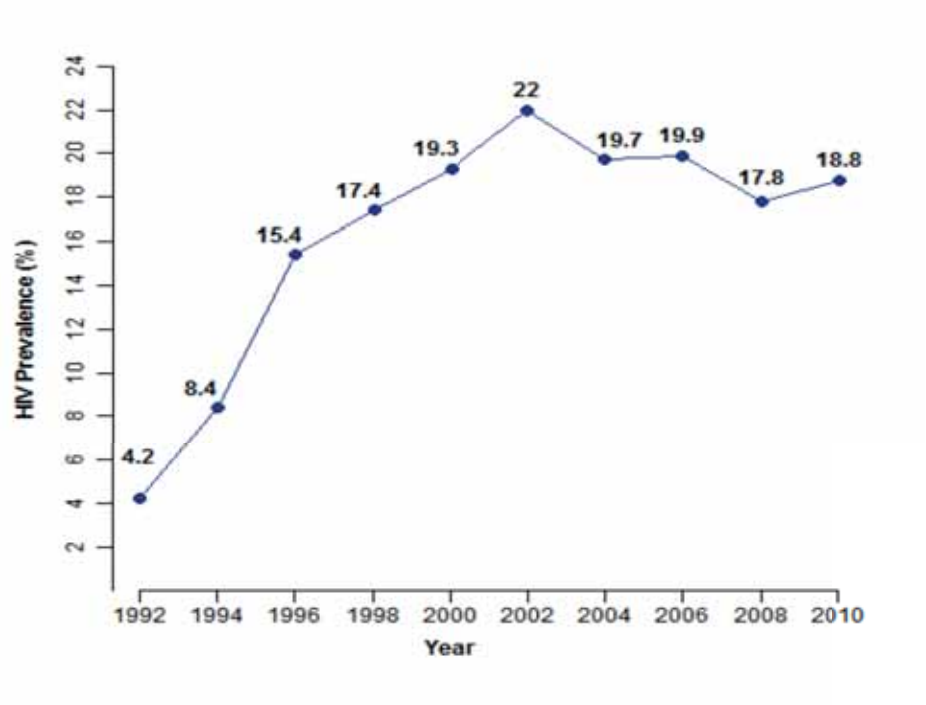
Communicable Diseases

Namibia has one of the highest HIV prevalence in the world and is one of the Sub-Saharan African countries most affected by the dual epidemic of HIV and TB. Of TB patients with known HIV status, 50% are found to be HIV positive in 2011, down from 59% in 2008.

According to the 2010 Antenatal Care (ANC) sentinel survey, HIV prevalence stands at 18.8%. 2011 estimates and projections points towards a 61% decrease on the number of new HIV infections occurring in the country. There are encouraging signs of reduction of prevalence among young people aged 15 to 24 years.

According to the ANC sentinel survey, the overall HIV prevalence among this age group was 10.3% in 2010, compared to 15.2% in 2004. The prevalence among the age group 25 to 49 years remained relatively stable (24.7% in 2008 and 26.4% in 2010).

Figure 2: Trends in HIV Prevalence among pregnant women attending ANC, 1992-2010



Source: MoHSS, Directorate of Special Programmes, 2010

The ANC sentinel survey did not identify any significant difference between the HIV prevalence rate in rural (19.1%) and urban areas (18.5%). However, there is a disproportionate regional distribution of the disease burden. The highest prevalence is recorded in Katima Mulilo, Caprivi region (35.6%), followed by Tsandi in Omusati region (25.5%). The lowest prevalence is registered in Rehoboth, Hardap region (4.2%).

Some of the identified drivers of the HIV epidemic in Namibia are multiple and concurrent partnerships, excessive alcohol use, intergenerational and transactional sex.

Data triangulated from various sources estimate the number of AIDS orphaned children at about 70,000 and an estimated 160,000 people aged 15 to 49 years are living with HIV. In 2009, AIDS related mortality was estimated at 23% of all deaths (about 6,000 deaths).

Syphilis prevalence ranged from 0.3% and 10% in 2010. The highest prevalence was registered in Gobabis, Omaheke region. Most health facilities offer Sexually Transmitted Infection (STI) treatment services, according to the 2009 Health Facility Census.

The WHO 2011 report on Global Tuberculosis Control estimates that the absolute number of TB cases is dropping globally and so is the case in Namibia. The TB Case Notification Rate (CNR) has been in a declining trend since 2007 (see Table 1.) TB case management has significantly improved over the years, as evidenced by the increase in the TB success rate for new smear positive cases (cohort year) from 76% in 2006 to 85% in 2010. The number of registered Drug Resistant TB (DR TB) cases has been progressively reduced since 2009. It is also important to note the significant and steady increase in the number of TB patients on Antiretroviral Therapy (ART), from 17% in 2007 to 54% in 2011.

Namibia recorded 39 cases of leprosy in 2011, of which three were new cases.

The burden of malaria continued to decline as the country moves towards elimination of the disease. In 2010, the incidence of malaria was estimated to be around 10.4 per 1,000 population and the mortality rate was 2.1 per 100,000 population. Corresponding figures for 2011 show an incidence of 6.7 per 1,000 population and a mortality rate of 1.6 per 100,000.

The majority of health facilities provide malaria treatment services, have laboratory capacity for diagnosing malaria and first-line antimalarial medicines are available, as per the findings of the 2009 Health Facility Census.

Table 1: TB status in Namibia, 2007 - 2011

INDICATOR	2007	2008	2009	2010	2011
Number of notified cases of all forms of TB	15,244	13,737	13,332	12,625	11,937
TB case notification rate for all forms of TB per 100 000	722	665	634	589	556
Number of new smear positive TB cases	5,114	4,928	4,608	4,464	4,608
TB cases with known HIV status	8,186 (54%)	9,188 (67%)	9,849 (74%)	9,534 (76%)	10,039 (84%)
TB patients with known HIV status who are HIV positive	4,358 (59%)	5,425 (59%)	5,676 (58%)	5227 (55%)	4,980 (50%)
HIV positive TB patients on CPT	1,495 (34%)	5,289 (98%)	4,434 (78%)	4,869 (92%)	4,885 (98%)
HIV positive TB patients on ART	749 (17%)	2,019 (37%)	1,995 (35%)	2,294 (43%)	2,700 (54%)
Treatment success rate for new smear positive TB cases (cohort year)	76% (2006)	83% (2007)	82% (2008)	85% (2009)	85% (2010)
Number of cases of MDR-TB	116	201	275	214	192
Number of cases of XDR-TB	3	20	17	8	2

Source: National TB and Leprosy Control Programme, 2011 Tuberculosis Report

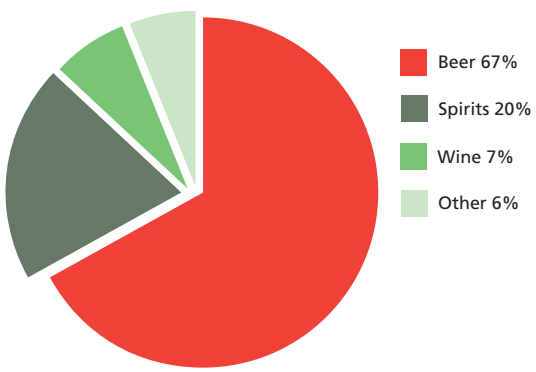
Noncommunicable diseases and conditions

It is now widely acknowledged that Noncommunicable diseases (NCD) are the number one cause of death in the world, particularly in low and middle income countries where the highest burden of mortality due to NCD among people aged under 60 years of age is recorded. It is estimated that by 2030, NCD will become the most frequent cause of death in Africa. The five major risk factors of mortality are raised blood pressure, tobacco use, raised blood glucose, physical inactivity and overweight and obesity.

In Namibia, data on morbidity and premature mortality due to NCD is scanty, but there are indications that the burden posed by NCD is further compounding the challenges faced by the health sector. Diabetes alone is emerging as one of the greatest threats to good health. Between July 2010 and July 2011, 3 650 new cases of the disease were recorded in the country's public health facilities, as reported by the National Health Information System.

According to the WHO Global Status report on alcohol and health, the most recent data available for Namibia is from 2005. In this report, robust estimates of five-year change in recorded adult (aged 15 years and above) per capita consumption, 2001-2005 shows an increase in per capita alcohol consumption in Namibia.

Figure 3: Namibia recorded adult (15+) alcohol consumption by type of alcoholic beverage (in % of pure alcohol), 2005*

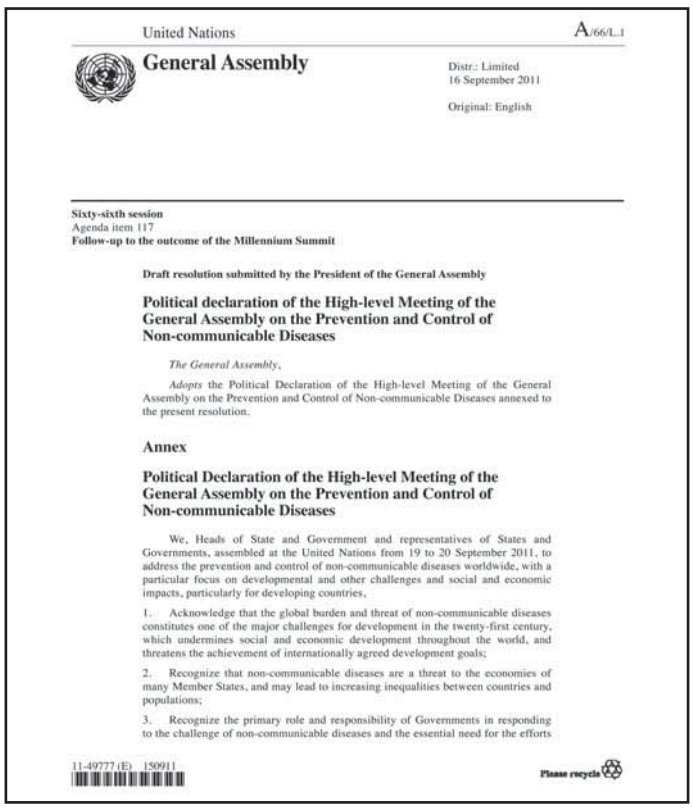


**Beer include malt beers. Wine includes wine made from grapes. Spirits include all distilled beverages. Others include one or several other alcoholic beverages, such as fermented beverages made from sorghum, maize, millet, rice, or cider, fruit wine, fortified wine, etc.*

Source: WHO Global Status Report on Alcohol and Health, 2011

Namibia has high level political commitment to address the challenges posed by NCD. His Excellency the President of the Republic participated at the High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases and called upon WHO and development partners to support his country control and prevent NCD.

The Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases calls for a whole-of government and a whole-of society effort to combat NCD.



United Nations A/66/L.1

General Assembly

Distr.: Limited
16 September 2011

Original: English

Sixty-sixth session
Agenda item 117
Follow-up to the outcome of the Millennium Summit

Draft resolution submitted by the President of the General Assembly

Political declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases

The General Assembly,

Adopts the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases annexed to the present resolution.

Annex

Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases

We, Heads of State and Government and representatives of States and Governments, assembled at the United Nations from 19 to 20 September 2011, to address the prevention and control of non-communicable diseases worldwide, with a particular focus on developmental and other challenges and social and economic impacts, particularly for developing countries,

1. Acknowledge that the global burden and threat of non-communicable diseases constitutes one of the major challenges for development in the twenty-first century, which undermines social and economic development throughout the world, and threatens the achievement of internationally agreed development goals;

2. Recognize that non-communicable diseases are a threat to the economies of many Member States, and may lead to increasing inequalities between countries and populations;

3. Recognize the primary role and responsibility of Governments in responding to the challenge of non-communicable diseases and the essential need for the efforts

11-49777 (E) 150911

Please recycle

Table 2: Namibia 2008 estimated prevalence (%) of NCD behavioural risk factors

	Males	Females	TOTAL
Current daily tobacco smoking	21.6	6.9	14.1
Physical inactivity	49.5	62.8	56.3

Source: World Health Organization – NCD Country Profiles, 2011

Table 3: Namibia 2008 estimated prevalence (%) of NCD metabolic risk factors

	Males	Females	TOTAL
Raised blood pressure	45.1	41.8	43.4
Raised blood glucose	…*	…*	…*
Raised cholesterol	…*	…*	…*
Overweight	20.3	41.2	31.1
Obesity	3.6	15.0	9.5

**… no data available*

Source: World Health Organization – NCD Country Profiles, 2011

Maternal, Newborn, Child and Adolescent Health

The health of a mother and the survival of her baby are inextricably linked. It is estimated that children who lose their mothers, are up to ten times more likely to die prematurely than those who have not.

Recent estimates from WHO, UNICEF, UNFPA and the World Bank indicate that globally, between 1990 and 2010, there was a reduction of 47% in maternal mortality. However, about 800 women worldwide are still dying on a daily basis of complications related to pregnancy and childbirth.

Pregnancy is a period of about nine months during which a woman carries a developing embryo and fetus in her womb. Every pregnancy is at risk of developing complications which can be life-threatening. Many of these complications can be prevented or minimized, provided quality services for early detection of complications and timely intervention by skilled health workers are available and accessible.

WHO defines 'skilled attendant' as an accredited health professional (e.g. doctor, midwife, nurse) who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns. In order to be able to provide life-saving services to women presenting with complications of pregnancy or childbirth, the skilled attendants need to be working in enabling environments, applying adequate policies and regulatory frameworks. Medicines and other essential supplies should also be available.

In Namibia, maternal, newborn and child mortality rates have been of great concern,

because of their increasing trends particularly maternal mortality; the high contribution of newborn mortality to child mortality and the insignificant progress being made to reverse the situation.

The majority of maternal deaths are due to direct obstetric complications such as eclampsia, haemorrhage and obstructed/prolonged labour. HIV/AIDS is estimated to be the leading indirect cause of maternal deaths in Namibia.

Contrastingly, Namibian women benefit from one of the best rates of Antenatal Care (ANC) coverage in the African Region. It is estimated that about 70% of pregnant women have four or more ANC visits, even though in general, the first visit occurs relatively late, after the fourth month of pregnancy.

Namibia also has a high rate of delivery at health facilities, most of them (76%) occurring in public health facilities. The per capita THE and high coverage of these two important indicators (ANC visits and delivery at health facilities) are in stark contrast with the unacceptable levels of maternal and neonatal mortality. This mismatch points towards challenges related to service delivery.

The results of the 2009 Health Facility Census reveals that about 80% of health facilities in Namibia, mainly health centres and clinics provide ANC services but only about 70% of them provide ANC, Post Natal Care (PNC) and Tetanus Toxoid Vaccine (TT). The Khomas and Erongo regions have fewer health facilities providing these services, with only about 60% of health facilities in Erongo region and 30% in Khomas region providing ANC services. It is also important to note that of those health facilities providing ANC services, an estimated two thirds only offer the services one or two days per week, 10% provide the services three or four days per week and only 20% provide ANC services five or more days per week.

Individual client cards, ANC guidelines and visual aids are important resources to support adequate management of pregnancy and childbirth. The survey noted that only one-third of facilities providing ANC services have written ANC guidelines on how to manage common pregnancy related complications. Only twenty percent of facilities have been found to have all three items, with private facilities and hospitals least likely to have them (only 7% of private facilities and 10% of hospitals complied with the requirement). On a positive note, over 90% of the facilities were found to have at least one of the essential equipment and supplies for providing basic ANC (e.g. functioning blood pressure apparatus and foetoscope, iron tablets, folic acid tablets, etc.).

Only 25% of health facilities providing ANC services had all medicines for managing pregnancy complications, which are found mostly in hospitals and in Khomas and Omaheke regions. This poses

In Khomas Region, only **30%** of health facilities offer ANC services.

problems of attending to complications of pregnancy and childbirth in a country where access to health care is made uneasy due to long traveling distances.

Caesarean sections and blood transfusion services are mostly available in hospitals and in Khomas and Erongo regions.

Table 4: Availability of transport for maternity emergencies

Type of transport	Percentage of facilities
Ambulance or other facility based vehicle	2
Vehicle based at another facility	86
Hired vehicles	3
Other arrangements	16

Source: Health Facility Census, 2009

Teenage pregnancy is common in Namibia, 16% of all pregnancies being among adolescents aged 15 to 19 years as per the NDHS 2006/07. The MoHSS estimates that the number of teenage pregnancies increased to 17.3% in 2010/11. There is a need for increasing availability and improving provision of adolescent-friendly services, to promote safe sex and address the reproductive health needs of young people.

Unmet needs for family planning are estimated to be low and most facilities provide modern contraceptive services and counselling.

The number of children aged 0 to 14 years living with HIV are estimated at 14,000. The majority of these children would have been infected through Mother-to-Child Transmission (MTCT) of HIV. Projections for 2011 estimates that about 4,400 Namibians will become newly infected with HIV, with a disproportionate incidence among young females: 73% of new infections are estimated to occur among young girls aged 15 to 19 years old against 27% among young boys. Similarly, the proportion of new infections among women aged 20 to 24 years is estimated to be 62%.

About 2/3 of health facilities providing ANC services in Namibia only do so one or two days per week.

Immunization, PMTCT, nutrition and child health services

Basic child health services such as outpatient care for sick children, immunization and growth monitoring are provided in most health facilities in Namibia, mainly in health centres (93%) and clinics (87%). However, private health facilities are less likely to provide such services (e.g. only 43% of private facilities provide immunization and outpatient services for sick children and only 37% provide growth monitoring services). Khomas and Erongo region are less likely to provide basic child health services than other regions.

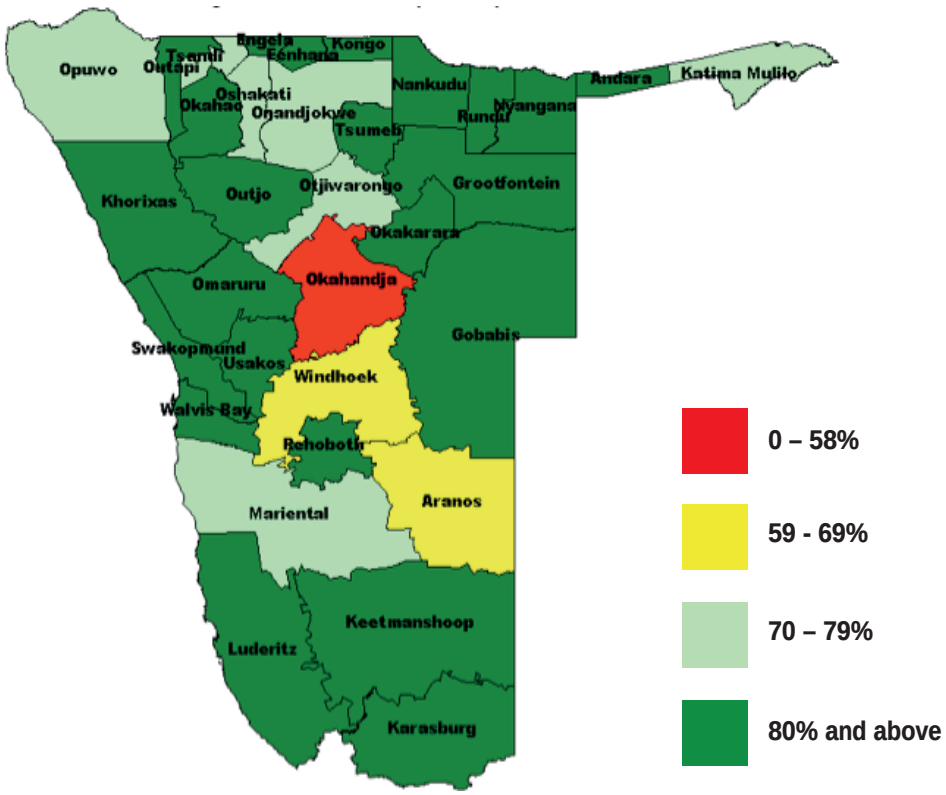
The Namibian immunization schedule includes one dose of tuberculosis vaccine (BCG), three doses of the pentavalent vaccine (against diphtheria, pertussis, tetanus, hepatitis B, and haemophilus influenza type B); four doses of oral polio vaccine and one dose of measles vaccine. This schedule is designed to protect children from infection and deaths caused by major childhood vaccine preventable diseases.

Immunization coverage stands at 82% among eligible children for Pentavalent-3

and 75% for measles. Districts need to scale-up the implementation of the Reach Every District (RED) approach at facility level to reach the recommended 80% in each district as per Global Immunization Vision and Strategy (GIVS). At present, 24 (71%) of the 34 districts have reached the recommended 80% for routine immunization (see Figure 4).

However, the 2009 Health Facility Census found that less than a third of health facilities providing immunization services have all the required equipment, all the necessary items for infection control

Figure 4: Immunization coverage, Namibia, 2011



Source: MoHSS: Directorate Primary Health Care (PHC) - Family Health Division: Routine EPI database.

and all the administrative good practices related to childhood immunization.

Malnutrition continues to compromise children's health in Namibia, as one of the underlying causes of poor health outcomes. Thirty percent of children aged less than five years are estimated to be stunted and rural children are more affected than children living in urban areas.

68% of health centres, 53% of hospitals and 32% of clinics provide the minimum package of PMTCT of HIV.

Around 90% of health facilities have treatment guidelines for providing services to sick children, but all items necessary to provide quality child health services are only available in less than half of health facilities that care for sick children. Caretakers of sick children are rarely advised on when to return to the facility or which symptoms they should pay attention to.

The census also observed that 68% of health centres, 53% of hospitals and 32% of clinics provide the minimum package of Prevention-of-Mother-to-Child Transmission (PMTCT) of HIV. The MoHSS estimates that by March 2011, 92% of health facilities were providing PMTCT services. This includes 34 hospitals and 280 health centres and clinics, with some regional variations between 70% and 100%. The uptake of ARV prophylaxis for PMTCT of HIV is reported to have increased from 60% in 2004/05 to 96% in 2010/11.

A major challenge in achieving the e-MTCT goal is related to full scale implementation of the four prongs and the fact that most women present for their first ANC visit during the second trimester of pregnancy, while the PMTCT guidelines envisage the initiation of prophylaxis or treatment as early as 14 weeks of pregnancy.

Promoting a Safer and Healthier Environment

In recent years Namibia has experienced a number of emergencies related to climate change and environmental safety. These include recurrent floods, disease outbreaks, notably measles, meningitis and Influenza H1N1 (2009). The northern, north west and north east regions where 60% of Namibia's population live are the most vulnerable. These northern regions include Oshana, Ohangwena, Omusati, Oshikoto, Kunene, Kavango and Caprivi. Poverty is also higher in these regions compared to other parts of the country. With the exception of Oshana region, the population at lowest wealth quintile ranges from 26% in Kunene to 49% in Caprivi, well above the national average of 17.5% (DHS, 2006-2007).

Since 2009, the country continued to face outbreaks of the Influenza H1N1 (2009) pandemic. In 2011, a total of 3,155 cases with no fatalities were recorded throughout Namibia. Although quite a number of regional and district staff were trained in disease surveillance, gaps persist in reporting surveillance data. Some districts still submit weekly disease surveillance reports late and the data is not analysed at the district level to guide decision-making and response measures to disease outbreaks.

Inadequate access to water and sanitation particularly in rural areas poses a major health risk for disease outbreaks. Two thirds of the population have non-improved household sanitation facilities and nearly 20% of the population require 30 minutes or longer to obtain drinking water.

The uptake of ARV prophylaxis for PMTCT of HIV increased from 60% in 2004/05 to 96% in 2010/11.


School Hea
Epidemics
Reseat
Education
Disability
Communication
Information
Nutrition
AIDS
Children
Hunger
Statistics
Immunizat
ealth Partner
Developm

Section 3

HIGHLIGHTS OF PROGRESS IN 2011

3. HIGHLIGHTS OF PROGRESS IN 2011

Taking cognizance of the aforementioned issues and challenges, the World Health Organization in collaboration with other partners in 2011 supported the Government of Namibia in putting the necessary interventions in place to address them. These include the development of appropriate policies, plans, standards and norms, advocacy, health promotion, building capacity of health workers and other stakeholders, surveillance, monitoring and evaluation.

This progress report is articulated around the four strategic priority areas of WHO's CCS 2010-2015 with Namibia's Government and highlights some of the strategic, technical, programmatic and operational support provided to improve health outcomes, in collaboration with our valued partners.

3.1 Strengthening Health Systems

WHO played its role of lead advisor in technical matters in supporting the Ministry of Health and Social Services (MoHSS) and relevant line ministries and government agencies, on all health related activities, including on issues relevant to the United Nations Development Assistance Framework (UNDAF) and Joint UN Team on AIDS (JUTA). WHO led coordination meetings on health issues with partners and UN Agencies to ensure harmonization of activities thus strengthening the collaboration and coordination with partners active in the health sector and streamlining and aligning partner's support to the MoHSS in particular and the Namibian Government in general. To this end, WHO made use of its locally based staff and its extensive technical, research and knowledge network, to help devise local solutions and advise the MoHSS on how best to ensure that Namibians have access to quality and affordable health services when and where they are needed.

3.1.1 Governance

Regional Committee 61

The MoHSS participated in the 61st Session of the Regional Committee for Africa held in Yamoussoukro, Cote d'Ivoire, from 29 August to 3 September 2011 to review WHO's work in the region and review and approve resolutions relevant to the African region. The Namibian delegation was led by the Honorable Minister of Health and Social Services.

The Namibian delegation with WHO Director General, Dr Margaret Chan, Regional Director, Dr Luis Sambo, WHO Representative, Dr Magda Robalo and GFATM Executive Director, Dr Michel Kazatchkine.

The WCO put together materials (books, banners, etc.) for display at an exhibition organized by the Regional Office for Africa.

One of the key outcomes of the Regional Committee Meeting was a resolution that was adopted by the Ministers of Health on the proposed African Public Health Emergency Fund (APHEF) – a major agenda item at the meeting. This set the annual recommended contribution of Member States to the Fund at a total of US$50 million. The ministers endorsed the designation of the African Development Bank as the trustee for the management of the Fund, and the domiciliation of a revolving fund with a limit of US$30 million at the WHO Regional Office for Africa in Brazzaville. The RC 61 focused on Health Systems Strengthening, Maternal and Child health, Health Security, among other issues.

2011 Enlarged Ministerial Management Meeting: "Fostering Change for Accelerated Delivery of Quality Health Services"

Every year, just before the end of the fiscal year (April to March), the MoHSS holds its Enlarged Ministerial meeting, under the leadership of the Honorable Minister of Health and Social Services. The meeting brings together all national, regional and district senior staff, to take stock of progress made during the year, identify challenges and propose solutions to address them and most importantly, chart the way for the new fiscal year, following directives from the Minister of Health and Social Services. At this year's meeting, the Minister highlighted issues related to the re-structuring of the ministry; human resources challenges – of 10,651 funded positions for the 2010/11 financial year, 1,789 were vacant; internal governance processes; establishment of private wards in State Hospitals; HIV/AIDS Management; Supervisory visits; partnerships; and the role of the media. A panel discussion to highlight areas of bold leadership as well as gaps and challenges was organized. Panelists were drawn from the University of Namibia (UNAM), civil society, National Assembly; National Youth Service, etc. The WHO Representative to Namibia was also a panellist and contributed inputs on how to improve the quality of service delivery.

Restructuring of the MoHSS

The 2008 Health and Social Services System Review recommended that among others, the MoHSS needed to review the core functions of the health sector and clarify roles and responsibilities of the various levels of the health system and review the ministry's organizational structure to be responsive to new challenges. This exercise would contribute to eliminating duplications, reducing fragmentation, strengthening accountability, fostering integration of services and improving coordination and collaboration among programmes and services. The restructuring exercise involves management structures from national to regional and district levels.

Following the development of the 2008-2013 Strategic Plan, the MoHSS embarked on the restructuring process with the objective of :

a) reviewing the existing organogram at various levels and clarifying linkages and reporting lines;
b) clarifying functions and responsibilities of the various departments, directorates, and divisions;
c) clarifying governance and service delivery mechanisms at the various levels; and
d) promoting a culture of accountability, efficient and effective service delivery.

To take this process forward, a Restructuring Committee was put in place in May 2009, comprising key stakeholders including WHO.

WHO provided technical support to this process, in collaboration with other partners namely UNICEF and USAID. In particular the WCO assigned a consultant to facilitate stakeholder consultations, review the MoHSS's current structure in light of new policy and strategic orientations and

propose a streamlined, lean and effective structure and functions that will guide the operations of the MoHSS. Based on this, a draft new structure was developed.

Further discussions and consultations with stakeholders and senior management of the MoHSS are still needed before the newly proposed structure could be finalized.

Health Development Partners Group (HDPG) Coordination meetings

WHO initiated the Health Development Partners Group (HDPG) meetings, given the need and interest from health development partners to improve information sharing, coordination and collaboration in the provision of support to the MoHSS and collectively address critical roadblocks. The need for such a forum arose in light of the changing context in which health partners are operating namely: the deepening financial crisis; diminishing resources among traditional health donors; the World Bank ranking Namibia to an upper middle-income country; MoHSS restructuring underway; and the need to consider a more strategic scope for health development actors towards sustaining health efforts. This is expected to contribute to achieve better programmatic coherence, hence better results and health outcomes. The members include UN agencies (WHO, UNICEF, UNFPA and UNAIDS), United States Government Agencies (USAID and CDC), European Union, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), and the Spanish Cooperation.

MoHSS Review, Planning and Management Meetings

WHO also participated and represented the UN family in the Primary Health Care Review and Planning meeting, which was held from 15 to 19 August 2011 and the national planning meeting held in Oshakati from 31 October to 4 November 2011 to review progress and agree on priorities and areas for UN support during 2012. The meetings were opportunities to sensitize MoHSS officials on proven strategies to further strengthen health care delivery in Namibia and improve health outcomes.

United Nations Development Assistance Framework (UNDAF) Common Country Analysis

A country analysis was undertaken by the UN Country Team (UNCT) to inform the strategic prioritization and programming framework for the 2013 – 2017 UNDAF. The WCO participated at different stages of the country analysis exercise. The country analysis process was framed around national development plans and policies. Specific attention was paid to the outcomes of the Mid-Term Review of the NDP3, Namibia's 3rd MDG Report, and the 2010 Universal Periodic Review of Human Rights. The UNDAF 2013 – 2017 is expected to provide a vision for UN cooperation with Namibia, contribute to equitable access to quality social services, employment generation, comprehensive social protection systems, human resource development systems strengthening, management of public affairs and social accountability, natural resource management and disaster risk management.

3.1.2 Service delivery

Essential District Health Package

WHO continued to support the development of the Essential District Health Package (EDHP), as part of the restructuring process of the MoHSS. The MoHSS restructuring and the EDHP are both aimed at improving availability and use of human and financial resources at service delivery levels, particularly at the district level. The EDHP is intended to ensure that scarce resources are put to best use, by targeting essential, cost-effective interventions that generate maximum health benefits. If well-defined and implemented, the EDHP will provide a standard for minimum health services to be provided at any given health facility, promoting equity and efficiency.

Infection Control Africa Network Conference and Patient Safety Programme

Namibia hosted the 3rd Infection Control Africa Network Conference from 31 October to 3 November 2011 in Windhoek. The Conference was attended by nearly 200 delegates from over twenty countries. Several WHO experts attended the meeting, conducted various sessions and made presentations.

The conference covered topics such as hand hygiene, injection safety, waste management and occupationally acquired diseases, decontamination and sterilization of medical devices, the high risk of communicable and health care hazards and infections resulting from inadequate cleaning and sterilization of devices, risk management and patient safety, impact of traditional practices on infection prevention and control, among others.

Namibia has made sterling progress in the area of infection prevention and control, with WHO and partner's support and through a South – South teaching collaboration between the Infection Prevention and Control Unit of the University of Stellenbosch and the Ministry of Health and Social Services.

Since 2009, WHO has been providing technical support to Namibia to implement the Hand Hygiene improvement strategy; implement surgical safety check list; scale-up implementation of "Safe Surgery Save Lives" and; develop Patient Safety Policy and guidelines. This technical support programme is rolled-out with the support of the IST/HSS. Some achievements worth noting have been registered to date: a training of trainers on hand hygiene good practices and implementation strategy was conducted, covering all 34 health districts; training of chief nurses from Windhoek Central Hospital (WCH) and other staff members from Khomas Region; a baseline assessment of hand hygiene practices was undertaken in eight pilot sites and; the WHO Surgical Safety Check-list is being rolled out at the cardiothoracic operating theatre of the WCH as of February 2011. Challenges to the Patient Safety Programme include recurrent stock-outs of hand hygiene commodities, among others.

3.1.3 Health Information Systems

Country Health Policy Process and African Health Observatory Portals

Further to the need for health system strengthening support to Namibia, the WHO Headquarters, Regional Office and Country Office in Namibia organized a mission to develop the Country Health Policy Process (CHPP) and African Health Observatory (AHO) portals. These portals aim to provide analytical health information to support the development and monitoring of country National Health Strategies, Policies and Plans by leveraging health information and knowledge networks. The goals of the AHO and CHPP are the establishment of a centralised one-stop portal for information sharing which will contain the latest research findings, partner reports, statistics among other information, for improved analysis, information sharing and decision-making on how best to channel and use health resources for greater impact.

The purpose of the HRH country profile is to serve as a tool for:

- Providing a comprehensive picture of the health workforce situation in Namibia;
- Systematically presenting the HRH policies and management situation to help monitor HRH stock and trends;
- Communication with and between policy-makers and stakeholders;
- Strengthening the HRH information system by establishing evidence for baselines and trends;
- Facilitating information sharing and cross-country comparisons.

Launching of Namibia Health Facility Census (NHFC) Report 2009

The report of the Namibia Health Facility Census (NHFC) that was conducted in 2009 was launched and disseminated in March 2011. The NHFC provides an overview of the status and quality of health infrastructure existing in Namibia. Specifically, the report covers: availability of specific client services, the extent to which facilities are prepared to provide services, the type of infrastructure, resources and support systems available and to what extent the service delivery process follow generally accepted guidelines. WCO provided financial and technical support for the implementation of the NHFC.

3.1.4 Human Resources Development

Human Resources for Health (HRH) Situation Analysis

WHO supported a Human Resource for Health (HRH) situation analysis in view of developing a policy and strategic plan, to ensure availability of sufficient, adequately trained, well distributed, and motivated health workers. The policy and strategic plan are intended to address the country's rising health needs and take into account the current stock of workers, from those expected to join the system and those expected to leave the system through retirement or attrition. The MoHSS is strengthening pre-service education and in-service training of health workers, and community health workers e.g. development of Primary Care Outreach guidelines and Health Extension Worker Strategy, which will soon be piloted.

3.1.5 Medical Products, Vaccines and Technologies

Medical Gas Supply in State Hospitals

Following an assessment of medical gas (particularly oxygen) systems and supply in Namibia conducted from 25th October to 13th November 2010, WCO supported the implementation of the recommendations of the assessment. The recommendations included the development of plans for the preventive maintenance programme; quality assurance programme to prevent production and supply of substandard medical gas products for use in the hospitals; as well as the development of a system for managing and monitoring the medical gas system by the MoHSS to ensure delivery of quality medical gas products and a tender document for procurement of oxygen and other medical gases for the MoHSS' facilities.

3.1.6 Health Financing

Meeting of the Committee of Experts of the 4th Joint Annual meetings of the AU Conference of Ministers of Economy and Finance and ECA Conference of African Ministers of Finance, Planning and Economic Development

WHO supported the participation of senior MoHSS representatives and decision-makers to the meeting of the Committee of Experts of the 4th Joint Annual Meetings of the African Union (AU) Conference of Ministers of Economy and Finance and the Economic Commission for Africa (ECA) Conference of African Ministers of Finance, Planning and Economic Development, held in Addis Ababa, Ethiopia in March 2011, under the theme "*Governing Development in Africa*". Among

other important issues, the meeting reviewed progress towards achieving the MDGs and followed up progress to date on important outcomes of major United Nations (UN) and AU Conferences, Summits and other meetings.

Relevant to the health sector was the "*Ten-year review of progress in the implementation of the Abuja Declaration on Health Financing in Africa*", related to the allocation of at least 15% of national budgets to the health sector. The meeting noted that to date, only six African countries had met the target and this has not prevented them from performing poorly in at least one of the health related MDGs.

Several recommendations emanated from the meeting, including among others:

a) the need to promote evidence based policy planning and strengthen research in various areas vital to health;
b) improve health sector's governance by linking resource allocations to quality of services and health outcomes; and
c) improve efficiency and effectiveness through implementation of the principles of the Paris Declaration and the Accra Agenda for Action.

Namibia National Health Insurance

The Namibia Social Security Commission (SSC) is mandated by the Social Security Act 34 of 1994 to establish the National Medical Benefit Fund. In September 2011, the SSC hosted a stakeholder's consultative workshop aimed at exploring health insurance models and available alternatives suitable to the Namibian context and learn from experiences of other African countries, namely Ethiopia, Ghana, Nigeria and South Africa. Prior to the workshop, the SSC had contracted Deloitte & Touche to undertake strategic research to inform the Namibia Medical Benefit Fund. The workshop was supported by USAID, with the participation of WHO and other stakeholders. WHO provided financial support for the operationalization of the Namibia National Health Insurance and Finance Technical Advisory Committee (HIFTAC). HIFTAC is intended to serve as an advisory committee to the SSC Board on issues related to the development of a National Health Insurance Scheme in Namibia.

3.2 Combating Priority Diseases

3.2.1 HIV/AIDS and Tuberculosis

Voluntary Medical Male Circumcision

The proportion of Namibian men who have been circumcised by 2007 is about 20%, according to the Namibia Demographic and Health Survey 2006/07. Most of these circumcisions were conducted by health professionals (70%).

WHO Country Office in Namibia in collaboration with MoHSS, IST/HIV, UNAIDS, USAID, NGOs and other partners held a consultative workshop on the draft Joint Strategy on Voluntary Medical Male Circumcision, October 2011.

The National Strategic Framework for HIV and AIDS Response in Namibia 2010/11 to 2015/16 set a target of 450,000 men and about 170,000 male newborns to be medically circumcised between 2010/2011 and 2015/16. As reported in the Annual Implementation Progress Report for the National Strategic Framework for HIV and AIDS, 2010/11, Namibia has managed to carry out slightly over 2,500 medical male circumcisions in 2010/11, up from only 262 in 2009/10.

In order to provide guidance in scaling-up voluntary medical Male Circumcision (MC) a draft Joint Regional Strategy was developed by WHO, UNAIDS and other partners. WHO Country Office in Namibia, in collaboration with IST/HIV and the MoHSS held a consultative workshop on the draft Joint Regional Strategy on Voluntary Medical Male Circumcision in October 2011. Multi-lateral agencies, USAID, NGOs, Government and UN organizations took part in the consultative workshop. The inputs of the workshop were shared with the IST/HIV for consideration during the finalization of the regional strategy.

WHO also participated in a two-day Tele-Conference (TC) on Male Circumcision and Monitoring and Evaluation (M&E) situation in selected countries from 17 to 18 November 2011. The TC was organized by UNAIDS Southern Africa Regional Office in collaboration with WHO Headquarters (WHO HQ).

The objectives of the TC were to:

- Share and synthesize the findings and experiences from within the region as compiled by a consultant on countries visited,
- Discuss harmonization of M&E of Male Circumcision across agencies and with countries, and;
- Provide recommendations on the identified areas for capacity building in the UNAIDS Country Office, government and other partners.

Botswana, Namibia, Zambia, Swaziland and Zimbabwe participated in the teleconference. From Namibia, WHO, UNAIDS, CDC, and MoHSS participated in the discussions. At the end of the discussions every country was provided with a template to submit their plans for technical support needed to strengthen Male Circumcision M&E activities.

HIV Drug Resistance

Collaborative surveillance, monitoring and research in the area of HIV Drug Resistance (HIV DR) has been on-going between Tufts University, the MoHSS, the University of Namibia (UNAM) and other partners, facilitated by WHO. The goal of this collaboration is to optimize patient care and minimize the emergence of preventable HIV DR.
An Early Warning Indicators (EWIs) workshop was held in April 2011 for participants drawn from all 38 ART sites in the country. Participants to the workshop used data from their respective sites and

Male Circumcision can prevent as many as 6 million new HIV infections & 3 million deaths in Sub Saharan Africa, over 20 years. WHO and UNAIDS therefore recommends the scaling-up of Male Circumcision as an element of HIV preventive interventions.

learned how to validate it using paper and Electronic Patient Monitoring System (EPMS). Abstraction of these EWIs was done centrally in 2010, by a data team composed of Management Sciences for Health (MSH), WHO, the MoHSS, and Tufts University. The team used the Electronic Dispensing Tool (EDT) to populate the WHO Abstraction Tool. The validation exercise is expected to improve data quality, strengthen ART services and prevent ARV resistance.

An HIV DR Adherence Measures study aimed at assessing patients' knowledge of their ARV medicines, the social characteristics of patients (distance from ART clinic, household income, etc.) and their impact on patients' treatment response as measured by routine viral load tests was undertaken during 2011. Data collection for this study was completed in April 2011, and analysis is being carried out at Tufts University under the Tufts/WHO/MoHSS collaboration.

Through the collaborative project with WHO and the MoHSS, Tufts University is also supporting the MoHSS conduct monitoring surveys of acquired HIV DR (both prospective and retrospective monitoring) using lot quality assurance sampling and dried blood spot specimens. WHO has provided financial support to the MoHSS to conduct the study, which is expected to be completed in 2012. Other on-going projects include threshold surveys of transmitted HIV DR; food insecurity and ART adherence study; operational research on ART Patient Tracing Intensification (PTI) and on ART adherence measures. There are plans to initiate a project on predictors on Pre-ART Lost-to-Follow-Up (LTFU) in Windhoek.

The WHO/MoHSS/Tufts University/UNAM collaborative project is materialized through secondment of medical students from Tufts University to the MoHSS.

The results of the various studies will help the MoHSS make evidence-based decision on maintaining the effectiveness of first-line ART and supporting ART programme practices associated with HIV DR prevention. The ultimate goal is to ensure sustainable and accurate EWIs abstraction for public health action, optimize patient care and minimize emergence of HIV DR.

Integrated Action Plan on TB and Leprosy

Following the finalization of the 2nd Mid-Term Plan on TB and Leprosy, the National Tuberculosis and Leprosy Programme (NTLP) drafted an M&E plan for monitoring progress in the implementation of the plan. On 10 February 2011, the NTLP held a one-day workshop to review the draft M&E Plan and Integrated Action Plan (IAP) on TB and Leprosy. The workshop was attended by staff from MoHSS M&E Unit, the NTLP, WHO, USAID, KNCV, and other implementing partners such as NGOs. At the end of the workshop, the two plans were reviewed. The workshop provided invaluable inputs and helped improve both plans for eventual submission to the Global Fund, to fulfil the Conditions Precedent.

Three I's for HIV and TB

Intensified TB case finding (ICF), Infection Control (IC), and Isoniazid Preventive Treatment (IPT), are considered critical for prevention, improving quality of life and reducing mortality among People Living with HIV (PLHIV). To improve the low coverage of these services in many African countries, WHO organized a five-day workshop titled, "*Workshop to Accelerate*

The Three 'I's:

Isoniazid preventive treatment (IPT), Intensified case finding (ICF) for active TB, & TB Infection Control (IC), key public health strategies to decrease the impact of TB on people living with HIV.

the Implementation of The Three I's For HIV and TB". Namibia was represented by staff from National TB and Leprosy and HIV Programmes of the MoHSS, USAID and WHO. At the end of the workshop, participating countries developed a draft plan of action on accelerating the implementation of the Three I's. The Three I's, IPT, ICF for active TB, and TB IC, are a key public health strategy to decrease the impact of TB on people living with HIV.

WHO also assisted in the development of a proposal titled "Demonstrating TB prevention, screening, diagnosis and care to scale in PEPFAR-supported sites". The proposal is expected to secure funding from PEPFAR, which amounts to nearly US$ 7 million. If successful, the proposal will enable MoHSS to strengthen the existing coordinating bodies at national and sub-national levels for the implementation of the Three I's in the four selected districts; expand phased implementation of TB-Intensified Case Finding and IPT for PLHIV in 79 health facilities in the selected districts; expand the implementation of TB Infection Control, expand the implementation of TB-ICF and TB-IC among PLHIV in community settings; and provide rapid TB diagnostic tests for all PLHIV who are TB suspects in the selected districts.

Capacity Building on TB Drug Resistance

TB Drug Resistance is posing serious financial and programmatic challenges in several countries around the world. Namibia is no exception to this problem. A workshop on TB Drug Resistance, Surveillance, Recording and Reporting was held from 30 to 31 May 2011 in Rwanda for National TB Programme staff from selected Anglophone countries. Namibia was among the selected countries and two MoHSS staff were trained in this workshop. In addition, two programme personnel from the NTLP, one staff from Katutura TB Unit and another one from the Namibian Institute of Pathology (NIP) were trained on Programmatic Management of Drug Resistant TB (PMDR-TB) in Kigali, Rwanda from 30 May to 3 June 2011. The purpose of the workshop was to help participating countries develop expansion plans for PMDR-TB.

WHO supported the MoHSS, National TB and Leprosy Programme to strengthen TB infection control and patient tracing mechanism to reduce Drug Resistant TB (DR TB)

Workshop on TB Technical Assistance Planning

WHO supported a workshop on TB Technical Assistance Planning, including on Global Fund supported activities, in the African Region, in Harare, Zimbabwe, from 30 November to 2 December 2011. Twenty seven countries from the WHO African Region participated in the workshop. Namibia was represented by one staff member from the NTLP and the Disease Prevention and Control (DPC) Officer from WHO Country Office. The objectives of the workshop were five-fold:

- Provide participants with an overview of TBTEAM, Global Fund Technical Assistance (TA) plans,
- Technical assistance planning at country level;
- Update participants on latest developments in the Stop TB strategy and link to technical assistance;
- Review existing country and regional TBTEAM plans for technical assistance for 2011 – 2012, and;
- Develop/update country specific and regional TBTEAM technical assistance plans for the period 2011 – 2013.

As part of the outcomes of the workshop, Namibia prepared and submitted a TB Technical Assistance Plan. The plan identifies programmatic areas requiring support and mapped-out the current support received from other partners. This plan allows for better prioritization, planning and coordination of technical support to countries at regional and global levels.

Cross Border Meeting with Angola on TB

Namibia and Angola share a long border, with active cross-border movement related to economic activities, health care seeking, educational opportunities, etc. This generates the need for strengthened collaboration between the two governments, particularly on health issues. To this end and at the request of national authorities, the WHO Representative accompanied the Honourable Minister of Health and Social Services on a visit to Angola, to discuss cross border collaboration to tackle drug resistance TB and other health challenges.

Similarly, a cross-border meeting was held between Angola and Namibia on 23 March 2011, on the eve of the 2011 World TB Day commemorations. Health and Home Affairs officials from Namibia and Angola met to discuss interventions to improve and sustain efforts towards reducing the spread of TB along its common border regions.

Global Fund Round 10 TB Proposal

WHO provided support in the revision of the Global Fund Round 10 TB Proposal based on the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM)'s 2nd Round Technical Review Panel requirements. The total budget of the Round 10 amounts to about USD 32 million over a five-year period.

National TB and Leprosy Steering Committee Meeting

WCO is a member of the National TB and Leprosy Steering Committee, where implementing partners and the NTLP shares progress reports, highlights challenges and identifies mechanisms to address them. One of the focus of the Steering Committee is on community-based TB management approaches. At the October meeting, poster presentations were made on: "*Using NGOs to implement community-based TB care in Namibia*"; "*Management of DR-TB among the San community*"; Update on CESTAS (new NGO working on TB)' activities; and "*Desert Soul Booklet on TB*". Discussions were also held on how to deal with patient refusal of treatment, particularly patients with DR TB.

3.2.2 Malaria

Micro-planning Meeting for Malaria Elimination Countries

Three Malaria Control Programme staff from the MoHSS and WHO took part in the Malaria Micro-planning Meeting for Malaria

Elimination Countries, held from 27 to 29 September 2011 in Harare, Zimbabwe, organized by IST/MAL. The objectives of the workshop were to:

- Review surveillance data for the last 12 months,
- Identify key gaps in data and propose changes in implementation and management;
- Develop plans to strengthen malaria surveillance and implementation for achieving malaria pre-elimination/elimination, and;
- Agree on a monitoring plan, (quarterly follow-up) for each of the four elimination countries.

The following goals for malaria elimination in the four countries were defined and agreed upon: Botswana and Swaziland to achieve zero malaria deaths in 12 months and zero cases in 24 months' time; while Namibia and South Africa would achieve zero malaria deaths in 24 months' time. The elimination countries amended their annual operational plans based on the recommendations of the meeting. A follow-up meeting is scheduled for February 2012.

Trans-Kunene Malaria Initiative (TKMI) Partnership

Namibia's and Angola's Health Ministers with support from WCO Namibia and Angola, the RBM partnership Secretariat, the Global Health Group from the University of California, San Francisco (UCSF) and the Southern Africa Malaria Elimination Support Team (SAMEST) entered into a partnership to curb the malaria burden along the common border by signing a historical Memorandum of Understanding (MoU) that launched the Trans-Kunene Malaria Initiative (TKMI). The MoU aims to strengthen cross-border collaboration to reduce malaria transmission to zero in the Trans-Kunene region comprised of Cunene and Namibe provinces in Angola and Kunene, Ohangwena, Omusati regions in Namibia.

The TKMI agreement drafted under the technical guidance and coordination of WHO Namibia and Angola country offices, the SADC Health Desk, the Roll Back Malaria Partnership's Southern Africa Network (SARN), the Global Health Group, UCSF and SAMEST addresses many of the challenges faced by the two countries, by proposing common preventive malaria strategies. Under

Left to Right: Namibia's WHO Representative, Dr Magda Robalo observes Namibia's Minister of Health and Social Services, Dr Richard N. Kamwi as he signs the historical agreement. Simultaneously, Angola's WHO Representative a.i. Dr Rui Vaz watches Angola's Minister of Health Dr José Van Dúnem signing.

this agreement, both countries commit to standardize and synchronize malaria control interventions such as Indoor Residual Spraying (IRS), distribution of mosquito nets and early treatment of malaria cases with effective antimalarial medicines. Capacity building, health promotion, surveillance, monitoring and evaluation are cross cutting interventions to be implemented as well.

WHO committed to rend technical advisory services to both health ministries in establishing the TKMI's governance and management structures to ensure its operationalization. Additionally, WHO will assist in developing a common disease surveillance system for the timely detection and control of malaria epidemics; support IRS, mosquito net distribution and targeted larviciding.

Revision of Malaria Policy

The National Vector-borne Diseases Control Programme (NVDCP) organized a workshop from 17 to 21 October 2011 to develop a draft document of a revised Malaria Policy, with support and facilitation from WCO. Organizations that also participated in this exercise included the Clinton Health Access Initiative (CHAI), Society for Family Health (SFH), Development Aid from People-to-People (DAPP) and Namibia Defence Force (NDF).

Participants work on revising the malaria policy and guidelines in view of implementing the pre-elimination strategy

The revision of the policy was necessitated by the Namibia's decision to achieve malaria pre-elimination by 2016 and elimination by 2020. This was supported by the SADC decision and subsequent External Malaria Programme Review which was carried out in July 2010.

Major areas amended in the policy include surveillance, criteria for malaria diagnosis and management at different levels and application of vector control interventions in the different malaria transmission zones.

GFATM National Strategy Application

The WCO played a pivotal role in the preparation and submission of an Expression of Interest (EoI) to the 2nd National Strategy Application launched by the GFATM. The Namibian Country Coordination Mechanism (CCM)-NaCCATuM (Namibia Coordination Committee for AIDS, Tuberculosis and Malaria) - designated WHO as Chair of the working group tasked to elaborate the EoI on the two eligible disease components: HIV/AIDS and Malaria.

Namibia was successful with its National Strategy Application EoI for Malaria. Hence, it started preparing for the Joint Assessment by an independent team. WCO was again entrusted by the NaCCATuM to lead preparations for the Joint National Assessment Organizing Body (JNAOB). The team and leader for the JNAOB were identified and endorsed by the NaCCATuM. Three members of the JNAOB attended a two-day orientation meeting organized by

WHO and partners supported the MoHSS to develop advocacy, communications and behaviour change strategy, the "Wipe-Out Malaria" campaign.

the GFATM in Geneva from 23 to 24 May 2011 and the Joint Assessment mission was undertaken from 8 to 19 August 2011. The mission's findings informed the development of a proposal to the GFATM and other donors, to address identified gaps.

Some of the weaknesses identified during the Joint Assessment include the following:

- The strategic plan objectives do not cover the period after 2016 when malaria pre-elimination is due to be completed,
- Detailed programmatic gap analysis is lacking;
- Lack of a clear systematic approach to deal with malaria in urban areas; and
- Non-enforcement of mandatory reporting by private-for profit health sector facilities.

Malaria Advocacy, Communications and Behaviour Change Strategy

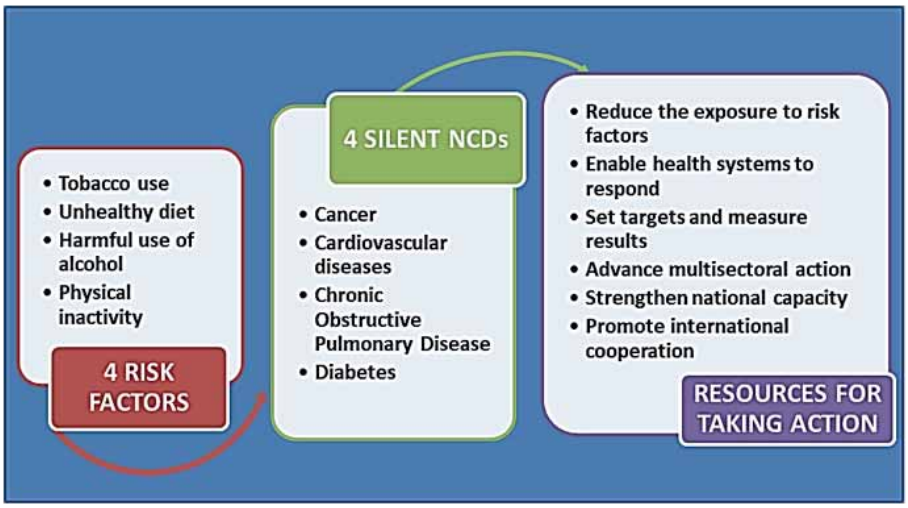
Namibia is among twelve countries, mostly in southern Africa, which has recorded more than a 50% reduction in malaria cases and deaths at health facilities. Consequently, Namibia is one of the countries identified for potential malaria elimination. To reach the goal of malaria elimination, the NVDCP, with support from WHO, SAMEST and other local partners, has developed a National Elimination Strategy to reduce local malaria transmission to zero.

To support these efforts, the WCO is supporting the MoHSS to implement a communications, advocacy and behaviour change strategy. The "Wipe-Out Malaria" campaign promotes three key malaria prevention and treatment measures namely, use of Insecticide Treated Nets (ITNs), IRS, and prompt testing for all suspected malaria cases followed by appropriate treatment. Various communication materials (pamphlets, radio, and community dialogue sessions) are being developed and tested to increase awareness about malaria control. The findings of the Malaria Indicator Survey (MIS) conducted in 2009 informed the development of evidence-based advocacy, communications and behaviour change interventions, as well as key messages and actions required to scale-up malaria prevention and control efforts.

3.2.3 Noncommunicable Diseases

Amidst global and national evidence of Noncommunicable Diseases (NCD) devastating impact on the health of people and economies, Namibia is taking measures to stem the rise of NCD. On the 20th September 2011, President Hifikepunye Pohamba speaking at the UN General Assembly's High-level Meeting on the Prevention and Control of NCD in New York, appealed for financial and technical support from the international community to accelerate the country's existing efforts to overcome the challenges of NCD.

Tackling NCD – A Holistic Approach



Given evidence of the rising toll of NCD, largely due to unhealthy lifestyles, Namibia is putting in place a number of programs to reduce the underlying causes of NCD. Most importantly, the restructuring of the health system is serving as an important opportunity to build synergies among programs such as the NCD, Tobacco Control Programme, Information, Education and Communication (IEC), Health Promotion, school health and community based-programs.

In addition, planned activities such as the development of the NCD strategy and training in management and control of major NCD in particular diabetes are expected to facilitate the implementation of community-based interventions addressing the modifiable risk factors for NCD.

Noncommunicable Diseases (NCD) Task Force and Strategy

WHO supported and facilitated the establishment of an integrated NCD Task force, under the leadership of the MoHSS. The functions of the Task Force ensure an integrated, multi-sectoral and coordinated approach to NCD prevention and control.

With support from WHO and Novo-Nordisk Diabetes Company, the MoHSS brought together about fifty public and private healthcare providers to draft a NCD strategy to stem the rise of an NCD epidemic in the country. The development of the NCD Strategy also provided health care workers with the latest knowledge on diabetes treatment, care and management.

Namibia Tobacco Products Control Act

The Namibia Tobacco Products Control Act (Act number 1 of 2010), is soon expected to come into operation. In preparation for this, from 10 to 12 May 2011, the MoHSS with technical and financial support from the WHO conducted a training workshop for over forty officials representing a wide-range of stakeholders who will be designated as Tobacco Products Control Inspectors to enforce the smoke-free public place policy. The overall objective of the training workshop was to provide participants with knowledge on the Act and to train them on the enforcement tools that include among others, inspections, penalties, litigations and reporting obligations.

WHO Representative, Dr Magda Robalo and Honourable Deputy Minister, MoHSS, Petrina Haingura and facilitators from the WCO and Regional Office at the training of Government officials on Tobacco Regulations Enforcement.

The number of road traffic fatalities and injuries have been recorded at 275 (2008), 525 (2009) and 539 (2010).

Injuries follow the same increasing trend as deaths at 1290 (2008), 3538 (2009) and 5125 (2010).

Road traffic accidents are due to a combination of factors stemming from infrastructure and road user behaviours such as poor road conditions, vehicle mechanical failures, high speed and drunk-driving.
(Annual Report on Road Crashes and MVA Fund Claims, 2010).

Fatal crash

Police conduct road safety campaign

Pole position

High road accidents a concern - minister

Petrol cowboy

Man dies in car accident

Road accident victims identified

Road Safety

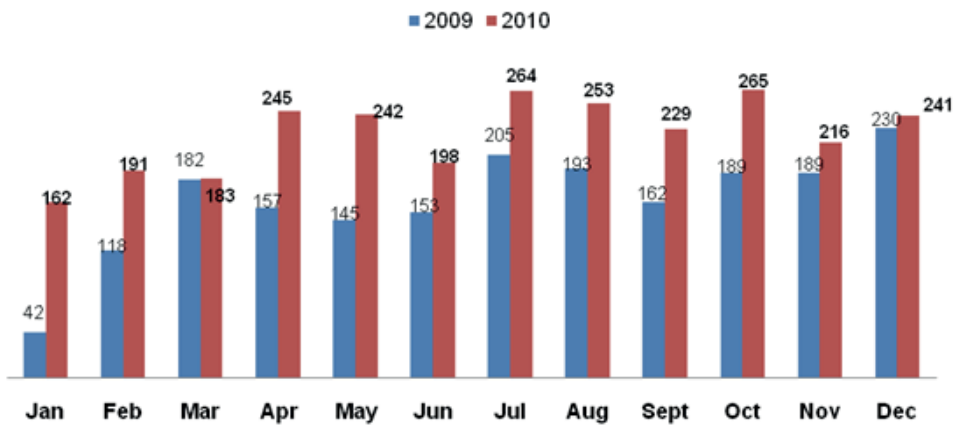
With an estimated population of 2.1 million and a vehicle population of 249,421 in 2010 (up from 229,806 in 2009), Namibia is recording increasing numbers of road traffic fatalities and injuries (Figure 5).

WHO provided technical and catalytic financial support to the Government to adopt the Global Plan of Action for Road Safety 2011 – 2020. Accordingly, on 11 May 2011, Namibia along with more than 150 countries worldwide launched the Global Decade of Action for Road Safety by initiating the Namibian Chapter of the Decade of Action 2011-2020, developed by the National Road Safety Council (NRSC) in collaboration with WHO, the Motor Vehicle Accident (MVA) Fund and other stakeholders.

To symbolize the launch, a special commemorative postage stamp produced in collaboration with Namibia Postal Services (NamPost) was unveiled. The launch was followed by the formation of sectoral working groups. Key components of Namibia's strategy focus on education and enforcement. The purpose of education is to change mind-sets, attitudes and behaviours to create a deep-rooted culture of road safety among all road-users. Another strong pillar of Namibia's strategy relates to enforcing compliance to legislation, regulations and standards to ensure behaviour change and prevent road traffic crashes and deaths.

WHO Representative Dr Magda Robalo, Minister of Works and Transport, Honourable Erkki Nghitima and officials from MVA, NamPost and NRSC at the launch of the Decade of Action for Road Safety.

Figure 5: Motor Vehicle Crash Trend by Month, 2009 - 2010



Source: MVA Namibia

3.3 Maternal, Newborn, Child and Adolescent Health

3.3.1 Emergency Obstetric and Neonatal Care

Capacity Building for Emergency Obstetric and Newborn Care

Developing and/or strengthening the capacity of health workers is one of the six pillars of health systems strengthening strategy. Despite Namibia's high rates of deliveries at health facilities - 81.4% - there is inadequate progress to achieve MDG 4 and 5, mainly due to systems bottlenecks related to quality service provision, among others.

WHO and partners trained **26** health workers as trainers for Life Saving Skills (LSS)/EmONC.

These trainers conducted **3** training sessions

Trained a total of **64** health workers

Her Excellency the First Lady of the Republic of Namibia Madam Penehupifo Pohamba and Hon. Minister of Health & Social Services of Namibia with the LSS/EmONC Trainers from American College of Nurses and Midwives.

Life Saving Skills (LSS/EmONC) Trainees in Practical Training session.

As part of strengthening the knowledge and skills of doctors, nurses and nurse-midwives, the WHO in collaboration with UNFPA, USAID, CDC, UNICEF and the GFATM and under the leadership of the MoHSS, trained 26 doctors, nurses and midwives as trainers for Life Saving Skills (LSS)/EmONC. These trainers have in turn conducted three training sessions in 2011 and trained a total of 64 health workers. The training is expected to improve the quality of services provided to pregnant women and their newborns. The plan is to have at least one LSS/EmONC trained health worker in every facility by 2014.

Revision of Scope of Work of Nurses and Midwives to Provide EmONC

Only four out of 34 hospitals provide comprehensive Emergency Obstetric Care (EmOC) according to an assessment conducted in 2006. The assessment also revealed that health workers had inadequate training in life saving emergency obstetric care. Therefore, clinics and health centres were not able to provide EmOC interventions required to save pregnant women and newborns's lives.

One of the reasons for not providing basic EmOC services is that the scope of work of nurses and midwives is very restrictive. This implies that the role of lower level health facilities is to refer pregnant women in need of basic emergency care to higher levels of care, mainly to hospitals. WHO Namibia Country Office, in collaboration with other partners is advocating for the revision/broadening of the scope of work of nurses and midwives to provide basic Emergency Obstetric and Neonatal care services. The Health Professions Council supports this revision and is willing to support recommendations that nurses and midwives perform life-saving interventions at lower level health facilities, provided that all the requirements are met.

Assessment of Maternity Waiting Homes

One of the strategies to bridge the geographical barrier to access basic and comprehensive EmONC in Namibia is the establishment/construction of Maternity Waiting Homes (MWH). While MWH do exist, their accessibility and the quality of services they provide have not been determined. Consequently, WHO Namibia supported the MoHSS conduct an assessment of existing MWH in the country. Throughout this assessment exercise, the partnership between the MoHSS, WHO, UNFPA, Namibian Planned Parenthood Association (NAPPA) and other partners was exemplary. The assessment was supported through the UNAIDS Programme Acceleration Fund (PAF-B). Data entry and analysis is in progress.

WHO in collaboration with its partners conducted a Maternity Waiting Homes (MWH) assessment to determine access to and quality of services provided to pregnant mothers. MWH aim to ensure that expecting mothers are closer to health facilities to prevent women and/or their babies from dying during childbirth.

3.3.2 Maternal and Neonatal Death Reviews

Beyond the numbers

Advocacy for Maternal and Neonatal Deaths to be notified has been successful and maternal and neonatal death notification is included in the draft Public and Environmental Health Bill. However, its implementation will require continuous advocacy and sensitization among decision-makers and implementers respectively.

A National Maternal, Peri and Neonatal Death Review (NMPNDR) Committee has been established to investigate the occurrence of maternal, peri-natal and neonatal deaths and identify remedial actions. Every maternal, peri and neonatal death at a health facility must be reported within seven days and investigated, with the aim of learning lessons from and improve on the management of complicated pregnancy and childbirth situations.

On 9 and 10 May 2011, the committee met to review all reported maternal, peri and neonatal deaths in the country. Findings from this review indicated knowledge and skills gaps of health workers to manage emergency obstetric and neonatal care, delay in getting services in the facilities, lack of adherence to protocols of maternal and neonatal care; lack of medicines; inadequate teamwork; poor management; improper recording and reporting and delays in referral. The committee is reviewing strategies to be undertaken at facility and community-level to prevent the occurrence of these unavoidable deaths.

The meeting concluded with a development of Regional Short-Term Action Plans to improve the NMPNDR process and implementation of recommendations of the review. The recommendations include improving knowledge and skills of health workers, inclusion of the goals, objectives and interventions of the Road Map for acceleration of maternal and neonatal deaths reduction into the Regional plans.

Coupled with this, supportive supervision and a national meeting were conducted to discuss the committee's findings and analysis of the causes of deaths. The committee presented and discussed its recommendations. A number of resolutions were passed to address the challenges and underlying causes of these deaths.

Training of health workers on the use of Maternal and Peri-Natal Death Review forms and guidelines was also undertaken in all regions. Different methodologies of Maternal and Peri-Natal Death Review were presented to the Regional and District Health Management and staff.

The NMPNDR committee recommended an urgent field visit to work with those regions that are not completing the standard guideline for reporting deaths. The supportive supervisory visits were conducted from 20 June to 2 July 2011. The WHO MCH officer delivered a presentation on WHO guidelines entitled, *Beyond the Numbers: Reviewing Maternal Deaths and Complications to Make Pregnancy Safer.* Feedback on the recommendations of the National Committee were discussed with the Regional, District and Health Facility MPNDR Committees. Various challenges were addressed and recommendations drawn. Some districts and hospitals did not have a MPNDR committee. The team advised all districts and hospitals to establish MPNDR Committees and report regularly to ensure timely availability of data and support for effective decision-making.

3.3.3 Integration of Reproductive Health and HIV/AIDS

Strengthening of PMTCT

Maternal and child health including Prevention of Mother-to-Child Transmission (PMTCT) of HIV continues to be a top priority for Namibia. On 10 March 2011, an unprecedented campaign against the HIV pandemic was launched by His Excellency the President of the Republic of Namibia and Her Excellency the First Lady Madame Penehupifo Pohamba in collaboration with the MoHSS, and partners such as the WHO, UNICEF, UNFPA, UNAIDS and CDC among others. The campaign aims to increase male involvement in the PMTCT of HIV. To reach zero transmission of HIV infection from mother to their newborn babies, this campaign addresses the missing link of male involvement. Research shows that father involvement in PMTCT, helps HIV positive mothers seek Antenatal Care (ANC), get tested earlier, improve adherence to PMTCT treatment and adopt safer infant feeding options. The campaign will, over a period of 10 months, encourage male partner involvement in ANC and access to PMTCT services before, during and after pregnancy. The campaign's slogan is *"An HIV-free tomorrow needs caring fathers today"*.

The goal of the PMTCT programme is to eliminate mother-to-child transmission of HIV by 2015. Namibia has made significant progress to reduce the transmission of HIV from mothers to their newborns. Most health facilities in the country provide PMTCT services although only half of them provide all four prongs of PMTCT. More than 90% of pregnant women are attending ANC and accessing PMTCT services. It is estimated that the HIV transmission from mothers to newborn children has reduced by almost 50% in just two years from 13.4% in 2006/07 to 7.0% in 2008/09. This indicates that PMTCT interventions are suceeding in getting parents to start PMTCT services early, adhere to treatment, lead a healthy lifestyle and give birth to an HIV-free baby.

Adding further impetus to this endeavour, the MoHSS revised the PMTCT guidelines in line with the WHO's 2009 revised Rapid Advice principles and recommendations of 2010. The MoHSS in collaboration with its partners are in the process of developing a Mother-To-Child Transmission elimination (e-MTCT) strategy.

His Excellency, President of the Republic of Namibia, Dr Hifikepunye Pohamba and the First Lady of the Republic of Namibia Ms Penehupifo Pohamba unveils the campaign logo.

Dignitaries included from left to right: UNICEF Representative, Mr I. MacLeod, Minister of Health and Social Services, Dr R. Kamwi, H.E the President of Republic of Namibia Dr Hifikepunye Pohamba, First Lady, Ms P. Pohamba, WHO Representative, Dr M. Robalo, US Ambassador, Ms W. Nesbit and Governor of Khomas Region, Mr S. Nuuyoma.

3.3.4 Child Nutrition and IMNCI

Deworming campaign

WHO assisted the MoHSS in presenting the benefits of deworming as a quick gain to improve the nutritional status of children to the Namibian Alliance for Improved Nutrition (NAFIN), which is led by the Right Honourable Prime Minister. Following extensive advocacy by WHO and partners toward improving child nutrition and reducing mortality, Cabinet decided to include deworming in the National Immunization Days (NID) and provide supplementary feeding to all pregnant and lactating women. WHO in collaboration with other partners are supporting the MoHSS to devise interventions and programmes to implement the Cabinet decision.

Namibia's application for a donation of Albendazole tablets from Glaxo-Smith Kline (GSK) to conduct a deworming campaign for children aged 5 – 14 years was supported by WHO. The donation has been approved and received in response to the Global Memorandum of Understanding signed between WHO and GSK. WHO has extended to the MoHSS and Ministry of Education (MoE) its technical support for scaling-up the country's school based deworming programme in 2012.

WHO also supported the drafting of a guideline on deworming for health workers and managers, for use during mass deworming of children under-five years of age, during the NID Campaigns, as well as a tally sheet for recording and reporting on the distribution of Albendazole. Support was also extended for the development of Information, Education and Communication (IEC) materials, such as brochures on deworming as a means to orient the public on the importance and benefits of deworming. The brochure has been translated into the six main local languages. The pamphlet will be used to support further de-worming interventions at schools, supplementary immunization campaigns, health facilities and health outreach points.

A total of 27 MoHSS staff were oriented on Soil Transmitted Helminths control, the benefits of deworming, administration of Albendazole and reporting. A WHO newsletter with detailed facts on deworming and how to manage any adverse events following administration of Albendazole including a choked child was provided to the participants.

Nutrition Landscape Analysis

NAFIN, under the leadership of the Right Honourable Prime Minister has requested the MoHSS to convene and coordinate the implementation of the Nutrition Landscape Analysis (NLA) exercise. A team comprised of representatives from various ministries, UN agencies, USAID, CDC, UNAM and NAFIN worked together to develop the data collection tools.

WHO supported Namibia's application for a donation of Albendazole tablets from Glaxo-Smith Kline (GSK) to conduct deworming campaign for children aged 5 to 14 years.

A NLA adaptation meeting was organized from 19 – 23 September 2011 for twenty two staff from different line ministries, participating bilateral and multi-lateral organizations, UNAM and NGOs. Guidelines for enumerators conducting the NLA were adapted from the Global WHO tool, to assist the enumerators on how to conduct an interview during the fieldwork. The adaptation workshop was also an opportunity to train and sensitize different stakeholders on the current nutritional challenges in Namibia.

The Nutrition Landscape data collection was launched by the Right Honourable Prime Minister Nahas Angula on 3 November 2011. Four teams consisting of five to six personnel from various ministries, agencies and offices visited all regions to collect data. Data entry, analysis and report writing is in progress.

New WHO Growth Standard and Nutrition Surveillance

The WHO Namibia Country Office has technically supported the training of 26 health professionals from all thirteen regions of Namibia on the New WHO Growth Standard and Nutrition Surveillance in the period 28 November to 2 December 2011. The WHO growth standards are designed to assist in the identification of severe acute malnutrition in children six to sixty months of age.

IMNCI Adaptation Workshop

An IMNCI adaptation workshop to incorporate Streptococcal sore throat into the IMNCI tools and guidelines was organized in the period 26 – 30 October 2011. The adaptation process was also an opportunity to orient senior IMNCI facilitators on the current recommendations and on rheumatic fever and rheumatic heart diseases. Rheumatic heart diseases are believed to be frequent in Namibia. Fifteen senior facilitators of IMNCI and MoHSS staff attended the workshop.

WHO supported the training of 26 health professionals from all thirteen regions of Namibia on the New WHO Growth Standard and Nutrition Surveillance

3.3.5 Immunization

Namibia's 15th National Immunization Days (NID) campaign

WHO provided extensive technical support to Namibia's 15th National Immunization Days campaign. The campaign aimed to immunize 320,000 under five-year old children against polio and provide Vitamin A supplementation and deworming medicine.

More specifically, WHO provided technical support to EPI micro-planning, logistics procurement, development and implementation of communication and social mobilization strategies to inform the public about the NID. Technical support was also provided from IST/IVD and a total of thirty independent monitors were trained before the commencement of the campaign.

Minister of Health and Social Services, Dr R. Kamwi launches Namibia's 15th NID campaign by immunizing the first child.

Extra efforts were made to reach urban and remote areas where approximately three children out of ten are either unimmunized or underimmunized putting them at risk of vaccine preventable childhood illnesses. To this end, WHO provided technical support for the development of IEC material and media items, such as radio adverts, posters, e-newsletters, communiques and media releases. WHO also supported the MoHSS to expand its partnership base to include the Medical Association of Namibia (MAN), Glaxo Smith Kline (GSK), Rotary International, First National Bank, and Telecom Namibia among other partners to endorse and publicise the NID campaign to increase coverage. Given WHO's extensive advocacy, Rotary Windhoek, Namibia donated approximately, 3,000 T-Shirts for NID Quality monitors, 80 Megaphones and 8,000 pamphlets worth over N$240,000.00.

During Round One, the campaign reached 298,029 children (95% coverage). During Round Two, children received the second dose of OPV along with de-worming medication to improve their health

The NID campaign for both rounds achieved over 90% coverage, reaching over 300,000 children in the second round.

WHO supported various aspects of the NID campaign, from micro-planning to logistics, procurement, social mobilization and quality monitoring, to ensure that children were not missed and to verify the NID data.

WHO African Regional Director Dr Luis Sambo at the opening session of the 3rd Annual Regional Immunization Conference, in Windhoek, Namibia from 5 - 8 December 2011 under the theme: 'Towards a polio-free Africa'.

Members of Rotary Club in Namibia also attended the Annual Regional Immunization Conference and contributed funding for IEC and advocacy materials.

and nutritional status. The campaign reached 303,396 children (97% coverage) in Round 2. Of Namibia's 34 districts, twenty two achieved 95% coverage, up by seven districts when compared with fifteen districts in 2010.

The NID campaign is estimated to have cost the Namibian Government more than N$10 million (approximately one million Euros).

Third African Regional Conference on Immunization (ARCI)

Namibia hosted the 3rd African Regional Conference on Immunization (ARCI) titled, "*Towards a Polio-free Africa*" from 5 - 8 December 2011. The Conference brought together more than 250 participants from nearly fifty countries. The aim of the Conference was to review progress made to interrupting wild poliovirus transmission in priority countries and the remaining challenges faced in eradicating polio in the African region.

Concerted efforts will be made to strengthen both the technical and logistical aspects of immunization systems, such as the vaccine cold chain supply; sustainable immunization financing; disease surveillance; integrated communications and social mobilization towards reaching every last child. The WCO country office was instrumental in providing logistical, secretarial and media support to the Conference.

Reaching Every District Approach

Based on the NID review, persistent challenges related to reaching children in urban and very remote settings were identified. It was noted that more efforts are needed in advocacy and social mobilization to reach unimmunized and underimmunized children. To this end, IST/IVD and WCO supported the training on Reach Every District (RED) approach from 18 to 24 September 2011 in Otjiwarongo. Eleven out of the thirteen regions participated in this training. A session on Communications and Social Mobilization was included in the training, to increase

WHO's IST/IVD and WCO supported the training on Reach-Every District (RED) approach from 18 to 24 September 2011 in Otjiwarongo. The training aimed to improve NID planning, data capturing and social mobilization activities to reach all eligible children.

immunization coverage. While regions may have EPI plans, for the past years social mobilization and communication interventions and indicators have not been included in their plans.

Rotary International, Rotary Windhoek branch donation to improve immunization

On 30 September 2011 WHO received a generous donation worth over N$240,000 from Rotary Windhoek and Rotary International to improve the immunization status of children aged less than 5 years against vaccine preventable diseases, in particular polio. The donation consisting of loudspeakers, Information, Education, Communication (IEC) materials and T-shirts was handed over to WHO during a Rotary luncheon for members. The items are aimed at awareness raising and public health education on vaccine preventable diseases, particularly polio. The items will be used for social mobilization to increase not only routine immunization, but also for supplementary immunization campaigns such as Maternal and Child Health Days and the National Immunization Day 2012 Campaign.

WHO receives a generous donation worth over N$240,000 from Rotary Windhoek to improve immunization against childhood vaccine preventable diseases, especially polio. Photo left to right: Rotary Past President (PPE), Mr Stewart Aston, WHO Representative, Dr Magda Robalo and Rotary President, Mr Dirk Schuler.

Polio Surveillance

Polio Risk Analysis was done for the period, January 2008 to December 2010, to guide the surveillance team in determining the high risk districts to be visited.

WCO also supported the 7th Polio Technical Advisory Group (TAG) meeting which took place in Lusaka, Zambia with the participation of five countries namely Angola, Republic of Congo, Democratic Republic of Congo (DRC), Namibia and Zambia. Namibia was first invited to the TAG meeting in 2007 following the importation of Wild Polio Virus from Angola in 2006.

The 2011 meeting was attended by members of the TAG, senior staff of the Ministry of Health in Angola, Congo, DRC, Namibia and Zambia, and partners including UNICEF, WHO, Bill and Melinda Gates Foundation (BMGF), Rotary and USAID. The highlight of the discussions at the meeting were summarized in a communiqué on cross border collaboration signed by the various Ministers of Health or delegates. In this regard, the five countries agreed to synchronize dates for the 2011 NID.

To improve polio surveillance, continuous support is provided both to the routine immunization and surveillance data managers, especially in cleaning and updating of routine immunization data.

The WCO also successfully solicited for the support of a Stop Transmission of Polio (STOP) consultant through the CDC sponsored programme to support disease surveillance in the country during the first, second and last quarter of the year under review.

The WCO supported active surveillance visits to several high priority areas during the last quarter of the year through the field office in Oshakati as well as with the support of the STOP consultant. To this end, supportive supervisory visits were conducted in seven regions with the main focus on in-service training on poliomyelitis and Acute Flaccid Paralysis (AFP) and other vaccine preventable diseases.

Namibia achieved and maintained certification standard surveillance indicators for AFP surveillance with stool adequacy of 86% and a detection rate of 4.2 per 100 000 children aged below fifteen years.

Measles in Pregnancy Research

A research on the outcome of pregnancy among measles infected women was conducted in collaboration with CDC and WHO. Data entry was finalized, but data cleaning is still being done. Research results are expected to be available in 2012. Namibia experienced a measles outbreak that spanned from 2009 to 2011.

A total of about 5,000 cases and 30 deaths were recorded between August 2009 and February 2011, making it the largest measles outbreak in Namibia. In 2002, the country had registered a significant measles outbreak which recorded over 1,000 confirmed cases.

The 2009 – 2011 outbreak is reportedly due to an important reservoir of susceptible (unimmunized) individuals, accumulated over several years.

3.3.6 Coordination, Advocacy and Resource Mobilization

Coordination

The UN system has established a Maternal, Newborn, Child Health and Nutrition (UN-MNCH & Nutrition) Coordination Committee which is chaired by WHO. The committee is comprised of UNFPA, UNICEF and UNAIDS. The committee works to coordinate maternal, newborn, child health and nutrition programmes in support to the Government and partners.

Resource Mobilization

Several proposals have been developed and submitted for funding either directly or through the MoHSS. Resource mobilization efforts were undertaken over the past years to help improve maternal and child health in the country and strengthen health systems.

The European Union (EU) has responded favourably, further to the WHO's advocacy efforts. The EU's response was also in line with the positive outcomes of the midterm review of its programmes in the country and the EU global commitment to support achievement of the least progressing MDGs. These resources, estimated at 10 million Euros, will be channelled through a Contribution Agreement with WHO for implementing the Programe for Accelerated Reduction of Maternal and Child Mortality (PARMaC).

Funding has also been mobilized from various other organizations, in partnerships to implement MoHSS led activities.

Toolkit for Advocating and Mobilizing Resources for Maternal and Child Health Interventions

Through the National Management Committee on MCH, WHO provided leadership in the research and development of a toolkit for advocating and mobilizing resources for maternal and child health interventions. The toolkit, endorsed by the MoHSS in September 2011, highlights five priority interventions that require immediate financial and technical support from local communities, private sector, development partners and other stakeholders.

The toolkit covers the following areas:

1. Skilled birth attendance,
2. Maternity Waiting Homes;
3. Maternal and Perinatal Mortality Study;
4. Adolescent Friendly Health Services;
5. Institutionalization of Maternal and Perinatal/Neonatal Death Reviews.

The Minister of Health and Social Services is expected to officially introduce the toolkit to potential donors during the first quarter of 2012.

3.4 Promoting a Safer and Healthier Environment

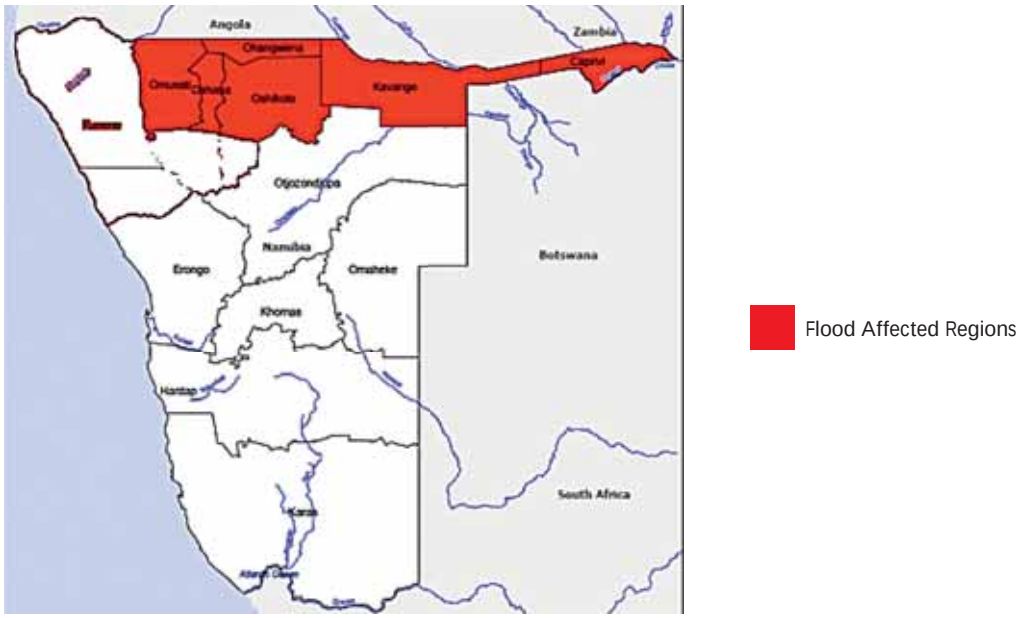
3.4.1 Emergency Risk Reduction, Preparedness and Response

Namibia has experienced a number of emergencies in recent years. In 2011, the country registered the occurrence of floods and disease outbreaks, notably Influenza H1N1 (2009) and measles.

Hon Minister of Health and Social Services and WHO Representative on a visit to flood affected areas to assess health damages.

The northern regions of the country where 60% of Namibia's estimated 2.2 million population lives remain the most vulnerable part.

Figure 6: Map of Namibia showing Flood Affected Regions in 2011



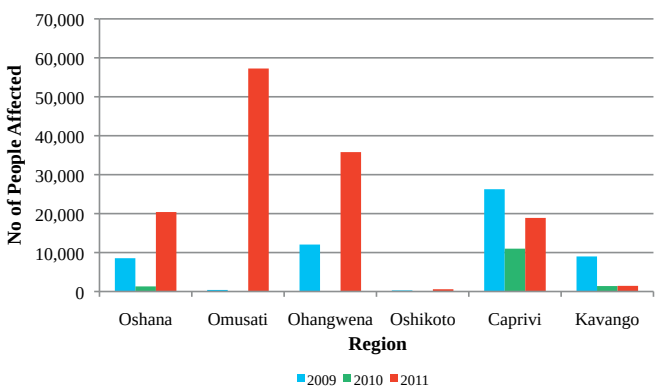
Source: FEMCO, 2011

Response to Floods

The 2011 floods began earlier than usual, with increasing magnitude, than that of 2009, along with higher water levels. Floodwaters haemorrhaged across six northern, north east and north west regions - Oshana, Ohangwena, Omusati, Oshikoto, Kavango and Caprivi - rendering several health facilities and health outreach points inaccessible. On 29 March 2011, His Excellency the President of the Republic of Namibia, Hifikepunye Pohamba declared a state of disaster in these regions.

More than 130,000 people were affected by the floods in the six regions with 17,555 relocated to 100 relocation centres. The number of people that drowned as a result of the floods was 111 in 2011 with 40% occurring in Oshana region. In 2009, floods affected 56,545 people and displaced 28,932 who were moved to relocation centres across the same six northern regions. There were 105 drownings during the 2009 floods.

Figure 7: Distribution of People Affected by Flood by Region in Namibia, 2009 – 2011



Source: FEMCO, 2011

At the peak of the floods in early April 2011, as many as forty health clinics and 180 outreach health points were rendered inaccessible in the regions of Oshana, Ohangwena, Omusati and Caprivi. Up to 56% of these inaccessible facilities and 40% of the cut-off outreach points were in Omusati region. As a result of this situation, delivery of basic health services such as immunization, Antenatal Care (ANC) and Postnatal Care (PNC), treatment and support for common illnesses and other diseases such as TB, HIV/AIDS, other chronic diseases such as hypertension and diabetes were affected.

There was also widespread destruction of food storage and crop fields rendering many households food insecure, thus increasing the risk of malnutrition among children. According to the Namibian Demographic and Health Survey (NDHS) 2006/07, approximately, 29% of children are stunted. Wasting is at 8% and underweight at 17%. The highest rates are in Kavango region with 39% stunting and the lowest is in Erongo with 22% of stunted children.

There has been repeated flooding since 2006. Through the development of flood contingency plans by the flood prone regions supported by WHO and other health partners, the government response has continued to improve. In 2011, WHO swiftly deployed technical experts to assist the Government. WHO experts from epidemiology, disease prevention and control, nutrition, public health and emergency health backgrounds supported the Government during the emergency and early recovery phases; they provided assistance with rapid health assessments, disease surveillance and control, emergency response and recovery plans, and other interventions.

WHO was engaged in the joint Government/ United Nations/ Namibian Red Cross Society (NRCS)/ other partners' rapid needs assessment conducted from 5 to 9 April 2011. WHO staff, were deployed to support the assessment in some of the severely flood affected regions of Caprivi, Ohangwena and Oshana.

WHO received USD250,915 from the UN Central Emergency Response Fund (CERF) to respond to the health impact of the 2011 floods. The funds were used to provide technical support and training to 92 NRCS community volunteers and fifteen MoHSS volunteers on health promotion and basic disease surveillance in Caprivi, Kavango and Omusati regions. These community trained volunteers are to support hygiene promotion, early detection and reporting of disease occurrence

NRCS, Executive Secretary, Ms Dorcas Kapembe-Haiduwa and WHO Representative to Namibia, Dr Magda Robalo partner in health response through training of 200 Red Cross volunteers to avert disease outbreaks.

Role Play NRCS Volunteers training, Katima Mulilo, Caprivi Region, 6 July 2011.

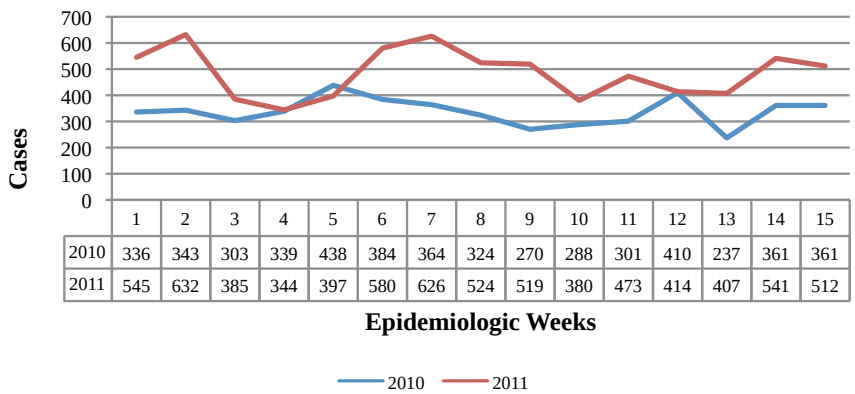
in their communities. Using the CERF funds, basic medical kits (two complete Interagency Diarrhoeal Disease Kit, ten Interagency Emergency Health Kits (IEHK) and one Supplementary Interagency Emergency Health Kit (IEHK)) were procured. The funds were also used to procure 6,000 ITNs to support MoHSS replenish its stock of ITNs which it had to distribute to children under five years of age and pregnant women in order to protect them from malaria during the floods.

In order to ensure early detection of and timely response to disease outbreaks, WHO closely monitored diseases of epidemic potential, such as diarrhoea, malaria, measles and meningitis, particularly in the six flood prone regions. Support was also provided for the analysis of surveillance health data from the regions.

Diarrhoea is one of the top five common causes of morbidity attended to at the outpatient departments in Namibia which is partly due to poor sanitation coverage and low use of latrines for faecal disposal. There were up to 20,555 cases of watery diarrhoea reported between January to April 2011 compared to 22,744 cases in the same period in 2010 in the six flood affected northern regions. Although Ohangwena, Omusati, and Oshikoto reported a decrease in cases, Oshana and Kavango regions reported an increase of acute watery diarrhoea cases during January to April 2011 compared to the same period in 2010 as shown in the graph below for Kavango region. The data from the Caprivi region did not indicate any marked increase in the number of cases in 2011 compared to 2010. Health education, use of water purification sachets and provision of sanitation facilities in the relocation centres contributed to the control of diarrhoeal disease during the floods.

Malaria cases also showed a decrease, which is probably due to the robust NVDCP activities which include indoor residual spraying, distribution of ITNs and effective case management. Thus, following the 2011 floods there was no increase in malaria cases compared to the numbers reported in the same period in 2010.

Figure 8: Watery Diarrhoea Cases by Week, Kavango Region, 2010 - 2011



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
2010	336	343	303	339	438	384	364	324	270	288	301	410	237	361	361
2011	545	632	385	344	397	580	626	524	519	380	473	414	407	541	512

Source: MoHSS, Kavango Region

There were up to 20,555 cases of watery diarrhoea reported between January to April 2011 compared to 22,744 cases in the same period in 2010 in the six flood affected northern regions.

Emergency Preparedness

WHO and other UN agencies supported the Government in the development of a National Disaster Risk Management Plan (NDRMP) and an Emergency Management Operational Procedure (EMOP) Manual. A consultative workshop was organized from 16 to 18 November 2011 to review the two documents. The workshop was coordinated by the Disaster Risk Management Directorate of the Office of the Prime Minister and attracted over 60 participants drawn from various stakeholder institutions including Ministries, Departments and Agencies, Regional Councils, Municipalities, the Red Cross and the United Nations Agencies.

WHO Representative Dr Magda Robalo hands over emergency health supplies to the Honorable Minister of Health and Social Services, Dr Richard N. Kamwi.

The NDRMP provides national guidance on disaster management to national, regional, local governments, business and community leaders and civil society organizations with tools to standardize and regulate the practice and management of disaster prevention, preparedness, response and recovery operations at all levels.

The EMOP are a set of standard procedures that operationalize the disaster response and/or contingency plans when responding to, and dealing with, a range of emergencies that may impact on Namibia. According to the plan, WHO is a member of the Health and Nutrition cluster, led by the MoHSS.

Ahead of the rainy season, WHO officially handed-over emergency medical supplies to the MoHSS on Monday 28th November 2011 at the Central Medical Stores in Windhoek. The medical supplies consisted of emergency health kits and medical supplies for diarrhoeal diseases and water testing kits. The WHO consignment is part of prepositioning of emergency medicines and supplies to enhance emergency preparedness and response capacity of the MoHSS. The donated items will be distributed to the regions where vulnerable populations and those potentially at risk (children under five years of age, pregnant woman, the elderly, among others) will benefit.

3.4.2 International Health Regulations (2005)

The International Health Regulations (IHR) is a legally binding international agreement whose purpose is "to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health

risks, and which avoid unnecessary interference with international traffic and trade."

The IHR (2005) has a broadened scope to include any event of international public health concern and is not limited to communicable diseases with epidemic and pandemic potential but may include emergencies due to contamination with toxins, chemicals or radioactive material due to industrial leaks or intentional release.

Member countries of WHO or State Parties are required to develop certain minimum core public health capacities to enable them detect and to notify WHO, and respond to all events that may constitute a Public Health Emergency of International Concern (PHEIC). The State Parties are expected to fully implement the IHR (2005) by 2012. In Namibia, as well as in other member states in the African Region, it is recommended that the IHR (2005) be implemented within the Integrated Disease Surveillance and Response (IDSR) framework. Both the IDSR and IHR (2005) share common functions such as detection, reporting, confirmation, verification, notification and timely response.

Revision of IDSR Technical Guidelines

MoHSS was supported to revise the existing IDSR technical guidelines which were developed in 2003. The revision became necessary as there are emerging diseases and conditions that were not addressed in the old guidelines. The purpose of the revision was to update existing information to include other priority diseases, conditions and public health events as well as ensure alignment with the IHR (2005).

Inter-Country Meeting on Cross Border Public Health Issues

WHO supported the participation of a Namibia delegation at a cross-border meeting held in Zambia from 14 to 18 March 2011. The meeting was attended by the respective Ministers of Health from five countries (Angola, Congo, DRC, Namibia and Zambia). Discussions were held on health issues related to cross-border activities such as cholera, polio, counterfeit drugs and Primary Health Care.

The ministers present at the meeting acknowledged the role of population movement coupled with poor sanitation and inadequate availability of drinking water in the transmission of cholera, poliomyelitis and other diseases, as well as the increasing circulation, use and proliferation of fake and counterfeit medicines. They collectively agreed to take action in their respective countries, in collaboration with other line Ministries, but also across commonly shared borders, to tackle the challenges identified.

Measles outbreaks

Measles cases have continued to be sporadically reported since the 2002 outbreak. In 2011, 881 suspected measles cases were reported in all thirteen regions. The Kavango and Caprivi regions were the most adversely affected. In Caprivi region, confirmed outbreaks were reported from Katima Mulilo district with 51 cases. In Kavango region, Andara and Rundu districts reported 18 and 63 cases respectively, which contributed to 15% of the total number of suspected cases (881) reported. There were no measles related deaths recorded.

The response to the outbreaks involved early case detection with appropriate case management including administration of vitamin A and intensification of routine vaccination. There was no mass or selective mass vaccination campaigns conducted in the affected districts.

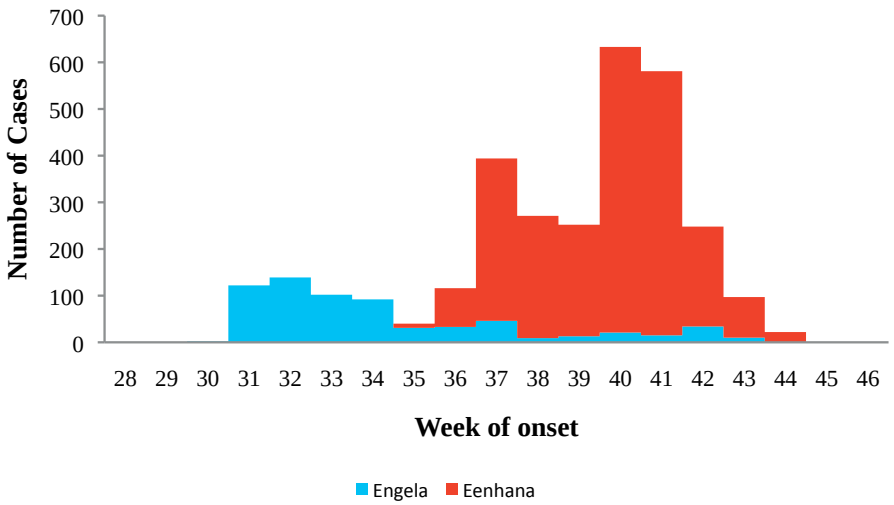
H1N1 (2009) outbreaks

Since the emergence of the Influenza H1N1 (2009) pandemic in 2009, Namibia has continued to report cases of the disease. In 2009, 72 confirmed cases with one death were recorded. In 2010, particularly during the post-pandemic period, the country experienced outbreaks of the virus, in 13

districts from eight regions with a total of 9,069 suspected cases of which 102 were confirmed from 139 samples tested. One death was reported. These cases occurred mainly in closed settings such as schools.

In 2011, a total of 3,155 cases were recorded throughout Namibia. The outbreak peaked during week 31 in Ohangwena region, Engela district. As at week 33, three cases were laboratory confirmed from Engela district and an outbreak was declared. Due to population movement within the country the disease continued to spread. Another cluster was detected in Eenhana district, an adjacent district to Engela with seven cases laboratory confirmed during week 37. The outbreak in Eenhana had the higher peak. A total of 2,442 cases recorded in Eenhana and 669 from Engela contributed to 98.6 % of the total number of cases in 2011. The majority of the cases (over 75%) were among people aged below 21 years.

Figure 9: Epidemic Curve of H1N1 Outbreaks, Engela and Eenhana districts, Jul - Nov 2011



Source: Epidemiology Division, MoHSS, 2011

The Epidemiology Division of the MoHSS and WHO provided support to the districts in their response to the outbreaks. WHO supported the MoHSS with technical guidelines, monitoring and guidance during National Health Emergency Management Committee meetings.

There was no H1N1 related death in any of the districts. This could be attributed to the improved level of preparedness, improved logistics, improved level of awareness about the disease in the population and excellent case management.

3.4.3 Environmental Health

WCO in collaboration with WHO HQ and the MoHSS organized a training workshop for medical doctors on Occupational Health and Safety from 14 to 15 February 2011, in Swakopmund, Erongo

region. The first week focused on occupational medicine and the second week on occupational hygiene. Fifteen Principal Medical Officers (PMOs) from all regions attended the training workshop.

The absence of focal points for occupational health at regional and district levels was recognized as a serious gap in executing the responsibilities of the MoHSS as stipulated in the Labour Act of 1992 which was later amended in 2007.

During the mission, WHO/HQ supported the review of the roles and responsibilities of the MoHSS as outlined in the Labour Act. Following the review, specific recommendations were made to assist in reorganizing the MoHSS, in order to enable it to execute its regulatory functions and fulfil its obligation as an employer. The current organizational setup does not make any distinction between these two functions.

3.4.4 Health Promotion

International Nurses Day

Namibia commemorated International Nurses Day (IND) 2011 on 3 June 2011 under the theme, *Closing the Gap, Ensuring Equitable and Accessible Care.* The theme focused on the important role of nurses in ensuring equitable and accessible healthcare. Good health access and equity exists when patients can get the right service at the right time in the right place. Gobabis, Rehoboth and Okahandja regions participated in the national event. WHO supported the event with technical, media and event management support.

The ability to access health services is critical for improving the health, well-being and life expectancy of all. Yet, achieving this fundamental requirement remains limited by cost, language, proximity, policies and practices, as well as many other factors. Nurses are essential to improving equity and access to health care and adding quality to the outcome of care. Nurses have an important role in achieving health equity and developing a clear understanding of how the health sector can act to reduce health inequities.

International Nurses Day (IND) 2011 was commemorated under the theme, Closing the Gap, Ensuring Equitable and Accessible Care.

According to the MoHSS, the country has approximately 12,000 nurses for a population of about two million. For many communities, particularly those in rural areas, nurses are their first point of contact for health care and treatment. Thus, in keeping with the theme, the event was used to reach out to communities with mobile outreach services, health education, etc.

Awareness-raising workshop on the Key Determinants of Health

The MoHSS with technical and financial support from WCO and AFRO held a multi-sectoral awareness-raising workshop on the key determinants of health from 27 to 28 July 2011. More than 50 participants from several sectors gathered for the first time to examine the underlying factors or 'social determinants' contributing to ill-health in order to adequately address them.

Participants at the workshop were drawn from all the national and the thirteen regional directorates of the MoHSS, the National Planning Commission which is responsible for coordinating development

initiatives in the country, the Ministry of Education, Ministry of Gender Equality and Child Welfare, Ministry of Works and Transport, Ministry of Regional and Local Government, Housing and Rural Development, Ministry of Environment and Tourism, Civil Society Organizations, UN Agencies in Namibia and the media as well as mission hospitals and health services regulators and development consultants.

It was important to bring all these stakeholders together to discuss and chart the way forward as action on the social determinants of health requires a multi-prong approach and inter-sectoral collaboration that would result in "health in all policies" and the realization of the country's vision for health and the attainment of Vision 2030 and the MDGs.

Some of the invited ministries and agencies were given opportunity to highlight policies and actions within their respective domains that contribute to improving health and social wellbeing. The discussions and deliberations highlighted the need for increased collaboration, joint planning, monitoring and evaluation and a way forward or road map in addressing the social determinants of health in the country. The workshop was an important preparation for the Namibian delegation of senior officials that participated in the World Conference on Social Determinants of Health held in Rio de Janeiro, Brasil in October 2011.

During the same period, the MoHSS prepared, with technical support from WHO, a case study on the 2006 Polio outbreak for sharing experiences with participants at the 2011 World Conference on Social Determinants of Health. The Namibia case study was part of the background documentations for participants under the theme, "*Social Participation*" in addressing social determinants of health and also reflecting on issues of leadership, good governance for health and public-private partnership.

World Conference on Social Determinants

A delegation from Namibia participated in the World Conference on Social Determinants of Health (SDH) that took place from 19 to 21 October 2011 in Rio de Janeiro, Brasil. Background materials together with the outcome from the Conference were widely disseminated to partners and stakeholders. As a follow up to the SDH awareness workshop and the world conference, discussions are underway to explore the possibility of holding a one day meeting to share the outcomes from the Conference in early February 2012.

Participants from various sectors attended the workshop to develop multi-sectoral approaches to address the social determinants of health.

As part of the Kobe Call to Action, the City of Windhoek (CoW) with support from WHO Namibia and WHO IST/HPR hosted a capacity-building workshop on a Healthy Cities Initiative, which aims to improve urban health through adopting comprehensive and multi-sectoral approaches.

Capacity-building Workshop on the Healthy Cities Initiative

While cities and towns offer excellent opportunities for residents to benefit from education, health and social services and to optimize their health and quality of life, on the other hand health hazards resulting from poor housing conditions and inadequate access to safe water and sanitation are fuelling a range of health problems.

As part of the Kobe Call to Action and related local and international commitments, from 3 to 5 August 2011, the City of Windhoek (CoW) hosted a capacity-building workshop on the Healthy Cities Initiative, with technical support from the WCO and IST/HPR. The aim of the workshop was to increase understanding and knowledge on the determinants of health in particular to the most vulnerable urban groups.

Over 40 participants representing the members of the steering committee of the healthy city programme, other local authorities (villages, towns and municipalities) and relevant stakeholders participated in this workshop and adopted recommendations for action. The Healthy City Project (HCP) strategy advocates an inter-sectoral approach to health development that focuses on the environmental, social and economic determinants of health, and aims to put health issues onto urban agendas. Actions agreed on at the workshop include, developing a core team of master trainers on the healthy city program, facilitating the formation of a healthy city network with other municipalities and local authorities and ensuring that public policies are health enhancing.

A concept note for the training of trainers for the healthy cities program has been developed in collaboration with the City of Windhoek. Since the adoption of the Healthy Cities Initiative in 2006, the CoW has implemented a number of health promotion activities and has become an exemplary local authority in Namibia.

World Tuberculosis Day

World Tuberculosis (TB) Day, 24 March 2011 was marked by Namibia's first National TB Road show, *"On the Move against TB"* which culminated in the central event in Rundu, Kavango Region. The road show comprised of two TB convoys, one travelling from

the south and the other through the north. Over seventeen days the convoy travelled more than 4 000km, passing through twenty towns. The road show focused on two key messages: '*Coughing for 2 weeks? Get TESTED for TB!*' and '*On treatment for TB? COMPLETE it!*' The country is showing significant progress on the TB control front, with an 85% treatment success rate.

The persistent health threat posed by TB, particularly the DR TB cases has called on Namibia and neighboring governments to intensify efforts for cross border health collaboration to protect their citizens. On 23 March 2011, Health and Home Affairs officials from Namibia and Angola met to discuss the current TB situation along the border regions to sustain and improve efforts toward reducing the spread of TB.

Namibia's National TB Roadshow, "On the Move against TB" kicked off on 7 March 2011 and travelled throughout Namibia spreading TB messages.

Present at the high-level meeting were Honourable Minister of Health and Social Services, Dr Richard Nchabi Kamwi, Angolan Consul-General, Ms Judite Albino da Costa, WHO Representative Dr Magda Robalo and Ms Karla Fossand, Deputy Director of the USAID Health Office, as part of the panel discussion.

World Health Day

The MoHSS with support from WHO commemorated World Health Day (WHD) from 6 - 7 April 2011 under the theme *"Combat Medicine Resistance: "No action today, No cure tomorrow."* On 7 April 2011, a Public Awareness and Education Programme was held at Katutura State Hospital to sensitize the public about the importance of treatment adherence and completion in particular to TB, HIV and antibiotic medicines. On this occasion, WHO launched the Six Point Call for Action to halt the spread of medicine resistance by introducing a comprehensive policy package for use by countries and partners.

Prior to the main event, on 6th April 2011, a 'Health Professional Seminar' targeting nurses, doctors and pharmacists from government and private sector institutions and who are critical in the development and implementation of policies and practices needed to prevent and counter the emergence of Antimicrobial Resistance (AMR) was held at Windhoek Central Hospital.

To ensure high participation, WCO Namibia organized the Health Professional Seminar, so that registered and qualified health workers obtained Continuing Professional Development (CPD) points from the two health professional bodies, Medical Association of Namibia and the Health Professions Council of Namibia (HPCNA). To obtain the CPD points, the seminar was organized to include various presentations from qualified health workers/organizations

The Namibia Institute of Pathology (NIP) developed a test and those who successfully passed the test received certificates regarding the WHD AMR seminar. Of the ninety participants in attendance, seventy received certificates of their CPD points.

WHO Representative, Dr Magda Robalo speaks on the 6 point strategy to combat AMR during World Health Day.

As part of the World Health Day commemoration, WHO and partners organized a Health Professional seminar on the status of AMR in Namibia and ways to combat it. The event was attended by more than 70 health workers.

World Breastfeeding Week 2011

WCO provided technical, media, and logistical support to the MoHSS for World Breastfeeding Week (WBW). The event was commemorated on 3 August 2011 in Otjiwarongo under the theme *"Talk to me! Breastfeeding - a 3D Experience"*. The theme focused on communication as an essential part of protecting, promoting and supporting breastfeeding. This third dimension includes cross-generation, cross-sector, cross-gender, and cross-culture communication and encourages the sharing of knowledge

and experience, thus enabling wider outreach. WCO advocated strongly for messages on breastfeeding to be aligned to WHO's revised PMTCT guidelines and enhance the existing campaign on PMTCT and male involvement, launched and led by the First Lady.

On the occasion of World Breastfeeding Week, the Minister of Health and Social Services launched a number of revised policies, strategies and IEC material towards improving maternal and child health.

Healthy Lifestyles Day

The decision to commemorate Africa Healthy Lifestyles Day was adopted by the African Union (AU) Executive Council in July 2008 and adopted by the SADC Ministers of Health as SADC Healthy Lifestyles Day. Healthy Lifestyles Day was first launched by the Chairperson of the SADC Ministers of Health Committee in South Africa on 26 – 27 February 2010 under the theme, "*Walking for a Healthy Heart.*"

Similarly, Namibia launched the day last year on 17th November 2010 and commemorated the day for the second time on 25 February 2011 in Windhoek. In order to raise awareness about NCD and associated risk factors, over 1,500 people were screened for high blood pressure, diabetes, high blood cholesterol and other risk factors such as obesity (measures of Body Mass Index (BMI) and waist circumference were taken). WCO provided all round support for the successful commemoration of the day.

Healthy Lifestyles Day was used as an opportunity to raise awareness about the importance of health check-ups to determine health status and to take the necessary steps towards adopting healthy lifestyles.

World AIDS Day 2011

Namibia joined the rest of the world in commemorating World AIDS Day on 1 December 2011 under the theme "*Getting to Zero: Zero new HIV infections. Zero discrimination. Zero AIDS related deaths".*

The event brought together hundreds of Namibians from all walks of life, to remember those who have lost their lives to AIDS and re-commit to healthy lifestyles, including consistent use of condoms, abstinence and safe sex,to curb the AIDS toll and prevent new cases of HIV infection from occurring. The Honorable Minister of Health of Botswana, Reverend Dr John G. N. Seakgosing was a guest of honor and key speaker at the event.

In her remarks on behalf of the United Nations family in Namibia, the WHO Representative recalled the bold targets adopted by the United Nations General Assembly's High-Level Meeting on AIDS held in June 2011: reduce sexual transmission of HIV by half, eliminate new infections in children, provide treatment for 15 million people living with HIV, end stigma and discrimination and close the AIDS funding gap.

WHO Representative Dr Magda Robalo, UNICEF Representative a.i. Mr Juan Carlos Ayala and UNAIDS Country Coordinator Mr Henk van Renterghem, on a "Getting to Zero" message, World AIDS Day 2011.

Getting to Zero:

Zero new HIV infections

Zero discrimination

Zero AIDS related deaths


School He
Resea
Education
Epidemics
TB deaths
Vital registration
systems
Care
Support
Zero discrimination
Plannin
Risk communic
Treatment
Epidemiological surveillan
HIV infecti
Environmental h
Disea
Poverty

Section 4

CONCLUSION

4. CONCLUSION

The health sector in Namibia continued to make progress in 2011 despite various challenges. With increased collaboration among all stakeholders within and outside the health sector the gains of 2011 should be consolidated and appropriate policies, strategies and interventions to improve the health status of the Namibian people should be adopted in 2012.

As Government and partners work together to tackle " known" diseases and challenges, new ones are emerging and "old" ones are becoming tougher to deal with. At the same time, complexities related to the changing climatic environment and continuing financial stress are making it more difficult for the Government to address existing and emerging challenges. Efficiency savings have become more important than ever, for Government and partners alike!

Namibia continued to be an unequal country to live in: a country where mothers and children are still dying during pregnancy and childbirth, due to preventable causes; a country afflicted by the dual HIV/AIDS and TB epidemic and by a significant prevalence of malnutrition among children aged less than five years.

But Namibia is also a country where malaria has ceased to be a major public health problem, and where Government expenditure on health is quite significant; Where commitment to tackle existing problems is high and has been sustained and where the few existing partners are coming together to make it work!

A lot has been achieved, and yet a lot is still to be done. With leadership, determination, commitment and partnership, it will be possible to overcome the challenges.


Research
Prevention
Care
Governance
Support
Environmental h
Accountabil
Zero discriminati
HIV infecti
Emergen

Section 5

ANNEXURES & REFERENCES

Annex 1: List of Participants/Delegations from the Ministry of Health and Social Services, Nongovernmental Organizations and other Government Ministries attending International Conferences, Workshops and Meetings out of Namibia, January – December 2011

Name	Programme/ Organizer	Period	Title of the Meeting/ Conference/ Workshop	Venue
Ms Theophilus Nantinda	IST/EPI	29 January – 3 February	Polio training for strengthening polio eradication strategies in the sub region	Harare, Zimbabwe
Mrs Rene A. Adams	HQ/MSD	5 – 13 February	1st Meeting of the Global Network of WHO National counterparts for implementation of the global strategy	Geneva, Switzerland
Buys Charlotte Audrey	HQ/NCD	7 - 12 March	4th International seminar on the public health aspects of Noncommunicable Diseases	Geneva, Switzerland
Dr Sikota Zeko Mr P. Shilunga Mrs Magrieta Diergaardt Mr Vasco Munsu	AFRO/EPR	14 - 18 March	Inter-Country meeting on Cross Border Public Health Issues	Lusaka, Zambia
Mr Lazarus Mwashekele Indongo	AFRO/EPR	14 - 18 March	Inter-Country meeting on Cross Border Public Health Issues	Lusaka, Zambia
Ms M. Allies	IST/EPI	15 - 19 March	Technical Advisory group meeting for Angola, Congo, DR Congo, Namibia and Zambia	Lusaka, Zambia
Ms Severina Neingo Mr Theobald Shiyambi Ms Aleta Noabes	IST/HPR	21 - 26 March	Consultative Meeting on School Health	Harare, Zimbabwe
Dr Naftal Tuyoleni Hamata	HQ/NCD	27 - 30 April	Ministerial Conference on Healthy Lifestyles and NonCommunicable Diseases Control	Moscow, Russia
Mrs Nicole Amanda Angermund Ms Marjorie Giovanna Van Wyk	IST/HPR	2 - 6 May	Consultation on implementation on WHA 63.23 Resolution to Scale up nutrition in the African Region	Harare, Zimbabwe

Name	Programme/ Organizer	Period	Title of the Meeting/ Conference/ Workshop	Venue
Dr P. Uusiku	HQ/RBM	9 - 27 May	20th RBM Board Meeting	Geneva, Switzerland
Ms Gertrude Edith Platt	IST/ATM	29 May – 4 June	Workshop to accelerate the implementation of programmatic management of drug resistant tuberculosis	Kigali, Rwanda
Ms Cecilia Lututu				
Dr Kudakwashe Simba				
Dr Farai Mavhunga	IST/ATM	29 May – 4 June	Workshop to accelerate the implementation of programmatic management of drug resistant tuberculosis	Kigali, Rwanda
Ms Clementine Muroua				
Ms Mavis Namasiku Liswaniso				
Ms Mooy Iitamalo	IST/EPR	30 May – 2 June	WHO/GFN Training course in Laboratory Based Surveillance Foodborne Diseases and Outbreak Detection and Response	Johannesburg, South Africa
Mr Jeremia Nghipundjwa				
Ms Magdaleena Nghatanga, Director: Primary Health care services.	AFRO	5 - 12 June	Programme Sub Committee Meeting	Brazzaville, Congo
Coetzee Sofia Magdalena	IST/MPS	5 - 9 June	Sub-Regional Workshop on preventing intimate partner and sexual violence against women	Nairobi, Kenya
Ms Ester Ashinkono				
Dr Sarah Shalongo	HQ/HTM	13 - 15 June	Meeting to review of IMAI/IMPAC operational tools and implementation experience for integrated PMTCT services	Geneva, Switzerland
Ms Nelago Justina Amadhila	IST/HSS	13 - 18 June	Health Workforce Strategic Planning Meeting	Harare, Zimbabwe
Ms Lydia Nashixwa	IST/ESA	13 - 18 June	Health Workforce Strategic Planning Meeting	Harare, Zimbabwe
Ms Clementine Muroua	HQ/IHR	18 - 26 June	WHO-EU Training Workshops on Biorisk Management and Shipping Infectious Substances	Accra, Ghana
Ms Mary-Anne Windwaai				
Ms Georgine Ngaisiue				
Ms Georgine Ngaisiue				
Mr Jeremia Nghipundjwa	IST	26 June – 3 July	Training on Sub-regional Trainers in the iHTP costing tool for maternal and newborn Health Interventions	Harare, Zimbabwe
Ms Francina Rusberg				

Name	Programme/ Organizer	Period	Title of the Meeting/ Conference/ Workshop	Venue
Ms Marytha Kakwibu Neo	IST/ATM	27 June – 2 July	Workshop on Implementation of the revised IMCI/IMAI/ IMPAC and 3 is of HIV/ TB guidelines for the acceleration of HIV/AIDS and TB Treatment, Care and Prevention in the African Region	Entebbe, Uganda
Mr Michael George Gawanab				
Ms Helena Nangombe	HQ/HTM	15 - 20 July	International AIDS Society meeting	Rome, Italy
Dr Nancy Unice Kapofi	HSS/IST	26 - 30 July	Meeting on surgical safety check list	Harare, Zimbabwe
Dr Pueya Mekondjo Nashideng				
Mrs Doreen Mainga	IST/FRH	31 July – 6 August	Workshop on Repositioning Family Planning: Capacity building in Advocacy skills of SRH programme staff and health Promoters in ESA Countries	Harare, Zimbabwe
Mrs Frieda Taapopi				
Ms Dawn Dineo Pereko	HQ/HTM	8 - 14 August	WHO Drug Resistance Expert Advisory Panel	Geneva, Switzerland
Mr Robert T. Nandjila	IST/HPR	16 - 20 August	Meeting on the Review of an Evidence-based Health Promotion Package and its Implications for practice in AFRO	Harare, Zimbabwe
Mr Johannes Henricus Mulder	WPRO	19 - 28 August	Training on TB infection Control	Lanzhou, China
Ms Kahitu Mary Anne Mburombu	IST/PHE	13 - 17 September	Consensus Meeting on Kobe call for action	Addis Ababa, Ethiopia
Ms Mary Nyaradzayi Mataranyika	HQ/EHT	22 - 25 September	Workshop on Transplant Legislation & the role of health authorities	Cape Town, South Africa
Ms Lucia Nghishogwa, District Malaria Manager	AFRO/ATM	26 - 30 September	Micro planning meeting for malaria elimination	Harare, Zimbabwe
Ms Clothilde Narib				
Mr Andreas Hans Angula				
Dr Francina Mwadina Shiweda	WCO	21 - 27 September	SADC Technical Committee for prevention and control of NCDs	Johannesburg, South Africa
Ms Hilde Liisa Nashandi	HPR	24 September – 2 October	Joint FAO/AFRO Workshop on Promotion of the Production and Consumption of Fruits and Vegetables	Kilimanjaro, Tanzania

Name	Programme/ Organizer	Period	Title of the Meeting/ Conference/ Workshop	Venue
Ms Lucille Catanyag Caparros	ARD	2 - 7 October	Polio and Measles Laboratory staff training in Data management	Harare, Zimbabwe
Mr Boniface Makumbi	ARD	19 - 22 October	Annual Polio and Measles Meeting	Harare, Zimbabwe
Mr Joshua Hidinwa	AFRO/DPC	13 - 19 November	Workshop on IHR core capacity exercise development and public health emergency management	Nairobi, Kenya
Ms Emma Helao	AFRO/DPC	14 - 18 November	Conference on Emergency medicine in developing world	Cape Town, South Africa
Mr Joshua Hidinwa Mr Alfred Du Plessis	AFRO/DPC	24 - 26 November	Workshop on IHR Legal core capacity building	Harare, Zimbabwe
Dr Nunurai Ruswa	AFRO/ATM	30 November – 2 December	Meeting on Technical Assistance Plans for Global Fund activities in the African Region	Harare, Zimbabwe
Ms D. Diergaardt Ms M.Katjire	IST/FRH	03 - 10 December	2nd Inter-country Orientation and Capacity Building Workshop on Application and use of IMCI Computerized Adaptation and Training Tool	Kigali, Rwanda
Ms Gertrude Platt	HQ/CDS	4 - 11 December	Global Workshop on Capacity building for Leprosy programme managers for Low Endemic Countries	Cairo, Egypt

Annex 2: List of International Experts, Regional Advisors, Consultants and Temporary Advisors on Technical Support missions to Namibia, January – December 2011

Name and Title	Programme/ Organizer	Period	Objective of Mission	Venue
Dr Ivan Dimov Ivanov	PHE/HQ	0 - 16 February	To provide Technical Support to the MOHSS to develop plan for implementation of the national occupational health strategy and to provide training of medical officers.	Windhoek and Swakopmund
Ms Kingsley Weaver, STOP Team member	IST/EPI	5 February- April	STOP Team program	Windhoek
Professor Cantrell Anthony Conyngham	PHE/HQ	18 - 26 February	To facilitate training on Occupational Health	Swakopmund
Dr Steven Hong	Tufts University/ WHO/MoHSS	6 - 14 April	Early warning indicator workshop	Windhoek
Dr Michael Jordan, Consultant	Tufts University/ WHO/MoHSS	10 - 15 April	Early warning indicator workshop	Windhoek
Dr Luis Gomes Sambo, RD	AFRO	18 - 22 April	5th Conference of African Union Ministers of Health in Namibia	Windhoek
Dr Nicholas Adjabu	AFRO	15 - 28 May	Technical assistance on the development of a plan to implement recommendations of assessment of Medical Gas system in State Hospitals	Windhoek
Dr Pierre Claver Kariyo	AFRO	15 - 21 May	Patient safety/Infection Lab waste mission	Windhoek
Dr Charles Byabamazima	IST/IVD	15 - 21 May	Accreditation review of the National measles Laboratory	Windhoek
Mr G. Kathurima	AFRO	18 - 21 May	Review Administration and Finance issues.	Windhoek
Dr Moses Chisale	IST/Libreville	25 - 28 May	Meeting on the Southern African access to Medicines Info Hub-Partnership for UN conference	Windhoek
Mr Paul Mcnamee, STOP Team member	IVD	2 June – 31 August	Stop Transmission of Polio (STOP)	Windhoek
Dr Samuel Okiror	IST/IVD	5 - 8 June	Assist the overall preparations of the SIAs and facilitate training of Independent monitors	Windhoek

Name and Title	Programme/ Organizer	Period	Objective of Mission	Venue
Ms Z. Machekanyanga	IST/IVD	5 - 18 June	Participate in Polio SIAs in Namibia	Windhoek
Dr Hawa Hamisi Senkoro	IST/PHE	2 - 6 August	Technical Assistance in a Capacity Building Workshop on the Healthy Cities Programme.	Windhoek
Dr Soce Fall	AFRO/MAL	8 - 15 August	Joint Assessment of National Strategy on Malaria	Windhoek
Mr John Okoth Agoro Nyerere	IST /HRH	14 - 28 August	HRH policy development	Windhoek
Dr Magda Awases	IST/HRH	21 - 28 August	Technical support for the development of Human Resources for health policy	Windhoek
Dr Akoko Vincent Orinda	WCO	11 September – 8 October	District health package and restructuring process	Windhoek
Dr Daniel Fussum	IVD	16 - 24 September	Technical assistance in the Reach Every District (RED) approach training	Otjiwarongo
Dr Jethro Magwati Chakauya	IVD	16 - 24 September	Technical assistance in the Reach Every District (RED) approach training	Otjiwarongo
Mr John Nyerere	HRH/IST-ESA	24 September – 7 October	HRH policy development	Windhoek
Mr Keith Shaba	IVD	24 September – 1 October	Preparations of upcoming meetings of TFI and ARICC	Windhoek
Dr Teshome Desta	IST/CAH	24 September – 1 October	Technical support for the incorporation of Rheumatic Heart Disease into the Integrated Management of Newborn and Childhood Illness (IMNCI) strategy	Otjiwarongo
Dr XIA WEI, STOP 38 team member	HQ/POL	1 October – 31 December	STOP 38	Windhoek
Dr Kaia Engesveen	WHO/HQ	26 October – 4 November	Technical support to conduct Nutrition Landscape Analysis	Windhoek and regions
Dr Mansour Adeoty	WHO/HQ/EHT/ DIM	27 October to 6 November	Annual Conference on Infection Prevention and Control	Windhoek
Dr Dheepa Rajan	HQ/HDS	14 - 23 November	Technical support at a workshop to review the Namibia Health Infrastructure and Technology policy	Windhoek

Name and Title	Programme/ Organizer	Period	Objective of Mission	Venue
Mr Gerhard Schmets	HQ/HDS	13 - 18 November	CHPP Stakeholders Meeting	Windhoek
Mr Christopher Zielinski	AFRO/AHO	15 - 18 November	Country Health Policy Portal (CHPP)	Windhoek
Mr Frank Terwindt	HQ/HDS	20 November – 2 December	Country Health Policy Portal (CHPP)	Windhoek
Dr Raquel Mahogue Maguele	AFRO	20 - 25 November	Technical support to the Training workshop on Diabetes Prevention and Control	Windhoek

1. *Global Plan for the Decade of Action for Road Safety 2011 - 2020*
2. *Global School-based Student Health Survey (GSHS), 2004*
3. Ministry of Health and Social Services, Namibia (2009): *The Roll-Out of Anti-Retroviral Therapy for HIV/AIDS*
4. Ministry of Health and Social Services, Namibia (2010): *Aide Memoire: Malaria Programme Performance Review towards a Malaria Free Namibia*
5. Ministry of Health and Social Services, Namibia (2010): *Comprehensive Review (2010) of Expanded Programme of Immunization in Namibia*
6. Ministry of Health and Social Services, Namibia (2010): *Malaria Strategic Plan, 2010 – 2016*
7. Ministry of Health and Social Services, Namibia (2010): *Namibia Health and HIV/AIDS Resource Tracking: 2007/08 & 2008/09*
8. Ministry of Health and Social Services, Namibia (2010): *National Guidelines for Antiretroviral Therapy, Third Edition*
9. Ministry of Health and Social Services, Namibia (2010): *National Health Policy Framework, 2010 - 2020*
10. Ministry of Health and Social Services, Namibia (2010): *National Tuberculosis and Leprosy Programme Annual Report, 2009 -2010*
11. Ministry of Health and Social Services, Namibia (2010): *Policy on Male Circumcision for HIV Prevention*
12. Ministry of Health and Social Services, Namibia (2010): *Report on the 2010 National HIV Sentinel Survey*
13. Ministry of Health and Social Services, Namibia (2010): *Road Map for Accelerating the Reduction of Maternal and neonatal Morbidity and Mortality*
14. Ministry of Health and Social Services, Namibia (2010): *Second Medium Term Strategic Plan for Tuberculosis and Leprosy 2010 – 2015*
15. Ministry of Health and Social Services, Namibia (2011): *Strategic Plan for Nutrition 2011 – 2015*
16. Ministry of Health and Social Services, Namibia and Macro International (2008): *Namibia Demographic and Health Survey, 2006 – 07*
17. Ministry of Health and Social Services, Namibia: *Report, 2006*
18. *Namibia Immigration Control Act, 1993*
19. OPM DDM (2009): *Report on Flood Disaster Response, 2009*
20. Republic of Namibia (2003): *Population and Housing Census, National Report. Basic Analysis with Highlights*
21. Republic of Namibia (2008): *Third National Development Plan (NDP3), 2007/2008 – 2011/12 Volume I*
22. Republic of Namibia (2008): *Third National Development Plan (NDP3), 2007/2008 – 2011/12 Volume II*
23. Ministry of Health and Social Services (2011): *Namibia Health Facility Census 2009*
24. United Nations (2011): *The Millennium Development Goals Report, 2011*
25. *United Nations General Assembly Resolution A/RES/64/255*
26. World Health Organization (2003): *World Health Survey*
27. World Health Organization (2009): *Maternal and Child Health in Namibia, 2nd edition*
28. World Health Organization (2010): *WHO Country Cooperation Strategy, 2010 – 2015, Namibia*
29. World Health Organization (2010): *2010 Annual Report, Namibia*
30. World Health Organization: *WHO Framework Convention on Tobacco Control Act*
31. Central Bureau of Statistics, 2010. *An Atlas of Namibia's Population: Monitoring and Understanding its Characteristics.* Central Bureau of Statistics, Windhoek

32. Ministry of Health and Social Services (2010/11). *Annual Implementation Progress Report for the National Strategic Framework for HIV and AIDS, 2010/11*
33. Central Bureau of Statistics, National Planning Commission (2010). *2006 Namibia Inter-censal Demographic Survey Analytical Report*
34. World Health Organization (2011): *Noncommunicable Diseases Country Profiles 2011*
35. World Health Organization (2010): *Global status report on Noncommunicable Diseases 2010*
36. World Health Organization (2011): *Global Tuberculosis Control 2011*
37. World Health Organization (2011): *Global Status Report on Alcohol and Health 2011*
38. *Making Pregnancy Safer - The critical role of the skilled attendant. A Joint statement by WHO, ICM and FIGO.* Geneva, World Health Organization, 2004
39. World Health Organization (2012): *Trends in Maternal Mortality: 1990 - 2010* WHO, UNICEF, UNFPA and The World Bank estimates
40. Ministry of Health and Social Services (2009): *2008/09 Estimates and Projections of the Impact of HIV/AIDS in Namibia*
41. UNICEF & UNAIDS (2011): *Children and HIV & AIDS in Namibia*
42. Ministry of Health and Social Services (2008): *Health and Social Services System Review*

World Health Organization
Namibia