ACHIEVING THE
MILLENNIUM DEVELOPMENT GOALS

A GUIDE FOR NAMIBIA’S PARLIAMENTARIANS
ACHIEVING THE MILLENNIUM DEVELOPMENT GOALS THROUGH FACTS, INSIGHTS & ACTIONS

A NEED FOR INCREASED FUNDING SUPPORT

MDG: F
MDG Achievement Fund

UNODC
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INTRODUCTION

Making the case for Parliamentarian leadership and action.

Outlining Parliamentarians’ critical responsibilities towards the achievement of the Millennium Development Goals and the challenges that they face.
The United Nations system in Namibia recognises the Namibian Government’s commitment towards the achievement of the Millennium Development Goals. This has been demonstrated in many ways, including the continuous periodic review on progress towards the attainment of the MDGs and the multi-sectoral approach taken by Cabinet to ensure that each sector gives a detailed account on its plans and how they directly contribute to the country’s ultimate success in achieving all the goals as part of the national development priorities.

At the same time, the 2008 Accra Declaration highlighted the “critical role and responsibility of parliaments in ensuring country ownership of development processes.” This role cannot be overemphasised, particularly for Namibia which aspires to an equitable approach to ensure that all rights of its citizens are realised.

It is against this background that the concept of developing an informative package on the MDGs for Parliamentarians was born. The package was conceived and developed by UNICEF, in coordination with the United Nations’ Communication Group, involving all agencies present in Namibia, and with the guidance of the Parliament of the Republic of Namibia through the Office of the Speaker of the House of Assembly. Much of the funding for its development came from the MDG Achievement Fund Joint Programme in Namibia, funded by the Government of Spain.

The package consists of three distinct but interlinked sections; and has three main aims:

1. To be used as a Reference Tool by Parliamentarians: providing them with easy access to relevant information and insights on where Namibia is at in relation to the MDGs, and at the same time highlighting issues constraining their achievement.

2. To provide and recommend Plans of Action, which are presented as recommendations that can be implemented in a short-term and as longer-term strategies for the implementation of broad-based institutional initiatives.

3. To highlight the necessity of multisectoral and cross-societal collaboration for achievement of the MDGs in Namibia, and the need for continuous monitoring to ensure that efforts are yielding the best possible results.

Whilst the package has been primarily developed for Parliamentarians, it will also serve as a valuable resource for Regional Governors, Councillors, community leaders, NGOs and development practitioners who are actively engaged in implementing and promotion of actions aimed at the achievement of the MDGs in Namibia.

UN in Namibia
In September of 2000 the largest gathering of world leaders in human history gathered for the Millennium Summit at United Nations in New York to reflect on the challenges of the new century and their common destiny. The nations were interconnected as never before, with increased globalization promising faster growth, high living standards and new opportunities. Yet their people’s lives were vastly different. As some States looked ahead to prosperity and global cooperation, many barely had a future, stuck in a vicious cycle of poverty, poor health, unemployment, gender inequality, conflict and a degraded environment.

To begin addressing these crises the convened leaders set down and agreed that human development is the key to sustain social and economic progress in all countries, as well as contributing to global security. Under my coordination, in my capacity as the President of the UN General Assembly at that time, the world leaders adopted a blueprint for a better future: the Millennium Development Goals. By 2015, the leaders renewed their pledge, the world would achieve measurable improvements in the most critical areas of human development and social justice.

With only 4 years until the MDG target year of 2015, Namibia has made substantial progress with regard to many of the goals. But the rate of progress remains unsatisfactory, due to challenges, including the impact of HIV and AIDS, vast inequities amongst our people and the volatile global economic situation. At the same time, there is still a gap in the knowledge of the MDGs amongst many Namibians, including Political Office Bearers and Civil Servants, who are expected to be the driving force in ensuring that the public is aware and all the goals are realised.

Parliament is an essential part of any democracy; hence our main role as parliamentarians is to safeguard our democracy vigorously through debating, examining and challenging the development objectives that we as a nation are implementing. However, we cannot demand accountability without having the necessary information. We need the knowledge that will enable us to make informed decisions. The leaders and the public must work together to make progress.

This package is meant to help bridge this information and knowledge gap. It will also allow all parliamentarians to have a solid understanding of the MDGs. It outlines recent and accurate information about the country’s achievements and challenges regarding the MDGs. It includes quick win recommendations and longer term strategies for the implementation of broad-based institutional programmes.

The package also puts emphasis on the importance of Government and community involvement; equity in the provision of services and opportunities; cooperation between all stakeholders; and oversight to assess and ensure that joint efforts are yielding the expected results.

Of great significance for all stakeholders is that the package summaries in useful ways the role that we as leaders and decision-makers must play in ensuring that appropriate laws and policies are enacted, that sufficient resources are allocated to implement the relevant policies to enable a sustainable and lasting change for the greater society and indeed all our people.

I am hopeful that this package will assist us as parliamentarians in recommitting ourselves to taking the required actions to enable the speedy implementation of policy, strategies and actions to ensure the Government of Namibia is able to fulfil its commitment to achieve the Millennium Development Goals by 2015.

Hon. Dr Theo-Ben Gurirab, MP
Speaker of the National Assembly
Parliament of the Republic of Namibia
Achieving the MDGs

The Millennium Development Goals (MDGs) establish the global standards for improving the quality of life for people burdened by poverty, disease, poor education and limited opportunities. Achieving the MDGs through social, economic and environmental development programmes is complex and requires the investment of significant resources over a considerable length of time. The difference between success and failure is in the policies, processes and working relations between all stakeholders.

**Leadership is the critical success factor.** Leadership is required to establish the strategies, enable the resources, motivate the community and sustain ongoing and meaningful change. The effectiveness of Namibia’s resources and international aid must be maximized through well-managed service delivery and good governance. This will ensure better development outcomes and also assure future assistance.

Significant advancements have been made since Independence, with improvements noted in almost all areas of society. However, the past 5 years have seen a worrying decline in progress. Renewed commitment, strategic focus and invigorated energy are essential to secure a better future for all Namibians.

**This Guide is a Reference Tool.** It has been designed to provide Parliamentarians with easy access to relevant information and insights to the issues impeding the achievement of the Millennium Development Goals.

**The Guide is a Plan of Action.** It includes quick win recommendations and longer term strategies for the implementation of broad-based institutional initiatives.

Throughout the Guide the emphasis is on the importance of Government and community involvement; equity in the provision of services and opportunities; cooperation between all stakeholders; and oversight to monitor and ensure that efforts are yielding the best possible results.

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The MDGs

WHAT ARE THE MDGS?

In September 2000, leaders from the 189 member states of the United Nations signed the Millennium Declaration - pledging to improve the quality of life for citizens around the world by eradicating poverty, promoting human dignity and equality, and achieving peace, democracy and environmental sustainability.

Eight Millennium Development Goals (MDGs) were identified to provide a practical means to prioritise socio-economic issues and measure progress towards achieving the Millennium Declaration’s commitment. There are many mutual dependencies across the MDGs and so they cannot be tackled in isolation of each other. Similarly, achieving the MDGs should not be viewed as the ultimate end point. Instead, the MDGs provide a results-oriented way to approach and support ongoing development and upliftment. Planning processes, implementation and monitoring infrastructure, as well as lessons learnt during this period, will benefit Namibia in the successful roll out of future social development programmes.

Each of the eight MDGs consists of a Goal, Targets and Indicators. The Goal is the main aim, the Targets establish how this main aim is to be achieved and the Indicators provide a way to measure and track progress.

COUNTDOWN TO 2015

The Baseline year for tracking the Indicators is 1990 and the Target year for achieving the MDGs is 2015.

With only 5 years until the Target date, it is critical that national priorities and programmes are aligned to deliver the maximum benefits from our resources and efforts. Namibia has made substantial progress against many of the MDGs, but the rate of progress is not sufficient to achieve our Targets in several areas.

Commitment and action is required now so programmes can be implemented to deliver the results required in 2015.

“The right thing for us to strive for is a strong partnership for world peace, human security and sustainable development”

Sam Nujoma, Founding President of Namibia (2007)
Namibia is Sub-Saharan Africa’s driest country and the second most sparsely populated country in the world. With over half the population relying on agriculture for a living, two-thirds of the estimated 1.95 million people live in the 6 northern regions of the country. Many live in areas that are remote and not easily accessible, isolated from health facilities and with limited infrastructure.

Namibia relies on natural resource extraction and exports consist largely of raw materials. Mining accounts for 8% of GDP, but provides more than 50% of foreign exchange earnings. Rich alluvial diamond deposits make Namibia a primary source for gem-quality diamonds. Namibia is the fourth-largest exporter of nonfuel minerals in Africa, the world’s fifth-largest producer of uranium, and a producer of large quantities of lead, zinc, tin, silver, and tungsten. However, the mining sector employs less than 3% of the population.

Namibia is one of the most unequal societies in the world. Inequality exists across gender, race, regional, ethnic, educational and class dimensions of our society. The United Nations Human Development Report of 2009, calculated a Namibian Gini coefficient of 0.743, highlighting gross income inequality.

GDP growth has been positive almost every year since Independence. In 2009, the economy shrank for the first time in 20 years, but is expected to grow by about 4.2% in 2010. This expansion will be driven by gradual strengthening of commodity prices and continued strong performance of the construction sector.

Human Development Index (HDI) and Human Poverty Index (HPI)

The HDI is a summary measure of three dimensions of human development: living a long and healthy life (measured by life expectancy), being educated (measured by adult literacy and educational enrolment) and having a decent standard of living (measured by the purchasing power of per capita income). The HDI for Namibia is 0.686 – 128th out of 182 countries. The HPI focuses on the proportion of people below certain thresholds in each of the HDI dimensions. Namibia’s HPI is 17.1% - 70th out of 135 countries.²

The Namibian People³

Namibia has an estimated population of 1,952,454 and the majority of people live in the relatively fertile northern regions, with only a small percentage inhabiting the arid south. While Oshivambo is the main home language for the majority of people in the country, there are a number of other main language groups that contribute to the country’s ethnic diversity.

THE TRIPLE THREAT TO PROGRESS

HIV/AIDS

• The AIDS epidemic seems to be stabilizing, but the country still has one of the highest adult HIV prevalence rates in the world - estimated at 13.3%. Death and/or reduced productivity due to ill health increases the likelihood of poverty for extended families. The number of orphans due to AIDS is estimated at 69,000, with most of these children being cared for by a relative.

• Health workers and teachers contracting HIV/AIDS intensifies the skills shortage in these already overburdened sectors.

FOOD INSECURITY

• The Global recession and weak external demand meant that the economy contracted by 1% in 2009. The average rate of inflation between 1990 and 2008 was 10%, but in 2008, inflation on food peaked at 16.3% and inflation on transport at 12.9%. With increasing unemployment and higher prices, food insecurity is a major issue.

• Natural disasters and climate change have had a terrible impact on poor families. From March 2009, devastating floods required emergency services for the displaced and affected population in the six northern regions of Caprivi, Kavango, Ohangwena, Omusati, Oshana and Oshikoto. The floods affected nearly 700,000 people and resulted in a breakdown of established sanitation systems and access to safe water, enabling the spread of disease. More than 56,000 people were displaced and had limited access to their crops, animals and shelter. Similarly, the recurrence of droughts in other parts of the country may negate the progress made towards our developmental goals.

DIMINISHING HUMAN CAPACITY

• Higher value-added productivity is constrained by limited access to knowledge and technology. The government wants to transform the current natural resource based industries into “knowledge intensive natural resource based industries” to yield higher productivity and better profitability. Yet there is a serious shortage of appropriately skilled labour. Economic growth and social development is constrained by the limited number of people with relevant skills available to work in the health care, education and private sectors.

• Issues with oversight and implementation limit the effectiveness of development programmes. Relatively new national institutions need consistent, quality support for planning, utilization of approved budget and mobilization of the required resources. Development programmes are delayed, or unable to deliver the best results, owing to difficulties in hiring appropriately skilled and experienced people.

POSITIVES IN SUPPORT OF PROGRESS

• Peace and political stability - Namibia continues to be one of the better governed and least corrupt countries in Africa. In 2008 the Ibrahim Index of African Governance ranked Namibia sixth out of 48 Sub-Saharan countries.

• Resources for growth & development - as a peaceful nation Namibia does not need to deploy a major percentage of its resources in national defense, or civil conflict resolution. Instead it can invest in social and economic development to uplift living standards and further assure internal peace and prosperity.

• Infrastructure - Overall Namibia ranked 74 out of 133 countries in a recent Global Competitiveness Report, scoring well in infrastructure, macroeconomic stability and institutions, but poorly in education and health. The country’s financial sector survived the global economic crisis largely due to regulations that protected the sector from international markets.

• Vision 2030 and the National Development Plans (NDP) - The main goals of NDP 3 include faster economic growth; reduced poverty and income inequality; increased private-sector employment; and faster land redistribution. In this way the MDGs are embedded within NDP 3 and are consistent with the national vision for the future.

• International support - Namibia’s sovereignty is recognized and respected. We have strong ties and good relations with South Africa, with close commercial and financial links between the two economies. Relations with Western trading partners are generally good, although an interim economic partnership agreement with the EU has yet to be concluded. Political and economic links with China and Russia are expanding and both countries are actively pursuing opportunities to increase trade.

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3 Although the defense budget has grown so that the share of total spending it receives is now double that at Independence, to just under 11% in 2009/10
Economic growth is an important enabler of development and higher quality living standards. But economic growth alone will not deliver the major social improvements needed to combat fundamental problems in Namibia today.

Government involvement is essential and recognized through the National Strategy. This National Strategy must be put into action. Namibia – government, communities and the private sector – must scale up its efforts if it is to achieve lasting improvements and a better life for all citizens.

Parliamentarians need to understand the areas where change can deliver the greatest impact and support those areas with:

- Legislation & Policies
- Budgeting & Resource Allocation
- Oversight through active Committee involvement in planning, execution and monitoring

Parliamentarians can also take advantage of opportunities for action. As leaders, Parliamentarians are responsible for guiding and enabling people to achieve their full potential. They achieve great things by motivating others to achieve great things.

Parliamentarian Action to support the MDGs should focus on:

- **Mobilising communities**: Involving local leaders and their communities in development programmes.
- **Supporting co-ordination**: Improving communication across ministries, tiers of government and international aid organisations to maximize the benefits that can be achieved through co-ordinated effort.
- **Advocating for results-driven implementation**: Strengthening monitoring and evaluation systems to ensure that national resources are being used effectively. This means actively identifying when programmes are not achieving the desired results and diverting resources to alternative programmes that can make difference.

“Critical role and responsibility of parliaments in ensuring country ownership of development processes”

Accra Declaration of 2008.
A snapshot of the facts.
Providing an overview of each of the Millennium Development Goals and focusing specifically on progress and priorities in Namibia.
## The MDGs at a Glance

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<th>Indicators</th>
<th>Namibia’s Progress</th>
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<td><strong>MDG 1: Eradicate Extreme Poverty and Hunger</strong></td>
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<tr>
<td>Halve, between 1990 and 2015, the proportion of people whose income is less than US$1 a day</td>
<td>• Percentage of Poor Households (incl severely poor hhs)*</td>
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<td>• Percentage of Severely Poor Households*</td>
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<td></td>
<td>• Poverty gap ratio (Gini co-efficient)</td>
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<td>Achieve full and productive employment and decent work for all, including women and young people</td>
<td>• Unemployment rate (broad concept)*</td>
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<td></td>
<td>• Growth rates of GDP per annum*</td>
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<tr>
<td>Halve, between 1990 and 2015, the proportion of people who suffer from hunger</td>
<td>• Prevalence of underweight children younger than 5 years</td>
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<td><strong>MDG 2: Achieve Universal Primary Education</strong></td>
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<td>Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling</td>
<td>• Net enrolment ratio in primary education</td>
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<td></td>
<td>• Proportion of pupils starting grade 1 who reach grade 5</td>
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<td>• Proportion of pupils starting grade 1 who reach grade 8</td>
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<td></td>
<td>• Literacy rate of 15-24 year olds, men and women</td>
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<td><strong>MDG 3: Promote Gender Equality and Empower Women</strong></td>
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<tr>
<td>Eliminate gender disparity in all levels of education by 2015</td>
<td>• Ratio of girls to boys in primary, secondary and tertiary education</td>
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<td></td>
<td>• Share of women in wage employment in the non-agriculture sector</td>
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<td></td>
<td>• Proportion of seats held by women in national parliament</td>
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<td><strong>MDG 4: Reduce Child Mortality</strong></td>
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<td>Reduce by two-thirds, between 1990 and 2015, the mortality rate in children younger than 5 years</td>
<td>• Mortality rate in children younger than 5 years</td>
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<tr>
<td></td>
<td>• Infant mortality rate</td>
<td></td>
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<td></td>
<td>• Proportion of 1 year old children immunised against measles</td>
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<td><strong>MDG 5: Improve Maternal Health</strong></td>
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<td></td>
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<tr>
<td>Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio</td>
<td>• Maternal mortality ratio</td>
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<td></td>
<td>• Proportion of births attended by skilled health professional</td>
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</tbody>
</table>
### Achieving the MDGs

#### FACTS

**Achieve, by 2015, universal access to reproductive health**
- Contraceptive prevalence rate
- Adolescent birth rate
- Antenatal care coverage (recommended 4 visits)
- Unmet need for family planning

**MDG 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES**

**Have halted by 2015 and begun to reverse the spread of HIV/AIDS**
- HIV prevalence among population aged 15-24 years
- Condom use at last high risk sex
- Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS
- Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years

**Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it**
- Proportion of population with advanced HIV infection with access to antiretroviral drugs

**Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases**
- Incidence and death rates associated with malaria
- Proportion of children younger than 5 years sleeping under insecticide-treated bednets
- Proportion of children younger than 5 years with fever who are treated with appropriate anti-malarial drugs
- Incidence, prevalence and death rates associated with tuberculosis
- Proportion of tuberculosis cases detected and cured under directly observed treatment short course

**MDG 7: ENSURE ENVIRONMENTAL SUSTAINABILITY**

**Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources**
- CO2 emissions, total, per $1 GDP (PPP)
- Consumption of ozone depleting substances
- Protected areas and communal conservancies*

**Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss**
- Proportion of population using an improved sanitation facility

**Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation**
- Proportion of urban population living in slums

**By 2010, to have achieved a significant improvement in the lives of slum dwellers**

* Namibia specific indicators, as defined in the 2nd Millenium Development Goals Report, 2008.
Achieving the MDGs

MDG 1: ERADICATE EXTREME POVERTY AND HUNGER

Insufficient progress has been made on poverty reduction. Aggressive social development programmes must be prioritised to bring about meaningful and sustained improvement.

“The Government sees the MDGs as rallying points for development efforts and resource allocation”
Nahas Angula, Prime Minister 2008

Quick Facts:

- Main causes of poverty are: HIV/AIDS, unemployment, lack of/inadequate access to social services and their poor quality, lack of/inadequate assets such as livestock or quality land and poor road infrastructure.

- Urban residents earn three times more than rural residents - although 65% of the population lives in rural communities they only account for 38% of the total national income.

- Income per capita is 40% lower in female-headed households.

- Salaries and wages are the main source of income for 46.3% of households.

- 51.2% of Namibians are unemployed (broad definition).

For the 49% of Namibia’s population living below the International Poverty Line – subsisting on less than US$1.25 per day – poverty means worrying about food, shelter and clothing. Being regularly deprived of these basics means that children are malnourished, underweight and their growth is stunted. For these Namibians survival is a struggle and unless their circumstances are dramatically changed, they have no hope of leading a long and healthy life.

In this way poverty is a burden on the nation. It stops people from productively contributing to the community and inhibits economic growth, which in turn leads to an even greater number of poor households. This vicious cycle of individual suffering and national decline must be broken.

Furthermore, poverty discriminates – most harshly affecting the elderly, women, those living in remote rural communities, people with little/no education and the most vulnerable children in our society.


**MDG TARGETS:**

Target: Halve, between 1990 and 2015, the proportion of people whose income is less than US$1/day.

**Indicators:**

- **In 2008 the Central Bureau of Statistics established a new poverty line.** The Cost of Basic Needs (CBN) defines households where adult consumption levels are below N$265.24 per month as poor and those below N$184.56 per month as severely poor.\(^{13}\) According to the CBN approach 27.6% of Namibians are poor and 13.8% are severely poor. This means there are three times more people living in severe poverty than previously recorded.

The United Nations Human Development Report of 2009, calculated a Namibian Gini co-efficient of 0.743, highlighting gross income inequality. This reflects that there has been little significant change in the distribution of wealth over the last 10 years.\(^{14}\)

<table>
<thead>
<tr>
<th>Year</th>
<th>% of Female Population</th>
<th>% of Male Population</th>
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</thead>
<tbody>
<tr>
<td>Poor</td>
<td>30.4%</td>
<td>25.8%</td>
</tr>
<tr>
<td>Severely Poor</td>
<td>15.1%</td>
<td>12.9%</td>
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</tbody>
</table>

**Baseline Year Progress Target**

- In 2008 the Central Bureau of Statistics established a new poverty line. The Cost of Basic Needs (CBN) defines households where adult consumption levels are below N$265.24 per month as poor and those below N$184.56 per month as severely poor.\(^{13}\) According to the CBN approach 27.6% of Namibians are poor and 13.8% are severely poor. This means there are three times more people living in severe poverty than previously recorded.

**Target: Achieve full and productive employment and decent work for all, including women and young people.**

**Indicators:**

- **Unemployment has escalated. Youth are the most severely affected - 60% of people aged between 15 and 34 years old are unemployed.\(^{15}\)**

Unemployment has escalated. Youth are the most severely affected - 60% of people aged between 15 and 34 years old are unemployed.\(^{15}\)

- In 2009, the economy constricted for the first time in 20 years, but positive growth is expected in 2010. Economic growth is key to combating poverty and unemployment.

**Target: Halve, between 1990 and 2015, the proportion of people who suffer from hunger.**

**Indicator:**

- **Some progress has been made against hunger and food insecurity, but achieving the target requires commitment.**
- **Stunted children are significantly short for their age; Underweight children have low weight for their age; Wasted children have low weight for their height.**


\(^{14}\)Completely equal distribution has value of 0 and unequal distribution has value of 1.


WHAT ARE THE CRITICAL AREAS?

- **Unemployment** – the labour market plays a vital role in the economy and in improving the quality of life of Namibians. Outside of the public sector, formal employment growth in mining and manufacturing industries has been limited, with most employment opportunities created in the service sector. Investment in employment intensive sectors needs to focus on generating opportunities and income for youths and women.

- **Economic growth** – a key area of concern is the growth rate of GDP/per person employed. Sustained labor productivity growth is critical for reducing poverty. This is achieved by increasing output, the demand for labor, and through higher wages and income. However, Namibia shows a decline in the labor productivity growth rate between 1992 and 2008. This is particularly concerning in the context of average Southern African regional increases of over 11%.17

- **Female-headed households** are more likely to be poor owing to a number of factors including inequitable distribution of assets and fewer opportunities for women in paid employment. Women are also more likely to be caring for children - their own and those of relatives who may have died, or moved away to find work. Many of these households are subsisting on stretched resources and require support.

- **Agricultural Transformation** is a fundamental development challenge. Science and technology can support increased agricultural productivity – through new high yield crop varieties, improvements in soil fertility, more efficient water usage and better pest, disease and weed control.

- **Disaster preparedness.** Natural disasters, as the result of climate change, are negating many of the positive advancements made against poverty and hunger. As a result of the flooding in early 2009, an estimated 544,114 people are at risk of long-term food insecurity over 2009/10.18 Furthermore, the cost of rebuilding damaged infrastructure reduces the resources available for accelerating MDG progress. It is important to strengthen emergency preparedness and early response systems by building regional and local resources, capable of assessing risks, preparing for and responding to disasters.

- **Eligibility and access to Child Welfare Grants.** Social safety nets are not catering for the needs of non-orphaned children – 82% of poor and vulnerable children are not orphans. Social protection should be extended to all needy children, with eligibility determined based on means testing rather than on orphaned status.19

WHAT IS BEING DONE?

- The National Development Plan 3 incorporates the National Poverty Reduction Strategy that “focuses on equitable and efficient delivery of public services, expansion of agricultural production and strengthening food security, and strengthening non-agricultural and informal sectors.”20

- The overall objective of the National Food and Nutrition Policy is to improve the nutritional status of the population.21

- Rural Development Policy and Strategy - 13 Community Development Committees have been established to identify development initiatives to improve living standards.

- Government is boosting capital expenditure by investing more in infrastructure and development projects such as the Green Scheme, a large scale irrigation initiative to triple the area of irrigated land in Namibia.

- Oil price fluctuations are buffered by the National Energy Fund. Petrol and diesel prices are only adjusted periodically. The prices set by government aim to stabilise transport costs and to cross-subsidise remote areas.

- No VAT on staple foods, such as wheat, maize and cooking oil.


- National Budget allocated N$6.8 million over 2008/09 to subsidise seeds, fertilisers, ploughing and weeding for farmers working in arid crop regions.

- The Agricultural Bank provides the private sector with a significant amount of money for agricultural projects. In 2008, the Namibian government and the African Development Bank gave the Agricultural Bank N$350 million.

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**MDG 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION**

“Every person in Namibia has the right to an education. Primary education will be provided free of charge by the government. All children must go to school until they have finished their primary education, or until they are 16 years old.”

The Namibian Constitution, Article 20

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**QUICK FACTS:**

- Repetition rates are very high – 21.9% of students repeat Grade 1 and 25.7% repeat Grade 5, emphasizing the importance of Early Learning to prepare children for the education system and the need to improve the quality of the learning.\(^{22}\)

- By Grade 6, **54%** of learners have repeated a grade at least once.\(^{23}\)

- **Two thirds** of all primary schools are found in the 6 northern regions of Caprivi, Kavango, Ohangwena, Oshikoto, Oshana and Omusati.

- The level of education among learners and teachers is considerably lower than in neighbouring countries. In reading, Grade 6 learners and their teachers scored below the regional average. In mathematics Namibian learners were bottom. Namibian teachers were second from the bottom.\(^{24}\)

- Early school-leaving is a greater problem amongst boys than girls.

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**FACTS**

- Investing in Education yields returns in better economic growth and improved standards of living for all Namibians. Educated people can create work, or gain formal employment and are fundamental to a knowledge based society. This is why Education Affairs and Services consistently receive over 20% of the National Budget so that Namibia has the resources to achieve its goal of equal education for all.

- Significant strides have been made regarding accessibility, but the quality of education is still grossly unequal. The results of external school examinations show that the best results are achieved by exclusive private schools, followed by the former white schools in towns. Rural schools continue to struggle to achieve good results.

- Historically, the bulk of the budget for Primary education has been spent on personnel costs, with very little allocated to learner resources such as textbooks. Improving the quality of primary education – in terms of the quality of teaching and the learning conditions - is imperative to enable students to fulfill their potential.

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MDG TARGETS:

Target: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.

Indicators:

- At the current rate of progress, 100% net enrolment in primary school should be achieved by 2015.
- The focus now needs to shift to enabling students to complete their primary education.

There is a slight decline in Survival Rates – starting as early as Grade 1 when 2% of learners drop out.

There is no difference in survival rates between boys and girls – both 89% as of 2007.

There is a more significant decline in the Survival Rate to Grade 8, when 28% of Namibian students have dropped out of the education system.²⁵

74% of girls complete Grade 8, compared to only 70% of boys.

- There have been significant improvements in Adult Literacy Rates. This Indicator is likely to be achieved.
- Educated parents – specifically literate mothers – are more likely to send their children to school.

WHAT ARE THE CRITICAL AREAS?

• **The quality of education** must continue to be prioritised to address the low levels of functional literacy and poor standards of mathematics. These poor learning outcomes mean that many people leaving school do not have the necessary skills to enter the work force. In this way economic development is constrained by a national skills shortage.

• **The quality of teachers** is improving, with the growing number of qualified teachers in the system, but more emphasis is required on consistent in-service training.

• **Regional disparities** in terms of teacher qualification, time spent on instruction and allocation of educational materials, such as textbooks and stationary, must be addressed with equity. Currently, teachers in many rural areas are less qualified, have higher student-teacher ratios and receive less funding. Allocating resources with equity would ensure that vulnerable children in schools in hard to reach areas have access to the same education opportunities.

• **Declining survival rates** and rising repetition rates are cause for concern. The completion of schooling is crucial to achieving a satisfactory level of education.

• **The behaviour of teachers and learners** in terms of absenteeism, poor motivation, illness and other factors is a significant enough problem to warrant investigation and appropriate intervention. Behavioural issues are decreasing the time spent on instruction and so directly impacting the quality of education.

• **School administrators** should promote and maintain a nationally established code of conduct and professionalism. They should be empowered with the resources required to achieve high standards and be held accountable for their results.

• **Learner supervision after school** to provide support for homework and compensate for the limited parental involvement in learning.

• **Counselling services for learners** are essential to counter the range of harsh conditions and negative experiences that learners have to contend with - whether from poverty, abuse and neglect at home or from detrimental circumstances such as corporal punishment, teacher absenteeism or bullying at school. Learners overwhelmingly support the need for counselors and the presence of teacher counselors in schools makes a positive difference.

• **Hostel accommodation must be appropriately resourced** so that children living in hotels are protected from abuse and are well-cared for, including being properly fed and supported with their homework.

WHAT IS BEING DONE?


• Education and Training Sector Improvement Programme (ETSIP) is a 15 year strategic plan designed to overhaul the primary educative system in Namibia by 2020. This programme has received funding from the World Bank and constitutes the first case of a World Bank loan to Namibia.

• Early Childhood Development (ECD) programmes and Pre-primary education lay the foundations for acquiring skills for successful lifelong learning – the more children that can get enrolled in the programme the better. Following recent Cabinet approval, Pre-Schooling is to be formalized and integrated within the General Education System.

• School Feeding Programme that supports Orphans and Vulnerable Children (OVCs) in Primary Schools will expand its coverage from some 167,000 beneficiaries in 2010 to 200,000 by 2013. Students’ concentration, and hence their ability to learn, is heavily influenced by their nutritional levels.

• Education Development Fund (EDF) provides schools with funds to offset the exemption of School Development Fee for learners who are unable to afford it.

• N$139 million was provided in the 2009/10 budget to develop learning spaces - the number of schools planned to increase from 1,700 to 1,800 and current schools will have new classrooms added and the number of school hostels is to rise to 197 by the end of 2009/10. All hostel students will be provided with food and learner supervision.

FACTS

“Violence against women and children harms families across generations, impoverishes communities and reinforces other forms of violence in our societies. Violence against women hinders our women from fulfilling their potential, restricts economic growth, undermines development and has profound health implications that affect both women and children.”

H.E. Hifike unfye Pohamba, President of Namibia

The root cause of gender inequality in Namibia is the low socio-economic and political status of women in our society. Historically, females have been considered inferior and provided access to fewer resources. They have been excluded from decision-making and not given equitable employment opportunities. HIV/AIDS, escalating levels of gender-based violence and the increase in the proportion of female-headed households have exacerbated these issues, making women more vulnerable to food insecurity and poverty.

While Namibia is actively tackling the legalities surrounding gender equality and women’s rights, there has not been sufficient change in attitudes towards women and their role in society. Few women reach high-level positions in the private and public sectors and patriarchal values are still widespread. This means that women tend to engage in the lowest levels of employment, many surviving in the informal economy.

Women are increasingly the sole caregivers, providers and protectors of the family.

These are important roles and yet women are not afforded the respect, adequate compensation, or the opportunities to allow them full economic independence and empowerment.

Quick Facts:
- The estimated rate of new HIV infections among females aged 15 to 24 years is 21%, more than double the rate of new infections among males of the same age group (10%).
- Because of traditional inheritance practices, 40% of widows aged 15 to 49 do not receive any of their husbands’ assets.
- 35% of Namibian women and 41% of men feel that there are circumstances when it is justified for a husband to beat his wife.
- 1 out of 3 Namibian women have experienced intimate partner violence.
- In 2009, 386 rapes of young girls were reported and 158 cases of grievous bodily harm against young boys.

The global Indicators look at equitable access to education, employment and government. They do not reflect the grave issues such as gender-based violence, the low-level of women reaching high-level positions, and harmful cultural practices.

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29Justifiable circumstances include: Neglecting the children (26% women, 28% men); Going out without telling husband (19% women, 27% men); Arguing with husband (16% women, 13% men); Burning food (12% women, 10% men); Refusing sex (12% women, 8% men) (NDHS 2006/07).
**MDG TARGETS:**

Target: Eliminate gender disparity in all levels of education by 2015.

*Indicators:*

- **Ratio of Girls to Boys in Primary Education**
  
  There is no significant inequality in the access to primary education between boys and girls.

- **Ratio of Girls to Boys in Secondary Education**
  
  There are more girls than boys in secondary education – survival rates for girls are consistently 4-5% higher for girls in every year of secondary school.32

- **Ratio of Girls to Boys in Tertiary Education**
  
  It is necessary to encourage and enable more girls to enter tertiary education. This would also lead to an increase in the number of women in higher positions in the private sector.

- **Share of Women in Wage Employment in the Non-agriculture Sector**
  
  This Indicator is tempered by the fact that the majority of women work in low level positions, almost 20% as domestic workers.33

- **Proportion of Seats held by Women in Parliament**
  
  There has been a slight decrease in female representation following the recent election.

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WHAT ARE THE CRITICAL AREAS?

- **Gender based violence** - a centralised database of gender-based violence has been initiated with the support of UNDAF, to monitor the escalation of violence against women. In 2009, more than 10,000 Namibians reported grievous bodily harm and 1,036 cases of rape were reported - 38% of which involved people under 18.34

- **Representation in decision-making** - the absence of an affirmative action measure in the national and regional electoral laws to address women’s representation in politics, especially in Parliament, remains a challenge.

- **Teenage pregnancy** is the main reason why girls drop out of school, 15% nationally and 34% in the Kavango Region. The rate of teenage pregnancy among secondary school graduates is 6% compared to 58% amongst girls with only pre-primary or no education at all.35 Education is clearly the key to addressing this issue.

- **Some cultural practices** prevent women from having control over their bodies and this may contribute to the spread of HIV. Furthermore, women and children are left destitute by inheritance practices that transfer all the deceased husband’s assets back to his family.

- **Addressing the social norms and values** that reinforce gender inequality. The resulting poverty and violence that is associated with gender inequality is extremely detrimental to children. Growing up in this environment, they inevitably inherit the attitudes and beliefs of their parents. It is essential that this cycle be broken through education and social awareness.

- **Equal employment opportunities**. With the high number of girls in primary and secondary school, the key challenge is to translate education into formal jobs for women.

WHAT IS BEING DONE?

- Namibia is a signatory to the Convention on Elimination of all Forms of Discrimination against Women (CEDAW) and the SADC Protocol on Gender.

- Many policies supporting gender equality and women’s empowerment, such as National Gender Policy (1997, revised in 2010) and National Gender Plan of Action (1998), the Combating of Domestic Violence Act (No.4 of 2003), the Married Persons Equality Act (No.1 of 1996), the Combating Rape Act (No.8 of 2000, the Affirmative Action (Employment) Act (No.29 of 1998) and the Education Act (No.16 of 2001).

- Civil society organizations are strong supporters of gender-specific law reform.

- FAO, UNDP, UNESCO, UNFPA and UNICEF are supporting the Government of the Republic of Namibia under a Joint Gender Programme to achieve three outcomes:
  1. Increasing the awareness and capacity for protecting the rights of women and girls, including reproductive rights;
  2. Mainstreaming gender into national development policies and frameworks, and implementing gender-responsive policies, programmes and budgeting;
  3. Enhancing the well-being of targeted women and girls through food security and livelihood improvement initiatives.

- Namibia has specialised centres for dealing with, amongst others, crimes of gender-based violence. There are 15 Woman and Child Protection Units covering every region in the country.

- Female school enrolment has showed consistent improvement over the years. In 2009, there were virtually equal numbers of girls and boys in primary school, and 116 girls for every 100 boys in secondary school. For many years, boys outnumbered girls in Grades 11-12, but that trend has been reversed in the last few years.36

MDG 4: REDUCE CHILD MORTALITY

I appeal to all and every member of the Namibian society to join me in combating the causes of maternal, infant and child mortality in Namibia. Together we will be a powerful resource for our mothers...Our women need our support. Our children count on us. We can’t let them down!”

MS Penehupifo Pohamba, The First Lady of the Republic of Namibia

QUICK FACTS:

- 53% of deaths of under 5 year old are attributed to HIV/AIDS.
- Probability of HIV Mother-to-Child Transmission is 16% during pregnancy, 50% during labour and 34% via breastfeeding.
- Almost 30% of Namibian children have stunted growth as a result of poor nutrition – 31.5% of boys and 26.4% of girls under 5 years old.
- 7.5% of children under five are wasted, implying acute malnutrition.
- Highest under five mortality rate is Ohangwena with 95 per 1,000 live births.
- There were over 1,000 confirmed cases of measles in 2009.

In Namibia, the main causes of death in children under five - diarrhoea, malaria, pneumonia, malnutrition and HIV/AIDS – are all preventable. Yet child mortality rates are high and getting worse. While a higher proportion of children die in rural areas, the figures for mortality in urban areas have also deteriorated.

HIV/AIDS is slowing down progress in maternal and child healthcare and the incidents of diarrhoea and pneumonia have increased five-fold since 1992. Outbreaks of malaria occur seasonally after heavy rains and impact young children in the poorest communities. The fundamental issue is the inequitable provision of health care across the 13 regions of the country. This can been seen in the marked regional differences in immunization coverage.

With 75% of all under five deaths occurring in the first year of life, significant improvements can be achieved by targeting care at young children.

FACTS

At current rate of reduction the mortality rate for children under 5 will be 1.5 times higher in 2015 than the desired target.

38Inter-Agency Child Mortality Estimation Group (IACMEG), 2006
MDG TARGETS:

Target: Reduce by two-thirds, between 1990 and 2015, the mortality rate in children younger than 5 years.

Indicators:

- The rising trend in child and infant mortality rates highlights that the accessibility and quality of child healthcare is inadequate.

- There has been declining coverage of immunization and the measles outbreak in the first quarter of 2010 is evidence that increased attention and commitment is required.
WHAT ARE THE CRITICAL AREAS?

• Coverage of grants and support to alleviate malnutrition, especially in children under two years old. Unemployment and poverty are significant factors contributing to child mortality as they increase the likelihood of food insecurity and malnutrition, making children more vulnerable to disease and death. Social safety nets are not catering for the needs of non-orphaned children – 82% of poor children are not orphaned.43

• Regional equity in child healthcare with the implementation and enforcement of stipulated policies that reinforce accountability for the quality of health service delivery. Improving healthcare in the most vulnerable and under-served regions in the country will immediately improve child survival rates.

• Education and empowerment of mothers to reduce child mortality through better spacing of pregnancies, immunization, better nutritional understanding and better sanitation. Informed mothers are also more confident about discussing issues with health workers and likely to seek help earlier when their children fall ill.

• Health Extension Workers are tasked with bridging the gap between health facilities and remote rural communities. They have resulted in a significant reduction in malaria incidence and deaths and a high coverage of PMTCT/ART44. They are trained to engage the community and can also be a resource to provide support for pregnant women and families with young children, informing them of the essentials that can protect their children from illness and promoting the use of available childcare and health care services.

• High impact health and nutrition interventions that focus on nutrition-related services for children. Recognising and strengthening the role of mothers in food security and nutrition - promoting exclusive breastfeeding for 6 months and encouraging women to supplement with breastfeeding for longer, providing Vitamin A, Zinc and other nutrients that have a positive impact on growth, development and survival.

• High immunization drop out rates as many children fail to receive subsequent vaccinations. It is also likely that other services such as growth and nutrition monitoring are also being missed.

WHAT IS BEING DONE?

• The Extended Programme for Immunisation means that fewer children will die or carry the burden of disabilities caused by preventable diseases, however there are serious regional disparities in coverage.

• A national policy on Community Based Health care (CBHC) was issued by the MoHSS in 2008 and Regional and District Health services received N$1.46 billion (Budget 2009/10) to provide people living in more remote areas with mobile clinics, better care and access to medication.

• The Reach Every District (RED) approach is targeting women and children during the Maternal Child Health Days.

• Vitamin A is provided by the Health Authorities and, by law, all salt must be enriched with iodine to ensure that children receive the required amount of iodine in their diet. However, as many as 40% of households in the northern regions acquire locally available salt which is not iodized, instead of purchasing iodized salt.45

• Ministry of Health and Social Services – has a good track record regarding their response to outbreaks, such as the polio campaign and controlling cholera in 2006.

• Actively promoting breastfeeding.

• The Health Sector Review 2008 aims to transform the Ministry of Health and Social Services into an effective and progressive public institution through the development of a strategic five year plan.

FACTS

**MDG 5: IMPROVE MATERNAL HEALTH**

Although childbirth is a natural process, there are circumstances where it can be life-threatening for both the woman and the infant. The overall physical condition and age of the mother is directly related to the likelihood of an uncomplicated delivery process. A healthy, well-nourished adult has much less risk of complications, whereas adolescents are two times more likely to die in childbirth, because of the immaturity of their bodies.

In Namibia, the direct causes of maternal deaths are eclampsia (high blood pressure, seizures and coma), obstructed and prolonged labour, haemorrhage and complications following an abortion. Indirect causes are related to HIV/AIDS and malaria infections.

Although most women in the country deliver their children in health facilities and are assisted by a skilled health professional, most of the health facilities do not have the capacity to treat emergencies during labour. In addition, the attending health professional is most often a nurse who is required to refer any complications to a doctor. To ensure that a doctor can be present at the birth, early identification of pregnancy complications is essential. This reinforces the importance of adequate antenatal care and of providing nurses with life-saving skills.

<table>
<thead>
<tr>
<th>QUICK FACTS:</th>
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<tbody>
<tr>
<td>• <strong>18.8% of pregnant women</strong> in Namibia are HIV positive.46</td>
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<tr>
<td>• Pregnant women are <strong>2 to 3 times</strong> more likely to get malaria.47</td>
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<tr>
<td>• <strong>15% of pregnant women</strong> will experience at least one life threatening complication during delivery.48</td>
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<tr>
<td>• Only <strong>49% of women with no education</strong> delivered their child in a health facility, compared to 98% of women who had completed secondary school.49</td>
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<td>• <strong>73% of rural births</strong> were attended by a skilled health professional.</td>
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<td>• <strong>16.6% deaths</strong> are attributable to post-partum sepsis and complications of abortion.</td>
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<tr>
<td>• There is <strong>only one</strong> Emergency Obstetric Care facility that meets WHO standards in the northern regions.50</td>
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There has been a dramatic increase in Maternal Mortality rates in the past 10 years and achieving the target will require major intervention.
MDG TARGETS:

Target: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio.

Indicators:

HIV/AIDS has a serious impact on maternal health and there are serious regional disparities in the availability of emergency obstetric care services.

Target: Achieve, by 2015, universal access to reproductive health.

Indicators:

There is a rising trend in the number of births attended by a skilled health professional, but this is not positively impacting the maternal mortality ratio as any complications must be referred to a doctor.

- Progress has been made regarding pregnancy prevention amongst adolescents, although there are significant regional disparities that must be addressed. For example, Kavango has a 34% adolescent birth rate.51

- It is significant that 58% of teenage mothers have no education/pre-school only and a further 25% did not complete primary school.

- Significant progress has been made in this area.

Coverage is based on those women who had at least four antenatal visits, as recommended by WHO.

Education is again linked with seeking antenatal care as 15% of mothers with no education/pre-school only reported no antenatal care.52

WHAT ARE THE CRITICAL AREAS?

- **Inadequate access to Emergency Obstetric Care** means that complications during delivery cannot be effectively treated and so often result in the death of the mother. The recommended travel time to an Emergency Obstetric Facility is 2 hours, but with only one facility in the Northern regions, travel times are much longer than that.

- **Early Antenatal Care is essential** to ensure that mothers are kept healthy during pregnancy and so reduce the likelihood of complications during delivery. Only 32.6% of women seek care in the first 3 months of their pregnancy, when early detection of problems is vital. Antenatal care also provides an opportunity for women and their families to be given information that could save their lives - how to keep healthy and how to recognize danger signs during pregnancy and childbirth.

- **The quality of care during delivery**, specifically with regard to handling complications. The skills of attending nurses must be improved to minimize the number of births referred to doctors and that require the pregnant woman to travel long distances.

- **Maternal and reproductive health care services** to improve the quality of service delivery. Reproductive health is relevant to both men and women’s health, covering issues associated with all major phases of life, such as family planning, safe motherhood and cancer of the reproductive system. The availability of drugs, supplies and equipment and the availability and distribution of trained midwives and medical staff must be more equitable.

- **HIV prevention** and family planning for women and couples living with HIV needs to be scaled up.

- **Teenage pregnancies remain an issue**. Adolescent girls and boys must be educated regarding the risks associated with childbirth for teenagers. Young girls’ bodies have not fully matured and so their birth canal and pelvic bones are not completely developed increasing the likelihood of complications during delivery. Teenage mothers are also more prone to anaemia, pre-term delivery and postnatal depression. Including boys in these educational programmes is essential as boys often coerce girls into risky behaviour.

WHAT IS BEING DONE?

- **Ministry of Health and Social Services** has a roadmap to accelerate maternal mortality reduction that outlines strategies, measure and guidelines required to improve maternal health.

- **The Namibian Government** supports the International Safe Motherhood Initiative and has pledged to provide high-quality, affordable reproductive health services to vulnerable and underserved populations.

- **The Reproductive Health Policy** aims to protect and support pregnant women and mothers.

- **Adolescent Friendly Health Services** provide teenagers with access to information, advice and support.

- **The provision of temporary accommodation for expectant mothers from rural areas so that they are able to deliver in a health facility.**

- **The Maternal Health Initiative Team**, funded by the Bill and Melinda Gates Foundation, are piloting an intervention to improve maternal health at an operational level, by bringing together nurses, doctors and pharmacists to clarify problems and develop solutions.53

- **MediClinic** is working with the Maternal Health Initiative Team to develop a continuous professional training programme for midwives in the public sector.

- **A regional weekly interactive radio show**, including a medical panel and listeners calling in, is being rolled out to encourage early antenatal care. In addition, volunteers from four NGOs are being trained to travel to communities to spread the message of the importance of early care.

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MDG 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

“We can halt the spread of AIDS. We can even reverse it... Above all, the challenge of AIDS is a test of leadership. Leadership has formed the basis of whatever progress we have achieved so far.”
Kofi Annan, Secretary General of the United Nations 2003

HIV/AIDS remains the top cause of death in our country. However, HIV is fully preventable and it is no longer necessarily a death sentence. Antiretroviral medicines can help people with HIV live healthy and productive lives, but prevention measures remain essential. Every person in the country must know how to avoid getting and spreading the virus and should be empowered to act on this knowledge.

Namibia has a generalised epidemic, with HIV primarily transmitted through heterosexual intercourse. While there is no significant difference in HIV prevalence between urban and rural areas, there are significant regional differences – for example 35.6% of pregnant women tested HIV positive in Katima Mulilo versus the lowest prevalence of 4% in Rehoboth.54

HIV infection compromises the immune system and so increases susceptibility to other diseases such as tuberculosis (TB). For the same reason HIV doubles the risk of developing clinical malaria.55 In response to HIV/AIDS, malaria and TB, it is critical that healthcare interventions are developed and implemented in collaboration and across multiple sectors of society.

57 SADC Namibia, AIDS Epidemic Update Report 2010
MDG TARGETS:

Target: Have halted by 2015 and begun to reverse the spread of HIV/AIDS.

Indicators:

The latest Sentinel Survey 2010 indicates a slight rise in prevalence rates among young pregnant women, aged 15-19 years old, and a slight decrease for those women aged 20-24 years old. This trend means that achieving the 2015 targets will be difficult.

HIV prevalence across pregnant women in Namibia is 18.8%.61

Indicators:

Namibia has seen an increase in condom use, particularly during higher-risk sex – when people have more than one sexual partner or when sexual intercourse is with a non-marital, non-cohabiting partner.

In 2006/07, 62% women and 78% of men aged 15-49 used a condom last time they had sex with a casual partner.

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Education and communication initiatives to improve knowledge and understanding of HIV appear to be reaching the desired audience. There has been a reduction in new infections among youths – 39% in 2002 down to 31% in 2008. However, there are still misconceptions amongst young men and to a lesser extent amongst young women regarding their personal risk of HIV infection. Social and cultural norms are strong influencers of behaviour and there are established norms that contribute to the spread of the virus. Continued efforts, not only to increase knowledge, but also to change what is considered acceptable behaviour is required.

**Target:** Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it.

**Indicators:**

Excellent progress has been made to provide access to ART for people living with HIV.

The 2008 universal access target of 80% set by the Ministry of Health and Social Services has been achieved.

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WHAT ARE THE CRITICAL AREAS?

FOR HIV?

- **Low utilization of HIV counselling and testing services** - whether it is routine in antenatal clinics, or voluntary through health care facilities, testing is critical to prevent further transmission. With counseling on HIV prevention and living with HIV, mother-to-child transmission can be minimized and the spread of the virus through sexual contact can be eliminated. Utilisation of counseling and testing services remains low because of the fear of discrimination. Efforts need to be geared at reducing the stigma of both the test and of receiving a positive result.

- **Fragmented co-ordination of multi-sectoral prevention interventions** has compromised the effectiveness of interventions. There is inadequate geographical and target group coverage and limited quality assurance to ensure effectiveness. Insufficient prevention funding continues to limit the capacity to co-ordinate and sustain prevention activities. As a result, many communities are not sensitized to the sexual behaviours, social norms, values and practises that contribute to new infection rates.

- **Wide variation in male circumcision rates by region.** Low levels of circumcision combined with multiple sex partners and low condom use may be an important contributor to the high prevalence of HIV. As of November 2010, the Male Circumcision Task Force has performed more than 1,800 voluntarily safe male circumcisions and over 95% of these men received HIV counselling and testing before the procedure.

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WHAT IS BEING DONE?

- **HIV/AIDS and Malaria, TB are priority programmes under a Directorate of Special programmes.** Government investment is increasing, but these programmes receive immense support from donor funding. Donor funding for these programs is expected to significantly decrease during the coming period.

- **Namibia has received assistance from the Global Fund for AIDS, TB and Malaria, as well as from the Millennium Challenge Account (MCA) and the President’s Emergency Plan for AIDS Relief (PEPFAR).**

- **A TB/HIV collaborative body has been established at a National level to oversee the implementation of the collaborative activities.** The aim is to reduce the burden of TB among HIV patients, as well as to reduce HIV burden among TB patients. Poor compliance to TB medication among people living with HIV can result in treatment failure and increase the chances of developing drug resistant TB. HIV Testing among TB patients has improved dramatically in recent years with over 74% of all TB patients tested for HIV.\(^{63}\)

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FOR HIV?


- **The National Strategic Framework for HIV and AIDS 2010/11-2015/16 (NSF) has been**
FACTS

developed to co-ordinate and manage the multi-sectoral response. The NSF identifies national priorities and national targets to which all stakeholders will collectively contribute. It also focuses on interventions to address societal issues contributing to the epidemic such as social norms, poverty and gender inequality. Gender and human rights are embedded in the implementation, and monitoring and evaluation strategies.

• The National Prevention Technical Advisory Committee has prioritized epidemic drivers – multiple concurrent sexual partners, transactional and trans-generational sex, alcohol, low levels of risk perception, low rates of male circumcision, and inconsistent use of condoms.

• Namibian Government targets to have 77 health facilities (30% of facilities and outreach clinics) providing ART to HIV-positive patients by March 2012.

• The Government freely distributes condoms at workplaces and in health facilities. During FY2009/10, 22.8 million male and female condoms were distributed. Furthermore, condoms are now being manufactured in Namibia.

• At the end of 2009, life skills based HIV prevention education was offered as a voluntary after-school activity in 75% of primary schools and 86% of secondary schools.

• The Take Control Task Force - under the Ministry of Information – rolled out a social multimedia marketing campaign on HIV/AIDS that co-ordinated messages at both national and community levels. It is aimed at addressing the social norms that make risky behaviour acceptable, such as Multiple Concurrent Partnerships.

• Knowledge and understanding of key populations at higher risk such as sex workers, men who have sex with other men (MSM) and prisoners can significantly reduce the transmission of HIV. Healthcare interventions should address these most at risk populations, irrespective of the legality of their behaviour. More information regarding the size, prevalence, vulnerabilities, specific risks and other relevant characteristics of sex workers, MSM and prisoners is essential and surveys are needed to gather this strategic knowledge.

• Insufficient levels of human and infrastructure resources to support the increased coverage of people living with HIV. This shortfall of resources will become even more significant with additional emphasis on the quality of service delivery. Stronger linkages with the private health sector are required to enable a co-ordinated effort and supplement much needed resources.

• Insufficient engagement of persons living with HIV. The national strategy and response to HIV has limited involvement from people living with HIV and there are no public officials overtly representing this group in government.

• Challenge of sustaining the National HIV response after the withdrawal of donor funding will be a challenge. Dependence on a few funding agencies poses a serious risk and should be addressed by a comprehensive sustainability strategy. Although fighting HIV/AIDS is a National priority and prevention funding has increased, it is still very reliant on external support and expertise.
Target: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.

Indicators:

Dramatic results have been achieved in the fight against malaria.

The government is committed to eliminating malaria by 2020.

TB Control programmes are having an impact and decreasing the incidence of TB in Namibia.

TB/HIV co-infection remains a major problem for TB control.

Drug-resistant TB is also a serious issue, with alarming number of multi-drug resistant and extensively-drug resistant cases being reported in all regions.

TB is the most common cause of death in persons infected with HIV.

High death rates are recorded among people receiving retreatment – required because of drug-resistant TB - and with extra-pulmonary TB.

The Directly Observed Treatment Short course (DOTS), using a patient-centred community-based approach is resulting in significantly improved treatment detection and success rates.

Indicator: Proportion of children under 5 years with fever who are treated with appropriate anti-malarial drugs.

- Although the NDHS 2006/07 was not conducted in the malaria season, it is reported that 9.8% children receive anti-malarial drugs for fever.

WHAT ARE THE CRITICAL AREAS?

FOR MALARIA?

- **Need for global funding** to scale up malaria interventions and improve coverage of house spraying, insecticide treated net distribution and treatment for infected patients.
- **Roll-out of critical retreatment campaigns** to ensure that the insecticide treatment nets remain effective through the high-risk malaria season.
- **Intermittent Preventive Treatment (IPT)** can significantly reduce the prevalence of malaria during pregnancy, reducing the incidence of premature delivery and low birth weight babies. Health care workers require training on the timing of doses, the interval between doses and what to do with the first dose is only given late in pregnancy.
- **Effective case management** must be maintained through monitoring of the efficacy of the National anti-malarial drug policy and ensuring prompt treatment of diagnosed cases. Knowledge sharing is essential to enable community health facilities to be fully prepared for the malaria season.

FOR TB?

- **An increasing number of cases of Drug Resistant TB** - including Multi-Drug Resistant and Extensively Drug Resistant TB - are being reported. Resistance to available drugs makes treatment more difficult and it is important that patients with these strains of TB are identified quickly so that effective treatment can be initiated and further drug resistant infections within the community can be prevented.
- **No national notification system for Drug Resistant TB.** Poor linkages and collaboration between the NTLP and NIP central TB laboratory, and inadequate linkages between hospitals and NIP laboratories.
- **The NIP Central TB laboratory in Windhoek needs to be upgraded.** It is only Biosafety Level 2, whereas the international recommendation for laboratories handling dangerous infectious agents such as MDR & XDR-TB strains is Biosafety Level 3 - to reduce the risk of transmitting infectious agents to staff and communities.
- **HIV care for TB/HIV patients.** Only 35% of the HIV positive TB patients were on ART in 2009, but guidelines are being introduced to provide ART to all TB/HIV co-infected patients.
- **The majority of community health care providers are supported by NGOs** with donor funding and the tenure of their employment is uncertain. The NTLP needs to develop a strategy for sustaining community based interventions so that the positive gains made in patient follow up and treatment adherence can be maintained.
- **Lack of TB infection control plans, limited facilities to isolate infectious TB patients and poor TB infection control practices.** Although there are some dedicated Multi-Drug Resistant beds in most regional centres, nearly all district hospitals and other facilities lack isolation rooms for TB patients.
- **Limited TB workplace safety measures for healthcare workers,** and there are no statutory TB screening/monitoring programmes for health care workers or laboratory staff.

WHAT IS BEING DONE?

FOR MALARIA?

- Ministry of Health and Social Services has committed to eliminating malaria by 2020, by increasing interventions to reduce the mosquito population in affected areas and provide people with insecticide treated nets for their protection.

FOR TB?

- The National Tuberculosis and Leprosy Programme (NTLP) established strong partnerships with multi-lateral non-government organizations and community-based organizations to improve TB Control activities and provide logistical support. The NTLP training strategy for basic and in-service training of health care workers on TB control has been instrumental in maintaining the competence of core health care providers at facility levels.
- **There is a national network of 36 district and facility laboratories for TB microscopy, culture and drug susceptibility testing for first line anti-TB medicines.**
- **Patient-centred treatments** - such as direct observation of treatment services (DOTS) - have been scaled up and are now offered within Community facilities.
- **Systematic recruitment and training of field promoters and lifestyle ambassadors has strengthened DOTS and markedly improved treatment success rates.**
- **A Government sponsored Drug Resistant TB treatment programme has standard guidelines for the management of these difficult cases and a sufficient selection of second line drugs are available for treatment.**
- **Personal respirators are available for use by health workers in multi-drug resistant TB sites, and some supplemental environmental controls – such as UV lights - are available in Katutura Hospital, a designated referral centre for Extensively Drug Resistant cases.**
- **TB isoniazid preventive therapy (IPT) is being rolled out in HIV ART programs to help prevent HIV infected individuals from developing TB.**
“Our biodiversity does not only provide us with our most basic needs such as the air we breathe, the water we drink and material we use for shelter, if well managed, it can provide us with cash that we may use to get other services that are necessary in today’s world...Proper utilization of our natural resources will lead to employment creation and that is a guarantee for peace and stability in any given community and nation.”
Hon. Netumbo Nandi-Ndaitwah, Minister of Environment and Tourism 2010

MDG 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

In Namibia, environmental protection is enshrined in the Constitution and integrated in national policies such as Namibia’s Green Plan, the Agricultural and Drought Policies, and the National Land Policy. The urgent need for economic growth presents a serious dilemma: whether to concentrate on short-term gains to be made through rapid economic expansion or whether to protect the environment for future generations. Recent improvements in protected areas should reduce biodiversity loss, although environmental degradation and rapid urbanization remain serious problems.

Tackling environmental sustainability must be done in the context of the other MDGs, as it directly impacts success in other development areas. For example, contaminated water is a primary cause of infant and child mortality and lowers overall health outcomes; the degradation of natural resources exacerbates the problems of poverty and hunger.

Climate change also poses a serious threat to environmental and natural resources. Namibia is particularly vulnerable due to its geographic location, variability in patterns of climate and socio-economic factors. The Ministry of Environment & Tourism (MET) has identified 7 areas where Namibia is most vulnerable due to climate change - water resources, marine resources, agriculture, biodiversity ecosystems, coastal zones and systems, health and energy.

QUICK FACTS:

- Only 17% of the rural population has access to an improved sanitation facility, compared to 60% of urban residents.\(^{66}\)
- The impact of Climate change may result in\(^{66}\):
  - Temperatures rising between 1°C and 3.5°C in summer and 1°C to 4°C in winter;
  - 5-15% increases in evaporation;
  - A shortened rainy season with around 25% reduction in runoff and drainage of the Zambezi, Kavango, Cuvelai and Kunene river systems;
  - 30-70% reduction in groundwater recharge;
  - Sea levels rising up to 30cm.
- The March 2009 floods affected 677,542 people – more than 56,545 were displaced and 28,932 were accommodated in temporary camps.\(^{67}\)

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MDG TARGETS:

Target: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources.

**Indicators:**

![Graph showing Total CO2 Emissions, per US$1 GDP](image1)

Based on Total CO2 emissions per US$1 GDP, calculated using Purchasing Power Parity (PPP), the increase since 1990 appears dramatic. However, our emission levels are still well below those of developed countries. The increase in CO2 emissions appears dramatic, but levels are still well below those of developed countries.

![Graph showing Consumption of Ozone Depleting Substances](image2)

Significant progress has been made in eliminating our consumption of Ozone Depleting Substances.

Target: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss.

**Indicators:**

![Graph showing Protected Areas & Communal Conservancies](image3)

Progress is being made to decrease biodiversity loss through the establishment of protected areas and communal conservancies.
Target: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation.

Indicators:

- An improved drinking-water source is defined as one that, by nature of its construction or through active intervention, is protected from outside contamination, in particular from contamination with fecal matter.
- An improved sanitation facility is defined as one that hygienically separates human excreta from human contact.
- Significant improvements have been made in the provision of safe drinking water through improved water sources.
- Basic sanitation has not been improved and major intervention, that focuses on equity for the most vulnerable, is required to raise the standard of living in this area.

Target: By 2010, to have achieved a significant improvement in the lives of slum dwellers.

Indicators:

Urban migration and population growth have contributed to the increase in the absolute number of Namibians living in slums. As a proportion of the total urban population, the percentage of people in slums has slightly decreased.
WHAT ARE THE CRITICAL AREAS?

- In 2008, 77% of the population people were not using “improved” sanitation facilities, with 53% defecating in the open, resulting in high levels of environmental contamination and exposure to the risks of worm infestations and microbial infections (such as trachoma, hepatitis and cholera).68

- There is a need for urban investment in terms of providing subsidies to smaller local authorities to provide the basic services to the poor, like land, sanitation and energy.

- Improve off-grid electricity supply by promotion and support of solar, wind and other sustainable energy programs. Local authorities should be encouraged to use solar street and decorative lights in order to save increasing energy cost especially given the potential increase by ESKOM in South Africa.

- Environmental education programmes should be developed and adequately funded to ensure that key community stakeholders are well-informed and can be held accountable for knowledge sharing and environmentally responsible actions.

WHAT IS BEING DONE?

- Under the urban/rural housing loans programme, households with a monthly income of less than N$3,000 will benefit from 1,300 houses being built in 2009/10.

- Increased resources are being spent on providing more rural households with electricity. The share of rural households with access to power from the national grid is to rise to 25% in 2009/10 and the share of rural households with off-grid electricity from renewable sources, such as solar power, is to rise to 12% in 2009/10.

- The National Emergency Management Committee, within the Office of the Prime Minister, has resources to ensure better and faster help for people affected by drought, floods and other disasters.

- Five Namibian government ministries are working with the GEF and its Implementing Agencies, the European Union, GTZ and the NGO community to overcome the barriers associated with halting and reversing land degradation through a Country Pilot Partnership for Integrated Sustainable Land Management (CPP-ISLM)69. The goal of this project is to combat land degradation using integrated cross-sectoral approaches that assure the integrity of dry land ecosystems and ecosystem services.

- The Namibia Forestry Act strives towards creating community forestry agreements between communities and the Minister of Environment and Tourism. A community forest is an area within a communal area of Namibia for which the communities obtained resource management rights (wood and non-wood products).

- The Benguela Current Large Marine Ecosystem (BCLME) Programme is designed to improve the structures and capacities of Namibia, Angola and South Africa to deal with the environmental problems that occur across the national boundaries, in order that the Benguela Current Large Marine Ecosystem may be managed as a whole.

- The Community Based Natural Resource Management Program restores, secures and enhances biodiversity and ecosystems processes that support sustainable benefits to conservancies. To date there are 53 conservancies registered with MET. These conservancies generate income for the communities through joint ecotourism and cultural tourism ventures, handicraft industries, hunting concessions and the sale of live animals for restocking other conservancies. By 2030, 70% of communal land could be within conservancies, empowering local communities to manage and benefit from their own resources in a sustainable way.

- Enhance Wildlife Based Economy in Rural Areas Project aims to relocate wildlife to areas under the management of conservancies. The project had relocated 3,600 animals from 1999 to 2007 and in 2009, 21 conservancies received 2,600 animals.

- The government’s Ministry of Fisheries and Marine Resources (MFMR) is currently running six pilot-aquaculture farms based on rural community participation in the northern Caprivi and Kavango regions. Mussel and oyster farming is happening at a large scale at coastal areas.

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The MDGs represent a contract between rich and poor countries. Optimal progress in poor countries depends to some extent on the actions of rich ones. MDG 8 outlines the commitments of developed countries and is a reminder that global security and prosperity depend on the creation of a more equitable world for all.

The key elements of globalization essential to socio-economic development include trade liberalization, debt relief, domestic resource mobilization, providing access to affordable medicines and new technologies and aid in the form of development assistance. These elements impact the achievement of the other MDGs.

Namibia believes in and advocates for greater African and Southern African regional cooperation and integration. The difficulties finalizing Economic Partnership Agreements (EPAs) with the European Union continue to pose a risk to the African trade development as restrictions on market access for African manufactures and agricultural produce are an important factor in explaining the decline in Africa’s share of world trade. Meanwhile, trade with emerging economies like China, India, and South Korea is growing, particularly in the mining sector.


QUICK FACTS:

- Volume of trade between China and Africa exceeded US$100 billion in 2008.70
- Namibia is a member of 46 international organizations and has diplomatic relations with most countries in the world.
- Part of the Common Monetary Areas with Lesotho, South Africa and Swaziland.
- Namibia signed the Paris Declaration in 2007 and it is hoped that this will improve the effectiveness of aid.
MDG TARGETS:

Target: In co-operation with the private sector, make available the benefits of new technologies, especially information and communications.

Indicators:

Mobile phone usage has increased exponentially. This is in spite of high costs - on average 25.3% of monthly disposable income.

Mobile phone coverage reported for 95% of the population.71

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WHAT ARE THE CRITICAL AREAS?

- **An effective regulatory environment** is crucial to reap the socio-economic benefits of Information Communication Technology. The Communications Bill was recently passed in 2009, establishing the Namibian Communications Commission (NCC) as an independent regulator for the entire ICT sector. This new regulatory environment should be closely monitored to ensure that the potential for increased investment and competition is realized.

- **Effective early-warning systems** for the Financial Sector and maintain a cautious and conservative monetary policy.

- **An integrated domestic economy** through the development of internal markets linking up enclave economies and through road and other infrastructure.

- **Decrease export dependency on demand in the developed countries**, China and India by vigorously pursuing regional integration and developing regional markets.

- **Promote Internet usage**. Usage only increased slightly between 2004 and 2007, from 3.7 users per 100 people to 4.9, due to access and usage cost. A majority of users continue to connect through a modem or ISDN dial-up (60.4%), but with recently launched services for wireless mobile Internet accessibility should increase.

WHAT IS BEING DONE?

- The Namibian Constitution has been praised internationally as being one of the best in the world – protecting the basic rights of all people and guaranteeing equal rights for all. It is non-sexist in its language and actively protects the rights of children.

- Namibia is a signatory to the New Partnership for Africa Development (NEPAD) initiative as well as the SADC Free Trade Area.

- Namibia hosts the Secretariat for the Southern African Customs Union (SACU), the SADC Parliamentary Forum and the SADC tribunal.

- The Parliament of Namibia hosted the recent Eastern and Southern Africa Parliamentary Workshop organized by the Inter-Parliamentary Union (IPU) and the United Nations Children’s Fund (UNICEF).
INSIGHTS

Going beyond the facts.
To provide a deeper understanding of some of the factors influencing developments and to highlight the elements that are inhibiting progress.
MDG1: ELEMENTS OF POVERTY

UNEMPLOYMENT

Poverty is primarily caused by a lack of sufficient income. Unemployment - being able to work, but unable to find paid work – increases the likelihood of food insecurity and contributes to reduced opportunities for the household, trapping the family in poverty.

The national unemployment rate is used as an indicator of economic hardship in the country.

Unemployment in Namibia is of a long term nature - **72.2% have been without a job for 2 years or more**

WHO IS MOST AFFECTED BY UNEMPLOYMENT?

**Female unemployment rates are higher than that of males in all instances.** At national rates, 58.4% of women are unemployed compared to 43.5% of men.

**Rural communities have the highest unemployment rates** – 72.1% of women and 56.8% of men are unemployed.72

**Youth unemployment is one the greatest concerns in Namibia** – 60% of people aged between 15 and 34 years old are unemployed. It is an immediate waste of exceptional resources and, more importantly, deprives youths of acquiring the skills necessary to get a job that would better their lives and the lives of their community.

The rate of unemployment is generally higher for those with the least education – 80.3% of women living in rural areas and with primary education only are unemployed. For those women who have education beyond Standard 10, the rate is 16.7%.

HOW IS UNEMPLOYMENT MEASURED?

A person is unemployed if they are part of the labour force- available for work and seeking work - but are without work. A person is considered employed if he/she has worked for pay, profit, or family gain for at least one hour in a week.

The labour force is made up of everyone in Namibia who is economically active – currently 55.4% of the population. This excludes children, students, homemakers, pensioners and the severely disabled.

The broad measure of unemployment includes all unemployed people whether they are actively looking for work or not. The strict measure only includes those who are actively looking for work.

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• 74.4% of the labour force is concentrated in urban areas and surplus labour continues to move into towns and cities to seek casual work.
• With the majority of people being employees or self-employed with no staff, there are very few people who are generating employment for others.

• Unemployment is linked with low levels of education.
• There is a dramatic decrease in unemployment amongst people who have senior secondary school and further education.

• The private sector accounts for only 51% of people currently employed.
• The Government and Parastatals are the employers for 30% of employed people.

• 18.5% of all Namibians are employed on a part-time basis
• 29.8% of the labour force is underemployed – they are employed but available for and would prefer to work more hours.
CHILD LABOUR

Child labour increases the likelihood of living in poverty, as it deprives children of education and an opportunity to acquire skills that can raise their standard of living. If the work is particularly dangerous, it may also result in physical disabilities that further increase the burden of poverty.

WHAT IS CHILD LABOUR?
Child labour is criminalized in Namibia. Children, in the context of child labour, are defined as persons under 16 years old and the law protects them from economic exploitation.

Child labour is defined as work that deprives children of their childhood, their potential and their dignity, and that is harmful to physical and mental development.73

It refers to work that is mentally, physically, socially or morally dangerous and harmful to children, and interferes with their schooling.

WHAT WORK ARE NAMIBIAN CHILDREN DOING?
There are far more working children in rural areas – with 85% of working children living in rural communities.74 Children support their families by tending animals, collecting wood/animal dung, collecting water and pounding mahangu. In the commercial agriculture sector, children of farm workers are often forced to work under the threat of eviction. Children are also heavily involved in communal farming - girls are responsible for 70% of field cultivation and boys account for 53% of livestock tending.

Children are engaged in paid and unpaid domestic work. It is common for girls to be sent by their parents to live with relatives in urban areas “to help out in the house”. They are rarely paid for the work they do and are vulnerable to sexual exploitation.

Within the informal sector, children often work for their parents making and selling crafts on the street, or working long hours at night in a shebeen. They may also be included as an unpaid extra, when adult is engaged for casual work.

Children are also co-opted into illegal activities – such as drug trafficking, housebreaking, prostitution and pornography. Children are engaged in sex work for money, or transactional sex for benefits in kind, working on the streets begging and scavenging.

WHY ARE CHILDREN WORKING?

Poverty is the primary reason why children are forced to work.
Children work in the home or in paid employment because they have no other choice – they have to help their family survive. In the Namibia Child Activities Survey 2005, 94.5% of working children reported that they were not paid for their work, but are involved in jobs that help the family. Only 1.4% said that they worked to “earn money”. They have to work when their parents are ill, unable to offer support or may even be deceased. The same survey found that children as young as 6 are involved in work-related activities.

A poor quality education system also contributes to child labour as education is perceived as irrelevant and a waste of time.

HOW ARE CHILDREN NEGATIVELY AFFECTED BY WORKING?

Time spent working impacts school attendance and school performance. It is not only that the children do not have time for homework; they are also exhausted when they are at school and this can lead to poor learning outcomes. Children are also more vulnerable to work-related illnesses and injuries as they are not mentally or physically mature.

Studies by the International Labour Organisation have also revealed a strong link between child labour and child trafficking.

WHAT IS THE ACTION PLAN ON THE ELIMINATION OF CHILD LABOUR (APEC)?

APEC is Namibia’s first national strategy to respond to child labour in a comprehensive manner. It recognizes that government is responsible for many of the actions required to eliminate child labour and proposes that child labour should be made a permanent agenda item – monitored and addressed by Parliament.

It is critical to include child labour prevention strategies in anti-poverty plans – such as linking rural social grants to school attendance; focusing on employment and income generating opportunities for adults; establishing systems in schools to identify children at risk.

Ensuring accountability for the action plan and mobilizing resources. APEC outlines the responsibilities of the ministries involved and establishes the monitoring and evaluation system for implementation.

One such action is a comprehensive communication campaign on child labour. It is essential to educate the public – parents and guardians on the disadvantages of involving children in time-intensive, or hazardous work activities and target the agricultural sector, through the Agricultural Union Congresses, as children are most vulnerable to exploitation in the commercial farming sector.

The Namibian Government is working with the International Labour Organisation (ILO) on a project towards the elimination of child labour (TECL II). In 2010, the Ministry of Labour and the ILO conducted a survey that highlights the strong linkages between child labour, child trafficking, poverty and HIV/AIDS. Two other studies were also conducted by TECL II, namely Child Labour in the Agriculture Sector and The impact of HIV/AIDS on Child Labour. Key findings from these studies are critical to addressing issues of child labour in Namibia.

NAMIBIA LABOUR ACT, SECTION 42, ON CHILD LABOUR, STATES THAT:

• A person must not employ a child under the age of 14 years.

• In respect of a child who is at least aged 14, but under the age of 16 years, a person – must not employ that child in respect of any work between the hours of 20h00 and 07h00; or on any premises where
  (i) work is done underground or in a mine;
  (ii) construction or demolition takes place;
  (iii) goods are manufactured;
  (iv) electricity is generated, transformed or distributed;
  (v) machinery is installed or dismantled; or
  (vi) any work-related activities take place that may place the child’s health, safety, or physical, mental, spiritual, moral or social development at risk.

• In respect of a child who is at least aged 16 but under the age of 18 years, a person may not employ that child in any of the circumstances unless the Minister has permitted such employment.

• It is an offence for any person to employ, or require or permit, a child to work in any circumstances prohibited under this section and a person who is convicted of the offence is liable to a fine not exceeding N$20 000, or to imprisonment for a period not exceeding 4 years or to both fine and imprisonment.

THE CONSTITUTION OF NAMIBIA, ARTICLE 15 CHILDREN’S RIGHTS

Children are entitled to be protected from economic exploitation and shall not be employed in or required to perform work that is likely to be hazardous or to interfere with their education, or to be harmful to their health or physical, mental, spiritual, moral or social development. For the purposes of this Sub-Article children shall be persons under the age of sixteen years.

No children under the age of fourteen (14) years shall be employed to work in any factory or mine, save under conditions and circumstances regulated by Act of Parliament.
Poverty and food deprivation can lead to a “hidden hunger”, where the body is being starved of the essential nutrients it needs to function. Malnutrition can stunt children’s physical and mental growth, robbing them of the opportunity to escape from poverty.

**WHAT IS MALNUTRITION?**
There is more than one type of malnutrition. The human body needs micronutrients - such as vitamin A, iodine, proteins, folic acid or iron – to function. A deficiency in any of these has consequences for health and development.

Malnutrition is caused by poor diet and/or disease. Food deprivation is often exacerbated by the debilitating effects of infectious diseases - such as diarrhoea and pneumonia – which also drain the body of essential nutrients.

**WHO IS MOST AT RISK?**
Critically vulnerable groups are developing foetuses, children up to the age of three and women before and during pregnancy and while they are breastfeeding.

If a pregnant woman is malnourished, her child may weigh less at birth (14% of newborns have low birthweights⁷⁵) and have a lower chance of survival. Malnutrition in an expectant mother, especially iodine deficiency, can also produce varying degrees of mental retardation in her infant.

Among children, malnutrition is especially prone to strike those who lack nutritionally adequate diets, are not protected from frequent illness and do not receive adequate care. Malnourished children are much more likely to die as a result of a common childhood disease and malnutrition during infancy - including the period of foetal growth - can lead to chronic conditions like coronary heart disease, diabetes and high blood pressure in later life.

**WHY IS MALNUTRITION SO DEVASTATING?**
Almost 1 in 5 Namibian children under the age of five is severely malnourished. Malnourished children have lifetime disabilities, weakened immune systems and lack the capacity for learning.

Malnutrition impedes mental and physical development. It dulls motivation and curiosity, and reduces play and exploratory activities. It also impairs mental and cognitive development by reducing the amount of interaction children have with their environment. They become adults with lower physical and intellectual abilities, lower levels of productivity and higher levels of chronic illness and disability.

**Malnutrition cause and effect:**
- Vitamin A deficiency is the chief cause of preventable blindness
- Severe vitamin A deficiency increases the chance of dying from diarrhea or measles.
- Iodine deficiency can cause mental retardation and delayed development.
- Iron deficiency anaemia can delay psychomotor development and impair cognitive development, lowering IQ by about 9 points⁷⁶.

**WHAT IS STUNTING?**
Stunting is when a child is shorter than they should be for their age and shorter than could be accounted for by any genetic variation. It is a severe effect of malnutrition. Stunting is particularly dangerous for women, as stunted women are more likely to experience obstructed labour and are thus at greater risk of dying while giving birth. Stunting is associated with having little to eat and that food being of poor dietary quality, as well as repeated and prolonged illness.

**STUNTING IN NAMIBIA⁷⁷:**
- 29% of children are stunted; 31% rural children and 24% urban children.
- 38% of children age 18-23 months are stunted; 14% percent are severely stunted.
- 32% of boys under the age of 5 are stunted, compared to 26% of girls.

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MDG2: EDUCATION FOR UPLIFTMENT

QUALITY

Of the 585,471 learners in Namibia, 69.5% are in the primary education system.\textsuperscript{78} As more children enter into the system, the quality of the education and the associated learning outcomes become of increasing importance. A poor quality education in childhood has a major bearing on adult illiteracy and limits productive contribution to the workforce.

Although our enrolment and completion rates are relatively high, most children leave school without the foundation skills and competencies they ought to have acquired. While youth literacy is estimated at 94.2%, a screening test by the International Adult Literacy Survey (IALS) recorded very low functional literacy, even amongst Grade 10 graduates. Similarly, a UNESCO Survey found that two-thirds of Grade 6 learners could not read with any level of competency.\textsuperscript{79}

In Grade 10 examinations - 63.8% of Mathematics students and 54.6% of English student achieve an E or worse.\textsuperscript{80}

HOW IS LITERACY BEING ASSESSED NATIONALLY?

Literacy is assessed based on the ability to read all, or part of a simple sentence such as – ‘The child is reading a book’, ‘The rains came late this year’, ‘Parents must care for their children’, and ‘Farming is hard work’.

It is therefore alarming that over 25% of girls and almost 39% of boys aged 15-19 years old in secondary school were not able to read even part of these sentences.\textsuperscript{81} This is a clear indicator that there are serious issues with the quality of education.

\textsuperscript{80}Ministry of Finance. Namibia’s Budget at a Glance: MTEF 2010-11 to 2012-13. Windhoek: MOF.
\textsuperscript{81}Ministry of Health and Social Services. (2008). Namibia Demographic and Health Survey 2006/07. Windhoek: MOHSS.
Teacher quality, time on instruction and textbook availability are 3 factors that have a significant influence on the quality of education delivered.\(^{82}\)

1. The Quality of the Teacher

Good teachers can overcome shortfalls in teaching resources. However, the World Bank found that in Namibia many “practising teachers have poor reading skills, grammar skills, elicitation techniques, limited vocabulary, and facility to adequately explain concepts”.\(^{83}\)

There is a trend towards a better qualified teaching force, but 26.3\% of the Primary teachers are still not qualified to teach. There are also great disparities in the qualifications of Primary teachers between the regions. In Kavango, 15\% of Primary teachers did not complete Grade 12, whereas in Khomas 91\% have formal teacher training and at least three years’ tertiary education.\(^{84}\)

In-service training courses are inconsistent. Individual educational regions initiate in-service courses depending on the needs of teachers in the region. As a result some teachers may attend several in-service courses, while other teachers in the same region may have none. It is advised that a national policy regarding the minimum number of in-service training courses be established.

2. Time spent on Instruction

Absenteeism of both teachers and students decreases the time spent on instruction. The recent SACMEQ study highlights that “the problem of learner and teacher behaviour seems to be widespread enough to suggest that it needs to be tackled in a wide scale.”\(^{85}\)

Teachers are guilty of regularly skipping classes, arriving late at school, and/or having prolonged absences – possibly due to health problems - in more than 50\% of primary schools. In addition, 26\% of learners are in schools where teachers are perceived to be guilty of alcohol abuse. Sexual harassment of learners’ also seems to be prevalent in schools (reported by more than 30\% of Grade 6 learners).

This behaviour amongst teachers is mirrored in the student population with schools reporting issues around learners arriving late at school, dropping out of school, fights and health problems.

HIV/AIDS threatens both teachers and learners. Teachers are absent for long periods due to health problems, while learners may also be ill or be forced to drop out of school to find work and support family members.

3. Textbook Availability

Between 2000 and 2007 the percentage of learners having to share reading and mathematics textbooks rose from 53\% to 68\% for reading

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\(^{85}\)SACMEQ III, 2007

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WHAT ARE REPETITION RATES?

Repetition is when a student fails to be promoted to the next grade at the end of the school year, because they have not acquired the competencies to move up.

Repetition rates continue to rise, wasting resources and increasing the burden on the education system.\(^{87}\) Repetition of grades means that 18\% of all learners are too old for their grade. Grade 1 repetition rose from 18.6\% in 2003 to 20.8\% in 2009.\(^{86}\)

Ineffective and poor quality education results in low learning outcomes and so higher rates of failure, repetition and children dropping out.

It is interesting to note that females have higher promotion rates and lower repetition rates than males up to Grade 8.
and 52% to 68% for mathematics. This indicates an increasing shortage in the supply of textbooks to schools in Namibia.

In no region are there sufficient books for all primary learners, but there are some regions where the shortages are more severe. Equal distribution of textbooks to all schools is a priority. Good care should be taken of textbooks to ensure that they are used for longer periods.83

In addition, the average number of classroom library books per learner is only two books per learner, per year. The number of books in classroom libraries should be increased.

WHAT ARE OUR STANDARDS FOR ENGLISH?

Both Namibian teachers and learners are well below the average competency for reading in the region. There is also great regional disparity - more than 55% of the Grade 6 learners in Caprivi, Ohangwena, and Oshikoto are unable to read for comprehension. There could be a serious problem with either their regional or home circumstances, or the way in which they are taught.84

WHAT IS THE LEVEL OF MATHEMATICS?

Over 72% of Namibian Grade 6 children are not basically numerate. This means that, by the age of 13, they cannot translate graphical information into fractions, or follow and interpret several repeated calculations contained within a sentence (e.g. multiple additions). Only 3.52% of 13 year olds can be categorized as mathematically skilled - able solve multiple operation problems using fractions, percentages and ratios and also translate verbal information into equations to solve problems.85

Namibian learners are bottom in mathematics, compared against other countries in Southern Africa. This is not surprising when Namibian teachers are also ranked second from bottom in terms of their competency. The overall, low average scores for Namibian Grade 6 mathematics teachers and their learners indicates that there could be a problem with either the mathematics curriculum or the training of mathematics teachers and the way they teach the subject.86

83 SACMEQ III, 2007
radical approach is required to improve the quality of the education system and enable Namibian learners to fulfill their potential. The Knowledge Is Power Programme (KIPP) offers an opportunity to target students who are disadvantaged by their socio-economic background and/or their rural location. It is an approach to education that has proven that all children have the potential to complete secondary school and go on to tertiary education.

WHAT IS THE KNOWLEDGE IS POWER PROGRAMME (KIPP)?

KIPP is a US-based initiative that redefines the notion of what is possible in public education, based on the principle that there are no shortcuts to achieving quality education. The essential elements that are required are:

- High quality, committed teachers
- More time spent on instruction
- A curriculum that is focused on preparing students for tertiary education
- A strong culture of achievement and support

KIPP recognizes that it takes hard work and discipline in order for students to acquire the knowledge, skills and character that they need to be competitive.

The KIPP motto is: Work hard. Be nice.

WHAT IS DIFFERENT ABOUT KIPP?

Teachers and students make a commitment to excellence. There are defined and measurable standards for academic achievement and conduct. Teachers, students and their parents sign a learning pledge promising to uphold their commitment to best quality education.

More time is spent on instruction. KIPP schools run from 7:30am to 5:00pm Monday to Friday and from 8:30am to 1:30pm every other Saturday. This means that KIPP students spend approximately 60% more time in class than their peers.

Focus on results. The relentless focus on high student performance and on standardized tests results in 100% of KIPP students outperforming their district average in reading and mathematics testing. KIPP has proved to have a significant impact on student achievement.

HOW CAN NAMIBIA LEVERAGE THE LESSONS LEARNT FROM KIPP?

- Work with the Millennium Challenge Corporation to establish a KIPP initiative in Namibia, co-opting support from KIPP education experts involved in teacher training and standardized testing.
- Identify under-served and disadvantaged communities that could benefit most from KIPP.
- Determine the optimal way to introduce KIPP in Namibia – either through the establishment of a number of pilot KIPP schools, or by focusing KIPP on students in Years 5 – 8 to ensure that these students go on to good quality secondary schools.

KIPP STUDENTS IN THE USA:

- 95% of students are African American or Hispanic.
- Over 75% of students are eligible to the federally-subsidized meal programme.
- 85% of KIPP students are accepted into college.
- KIPP students have secured more than US$25 million in scholarships and financial aid since 2000.
PROTECTION FROM POVERTY

Child poverty threatens future growth as it deprives children of the development opportunities that they need to become contributing and productive members of the community. With child poverty being so widespread in Namibia – 43.3% of children live in poverty91 - pro-active intervention is required to protect and educate the current generation of children, and break the cycle of poverty.

HOW ARE POOR CHILDREN MORE VULNERABLE?

Their basic needs are not being met. Half of all children lack at least one basic material need – shoes, two sets of clothes and a blanket. Orphans and vulnerable children under five years of age are less likely to be well nourished than other children - 27% of orphans and vulnerable infants and children are underweight for their age, compared with 21% of other children. Rural children are less well nourished than urban children.92

Many children live with relatives. Only 25.8% of children live with both biological parents. Economic circumstances mean that it is common for children to live with members of their extended family, while a parent travels away for work. HIV/AIDS is also a factor, with most orphans and vulnerable children being cared for by relatives. The pressure on the extended family to care for additional children means that household resources are stretched. The well-being of the children – in terms of food, health and education - depends upon the wealth of the household.

Children have limited internal and external support. Poor parents struggle to nurture and support their children, because of limited resources, their own limited education and, in some cases, inadequate parenting skills. Furthermore, only 17% of households receive any assistance for medical, social, educational, material, and emotional needs. Similarly, only 16% of households with chronically ill or recently deceased adults receive regular medical support or other care.

They are more at risk of abuse and exploitation. The stress of poverty and food insecurity can result in parents or caregivers suffering from depression, abusing alcohol, resorting to domestic violence, or co-opting children into employment. Young girls are also more likely to be enticed into an early marriage. In this way poor children may be exposed to situations that are damaging to them both physically and psychologically.

Young, vulnerable girls are more likely to engage in early sexual activity. 10% of orphaned, or vulnerable girls are sexually active before they are 15 years old compared to 7% of other girls. Early sexual activity increases the risk of HIV infection and unplanned pregnancy. Almost half of all new HIV infections are expected to occur among youths age 15 to 24, with young women accounting for 3 out of every 4 new infections. The direct relationship between increased education and teenage pregnancy is clearly established.

HOW DOES SOCIAL PROTECTION SUPPORT EDUCATION?

The National Plan of Action (Ministry of Gender Equity and Child Welfare, 2007) outlines a five-year strategic plan on rights and protection, education, health and nutrition, care and support services and mobilisation, integration and networking. It also includes a monitoring and evaluation plan.

Welfare grants are primarily spent on food and education.93 As school attendance is a condition of receiving the grant, school enrollment and attendance is encouraged. Although grant recipients are also exempted from paying into the School Development Fund, in practice many of the families receiving grants are better off than other poor households and so pay the fees to support their school.

Grants increase the time spent at school. Household poverty can mean that children are required to miss school to help out with chores, or drop out of school altogether. Increases in education levels translate into better job opportunities and better household incomes.

Teacher counsellors are helping learners despite resource constraints and limited support.94 In addition to struggling with poverty, hunger and illness, learners often find school a difficult and negative environment. Corporal punishment and the lack of a positive learning culture means that they have little support. Counselling can provide learners with motivating encouragement, advice and practical interventions, equipping them with the life skills and helping to build resilience to difficulty. Ensuring that all schools have a well-trained Teacher Counsellor who receives the support of the School Principal is critical to protecting and nurturing vulnerable children.

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MDG3: BEING A WOMAN IN NAMIBIA

FEMALE POVERTY

WHY ARE WOMEN MORE VULNERABLE TO POVERTY?

The burden of supporting the family is increasingly falling to women, but women still do not have equal access to resources and opportunities for employment. Currently 41% of households are female-headed, yet they only receive 29% of total income. Similarly, consumption per capita in male-headed households is 40% higher than in female-headed households. As the number of female-headed households increases, women must be empowered to support their families and ensure the health and survival of their children.

Women and their children are especially vulnerable when the husband dies and his family seizes all the family assets, leaving the widow and children destitute. The Married Persons Equality Act guarantees a number of rights to assets that do not apply in customary marriages. Thus women married under customary law are not protected from some cultural practices that may be harmful to them.

HOW CAN WE ALLEVIATE FEMALE POVERTY?

Women must be given equitable access to resources and opportunities for employment. Education is a key tool to empower women in terms of knowing their rights, obtaining formal employment and increasing their standard of living. Employment also encourages gender equality by generating higher levels of respect from the community and greater personal dignity and self-respect.

Women need to get involved with decision-making – given an equitable role in decision-making, women are less likely to justify wife abuse and are more likely to receive proper health care when pregnant or ill. Women’s participation in decision-making is an important step towards women’s empowerment.

HOW DOES POVERTY AFFECT WOMEN IN URBAN AREAS?

In urban areas, a female-headed household tends to consist of a single parent, her dependent children and other relatives who are co-habiting with them. These relatives may also have dependent children and together they provide for everyone in the household, contributing towards expenses and sharing child-rearing responsibilities.

Living in towns and cities is expensive. Income has to be spent on non-food items such as rent, transport, water and electricity, possibly even childcare - leaving less money to spend on food. Estimates of urban poverty that are based on the percentage of income spent on food consumption are likely to underestimate the extent of poverty in urban areas.

HOW DOES POVERTY AFFECT WOMEN IN RURAL COMMUNITIES?

Poverty levels are highest among female-headed households with one or more children, living in a rural area. Because of labour migration and AIDS mortality, the most common female-headed family in a rural community is a grandmother and her grandchildren - left behind when their parents head into the towns to look for work, or have died from HIV/AIDS. Often the state-provided pension is the only source of cash income to these families.

Female-headed households in rural communities have less access to land and livestock than men. For example, approximately 66% of female-headed households with plots in rural areas have access to draught animal power, compared with 92% of male-headed households.


WHAT CONSTITUTES GENDER-BASED VIOLENCE?

The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) defines gender-based violence as “violence that is directed against a person on the basis of her or his gender or sex.”

Gender-based violence is more than sexual assault and rape – it is physical, financial, sexual and psychological harm to impose subservience and perpetuate male power and control. It includes acts that inflict physical, mental or sexual harm and suffering, as well as acts that limit freedom or deny opportunities. Selective malnourishment of female children, forced prostitution and several harmful traditional practices are also forms of gender-based violence.

Gender-based violence reflects and reinforces gender inequality and can damage the health of women and girls directly and indirectly. Direct consequences include, among other injuries, gynaecological and mental health disorders, adverse pregnancy outcomes, and sexually transmitted infections. Indirect consequences of violence include dangerous health practices such as smoking, alcohol and drug use, and sexual risk taking.

WHAT ARE NAMIBIAN’S ATTITUDES TOWARDS GENDER-BASED VIOLENCE?

Some forms of violence are socially acceptable in Namibia. Violence up to the level of slapping, as well as emotional pressure is tolerated and consistent with traditional social norms. Whereas Common law allows for a certain level of chastisement by parents, the disciplining of children in ways that can be considered violent is still socially permissible.

Gender-based violence is a family matter. As the abuse tends to happen behind closed doors, it is viewed as a private issue that does not involve the community or the police. If the violence becomes excessive, it is up to the immediate family to intervene to protect the survivor. In extreme cases the family may choose to involve the traditional court. As a result, legal protection is limited.

Gender-based violence is getting worse. This attitude is supported by the increase in the number of rape and domestic violence cases reported annually. The older generation thinks that this is because of weakening social norms and believes that returning control in the relationship to the male of the family is the solution, whereas the younger generation seeks a strengthened role for women in society.

Efforts to reduce gender-based violence must involve men and women. Namibians recognize that men must be part of the solution and that “given the opportunity and know-how many men are eager to challenge customs and practices that endanger women’s health.”

WHAT ARE THE FACTORS INFLUENCING GENDER-BASED VIOLENCE?

Knowledge and education, economic empowerment, access to and control of resources, and social benefits can mitigate gender-based violence. Personal history - witnessing marital conflict as a child or being abused as a child - is also a factor in attitudes and the acceptance of such behaviour.

One of the most common forms of violence against women is domestic violence (i.e. violence by intimate partners). Domestic violence happens behind closed doors and is often treated as a private family matter.

Cultural and social norms influence gender roles and behaviour, attitudes towards women and the use of violence as a way to resolve conflicts. Legal and political frameworks can be established to protect women and children, but it is essential that communities and families, men and women, strongly believe that gender-based violence is unacceptable and that such behaviour is appropriately penalized.

HOW DOES THE LAW PROTECT AGAINST GENDER-BASED VIOLENCE?

Formal protection is available through the Combating of Rape Act and the Combating of Domestic Violence Act. However, effective implementation and consistent enforcement of these laws is a challenge. Women and Child Protection Units (WCPUs) represent progress towards the protection of vulnerable members of society.

Laws combating sexual exploitation, stalking and trafficking are less developed and should be a core focus in the fight for gender equality to ensure that all forms of gender-based are prohibited under the law.

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99UNHCR, 2003
WHAT IS HUMAN TRAFFICKING?

Human beings are recruited, transported and traded for exploitation and profit. This is why human trafficking is referred to as modern slavery. As it was with slavery, the most common victims are women and children who are forced or deceived into submission. They are illegally moved within the country, or across borders to be sold to work in both legal and illegal occupations.

Trafficking of women and girls for sexual exploitation is a lucrative business. Poverty, limited education and/or employment opportunities and hopes for a better future make young people vulnerable to the deceit of traffickers. Orphans are particularly vulnerable to exploitation.

IS HUMAN TRAFFICKING AN ISSUE IN NAMIBIA?

There is no evidence of an organized network of human traffickers in Namibia. However, there are individuals and families who are guilty of trafficking, especially with regards to women and children. There are indications that trafficking occurs within the country as well as across borders. Cases are not documented, investigated or prosecuted, although there is a possibility that they exist.100

Namibia is a source, a destination and a transit country for human traffickers. While there is not enough reliable information on the issue in Namibia, there is sufficient anecdotal evidence to suggest that trafficking is a problem that warrants attention. Women are trafficked for prostitution, forced labour and forced marriages. Children are being trafficked for sexual exploitation, illegal adoption, organ/body parts, domestic servitude, agricultural labour and livestock herding. Traffickers between Angola, Zambia and South Africa may perceive Namibia as a safe transit route.

WHAT IS THE SITUATION WITH PROSTITUTION?

Prostitution is illegal in Namibia. It is a criminal offence to solicit sex for money, keep a brothel, work in a brothel and live on the earnings of prostitution.

Prostitution is lucrative, but dangerous. In a 2008 Baseline Survey conducted by the National Social Marketing Programme, poverty was given as the primary reason that women become prostitutes, while 9.2% reported being forced into commercial sex work.101 Prostitutes risk their lives working in dangerous places where they are vulnerable to attack and abuse. In addition, condom use amongst prostitutes is inconsistent and so they risk contracting sexually transmitted infections. Prostitutes are one of the most at risk groups for contracting HIV.

The health status and human rights of sex workers is deteriorating. Police are reluctant to help sex workers when they have been abused and police violence during brothel raids and street sweeps is common. Prostitutes report that police brutality also includes forced sex, confiscating and destroying condoms and extortion of bribes.

HOW CAN PROSTITUTION-RELATED ISSUES BE ADDRESSED?

Anti-discrimination and human rights training for police and health officials dealing with sex workers is required. Prostitutes have a right to police protection and the police should be trained and disciplined in their dealings with sex workers, not provided the opportunity to abuse their position. Similarly health workers should be trained on the healthcare interventions required by this group. All training needs to address the stigma of sex work and discrimination suffered by sex workers when dealing with these public services.

Targeted health interventions to ensure HIV prevention and promote sexual and reproductive health amongst sex workers. Resources should be allocated to provide these services to sex workers. For example, sex workers in Namibia are reportedly frustrated that existing HIV/AIDS education is irrelevant to their lives.102

Enable and support NGO engagement with prostitutes to better understand this group - the numbers of people affected, the social and health issues they face, what specific health and social services are required and how their rights can be protected.

100Office of the Prosecutor General 2007 in the Baseline Assessment of Human trafficking in Namibia, MGECW 2009
**MDG4: CHILDHOOD ESSENTIALS**

**BREASTFEEDING**

**WHY IS BREASTFEEDING SO IMPORTANT?**

Breastfeeding is a baby’s first immunization against environmental hazards. It helps protect the infant against diarrhea, ear and chest infections and other health problems. This is because breast milk contains antibodies that transfer the mother’s immunity and resistance to disease to the infant.

Breast milk also contains the perfect balance of nutrients for a baby - energy, protein, vitamin A and iron. It is easy for the baby to digest and fully meets the baby’s need for fluids. As the most efficient source of nourishment, breastfed babies are generally healthier and achieve optimal growth and development compared to those who are fed formula milk. This is why breast milk is the recommended way of feeding all infants - even when other substitutes are affordable, clean water is available and good hygienic conditions for preparing infant formula exist.

Breastfeeding is good for bonding, making infants feel secure and loved. This is important for their growth and development.

Exclusive breastfeeding is recommended for the first 6 months of life. This means that the baby consumes ONLY breast milk – no other liquids or solids, not even water.

Breastfeeding benefits the mother by helping her womb contract and so reducing the risk of heavy bleeding and infection.

**WHAT ARE THE RISKS OF ARTIFICIAL FEEDING?**

Bottle-feeding a baby infant formula or animal milk increases the risk of illnesses that can compromise their growth and may even result in death and disability. Breastfed babies receive protection from these illnesses through their mother’s milk.

Babies have more difficulty digesting substitutes and if water is contaminated there is an increased risk of diarrhoea, respiratory and ear infections and other illnesses. If the balance of nutrients is not right, or there is harmful bacteria in the formula, the infant may not develop and grow sufficiently to stave off illness.

Formula is expensive and women need to be able to afford adequate quantities - approximately 20 kgs of formula would be required in the first 6 months.\(^{103}\)

National figures for exclusive breastfeeding are low at around 15%. However a recent study by the Ministry of Health and Social Services in the northern regions found that around 62% of infants are exclusively breastfed, but only for 1-2 months. Sickness or absence of the mother are the primary reasons for infants being fed with solid or semi-solid foods. It is interesting to note that very few were fed with either fresh or powdered milk.\(^{104}\)

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IMMUNISATION

WHAT IS IMMUNISATION?

Immunisation is the most cost effective health intervention.

Immunisation is a vaccine that protects children from particularly dangerous diseases. Early protection is critical to avoid contracting a disease that may cause death or disability. For this reason, every child should complete the recommended series of immunisations. If a child does not complete the full series of immunisations in the first and second year of life, it is extremely important to have the child fully immunized as soon as possible.

Without immunisation, a child is more likely to become sick, permanently disabled or undernourished. Vaccines work by building up the child’s defences against diseases, but they only work if given before the disease strikes. It is safe to immunise a child who has a minor illness, one who has a disability, is malnourished or is HIV positive. And if there is no history of immunisation, it is safe to repeat doses.

WHAT OTHER IMMUNISATION INITIATIVES CAN HELP PROTECT NAMIBIANS?

Strengthening cross-border immunisation with Angola. Immunisation works by directly protecting individuals who have received the vaccine and indirectly by reducing the incidence of the disease amongst the population. This indirect protection is referred to as “herd immunity”. With the movement of people back and forth across the northern border, it would be beneficial for Namibia and Angola to work together to strengthen routine immunisation across both populations and so increase the herd immunity in both countries.

WHAT ARE THE ESSENTIAL VACCINES?

At a minimum, all children should be immunized as follows:

<table>
<thead>
<tr>
<th>Essential Vaccine</th>
<th>For Immunity Against</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCG</td>
<td>Offers partial protection against some forms of TB and leprosy</td>
</tr>
<tr>
<td>DTP/DPT</td>
<td>Diptheria, tetanus and pertussis</td>
</tr>
<tr>
<td>Measles</td>
<td>Measles – a major cause of malnutrition, poor mental development and hearing and visual impairments. Measles is very contagious.</td>
</tr>
<tr>
<td>Polio</td>
<td>Polio – can cause disability for life</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Can lead to serious liver problems including cancer</td>
</tr>
<tr>
<td>HiB</td>
<td>Haemophilus influenzae, a cause of pneumonia and meningitis</td>
</tr>
</tbody>
</table>

Vitamin A should be distributed during routine immunisation. It is an important part of measles treatment and presently 95% of children are receiving Vitamin A supplements.¹⁰⁵

HOW DOES MOTHER-TO-CHILD TRANSMISSION OCCUR?

HIV can be transmitted from an HIV-infected mother to her child during pregnancy, labour, delivery or breastfeeding. This is known as mother-to-child transmission (MTCT). Without intervention, the risk of MTCT ranges from 20% to 45%. With specific interventions to non-breastfeeding mothers, the risk of MTCT can be reduced to less than 2%, and to 5% or less if the mother is breastfeeding.

Mother to child transmission infects over 6,000 infants with HIV each year and is likely to increase the proportion of under 5 deaths by 20%. In 2008/09, 11,600 women were in need of PMTCT services. Infant and child mortality is increasing in communities with a high prevalence of the virus and it is estimated that infant mortality will be 60% higher in 2021 than it would have been without HIV/AIDS.

Without treatment, approximately 50% of HIV infected children will die before their second birthday.

HOW CAN MTCT BE PREVENTED?

The prevention of mother-to-child transmission is a highly effective intervention and has huge potential to improve both maternal and child health. To prevent the transmission of HIV from mother to baby, the World Health Organization (WHO) promotes a comprehensive approach, which includes the following four components:

- Primary prevention of HIV infection among women of childbearing age;
- Preventing unintended pregnancies among women living with HIV;
- Preventing HIV transmission from a woman living with HIV to her infant; and
- Providing appropriate treatment, care and support to mothers living with HIV and their children and families.

In March 2002, the MoHSS introduced the Prevention of Mother to Child Transmission of HIV (PMTCT) programme as a pilot in Katutura and Oshakati State hospitals. By March 2009, 292 health facilities were providing PMTCT services, including all 34 district hospitals.

Namibia has now achieved the United Nations General Assembly Special Session (UNGASS) goal of 80% coverage with PMTCT rolled out to over 85% of all health facilities in Namibia. Identifying HIV positive women through Voluntary Counselling and Testing is the first step into the PMTCT program. In 2008/9, 58% of pregnant HIV infected women received ART prophylaxis for the prevention of MTCT. At that time transmission risk was reported to be at 12.7%.

Medicines for PMTCT are available and financially supported, although there is an overall shortage of health workers trained in the latest PMTCT guidelines.

WHAT ARE THE KEY SUCCESS FACTORS?

Reduce stigma by engaging opinion leaders at the community level, normalize HIV and facilitate access to services for all women living with HIV (including sex workers and drug users). Programmes must also strengthen the relationship between the formal health system and community organizations to expand HIV prevention services and treatment literacy and preparedness. National programmes should ensure that antenatal care, labour and delivery, and postpartum services provide a user-friendly environment for women living with HIV.

Community health workers play an important role in increasing the uptake of PMTCT services by providing information on access to services, expanding treatment literacy related to the use of ARTs, supporting treatment preparedness and adherence, and encouraging positive prevention and disclosure of HIV status.

Male partners play an equally important role in the scale-up of PMTCT services. In Botswana and Zambia, where disclosure of HIV status among pregnant women is relatively high, families and male partners are involved in decisions around ART and infant feeding.

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MDG5: CARE FOR MOTHERS

EMERGENCY OBSTETRIC CARE

The direct causes of maternal deaths are eclampsia, obstructed labour, haemorrhage and complications of abortion. With about 15% of pregnant women experiencing at least one life threatening complication during delivery, obstetric interventions during labour are critical for reducing maternal mortality.

WHAT CONSTITUTES EMERGENCY OBSTETRIC CARE?

Basic Emergency Obstetric Care facilities offer services for:
1. Normal delivery, including instrumental assisted vaginal delivery
2. Manual removal of the placenta and retained products
3. Intravenous sedatives, antibiotics, and oxytocin.

A Comprehensive Emergency Obstetric Care facility offers all the basic obstetric care, as well as surgical procedures - including caesarian section under anesthesia and safe blood transfusions.

The World Health Organisation recommends that for every 500,000 people, there should be at least four Basic Emergency Obstetric Care facilities and one Comprehensive Emergency Obstetric care facility.

WHAT IS THE AVAILABILITY OF EMERGENCY OBSTETRIC CARE IN NAMIBIA?

Namibia has four comprehensive Emergency Obstetric Care facilities, but there are no Basic facilities in the country. Three of the four facilities are in the central regions - two in Windhoek, one in Otjiwarongo and one in Oshakati. The highly populated northern areas have inadequate emergency obstetric care. This serious shortage of basic emergency obstetric care facilities is regarded as a leading cause of maternal deaths in the northern regions of Namibia.

It is essential that Emergency Obstetric Care facilities be established in the highly populated regions in the North. In the interim, Community-based health providers, community health extension workers, and Traditional Birth Attendants need to support expectant mothers by educating women and their families to recognize signs of life-threatening complications and know when and where to seek appropriate care if complications arise.

An effective referral system for critical cases, one that includes radio communications and emergency transport, must also be established.

MOBILE PHONES HAVE POTENTIAL TO IMPROVE HEALTHCARE SERVICES

- Health Extension Workers can seek advice
- MoHSS can send out education texts to HEWs and alerts to the public
- Create a network of midwives who can support each other
- Provide alerts for emergency cases being transferred to hospital

Technology should be optimized in all interactions with the public. Educational messages and health alerts can be incorporated on all Ministries’ automated telephone-answering systems, leveraged through the post office network, as well as via automated bank tellers.
ANTENATAL CARE

WHY IS ANTENATAL CARE IMPORTANT?

It is recommended that a pregnant woman has at least four antenatal visits during her pregnancy. During these visits she will be assessed in terms of her general health, the health of the foetus and for the risk of complications during delivery.

Specific assessments and actions undertaken during an antenatal visit include:

- Screening for hypertension and treating as needed
- Immunising the mother against tetanus
- Checking for anaemia and treating with iron supplements as necessary
- Giving micronutrient supplements
- Intermittent preventive treatment for malaria

Access to antenatal care differs by region – it appears to be lowest in the Ohangwena sample where 50% of the mothers reported no antenatal care during their most recent pregnancy. However, the mothers of the children in the Kavango sample appeared to have the best access to antenatal care with more than 40% of the pregnancies being attended by a doctor and nearly all reported receiving a tetanus toxoid injection.

INNOVATIONS IN POLITICAL LEADERSHIP FROM RWANDA

The entire government works for the health of women and children. It is not only the responsibility of The Ministry of Health, as WHO recommends there is “Health in all Policies”.

Parliament is action focused and takes responsibility for monitoring health and development efforts. Focus on gender equality is achieved by highlighting women-centred actions in their plans and reports. For example, Maternal deaths are monitored and actions developed by Parliament.

Local government is accountable for health results. It is their responsibility to implement the national policies and deliver basic services. Local governments work with civil society to develop District Health Plans. The District Mayor reports to Parliament on the delivery of the Health Plan every year, in a public, televised session. Local communities carry out maternal death audits and all audits are sent to the Ministry of Health.

Communities are engaged through involvement in the District Health Plan. This creates a partnership between Local government, health facilities and the community.
MDG6: NAMIBIA’S HEALTHCARE CHALLENGES

HEALTHCARE SERVICES

At the 2001 Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, leaders in Africa pledged in 2001 to devote 15% of their national budgets to health and to strengthen health systems to provide comprehensive maternal, newborn and child care services.

In Namibia, the allocation to Health and Social Services is only 9.4% of the national budget. There is a shortage of health care workers and access to health care facilities and services remains an issue – this means that vulnerable groups such as women and young children are not adequately served by the system.

HIV/AIDS

WHAT IS HIV/AIDS?

HIV is the human immunodeficiency virus that damages the body’s immune systems so that it cannot fight off other diseases. AIDS – acquired immune deficiency syndrome - is the last stage of the HIV infection, where the body is so weakened that it is unable to cope with any illness.

There is no cure for HIV and there is no vaccine to prevent infection. However, antiretroviral treatments (ART) can effectively booster the immune system and enable people with HIV to lead long and healthy lives.

WHAT ARE THE EPIDEMIC DRIVERS OF NEW HIV INFECTIONS?

Low levels of risk perception are compounded by social norms that make risky behaviour acceptable.

Having multiple concurrent sex partners increases the risk of the HIV infection being transmitted through the population. With sex outside of marriage being the norm and a large proportion of the population spending time away from home for work related reasons, it is more likely that people will have multiple sex partners.

Transactional and trans-generational sex is a common and acceptable practice. However transactional and trans-generation sex is also commonly associated with vulnerability as a result of poverty and food insecurity. With women more likely to be in this vulnerable position, they are frequently unable, or unsuccessful, in negotiating to use a condom.

Drinking and abusing alcohol increases the likelihood of a high-risk encounter. Under the influence of alcohol people are less inhibited, unable to make reasonable decisions and so are more likely to engage in higher risk sexual encounters - including unprotected sex, or sex with a casual partner.

WHAT IS THE CURRENT SITUATION IN NAMIBIA ?

Namibia has a maturing epidemic with a declining number of new infections. The prevalence in older adults is the highest (27% among women aged 30-34 years) while the prevalence amongst younger women (aged 15-19 years old) declined from 12% in 2000 to 5% in 2008. The prevalence amongst women aged 20-24 years decreased from 20% in 2000 to 14% in 2008.

In 2008/09, it is estimated that the HIV prevalence in the general population aged 15 to 49 years in Namibia was 13.3%. There were approximately 6,130 AIDS-related deaths – approximately 23% of all deaths in Namibia.
Males who are not circumcised have an increased risk of infection. Namibia has an active male circumcision task force that has developed a Communication Strategy and educational awareness materials. A male circumcision policy has been finalised and a male circumcision indicator will be included among the national indicators to monitor this important prevention initiative. In addition, Namibia has begun to offer male circumcision in at least one hospital in each of Namibia’s 13 regions.

Not using a condom every time is risky behaviour. Condom use by people with 2 or more partners and amongst people with non-regular partners is relatively high - 62% women and 78% men used a condom at last sex with non-regular partner. However, rates of consistent condom use are much lower – only 48% women and 58% of men reported consistently using a condom with their last partner.

Sex workers, men who have sex with men (MSM), Intravenous Drug Users (IDUs) and prisoners are the most at risk groups for HIV infection. The size of either the sex worker or the MSM populations has not been determined. However, The World Bank estimates suggest that there are approximately 11,000 sex workers and 2,600 MSM in Namibia.

MALARIA

WHAT IS MALARIA?

Malaria is a parasite that lives and thrives in our bloodstream. The parasite destroys the red blood cells and so causes anaemia, which can be severe enough to be fatal. Malaria can damage the brain and other vital organs, cause heart failure, respiratory distress, kidney failure and bleeding disorders. Repeated malaria infections can lead to life threatening anaemia. Symptoms of malaria include high fever, diarrhoea, vomiting, headache, chills and flu-like symptoms.

HOW IS MALARIA SPREAD?

Malaria is transmitted by the night-biting Anopheles mosquito. If the mosquito bites someone infected with malaria, the parasite is transmitted to the mosquito, where it develops and is then passed on to someone else when the mosquito feeds again.

Namibia has unstable transmission of malaria, meaning that it is highly seasonal – occurring only at certain times of the year. This means that the population does not develop sufficient immunity against the parasite and so epidemics are more likely to occur.

WHO IS MOST AT RISK?

In Namibia, the entire population living in a malaria zone is at risk of severe disease and death. There are sectors of the population who are more vulnerable to infection and for whom the disease can be fatal, or have long lasting consequences.

A severe infection can kill a child within hours. Children under 5 years old are most susceptible to malaria because they have very little acquired immunity to resist it. It can worsen rapidly, causing coma and death. Malaria that results in chronic anaemia may impede a

HOW IS HIV BEING TREATED?

Antiretroviral therapy (ART) is proving an effective treatment for people with HIV and survival rates for adults are 85% in the first 12 months and 95% for subsequent years.

All districts or local administration units have at least one health facility providing ART. By March 2010, 75,681 people were receiving ART of which 10.5% are children. ART has been scaled up using resources from international partners such as the Global Fund and PEPFAR, as well as additional budget from the Government. In order to provide ART services to all Namibians who are in need, Namibia has introduced approaches such as Integrated Management of Adult Illness (IMAI) and ART outreach services that bring healthcare services closer to the people that need them.

child’s growth and intellectual development. This weakening of the body makes the child susceptible to other illnesses, most commonly diarrhoea and respiratory infections.

The risk of getting malaria is two to three times greater for pregnant women. Malaria during pregnancy can cause anaemia in the mother, spontaneous abortion, miscarriage, stillbirth and even death. Malaria can impair foetal growth, resulting in children born with low birth weights - decreasing their chances of survival and development.

Having HIV doubles the risk of developing clinical malaria. Malaria infection suppresses the immune systems and increases the HIV viral load – leading to increased transmission of the virus and more rapid progression of illness.

HOW IS MALARIA PREVENTED?

Insecticide treated nets (ITNs) can cut malaria transmission by more than half. Long lasting insecticidal nets means that frequent retreatment is not necessarily and the effectiveness of the net is much greater over time.

Indoor spraying also helps prevent the transmission of malaria, but is not as effective as using the ITNs.

Pregnant women should be given Intermittent Preventative Treatment (IPT) for malaria – ideally during the second and third trimesters when the foetus is gaining significant weight. IPT is effective in reducing anaemia in mothers and preventing placental malaria infection. In Namibia, 20% of pregnant women receive IPT doses during an antenatal care visits. These women are mostly based in the North and live in rural communities.\textsuperscript{112}

TUBERCULOSIS (TB)

WHAT IS TB?

Tuberculosis is a bacterial infection, transmitted in droplets through the air when an infected person coughs or sneezes. The infection is concentrated in the lungs and the most common cause of death is simple respiratory failure - as the bacteria destroys lung tissue and inhibits oxygen absorption. But TB may spread to other parts of the body, ultimately resulting in organ failure.

TB is a curable disease. Under normal circumstances 90% of patients can be successfully cured within 6 months. However if the patient has developed or contracted a drug resistant form of TB, then more costly drugs, including injectable antibiotics, are required. Treatment time for drug resistant patients may take longer than 2 years and success rates are between 50%-70%.

WHAT IS THE INCIDENCE OF TB IN NAMIBIA?

HIV and Poverty and are the two key factors contributing to the prevalence of TB in Namibia. The TB case rate in Namibia - 634 per 100,000 population\textsuperscript{114} - is the second highest in the world, with HIV co-infection estimated at 60%. Even with the widespread availability of ART, TB continues to be the leading cause of death for people with HIV.

HOW IS MALARIA TREATED?

Prompt and effective treatment for malaria is critical to stop the parasite multiplying and causing irreversible damage and possibly death. For this reason, rapid diagnostic testing is essential to minimize the delay in identifying the infection and to begin treatment as quickly as possible.

The parasite has built up resistance to certain antimalarial drugs, such as chloroquine and sulphadoxine-pyrimethamine (SP). This means that these drugs have lost their effectiveness so that the parasite continues to thrive in the bloodstream and that the patient remains infectious.

WHO recommends the use of combination therapies in Africa, such as Artemether/lumefantrine (Coartem®), Artesunate + amodiaquine, or Artesunate + SP (if efficacy remains high).\textsuperscript{113}

\textsuperscript{112}Ministry of Health and Social Services. (2008). Namibia Demographic and Health Survey 2006/07. Windhoek: MOHSS.
WHAT IS DRUG RESISTANT TB?

A patient with Drug-Resistant TB (DR-TB) cannot be successfully treated with the available and commonly used anti-TB medicines. In these cases, the TB bacteria does not respond to the drugs and this is most common when a patient has previously started a treatment course, but not completed it – i.e. dropped out, or defaulted on their treatment. Any interruption in medication is serious as it leads to increased resistance and makes future treatment more difficult and costly.

Once a person has developed DR-TB, they can infect others with their drug resistant strain of TB. It is essential that patients are screened for DR-TB and monitored while on treatment to ensure that DR-TB can be diagnosed early.

DR-TB is proving to be a challenge for TB control efforts in Namibia. The MoHSS has funded the procurement of the required second line medicines to ensure that patients diagnosed with DR-TB can receive effective treatment. However, the difficulties and expenses associated with treatment and management of DR-TB more than emphasise the importance of minimising the emergence of TB drug resistance at all costs.

DR-TB has been reported from all 13 regions of the country, with the majority of the reported cases from Kavango, Khomas, Otjozondjupa, Ohangwena, Oshana and Erongo regions.

In 2009 a total of 372 cases of all forms of DR-TB were reported, of which 275 had MDR-TB, 80 had poly-drug resistant TB and the remaining 17 had XDR-TB.

WHY IS COLLABORATIVE TREATMENT OF TB AND HIV IMPORTANT?

TB treatment success rates are poor for HIV positive TB patients not on ART. In addition to other HIV prevention efforts, ART is an important factor in TB control as people receiving ART are less likely to transmit HIV and less likely to contract TB. TB/HIV co-infection rates are high because of the impact of HIV on the immune system - 58% TB patients with a known HIV status are HIV positive. It is essential that TB/HIV co-infected patients are diagnosed as early as possible.

HIV counselling and testing of TB patients remains one of the key TB/HIV collaborative interventions. Coverage of HIV testing for TB patients continues to improve - 74% of TB patients registered in 2009 have an HIV result. Namibia wants to achieve HIV testing rates of more than 95% for TB patients. DOTS stations encourage TB patients to take HIV tests when they are tested or treated for TB and many of the community-based HIV care and support organisations provide patient and community education on TB/HIV issues.

WHAT IS DOTS?

Namibia follows the Directly Observed Treatment- Short Course Strategy (DOTS) - as recommended by WHO. Treatment of TB is provided free of charge in all government and NGO health facilities.

Community-based directly observed therapy (CB-DOT) is improving the adherence to TB treatment across all categories of patients. It is anticipated that community based services will result in an overall reduction in the prevalence of TB. By the end of 2009, 12 of the 13 regions had some form of community TB care support through non-governmental organisations. Due to the vast distances between health facilities, this exercise will become increasingly more difficult and expensive, as efforts are made to reach the hard-to-reach populations in remote areas. It is therefore important for regions to explore ways to leverage on existing community systems to provide support for TB patients.

Advocacy, communication and social mobilization improve community awareness, demand and utilisation of services. Full regional, district and health facility coverage of community TB care support are required to ensure that all patients have access the appropriate support.

The World Health Organization (WHO) recommends collaborative HIV/TB activities such as The Three I’s:

1. Isoniazid preventive treatment (IPT) – to prevent the progression of latent TB infection to active disease
2. Intensified case finding TB screening - to find undiagnosed TB cases in people living with HIV
3. Infection control for TB - to prevent anyone from catching TB while in a health facility or other crowded settings such as prisons
MDG7: ENVIRONMENTAL PROTECTION

SAFE DRINKING WATER AND BASIC SANITATION

HOW DO SAFE DRINKING WATER AND BASIC SANITATION IMPACT OUR HEALTH AND DEVELOPMENT?

Diarrhoea is the leading cause of death in young children. Young children are more vulnerable than any other group to the ill effects of unsafe water, bad sanitation and poor hygiene. These factors contribute to 88% of deaths from diarrhoeal diseases. Good hygiene, basic sanitation and safe drinking water are essential to reduce the risk of diarrhoea.

Many illnesses are caused by the germs found in human faeces. These germs get into water, on food, hands, utensils and surfaces and are then swallowed. Safe disposal of all faeces - human (babies, children and adults) and animal - is the single most important action to prevent the spread of germs by people or flies.

WHAT IS MEAN BY SAFE DRINKING WATER?

Drinking water is considered safe if it meets certain microbiological and chemical standards. Safe water sources include properly constructed and maintained piped systems, public standpipes, boreholes, pond sand filters, protected dug wells, protected springs and rainwater collection. Water from unsafe sources may come from rivers, dams, lakes, ponds, streams, canals, irrigation channels, unprotected wells and springs.

Unsafe water needs to be treated by boiling, filtering purifying or disinfecting. Information on home treatments, protecting water sources and storing water should be made available to communities. Furthermore, the economic costs of collecting water from unsafe sources can be great – in terms of time spent by women and children carrying water and the associated health risks of the unsafe water.

Women have proved more reliable in maintaining safe water systems because it is traditionally their role to provide the water for the family. Community training should focus on equipping women with the knowledge and tools to maintain the local system.

WHO IS RESPONSIBLE FOR BASIC SANITATION?

Local authorities are not able to meet the demand for services – in particular for the low-income groups in informal settlements. The set up of basic infrastructure is very expensive and urban migration means that more people are living in informal settlements, often in unhealthy living conditions - without access to safe drinking water and basic sanitation.

Everyone in the community needs to work together to build and use toilets, practise good hygiene, protect water sources and safely dispose of waste water and refuse. It is important for governments to support communities by providing information on how to design and build toilets that all families can afford. Adequate hygiene education is essential and the solutions required include low cost sanitation, drainage systems, safe drinking water and refuse collection.

Decisions about sanitation are made at the household level and so regional and local authorities must provide technologies that people want to use. These technologies must be affordable and easily maintained by poor communities. The deciding factors regarding which technologies to implement should focus on ownership and sustainability.
CONSERVATION

WHAT ARE NAMIBIA’S CONSERVATION ISSUES?

- Environmentally friendly tourism and natural resource extraction are crucial long-term challenges.
- Population growth has lead to soil erosion and bush encroachment due mainly to overgrazing/overstocking.
- A growing mining industry has made scarce water supplies worse.
- Floods and droughts in northern Namibia adversely affected agriculture and damaged infrastructure.

HOW ARE OUR NATURAL RESOURCES MANAGED?

Regulations are required to restrict overfishing. The Ministry of Fisheries and Marine Resources established A Total Allowable Catch for commercial fish to ensure that there is no long term damage to fish stocks. Fishing had accounted for approximately 28% of Namibia’s GDP in 1969 but its share had dropped to 4% by 1990. This was the result of exploitation of natural resources for immediate profits, without consideration for sustainable utilisation. Fishing is still a significant sector of the economy, providing employment and income for the population. Currently about 0.4% are employed by the fishing industry.115

It is essential to work with and educate communities that are engaged in the unsustainable practices or that are able to more effectively monitor and enforce environmental regulations. In many cases, educating communities about the risks of such activities to their livelihood can be enough to greatly enhance the use of more environmentally friendly approaches.

Limited access to clean fuels has a direct impact on rural households. These communities rely on wood, charcoal, crop residues and dung as their primary source of domestic energy for cooking and heat. Indoor air pollution caused by these fuels is harmful to our health and may even result in death, mostly among women and children.

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MDG8: INTERNATIONAL COMMITMENTS

FOREIGN INVESTMENT & TRADE

WHAT CAN BE DONE TO INCREASE TRADE?

Aid for trade needs to be increased. International aid should be secured to help develop the industries that can supply goods for export and to build the infrastructure required to support trade. It must be used for programmes that are practical, sustainable and add value to the economy.

Develop our trade capacity. Expand and diversify products for export and identify opportunities to process raw materials. Tackle the trade rules that restrict our trade to primary commodities. Secure agricultural subsidies from developed countries to increase production and the goods available for export.

Expand the number of trading partners, globally and within Africa. Intra-Africa trade is particularly underdeveloped. African leaders have committed to removing the barriers to trade but free trade agreements have yet to be implemented.

Collective regional action is essential for Namibia. It could increase employment opportunities and improve the growth rate of GDP per person employed. Policies adopted by regional economic communities could have a significant impact on domestic output and provide direction for the development of private sector opportunities.

The government aims to change the procedures governing foreign investment in Namibia, as the current regulations and incentives have failed to attract the hoped-for levels of investment.

OFFICIAL DEVELOPMENT ASSISTANCE (ODA)

WHAT IS ODA?

Sub-Saharan Africa continues to be the largest recipient of ODA, having more than doubled receipts in current dollars between 2000 and 2007. This is consistent with the high proportion of poor in the region.

ODA to Namibia has been decreasing – from US$130 per capita in 1990 to US$88 per capita in 2006. The 2015 target for ODA is US$90 per capita.

WHAT ARE ILLICIT CAPITAL OUTFLOWS?

Capital that leaves the country and so reduces the resources that could be used for development. Common sources of capital outflow include mis-invoicing in order to avoid commercial tax, proceeds from bribery, theft, human trafficking and drugs. Debt servicing costs and illegitimate sovereign debt are other ways that capital can leave the country.

In March 2010, Global Financial Integrity (GFI) published a study of capital outflow in developing countries and concluded that the high rate of illicit capital outflow has undermined donor-driven efforts to end poverty and boost economic growth and is the main stumbling block to development.116

The Bank of Namibia reported that in 2009 the net outflow of capital to South Africa was N$7.7 billion. This export of billions of dollars of savings to South Africa, and other countries, is slowing down the growth of the local economy. Namibia needs to increase access to financial services - especially to women – to encourage investment in the domestic economy. Retaining local capital in this way enables economic growth and job creation, thus addressing the issues of high unemployment and income disparity.

WHAT ARE THE ISSUES WITH ODA?

The global recession means that some donor countries are cutting their budgets for official development assistance to deal with internal issues. There also continues to be a gap between commitments made and actual delivery of ODA, most notably in relation to the United Nations target.

Several developed and developing countries have resorted to protectionist measures. Not only with respect to ODA commitment, but the technological divide between developed and developing countries seems likely to widen further as developed countries focus on stabilising their own economies.

The Paris Declaration recognizes that donor and recipient countries need to improve the quality and effectiveness of aid. In some areas, the lead responsibility rests with the recipient country but donors will have to be more insistent on required outcomes if the goals of the Paris Declaration and the Accra Agenda for Action are to be met. However, the implementation of Aid quality and effectiveness measures has been slow. Improvements must be made in the area to assure future Aid allocations.

WHERE SHOULD AID BE FOCUSED?

The overriding objective of the Millennium Declaration and its MDGs is to reduce poverty. ODA should be directed towards poor people in poor countries because of their low levels of development, vulnerability to external shocks and limited access to other sources of international financing for development.

The health sector is a priority because although health receives a significant share of its resources from the National Budget, these resources are not replaced through private investment. Aid is often the only reliable alternative when public funds for health are limited.
Regional Equity is the key to achieving dramatic results. Providing details of what needs to be done and how to achieve these results through Budgeting, Oversight and Practical Programmes.
We hereby commit ourselves to give more visibility to social development at national level, mainstream social development in all socio-economic programmes and budgets; and promote inclusive policies and a community-driven development;”

African Union, Windhoek Declaration on Social Development, October 2008

## SOCIAL PROTECTION & DEVELPMENT

### BUDGETING & RESOURCE ALLOCATION

<table>
<thead>
<tr>
<th>Action</th>
<th>MDGs</th>
<th>Details</th>
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</thead>
</table>
| Actively seek Foreign Aid | 1-8 | - Highlight the needs and social conditions in rural areas and identify the practical ways in which ODA can alleviate these conditions.  
- Plan and develop robust, pro-poor social development and social protection programmes that maximize ODA effectiveness.  
- Seek stable funding commitments for a minimum period of five years. |
| Provide safety nets for the poor and vulnerable | 1-7 | - Include budget allocations to alleviate food insecurity.  
- Use income transfer programmes to immediately improve the lives and opportunities for severely poor families.  
- Provide benefits to families and children based on need, rather than HIV or orphan status. |
| Budget for Evaluating Programme Effectiveness | 1-8 | - Allocate resources for community based monitoring and evaluation systems. |
| Develop a Children’s Budget | 1, 2 & 4 | - Identify key areas of government expenditure specifically related to Children  
- Track allocations and ensure effective spending |
| Approve the Disaster Relief & Recovery Bill | 1, 2 & 6 | - Advocate for implementation of the Disaster Relief & Recovery Policy  
- Ensure allocation of regional budget to emergency preparedness and recovery. |

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### OVERSIGHT

<table>
<thead>
<tr>
<th>Provide leadership and co-operation</th>
<th>MDGs 1 - 8</th>
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<tbody>
<tr>
<td>• Ensure that social protection policies are pro-poor and child sensitive.</td>
<td></td>
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<tr>
<td>• Call for co-operation from Development Partners to develop programmes that are effectively implemented and monitored.</td>
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<thead>
<tr>
<th>Mobilise Communities</th>
<th>MDGs 1 - 7</th>
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<tbody>
<tr>
<td>• Focus on equity and provide opportunities for poor people - especially women and youths - to participate in decisions that affect their lives.</td>
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<tr>
<td>• Build local technical capacity for evaluating intervention processes and outcomes.</td>
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<tr>
<td>• Ensure that programme effectiveness feedback includes input and recommendations from the community at which the programme is aimed.</td>
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<table>
<thead>
<tr>
<th>Focus on effectiveness</th>
<th>MDGs 1 - 7</th>
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<tbody>
<tr>
<td>• Initiate parliamentary hearings and conduct on-site enquiries to assess the value and effectiveness of social protection schemes.</td>
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<tr>
<td>• Work with civil and international organizations to co-ordinate efforts.</td>
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### PRACTICAL PROGRAMMES

<table>
<thead>
<tr>
<th>Enshrine Social Protection and a Legal Right</th>
<th>MDGs 1 - 6</th>
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</thead>
<tbody>
<tr>
<td>• Inscribe social protection in national legislation.</td>
<td></td>
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<tr>
<td>• Support the delivery of social protection country-wide.</td>
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<tr>
<td>• Recognise long term government responsibility for sustained social protection.</td>
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<tr>
<th>Leverage the Disaster Relief Infrastructure</th>
<th>MDG 1</th>
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<tbody>
<tr>
<td>• Respond to immediate needs by providing assistance to poor communities through the use of existing drought aid, nutrition programmes, food assistance and safety nets.</td>
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<tr>
<td>• Focus on vulnerable groups such as women and children.</td>
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<table>
<thead>
<tr>
<th>Protect the most Vulnerable</th>
<th>MDGs 1 - 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ensure free, easily accessible and inclusive birth registration, especially in remote rural communities</td>
<td></td>
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<tr>
<td>• Review the selection criteria for eligibility of child support grants – focusing on needs, rather than orphan status.</td>
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<tr>
<td>• Extend social protection grants to also include non-cash elements, such as food, food vouchers, school uniforms, other clothing and blankets.</td>
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<tr>
<td>• Simplify the system for allocating foster grants to ensure that vulnerable children receive the support they need and are not disadvantaged by their inability to navigate bureaucracy.</td>
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<tr>
<td>• Enhance national and regional action plans with specific actions to reduce hunger and malnutrition. Explicitly detail what financial aid and technical assistance is required.</td>
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</table>
### Support Increased Agricultural Productivity

**MDG 1**

- Protect farmer’s rights and encourage them to invest in land improvements that raise long-term productivity.
- Support intervention to increase and sustain labour productivity growth, such as assisting small scale farmers with credit extension services, fertilizers and high-yield crop varieties.
- Develop agriculture production by sustaining the government subsidies on fertilizers, pesticides and high yield crop seeds. This will help to strengthen people’s resilience to climate change and improve their capacity to produce food.
- Increase public spending on agriculture to be in line with the Government’s commitment - made in the Maputo Declaration on Agriculture and Food Security (2003) and the Sirte Declaration on Agriculture and Water (2008) - to allocate 10% of public spending on agriculture and food security. The National budget for 2010/11 currently allocates only 5.5% to Agriculture, Water and Forestry.

### Create Employment Opportunities

**MDGs 1 & 2**

- Improve the quality of education and work with the private sector to promote a curriculum that is knowledge and relevantly skills based.
- Encourage internships and apprenticeships in Government and the Private Sector to provide youths with an opportunity to acquire market relevant skills.
- Support youth entrepreneurship through programmes that facilitate access to credit and provide small business support such as planning, budgeting and business management.
- Provide incentives for youth recruitment in the form of tax rebates, or wage subsidies to make young, inexperienced workers more attractive to potential employers.

### Discourage anti-social behaviour

**MDGs 1, 2, 3 & 6**

- Promote sport and recreational opportunities for children and young people to provide them with choices that help keep them away from alcohol, drugs, violence and crime.

### Support Community-based initiatives

**MDG 1**

- Provide expertise to local communities for their conservation efforts, by securing experts to introduce systems that also create sustainable livelihoods for the local inhabitants.
- Promote the care of children within the extended families and communities – orphanages should be a temporary and last resort solution.
- Implement family-centred services integrating health, education and social support.

### Protect Women and Girls

**MDG 1 & 3**

- Actively encourage increase in survival rates for girls.
- Introduce mechanisms that enable girls to complete senior secondary school and go on to tertiary education.
- Use social protection measures to enhance women’s economic and social participation – such as designating female members to receive welfare grants.
- Provide micro-enterprise training and opportunities for women and girls.
## EDUCATION

### BUDGETING & RESOURCE ALLOCATION

<table>
<thead>
<tr>
<th>Prioritise Early Childhood Development (ECD)</th>
<th>MDGs 1 &amp; 2</th>
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<tbody>
<tr>
<td>• Allocate budget for Primary Schools to establish Pre-Primary classes.</td>
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<tr>
<td>• Support resources for the development of a standard educational pre-primary syllabus.</td>
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<tr>
<td>• Incentivise private providers to increase the availability of Early Childhood Development centres. (eg. Tax relief, start up subsidy, low interest set-up loans or provision of free materials and equipment).</td>
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<table>
<thead>
<tr>
<th>Adhere to needs-based budgeting</th>
<th>MDGs 1 &amp; 2</th>
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<tbody>
<tr>
<td>• Allocate financing and spending by learner to target the disadvantaged and poor performing regions.</td>
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<tr>
<td>• Ensure Regional Equity in the distribution of education inputs such as textbooks.</td>
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<tr>
<td>• Fund the development of Teacher Counsellors in every school and advocate for the development of a socio-economic profile and history for each learner with ongoing monitoring.</td>
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<thead>
<tr>
<th>Focus on improving Quality</th>
<th>MDGs 1 &amp; 2</th>
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<tbody>
<tr>
<td>• Focus spending in Primary Education on the fundamental areas of teacher quality and textbook availability.</td>
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<tr>
<td>• Provide the budget for annual teacher refresher workshops, using teacher initiatives for knowledge sharing and experiential advice.</td>
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<tr>
<td>• Allocate budget and resources for regular school inspections.</td>
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### OVERSIGHT

<table>
<thead>
<tr>
<th>Promote informed decision-making</th>
<th>MDG 2</th>
</tr>
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<tbody>
<tr>
<td>• Identify key success measures – teacher and learner attendance, proof of planning (annual scheme of work, daily record sheets and homework assignments), repetition rates, survival rates ensure these are communicated to all stakeholders, including parents and students.</td>
<td></td>
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<tr>
<td>• Monitor and provide support, incentives and involvement to those schools not meeting the targets in terms of learner outcomes, high repetition rates and low survival rates.</td>
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<thead>
<tr>
<th>Decentralise responsibility</th>
<th>MDG 2</th>
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<tr>
<td>• Strengthen school administration systems by empowering Administrators to achieve their educational targets.</td>
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<tr>
<td>• Monitor educational targets and hold Administrators accountable for the results.</td>
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<tr>
<td>• Advocate for and monitor teacher performance management.</td>
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<tr>
<td>• Recognise and motivate strong performers. Provide salary increments based on proven performance.</td>
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### PRACTICAL PROGRAMMES

<table>
<thead>
<tr>
<th>Prioritise Early Childhood Development (ECD)</th>
<th>MDGs 1 &amp; 2</th>
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<tbody>
<tr>
<td>• Scale-up pro-poor community based ECD interventions to improve learner readiness for Primary education.</td>
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<thead>
<tr>
<th>Improve the Quality of the Primary Education system</th>
<th>MDGs 1 &amp; 2</th>
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<tbody>
<tr>
<td>• Ensure that all primary schools are equipped with the necessary textbooks and classroom materials.</td>
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<tr>
<td>• Investigate the benefits and implementation requirements of the “Knowledge is Power Programme” (KIPP) for poor communities.</td>
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<tr>
<td>• Establish KIPP classes or schools within poor communities to increase the quality of education and the number of poor children proceeding to secondary and tertiary institutions.</td>
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<thead>
<tr>
<th>Improve access to education</th>
<th>MDGs 1 &amp; 2</th>
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<tbody>
<tr>
<td>• Support child grants and bursary schemes to poor children.</td>
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<tr>
<td>• Improve the management and monitoring of hostel accommodation, ensuring the safety and well-being of children in hostels.</td>
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<tr>
<th>Recognise the importance of Nutrition</th>
<th>MDGs 1 &amp; 2</th>
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<tr>
<td>• Increase the coverage of the School Feeding Programme to counter the affects of poor nutrition on concentration and encourage learners to stay in school.</td>
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<tr>
<td>• Implement minimum nutritional supplements in all state schools – for example, one piece of fruit and milk daily for all children.</td>
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<tr>
<td>• Encourage schools to establish their own food gardens.</td>
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<tr>
<td><strong>Actions</strong></td>
<td><strong>MDGs 1 &amp; 2</strong></td>
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</table>
| **Improve Quality of Teaching** | • Implement a merit appraisal system for teachers, including inputs from all stakeholders – School Principal, colleagues, learners, Regional inspectors.  
• Establish a formal system of substitute teachers to reduce the impact of teacher absenteeism.  
• Improve the validity and effectiveness of in-service training courses for teachers.  
• Encourage teachers to know their HIV status and get treatment as needed  
• Collaborate with volunteer organisations such as VSO, Peace Corps and World Teach to provide qualified, good quality teaching professionals to support the education system – especially in remote, rural areas. |
| **Establish super state schools in every region** | • Recognise strong performers in Primary School and select these children to be enrolled in super state schools with a view to tertiary education.  
• Provide bursaries and scholarships for poor children to enable them to be enrolled in these selective schools  
• Leverage hostel accommodation to ensure that children from remote rural communities have the same schooling opportunities. |
| **Improve access to education** | • Support child grants and bursary schemes to poor children.  
• Improve the management and monitoring of hostel accommodation, ensuring the safety and well-being of children in hostels |
| **Support National Competitions** | • Promote competition amongst schools with nationally sponsored Olympiads – for example, in Maths, Science, English - spelling and debating.  
• Recognise and reward students that excel in National Competition. |
## HEALTHCARE

### BUDGETING AND RESOURCE ALLOCATION

<table>
<thead>
<tr>
<th>Prioritise Healthcare</th>
<th>• Adhere to the Abuja Declaration by allocating and releasing at least 15% of the total annual national budget to Healthcare.</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDGs 1, 4, 5 &amp; 6</td>
<td></td>
</tr>
<tr>
<td>Promote Child and Maternal Health</td>
<td>• Allocate at least 10% of the Healthcare budget for reproductive health services.</td>
</tr>
<tr>
<td>MDGs 4 &amp; 5</td>
<td></td>
</tr>
<tr>
<td>Adhere to needs-based budgeting</td>
<td>• Implement a pro-poor healthcare financing model that is sustainable and strengthens accessibility and services to those poor communities that need it most.</td>
</tr>
<tr>
<td>MDGs 1, 4, 5 &amp; 6</td>
<td></td>
</tr>
<tr>
<td>Support Community Based healthcare</td>
<td>• Mobilize adequate resources to support Health Extension Workers, Community Child Care Workers and other community-based activities.</td>
</tr>
<tr>
<td>MDGs 4, 5 &amp; 6</td>
<td></td>
</tr>
</tbody>
</table>
| Decentralise responsibility | • Empower and enable local authorities to improve Healthcare facilities and hold them accountable for results.  
• Accelerate change by leveraging resources based in local communities – such as the Health Extension Workers. |
| MDGs 4, 5 & 6        |                                                                                                                                 |

### OVERSIGHT

| Provide vital and decisive leadership | • Identify key success measures – teacher and learner attendance, proof of planning (annual scheme of work, daily record sheets and homework assignments), repetition rates, survival rates ensure these are communicated to all stakeholders, including parents and students.  
• Monitor and provide support, incentives and involvement to those schools not meeting the targets in terms of learner outcomes, high repetition rates and low survival rates. |
| MDGs 1, 4, 5 & 6     |                                                                                                                                 |
| Maximise collaboration across ministries and with external parties | • Work in partnership with the private sector, civil society, religious and other community-based organizations to implement well planned interventions.  
• Foster a multi-sectoral approach by calling for committed participation of all stakeholders in the fight against HIV/AIDS and TB.  
• Strengthen the functional collaboration between the National TLP and HIV programmes at national and regional levels to enhance implementation, supervision and monitoring of TB/HIV interventions. |
| MDGs 4, 5 & 6        |                                                                                                                                 |
| Promote informed decision-making | • For each intervention, identify the key measures of success and ensure that the relevant mechanisms are established to track progress.  
• Demand regular data collection and reporting to enable effective monitoring of progress. |
| MDGs 4, 5 & 6        |                                                                                                                                 |
| Prioritise Maternal & Child Health monitoring | • Develop an integrated Maternal and Child health information system and improve maternal and child health data – to improve communication systems and strengthen the capacity of Health workers  
• Monitor maternal mortality at the Cabinet level, making maternal deaths a national priority.  
• Work with the private sector to ensure the development and delivery of affordable, essential medicines and new technologies for maternal health. Track immunisation coverage, including drop out rates for follow-up vaccinations. |
| MDGs 4, 5 & 6        |                                                                                                                                 |
| Use tested Tools to evaluate programme effectiveness | • Identify relevant management tools – such as the Care Delivery Value Chain\(^{115}\) - to strengthen planning and expose current delivery weaknesses.  
• Use resources more efficiently and target investment to overcome delivery bottlenecks using the Learning Collaborative Model, developed by the Institute for Healthcare Improvement.  
• Establish processes for continuous learning so that implementation challenges can be effectively faced and overcome. |

### PRACTICAL PROGRAMMES

#### FOR MATERNAL & CHILD CARE:

<table>
<thead>
<tr>
<th>Prioritise Malnutrition</th>
<th>MDGs 4 &amp; 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Provide micronutrients – Vitamin A, Iodine and Iron - to children that are at risk of malnutrition.</td>
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<tr>
<td>- Provide regular de-worming to ensure nutrition absorption.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Promote breastfeeding</th>
<th>MDGs 4 &amp; 5</th>
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<tbody>
<tr>
<td>- Actively advocate for exclusive breastfeeding up to 6 months of age.</td>
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<table>
<thead>
<tr>
<th>Minimise mortalities from diarrhoea</th>
<th>MDG 4</th>
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</thead>
<tbody>
<tr>
<td>- Support community education of diarrhoea. Raise awareness of what causes diarrhoea, why it must be treated immediately and how to prevent the conditions that cause it.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Encourage better hygiene &amp; sanitation</th>
<th>MDGs 4, 5, 6 &amp; 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Promote good hygiene behaviours, such as hand-washing, bathing and using sanitation facilities.</td>
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<table>
<thead>
<tr>
<th>Reduce maternal mortality</th>
<th>MDGs 4 &amp; 5</th>
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</thead>
<tbody>
<tr>
<td>- Promote antenatal visits – including tracking pregnancy progress, early identification of complications, pregnancy spacing education, tetanus toxoid injections, vitamin A supplementation, folic acid supplements.</td>
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<tr>
<td>- Expand the National Midwifery Programme and assign midwives to rural areas.</td>
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<tr>
<td>- Identify medical officers who can receive additional training in performing Caesarean Sections and administer anaesthetics. This will enable the expansion of emergency obstetric services and compensate for the shortage of specialists.</td>
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<tr>
<td>- Actively promote and enhance the health education of mothers.</td>
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</table>

<table>
<thead>
<tr>
<th>Prevent Mother-to-Child HIV Transmission</th>
<th>MDGs 4 &amp; 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Provide free formula milk to HIV infected mothers with babies.</td>
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<tr>
<td>- Scale up training on PMTCT and early infant diagnosis of HIV.</td>
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</tr>
<tr>
<td>- Improve infrastructure - currently there is limited space and access in facilities - including laboratory capacity for rapid testing.</td>
<td></td>
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<tr>
<td>- Expand and strengthen outreach to maternal and child health services</td>
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<table>
<thead>
<tr>
<th>Prioritise Reproductive Health</th>
<th>MDGs 4 &amp; 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Mobilise communities to understand importance of family planning, spacing pregnancies, good nutrition and hygiene.</td>
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<tr>
<td>- Advocate for increased male involvement</td>
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<tr>
<td>- Develop Centres of Excellence - trialling and proving best practices - in selected regions that can then be rolled out to the rest of the country.</td>
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</tbody>
</table>

#### FOR HIV:

<table>
<thead>
<tr>
<th>Improve infrastructure</th>
<th>MDGs 1 &amp; 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Scale up community based services</td>
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<table>
<thead>
<tr>
<th>Improve human capacity</th>
<th>MDGs 1 &amp; 6</th>
</tr>
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<tbody>
<tr>
<td>- Establish medical and public health tertiary education in Namibia</td>
<td></td>
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<tr>
<td>- Provide bursaries for students who want to become health professionals</td>
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<tr>
<td>- Advocate for and monitor pre and in-service training programmes</td>
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<thead>
<tr>
<th>Increase HIV Identification</th>
<th>MDG 6</th>
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<tbody>
<tr>
<td>- Publicly support and advocate for provider-initiated HIV testing and counseling</td>
<td></td>
</tr>
<tr>
<td>- Advocate for routine antenatal screening</td>
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<tr>
<td>- Publicly support couples testing</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Lead social and behaviour change</th>
<th>MDGs 4 &amp; 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Mobilise community leaders to challenge the social norms that make high risk behaviour acceptable</td>
<td></td>
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<tr>
<td>- Lead the communities by being role models for changing cultural norms and values</td>
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</tbody>
</table>
### Prioritise Prevention Strategies
**MDGs 1, 2 & 6**
- Prioritize and expand resources for prevention
- Implement combination prevention
- Implement evidence-based interventions that address the drivers of the epidemic
- Introduce HIV education as part of the formal school curriculum.
- Support male circumcision for all newborns and men in Namibia
- Focus on women and youth - avoiding new infections among the youth is essential to reverse the spread of HIV. The vulnerability of young women and youth in urban and rural areas can be mitigated with education and employment opportunities.
- Focus on Rural and Migrant populations - harder and costlier to access, it is important to work with migrant communities, particularly agricultural workers and transport workers who appear to be particularly vulnerable to infection

### Extend Treatment Programmes
**MDG 6**
- Extend ART coverage so that it is available to all people living with HIV
- Implement mobile services for those people living in remote, hard to reach areas

### Support Research
**MDG 6**
- Support research to understand the epidemic drivers amongst higher risk populations (sex workers, men who have sex with men, intravenous drug users, prisoners)
- Conduct intervention research to increase the effectiveness of prevention programmes

### FOR MALARIA:

### Prioritise Prevention Strategies
**MDGs 4, 5 & 6**
- Distribute Insecticide Treated Nets as part of antenatal care in malaria regions – at antenatal centres and child health clinics.
- Promote public education campaigns to ensure the widespread acceptance and correct use of ITNs.
- Support the counselling to women on dangers posed to them and their babies by malaria and the steps they can take to protect themselves.
- Advocate for indoor residual insecticide spraying in epidemic prone areas.
- Mobilise communities to clear breeding sites and use chemical treatments to kill larvae.
- Establish epidemic forecasting and preparedness.

### Improve Identification
**MDGs 4, 5 & 6**
- Advocate for screening for malaria signs and symptoms as a routine part of antenatal care.

### Maximise Treatment Effectiveness
**MDGs 4, 5 & 6**
- Clarify the guidelines on the treatment of children under 5 who have fever – currently there is confusion whether children should be treated symptomatically according to IMCI guidelines, or if they should be tested for malaria first.
- Include Intermittent Preventive Treatment for infants to reduce malaria and consequent anaemia as part of routine vaccinations and delivered through the Expanded Programme on Immunization.
- Promote Intermittent Preventive Treatment for pregnant mothers to reduce the incidence of premature delivery and low birth weight babies.
### FOR TB:

| **Maximise Treatment Effectiveness**<br>MDG 6 | Support clinic and community based DOTS treatment support and the tracing of patients who interrupt treatment. |
| **Prioritise Drug Resistant TB management**<br>MDG 6 | • Support systematic testing for drug resistance on all new and previously treated TB cases in order to timeously identify cases of Multi-Drug Resistant TB
• Implement state-of-the-art rapid diagnostics to ensure early detection – WHO recommended Xpert MTB/RIF rapid diagnostic test.
• Prioritise the management of drug resistant TB and establish a monitoring system for treatment outcomes
• Collaborate with the WHO Green Light Committee for additional technical assistance and concessionary priced quality assured second line anti-TB drugs. |
| **Improve Identification**<br>MDG 6 | • Advocate for the introduction of the WHO recommended Xpert MTB/RIF rapid diagnostic test for tuberculosis and rifampicin resistance, a proxy for multidrug resistant tuberculosis - will enable detection of TB and drug resistance in less than 2 hours.
• Introduce a manual TB laboratory register - alongside the electronic laboratory database - customized to capture critical TB laboratory data required by the National Tuberculosis and Leprosy Programme. |
| **Maximise Infection Control**<br>MDG 6 | • Establish a Biosafety Level 3 TB Laboratory to enable the safe handling of highly infectious agents such as MDR/ XDR-TB strains.
• Enforce the implementation of TB Infection Control guidelines in all health facilities and relevant community settings. |
## KNOWLEDGE & DATA

### BUDGETING & RESOURCE ALLOCATION

<table>
<thead>
<tr>
<th>Support Data Collection</th>
<th>• Provide national statistical systems with adequate and regularized financing to ensure their autonomy and independence in operations.</th>
</tr>
</thead>
</table>
| Support Policy, Resource & Issues Monitoring | • Identify the resources available for policy implementation.  
• Use tracking surveys to monitor and measure effectiveness |

### OVERSIGHT

| Utilise Data for Learning & Improvement | • Utilise sound data and knowledge as a basis for public policy decision-making.  
• Regularly monitor the implementation of policies designed to assist women and children  
• Identify targets and indicators for specific policies  
• Develop short, medium and long-term lines of analysis |

### PRACTICAL PROGRAMMES

<table>
<thead>
<tr>
<th>Prioritise the MDGs</th>
<th>• Set up and support national MDG data collection for regular data reporting, validation, storage and dissemination.</th>
</tr>
</thead>
</table>
| Ensure Quality from the Central Bureau of Statistics | • Strengthen civil registration and vital statistics production systems and conduct regular censuses and surveys.  
• Establish the mechanisms to gather disaggregated data on specific age groups, gender and vulnerabilities. |
| Support in-depth analysis of data on critical issues | • Advocate for knowledge generation in priority areas, such as Child Poverty, Education, Children and Crime, Adolescents on ART, and so on. |
| Increase public access to Data | • Enable better dissemination and use of data – especially health data.  
• Support forums for the sharing of data. |