



# Namibia Nutrition Brief

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## Country context

MALNUTRITION STATUS (NUMBER,%):

#### Child stunting



Child wasting (2013) 7% 23,000

Child overweight (2013)



Human Development Index rating: 129 out of 189 countries (2017)

#### Gross Domestic Product per capita: PPP\$ 11,135<sup>a/</sup> (2018)

**Poverty rate:** 13.4%<sup>b/</sup> (2015)

Under-five mortality: 40 per 1,000 live births (2018)

Maternal mortality: 195 per 100,000 live births (2017)

Malnutrition figures are rounded off to the nearest whole number. Population estimates in 2016 are from ISTEEBU. PPP: Purchasing Power Parity. a/ In current international dollars. b/ Population living on less than US\$1.90 a day at 2011 PPP. Source: UNICEF, WH0, World Bank (2018)<sup>1</sup>, UNDP (2018)<sup>2</sup>, WB (2019)<sup>3</sup> and SOWC (2019)<sup>4</sup>

# Why invest in nutrition?

Combating malnutrition in all its forms is one of the greatest global development challenges. In Africa, 56.6 million children under the age of five are stunted (have a low height-for-age or are suffering from chronic under nutrition).

In Namibia, this number stands at approximately 72,000 children, meaning that around 1 out of every 5 children in Namibia are already stunted. These children will likely not reach their full growth and developmental potential because of the irreversible physical and cognitive damage caused by persistent nutritional deprivations.

Good nutrition is the foundation of child survival, health and development; wellnourished children are better able to grow and learn, to participate in and contribute to their communities. Stunting is associated with poor brain development, which affects a child's cognitive development, educational attainment and productivity in adulthood which in turn has an effect on the development potential of a nation.

Being malnourished in early childhood elevates the risks of infant morbidity and mortality, increases healthcare costs and social safety net expenditures, lowers the efficiency of investments in education, decreases lifelong income-earning potential and labor force productivity resulting in a vicious cycle of poverty, ill health and poor nutrition which is transmitted across generations.

The developmental, economic and social impacts of malnutrition, especially in the early years of life, are serious and long lasting for individuals, their families, communities and countries. The costs of undernutrition in Africa and Asia are equivalent to losing 8-11 percent of GDP every year, while investments in nutrition offer a \$16 return for every \$1 invested<sup>5</sup>.

In the words of King Letsie III of Lesotho, the AU Nutrition Champion and FAO Ambassador, "Together we can eliminate child malnutrition in all its forms by 2030 for optimal human capital development and a more prosperous Africa!"

# Nutrition profile

#### Stunting rates across countries

Compared to other nations with a similar Human Development Index (HDI), Namibia HUMAN DEVELOPMENT INDEX 2017 has a higher prevalence of stunting compared to Honduras, Nicaragua, Morocco, among other countries, and a lower stunting prevalence compared to Tajikistan, India, Guatemala and Timor-Leste, Namibia's 23% of stunted children<sup>1</sup> is classified as high<sup>11</sup> according to international benchmarks.



Source: UNDP (2018)<sup>2</sup> and WB (2019)<sup>3</sup> for stunting rates (most recent year available 2007-2018).

# Child nutrition status: trends for the period 1992-2013

While there has been progress, still 23% of children in Namibia are already stunted and will not reach their full growth potential. There has been a steady reduction in both the prevalence and the number of stunted children since 1992. Stunting levels have declined 36 percent (or 13 percentage points) between 1992 and 2013 (from 36% to 23%), while the numbers of stunted children have declined 19 percent over the same period (from 89 to 72 thousand

KEY INDICATORS	VALUE	YEAR
Low-birthweight (% of births <2.5kg)	13%	2013
Infants exclusively breastfed (% of children under 6 months)	48.5%	2013
<b>Children fed 5+ food groups</b> (% of children 6-23 months)	24.9%	2013
Children who received a minimum acceptable diet (% of children 6-23 months)	12.5%	2013
Anaemia in children (% of children 6-59 months)	47.5%	2013
Anaemia in women of reproductive age (% of women age 15-49)	20.7%	2013
Women who are thin according to BMI (<18.5 kg/m2) (% of women age 15-49)	13.9%	2013
Women who are overweight or obese according to BMI (≥25 kg/m2) (% of women age 15-49)	31.6%	2013

kg/m2) (% of women age 15-

children), showing improvements are not keeping pace with population growth. Child wasting has fluctuated over time remaining at a medium level (5-<10%) according to global benchmarks<sup>11</sup>. Child overweight has fluctuated in the range of 3 to 5% which is classified as a low level low (2.5-<5%)<sup>11</sup>.



Source: UNICEF, WHO, World Bank (2018)<sup>1</sup> Note: UNICEF, WHO, WB (2018) does additional analysis to the original data sources compiled. Thus, in some cases total prevalences slightly differ from those in original datasets. For example, DHS 2013<sup>10</sup> reports 23.8% for Stunting, 6.2% for Wasting, and 3.4% for Overweight in 2013.

Source: DHS (2013)<sup>10</sup>, UNICEF (2019)<sup>12</sup>

# Overlapping forms of child malnutrition

2013 (%)

Different forms of malnutrition coexist within the same children: 1.5% of children under-five are both stunted and wasted, and 1.3% are both stunted and overweight. Children who are both wasted and stunted are 12.3-times more likely to die than their well-nourished counter-parts<sup>7</sup>. Children under-nourished in the first 2 years of life and who rapidly gain weight during childhood or adolescence have an increased risk of chronic disease related to nutrition<sup>8</sup>. There is a need for double-duty actions<sup>9</sup> designed to tackle both undernutrition and obesity, and to effectively address the underlying



Source: UNICEF (2018a)<sup>6</sup>.

causes of all forms of malnutrition such as poverty, lack of access to varied, nutritious and healthy foods, sub-optimal child feeding practices, etc.



According to global benchmarks<sup>11</sup>, child stunting is classified as very high (more than 30%) in Ohangwena, as high (20-<30%) in 7 regions, and as medium (10-<20%) in 5 regions. Child wasting is classified as medium (5-<10%) in 9 out of

the 13 regions in Namibia. Omaheke has the highest wasting prevalence at 10.4% (classified as a high level), while Oshana, Otjozondjupa and Khomas have low levels of child wasting (2.5%-<5%).

## Stunting rate by background characteristics

2013 (%)



### Malnutrition by age of children

2013 (%)

Stunting increases rapidly from 9 months of age when children should receive increasing and more regular amounts of solid foods. It reaches its highest peak between 24-35 months (35%). It then slows down but remains at 21%, demonstrating its life-long and lasting effects. Child wasting fluctuates across ages. It is highest in children at 6-23 months old. It then remains at low levels<sup>11</sup> of less than 5% in children of 24 months onwards. Overweight generally remains low (2.5-<5%) or very low (<2.5%) across all age cohorts.



## Country progress towards World Health Assembly 2025 nutrition targets<sup>13,14</sup> (%)see technical note

## Child stunting (THOUSANDS)

Target: 40% reduction in the number of children under-5 who are stunted



## Anaemia in women

Target: 50% reduction of anaemia prevalence in women of reproductive age



WHA 2025 target prevalence

For stunting, overweight and exclusive breastfeeding, there is not enough data after the WHA baseline year of 2012 to estimate progress in 2025 using current trajectory. Thus, the 2018 Global Nutrition Report<sup>13</sup> states there is insufficient data to classify the progress towards these targets. Namibia would achieve the WHA nutrition targets if by 2025 there are no more than 41,000 stunted children (or achieves a target prevalence of 11.2% in 2025), if it prevents any increase in overweight

Child overweight

Target: no increase in childhood overweight rate



#### Exclusive breastfeeding (%)

Target: increase rate up to at least 50%

Insufficient data



target prevalence

from the current 4% in 2013, and if it increases the exclusive breastfeeding rate up to at least 50%. If the anaemia rate in women follows the current trajectory, it would drop to 18% in 2025. While this shows some progress, this decline in the prevalence will not be enough to achieve the WHA target prevalence of 12% in 2025. Thus, Namibia needs to accelerate actions to achieve the WHA 2025 target of anaemia in women.

#### Technical note on the WHA 2025 nutrition targets

The classification of progress towards achieving the nutrition targets (on track, off track-some progress, off track-no progress or worsening) can be found at the 2018 GNR<sup>13</sup>. The methodology is based on the rules proposed by the WHO/UNICEF Technical Expert Advisory Group on Nutrition Monitoring (TEAM). When countries have only one data point or none after the 2012 WHA baseline, the assessment on progress is usually reserved (insufficient data). These rules are based on a metric called average annual rate of reduction (AARR), which reflects the average percent change in prevalence over a period of time. There are two types of AARR to show recent trends: i) the current AARR, which reflects recent trends in prevalence from 2008 onwards, and ii) the pre-baseline AARR, which reflects trends before the baseline year (from 1999 to 2012). When data is available showing a linear trend, any of these metrics is used to estimate the prevalence in 2025. This section in the report shows values from the WHO Global targets tracking tool<sup>14</sup> for: 1) the WHA baseline year (the most recent time point prior to 2012), 2) the most recent available time point, 3) the estimated prevalence/number in 2025 when available, and 4) the WHA target in 2025. For most indicators the DHS is used as the main source. For anaemia in women, the WHO Global target tracking tool<sup>14</sup> uses the anaemia estimates in the Micronutrients Database. WHO Vitamin and mineral nutrition information system, 2017.

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# Actions for scaling up interventions<sup>15,16</sup>

This section shows the estimated scale that different interventions are achieving in 2018

(current coverage), and the estimated scale which they intend to achieve by 2025 (target coverage)

### Interventions currently being implemented

NUTRITION-SPECIFIC INTERVENTIONS ACROSS THE LIFE-CYCLE





(provided by UNICEF country office)<sup>15</sup>. The presence or absence of the conditions needed to achieve scale are shown in the pie charts based on Addai and Matji<sup>16</sup> (provided by UNICEF country office)<sup>15</sup>. All nutrition-specific interventions currently being implemented in Namibia have the potential to grow significantly from the current levels since all enabling requirements for achieving large scale are present. These interventions include IYCF counselling at prenatal and postnatal care-points, maternal micronutrient supplementation, Vitamin A and deworming in children, and management of SAM and MAM.

Similarly, all existing nutrition-sensitive interventions can be further scaled up since they also have all the enabling conditions to achieve larger coverage. Nutrition-sensitive interventions are long term resilience building interventions that have the potential to address the underlying causes of child undernutrition. Maternal multiple micronutrient supplementation and MNPs for children are proposed interventions. These interventions would need more partnership, capacity or fiscal space to facilitate their growth.

#### Proposed Interventions

Maternal multiple micronutrient supplementation, daily



Home fortification with multiple **micronutrient powders (MNPs) for children 6-23 months** 



#### NUTRITION-SENSITIVE INTERVENTIONS ACROSS THE LIFE-CYCLE

