



Ministry of Health and Social Services

NATIONAL STRATEGY

REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH & NUTRITION

2025-2030

REPRODUCTIVE



ADOLESCENT HEALTH



MATERNAL



CHILD



NEWBORN



& NUTRITION



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Ministry of Health and Social Services

NATIONAL STRATEGY

REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH & NUTRITION (RMNCAH&N)

2025 - 2030

Fostering Integrated Reproductive, Maternal, Child, Newborn
and Adolescent Health & Nutrition in the context of the
Sustainable Development Goals





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ACRONYMS

ADH	Adolescent Development and Health
AFHS	Adolescent Friendly Health Services
AHD	Adolescent Health and Development
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARR	Annual Rate of Reduction
ARV	Antiretroviral
ASRHR	Adolescent Sexual and Reproductive Health and Rights
AU	African Union
BCC	Behavioural Change Communication
BCG	Bacillus Calmette Guerin
BEmONC	Basic Emergency Obstetric and Newborn Care
CBOs	Community-Based Organizations
CBHC	Community-Based Health Care
CCS	Country Cooperation Strategy
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CFR	Case Fatality Rate
CI	Comprehensive Improvement Plan
CMS	Central Medical Store
CMR	Child Mortality Rate
CPAP	Continuous Positive Airway Pressure
CSOs	Civil Society Organisations
CSE	Comprehensive Sexuality Education
CVD	Cardiovascular Disease
DHIS	District Health Information System
DHS	Demographic and Health Survey
DOCFR	Direct Obstetric Case Fatality Rate
DPT	Diphtheria Pertussis Tetanus
ECS	Elimination of Congenital Syphilis
EmONC	Emergency Obstetric and Newborn Care
EMTCT	Elimination of Mother-to-Child Transmission of HIV
EMM	Essential Medicines and Medical Supplies
ENC	Essential Newborn Care
EPI	Expanded Programme on Immunisation
EHSP	Essential Health Service Package
ETR	End of Term Review
EPPM	Ending Preventable Maternal Mortality
EMRS	Emergency Medical Rescue Services
ENAP	Every Newborn Action Plan
ESA	Eastern and Southern Africa
EVM	Effective Vaccine Management
FANC	Focused Antenatal Care
FAO	Food and Agricultural Organization
FBOs	Faith Based Organisations
FP	Family Planning
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHI	Global Hunger Index
GNI	Gross National Income
GUD	Genital Ulcer Disease
HBV	Hepatitis B Vaccine
HCWs	Health Care Workers
HDI	Human Development Index



HEB	HIV-Exposed Babies
HEI	HIV-Exposed Infant
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPP	Harambee Prosperity Plan
HPV	Human Papilloma Virus
HRH	Human Resource for Health
HSS	Health Strengthening System
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IFAD	International Fund for Agricultural Development
IMMR	Institutional Maternal Mortality Ratio
IMNCI	Integrated Management of Newborn and Childhood Illnesses
IMNCAH	Integrated Maternal, Neonatal, Child and Adolescent Health
IMR	Infant Mortality Rate
IPTp	Intermittent Preventive Treatment in Pregnancy
IRMNCAH&N	Integrated Reproductive Maternal, Neonatal, Child and Adolescent Health & Nutrition
ITNs	Insecticide-Treated-Nets
LEEP	Loop Electrosurgical Excision Procedure
LLIN	Long Lasting Insecticidal Net
LCG	Labour Care Guide
LARC	Long-Acting Reversible Contraceptives
LMIS	Logistics Management and Information System
MAM	Moderate Acute Malnutrition
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCV	Measles-containing Vaccine
MDGs	Millennium Development Goals
MGECW	Ministry of Gender Equality and Child Welfare
MMEIG	United Nations Maternal Mortality Estimation Inter-agency Group
MMR	Maternal Mortality Ratio
MMR	Measles, Mumps, and Rubella
MNCAH	Maternal, Newborn, Child and Adolescent Health
MHSS	Ministry of Health and Social Services
MOU	Memorandum of Understanding
MPDSR	Maternal, Perinatal Death Surveillance and Review
MPNDR	Maternal Peri/Neonatal Death Review
MTCT	Mother-to-Child Transmission
MYNSSC	Ministry of Youth, National Service, Sports and Culture
NACS	Nutrition Assessment Counselling and Support
NAPPA	Namibia Planned Parenthood Association
NCDs	Noncommunicable Diseases
NDHS	Namibia Demographic and Health Survey
NDP	National Development Plan
NEMLIST	National Essential Medicine List
NGOs	Non-Governmental Organisations
NHA	National Health Account
NHMIS	National Health Management Information System
NHPF	National Health Policy Framework
NSAFHS	National Adolescent-Friendly Health Services Standards
NSF	National Strategic Framework
OHT	One Health Tool
OMAS	Offices, Ministries and Agencies
OoP	Out-of-Pocket
ORS	Oral Rehydration Salts
PAC	Post-Abortion Care
PARMACM	Program for Accelerating the Reduction of Maternal and Child Mortality

PCV	Pneumococcal Conjugate Vaccines
PHC	Primary Health Care
PEP	Post Exposure Prophylaxis
PEPFAR	US President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Postnatal Care
QoC	Quality of Care
ORS	Oral Rehydration Salts
RH	Reproductive Health
RMNCAH&N	Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition
RMS	Regional Medical Stores
RMTs	Regional Management Teams
RNCAH	Reproductive, Newborn, Child and Adolescent Health
RUSF	Ready-to-use Supplementary Food
RUTF	Ready-to-Use Therapeutic Feeds
RTI	Respiratory Tract Infection
SADC	Southern African Development Community
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendant
SBCC	Social Behavioural Change Communication
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender-Based Violence
SF	Signal Functions
SOP	Standard Operating Procedures
SRCH	Sexual, Reproductive and Child Health
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
SUDs	Substance Use Disorders
TB	Tuberculosis
THE	Total Health Expenditure
TFR	Total Fertility Rate
TWG	Technical Working Group
U5MR	Under-Five Mortality Rate
UDS	Urethral Discharge Syndrome
UHC	Universal Health Coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNIGME	United Nations Inter-Agency Group on Childhood Mortality Estimation
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
UNSG	United Nations Secretary General
VDS	Vaginal Discharge Syndrome
VIA	Visual Inspection with Acetic Acid
VILI	Visual Inspection with Lugol's Iodine
VMMC	Voluntary Medical Male Circumcision
VPD	Vaccine Preventable Diseases
WCBA	Women of Childbearing Age
WFP	World Food Programme
WHO	World Health Organization
WLHIV	Women Living with HIV



FOREWORD

Addressing the health and nutrition of women, children, and adolescents is a priority and a key developmental agenda of the Government of the Republic of Namibia (GRN). It is imperative, therefore that the Ministry of Health and Social Services (MHSS), which is mandated to provide and oversee public health in the country, it also leads the development of guiding frameworks, reviews, monitors, and evaluates health Programmes for women, children, and adolescents. The Ministry further collaborates with the public and private sectors stakeholders to achieve its outcomes, ensuring the health of the nation, and uplifting the social determinants of health. National commitments, as evidenced in Vision 2030, the Harambee Prosperity Plan (HPP) 2016-2020, the National Development Plans (NDPs) and the Ministry's Strategic Plan, prioritise the health and wellbeing of women, children and young people in Namibia. In addition, Namibia is a signatory to global commitments, including the Global Strategy for Women's, Children's, and Adolescents' Health (2016-2030); the Every Newborn Action Plan (ENAP) endorsed at the World Health Assembly (WHA) in 2014, aimed at ending preventable maternal and child deaths by 2035; the Abuja Declaration signed by African Union Member States in 2001, aimed at increasing investment in health, particularly, to ensure that Member States allocate 15% of national budget to health care. This strategic investment in health will propel countries to achieve the Sustainable Development Goals (SDGs), Global Nutrition Targets by 2030, as well as other key health goals and targets.



As Namibia strives to achieve the SDGs, critical action is needed to specifically address maternal, child health, and nutrition targets. This national strategy is therefore guided by, and aligned with the following resolutions contained in the Every Newborn Action Plan (ENAP) (WHA 67.10): prevention of birth defects (WHA 63.17); universal health coverage (UHC) of maternal, newborn and child health interventions (WHA 58.31); women, health and development (WHA 45.25); newborn health (WHA 45.22); and the updated Global Strategy for Women's, Children's and Adolescents' Health 2016-2030 (WHA 69.2), which was revised in 2022. In addition, a resolution was passed at the 77th World Health Assembly 2024, to accelerate progress towards reducing maternal, newborn and child mortality in order to achieve SDG targets 3.1 and 3.2.

Because the determinants of women's and children's health are so broad, the updated global strategy has translated the holistic approach of the SDGs into a series of precise actions. These encompass multiple sectors, and are supported by an accountability framework designed to meet the set targets for ending preventable deaths of newborn and young children, and substantially reducing maternal mortality. The strategy also acknowledges the unique health and nutrition challenges facing young people, as well as their pivotal role alongside women and children as key drivers of change in the post-2015 era. It takes a lifecycle approach that aims for the highest attainable standards of health and wellbeing – physical, mental and social – at every age, cognisant that a person's health at each stage of life affects health at other stages, and also has cumulative effects for the next generation. In addition, it adopts an integrated and

multisectoral approach, recognising that health-enhancing factors including nutrition, education, water, clean air, sanitation, hygiene and infrastructure are essential to achieving the SDGs.

In developing this integrated National Strategy for Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH&N), Namibia has embraced these principles and approaches. Furthermore, the importance of involving all stakeholders, in a whole-society, whole-government approach is acknowledged. The sixth National Development Plan (NDP6) currently under development, further ensures strategic investments in health, specifically the health and nutrition of Namibian women, children and adolescents health. The development of this strategy was also guided by evidence from the review of reproductive, maternal, newborn, child and adolescent health and nutrition in Namibia, as well as results from the Second National Emergency Obstetric and Neonatal Care (EmONC) assessment, the Health System Review (2021), and the review of NDP5.

Given that Namibia's UHC index is more than 70%, implementing this strategy with fidelity will propel Namibia closer to achieving UHC. Lastly, it is the expectation that this strategy will be the overarching document guiding the implementation of activities aimed at addressing the health and nutrition of all women, children, and adolescents in Namibia.



Dr ESPERANCE LUVINDAO, MP
MINISTER



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Management Teams and District Coordinating Committees in the development of this strategy. The role of national and regional experts, Dr Ene Nkem – Lead Consultant (WHO), Ms Claudia Mbapaha, and Mr Ermias Dessie, who supported the review and costing of this strategy respectively, is appreciated. The immense contribution of all stakeholders and individuals who participated in the development of this strategy is acknowledged. Together, this is a step in the right direction towards achieving the SDGs, and improving the health and nutrition of all women, children and adolescents in Namibia.

Finally, the Ministry expresses its appreciation to Dr Temptation Chigova (WHO Namibia), Ms Hilma Shikwambi, Dr Mary Brantuo, Dr Naemi Shoopala, Ms Esperanca van Der Merwe, Mr Tuutaleni Shilyomunhu, and Ms Francina Rusberg, the resource persons who supported the development of the strategy at different stages, as well as all the administrative officers who provided logistics.



Mr Penda Ithindi
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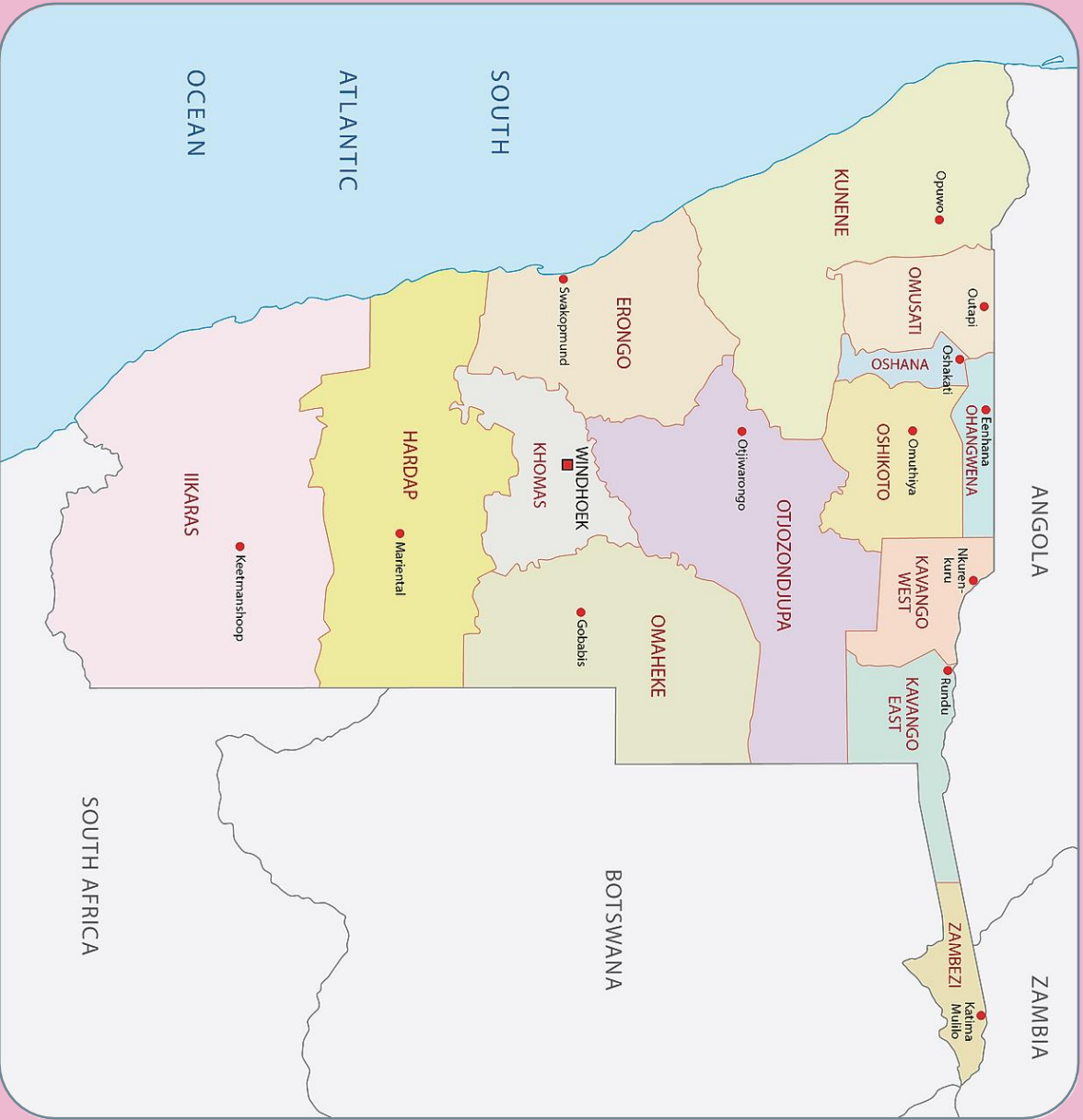


FIGURE 1: Map of Namibia



1. Introduction

Chapter 1 provides a comprehensive overview of Namibia's national context, setting the stage for understanding its health system and development priorities. The geography, population dynamics, and economic status of the country as an upper-middle-income nation are outlined, and social challenges such as inequality and disparities in service access are highlighted. It also delves into Namibia's health system, governance structures, and key policies guiding health care delivery and concludes by introducing the national frameworks supporting reproductive, maternal, newborn, child, and adolescent health, and nutrition (RMNCAH&N).

1.1 Country Context

1.1.1 Geography and Political Context

Namibia is located in the south-western part of Africa, with a geographical area of approximately 824,000 km².¹ The country is bordered by the Atlantic Ocean to the west, Angola and Zambia to the north, Botswana to the east and South Africa to the south and southeast (Figure 1). The Namib Desert stretches along the entire west coast of the country, while the Kalahari Desert runs along the southeastern border with Botswana. Geographically, Namibia consists of five distinct areas: the Central Plateau, the Namib Desert, the Great Escarpment, the Bushveld, and the Kalahari Desert, of which the central, southern, and coastal areas are mostly arid.

According to the 2023 population and housing census report, Namibia's total population stands at 3,022,401, with a population density of 3.7 persons per km², making Namibia one of the least densely populated countries in the world.¹ Of the total population, females (1,548,177) outnumbered males (1,474,224). The difference in the proportion of male and female populations in the 2024 census report is comparable to the 2011 census results.

Administratively, Namibia has 14 regions: Zambezi, Kavango East, Kavango West, Kunene, Oshana, Oshana, and Oshikoto in the north; Omaheke, Otjozondjupa, Erongo, and Khomas in central Namibia; and Hardap and //Kharas in the south. Namibia's regional population densities vary considerably, with almost two-thirds of the population living in the four northern regions, and less than one-tenth living in the south. The capital city of Windhoek is located in the Khomas region (Figure 1).

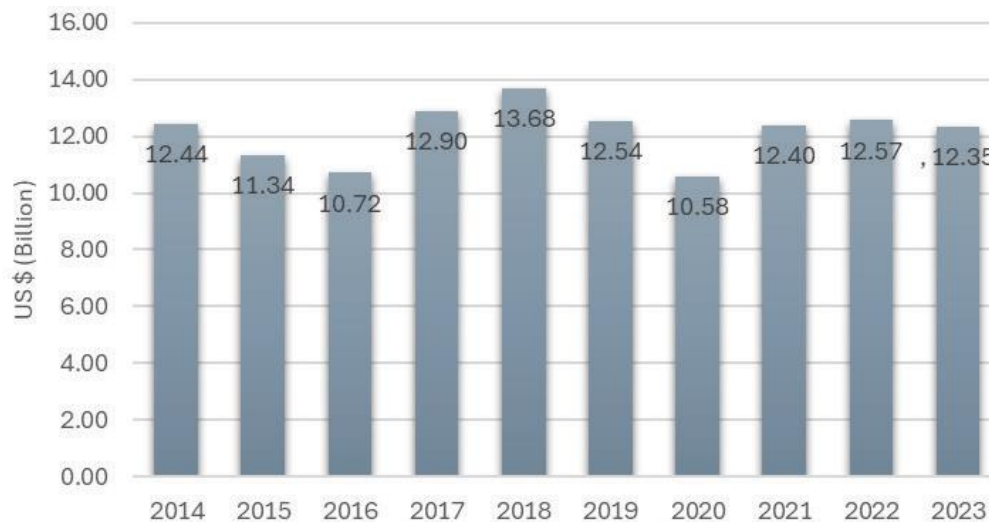


1.1.2 Social and Economic Development Context

Namibia is ranked as an upper-middle-income country (UMIC), which according to the World Bank is defined as a country that has a Gross National Income (GNI) per capita of between USD 4,045 and USD 12,525. Namibia's GNI per capita in 2023 was USD 4,742,² which is closer to the lower band of the per capita GNI classification for upper-middle-income countries.² While this is a good indicator for economic status and investment purposes, it has become its Achilles heel when it comes to attracting foreign direct aid, particularly in the health sector. Since the reclassification, Namibia is considered ineligible for aid, and donor support has decreased for critical programmes such as HIV/AIDS, Tuberculosis (TB), Malaria, immunisation, and noncommunicable diseases (NCDs).

Gross domestic product (GDP) measures the national income and output for a country's economy. The GDP is equal to the total expenditures for all final goods and services produced within the country within a stipulated period. Namibia's GDP was worth USD 12.31 billion in 2021, according to official data from the World Bank, representing 0.01 percent of the world economy. The GDP decreased to 12.54 in 2019 from 13.68 in 2018, declining to 10.58 in 2020. In 2021 however, a slight recovery in growth was recorded (12.31), and a further increase to 12.4 in 2022 (Figure 2).

FIGURE 2: Namibia GDP 2014 - 2023 (World Bank, 2023)

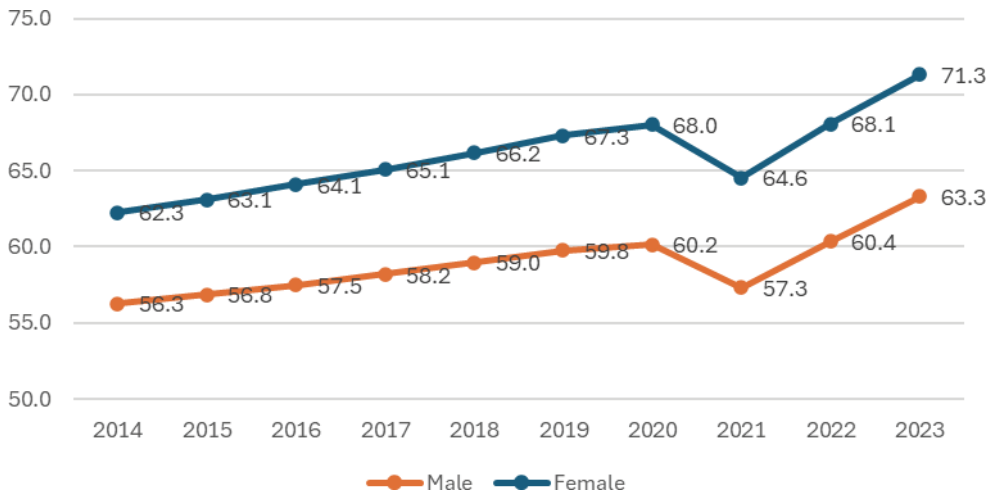


Life expectancy is defined as a statistical measure of how long a person may live, based on demographic factors such as gender, current age, and most importantly the year of their birth, or at age zero. Life expectancy still varies greatly between different regions and countries of the world. The biggest impacts on life expectancy are quality of public health, medical care, and diet. As of 2020, Japan, with an average life expectancy of 85 years and Singapore (84 years), were the countries with the highest life expectancy, while the lowest life expectancy is mostly recorded in countries on the African continent.



Figure 3 presents the average life expectancy at birth, by sex, in Namibia from 2014 to 2023. In 2023, life expectancy at birth for females in Namibia was about 71.3 years, and 63.3 years on average for males. This data shows an increase in life expectancy in the last 10 years, from 62.3 and 56.3 for females and males respectively, positioning Namibia above the average in Africa, at 61 years for males and 64 for females. The average global life expectancy in 2022 was estimated at 70 years for males, and 75 years for females by the global data and business intelligence platform Statista.

FIGURE 3: Life expectancy at birth, by sex in Namibia, 2014–2023 (World Bank, 2023)



The 2021 Human Development Index (HDI) produced by the United Nations Development Programme (UNDP) is a summary measure for assessing long-term progress in three basic dimensions of human development: a long and healthy life, access to knowledge, and a decent standard of living. Namibia’s HDI value for 2021 was 0.615, placing the country in the medium human development category, and ranked at 139 out of 191 countries and territories.³

Namibia however faces significant challenges in terms of inequality, ranked as one of the world’s most unequal countries. Its Gini coefficient of 59.1 in 2015 was second only to South Africa. Geographical disparities in both economic opportunities and access to services are large and widening. High levels of inequality result in starkly different poverty rates across different groups, including by age and gender.

The government of Namibia (GRN) has continued to pursue policies and programmes to reduce poverty and bolster sustainable development as reflected in Vision 2030, the country’s overall development agenda which guides the formulation of the 5-year NDPs. The current NDP5 covers the period 2017/18 to 2021/22 and is structured around four main pillars: economic progression, social transformation, environmental sustainability, and good governance.⁴ Human capital and social development constitute the two sub-areas of the social transformation pillar, with “capable and health human resources” as the goal. NDP5 thus prioritises increased investments in the health



sector, with the aim of developing and nurturing a healthy and productive workforce. It also recognises the need to accelerate demographic transition as part of the social transformation agenda through “investments that facilitate rapid fertility decline, enhance child survival and improve education, and general empowerment of women.” The current administration, since its inauguration in 2015, has also prioritised the fight against poverty and hunger, launching the first Harambee Prosperity Plan (HPPI) in 2016, followed by HPPII in 2021. HPPII has five pillars - Effective Governance and Service Delivery, Economic Advancement, Social Progression, Infrastructure Development and International Relations and Cooperation, and seeks to accelerate development in these priority areas including the elimination of hunger (Figure 4). Vision 2030, NDP5, and HPPII together provide an overarching national development framework for Namibia.



FIGURE 4: Harambee Prosperity Plan

1.1.3 Health System Context

Namibia’s health sector is currently governed by the National Health Policy Framework 2010-2020 (NHPPF),⁵ with a revised draft framework in process at the time of publishing this strategy. Informed by Vision 2030, NHPPF envisioned “a healthy nation, which is free of diseases, poverty and inequality”.⁶ Other instruments demonstrating GRN’s commitment towards improved healthcare delivery include the Public Health and National Environmental Health Act (2015), International Health Regulations (IHR) (ratified 2007), Hospitals and Health Facilities Act (1994), NDP5 (2017 – 2022), Medium-Term Health Strategic Framework (2017 – 2022), Country Cooperation Strategy (CCSIII), and MHSS Strategic Plan 2017/18-2021/22. Several policies are currently under review and a number of bills have been approved, and are awaiting enactment, including the Mental Health Bill, and the Food and Safety Bill.

The need for increased investments in the health sector to harness a healthy and productive workforce are detailed in the social transformation pillar of NDP5. The MHSS Strategic Plan (2017/2018 – 2021/2022) is in the process of being replaced by a new National Health Sector Strategic Plan.⁷

The following elements constitute the Namibian healthcare system context, and are discussed in detail below:

- a. leadership and governance;
- b. service delivery,
- c. health workforce,
- d. health information systems,
- e. medical products, vaccines and technologies, and
- f. health financing.

TABLE 1: Health System Context Elements

A. LEADERSHIP AND GOVERNANCE
<p>The Ministry of Health and Social Services (MHSS) has the mandate for nationwide health services delivery and focuses mainly on the public sector. To deliver on its mandate, MHSS has established the following directorates at national and regional level:</p> <ol style="list-style-type: none">1. Primary Health Care Services2. Social Welfare Services3. Special Programmes4. Finance and Procurement5. Tertiary Health Care and Clinical Support Services6. Policy and Planning7. Human Resources Development8. Human Resources Management and General Services9. Health Care Technology & Facility Management10. Atomic Energy & Radiation Protection Authority11. Health Information & Research12. General Management13. Pharmaceutical Services.

The overall vision of Namibia's NHPF (2010-2015) is for "a healthy nation, which is free of poverty and inequality", with the mission of MHSS "to provide a determined leadership to make health and social welfare services effective, and efficient; to facilitate conditions for organised communities, households and individuals to take control of their health and to liaise with other sectors and partners driven by a shared commitment to health of the nation."

The National Health Act of 2015 serves as the framework for a structured uniform health system within Namibia.⁸ The Act also seeks to "consolidate laws relating to state hospitals and state health services, and to regulate the conduct of state hospitals and state health services; to provide for financial assistance for special medical treatment of State patients; and to provide for incidental matters". It further empowers the Minister to "initiate, formulate, implement, monitor, evaluate and develop policies required for optimal service delivery or performance and to protect, promote, improve and maintain the health of the population", and also designates the Permanent Secretary as the chief health officer of the Ministry. The Act provides for "the establishment of a Regional Health Board for every region, and a District Health Board for the area of every district health office". The state hospital and state health service falls under the responsibility and control of the Minister.

B. SERVICE DELIVERY

Health services in Namibia are mostly provided through the public health system via a network of interlinked facilities, consisting of the national referral hospital (Windhoek Central Hospital), intermediate hospitals, public district hospitals, health centers, and clinics. MHSS currently manages about 475 public health facilities (43 hospitals, 60 health centers, 496 clinics and 3 intermediate hospitals). In addition, about 1,150 outreach points have been established across the country to complement the static facilities, in response to the country's peculiar geospatial features of vast land area, sparse population distribution, and lack of ready access to static health facilities in several communities. As of October 2024, 53 outreach points had been upgraded to health posts across various regions.

The private sector owns about 11% of the health facilities in the country, thereby complementing the services provided by the state. Services provided by the private sector are, however, mostly urban-based and delivered through multiple channels, including medium-sized hospitals, doctors' consulting offices, private pharmacies, and nursing homes. Faith-based health services are entirely subsidised by the government.

A policy on community-based healthcare (CBHC) was developed in line with the 1992 Primary Health Care/Community-Based Healthcare guidelines to complement the work of the government in its effort to provide much needed health and social services to communities, within the overall objective of improving national health outcomes.⁹ As such, the CBHC policy is a strategy for achieving the goals of primary health care (PHC), and reinforces its concepts and principles by addressing all health-related matters affecting communities directly. Clinics, health centers, mobile outreach services, Community-based Organisations (CBOs), Non-Governmental Organisations (NGOs), Faith-based Organisations (FBOs), private sector organisations and practitioners, and community-based traditional health practitioners form the structure or network for the provision of community-based healthcare services in the context of PHC.

C. HEALTHCARE WORKFORCE

The policy framework for human resources in health is provided by the Human Resource Strategic Framework, which spans a 30-year period (1997- 2027),¹⁰ and the ten-year Human Resources Strategic Plan 2020-2030. Within MHSS, human resources development is coordinated by the Directorate of Policy, Planning and Human Resources Development, while human resource management is under the Directorate of General Services and Administration.¹¹

Key findings from the Health Care Workforce Status Report 2022 reported that MHSS has a total of 19,976 staff members, of which 81% are government-funded, and 19% donor funded.¹² The US President's Emergency Plan for AIDS Relief (PEPFAR) funds 17% of healthcare workers (HCWs), and the remaining 2% are funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and Cuban volunteers. There is a concern around sustainability of these positions in the event of dwindling donor funding, given that donor funded HCWs play a pivotal role in the delivery of services contributing to the control of the HIV and AIDS epidemic, and the attainment of UHC.

The report further noted a variation in staffing levels across regions, directorates, facilities, and HCW cadres. Across the regions, staffing levels range from as low as 46% in Kavango East to 68% in Oshana. Staffing levels for the Intermediate Hospitals and Windhoek Central Hospital are at an average of 71% while at the national level, six directorates have less than 50% of their approved posts filled. Very low staffing levels were also noted among HCW cadres in nutrition and dietetics, eye care, pharmacy, medical technology, psychology, physiotherapy, and occupational therapy. These findings suggest a more targeted recruitment to specialised services is needed in understaffed regions, directorates, facilities, and service settings to alleviate work pressure and improve availability, accessibility and quality of health services. The inequitable distribution of workforce across and within health sectors, geographically and by service and service settings, was also noted in the 2017 World Health Statistics.

The report furthermore revealed gender disparity with respect to senior leadership positions in the Ministry, despite 72% of the health workforce being female. Males are mainly in middle to executive management posts, while females occupy most of the lower management and technical levels, suggesting a need for continued affirmative action to minimise gender disparity.

Inadequate local capacity for the training of health professionals means that Namibia is heavily reliant on foreign-trained professionals. To address this challenge, GRN is gradually expanding opportunities for in-country training, such as the introduction of new nursing training programmes in recent years, and sponsoring training for health professionals abroad. Currently, the training of medical doctors, pharmacists and radiographers is only undertaken at the University of Namibia (UNAM), with the training of registered nurses conducted at UNAM, the International University of Management (IUM), Welwitschia University, and other training institutions.

The National University of Science and Technology (NUST) undertakes the training of environmental health practitioners, biomedical technicians, and laboratory technologists. The lack of postgraduate clinical training for various groups of health professionals is one of the major human resources challenges confronting Namibia.

D. HEALTH INFORMATION SYSTEM

Namibia's past health information system (HIS) has been described as "consisting of a large number of systems and databases that have little interoperability, completed by processes that are largely paper-based, and having either fragmented or nonstandard formats". Several initiatives in recent years have seen a move towards a more unified and integrated service. The MHSS Directorate of Health Information and Research acts as general coordinator and steward for Namibian HIS, responsible for the National Health Management Information System (NHMIS). In addition to facility-based data, health-related information and data are also obtained from the surveillance system, systems and programme assessments/review processes, and periodic surveys such as the Demographic and Health Survey (NDHS). This is however, a cost-intensive undertaking, and last conducted in 2013. The use of routine health facility data could be prioritised, between long waiting intervals of data from population-based surveys like NDHS. As such, reliance on NDHS data compromises programming and monitoring of health programs. Other relevant policies and plans relating to the health information system are in place.

The Health Strengthening System (HSS) review report revealed several achievements made toward strengthening Health Management and Information Systems (HMIS) from 2009 to 2020. These include amongst others, the migration of the District Health Information System (DHIS) system from the desktop-based DHIS1.4 to the second version, web-based DHIS2, significantly improving access. DHIS2 is a routine data monitoring system that provides a single platform to capture and aggregate all health data. The DHIS2 platform provides for enhanced integration of data, and for making data available to stakeholders for decision-making. In an effort to increase human resources in the Health Information unit Namibia recently introduced an academic degree programme in Health Information Management. An eHealth strategy is currently in process and focuses on the digitalisation of the Health Information System.

ICD-10 is the 10th revision of the International Classification of Diseases, a medical classification list by the World Health Organization. It contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases. It allows for more precise classification of some conditions, and up-to-date auditing of the HIS. The adoption of this coding system provides a global common language for recording, reporting and monitoring diseases, as well as comparison and sharing of data in a consistent and standardised manner between hospitals, regions and countries.

Despite these initiatives however, HIS in the country remains fragmented. Several disease programs have silo databases that do not feed into the central DHIS2 system. This has presented challenges when consolidating national reports as one would have to navigate through different systems to gather the data. Some gaps also exist in terms of data quality and the use of data for decision-making, particularly at sub-national level. Moreover, HMIS staff numbers at the Ministry and in the regions remain low despite efforts to increase HMIS workforce capacity through university qualifications. While data is currently being collected manually and later captured into DHIS2, it is prudent to implement digital solutions from point of care (POC) level upward. Some data collection tools are no longer in synch with the DHIS2 central data management tool. For example, tools for recording Antenatal Care (ANC) services recorded up to a minimum of 8 antenatal contacts while the DHIS2 system was only capturing up to 3 visits.

E. MEDICAL PRODUCTS, VACCINES AND TECHNOLOGIES

Namibia operates a government-owned and nationally driven integrated pharmaceutical supply chain, whereby the Central Medical Store (CMS) within the MHSS structure oversees the procurement, storage and distribution of all pharmaceuticals and clinical supplies for use in health facilities in the public sector, including essential medicines, surgical supplies, and laboratory investigation materials. The Division of Pharmaceutical Services in the Directorate of Tertiary Health Care and Clinical Support Services provides coordination and direction for all pharmaceutical matters in Namibia. CMS is a sub-division within the Division of Pharmaceutical Services, and distributes directly to the two Regional Medical Stores (RMSs) in Rundu and Oshakati, and to about 45 health facilities across the country, including most of the district hospitals.

An assessment of the national supply chain carried out in 2013 noted that “the public health supply chain in Namibia has many strengths, evidenced by their strong performance across most functional areas and existence of key processes and systems in place.” The report, however, also noted that “non-compliance with day-to-day warehousing Standard Operating Procedures (SOPs), high staff turnover rates, limited training for new staff, and fundamental changes to procurement processes put the performance of the CMS in these areas at risk in the near and long term.” To improve supply chain capability and mitigate risk of potential performance decline, recommendations made included: re-invigorating compliance to SOPs and processes, evaluating procurement policies and procedures, and implementing a robust performance management system to assess its key functions of procurement, warehousing, and transportation.

Another review noted considerable problems with compliance with the national standard treatment guidelines on the part of health workers in public sector facilities. Namibia has taken commendable actions in updating the essential drug list to embrace life-saving commodities advocated for by the Global Strategy for Women, Children and Adolescent Health strategy. In addition, there is also the need to build capacity of health workers as well as monitor and ensure compliance with national standards in every aspect of pharmaceutical and health commodity management.

The Directorate of Pharmaceutical Services has advanced pharmaceutical supply management through digital innovation. The MoHSS Pharmaceutical Information Dashboard is a web-based platform that enhances near real-time visibility of essential medicines, vaccines, and clinical supplies across all levels of care in Namibia. It plays a critical role in supporting timely and evidence-based decision-making by enabling early identification of stock imbalances, facilitating rapid redistribution, and improving overall supply chain responsiveness to prevent stock-outs and reduce wastage. The dashboard consolidates data from the Electronic Dispensing Tool (EDT), implemented at all district hospitals and some primary health care facilities; the Facility Electronic Stock Card (FESC), used at all district and referral hospitals; SYSPRO at the central level; and National Pharmaceutical Management Information System (PMIS) indicators.

Moreover, the NHPF and MHSS strategic plan set out a broad Essential Medicines and Medical Supplies (EMMS) goal of ensuring that quality, affordable and efficacious medicines, and medical products are available through timely supplies, and provide a basis for adequate treatment interventions in health facilities. The MHSS strategic plan outlined two indicators for tracking progress toward this goal: i) percentage availability of essential medicines, and ii) percentage of quantity demanded that is supplied by CMS at service level. Based on the HSS review, CMS managed to supply 90% of medicines and medical products that health institutions ordered in 2020 against the set target of 90%. However, the review could not obtain any data on the indicators for tracking the availability of essential services at the facility level.

F. Health Financing

For many years, Namibia has been classified as an upper middle-income country with a very unequal distribution of wealth, which magnifies health inequalities in the country. In July 2025, Namibia was downgraded to a lower middle-income status by the World Bank. This requires that Namibia reassess its economic and health financing strategies, given that Healthcare financing in Namibia is mainly tax-based. The main share of funding is spent on financing hospital care, HIV and AIDS and the health wage bill, while reproductive health and primary care services are expected to manage a minimal budget. Almost 80% of donor funding is allocated to the HIV and AIDS response. A quarter of total health spending is paid by private sector employers as contributions towards insurance coverage managed by Medical Aid Funds (MAFs), with the insured however still reporting very high out-of-pocket payments. Furthermore, GRN spends about 10% of total employee remunerations on the government-subsidised insurance enrolment of public employees into the Public Service Medical Aid Scheme (PSEMAS). This subsidy further increases inequities as it means that 25% of government health spending caters to only 12% of the population.

As the largest funder of healthcare, GRN is committed to strengthening the health sector and is considering changes to health financing to achieve the UHC agenda as indicated in NHPF 2010–2020, making efforts towards growing the health budget towards the realisation of this aim. The MHSS strategic plan 2017/18-2021/22 prioritised adequate government funding for health as a critical component to achieving this target by the end of the implementation period, and has put measures in place to track budgetary allocations and expenditure for the health sector. The budget allocated for pharmaceuticals supply has increased significantly over the years. The UNICEF 2022/23 health budget brief reported total government expenditure exceeding the 15% target for African Union member states for the health sector. With a sector allocation of 16.6% of total budget in 2022/23 and average per capita spending estimated at USD 407 (NAD 6,500), health spending in Namibia is one of the highest in the Southern African Development Community (SADC) region.¹⁴

1.1.4 National Framework for Reproductive, Maternal, Newborn, Child and Adolescent Health & Nutrition

One of the key priorities of GRN, and particularly MHSS, is improving the health and nutrition status of Namibian women, children, and adolescents.¹⁵ The high level of commitment directed towards these priority areas is witnessed by the national commitment articulated in HPP (2016-2020), particularly Pillar 3 (Improved Access to Public Healthcare) with a focus on reducing maternal and infant mortality, including morbidity and infectious diseases, improved nutrition and UHC coverage.

In addition, NDP5 (strategic implementation 3.6) articulates the health and nutrition targets to be attained during the period 2017-2022. The strategy for ensuring the health and wellbeing of all Namibians encompasses the following programmes:

- a. Human Resource Development,
- b. Medical Equipment Management,
- c. Emergency Medical Rescue Services (EMRS),
- d. Pharmaceutical Services,
- e. Physical Infrastructure Development,
- f. Health Research and Health Information, and
- g. Public Health Threats.

The Public Health Threats programme is comprised of the following projects, and aims to enable individuals and communities to prevent and control communicable and noncommunicable diseases, and to reduce morbidity and mortality rates due to these diseases and conditions across the life course.

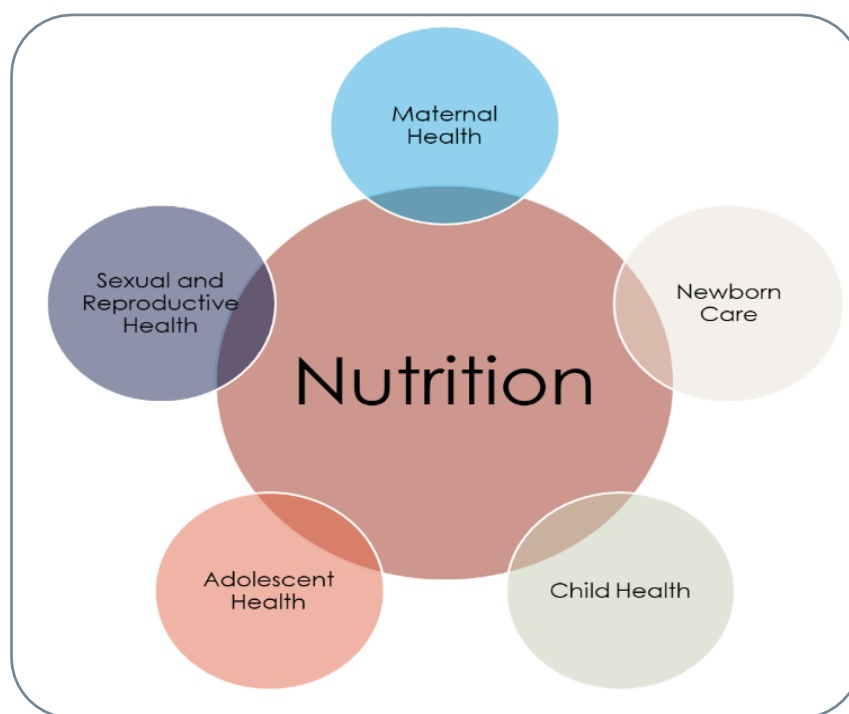
- i. Women's, Children's and Adolescents' Health,
- ii. Communicable and Noncommunicable Diseases,
- iii. Community-Based Health Services, and
- iv. Nutrition.

The strategic priorities, outcomes and focus areas of the 2018-2023 Country Cooperation Strategy also focus on, and prioritise NCDs, communicable diseases, RMNCAHN, and health systems strengthening.¹⁶

The 2018-2022 Namibia RMNCAH&N National Strategy¹⁷ was developed with the overarching goal to improve the quality of care related to sexual and reproductive, maternal, newborn, child and adolescent health, and nutrition across the continuum with an emphasis on integration (Figure 5). The integration agenda synchronises the mission of MHSS "to provide integrated, affordable, accessible, equitable, quality health and social welfare services that are responsive to the needs of the population". This strategy was informed by and aligned to Namibia's commitments to the updated Global Strategy for Women's, Children's and Adolescents' health, the Newborn Action Plan, and Ending Preventable Maternal Mortality (ENAP and EPMM)^{18,19} by 2035, ending the AIDS epidemic by 2030,²⁰ Global Nutrition Targets²¹ and the SDGs.²²



FIGURE 5: Integrated package for the health of women, children and adolescents



1.1.5 Rationale and process for updating the Namibia National Strategy for Women’s, Newborn, Children’s and Adolescents’ Health & Nutrition (2018- 2022)

Rationale

The expiration of the National RMNCAH&N Strategy (2018 – 2022) required Namibia to revise its strategy for the next five years (2025 – 2030). As we approach the SDG midpoint, between their 2015 launch and 2030 deadline, there is a critical need for Namibia to accelerate actions to achieve the health targets related to RMNCAH&N, in line with its national objectives. While some progress has been made towards achieving national health objectives and the SDG 3 targets related to the health of women, children and adolescents, the maternal mortality ratio and under-five mortality rate remain high, with inadequate coverage of high impact interventions across the continuum of care and inequities across regions. Skilled birth attendance has however improved from 88.2% in 2013 to 95% in 2020 (Maternal Mortality Inter-Agency Group).²³ In addition, the COVID-19 pandemic has had a wide-ranging impact on essential services for women, children and adolescents in Namibia, as with most countries in the African region.

Realising the slow progress in improving coverage of cost-effective RMNCAH&N interventions in the WHO African Region, the Regional Committee for the Africa Region meeting in August 2022 in Lome, Togo, (comprising Honourable Ministers for Health), called on countries to, among others, take actions to improve RMNCAH&N interventions towards the achievement of the SDG goals and targets of the global strategy.

This revised National RMNCAH&N Strategy (2025-2030) builds on the modest achievements in women’s children’s and adolescents’ health during the implementation of the 2018-2022 strategy, and uses the lessons learned to provide guidance on strengthening the health system and scale-up coverage of cost-effective RMNCAH&N interventions, focusing on equity, quality, and primary care approaches, and with improved demand and access to services.

Process

Cognisant of the multi-programmatic and multisectoral approach embedded in this strategy plan, stakeholders from government ministries, development partners, training institutions, NGOs and CSOs engaged in a participatory process through all stages of its development.

The planning process for revision of the RMNCAH&N Strategy commenced with a situational analysis utilising available information from the 2022 Health Sector Performance Review Report and other related national and international documents. Key inputs from the first consultation workshop based on contributions from stakeholders, inputs of the second stakeholders’ workshop for validation of the draft strategy, and finalisation of the updated RMNCAH&N Strategy were collated for final approval (Figure 6).

Additionally, an extensive desk review of a wide range of relevant literature pertaining to RMNCAH&N globally, regionally and nationally was commissioned, as well as a comprehensive review of national, regional, and global guidelines and programs to identify potential gaps in Namibia’s current strategy, with specific reference to examples of good practice.

FIGURE 6: Process of RMNCAH&N strategy update



2. Introduction

Chapter 2 presents an overview of the health situation of women, newborns, children, and adolescents in Namibia as informed by the HSS report and other relevant data sources i.e., DHIS, and WHO Global Health Observatory. This situational analysis incorporates and summarises recent information obtained from the National RMNCAH&N Strategy (2018-2022) review, inputs from stakeholders meetings, and the desk review of relevant national and international instruments pertaining to RMNCAH&N.

Thematic areas, policy guidelines governing these areas, national programme initiatives as well as performance trends for each of these thematic areas, challenges, and interventions to address the challenges of RMNCAH&N are presented below.

2.1 Current Status of Women, Children and Adolescents in Namibia

Maternal health traditionally encompasses antenatal care, delivery, and postnatal care. Namibia has recorded progress in reducing maternal neonatal, infant and child morbidities and mortalities, however the annual rate of reduction is insufficient to meet the SDG 2030 targets. Currently in Namibia, statistics show neonatal mortality at 24 deaths per every 1,000 live births, whilst under 5 (U5) mortality is at 41/1,000 live births.²³ Overall, neonatal deaths are reducing at a slower pace than the U5s. The maternal mortality ratio (MMR) is also high at 139/100,000 live births, and twice the set goal of 70 deaths per 100,000.^{23b} Considering that 2030 is merely 5 years away, the set MMR target will not be achieved at the current rate, hence the call for accelerating the reduction in maternal, neonatal and child morbidities and mortalities.

Healthcare services provided by CHWs and Health Extension Workers was introduced in 2014. The focus of these cadres includes house-to-house visits, and encouraging early attendance of ANC through information, education, and communication (IEC) messaging to all women of reproductive age, amongst others. To this end, mobile outreach health services including ANC and postnatal care were established to cater for hard-to-reach communities.

Moreover, the integration of services with the aim to minimise waiting times is ongoing. In 2021, MHSS launched the ANC guidelines in line with the latest WHO recommendations, to guide healthcare professionals to provide integrated antenatal care services to all pregnant women and adolescent girls. This is achieved through a continuum of care for the delivery of evidence-based interventions likely to improve maternal, foetal, and neonatal health and survival. Key components of the guidelines include danger signs enforcement, emergency preparedness, increased number of ANC visits from 4 to 8, early initiation of ANC upon detection of pregnancy, and obstetric ultrasound assessment before 24 weeks. There is a need to update health workers on the revised ANC guidelines. A revision of the Intrapartum Guidelines is in progress, consistent with WHO

recommendations for intrapartum care for a positive childbirth experience. These guidelines highlight the importance of woman-centered



care to optimise the experience of labor and childbirth for women and their babies through a holistic, human rights-based approach. Updated recommendations for the management of obstetric complications are also included. In addition, the Maternity Record was revised and aligned to the intrapartum care guidelines, incorporating the Labour Care Guide (LCG).²⁴ Training of healthcare workers on the LCG was also conducted.

Consistent with Goal 3 of HPP II, ‘Improved Access to Public Healthcare’ to realise improved and increased public health infrastructure, MHSS in collaboration with partners, constructed six functional maternity waiting homes. The Program for Accelerating the Reduction of Maternal and Child Mortality (PARMaCM) funded the construction of maternity waiting homes in Okongo, Gobabis and Opuwo districts. Additional waiting homes were renovated by MHSS in Onandjokwe, Engela and Oshakati districts.²⁵ The Social Security Commission (SSC) is funding the ongoing construction of new maternity waiting homes in Katima Mulilo and Outapi districts.

Since 2009, data on maternal and newborn deaths has been captured through the Maternal, Peri/neonatal Death Reviews. The 2018-2021 triennial report for the confidential enquiry into maternal, stillbirth and neonatal deaths in Namibia was finalised and disseminated. Overall, 98% of births are delivered in hospitals, and ANC attendance for women who died, or lost their baby during pregnancy or after birth, was high. Almost 45% (65/145) of maternal deaths occurred at an intermediate hospital, 24% (35/145) at district hospitals and 14.5% (21/145) at the national hospital. Eleven (7.6%) of the maternal deaths occurred at home. Being over the age of 35, instrumental birth, and birth by Caesarean section were significant risk factors for either maternal death, or near fatality. HIV-positive women had a 2.2 times higher risk for mortality.²⁶

The Maternal and Newborn Quality Improvement of Care (MaNICare) project was launched and piloted, and is under implementation in selected districts. Namibia is a signatory to, and has committed to the Global Targets and Milestones for Every Newborn Action Plan and Ending Preventable Maternal Mortality (ENAP and EPMM). Integrated management of neonatal and child illness (IMNCI) as well as Kangaroo Mother Care (KMC) are being implemented for sick, and low birth weight newborns. Revision of the post-natal care (PNC) guidelines are in progress and will address changes in PNC scheduling, from the current 6 hours, 6 days, 6 weeks and 6 months timeframe, to the WHO-recommended 24 hours, 3 days, 7 days, 6 weeks. PNC follow-up contacts are also advised for a positive postnatal experience.

Addressing the RMNCAH&N objective to ‘End all forms of malnutrition, and address the nutritional needs of adolescent girls, pregnant and lactating women and children’, the 2022 Baby Friendly Hospital Initiative (BFHI) guidelines were revised,²⁷ and training of healthcare workers is underway to promote, protect and advocate for breastfeeding practices. WHO recommends early initiation of breastfeeding within half an hour after birth. Breastfeeding is an effective prevention tool against malnutrition.²⁸ Exclusive breastfeeding has been documented to reduce childhood illnesses, especially diarrheal diseases which contribute to malnutrition. Most of the nutrition intervention coverage indicators are however not linked to the RHIS, and are therefore underreported, as they are not measured. Strengthening data capturing, monitoring and reporting on nutrition

is crucial in this regard. Consideration is given for inclusion of the national food and nutrition security policy and its implementation plan, coordinating mechanisms such as the Food and Nutrition Service (FNS) council, FNS inter-agency steering committee, and Technical Working Groups (TWGs).

While progress has been made towards achieving national health objectives and SDG 3 targets related to women's, children's and adolescents' health, the maternal mortality ratio and U5 mortality rate remain high, with inadequate coverage of high impact interventions across the continuum of care and inequities across regions. Different health departments and programmes including RMNCAH&N need to contribute to the strategic directions, goals and strategies of the next generation National Health Sector Strategic Plan (NHSP).

Regarding the Expanded Program on Immunization (EPI), a cohort register has been updated to include new vaccines. Additionally, the Effective Vaccine Management (EVM) assessment, and comprehensive Improvement Plan (cIP) 2020-2022 was conducted, and recommendations are being implemented. National vaccination coverage for the first dose of Measles and Rubella Vaccines has improved. New vaccines (COVID-19) will be added to the routine EPI schedule. Second dose of Inactivated Polio Vaccine (IPV) and booster dose of Pneumococcal Conjugate Vaccines (PCV) need to be added to the routine immunisation schedule. GRN also plans to introduce human papillomavirus (HPV) vaccines in the public health sector in the near future.²⁹

Despite these achievements, a delay in finalisation of guiding documents for health workers, revision of policy documents in line with new developments, as well as inconsistent implementation of EPI service delivery strategies due to inadequate human and material resources, are some of the challenges that have been encountered. There is a need to accelerate the implementation of the HPV vaccine in public health facilities, and to conduct regular refresher training for healthcare providers on Adolescent-Friendly Health Services (AFHS) and Adolescent Sexual Reproductive Health Rights (ASRHR). The introduction of Long-Acting Reversible Contraception (LARC) in institutions of higher learning is required.

Visual Inspection with Acidic Acid (VIA) for cervical cancer screening needs to be institutionalised. Vacancies in health facilities and implementation of task shifting needs consideration. Challenges in the supply chain regarding stock of contraceptives need to be addressed. Advocacy for additional budgets for Sexual and Reproductive Health and Rights (SRHR) could go a long way to address SRHR supplies and commodities. Finally, strengthening integration of SRHR/HIV/GBV at PHC level is of paramount importance.

As countries around the world countdown to the endpoint of the Global Strategy for Women's Children's and Adolescents' Health (2016-2030), a roadmap is needed to achieve the highest attainable standard of health for all women, children and adolescents, to transform the future and ensure every newborn, mother and child not only survives, but thrives. In this regard, WHO/AFRO has called on countries to take actions to improve coverage of cost-effective RMNCAH&N interventions towards achievement of the goals and targets of the global strategy, and thus UHC for all.



2.2 Maternal Health

Based on available data recorded for the period 2017 to 2022, overall progress for most of the maternal, newborn and child health indicators were reported to be on track to surpass the 2030 targets. The performance trend for these core indicators will be discussed in this chapter.

2.2.1 Policy documents and guidelines

Maternal, child, newborn and adolescent health targets are aligned to Vision 2030 HPPII, Agenda 2030 for Sustainable Development, AU Agenda 2063,³⁰ and the Global Strategy for Women's Children's and Adolescents' Health (2016-2030).³¹ Vision 2030 expresses, among others, the country's aspiration to reduce the MMR to 20/100,000 live births by 2030.³² Namibia has also ratified the International Labour Organization (ILO) Maternity Protection Convention no. 183, EPMM, and other legal instruments for reducing maternal morbidity and mortality.³³

The key policy document and guidelines relating to maternal health in Namibia include the following:

TABLE 2: Key policy documents and guidelines relating to maternal health

MATERNAL HEALTH
<ul style="list-style-type: none">• Namibia National Health Policy Framework (2010-2020)³⁴• Namibia National Strategy for Women's, Children's, and Adolescents' Health and Nutrition (2018-2022)• Health Sector Performance Review Synthesis Report (April 2022)³⁵• Namibia (2013) Demographic and Health Survey³⁶• Ministry of Health & Social Services HIS, 2011• Ending Preventable Maternal Mortality (EPMM)• Namibia National ART Guidelines 2019³⁷• Family Planning Guideline³⁸• National Guidelines for Antenatal Care for a Positive Pregnancy Experience (2020)³⁹• National Development Plan 5 (2017 – 2022)• Health Strategic Framework (2017 – 2022)• The Country Cooperation Strategy (CCSIII)

2.2.2 National programme and service initiatives

The MHSS-driven Maternal Newborn Health (MNH) programme has the following specific objectives, to:

- » Strengthen utilisation of MNH policies, guidelines, protocols, and service standards by all service providers.
- » Provide skilled attendance during pregnancy, childbirth, and the post-natal period at all levels of the health care system.
- » Equip all health facilities with required equipment and supplies in accordance with national health standards.

- » Strengthen community-oriented IEC and Behavioural Change Communication (BCC) strategies.
- » Strengthen monitoring and evaluation activities at district and national levels.
- » Implement Maternal and Newborn QI of Care (MaNICare)
- » Achieve EPMM milestones.
- » Implement Every Newborn Action Plan (ENAP), Integrated Management of Neonatal and Child Illness (IMNCI), Kangaroo Mother Care (KMC).
- » Strengthen the role of community health workers in maternal and neonatal health at community level.

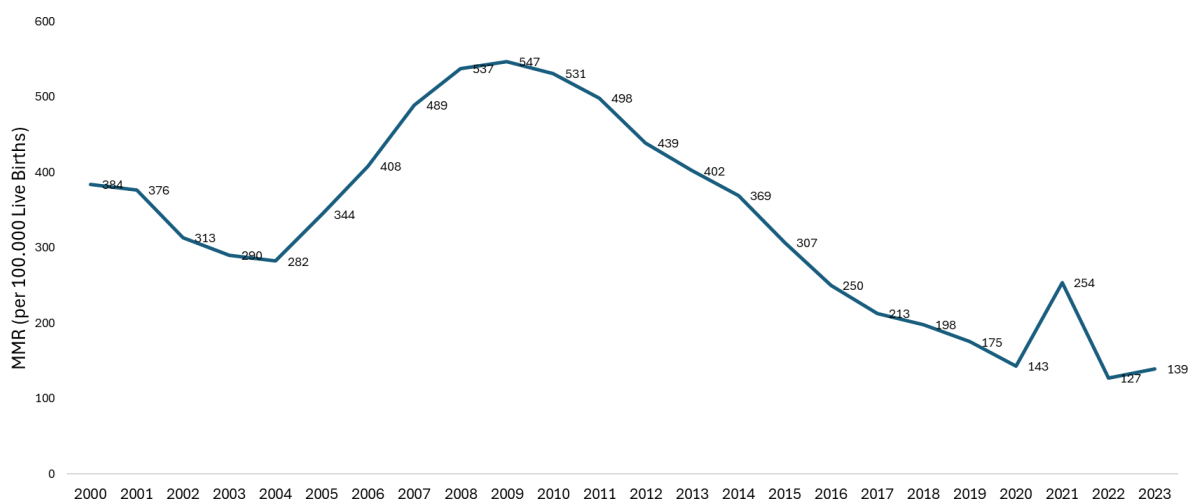
2.2.3 Performance trends

A. Impact Indicators

i). Maternal Mortality Rates

The NHPF and MHSS strategic plan identified MNH as a public health priority. MMR in Namibia has been on the decline over the last decade. According to comparative MMR estimates reported by MMEIG, WHO, UNICEF, UNFPA, World Bank, and the UN Population Division for the period 2000-2020, Namibia modestly reduced its maternal mortality rate by 28% between 2015 and 2020 (299 per 100,000 LB in 2015 to 215 per 100,000 LB in 2020). While this is commendable, the rate of progress is insufficient to propel Namibia to achieve SDG 3.1 by 2030 at the current maternal mortality rate of 215 per 100,000 LB (Figure 7). The country’s Annual Rate of Reduction (ARR) of 7.93% between 2010 and 2020 fell short of the estimated global ARR of 11.7% for the same period. It is now estimated that to achieve the SDG global target of 70 per 100,000 LB, countries of the world (including Namibia) now need to achieve and sustain ARR of 11.6% until 2030.

FIGURE 7: Trends in maternal mortality estimates 2000-2023. (Source: MMEIG 2025)



The confidential enquiry into maternal deaths, stillbirths and neonatal deaths for 2018-2021 revealed that half of maternal deaths (51%, 75/145) were from direct causes, 38% (55/145) from indirect causes and in 11% (16/145) the cause could not be established. Obstetric hemorrhage (19.3%, 28/145), hypertensive disorders (12.4%, 18/145), pregnancies with abortive outcome (9.6%, 14/145), and pregnancy-related infections (5.5%, 8/145) were the leading causes of direct maternal deaths in Namibia. Hepatitis E (11.7%, 17/145), cardiac disease (8.2%, 12/145), TB and other maternal infections (each 7.5%, 11/145) were the most common indirect causes of maternal mortality.

Based on this review, the Maternal and Peri/Neonatal, Still Births Death Review Committee concluded that 57% (82) of the cases were preventable, and an indication of poor quality of care. Improvements in the quality of care may have effected a different outcome, and is essential for preventing these deaths in the future.

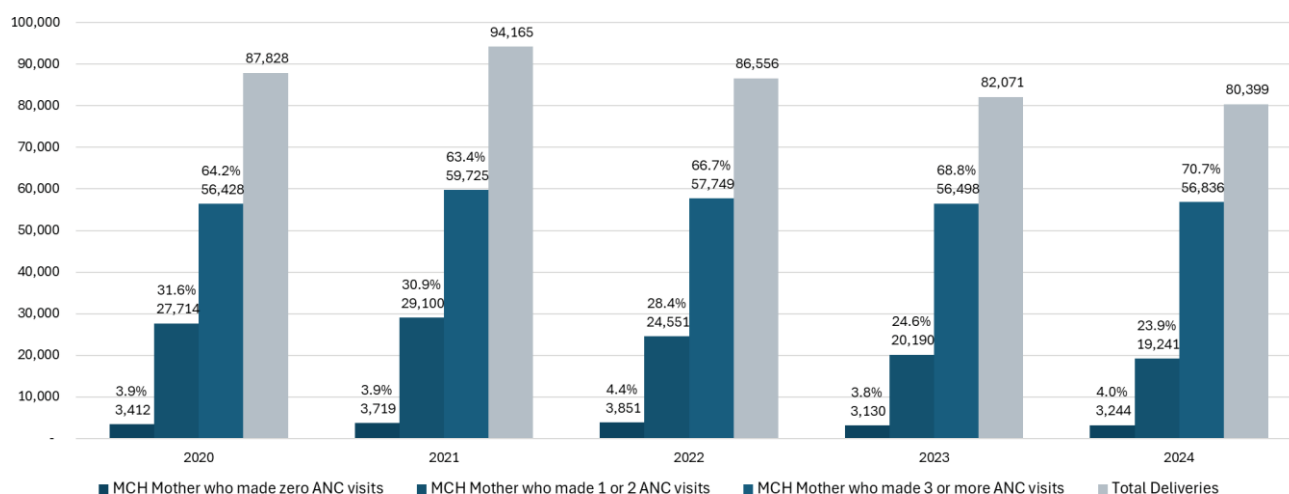
2.2.4 Service coverage and quality indicators

i) Antenatal care

In Namibia, ANC services are readily available, and free of charge in all health facilities across the country. Over the past decade, Namibia has adopted the principles of the Focused Antenatal Care (FANC) model. The FANC approach suggests at least four ANC visits, and has been widely embraced by other low- and middle-income countries. However, only 64% of pregnant women globally had the recommended minimum four visits during 2007–2014. Evidence during the last few years shows that the FANC model is associated with more perinatal deaths (stillbirths) than ANC models that comprise at least eight contacts between the pregnant woman and the healthcare provider. Furthermore, women were also not satisfied with the quality of antenatal care they were receiving during their focused ANC visits. Based on WHO recommendations on antenatal care for a positive pregnancy experience, ANC models with a minimum of eight contacts are now recommended to reduce perinatal mortality and improve women's experience of care. FANC is no longer recommended.

In this regard, consistent with the latest global evidence and WHO recommendations, Namibia has adopted the standard ANC model with eight contacts and developed the National Guidelines for a Positive Pregnancy Experience 2020 to guide health workers in the provision of integrated ANC services to all pregnant women and adolescent girls, for the delivery of evidence-based interventions to improve maternal, foetal and neonatal health and survival. The new ANC model aims to ensure equitable access to, and appropriate utilisation of quality ANC services provided by appropriately skilled healthcare workers to enable the client to achieve a positive pregnancy experience and outcome. Figure 8 depicts Namibia's performance in terms of ANC contacts for 2020-2024.

FIGURE 8: Antenatal care contacts performance 2020 - 2024 (Source: DHIS data)



The data shows an increase in the number of pregnant women with three (3) or more contacts, from 64% of total women at delivery in 2020, up to 70.7% in 2024. This is partly attributed to the COVID-19 pandemic response which had direct implications on implementation of outreach services, especially the far and remote areas. This performance is below the 80% target set in the 2018-2022 RMNCAH&N strategy. There is a need for a more targeted approach aimed at increasing ANC coverage including community mobilisation and sensitisation on the importance of ANC services.

The Government advocates for all pregnant women to access ANC, and more so during the 1st trimester or as soon as pregnancy is established. This demonstrates GRN's commitment to improve maternal, foetal and neonatal health and survival. Factors such as the negative attitude of healthcare workers, long distances to and from health facilities, lack of transport money to travel to and from the health facilities, lack of knowledge regarding ANC, attitude towards pregnancy and others, were found as hindrances to the utilisation of ANC services and contributed to low uptake of ANC care. These findings imply the need to devise appropriate interventions for increased ANC uptake in the country.

ii) Childbirth

The time of birth is critical to the survival of women and their babies, as the risk of morbidity and mortality increases considerably if complications arise. In line with the targets of SDG 3 to ensure healthy lives and promote well-being for all at all ages, and the new Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), global agendas are expanding their focus to ensure that women and their babies not only survive labour complications if they occur, but also thrive and reach their full potential for health and life.

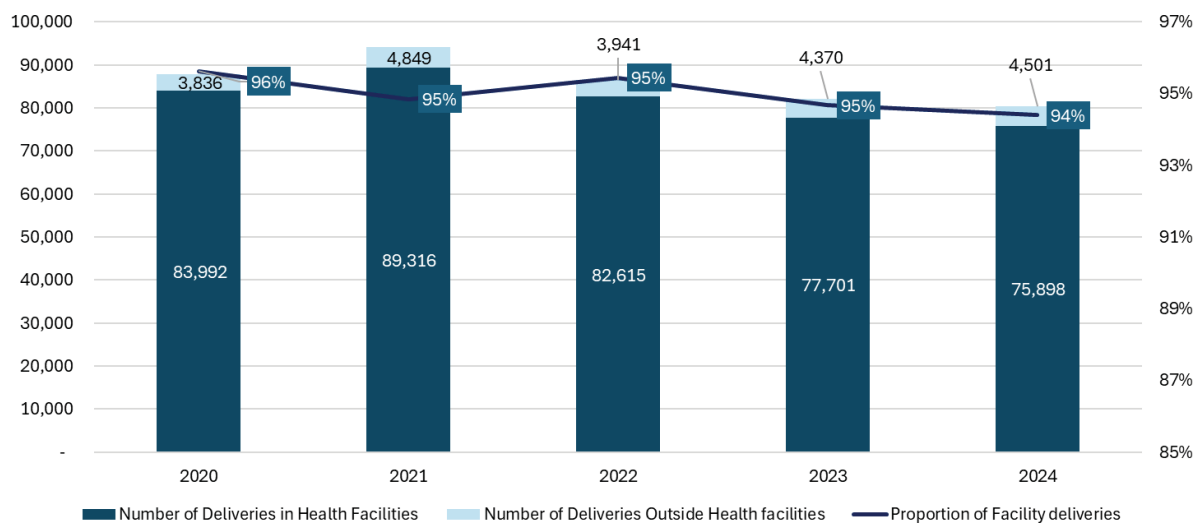
In 2018, WHO released recommendations for intrapartum care for a positive childbirth experience. This recommendation promotes the delivery of a package of labor and childbirth interventions that is critical to ensuring that giving birth is not only safe but also a positive experience for women and their families. It highlights how woman-centred care can optimise the quality of labour and childbirth through a holistic, human rights-based approach. By outlining a new model of intrapartum care that is adaptable

to individual country contexts, the guideline enables substantial cost-savings through reduction in unnecessary interventions during labour and childbirth. Namibia has adapted these recommendations to local context and developed the National Guidelines for Intrapartum Care for a positive childbirth experience. The implementation of these guidelines is in progress.

Coverage of Skilled Birth Attendants (SBAs) is important due it’s correlation to the quality of care received during delivery, and birth outcomes for the mother and the newborn. Ensuring that all births are assisted by skilled health personnel is critical for reducing maternal and newborn deaths. Therefore, a trained health worker with midwifery skills (SBA) is recommended for all deliveries. SBA coverage estimates an increase from 92% in 2015 to 95% in 2020 (MEIG Namibia profile, 2022).

Namibia has adopted a health facility childbirth policy. Health facility childbirths provide access to SBAs who monitor the health of mother and baby during labour and delivery, and can intervene quickly if any complications arise. This can greatly reduce the risk of maternal and neonatal mortality and morbidity, as it creates opportunities for postpartum care, support for breastfeeding, improved outcomes, and access to emergency obstetric care. The number of total deliveries versus the number of deliveries which occurred in health facilities remain relatively proportionate, ranging between 94% and 96% (Figure 9). To address some of the geographical challenges in accessing maternal health services and improve access to skilled care and facility deliveries, several maternity waiting homes were constructed in selected regions of the country during the reporting period.

FIGURE 9: Health facility deliveries rate (Source: DHIS)



Namibia has adopted a health facility childbirth policy. Health facility childbirths provide access to SBAs who monitor the health of mother and baby during labor and delivery, and can intervene quickly if any complications arise. This can greatly reduce the risk of maternal and neonatal mortality and morbidity, as it creates opportunities for postpartum care, support for breastfeeding, improved outcomes, and access to emergency obstetric care. The number of total deliveries versus the number of deliveries which occurred in health facilities remain relatively proportionate, ranging between 94% and 96%. In an effort to address some of the geographical challenges in accessing maternal health services and improve access to skilled care and facility deliveries, several maternity waiting homes were constructed in selected regions of the country during the reporting period.

iii) Postnatal Care

The postnatal period, defined here as the period beginning immediately after the birth of the baby and extending up to six weeks (42 days), is a critical time for women, newborns, partners, parents, caregivers, and families. Yet, during this period, the burden of maternal and neonatal mortality and morbidity remains unacceptably high, and opportunities to increase maternal well-being and to support nurturing newborn care have not been fully utilised. PNC care services are a fundamental component of the continuum of maternal, newborn and childcare, and key to achieving the SDGs on reproductive, maternal and child health, including targets to reduce maternal mortality ratios and end preventable deaths of newborns.

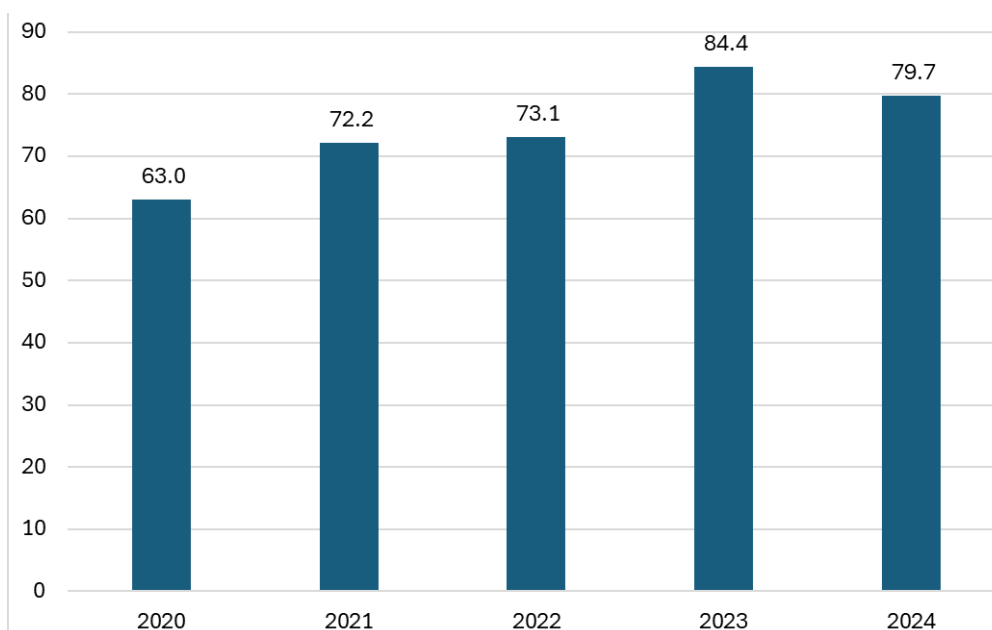
In this regard, WHO released recommendations on maternal and newborn care for a positive postnatal experience with the aim to improve the quality of essential, routine postnatal care for women and newborns, and the ultimate goal of improving maternal and newborn health and well-being. WHO recognizes a ‘positive postnatal experience’ as a significant endpoint for all women giving birth and their newborns, establishing the platform for improved short- and long-term health and well-being.

Postnatal care services are available across Namibia, and mostly provided at PHC clinics and health centers. However, Namibia’s PNC service is currently based on the old WHO model, which recommends PNC within 6 hours, 6 days and 6 weeks after birth. The country is about to move to the new model, which specifies two full assessments on the first day, followed by three additional visits – on day 3 (within 48–72 hours), between days 7 and 14, and 6 weeks after birth, in line with the WHO positive postnatal experience recommendations. Figure 10 represents the trends in PNC coverage services.

While the target set for this performance indicator was 90%, PNC attendance within 2 days post-delivery was recorded at its lowest in 2020 (66%), highest in 2023 (84%), and dropped to 79% in 2024. To achieve the 90% target, there is need for strengthening PNC service delivery to facilitate early recognition of complications and prompt actions, and referral and management for improved maternal and neonatal outcomes.



FIGURE 10: Maternal postnatal care coverage (Source: DHIS II)



iv) Emergency Obstetric and Newborn Care Process Indicators

A national Emergency Obstetrics and Newborn Care (EmONC) assessment was carried out in 2016 to determine the capacity of public sector health facilities in Namibia in terms of Emergency Obstetrics and Newborn Care (EmONC) Signal Functions (SF).⁴⁰ These are interventions targeted to reduce maternal and newborn mortality and morbidity from seven leading direct obstetric complications. Key findings from the EmONC assessment were as follows:

- i. Only 5% (six) of the 123 health facilities could perform all the expected EmONC SF.
- ii. All hospitals are designated to provide Comprehensive Emergency Obstetric and Newborn Care (CEmONC) functions. However, only 17% (six) of hospitals provided all nine CEmONC functions, none of the 78 health centres and clinics (although designated to provide Basic EmONC (BEmONC) provided all the BEmONC SF.
- iii. Manual removal of placenta, removal of retained products and Assisted Vaginal Delivery (AVD) were the least performed SFs in hospital, health centres and clinics. The number of functional BEmONC facilities was at 0 in 2016 while a slight increase was notable in the number of facilities with functional CEmONC from 5 in 2016 to 6 in 2021.

A more up to date EmONC assessment needs to be conducted to facilitate monitoring and programming, as well as a follow-up (2nd) EmONC assessment to obtain realistic and real time progress on the implementation of this intervention in the country.

2.3 Neonatal Health

2.3.1 Policy documents and guidelines

The key policy document and guidelines relating to newborn care and neonatal health in Namibia include the following:

TABLE 3: Key policy documents and guidelines relating to neonatal and newborn health

NEONATAL AND NEWBORN HEALTH
<ul style="list-style-type: none">• National Roadmap for Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis (2020-2024)⁴¹• Namibia National Health Policy Framework 2010-2020• Namibia Child Survival Strategy (2014-2018)⁴²• Plan for Elimination of New Paediatric HIV Infections and Keeping Mothers Alive 2011/12-2015/16⁴³• Every Newborn Action Plan (2014-2018)⁴⁴• National Policy on Sexual, Reproductive and Child Health (2013)⁴⁵• National Guidelines on Infant and Young Child Feeding⁴⁶• National Policy on Infant and Young Child Feeding⁴⁷• Baby Friendly Hospital Initiative (2022)• Expanded Programme on Immunisation Strategy (2018-2022)⁴⁸• National Guidelines for Antenatal Care for a Positive Pregnancy Experience (2020)⁴⁹

2.3.2 National programme and service initiatives

In response to the ‘child survival’ call to action forum held at Georgetown University in Washington, DC in 2012, MHSS with the collaboration of UNICEF and WHO developed and implemented a child survival strategy to reduce child mortality to below 20/1000 live births by 2035. The Every Newborn Action Plan (ENAP) roadmap for action, charts the path towards ending preventable newborn mortality, reducing disability and ending preventable stillbirths. ENAP was prepared in response to country demand, based on the most recent evidence on cost-effective clinical interventions and lessons from countries in which the rates of newborn mortality and stillbirth have been reduced, and newborn health outcomes improved. Meeting the recommendations in the plan will also support attainment of the Global Strategy for Women’s, Children’s and Adolescents’ Health, UHC for all and the SDGs. Namibia is one of the 93 countries implementing the recommendations of ENAP and monitoring their progress.

2.2.3 Performance Trends

A. Impact Indicators

i) Stillbirth Rate

Stillbirth refers to babies born with no signs of life at or after 28 weeks of pregnancy. Stillbirths and neonatal deaths continue to account for most deaths among women, children and adolescents, but at the same time receive the lowest investment along the continuum of care. Stillbirth rates were recorded at 17/1000 total births in 2021. Almost all intrapartum stillbirths are preventable with the provision of quality care during childbirth. Many antepartum stillbirths can be prevented through high quality ANC. By 2030, all countries are expected to have reached the target of 12 or less newborn deaths per 1000 live births, and continue to reduce death and disability, ensuring that no newborn is left behind. The confidential enquiry into maternal, stillbirths and newborn mortality revealed that the main causes of stillbirths were sepsis, birth trauma, placental insufficiency, anomalies, cord prolapse, and intrauterine asphyxia. However, caution should be exercised in the interpretation of these findings, as a large portion of deaths were classified as ‘unknown’. Nonetheless, this provides an overview of the current situation in Namibia in terms of reporting, collecting and aggregating data, reviewing stillbirths and neonatal deaths and classifying them accordingly. This also provides an opportunity in gauging how and where improvements to data collection can be made during subsequent review periods.

ii) Neonatal Mortality Rate

Neonatal deaths refer to deaths within the first 28 days of life. The Maternal Perinatal and Neonatal Deaths Review (MPNDR) 2018-2021 identified the following common specific causes of neonatal mortality in Namibia: birth asphyxia, neonatal sepsis, meconium aspiration, respiratory distress, prematurity, and congenital abnormality.

iii) Trends in Neonatal Mortality Rates

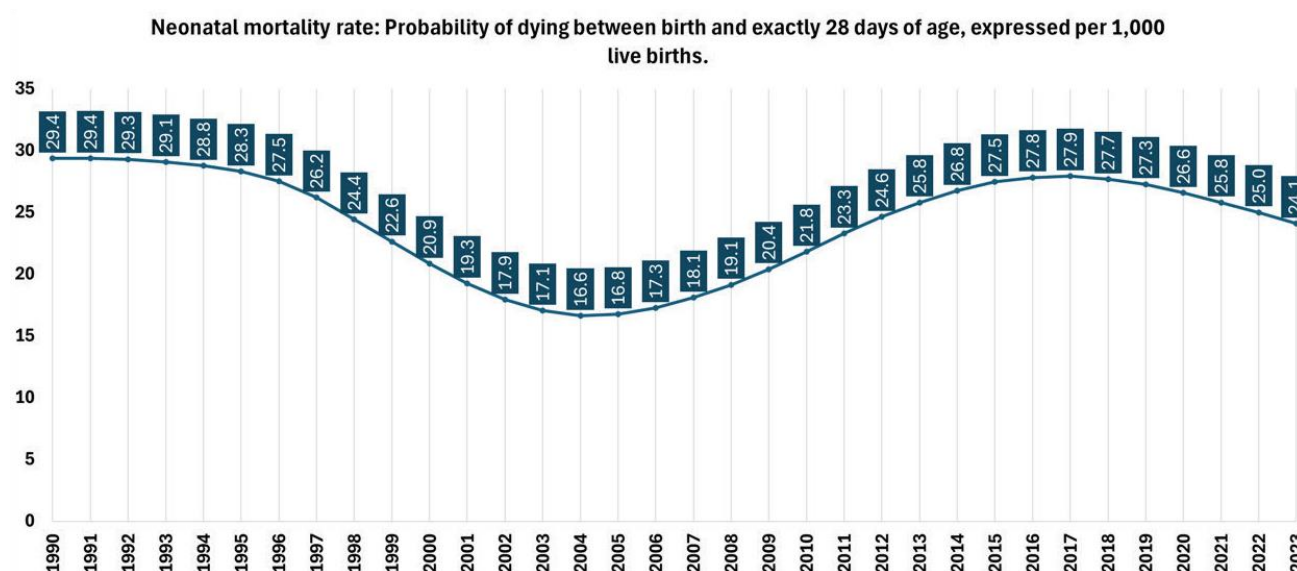
Trends in Namibia’s Neonatal Mortality Rate (NMR) are presented in Figure 11. Preventing neonatal mortality is a crucial public health goal and several strategies can help reduce the risk of these deaths: adequate prenatal care, management of pre-existing medical conditions, lifestyle changes i.e., smoking, drinking alcohol, or using drugs during pregnancy, early detection and treatment of complications as well as access to high-quality obstetric care. Namibia has witnessed a steady decelerated reduction in neonatal mortality. In 1990, NMR was recorded at 29 per 1000 LB and decreased to 16 in 2004, followed by a continual rise to 28 in 2018, and a subsequent steady decline to 24 in 2024. This figure however represents only a minimal reduction, at a rate of 1.2% on average, over a period of 30 years. According to the United Nations Inter-Agency Group on Childhood Mortality Estimation (UNIGME) NMR in Namibia is at 24 in 2025.

To accelerate reduction in NMR, and to reach the ENAP target of 12 or less newborn deaths per 1000 live births, the following four indicators have been formulated:

- i. four or more ANC contacts,
- ii. births attended by skilled health personnel,
- iii. PNC within 2 days, and
- iv. care for both small and sick newborns.

By 2030, UNICEF and WHO expect all countries to have reduced neonatal death and disability, ensuring that no newborn is left behind, and substantial progress is made towards improving newborn health and survival.

FIGURE 11: Trends in neonatal mortality rates, 1990-2023 (United Nations Inter-agency Group for Child Mortality estimation report, 2025)



2.4 Child Health

2.4.1 Policy documents and guidelines

The key policy document and guidelines relating to child health in Namibia include:

TABLE 4: Key policy documents and guidelines relating to child health

CHILD HEALTH
<ul style="list-style-type: none"> Namibia National Health Policy Framework 2010-2020 Health Sector Strategic Plan (2014 – 2018) National Policy on Sexual, Reproductive and Child Health (2013) Namibia Child Survival Strategy (2014-2018) (aligned to NDP4) Malaria Strategic Plan (2010-2016)⁵⁰ National Malaria Vector Control Guidelines (2014)⁵¹ National Guidelines on Infant and Young Child Feeding (May 2011) National Policy on Infant and Young Child Feeding Strategic Plan for Nutrition (2011-2015)⁵² Namibia Strategic Plan for Expanded Programme on Immunisation (2018 - 2022) National Guideline for the Prevention of Mother-to-Child Transmission of HIV (2017)⁵³

2.4.2 National Programme and Service Initiatives

- **Child Survival Strategy (2014):** To contribute to the accelerated reduction of U5 morbidity and mortality to reduce the U5 mortality rate to 24 by 2018, and below 20 per 1000 live births by 2035.
- **EPI Strategy (2018):** To accelerate the reduction of vaccine-preventable morbidity and mortality in children under 5 years old, towards achievement of Millennium Development Goal (MDG) 4 and beyond.
- **Sexual Reproductive Health Policy (2013):** To enhance the attainment of the highest possible standard of sexual reproductive health, child health and nutrition for the Namibian population through provision of equitable, accessible, and affordable health and nutrition information and services.

2.4.3 Performance Trends

A. Impact Indicator

i). Childhood mortality: Infant and under-five mortality rate

Infant mortality rate (IMR) relates to the probability of dying between birth and the first birthday, while child mortality rate (CMR) relates to the probability of dying between the first and the fifth birthday, and under-five mortality rate (U5MR) relates to the probability of dying between birth and the fifth birthday. To reduce child mortality, various interventions are being implemented at different levels, including healthcare systems, community-based approaches, and individual practices. Namibia has adopted the Integrated Management of Neonatal and Childhood Illness (IMNCI) approach with the focus on the following steps:

- i. assessment and classification of the sick child,
- ii. treating the child,
- iii. follow-up, and
- iv. counselling the mother.

The implementation of this approach is widely scaled up to cover all health facilities in the country. Over the past 30 years, notable progress was achieved in the prevention of childhood illnesses and management of child health. Figure 12 illustrates infant mortality rate trends. According to UNICEF, IMR in Namibia decreased from 56/1000 in 1990 to 38/1000 in 2023.⁵⁴ This performance signifies an annual decrease rate of less than 1%. The SDG targets for U5 mortality are set at 25 deaths per 1000 live births. Namibia's U5 mortality is at 41 and therefore the country should fast track reduction to achieve the 2030 targets (Figure 13).

FIGURE 12: Infant mortality (UNICEF Mortality Estimate, 2023)

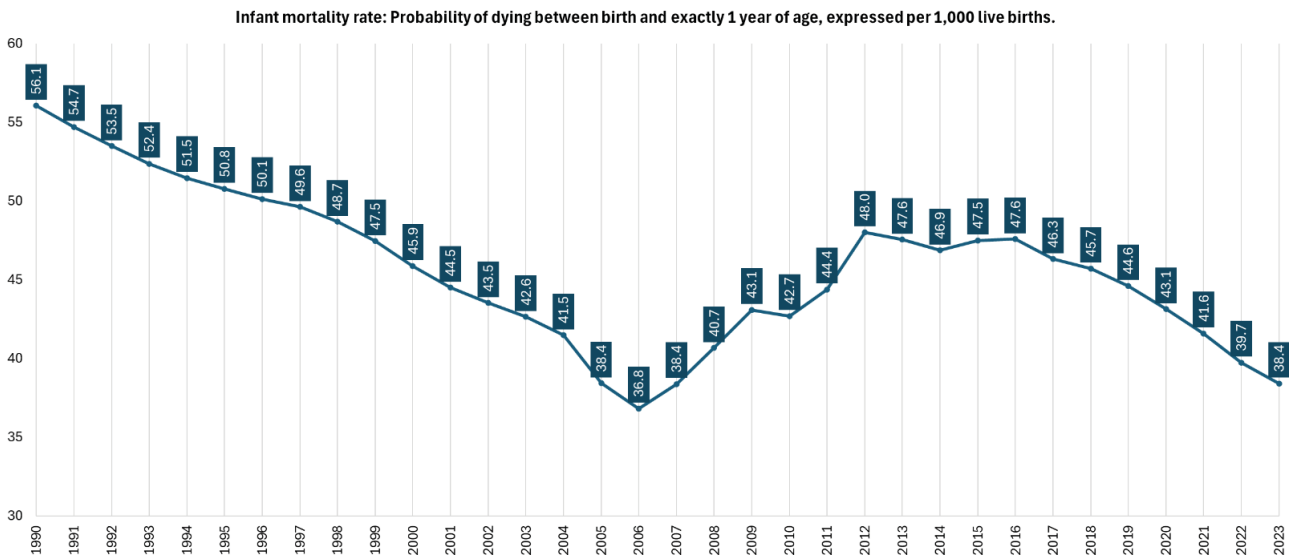
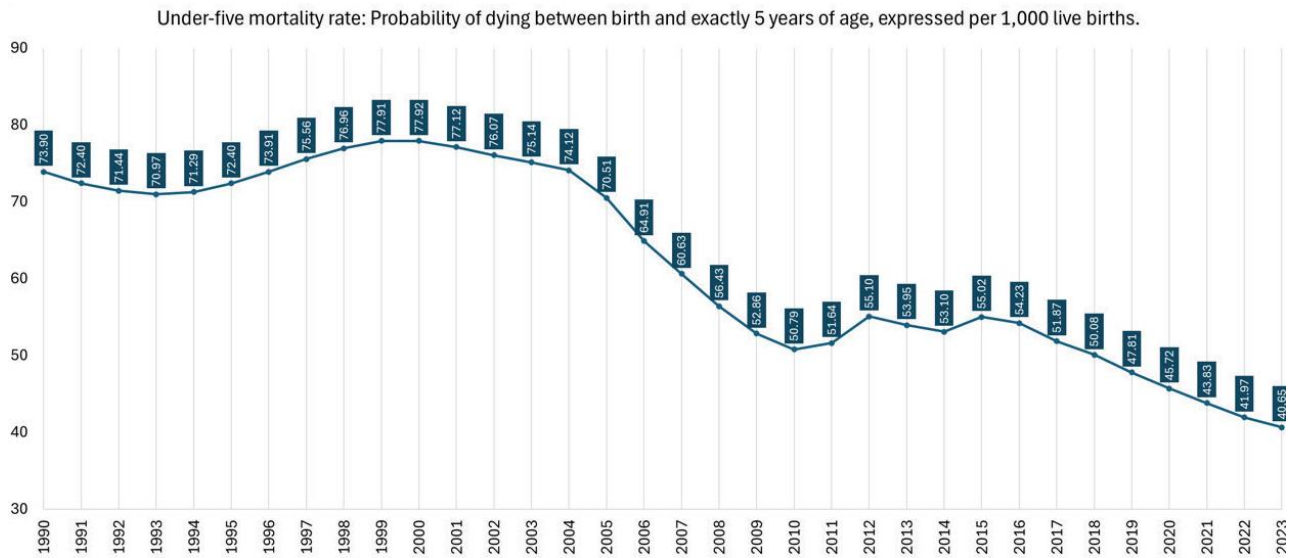


FIGURE 13: Under-5 mortality rates



B. Coverage Indicators

i) Childhood immunisation services

Childhood immunisation coverage refers to the percentage of children in a given population who have received the recommended vaccines according to their age. WHO recommends a series of vaccines for children to protect them from a range of vaccine-preventable diseases such as Measles, Polio, Hepatitis B, and others. Childhood immunisation coverage is an important indicator of the overall health of a community, as it can help to prevent the spread of infectious diseases and reduce morbidity and mortality rates in children. High coverage rates can also contribute to herd immunity, which means that even those who are not vaccinated are protected because the disease is less likely to circulate in the community.

The recommended vaccines and their schedules in Namibia are consistent with WHO recommendations, which suggests that children receive the following vaccines:

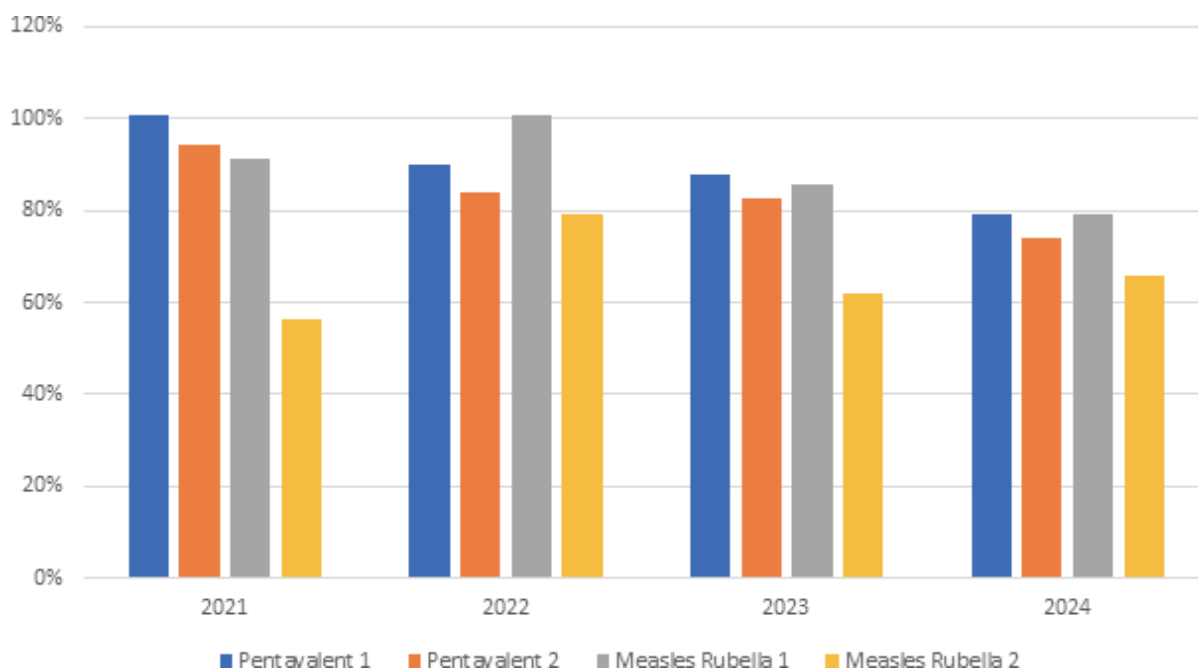
- BCG vaccine (against Tuberculosis),
- Hepatitis B vaccine,
- Polio vaccine at birth and Penta (DPT-HepB-Hib1) vaccine
- Measles-Rubella (MMR)
- Rotavirus, Pneumococcal (PCV)
- Oral Polio Vaccine (OPV)
- Inactivated Polio Vaccine (IPV) vaccines for surviving infants from six weeks after birth.

Other vaccines that may be available include Tetanus and Diphtheria (Td) for women of reproductive age, and Diphtheria and Tetanus (DT) as a booster dose at five and ten years of age. The Influenza vaccine has been available in private health facilities. The Ministry is introducing the HPV vaccine in the public sector, starting with girls 9-14 years old.

According to WHO, high immunisation coverage is achieved when at least 90% of children receive the recommended vaccines. However, the actual coverage rates may vary depending on factors such as access to healthcare, parental attitudes towards vaccination, and cultural beliefs. It is important for healthcare providers and policymakers to work towards improving childhood immunisation coverage rates to protect the health and well-being of children and communities.

A comparison of childhood immunisation indicators (Figure 14) shows an overall decrease in uptake of Penta 1 from 100% in 2020, to a little under 80% in 2024. Measles Rubella 2 is still under 70% below the 90% target. This can be attributed to challenges related to geographical distribution of the population, including distance and physical terrains.

FIGURE 14: Comparison of childhood immunisation indicators (source: WHO GHO and RHIS) and administrative coverage of the same period



ii) Prevention and management of common childhood illnesses

Childhood illnesses are a common concern for parents and caregivers worldwide. Children are particularly susceptible to various illnesses due to their developing immune systems and frequent exposure to pathogens in their environment. Children from lower income households remain at higher risk of childhood morbidities and mortalities due to water, sanitation and hygiene (WASH) conditions, diarrheal diseases and malnutrition. However, with the right preventive measures and effective management strategies, the impact of these illnesses can be minimised, ensuring the well-being and health of children.

Prevention plays a crucial role in reducing the incidence and severity of common childhood illnesses. It involves adopting practices that promote a safe and healthy environment, immunisations to protect against vaccine-preventable diseases, and educating parents and caregivers about proper hygiene and sanitation practices. By implementing preventive measures, the risk of children falling ill can be significantly reduced and a foundation established for their overall health and development.

The prevention and case management of childhood illnesses programme focuses on diseases such as Malaria, Pneumonia, TB, and diarrhoea, malnutrition, comprehensive care of children infected with, or exposed to, HIV, including infant HIV testing (Early Infant Diagnosis), and provision of antiretrovirals, prevention and response to child maltreatment, and prevention of harmful practices and care for children with developmental delays, including treatment and rehabilitation of children with congenital abnormalities and disabilities. With regards to Malaria, data related to the proportion of children who slept under any net for malaria prevention, either an Insecticide-Treated Net (ITN) or a Long-Lasting Insecticidal Net (LLIN), was not available during



the review process. This will be collected through the appropriate mechanisms during the implementation of the 2025/26 – 2029/30 RMNCAH&N strategy.

The process of prevention and management of childhood illness entails assessment and classification of the sick child, treatment, provision of appropriate follow-up, and counselling for parents or caregivers, in accordance with local and international guidelines such as IMNCI guidelines and WHO hospital care for children pocketbook.

Data related to the following coverage indicators: i. the proportion of children with diarrhoea who received oral rehydration therapy, ii. the proportion of U5 children with fever who took any antimalarial for fever, or those who took artemisinin-based combination therapy, iv. the proportion of U5 children with suspected acute respiratory infection who received appropriate antibiotics, and v. the rate of care-seeking for U5s with acute respiratory infection is best collected through the periodic patient care auditing process, and should be linked to the quality improvement (QI) system. The QI process assists with identification of poor performance, seeks possible contributing factors to the poor performance, and uses available data to improve performance.

2.5 Adolescent Health

Adolescents constitute the segment of a population aged 10-19 years of age. The SADC SRHR Strategy 2019-2030 supports member states by providing a policy and programming framework that improves SRHR of all people living in SADC, and contributes towards Member States meeting the SDGs and related commitments.⁵⁵

Some of these commitments are:

- a. ensure that adolescents and young people both in and out of school have access to good quality, comprehensive, age-appropriate, scientifically accurate life skills-based Comprehensive Sexuality Education (CSE),⁵⁶ with linkages to youth-friendly SRH services,
- b. Advancing the SRHR of adolescents through ensuring access to quality, people-centred SRHR services and build the capacity of healthcare workers to deliver these services;
- c. Protecting adolescents from child marriage through limiting the age of consent to marriage to 18 years, and
- d. Reducing the criminalisation of adolescents engaging in consensual sexual relations.

Substance use is often initiated in adolescence and adolescents are therefore more prone to substance abuse and associated health conditions. Prolonged heavy use of drugs and/or alcohol may result in an array of serious health conditions. Thus, addressing Substance Use Disorders (SUDs) from a life stage perspective, with assessment and treatment approaches incorporating co-occurring disorders is necessary to successfully impact the adolescent's overall health.⁵⁷

Adolescents are also at a higher risk of motor vehicle accidents due to their relative inexperience, impulsive behaviour, and tendency to take risks. Preventing adolescent motor vehicle accidents involves a combination of educational, behavioural, and regulatory interventions.

Additionally, high exposure to violence tends to be associated with high levels of emotional disorders in adolescents, suggesting an urgent need for interventions to reduce exposure to violence in young people. National programme and service initiatives should consider integrating these approaches in adolescent health service delivery packages.

In Namibia, as in other countries, adolescents become sexually active at a very young age, with limited protection against Sexually Transmitted Infections (STIs), including HIV and unwanted pregnancies. Despite this known sexual activity, adolescents still face significant barriers to accessing SRH services. According to the National Adolescent Friendly Health Services Standards (NSAFHS) of 2024, cultural norms, beliefs and practices, and health facility operating hours, coupled with the unwelcoming attitudes of health service providers, lack of confidentiality and no privacy at health facilities, often discourages adolescents from accessing needed services.⁵⁸

Namibia has re-affirmed the East and South Africa (ESA) commitment and will continue with the implementation of CSE, recently renamed ‘Skills-based HIV and Health Education’.⁵⁹ Embedded within the ESA commitment is the scorecard on SRH which aims to hold SADC Member States accountable by tracking the progress of the targets of the SADC SRHR strategy and the SDGs. Member states report on their progress every two years. To achieve this vision SADC Member States will fast track the following outcomes:

- » Reduction in the rates of teenage pregnancies.
- » Creation of an enabling environment for adolescents and young people to make healthy sexual and reproductive choices that enhance their lives and well-being.
- » Ensure universal access to integrated, comprehensive SRH services, particularly for young people, women and key, and other vulnerable populations, including in humanitarian settings.
- » Elimination of sexual and gender-based violence and other harmful practices, especially against women and girls.⁶⁰

2.5.1. Policy documents and guidelines

The key policy documents and guidelines relating to adolescent health in Namibia include the following:

TABLE 5: Key policy documents and guidelines relating to adolescent health

ADOLESCENT HEALTH
<ul style="list-style-type: none"> • Namibia National Health Policy Framework 2010-2020 • Health Sector Strategic Plan (2014 – 2018) • SADC SRHR Strategy (2019-2030) • National Policy on Sexual Reproductive and Child Health (2013) • National Standards for Adolescent Friendly Health Services (2011) • National School Health Policy (2008)⁶¹ • National Youth Policy (2018)⁶² • Eastern and Southern Africa Score Card (2019-2030) • ESA Commitments (2022-2030)⁶³ • Minimum Initial Service Package⁶⁴ • National Guidelines on Family Planning (2019)



2.5.2 National programme and service initiatives

A UNAM-led assessment of the utilisation of Adolescent Friendly Health Services in the Otjozondjupa region of Namibia revealed the following:

- i. poor service utilisation by adolescent girls,
- ii. poor condom use among the sexually active study participants,
- iii. non-participation of adolescent girls in healthcare committees, and
- iv. lack of participation in development and distribution of IEC materials amongst adolescents.

Some of the key recommended strategies to accelerate active participation of adolescents in the implementation of the AFHS standards, particularly in Otjozondjupa region and Namibia at large, is the use of innovative channels for the delivery of IEC health messaging targeted at adolescents such as the introduction of online health information services and harnessing of social networking systems to effectively reach adolescent audiences.

2.5.3 Performance trends

A. Impact Indicator

Namibia has ratified the SADC SRHR Strategy and is committed to its strategic outcomes, which include the reduction of unplanned pregnancies and unsafe abortion; reduction of teenage pregnancies; universal access to integrated, comprehensive SRH services, particularly for young people, women, and key and other vulnerable populations, including in humanitarian settings, ensuring SDGs 3.7 and 5.6, amongst others. Moreover, in 2021 the Ministers of Education, Health, Gender, and Youth, together with senior government officials recommitted themselves to step up efforts to ensure adolescents' and young people's access to good quality CSE and youth-friendly SRH services in the ESA region, and to work in partnership with young people, parents, civil society, and community and religious leaders to achieve the goals set out in the 2013 ESA Commitment.

While data related to mortality rate for adolescents in Namibia is unavailable, according to estimates developed by the 2022 UN IGME report for Sub-Saharan Africa, a steady reduction in the adolescent mortality rate was noted from 1990 to 2021, from 12 per 1,000 to 6/1,000 amongst the age group 10–14, and from 18/1000 (1990) to 10/1000 (2021) for the age group 15–19. This translates into an annual reduction rate of 2.1% (10-14) and 1.9 % (15-19) respectively for that period. Nearly 3.8 million adolescent deaths occur globally among adolescents aged 10–19 years, and a combined 71% of these in sub-Saharan Africa (9.4 million, 50%) and Southern Asia (4.0 million, 21%). The lowest adolescent mortality was recorded in Australia and New Zealand at 0% (10-14) and 2% (15-19), at an ARR of 2.8% and 2.4% respectively.

Strengthening efforts to reduce adolescent mortality rates requires collaboration with multiple stakeholders and a comprehensive approach that addresses various factors contributing to mortality. This includes improved access to quality healthcare, promotion of SRH education, healthy lifestyles, physical activity, and proper nutrition

initiatives, discouraging tobacco and alcohol use, and providing mental health support, reducing injuries and accidents, empowering and educating adolescents, and skill development, as well as strengthening data collection and monitoring.

Figures 15a and 15b show school dropout by regions, and reason during 2024. Overall, regions with the highest school dropouts were Ohangwena (1,741) followed by Kavango East (1,562), and Kunene (1,383). Similarly, school dropouts associated with pregnancy were the highest in these same regions. Conversely, //Kharas (310), Oshana (375) and Erongo (484) had the least school dropouts. Main reasons cited for dropouts include early marriage, followed by pregnancy-related and distance.

FIGURE 15a: School dropout by region (Source: EMIS, 2024)

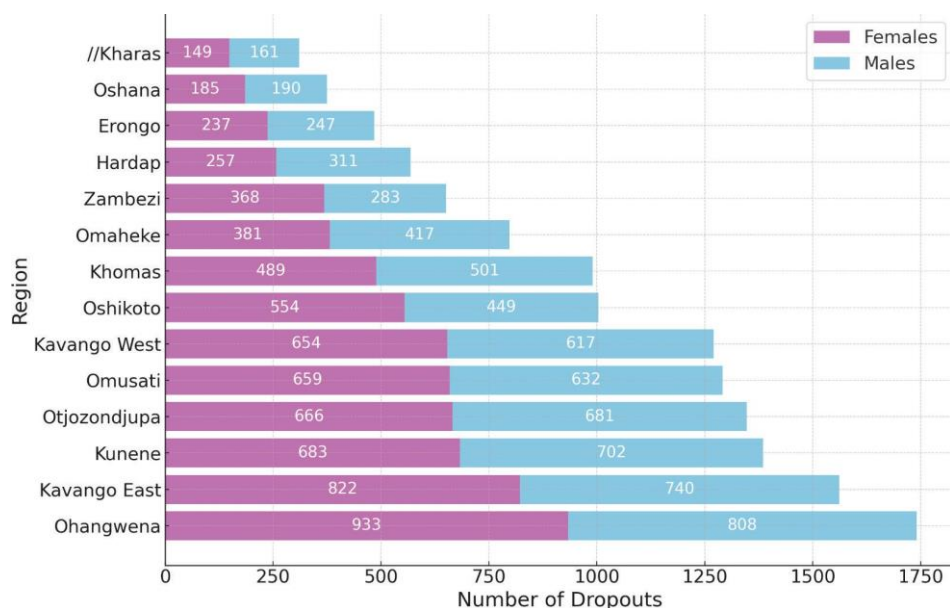
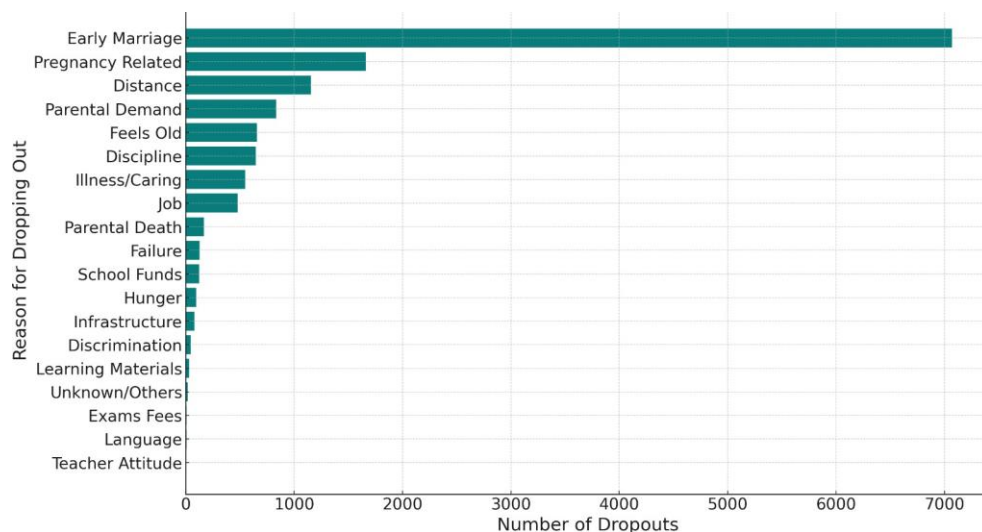


FIGURE 15B: School dropout by reason (Source: EMIS, 2024)



In addressing the SRH needs of adolescents, reference is made to the MHSS Adolescent and Young People job aid, and the revised Family Planning guidelines and related protocols, to include long-term acting reversible contraceptives methods. The revision of the School Health Policy and a multisectoral approach to reduce adolescent pregnancy is a crucial initiative for consideration.

B. Coverage Indicators

According to the 2014 MHSS joint review, AFHS were being implemented in 19 out of 34 health districts in the country. The Namibia Planned Parenthood Association (NAPPA) has trained approximately 1,366 Health Extension Workers (HEW) from 25 districts in 11 regions in AFHS, while 72 officers from the Health, Education and Gender ministries have been trained on school health. Recent data related to the current status of AFHS, as well as the number of personnel who are trained in AFHS in the country was not confirmed during this review process. Post-2014 review, MoHSS, in collaboration with UNFPA and WHO, introduced and supported the delivery of integrated health services. The trained healthcare workers has increased over the decade including through the roll out of the Adolescent Job Aid

The Minimum Initial Service Package (MISP) for SRH in Crisis Situations was introduced – a series of crucial, lifesaving activities to respond to the SRH needs of affected populations at the onset of a humanitarian crisis. Other coverage indicators and initiatives for monitoring during the 2025 – 2030 RMNCAH&N strategy include the following:

- » Adolescence job aid trainings were rolled out in all the regions.
- » Revision of the School Health Policy was finalised.
- » Revival of school health task forces in all regions was completed.
- » Namibia has re-affirmed the ESA commitment and will continue with the implementation of CSE (Skills-based HIV & Health Education in Namibia)
- » Substance abuse programmes are in place.
- » Suicide prevention programmes were instituted.
- » Road Safety and accident awareness initiatives have been introduced.

2.6 Sexual and Reproductive Health

2.6.1 Policy documents and guidelines

The Government developed a National Policy on Sexual, Reproductive and Child Health (2012) to guide MHSS, partners and stakeholders in health and development, to deliver quality sexual, reproductive, child health and nutrition services to the Namibian population. Recognising that SRH is a fundamental human right as enshrined in the constitution of the country, GRN is committed to the assurance of quality SRH among the population, which contributes to improved quality of life, and is key to socio-economic development of the nation. The strategic assessment on unintended pregnancies, contraception and unsafe abortion was developed to facilitate a situational analysis around this area. The findings from this assessment will inform the revision of official SRH policies.

Underpinning the national SRH policy is the SADC SRHR strategy which advocates for improved SRHR services to reduce morbidity and mortality, unlock human development

potential, and meet the SDGs and the targets of the AU Maputo Plan of Action 2016– 2030 in the SADC region. The vision of this strategy is to ensure that all people in SADC enjoy a healthy sexual and reproductive life, have sustainable access, coverage, and quality SRHR services, information and education, and are able to fully realise and exercise their SRH rights, as integral to sustainable human development.

Other SRH-related policy documents and guidelines include the following:

TABLE 6: Key policy documents and guidelines relating to SRH

SRH
<ul style="list-style-type: none"> • Namibia National Health Policy Framework (2010-2020) • Health Sector Strategic Plan (2014 – 2018) • Family Planning Guidelines and Related Protocols to include LARC Methods (2019) • National Cervical Cancer Prevention Guidelines⁶⁵ • Combination Prevention guidelines and a standard package for health services identified for target population • National Essential Medicine List (NEMLIST)⁶⁶ • Standard Treatment Guidelines⁶⁷ • SADC-SRHR-Strategy (2019-2030) • ESA Strategy

2.6.2 National programme and service initiatives

The services covered under the SRH agenda in Namibia include the following issues: family planning; sexually transmitted infections; cervical cancer prevention and control; and sexual and gender-based violence. Below are some of the programmes and initiatives supporting these thematic areas:

- » Strategic assessment on unintended pregnancies, contraception and unsafe abortion resumed background paper developed.
- » Menstrual health and hygiene study undertaken, and key recommendations identified.
- » National Formative Study on Child Marriage undertaken, and key recommendations presented to cabinet.
- » Revision of the School Health Policy.
- » Forecasting of family planning and maternal health commodities undertaken to guide future procurement.
- » Signed Co-operation Agreement for Receipt and Use of Implanon/NXT (CARUI) between the MHSS and the manufacturer of implants.
- » Minimum Initial Service Package (MISP) for Reproductive Health in Emergency readiness assessment and action plan.
- » Development and signing of the FP2030 Commitment for Namibia.

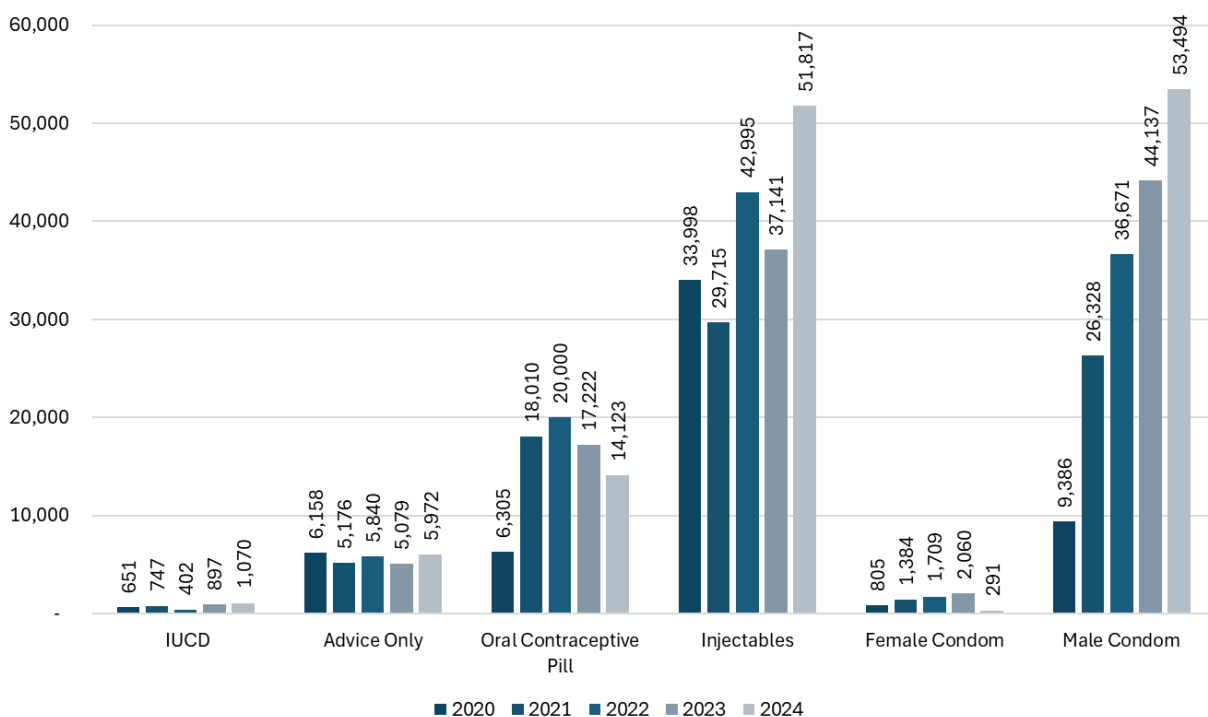
2.6.3 Family planning programme performance

Family planning (FP) and access to contraceptives are crucial, both for individuals and society. They are essential components of SRHR, and are critical for achieving sustainable development and improving the well-being of individuals, families, and communities: improved health outcomes, empowerment of women, reduction of



poverty, environmental sustainability, and improved social and economic development. Namibia has reduced the unmet family planning need from 12.3% in 2012 to 10.6% in 2023, according to the FP2030 family planning estimation tool. Injectables, male condoms, and oral contraceptives are the most common method of contraception⁶⁸ in Namibia. IUDs and female condoms are the least utilised contraceptive methods. Studies are needed to determine the acceptability and availability of these methods in public health facilities. Figure 16 illustrates contraceptive use by type from 2020-2024. Namibia introduced implants in the public sector in 2018, with keen interest by young women and women to access this method. The HIS system needs to ensure that indicators of all modern contraceptive methods, e.g., implants are integrated within the HIS system for proper monitoring and decision making.

FIGURE 16: Contraceptive use by type, 2020-2024 (Source: DHIS)



2.6.4 Performance trends: HIV and AIDS, PMTCT and other STIs

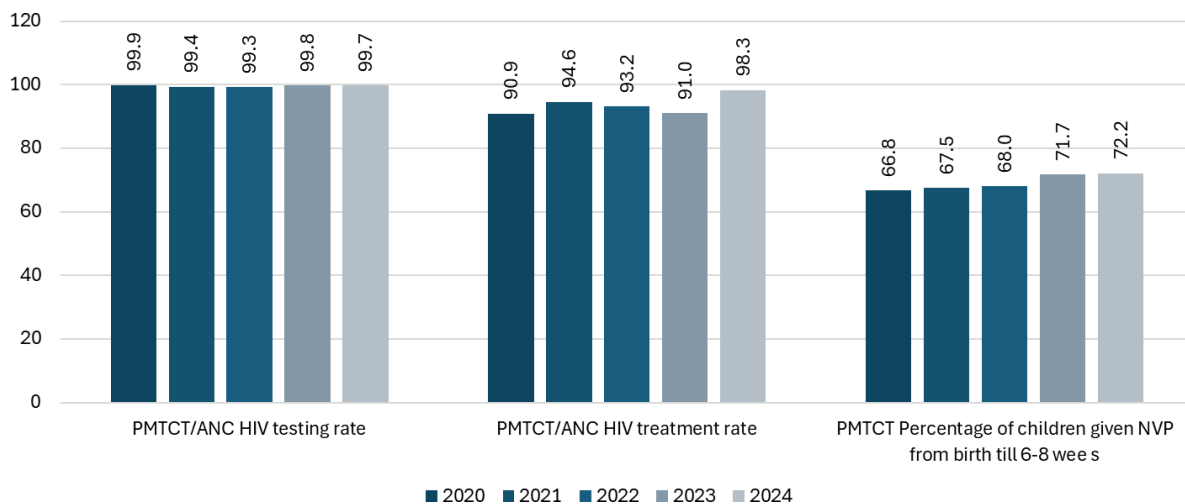
i) HIV and AIDS PMTCT

Namibia is committed to control the HIV epidemic and eventually end AIDS-related deaths by 2030. To realise efficient epidemic control, interventions include provision of quality ART treatment care and support and HIV prevention services to all persons in need, as stipulated in the National HIV policy of 2007, and in collaboration with relevant stakeholders.

GRN's leadership and rapid adoption of new international guidelines and best practices such as the elimination of HIV MTCT has also resulted in high HIV treatment and Prevention of Mother-to Child Transmission (PMTCT) coverage levels. PMTCT programme data in Namibia suggests that close to 100% of pregnant women attending ANC were tested for HIV, and about the same number were on ART.

Despite this progress, over the course of FY19 a total of 1,138 women were newly diagnosed HIV-positive, either late in pregnancy or at labour and delivery. Figure 18 indicates PMTCT/ANC/HIV treatment at between 90-98%. Conversely, infants being treated with the paediatric antiretroviral Nevirapine (NVP), from birth to 6-8 weeks, increased from 69% in 2020 to 72% in 2024. Late diagnosis of HIV during the PMTCT continuum places mothers at substantial increased risk of HIV MTCT (Figure 17).

FIGURE 17: Trends in HIV testing, PMTCT rate and PMTCT maternal coverage amongst pregnant women receiving antenatal care 2020-2024 (Source: HIV programme data)



ii) Other Sexually Transmitted Infections (STIs)

Sexually Transmitted Infections (STIs) are associated with increased HIV transmission, infertility, and other sexual health complications. STIs are diseases that are transmitted via sexual intercourse, especially unprotected oral, anal, and vaginal sex. STIs are a serious public health problem and can cause complications and long-term sequelae e.g., infertility. They can be spread to sexual partners and increase the risk of HIV/ AIDS transmission and acquisition. The syndromic management approach is used for the treatment, care, and control of STIs in Namibia. Early case detection and effective management of STIs is crucial in controlling HIV infection. The strategic objective of the programme is to reduce the incidence of STI cases and their related complications through improved STI case management, capacity building among healthcare workers, and strengthened STI surveillance, monitoring, and evaluation.

According to the 2021/2022 programme report, the prevalence of Urethral Discharge Syndrome (UDS) was reported at 34%, Vaginal Discharge Syndrome (VDS) 30%, lower abdominal Pain (LAP) 10%, and Genital Ulcer Disease (GUD) 8%, while ‘other’ STI was reported at 17% (Spectrum 2022). According to the MHSS DHIS2 annual report of 2023/2024, the regions with the highest numbers of STIs were Khomas (22,740) followed by Ohangwena (11,535), and Otjozondjupa (9,734). It is worth noting that UDS in men is used as a proxy for measuring the impact of STI prevention and control programs in Namibia. STI control efforts at the national level are coordinated mainly at the Directorate of Special Programs by the HIV/STI subdivision (Figure 18a).

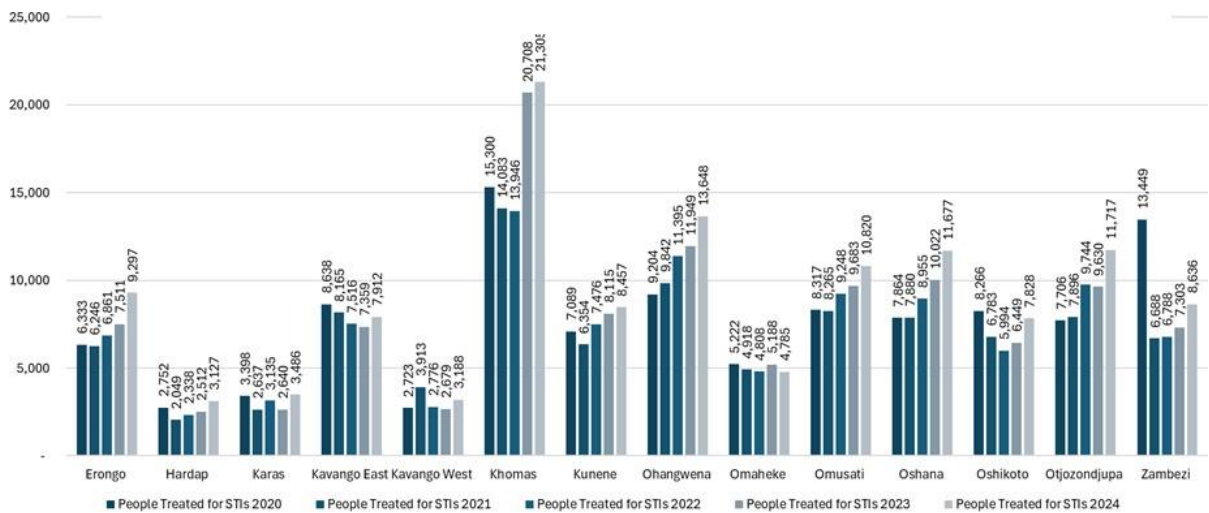


During the fiscal year 2023-2024, the five regions with the highest STI cases were Khomas, Ohangwena, Zambezi, Otjozondjupa, and Oshana, while the least STI cases were recorded in Omaheke, //Kharas and Kavango West regions (Figure 18b).

FIGURE 18A: Cases and rates of STI syndromes, 2020-2024 (Source: HIMS)



FIGURE 18B: Total number of STI cases per region in 2024 (Source: HIMS)

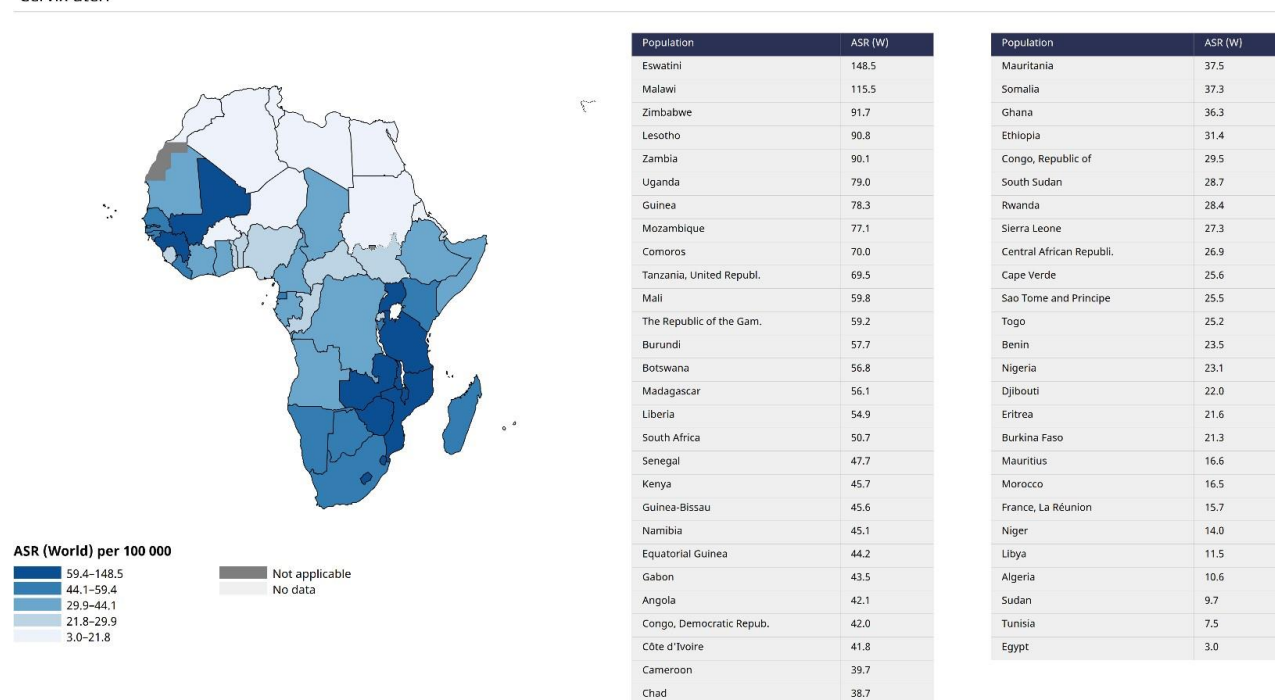


iii) Cervical Cancer Performance Trends

Namibia has a population of 855,578 females, aged 15 years and older who are at risk of developing cervical cancer. HPV infection is the leading cause of cervical cancer. HPV is a sexually transmitted infection that can cause changes in the cells of the cervix that can lead to cancer. Current estimates indicate that 375 women are diagnosed with cervical cancer annually, and 214 die from the disease (Figures 19 and 20). Cervical cancer ranks as the second most frequent cancer among women in Namibia, and the second most frequent cancer among women between 15 and 44 years of age.

FIGURE 19: Cervical cancer incidence rate in 20 to 64 year age group (Source: Globocan, 2022)⁶⁹

Age-Standardized Rate (World) per 100 000, Incidence, Females, age [20-64], in 2022
Cervix uteri



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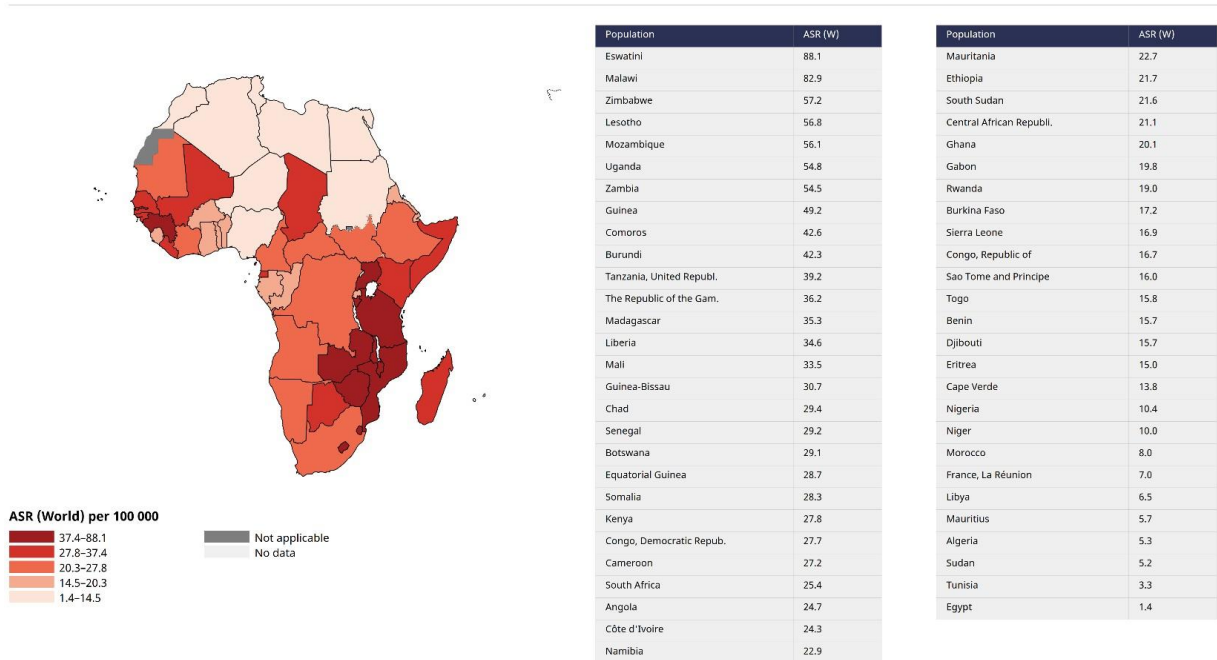


The trend in cervical cancer in Namibia has been fluctuating over the past five years. In 2015, 295 women were diagnosed with cervical cancer, increasing to 343 in 2016. A slight reduction was recorded in 2017 (321), and a significant further reduction to 121 was noticeable in 2018. However, despite implementation of the Namibia Cervical Cancer Screening and Treatment Programme in 2019, an alarming increase to 354 cases were recorded (Figure 21). This could be due to lack of regular screening and early detection. This trend needs further investigation and the strengthening of community mobilisation, information, communication, and education programmes. There is a need for wide scale-up of visual inspection with acetic acid (VIA) programmes in high HIV burden settings and hard to reach populations in all regions, to improve uptake and timely management of cases.



FIGURE 20: Cervical cancer mortality rate in 20 to 64 year age group (Source: Globocan, 2022)

Age-Standardized Rate (World) per 100 000, Mortality, Females, age [20-64], in 2022
Cervix uteri

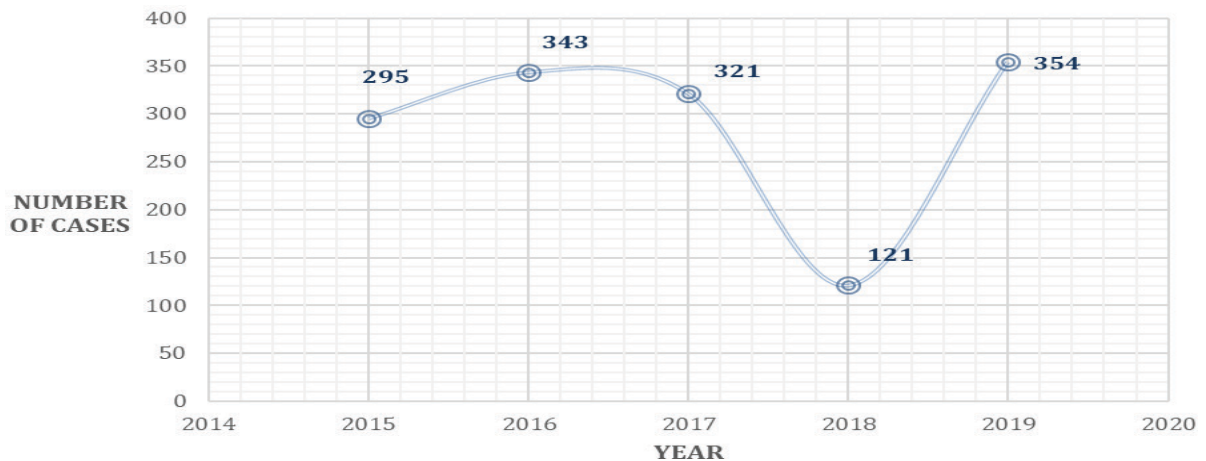


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FIGURE 21: Trend in cervical cancer cases, 2014-2020 (Source: Cancer Association of Namibia data, 2020)



Cervical cancer can however be prevented through primary HPV vaccination, secondary cervical cancer screening, treatment of precancerous lesions, and tertiary prevention through early detection and management. HPV vaccination, which is ideally given to girls aged 9-13 years in resource-limited settings, and for both girls and boys where resources permit, works as a prophylactic vaccine by boosting the immune system to better fight and clear HPV virus from the body at later exposure.

The goal of cervical cancer screening is to identify women who are at risk of developing cervical cancer and to provide them with appropriate interventions to prevent the disease. There are several methods for cervical cancer screening including a PAP smear, HPV DNA testing, and VIA or Lugol's iodine (VILI). In Namibia the two main screening tests are VIA and the PAP smear which involves collecting cells from the surface of the cervix and examining them under a microscope to detect any abnormal changes. VIA or VILI is a low-cost method of cervical cancer screening that involves applying a solution to the cervix to make abnormal cells more visible.

The frequency of cervical cancer screening depends on a woman's age and risk factors. WHO recommends that women should begin cervical cancer screening at the age of 25, and should continue to be screened regularly until the age of 65. At the time of this review, Namibia was revising the 2018 Comprehensive Cervical Cancer Prevention (CECAP) guidelines to align with the WHO guidance.

In 2019, WHO launched the cervical cancer elimination strategy in which the following ambitious targets were set for all countries to achieve by 2030:

- a. 90% of all girls vaccinated for HPV before age 15,
- b. 70% of all adult women screened by age 35, and again by age 45, and
- c. 90% of women identified with precancerous lesions treated.

Until recently, HPV vaccination was not available to the majority of the target group, but has recently been approved for use in public health facilities in Namibia. It was also noted that most women are not screened regularly for cervical cancer, warranting increased community sensitisation. Moreover, a high proportion of trained nurses do not screen due to lack of interest and competing activities, and most nurses are not trained in the recommended screening methods. Regular refresher training for healthcare providers on AFHS and ASRHR is required. The RMNCAH&N stakeholders review meeting recommended institutionalisation of VIA, cervical cancer screening, and the increased access to LARC and other modern contraceptive methods in institutions of higher learning in Namibia.

There is no comprehensive cervical cancer prevention and control strategy or implementation plan in place, and considerable programmatic challenges with the implementation of the screening programme have been documented. Cervical screening is not fully integrated into other SRH services, including FP, PNC and ART/TB clinics at facility level. Also, cervical cancer prevention and control is not part of the standard curriculum for health extension workers. At the time of this review, advanced plans for introduction of the HPV vaccine in July 2025 were underway, making it a standard part of the national immunisation schedule. Screening coverage is further challenged by the current PAP smear approach that relies on cytology for diagnosis. The long turnaround time (over 2 weeks) in cytological procedures and recurrent delays in receiving cytology reports are also a challenge.

As of March 2025, Namibia has trained about 400 facility-based healthcare workers in cervical cancer screening (VIA PAP), and about 260 community healthcare workers on demand creation for cervical cancer screening. At the time of this review, 40 HCWs have been trained in HPV DNA testing. However, due to frequent staff changes there



remains a need for further training of healthcare providers to ensure that services continue. Gaps exist in community awareness and there is a need to strengthen demand creation activities on cervical cancer prevention to improve knowledge, change behaviour, and promote service uptake. This will contribute to achieving the 90-70-90 targets for cervical cancer elimination through increased vaccination coverage, screening coverage, and early treatment of confirmed cancer. Geography, distance, finances, and time also constitute formidable barriers to access, particularly among poor households and rural-based women.

2.7 Nutrition

Optimal nutrition is a basic need crucial to the realisation of Vision 2030, NDP5, and the SDGs and HPPII. Undernutrition plays a major role in the global burden of disease. Malnutrition is cited as one of the major causes of death in children under 5 years old. Malnourished children are more likely to drop out of school, less likely to benefit from schooling, and more likely to earn less income as adults. Reducing malnutrition among children can potentially put Namibia on track to achieving all the SDGs. The existing range of cost-effective health sector interventions to improve nutrition makes nutrition interventions one of the best approaches to improving health service efficiency and quality.

Namibia has adopted the Scaling Up Nutrition agenda with a view to eliminating all forms of malnutrition, and MHSS has developed relevant guidelines and implemented relevant interventions to meet the related national goals. Infant and young children feeding (IYCF) counselling services and support are offered at all health facilities and the recent WHO recommendations have been incorporated into the IYCF guidelines to bring them to date. Whereas MHSS has indicated commitment against the marketing of breastmilk substitutes, the breastfeeding policy is not being consistently implemented due to some challenges, and some health facilities still request clients to bring formula milk with them to the hospitals.

Health clinics provide well baby services with growth monitoring services as an integrated and core aspect of healthcare services. Namibia is implementing the Nutrition Assessment, Counselling and Support (NACS) programme to address malnutrition in children, adolescents, pregnant women, and postpartum women up to 6 months, and people living with HIV and TB. While NACS services are available in all regions, they are not on offer in all 343 health facilities nationwide. Relevant job aids, equipment, supplies, and tools as well as IEC materials are readily available in implementing facilities. Many health workers are trained in NACS and inpatient management of severe acute malnutrition (SAM) in hospitals. Management of acute malnutrition is carried out at various levels of the health system – community, clinic, health centre and hospital levels. Children with moderate acute malnutrition (MAM) are treated with Ready-to-Use Supplementary Food (RUSF), and SAM without medical complications is managed at the primary care level, and at home using high energy, vitamin and mineral rich RUTF. However, children with SAM and who have no appetite, or have medical complications, are referred to hospitals for management, and are then followed up by a nearby health facility on discharge. Services are also integrated into other service delivery points.

2.7.1 Policy documents and guidelines

- National Infant and Young Child Feeding Guidelines
- Revised Food and Nutrition Security Policy (2021)
- Food and Nutrition Security Policy Implementation Action Plan (2021)
- Baby Friendly Hospital Initiative Guidelines (2022).

2.7.2 National program service initiatives

- Global hunger Index (2022)
- Human Development Report (UNDP, 2020/21)
- Revised 2022 BFHI guidelines.

2.7.3 Performance trends

Data on the malnutrition status of women and for U5 children was not available at the time of review. Data obtained from The Global Hunger Index (GHI),⁷⁰ and low birth weight rates and malnutrition fatality rates in Namibia were consulted to inform this research.

i). Global Hunger Index (GHI)

GHI is a tool designed to comprehensively measure and track hunger at global, regional, and national levels, reflecting multiple dimensions of hunger over time. Each country's GHI score is calculated based on a formula that combines four indicators:

- **Undernourishment:** the share of the population with insufficient caloric intake.
- **Child stunting:** the share of children U5 who have low height for their age, reflecting chronic undernutrition.
- **Child wasting:** the share of children U5 who have low weight for their height, reflecting acute undernutrition.
- **Child mortality:** the share of children who die before their fifth birthday, partly reflecting the fatal mix of inadequate nutrition and unhealthy environments.

In combination, GHI captures the multidimensional nature of hunger using a 100-point scale, with the severity scale as follows: Low: ≤ 9.9 ; Moderate: 10.0–19.9; Serious: 20.0–34.9; Alarming: 35.0–49.9 and extremely alarming: ≥ 50.0 .

Namibia's position has improved from a serious GHI score for the period of 2000- 2014 to a moderate GHI score in 2022. This suggests an absolute improvement of -4.2 or 18%. However, a lot more still needs to be done to arrest malnutrition rates in the country. More up-to-date local programme data is needed to inform policy and practice, monitoring and programming.

TABLE 7: GHI - Namibia (Source: Global Health Index)

Year	2000	2007	2014	2022	Absolute change since 2014	Percentage change since 2014
GHI score	25.4	26.8	22.9	18.7	-4.2	-18.3

Stunting and underweight are two important indicators of a child’s nutritional status and overall health. These terms are often used to assess child development and well-being, particularly in the context of growth and malnutrition. Underweight refers a child’s weight-for-age significantly below the standard growth curve for their age group. It indicates acute malnutrition, typically caused by a recent lack of adequate food intake. Underweight children may appear thin and frail due to insufficient calorie consumption. Namibia recorded a marginal increase of 0.2% in the percentage of children under five years who were underweight at health institutions from 2016 to 2020 (Figure 22).

FIGURE 22: Proportion of U5 children stunted and overweight (Source: MHSS, 2024 Smart Survey)

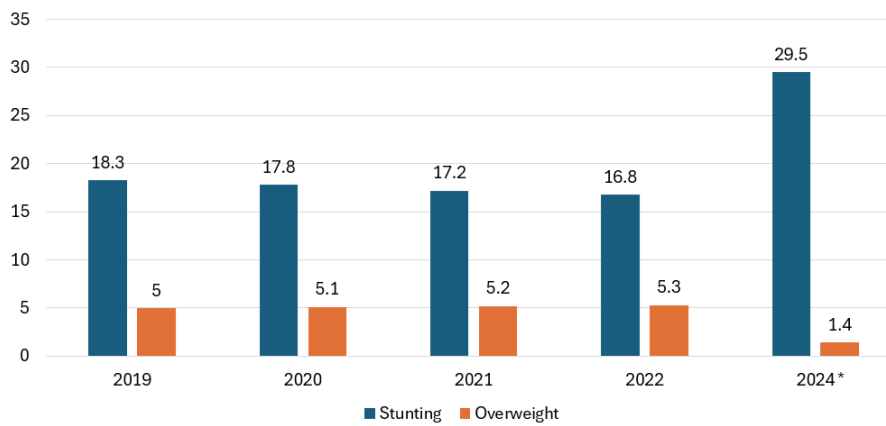
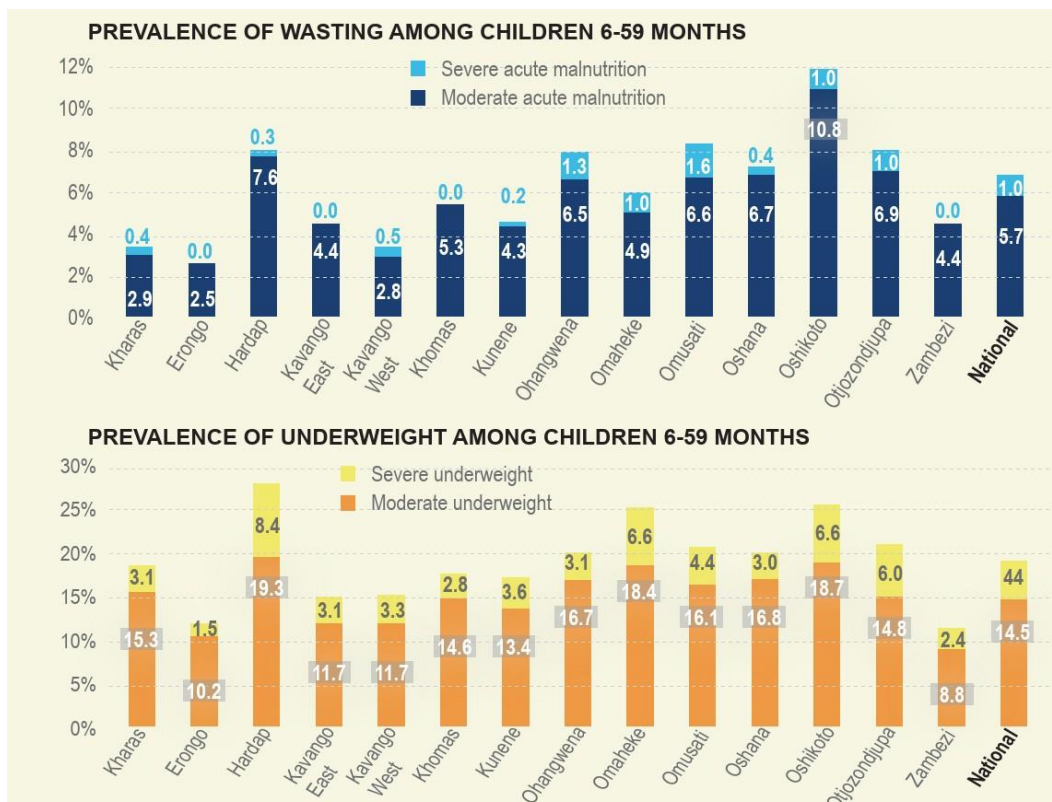


FIGURE 23: Proportion of U5 children underweight and wasted (Source: Namibia MHSS 2024 Smart Survey)



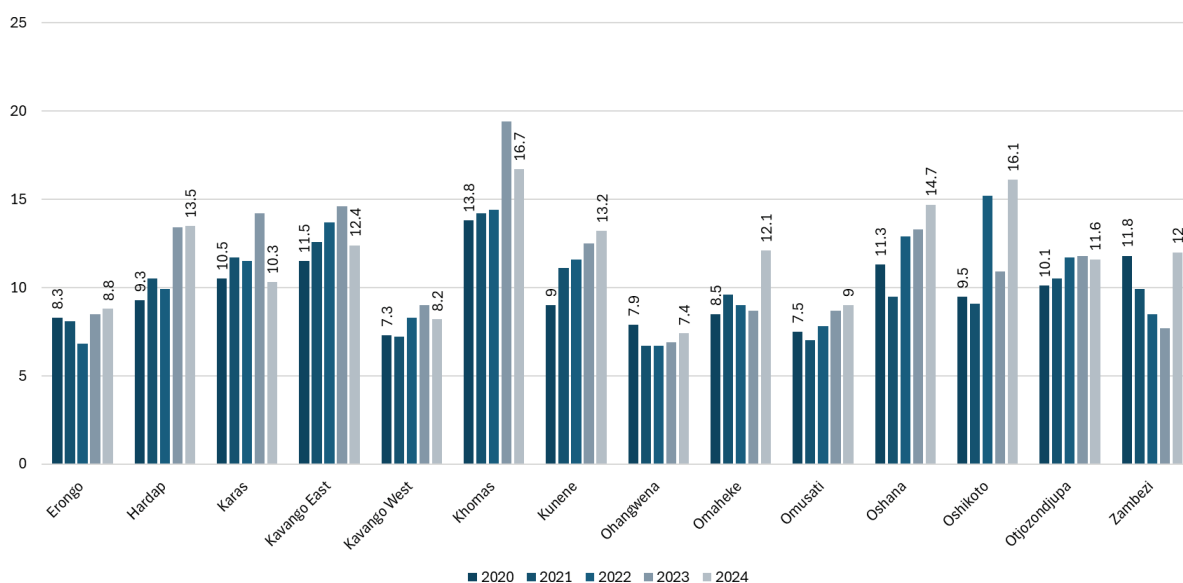
Stunting refers to a child’s height-for-age significantly below the standard growth curve for their age group. Stunting among U5 children increased by 0.8%, from 1.4% to 2.2% in 2020 (Figure 23). Addressing underweight and stunting in children requires a comprehensive, multisectoral approach involving healthcare, education, social services, and policy changes to create an environment that supports healthy child development.

ii) Low Birth Weight

There is a well-established correlation between low birth weight (LBW) and malnutrition. Malnutrition during pregnancy can lead to poor foetal growth and development, resulting in a low-birth-weight baby. Low birth weight is defined as a birth weight of less than 2,500 grams (5 pounds, 8 ounces), and is associated with increased risk of infant mortality, developmental delays, and chronic health problems later in life. Malnutrition in pregnancy can occur due to a variety of factors, including inadequate food intake, poor diet quality, nutrient deficiencies, and infections. To reduce the risk of LBW and malnutrition during pregnancy, it is important for pregnant women to have a healthy and balanced diet, with adequate intake of key nutrients such as protein, iron, folate, and calcium. It is also important to address any underlying medical conditions or infections that may contribute to malnutrition. Prenatal care can help identify and address these issues and improve health outcomes for both the mother and baby.

LBW continues to be a significant public health problem globally and is associated with a range of both short- and long-term consequences. Overall, it is estimated that 15% to 20% of all births worldwide are low birth weight, representing more than 20 million births a year. This RMNCAH&N review notes the highest LBW rate in Khomas region at 14.2%, followed by Kavango East region at 12.6%, and //Kharas region at 11.7. Regions with lowest LBW rate were Ohangwena, Omusati and Kavango West at 6.7%, 7.0% and 7.2% respectively (Figure 24).

FIGURE 24: Low birth weight by region (DHIS, 2024)



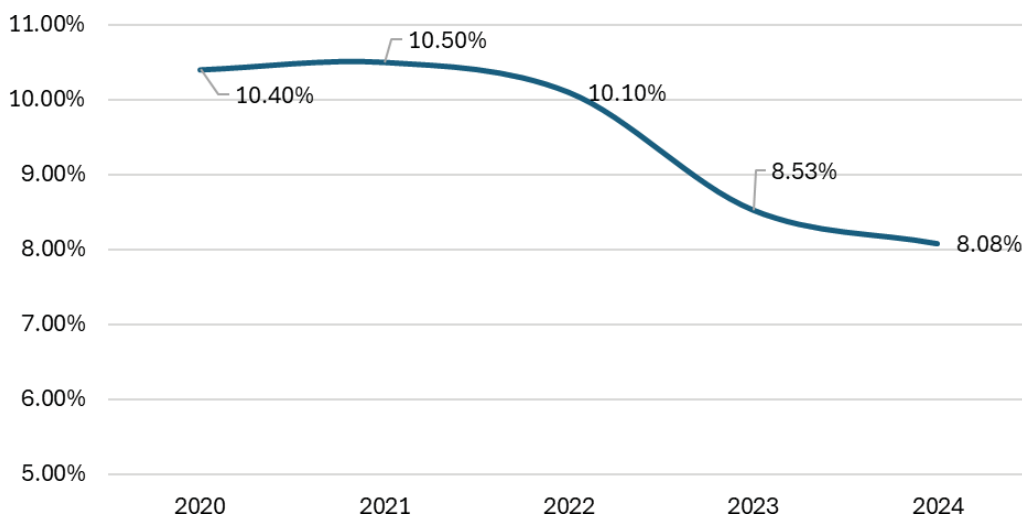
Evidence-based interventions to prevent LBW, its components (preterm birth and small for gestational age) and their associated morbidity and mortality, with emphasis on community settings need to be considered to target the hardest hit regions.

iii) Malnutrition Case Fatality Rate (CFR)

Malnutrition can lead to increased morbidity and mortality, particularly in vulnerable populations such as children, pregnant women, and older adults. The case fatality rate of malnutrition depends on various factors, including the severity of malnutrition, the presence of other health conditions, and access to healthcare. SAM is a life-threatening condition that can lead to high case fatality rates if left untreated. According to WHO, the case fatality rate of SAM can range from 5% to 60%, depending on the context and severity of the situation.

Improving access to adequate nutrition, healthcare, and other interventions can help prevent and treat malnutrition, and reduce the associated morbidity and mortality. The malnutrition CFR in Namibia decreased from 12.4 in 2020, to 8% in 2024 (Figure 25). Effective strategies for reducing CFR include promoting breastfeeding, improving access to nutrient-rich foods, providing vitamin and mineral supplements, and addressing underlying health issues such as infections and chronic diseases.

FIGURE 25: Malnutrition case fatality rate (Source: DHIS, 2024)



3. Introduction

Chapter 3 outlines the vision, mission, guiding principles, goals, and primary targets of the RMNCAH&N Strategy. It aligns with national health policies and global commitments to improve the health and well-being of women, newborns, children, and adolescents in Namibia. It sets the foundation for strategic actions aimed at accelerating progress toward national and global health goals by 2030.

3.1 Vision, Mission, Principles, Goals and Objectives and Primary Targets

The vision, mission, goal and objectives of this Strategy draw from, and are aligned with the Global Strategy for Women's, Children's and Adolescents' Health, and Namibia's Health Policy and National Health Sector Plan, while the targets are in line with the Global Targets and Milestones for Every Newborn Action Plan and Ending Preventable Maternal Mortality (ENAP and EPMM).

3.1.1 Guiding principles

The guiding principles of this Strategy are as follows:

Country-owned and government-led

The Strategy is fully owned by the government and people of Namibia and its implementation will be purposefully driven by the government. The Strategy fully accords with NDP5, the HPPII, and NHPF (2010-2020), and will contribute towards the achievement of the overall national vision and goals for the health and development of Namibians.

Right to health

All Namibians have the right to enjoy good health through access to primary care and referral level services according to need.

Equity and fairness

Health and social welfare services will be affordable, and the principle of equity and fairness will underpin the commitment expressed in the Strategic Plan.

Integration of services

Services shall be integrated at various levels of the health system to improve effectiveness and efficiency in service delivery.

Quality-driven and innovations

Quality of care is, and will be, a pivotal dimension of all health services and will be a cornerstone in the promotion and provision of services that respond to, and meet the needs of women, children newborn and adolescents. As part of the effort to ensure quality, this Strategy embodies the principles of innovation, to challenge norms and produce transformative results.

Intersectoral collaboration

The health sector will actively collaborate with other relevant sectors as well as ensure active collaboration within the health system, between public- and private health sub-sectors, to implement the Strategy and achieve the desired goal of improved health and well-being of women, children, newborn and adolescents.

Community participation and involvement

Communities and constituent households will be empowered for health actions, and community systems and structures strengthened and mobilised to actively participate in the implementation of the Strategy, including decision-making processes, relevant service delivery, and participatory monitoring and evaluation.

Adolescent empowerment and engagement

Adolescents in Namibia shall be empowered and fully engaged to play an active role in planning and implementation, as well as monitoring and evaluation of relevant activities and services, in recognition of their rights as well as potential to contribute meaningfully to health development. Significant attention shall also be paid to making health services adolescent-friendly and adolescent-responsive so as to maximize adolescents' uptake of services, and optimal benefit from the health system.

Gender equity and mainstreaming

Gender equity and considerations shall be mainstreamed into all health development processes and actions to ensure that health services are gender-sensitive and responsive, to appropriately meet the varied needs of women and their partners, boys and girls, as well as male and female adolescents.

Synergy with national health and development agenda and goals

This Strategy will align with, and contribute toward, the achievement of the broad health policy objectives and the national developmental goal of the Namibian government and its people.

Evidence-based

This Strategy and its strategic action is based on evidence of what works globally and nationally – so as to facilitate the achievement of desired outcomes and impact in an efficient and cost-effective way, and in the shortest time possible.

Accountability

This Strategy is developed in the recognition that the lives of every woman, child and adolescent in Namibia count, and there is a need for accountability towards their attainment of health as guaranteed in the constitution.

3.1.2 Goal

To accelerate health development and reduction of preventable maternal, newborn, child and adolescent morbidity and mortality in line with the national development vision and framework.

3.1.3 Objectives

The objectives of this RMNCAH&N Strategy 2025/26 - 2029/30 remain consistent with the Vision2030 objective of attaining the goal of eliminating physical, psychological, and social ailments. The RMNCAH&N Strategy is furthermore aligned to the Global Strategy for Women's, Children's and Adolescents' Health, 2016-2030 which strives for a world in which every woman, every child, and every adolescent – everywhere – is able to not just survive, but to thrive through transformation.

To realize these objectives, every pregnant woman and every newborn, without exception, must have access to high-quality, affordable services before, during and after the time of birth. Accessible services are especially important for populations that are underserved and marginalised, especially remote and nomadic populations, including comprehensive specialised and intensive care services where appropriate.

Setting out these objectives provides a framework for addressing maternal, neonatal, and child health challenges currently facing Namibia, and aims to develop and restructure new and existing interventions to improve and increase their impact on maternal, neonatal, and child survival to achieve national and international targets. Cognisant of, and committed to the signed international treaties and national priorities, the following objectives will guide the development of the RMNCAH&N Strategic Plan 2025 - 2030 in summary (Table 8). Implementation and targets of these objectives are discussed in detail in the next chapters.

TABLE 8: Objectives and primary targets of RMNCAH&N Strategic Plan (2025-2030)

SURVIVE	THRIVE	TRANSFORM
<p>By ending preventable deaths of women, newborns and children, and adolescents, as well as stillbirths.</p>	<p>By realising health and rights in all settings for women, children and adolescents</p>	<p>By driving a global-centered movement for comprehensive change for women, children and adolescent health, and sustainable development</p>
<ul style="list-style-type: none"> » Reduce maternal mortality from 139 to 140/100 000 by 2030 and to less than 70 (EPMM Global Target) by 2030. » Reduce still birth rate from 17 to 9/1000 of total births. » Reduce neonatal mortality from 24 to 10/1000 LB by 2030. » Reduce under five mortalities from 39 to 30/1000 LB by 2030. » End epidemics of HIV, tuberculosis, malaria, neglected tropical diseases and other communicable diseases. » Reduce premature mortality from NCDs. 	<ul style="list-style-type: none"> » Ensure universal access to sexual and reproductive healthcare services and rights in 50% of health facilities by 2030. » Reduce adolescent pregnancy rate from 19 to 15% by 2030. » End all forms of malnutrition, and address the nutritional needs of adolescent girls, pregnant and lactating women and children. » Reduce stunting in U5 children from 24 to 12%. » Reduce wasting in U5 children from 6 to 4% by 2030. » Reduce overweight in U5 children from 3 to 2.5% by 2030. » Reduce anemia in adolescent girls (15-19) from 19% to 11% by 2030. » Reduce anemia in women of reproductive age from 21% to 10% by 2030. » Promote health and wellbeing. » End all forms of malnutrition, and address the nutritional needs of adolescent girls, pregnant and lactating women and children. » Ensure universal access to SRH services and rights. 	<ul style="list-style-type: none"> » % of healthcare workers trained on the clinical handbook for the healthcare of survivors subjected to IPV and/or sexual violence, aggregated by age, gender and region. » Number of GBV survivors, including children receiving healthcare as a result of abuse, aggregated by age, gender and region. » % sexual assault cases receiving PEP and emergency contraceptives aggregated by age, gender and region. » Reduce the proportion of women and girls aged 15 and older subjected to sexual violence in the last 12 months: <ul style="list-style-type: none"> • Age 15-19 years from 4.5 to 1.5% by 2030. • Age 15-49 years from 3.7 to 1.2% by 2030. » Reduce the proportion of young women aged 20-24 who were married or in a union before age 18 to 4%. » Create enabling and conducive environment for women, newborn, children and adolescents e.g. AFHS, maternity waiting homes, BFHI etc. » Eliminate all harmful practices, and all discrimination and violence against women, girls and boys, and including men.



4. Introduction

Chapter 4 presents the Reproductive, Maternal, Newborn, Child and Adolescent priority interventions with corresponding objectives and set targets. The prioritisation of these strategies is aligned to the Global Targets and Milestones for ENAP and EPMM, and the Global Strategy for Women’s, Children’s, and Adolescents’ Health (2016–2030). The latter is a bold roadmap for ending all preventable maternal, newborn and child deaths, including stillbirths, by 2030, and improving their overall health and well-being.

These groups are at the heart of the SDG agenda. The need to ensure effectiveness and efficiency in programming towards achieving optimal health and well-being of women, newborn, children, and adolescents in Namibia in the context of available and projected resources, and without compromising quality and equity, are prioritised interventions in this Strategy. The determination of priority interventions is based on available evidence on the potential impact of various interventions against the background of the burden of health problem among women, newborn, children, and adolescents in Namibia. The priority interventions and the related delivery channels (facility, home, community) for each intervention are presented below.

4.1 Objectives, Intervention Packages and Targets

The Global Strategy for Women’s, Children’s and Adolescents Health 2016-2030 aims to achieve the highest attainable standard of health for all women, children, and adolescents, transform the future and ensure that every newborn, mother and child not only survives, but also thrives. It puts women, children and adolescents at the heart of the new UN SDGs. The objectives, interventions and targets are outlined in Table 9.

TABLE 9: Objectives, intervention packages and targets

Objective 1: SURVIVE: End preventable deaths among women, newborns, children and adolescents.
Outcome Indicators

1. Reduce maternal mortality ratio from 139 to 60/100 000, by 2030 [at an annual reduction rate of 16%].
2. Reduce neonatal mortality rate from 24 to 10, by 2030, at a ARR of 2.8.
3. Reduce under five mortality rate from 41 to 24, by 2030, at a ARR of 3.4.
4. Reduce mortality rate among 0-9-year-olds from 19 to 6, by 2030, at ARR of 2.6.
5. Reduce adolescent mortality rate of 10-14-year-olds, from 38 to 11, and that of 15 – 19-year-olds from 5 to 2.
6. Reduce adolescent birth rate (10 -14, 15 -19-year-olds) from 0.3 to 0.15.
7. Reduce prevalence of stunting in under 5 children (SDG 2.2.1) from 29% to 17% at an ARR of 2.2.
8. Reduce MTCT rate for HIV from 5% to 2% by 2030.
9. Reduce prevalence of anaemia in women of reproductive age from 21% to 16% at an ARR of 1%.
10. Reduce stillbirth rate (fresh and macerated) from 17 to 9, by 2030, at an ARR of 1.6.

THEMATIC AREA	INTERVENTION PACKAGES	TARGETS
Maternal Health	a. Pregnancy <ul style="list-style-type: none"> Health Education and Promotion packages (pregnancy and pre-pregnancy). Nutritional information, education, counselling and interventions, including counselling about healthy eating and physical activity, and provision of iron and folic acid supplements. Offer preventive measures: Tetanus toxoid vaccination, and malaria prevention, including the use of intermittent preventive treatment in pregnancy (IPTp) and sleeping under insecticide treated nets. Counselling on post-partum family planning and postnatal care. Birth preparedness and complication readiness education and counselling. Management of emergency conditions, including premature rupture of the membrane, risk of preterm delivery, danger signs recognition and other complications. Maternal assessment, monitoring, screening, detection and management of health risks and conditions Promotion of antenatal uptake with minimum of 8 contacts: with the first contact in the first trimester (up to 12 weeks of gestation), two contacts in the second trimester (at 20 and 26 weeks of gestation), and five contacts in the third trimester (at 30, 34, 36, 38 and 40 weeks). 	<ol style="list-style-type: none"> 1. Pregnant women with ANC contacts during the 1st trimester (before 24 weeks). 2. Proportion of women and neonates with early routine postnatal follow up care (within two days). 3. Proportion of pregnant women (15-49 years) tested for HIV. 4. Proportion of women who deliver via caesarean section. 5. Proportion of women in preterm labour receiving at least one dose of ante natal corticosteroids. 6. Proportion of pregnant women receiving magnesium sulphate and antibiotic

<p>b. Birth and delivery</p> <ul style="list-style-type: none"> • Routine monitoring with Labour Care Guide with timely and appropriate care. • HIV counselling and testing (if status now known or not already tested) and prevention of mother-to-child transmission. • Management of normal labour and delivery. • Active management of third stage of labour with the use of uterotonics for the prevention of postpartum haemorrhage (PPH) during the third stage of labour. • The WHO has introduced the fourth stage of labour, and the Namibia Intrapartum Care Guideline has incorporated this guidance to ensure monitoring of women 4 hours after delivery for all births including delayed cord clamping (DCC). • Hygienic management of the cord at birth, including use of chlorhexidine where appropriate. • Induction of labour with appropriate medical indications. • Basic emergency obstetrics and neonatal care facility package: administering antibiotics; administering uterotonic drugs (oxytocin), administering anticonvulsants (Magnesium Sulphate); manual removal of the placenta; removal of retained products following miscarriage or abortion; assisted vaginal delivery, preferably with vacuum extractor; basic neonatal resuscitation care. • The comprehensive emergency obstetric and newborn care package that includes all the basic functions above plus Caesarean sections, safe blood transfusion and provision of care to sick and low-birth weight newborns, including resuscitation. • Facility-based childbirth with a skilled birth attendant. • HIV counselling and testing (if status now known or not already tested) and prevention of mother to child transmission. • Management of post-partum haemorrhage. • Respectful maternity care including (effective communication and companionship during labour and childbirth.) • Analgesia for pain relief including non-pharmacological methods e.g. relaxation techniques for pain management, encouraging oral fluid and food intake including maternal mobility and position. • Encourage the adoption of a birth position of the individual woman's choice, apply techniques to reduce perineal trauma and facilitate spontaneous birth. • Avoid routine/ liberal use of episiotomy and application of manual fundal pressure to facilitate childbirth during the second stage of labour.

<p>prophylaxis for improved neonatal outcomes.</p> <ol style="list-style-type: none"> 7. Number of quarterly national maternal/perinatal death review meeting reports. 8. Number of regions reporting the number of maternal deaths to the national level on a monthly basis.

THEMATIC AREA	INTERVENTION PACKAGES	TARGETS
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Maternal Health	c. Postnatal care <ul style="list-style-type: none"> • Care in the facility for at least 24 hours after an uncomplicated vaginal birth including: • Physiological assessment of the woman. • Oral analgesia for perineal pain relief. • Provision of postnatal care in first 24 hours for every birth: Discharge from health facilities should be delayed for at least 24 hours, and visit carried out to women (and babies) with home births within the first 24 hours. • Chlorhexidine should be used as appropriate after home deliveries. • Prevention, early detection and management of pregnancy and childbirth-related complications. • Management of post-partum hemorrhage. • Prevention and management of eclampsia. • Prevention & treatment of maternal anaemia. • Detection & management of post-partum sepsis. • Screening and management of post-partum depression. • Detection and management of health risks and pre-existing conditions. • Routine post-partum screening for cervical cancer in appropriate age group. • Screening for HIV and initiation or continuation of antiretroviral therapy. • Early detection of maternal morbidities. • Health education and health promotion. • Nutrition and lifestyle counselling, management of inter-partum weight. • Postnatal contact with and appropriately skilled health care in the health facility. • Promotion, protection and support of exclusive breastfeeding for 6 months. • Family planning advice with specific reference to birth spacing as well as education and counselling on contraceptives. 	
Neonatal Health	<ul style="list-style-type: none"> • Fetal assessment, monitoring and interventions • Essential Newborn Care: Neonatal resuscitation with bag and mask, skin to skin contact of mother/father baby, initiation of breastfeeding within 30 minutes, initiation of prophylactic ART for HEI and care for small babies. • Kangaroo Mother Care (KMC) for small babies, extra support for feeding small and preterm babies with breast milk, presumptive antibiotic therapy for newborns at risk of bacterial infection) • Sick Newborn Care: Continuous positive airway pressure to manage babies with respiratory distress syndrome, Detection and case management of possible severe bacterial infections, Management of newborns with jaundice and selected health conditions, Detection & management of genetic problems, Kangaroo mother care for small babies and Maternal & perinatal death audits). 	<ol style="list-style-type: none"> 1. Proportion of infants who were breastfed within the first hour of birth. 2. Proportion of infants less than six months who are exclusively breastfed. 3. Newborn vaccination coverage (SDG 3.b. 1). 4. Proportion of facilities providing essential newborn care including skin to skin approach services. 5. Proportion of infants who were initiated on prophylactic ART for HEI . 6. Proportion of facilities (hospitals) providing KMC for management of LBW babies nationally. 7. Proportion of health facilities implementing e-birth notification systems. 8. Number of sick and small newborn care units at district and referral level hospitals.
THEMATIC AREA	INTERVENTION PACKAGES	TARGETS

<p>Child Health (under 5 years)</p>	<ul style="list-style-type: none"> • Exclusive breastfeeding for 6 months; continued breastfeeding and complementary feeding from 6 months. • Dietary counselling for prevention of undernutrition, overweight and obesity. • Periodic vitamin A supplementation and deworming where appropriate; Iron supplementation, where appropriate; case management of malnutrition cases. • Routine immunization (including Haemophiles influenza, pneumococcal, and rotavirus vaccines). • Prevention and case management of childhood illnesses including malaria, pneumonia, TB, and diarrhoea. • Comprehensive care of children infected with, or exposed to, HIV, including infant HIV testing (early infant diagnosis) and provision of antiretrovirals. • Prevention and response to child maltreatment; and prevention of harmful practices. • Care for children with developmental delays, including treatment and rehabilitation of children with congenital abnormalities and disabilities. • Implement Revitalised Baby-Mother Friendly Health Initiative. 	<ol style="list-style-type: none"> 1. Proportion of HF implementing prevention and management of childhood illnesses (IMNCI) including malaria, pneumonia, TB and diarrhoea. 2. Paediatric ARV coverage. 3. Proportion of under five children who slept under insecticide treated nets (ITN) in malaria endemic regions.
<p>Stillbirths</p>	<ul style="list-style-type: none"> • Develop and implement plans and policies for improving maternal and newborn survival and health and for preventing stillbirths, in line with the recommendations in the 'Every Newborn Action Plan' and WHO guidelines. • Have a preparedness and response plan that includes promoting maternal and newborn survival and health and preventing stillbirths and have a coordinated mechanism in place for its implementation, ensuring procurement of emergency supplies and monitoring survival and health outcomes. • Have allocated sufficient domestic and international resources to strengthen their health systems and implement their plans for improving maternal and neonatal survival and health and for preventing stillbirths. • Have adopted and implement the WHO standards for respectful, effective maternal and newborn care, including prevention of stillbirths and care after death. • Develop and implement strategies and plans to increase the number, distribution, mentoring and retention of personnel for maternal and newborn health and to enhance their competence for respectful maternal and newborn care, prevention of stillbirths and care after death. • Ensure timely procurement, equitable distribution and access, appropriate use and maintenance of essential medical commodities and products (equipment, technologies and diagnostics) to facilitate the delivery of high-quality, affordable maternal and newborn care, including care to prevent stillbirths. • Routinely track, collect and use data to monitor Every Newborn targets for newborn mortality and stillbirths, coverage targets to 2025 and the quality of care, using routine data or, if appropriate, data from surveys or assessments of service readiness, including consideration of inequalities at national and subnational levels • Generate and use emerging evidence, including knowledge exchange, to improve maternal and newborn health and survival and to end preventable stillbirths. • Develop and implement accountability mechanisms to improve newborn health and prevent stillbirths, including coordination of stakeholders, and processes to count and review deaths, and have promoted a shift in potentially harmful social norms. 	<p>Reduce stillbirth rate from 17 to less than 9/1000 total births by 2030 [at an annual reduction rate of +-2%]. (ENAP target=<12/1000 total births by 2030).</p>



Objective 2: THRIVE: Promote the health and wellbeing of women, newborn, children and adolescents

Outcome Indicators

1. Increase coverage of essential health services (is defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population).
2. Increase proportion of women aged 15 – 49 years who make their own informed decisions regarding sexual relations, contraceptive use, and reproductive healthcare.
3. Reduce Prevalence of malnutrition (wasting and overweight) in under five children (SDG 2.2.2.)
4. Reduce unmet family planning need.

THEMATIC AREA	INTERVENTION PACKAGES	TARGETS
SRH	<ul style="list-style-type: none"> • Ensure universal access to sexual and reproductive health-care services and rights UHC from the Namibian context constitutes universal health care which will ensure the equitable provision of healthcare services for all Namibians, irrespective of social class. • Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all by 2030. • Implement a system for Women of Childbearing Age (WCBA) (15-49) in making decisions regarding sexual relations, contraceptive use, and sexual reproductive health care. • Increase coverage to EmONC facilities to the population accessible within 2 hours of travel time. • Ensure universal access to sexual and reproductive health-care services and rights. • Implement revised family planning guidelines and related protocols to include long-term acting reversible and mixed methods of family planning. • Introduce the use of combination prevention guidelines as well as a standard package for health services identified for target population • Reinforce adherence to the National cervical cancer prevention guidelines. 	<ol style="list-style-type: none"> 1. Proportion of females 15 – 49 years subjected to violence (physical, sexual) in the last 12 months. 2. Proportion of population with physical access to the closest EmONC health facility within 2 hours of travel time. 3. Proportion of facilities offering integrated management of RMNCAH&N, Communicable and NCDs services. 4. Proportion of higher learning institutions introducing VIA, Cervical cancer screening and LARC in curricula. 5. Proportion of health facilities with SRHR refresher trainings conducted for healthcare providers (x 2 trainings per region per year). 6. Proportion of PHC facilities with integrated SRHR/HIV/GBV. 7. Number of HF providing basic seeking emergency obstetric care (BEmONC). 8. Number of HFs providing comprehensive seeking emergency obstetric care (CEmONC). 9. % of women of reproductive age (15 – 49) who have their need for family satisfied with modern methods. 10. Proportion of eligible women screened for cervical cancer (VIA, PAP, and HPV). 11. Proportion of women screened for cervical cancer who have received results. 12. Proportion of screen women with abnormal results.

THEMATIC AREA	INTERVENTION PACKAGES	TARGETS
<p>Adolescent Health</p>	<ul style="list-style-type: none"> • Health promotion, including information, education and behavioural counselling: (Information, education and counselling will be provided to adolescents regarding all relevant areas of health and development to improve their health knowledge as well as health-related attitudes and behavior, including uptake of relevant health services). • Including pubertal development and healthy lifestyles; relationship, gender equality and sexuality; abstinence, safer sex and pregnancy prevention methods, including the use of dual methods of protection. • HIV prevention, HIV testing services, and prevention and treatment of other forms of sexually transmitted infections; diet and nutrition; gender-based violence, physical violence, and bullying; prevention of tuberculosis; substance use and mental health, any forms of violence and other leading causes of morbidity and mortality among adolescents e.g. suicide and road traffic accidents. • The use of e-health and mobile communication technology interventions will be considered as part of the effective and innovative approaches to reach adolescents with health information and education. Information will also be provided to adolescents to facilitate their participation and engagement in health programs. • Promote adolescent-friendly health services including: <ul style="list-style-type: none"> - Routine immunisation (e.g. human papilloma virus (HPV), hepatitis B, diphtheria-tetanus, rubella, measles) - Promotion of healthy behaviour (e.g. nutrition, physical activity, avoidance of use of tobacco, alcohol or drugs and menstrual hygiene) - Prevention of early and unwanted pregnancy and STIs, including HIV - Psychosocial assessment (such as using the HEADSSS checklist - home, education/ employment, eating, activity, drugs, sexuality, safety, suicidal thinking and depression status), and screening for key health problems, including sexual and reproductive health issues, drug use, exposure to gender-based violence, substance use, and mental health issues. • Counselling and psychosocial support for health concerns and related services for adolescent mental health and well-being. • Preventing adolescent motor vehicle accidents requires a combination of educational, behavioural, and regulatory interventions. • Screening and management of health problems, including HIV, HPV and STIs, post-abortion care and counselling, nutritional health, and mental health. • Referrals for relevant health conditions, social support services, and/or other adolescent- health service settings such as schools and service-provision CSOs. • The school will be used as a cost-effective platform to reach adolescents with health information, education and counselling, as well as relevant health services. • The broad dimension of school health services will include menstrual hygiene management education, water, sanitation, and hygiene issue, nutrition, and comprehensive sexuality education. • The health- promoting school initiative will be promoted as an approach for strengthening school health issues including health education, comprehensive sexuality education (CSE), school hygiene interventions, menstrual hygiene management education. • Government must also strengthen the referral mechanisms between schools and healthcare providers to better measure and track uptake of services by young people. 	<ol style="list-style-type: none"> 1. Reduce early and unintended pregnancies among young people by 75% by 2030 (ESA commitment Target). 2. Reduce leading causes of morbidity and mortality among adolescents e.g. suicide, drug and alcohol abuse, violent behaviours and road traffic accidents by 50% by 2030. 3. Proportion of schools with integrated CSE curriculum. 4. Proportion of facilities providing health promotion programmes and BCC initiatives such as radio dramas and “edutainment” interventions. 5. Proportion of facilities adolescent friendly services with integrated RMNCAH&N related services. 6. Proportion of facilities introducing psychosocial assessment with HEADSSS (Home Education Employment Activities Drugs Sexuality Suicide/ Depression). 7. Proportion of adolescent girls (15 – 19) subjected to violence (physical and sexual) in the last 12 months. 8. Proportion of adolescent girls (15 – 19) screened for HIV.



THEMATIC AREA	INTERVENTION PACKAGES	TARGETS
Adolescent Health	<ul style="list-style-type: none"> • Government commitments towards a comprehensive package of information, services and commodities that is free and available in all health facilities, as well as in secondary schools, colleges and universities. • Promotion of adolescent participation in skills-building through training of adolescent peer educators, establishment of adolescent-friendly spaces in health facilities, and training of health workers on adolescent responsive SRHR etc. • Implement revised family planning guidelines and related protocols that include long-term acting reversible contraceptives methods and mixed methods of family planning and GBV clinical guidelines for health care of survivors subjected to intimate partner violence or sexual violence. • Introduce the proposed of intervention packages to target out-of-school adolescents: <ul style="list-style-type: none"> - Strengthen the use of adolescents and young people job aid, non-formal education programmes, vocational training programs, life skills education Programmes, mentoring programmes, and health education programmes. - Introduce the use of combination prevention guidelines as well as a standard package for health services identified for target population - Community-based programmes and child protection programs to provide support to adolescents who have experienced abuse, neglect, or exploitation. - Improving resource mobilisation and more effective Public Resource Management Systems to catalyse youth social enterprise and skills capacity building. 	
Nutrition	<p>Infant and Young Child Feeding nutrition packages:</p> <ul style="list-style-type: none"> • Early Initiation of breastfeeding (within the first hour), Baby and Mother Friendly Health Facilities on infant and young children feeding. <p>Address Micronutrient Deficiencies through:</p> <ul style="list-style-type: none"> • Periodic Vitamin A Supplementation, Salt Iodization, Food Fortification and Periodic iron/folate supplementation. • Zinc/ORS Combination Treatment of Diarrhoea. <p>Maternal Nutrition</p> <ul style="list-style-type: none"> • Integrate key nutrition messages during ANC and PNC. <p>Nutrition Surveillance</p> <ul style="list-style-type: none"> • Programme planning and emergency preparedness. <p>Management of Severe and Moderate Malnutrition</p> <ul style="list-style-type: none"> • Improve commodity supply chain for moderate and severe acute malnutrition (MAM / SAM). • Maintain nutrition equipment: Mid-Upper Arm Circumference (MUAC) tapes, weighing scales and height measuring boards. • Intensify and expand competency-based training of health workers and community health workers on management of SAM. <p>Adolescent Nutrition</p> <ul style="list-style-type: none"> • Integrate periodic iron/folate supplementation through FP. 	

Objective 3: TRANSFORM: expand enabling environment for women, newborn, children and adolescents through policy and legal reforms

Outcome Indicators

1. Reduce maternal mortality ratio from 139 to 60/100 000, by 2030 [at an annual reduction rate of 16%].
2. Reduce neonatal mortality rate from 24 to 10, by 2030, at a ARR of 2.8.
3. Reduce under five mortality rate from 41 to 24, by 2030, at a ARR of 3.4.
4. Reduce mortality rate among 0-9-year-olds from 19 to 6, by 2030, at ARR of 2.6.
5. Reduce adolescent mortality rate of 10-14-year-olds, from 38 to 11, and that of 15 – 19-year-olds from 5 to 2.
6. Reduce adolescent birth rate (10 -14, 15 -19-year-olds) from 0.3 to 0.15.
7. Reduce prevalence of stunting in under 5 children (SDG 2.2.1) from 29% to 17% at an ARR of 2.2.
8. Reduce stillbirth rate (fresh and macerated) from 17 to 9, by 2030, at an ARR of 1.6.

THEMATIC AREA	INTERVENTION PACKAGES	TARGETS
Maternal Health	<ul style="list-style-type: none"> • Introduce eight or more antenatal care contacts. • With the first contact in the first trimester (up to 12 weeks of gestation), two contacts in the second trimester (at 20 and 26 weeks of gestation), and five contacts in the third trimester (at 30, 34, 36, 38 and 40 weeks). • Increase births attended by skilled health personnel in health facilities. • Institute early routine postnatal care (within 2 days) • Every mother and baby should have a total of four postnatal visits with the schedule stated below, and home visits should be carried out by appropriately skilled health workers. 	<ol style="list-style-type: none"> 1. 90% coverage of four or more antenatal care contacts by 2030 (EPMM Target 1). 2. Proportion of women with four or more ANC contacts. 3. Proportion of births attended by skilled health personnel (SDG 3.1.2). 4. Early routine postnatal care contact at health facility on day 3, day 7 – 14, and 6 weeks. 5. 80% global coverage of early postnatal care by 2030 (EPMM target). 6. % of women aged 20 – 24 years who were married or in a union before the age of 18 years (SDG 5.3.1).
Adolescent Health	<ul style="list-style-type: none"> • Eliminate all harmful practices and all discrimination and violence against young women, girls and boys. • Implement GBV clinical guidelines for health care of survivors including adolescents subjected to intimate partner violence or sexual violence. 	End Child Marriage by 2030 (UNFPA-UNICEF Global Programme Target).
Sick Child Health	<ul style="list-style-type: none"> • Strengthen the implementation of IMNCI at all levels, including community IMNCI (iCCM). • Facilitate at least one level inpatient unit to care for small and sick newborns per region, with respiratory support including provision of continuous positive airway pressure. • Improve the quality of care given to sick children in health facilities through a system for reviewing the outcomes of each child admitted. • A system should keep records of all children who died in the hospital, trends in case fatality can be compared, and the treatment given can be discussed with staff with the aim of identifying any problems and findings solutions. • Clinical audit meetings to discuss near-miss events or deaths in children can be helpful. • Audit of hospital paediatric care can be carried out by comparing the quality of care given against standard guidelines. 	80% of regions/ districts have at least one level-2 inpatient unit to care for small and sick newborns, with respiratory support including provision of continuous positive airway pressure (ENAP target)

5. Introduction

Chapter 5 outlines 14 strategic pillars aimed at reducing maternal, newborn, child, and adolescent morbidity and mortality in Namibia. These include strengthening the health workforce, improving quality and equity of care, expanding cost-effective interventions, and increasing sustainable funding. Additional priorities involve enhancing data systems, logistics, multisectoral partnerships, and community engagement. Targeted programming for adolescents and children, and scaling up responses to gender-based violence are emphasised. Collectively, these strategies support resilient health systems and equitable service delivery across the RMNCAH&N continuum.

5.1 Implementation Strategies and Priority Actions

The goal of strategic priorities in maternal, newborn, and child health (MNCH), and adolescent health is to improve the health and well-being of women, newborns, children, and adolescents in Namibia, through reducing maternal and newborn mortality and morbidity, improving access to quality care and services, promoting the health and development of children and adolescents, and strengthening health systems and community engagement.

Specifically, the strategic priorities in MNCH, and adolescent health and nutrition, include improving maternal and newborn health through antenatal, delivery, and postpartum care; promoting early and exclusive breastfeeding; preventing and managing childhood illnesses; ensuring access to immunisations; preventing and managing adolescent health issues, including sexual and reproductive health; and strengthening health systems to ensure equitable access to quality healthcare for all. By focusing on these priorities, it is hoped that maternal and child health outcomes will improve, children and adolescents will be healthier, and can reach their full potential.





The following 14 implementation strategies were identified to address the priority areas and targets set in the previous chapters:

TABLE 10: Strategic pillars of the RMNCAH&N Strategy

Strategy	Key Strategic Pillar
1. HR Capacitation	5.1.1 Strengthen human resources in health for RMNCAH&N
2. QoC RMNCAH&N	5.1.2 Improve the quality and equity of RMNCAH&N Care
3. Cost-effective interventions	5.1.3 Increasing coverage and equity of cost-effective interventions
4. Increased funding	5.1.4 Improve the funding for, and cost-efficiencies of public health and RMNCAH&N programming
5. Logistics management	5.1.5 Strengthen logistics management systems for RMNCAH&N commodities
6. Strengthen partnerships	5.1.6 Strengthen partnerships with community structures and systems
7. Multisectoral engagement	5.1.7 Improve multisectoral engagement and collaboration
8. Data generation	5.1.8 Improve data generation and utilisation for programming and accountability
9. Improved research	5.1.9 Improve research, innovation and knowledge management
10. Response and resilience	5.1.10 Strengthen response and resilience
11. Maternal mortality	5.1.11 Reduce maternal mortality
12. Neonatal, infant child health programming	5.1.12 Targeted neonatal, infant and child health programming
13. Adolescent SRHR	5.1.13 Targeted interventions for adolescent sexual reproductive health and rights
14. Sexual and GBV (SGBV)	5.1.14 Improve detection, prevention and management of sexual and gender-based violence

5.1.1 Strengthen human resources in health for RMNCAH&N

Namibia’s operational plans and strategies to increase the number, distribution, mentoring and retention of personnel for maternal and newborn health, and to enhance their competence for respectful maternal and newborn care, and prevention of stillbirths and care after death, should be developed and implemented. An appropriately skilled health workforce in adequate number and equitably distributed is key to improving health service delivery on a national platform. The RMNCAH&N Strategy should be linked to the National Strategy for HRH for increased human resources capacity. Addressing the existing RMNCAH&N-related HRH inadequacies in Namibia is therefore a crucial task for the health and well-being of women, newborns, and adolescents. The following planned priority actions are aimed at strengthening human resources in RMNCAH&N (Table 11).

TABLE 11: Strategic activities for strengthening human resources in health for RMNCAH&N

Strategic Activities
Implement the Affirmative Action Plan to ensure gender-responsive training and retraining for existing health workers to build greater capacity, and to be able to offer integrated services at sub-national level.
Implement reform of CHW cadres, including task-sharing and task-shifting to increase the number of CHWs as per the national HRH strategy.
Review the pre- and in-service curriculum, to improve capacity for technical performance and effective care delivery.
Promote gender-appropriate and gender-responsive mentoring for healthcare workers at all levels, strengthen supportive supervision, and improve regular monitoring of performance.
Recruit additional health workers with an appropriate gender balance, particularly in the areas of greatest inadequacies, to improve health workforce in the public sector, as well as the equitability of the workforce.
Implement staff retention strategies to retain experienced and specialised staff across all levels of care.

5.1.2 Improve the quality and equity of RMNCAH&N care

High-quality maternal and newborn health care are essential health services, which must be sustained to protect the lives and health of women and children. The country should adopt, implement and monitor the WHO standards for respectful, effective maternal and newborn care, including prevention of stillbirths and care after death, and have a system for learning from experience. Well-developed and implemented RMNCAH&N plans and policies in line with WHO guidelines, and with achievable targets for improving maternal and newborn survival and health, and for preventing stillbirths, should be in place. These targets should include core impact indicators such as MMR, NMR and SBR, and be adopted at regional and district level. Moreover, plans for addressing maternal and newborn morbidities and mortality, as well as stillbirths should be developed, costed and implemented, including a strengthened legal and policy framework to support maternal and newborn health. These plans should include ENAP and EPMM coverage targets (2020-2025), including essential newborn care, and the care of both small and sick newborns.

The report on the confidential enquiry into maternal deaths, stillbirths and neonatal deaths review for 2018-2021 revealed that 56.6% (82/145) of maternal deaths were preventable, due to poor quality of care. Improvements in quality of care may produce better outcomes, and prevent these deaths in the future. Most case files reported a combination of a multitude of factors, indicating that solutions may not be simple, but rather require a complex, multisectoral approach. To improve the quality of care, and to reduce both maternal and perinatal mortality, all facilities need to have an adequate number of appropriately trained staff. Maternity and neonatal care teams consisting of doctors and nurse-midwives need to contain a balance of diverse skills, with experienced staff available to guide more junior staff.

Poor quality of care contributes significantly to RMNCAH&N morbidity and mortality in Namibia. Improving the quality of care (QoC) across all levels and for all RMNCAH&N-related services is, therefore, a major priority in achieving the goals and objectives of the Plan. The context of this Plan should serve to catalyse efforts towards improving QoC, building on previous tentative steps in this regard. The WHO QoC Framework provides a platform for review and critical actions to improve quality of care across all domains of RMNCAH&N in Namibia (Figure 26).

A key focus of the SDGs is to ‘leave no one behind’ and one of the principles that underpin this Strategy is equity. Because poor communities and vulnerable populations generally have worse RMNCAH&N outcomes, efforts to improve QoC and expand access to interventions must be equitable, to ensure meaningful and transformational results. A national assessment to determine the barriers to service accessibility by lower socio-economic status and remote populations is essential to the design of quality RMNCAH&N services. Implementation of WHO QoC standards and introduction of the maternal and perinatal death surveillance and response (MPDSR) flagship programme is vital for improving the quality of maternal and newborn care.

FIGURE 26: Quality of care for pregnant women and newborns – the WHO vision (Source: Tuncalp et al., 2015)

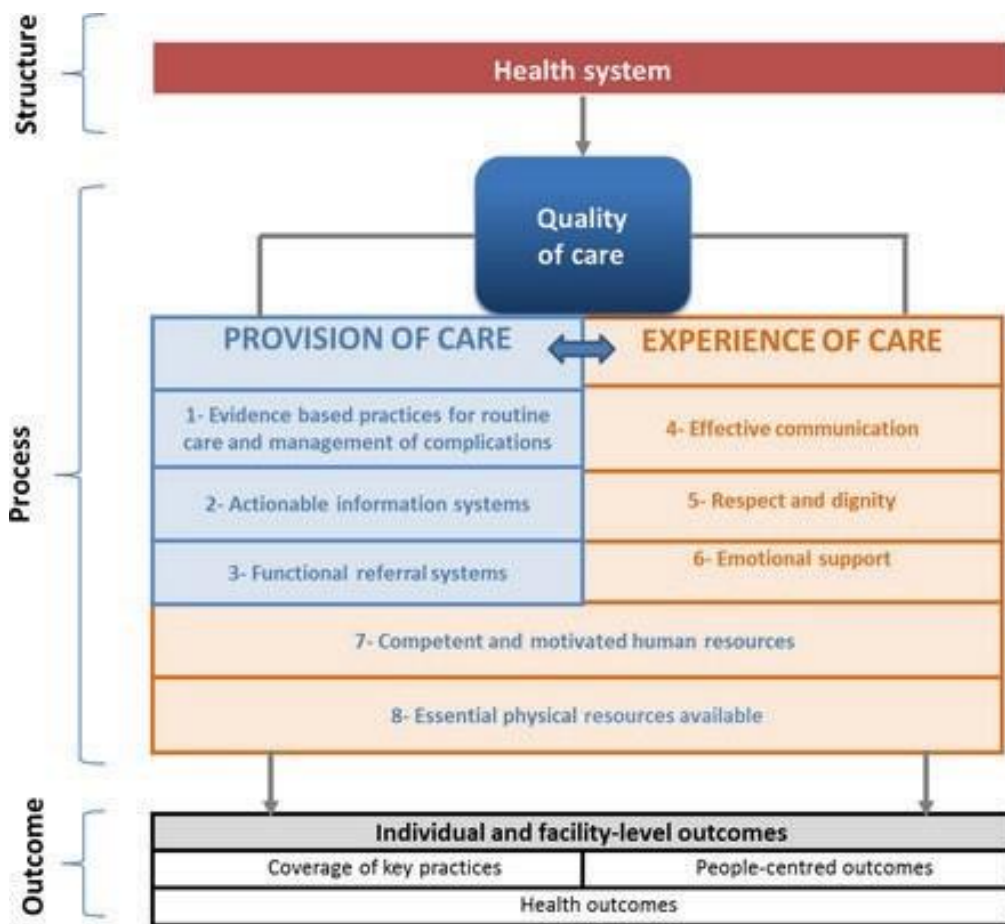


TABLE 12: Strategic activities to improve the quality and equity of RMNCAH&N care

Strategic Activities
Develop standards, action plans, guidelines and policy statements for RMNCAH&N care – based on the WHO QoC Framework.
Develop quality-driven standards for adolescent healthcare and develop appropriate interventions for adolescent health using the Global Accelerated Action for the Health of Adolescents (AA-HA) framework as guidance.
Operationalise the quality assurance strategy for health services.
Establish effective quality improvement systems for high quality RMNCAH&N services and strengthen quality improvement structures at all levels, including quality improvement committees and teams.
Strengthen the accountability system for quality performance, including a regulatory framework for healthcare professionals, as well as MPDSR.
Explore and evaluate approaches to motivate staff to improve quality of care.
Improve RMNCAH&N access and QoC in disadvantaged communities and vulnerable populations.
Ensure the provision and availability of relevant inputs and resources – human, infrastructure, logistic support and other systems across all levels.
Strengthen efforts towards universal access to healthcare for all women, men, children and adolescents.
Facilitate the expansion of the MCH Quality of Care Improvement (QoC/QI) Collaborative (MANICARE) to include all district hospitals.
Facilitate the implementation of MPDSR, and strengthen regional notification and reviews.
Develop national safe-, and post-abortion care guidelines.
Facilitate the finalisation and implementation of the ANC, intrapartum, PNC and newborn care guidelines.

5.1.3 Increasing coverage and equity of cost-effective interventions

The WHO 2022 Report on UHC revealed that inequities in service coverage (a measure of the uptake and use of needed health services) is on an upward trend in the African region. However, the largest improvement is in services addressing infectious diseases, compared to those addressing NCDs and RNMCAH. Services targeting NCDs have the lowest improvement.

Moreover, within programme areas, the report further highlighted deepening inequalities in service utilisation in surveyed countries. For instance, the data shows a variation of 24 index points between the highest and lowest population groups for the RMNCAH&N subindex score.

TABLE 13: Strategic activities for increasing coverage and equity of cost-effective interventions

Strategic Activities
Finalise and implement the essential health service package for enabling individuals and communities to have equitable access to quality essential health services without suffering financial hardship.
Prioritise high burdened regions or those with poor performance to implement targeted RMNCAH&N interventions towards improved national indicators.
Interventions should address the 2 dimensions of continuum of care: Life course and community to health facility, and Capacity strengthening at national and regional levels.



5.1.4 Improve the funding for, and cost-efficiencies of public health and RMNCAHN programming

Refocusing investment on the greatest burden of deaths and disability will result in real change for women’s and children’s health. Investment in care during pregnancy, childbirth and the first month of life is the smartest investment, with a quadruple return: saving mothers and newborns, preventing stillbirths, reducing disabilities, and paving the way for optimal child development and lifelong health and well-being.

Despite Namibia’s commendable overall spending for the health sector which approximates the Abuja Declaration 15%, there are significant gaps with regards to the funding of the public health sector. In addition, most of the programme areas of RMNCAH&N have not attracted sufficient funding by the government, and have relied more on donor support, which is increasingly dwindling. Some RMNCAH&N programme areas do not have a dedicated budget line in the budget. The country should therefore aim to allocate sufficient domestic and international resources to strengthen health systems, and implement plans for improving maternal and neonatal survival and health, and for preventing stillbirths. Improving equitable access to RMNCAH&N services, quality of services, human resources capacity, other strategies, and key activities for achieving the goals and objectives of this Plan demand increased funding. Concomitantly, there is the need to improve cost-efficiency of programming in the health sector to get “more health for the money”, and with greater focus on high impact interventions, accountability, and cost-optimising approaches, particularly in the face of national economic challenges.

TABLE 14: Strategic activities to improve the funding for, and cost-efficiencies of public health and RMNCAH&N programming

Strategic Activities
Identify and implement innovative approaches to improve health and RMNCAH&N funding nationally.
Advocate for budget lines for each key RMNCAH&N area, and commitment of budget to each RMNCAH&N related budget line.
Develop and strengthen partnerships and coordination of MHSS with other Offices, Ministries and Agencies (OMAS), health development partners and the private sector – both non-, and for-profit – to increase funding outputs for RMNCAH&N.
Promote an evidence-based approach, high impact interventions, and promote cost-efficiencies of public health and RMNCAH&N programming
Joint planning, implementation, monitoring and evaluation among health sector partners and units.
Strengthen mechanisms for accountability regarding RMNCAH&N resources, and roles and responsibilities of stakeholders.
Advocate for increased funding towards RMNCAH&N, including domestic resource mobilisation.

5.1.5 Strengthen the logistics management systems for RMNCAH&N commodities

Lifesaving commodities – including essential drugs for maternal and neonatal care, vaccines, contraceptives, and relevant laboratory materials – are critical to providing high quality services that effectively respond to the health needs of clients, meet their expectations, as well as produce the desired health effect. In this respect, current challenges with the commodity logistic management system resulting in non-availability or inadequacy of commodities and supplies need to be addressed.



TABLE 15: Strategic activities for strengthening the logistics management systems for RMNCAH&N commodities

Strategic Activities
Review the logistic management system for improved performance.
Finalise the Inventory Gap analysis report on cold chain storage system for vaccines, and address the gaps.
Update the National Essential Medicine list to include omitted lifesaving commodities and products.
Ensure timely procurement, equitable distribution and access, appropriate use and maintenance of essential medical commodities and products (equipment, technologies and diagnostics) to facilitate the delivery of high-quality, affordable maternal and newborn care, including care to prevent stillbirths.
A standard package of commodities for Essential Health Services that include Essential Newborn & Small and Sick Newborn Care should be integrated into the budget allocation.
Strengthen implementation of the quantification process by Central Medical Store as well as advocate for essential maternal and newborn care equipment for regions (fetoscope/dopplers, ambubags, fetal monitors etc.).

5.1.6 Strengthen partnerships with community structures and systems

Community engagement is an important process towards ensuring ownership at the local level and sustainability of efforts and results. In this regard, the inclusion of social, behavioural and community engagement mechanisms and tools are crucial. The individual and households are nested in the community system and its dynamics, and their health behavior is greatly influenced by the community. The community structure, including leadership systems, faith-based institutions, and CBOs are potentially great allies in expanding access to health services and delivering critical services, including home visits, promotion of key child health household practices, provision of peer-to-peer and psychosocial support, tracking and responding to abuse of children, sexual and gender-based violence, monitoring uptake of services, and ensuring accountability with regards to health outcomes, including maternal and perinatal mortality.

TABLE 16: Strategic activities to strengthen partnership with community structures and systems

Strategic Activities
Actively engage community leaders, religious leaders and other key stakeholders to promote the participation of women and diverse groups in RMNCAH&N committees, and to engage in dialogue on mechanisms for improving the health of women, children and adolescents at the local level.
Consistently involve community stakeholders in the development, implementation and monitoring and evaluation of health-related plans and actions.
Enhance gender equality in community health systems, for example through provision of training and stipends for CHWs.
Strengthen structures at the community level for including involvement of women-led and diverse CBOs in RMNCAH&N plans and actions.
Intensify social mobilisation at the community level for key RMNCAH&N issues such as breastfeeding, and adolescent health.



5.1.7 Improve multisectoral engagement and collaboration

Health is ultimately best served using a multisectoral approach, and several other sectors also contribute significantly to optimal RMNCAH&N outcomes. The school system, for example is critical to adolescent health as a cost-effective platform for sexuality education, screening and detection of health problems, and provision of health-related services including WASH interventions, and mental health and wellness support services. Broadcast, digital and print media are essential across all RMNCAH&N domains for improving health information and education, and as a voice for accountability, while the Ministry of Gender and NAMPOL, among others, are potent partners in addressing the issue of sexual and gender-based violence.

TABLE 17: Strategic activities to improve multisectoral engagement and collaboration

Strategic Activities
Establish and strengthen existing platforms for multisectoral dialogue, joint planning, implementation and monitoring of results.
Establish new partnerships and develop framework for more result-oriented public-private-partnerships, and enhanced engagement of the private sector in health partnerships and programmes.
Strengthen multisectoral coordination and accountability structure.

5.1.8 Improve data generation and utilisation for programming and accountability

Data systems, and the evidence they generate, are strategic to effective decision-making, monitoring of progress and equity in programme implementation, and assessing results achieved. There is a need to strengthen data systems to ensure that they satisfactorily address all elements of RMNCAH&N, including appropriate age specifications in data collection instruments and processes. Data should also be disaggregated by age, gender, social, and geographic factors, to facilitate adequate focus on constituent groups. The entire spectrum of the data system should be assessed to ensure the timely generation and dissemination of high quality and reliable data, with high a degree of coverage and completion. A thriving culture of data demand, dissemination, and utilisation in decision-making needs to be vigorously cultivated and promoted to improve programming, and to drive accountability.

TABLE 18: Strategic activities to improve data generation and utilisation for programming and accountability

Strategic Activities
Strengthen the use of routine health facility data between long waiting intervals, and retrieval of data from population-based surveys like NDHS to improve monitoring, programming and accountability for RMNCAH&N.
Review health facility registers and the monthly summary form for DHIS 2 to ensure that they adequately capture data for monitoring globally agreed and country relevant indicators, for programming and progress monitoring for RMNCAH&N.
Ensure that the key indicators for all areas of RMNCAH&N, particular areas where there are significant gaps, are incorporated into NDHS.
Explore the potential for conducting Multiple Cluster Indicator Surveys about mid-way in the periodicity of the NDHS to improve the monitoring of population-level results and impact indicators.
Promote research, including epidemiological, operations, and implementation research, as well as strengthen monitoring and evaluation for improved assessment of efforts and outcomes, and contribute to the functioning of data systems.
Promote data demand by health planners, community leaders and other stakeholders, and the use of data for planning and accountability at all levels.
Strengthen the mechanism for data quality assurance and public dissemination of results, including increasing use of online sources.
Publish annual report on the state of implementation of this Strategic Plan and the status of women's, children's and adolescents' health.
Harmonise data generated from different data capturing systems to improve accuracy and completeness.
Disaggregate data to expose health inequalities and those being left behind, to achieve UHC.
Institute national and regional accountability processes for periodic review and monitoring of progress towards agreed national targets, through annual review and planning meetings with regions.
Introduce scorecards for accountability, including the development and implementation of accountability mechanisms to improve newborn health and prevent stillbirths.
MPDSR processes need reinforcement at all levels of RMNCAH&N care.
Revival of MNH TWGs and sub-committees to strengthen QI for maternal and newborn health.
Facilitate the alignment of data capturing and reporting systems with data collection tools (linked to ENAP & EPMM milestones and key indicators in RMNCAH&N).
Improve civil registration and vital statistics (CRVS) e-Notification of births and deaths, for data accuracy and Medical Certificates of Cause of Death (MCCD) completion.



5.1.9 Improve research, innovation and knowledge management

Locally generated data and using emerging evidence, including knowledge exchange, is key to improving maternal and newborn health and survival and to end preventable stillbirths.

TABLE 19: Strategic actions for research, innovation and knowledge management

Strategic Activities
Advocate and collaborate with MHSS Research Division to conduct research around RMNCAH&N.
Identify and gather innovations, and indigenous knowledge management and practices aimed at improving RMNCAH&N.
Develop a repository for RMNCAH&N-related information.
More specifically, based on the analysis of the available data from desk and literature reviews, the following areas need continuous research and evaluation:
Explore the most successful strategies for improving the quality of care provided by health workers.
Investigate the underlying factors to perinatal mortality in Namibia disaggregated by region.
Elucidate the patterns and prevalence of cervical cancer in the country.
Investigate bottlenecks in data collection, analysis and review processes at different administrative levels for RMNCAH&N programming and monitoring.
Determine the prevalence of malnutrition especially in U5s and pregnant women per region.
Strengthen multilateral collaboration with training institutions, as well as both public and private healthcare institutions for implementation of the research agenda.
Use findings from evidence-based studies to inform policy and practice, and to ultimately reduce preventable maternal and neonatal morbidities and mortality.

5.1.10 Strengthen response and resilience

Given emerging diseases, recurrences of pandemics, increase in NCDs, economic fluctuation, climate change and increase in humanitarian situations, it is vital to put plans in place which support the most efficient strategies aimed at building back, or rebuilding the healthcare system.

TABLE 20: Strategic activities for response and resilience

Strategic Activities
Build resilient health systems to better prepare, respond and mitigate impact of current and future health emergencies.
Promote self-care interventions as well as development of, and training on, Minimum Initial Service Package (MISP).
Review the existing emergency preparedness and response plan to include RMNCAH&N interventions with a coordinated mechanism for its implementation, ensuring procurement of emergency supplies and monitoring survival and health outcomes.
Review and strengthen national emergency strategic plan to mitigate the impact of climate change and disease outbreak.
Strengthen coordination with private companies and stakeholders for better emergency preparedness efforts.

5.1.11 Reduce maternal mortality

Obstetric haemorrhage, hypertensive disorders, pregnancies with abortive outcomes, and pregnancy-related infections remain the leading causes of direct maternal deaths in the country. MHSS is committed to accelerate efforts in the reduction of maternal, newborn and child morbidity and mortality through implementation of a minimum package of maternal, neonatal, child and adolescent health and family planning services, with the aim to improve mother and child health outcomes. The RMNCAH&N Strategy aims to promote and safeguard the wellbeing of patients and healthcare workers by ensuring that appropriate policies and guidelines are in place, and consistently implemented at all levels of the healthcare system.

TABLE 21: Strategic activities to reduce maternal mortality

Strategic Activities
Strengthen supply chain management for reproductive health commodities and essential equipment.
Increase access to contraception to help prevent unintended pregnancies and reduce the need for unsafe abortions, through improving education on contraceptive methods and their availability.
Strengthen the capacity of HCWs in providing RMNCAH&N services.
Strengthen community support systems in responding to sociocultural and religious and harmful practices that negatively impact RMNCAH&N. Support the process to finalise the enactment of the legal framework for traditional health practice.
Provide comprehensive life skills-based education and disease prevention to help adolescents and young adults make informed decisions about sexual activity and contraception, and ultimately reduce unintended pregnancies.
Standardise RMNCAH&N quality improvement initiatives and scale up high impact interventions.
Strengthen prevention and management of communicable and non-communicable diseases contributing to maternal mortality.
Reduce stigma surrounding abortion. Legal restrictions and lack of information surrounding abortion prevents women from seeking safe abortion services, leading them to turn to unsafe methods. Addressing this stigma through education and public awareness campaigns can help reduce the risk of unsafe abortion.
Improve post-abortion care services to reduce the risk of complications from unsafe abortions by ensuring access to health facilities, and training of healthcare providers on provision of effective post-abortion care services.
Increase empowerment of women by providing education, access to job creating opportunities, and other resources to give women greater control over their lives and their reproductive health decisions.
Address societal issues such as poverty, gender inequality, and lack of access to education and healthcare to help reduce the incidence of unintended pregnancies and unsafe abortions.



5.1.12 Targeted neonatal, infant and child health programming

Despite the reduction in mortality rates amongst the age group 0–5 years from 26 to 10 deaths per 1,000 live births (1990 – 2021), sub-Saharan Africa has the highest U5 mortality rates. Globally, the causes of death amongst this age group include NCDs, drowning, HIV and AIDS, injuries, and Respiratory Tract Infection (RTI), amongst others.

TABLE 22: Strategic activities for neonatal, infant and child health programming for the 0-5 age group

Strategic Activities
Conduct analysis of the evidence for priority interventions that address the major causes of mortality, morbidity and determinants of health and wellbeing in children U5.
Promote delivery strategies and platforms for scaling up evidence-based interventions for children aged 0-5 years in the context of UHC.
Develop enabling policies and intersectoral actions that enable implementation of cost-effective interventions.
Targeted interventions on IMNCI including cIMNCI.
Support the implementation of the Integrated Early Childhood Development (IECD) policy.
Strengthen competency-based training and skills of HCWs.
Strengthen Immunisation against Vaccine Preventable Diseases (VPDs) and ensure sustainable supply and delivery of vaccines, and cold chain equipment.

5.1.13 Targeted interventions for adolescent sexual reproductive health and rights

Adolescence is a unique stage of human development and an important time for laying the foundations of good health, thus needing special attention in national development policies, programmes, and plans. The strategic actions are intended to promote overall health and wellbeing of adolescents, to reduce morbidity and mortality. According to the WHO Global Health Estimates of 2021, the main causes of mortality among younger adolescents were HIV/ and AIDS, TB, Lower Respiratory Tract Infections, road injury and drowning.

TABLE 23: Strategic activities for adolescent health

Strategic Activities
Support the Ministry of Education and other stakeholders to operationalise the Integrated School Health and Safety policy and prevention of Learner Pregnancy and Management Policy.
Strengthen integration and multisectoral collaboration for adolescent evidence-based health interventions.
Build the capacity of HCWs to provide adolescent-friendly SRH services, including maternal health care.
Develop and implement innovative strategies to reach out-of-school, and the most vulnerable adolescents.

5.1.14 Improve detection, prevention and management of sexual and gender-based violence

Violence against women and girls constitutes a profound violation of their human rights, often remaining concealed, stigmatised, and inadequately recognised by health professionals and other service providers. In Namibia, despite the existence of a comprehensive policy and legal framework, women and girls continue to face violence throughout various stages of their lives, whether at home, in schools, or within their communities. Globally, and in Namibia, one in three women experience physical and/or sexual violence, with most cases perpetrated by intimate partners. Notably, Namibian women continue to experience violence during pregnancy, and a significant number of cases go unreported. Strategic actions are aimed at prevention and management of GBV and Intimate Partner Violence (IPV).

TABLE 24: Strategic activities to improve detection, prevention and management of SGBV

Strategic Activities
Scale-up GBV services including services for Violence Against Children (VAC) and adolescents.
Promote multisectoral collaboration and community engagement on GBV.
Include GBV care/management in the pre- and in-service training curriculum of HCWs.
Create awareness about reproductive health, VAC and GBV.
Provide appropriate services for those who have undergone early childhood marriages and harmful cultural practices.





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CHAPTER 6

6. Introduction

Chapter 6 outlines the implementation and coordination framework essential for delivering the RMNCAH&N Strategy in Namibia. It highlights a multitiered structure involving national, regional, district, and community levels to ensure integrated, equitable, and efficient execution of programmes. Strong partnerships across government units, development partners, and communities will drive coordinated action and accountability. The need for costed annual work plans, clear roles, and robust governance to achieve the strategy’s goals is emphasised.

6.1 Implementation and Coordination Framework

This Strategic Plan brings together programmes that are domiciled in different units and departments within MHSS in the national interest of improving the health and well-being of women, children and adolescents in a cost-effective and efficient manner. In the implementation of the Plan, each unit, and department will continue to play their role in line with specified national mandates, leveraging on partnerships with stakeholders including line ministries, development and implementing partners, as well as community and service recipients. To operationalise the strategy, annual work plans must be developed at national and regional levels by programme area (for each of the 14 regions), that will contribute to the achievement of the goals, objectives and targets. In this context, a strong partnership and coordination framework is required for success.

6.1.1 National level

National Steering Committee

The National Steering Committee provided for in the 2013 National Policy on Sexual, Reproductive, and Child Health (SRCH) shall be the Steering Committee for this Strategy and shall be formally referred to hereafter as the Integrated RMNCAH&N (IRMNCAH&N) National Steering Committee. The membership of the committee shall be gender- and stakeholder representative to promote equity and gender responsiveness. The Committee will provide strategic direction and overall policy guidance for the implementation of this Strategy. The roles and responsibilities are as defined in the National Policy on Sexual, Reproductive, and Child Health. The Minister (or designate) will serve as the Chair of the Committee, with the Executive Director (formerly Permanent Secretary or designate) as the Deputy. The Directorate of PHC will serve as the secretariat.

National Technical Working Group

The Technical Committee specified in the 2013 National Policy on SRCH will now be known as the IRMNCAH&N Technical Working Group (TWG). The roles and responsibilities of the TWG are outlined in the Policy. Broadly, the TWG will articulate the technical strategic technical guidance in line with the overall policy direction specified by the National Steering Committee. Thus, the TWG will “unpack” the implementation dimension of the policy guidance given by the Steering Committee, and

provide general guidance to the implementation to be carried out by each programme area. The TWG will serve as the clearing house for Programme Managers and the fulcrum for the integration of implementation ideas and plans. The Deputy Executive Director (formerly Deputy Permanent Secretary) shall be the Chair of the TWG and the Director, PHC director will be his/her Deputy. The Department of Family Health in the PHC Directorate will serve as the secretariat for the implementation of partnership at the national level.

6.1.2 Regional and district levels

The Regional RCH Committee specified in the 2013 National Policy on SRCH will henceforth be the Regional Integrated RMNCAH&N Committee and will perform the roles specified in the Policy in this context for the region. The Regional Director will be the Chair of the Committee. The District equivalent will similarly serve in the manner described for the region with respect to the District. The head of the District Team will head the District IMNCAH Committee.

6.1.3 Community level

The community health system constitutes a critical part of the systems for health in the context of this Strategy, and strengthening the community health system, including the operations of CHWs, and supporting other community health-decision organs, is an important element within the framework of strategy implementation. At every community level (village/settlement), a Community Health (IRMNCAH&N) Committee/Village Health Committee shall be established in consultation with the community leadership, and the committee will have as part of its membership a representative of the community chief or leader, CHW, women leaders in the community, (or representatives of the community women), a youth representative, and any other community influencers.

The Clinic Health Committee will be comprised of the head of the government health facility in the community, the heads of a secondary and a primary school in the community, and representative of CHWs, as well as religious and traditional leaders. The Committee will meet every two months and make inputs to the deliberations at the district level through its reports and submissions, and interact with the District Committee physically where necessary. The committee will provide local contexts into programming efforts to ensure that the programme implementation response is appropriate to the local context, and is culturally sensitive. The committee members shall also serve as a structure to promote community participation and involvement in the implementation of the strategy, as well as promote community ownership of the various health programmes. Furthermore, the community committee will serve as a local accountability mechanism.

6.1.4 Implementation framework in summary

The RMNCAH&N Framework shall be implemented over a five-year period at national, regional and district levels, and annual work plans should be developed to implement the key actions and interventions. The implementation of this Plan will require harmonised and integrated actions by MHSS and other line ministries, regional and district management teams, partner organisations and community structures.



MHSS will provide leadership in implementing the plan, but will do so based on the principles of partnership and collaboration. At national level, costed annual work plans shall be developed jointly by MHSS and implementing partners (other government agencies, UN partners, civil society and NGOs and various private sectors), focused on the key programmes: SRH, nutrition, adolescents, HIS, MCH, HIV and AIDS, amongst others.

This Plan will subsequently be operationalised through annual work plans which will be developed by regions and districts in alignment with achieving the objectives of the 2026/26-2029/30 RMNCAHN&N Strategy.

Risks and challenges

Major risks and challenges to successful execution of the strategy include: the health sector's dependence on donor financing; potential non-incremental percentage of Government budget spending on health, as well as misalignment of partner funding to global declarations and cooperation frameworks/plans within the Ministry. Inefficiencies including adopting a silo approach in programme implementation can potentially pose risks to the successful implementation of this Strategy. National, regional and global pandemics also remain a risk.

To overcome or mitigate these risks and challenges, MHSS and partners will strengthen and sustain advocacy for investing in women, children's and adolescents' health for Namibia's social and economic development throughout the lifetime of the Strategy. The implementation of these programme services through an integrated approach will contribute to the maximisation of resource utilisation and efficiencies.

Moreover, at the regional and district levels, the relevant MHSS management structures shall provide leadership and stewardship roles.





7. Introduction

Chapter 7 sets out the monitoring, evaluation, research, and accountability framework essential for tracking progress in implementing the RMNCAH&N Strategy. It outlines a results-oriented approach that emphasises regular data collection, evidence-based decision-making, and continuous learning. The chapter highlights mechanisms for periodic reviews, national performance indicators, and gender-responsive research to inform programming. Together, these efforts aim to promote transparency, improve service delivery, and ensure accountability for the health and well-being of women, children, and adolescents in Namibia.

7.1 Monitoring and Evaluation, Research and Performance Indicators and Accountability Framework

The monitoring and evaluation framework for this Strategy embodies regular monitoring activities, periodic evaluation, and research activities that will take place intermittently in the lifespan as needed. The monitoring and evaluation process as well as related research are intrinsic parts of the data systems that can contribute to improved accountability, which is one of the underlying principles of this Strategy. Accountability encompasses three interrelated ideas: monitoring, review and action. Strengthening the national health management information system and the overall data system, as well as improving national capacity to monitor and evaluate are fundamental to improving accountability for RMNCAH&N.

7.1.1 Monitoring and evaluation process

Monitoring of activities shall take place regularly and at every level to ensure that the implementation of the plan is on track, and to allow for corrective actions and adjustments of the plans when necessary. The National TWG shall meet at least twice a year to specifically review implementation reports, and the progress being made, as well as new technical impetus that may be necessary. The reports will culminate in an Annual Joint Review Process that will involve stakeholders at various levels as well as representatives of international development partners, to report on progress of the state of women, children's and adolescents health in Namibia.

A mid-term review shall be conducted in 2028, and an end-of-term evaluation will be conducted at the end of the 5-year period of the Plan in 2030. The mid-term review will provide an opportunity to review progress made, and the associated factors, and re-strategise for the second half of the Strategy period. Additionally, routine collection of facility data for programming shall be strengthened, and a quarterly review of data and data triangulation introduced.

7.1.2 Research

Research shall be a critical part of the implementation agenda for this Plan and will complement the monitoring and evaluation process. Research will also provide opportunities for innovation, for example, in terms of developing and applying new implementation approaches, and evaluating them for scaling up. As such, gender-sensitive and gender-responsive research will be actively promoted to inform the development, implementation, monitoring and evaluation of health promotion policies and programmes, and integrated across all levels. Efforts will incorporate both existing and ongoing research activities, as well as new research activities.

An annual National Research RMNCAH&N Agenda will be developed following the Annual Joint Review: the research may be diverse in nature, including epidemiological, basic, operational, and implementation science, as the need arises. Such research will be funded by the government and its partners to improve understanding of the RMNCAH&N situation and the health status of women, children, and adolescents in Namibia, and clearly identify associated factors. Research can also afford stakeholders the opportunity to evaluate implementation strategies and approaches for their impact, cost-effectiveness and other outcomes, as well as to analyse policy implementation and effectiveness. The government will also invest in building the research capacities of relevant health workers to strengthen their critical thinking skills, appreciate and facilitate the application of evidence to their work, and incorporate relevant research elements, for example, operational research into their day-to-day activities for improved outcome.

7.1.3 Performance indicators

The following core indicators for monitoring the implementation of the Strategy are consistent with the recent Global Reference List of Health Indicators which categorizes each indicator into one of the four domains: health status, risk factor, coverage, or health systems (Table 23). These indicators are also aligned with the SDG indicators, the Global Strategy for Women's, Children's and Adolescent Health, and the ENAP and EPMM frameworks. They further reflect the vision and objectives of this Strategy's priorities which will be monitored regularly and reported on with respect to RMNCAH&N.

Table 25 on the following pages presents the core indicators for monitoring the implementation of the Strategy.



TABLE 25: Core indicators for monitoring implementation of the Strategy

INDICATORS	FOCAL GROUPS	Baseline 2024/2025	Year 1 2025-2026	Year 2 2026-2027	Year 3 (Mid Term Review) 2027-2028	Year 4 2028-2029	Year 5 (End Term Review) 2029/2030
OUTCOME							
Maternal mortality ratio (SDG 3.1.1) (baseline from MMEIG 2025)	Mothers	139/ 100,000	123/ 100,000	107/ 100,000	91/ 100,000	75/ 100,000	60/ 100,000
Neonatal mortality rate (SDG 3.2.2) (baseline from UNGME 2025)	Newborn	24/1,000	21/1,000	18/1,000	16/1,000	13/1,000	10/1,000
Stillbirth rate (disaggregated by fresh and macerated)	Newborn	17/1,000	15/1,000	13/1,000	11/1,000	10/1,000	9/1,000
Infant mortality rate	Infants	14/1,000	13/1,000	12/1,000	11/1,000	10/1,000	9/11,000
U5 mortality rate (SDG 3.2.1) (Baseline from UNGME 2025)	Children	41/1,000	38/1,000	35/1,000	31/1,000	28/1,000	25/1,000
Mortality rate (0-9 age group)	Children	19	15	12	9.5	7.5	6
Adolescent mortality rate (10-14 age group)	Adolescents	37.5	29.4	23	18	14	11
Adolescent mortality rate (15-19 age group)	Adolescents	7.5	5	4	3	2%	2
Total fertility rate (births per woman)	Women of reproductive age	3.7	3.6	3.5	3.2	3.0	2.9
Adolescent birth rate per 1000 women in that age group [disaggregated also by (10- 14, 15-19)] (SDG 3.7.2)	Adolescents	0.3	0.28	0.27	0.25	0.23	0.21
Prevalence of LBW and small for gestational age	Children	10%	10%	9.8%	9.5%	9.0%	8.5 %
Prevalence of stunting in U5 children (SDG 2.2.1)	Children	29.5%	27%	25%	22%	20%	17.5%
Prevalence of wasting in U5 children (SDG 2.2.2)	Children	6.7%	6.2%	5.5%	5.3%	5.0%	4%
Prevalence of overweight in U5 children (SDG 2.2.2)	Children	2.2%	2.0%	1.8%	1.7%	1.6%	1.5%
Prevalence of anemia in girls aged 15-19.	Adolescents	19%	17%	15%	13%	12%	11%

DATA SOURCES: Routine Health Information System (RHIS), HMIS, data from supervisory visits, surveys, DHICS, DHIS2, MICS, NDHS

TABLE 25: Core indicators for monitoring implementation of the Strategy (contd.)

INDICATORS	FOCAL GROUPS	Baseline 2024/2025	Year 1 2025-2026	Year 2 2026-2027	Year 3 (Mid Term Review) 2027-2028	Year 4 2028-2029	Year 5 (End Term Review) 2029/2030
OUTPUT INDICATORS							
HIV PMTCT: MTCT rate	Mothers	1.3%	1.2%	1%	0.8%	0.7%	0.6%
Proportion of infants who were breastfed within the first hour of birth	Infants	83.5%	86%	90%	95%	4.5%	4%
Percentage of infants <6 months who are fed exclusively with breast milk	Infants	60%	65%	75%	8%	7%	5%
Proportion of females (15-49 years) subjected to physical violence in the last 12 months.	Women, Adolescents	13.8%	12%	10%	9%	7%	4%
Proportion of adolescent girls (15-19 years) subjected to sexual violence in the last 12 months.	Adolescents	4.5%	4%	3.5%	3%	2.5%	1.5%
Proportion of women and girls aged 15-49 years subjected to sexual violence in the last 12 months.	Women, Adolescents	3.7%	3.5%	3%	2%	1.5%	1.2%
Percentage of women aged 20-24 who were married or in a union before age 18 (SDG 5.3.1)	Adolescents	8.5%	8%	7%	6%	5%	4%
Facility-based childbirths with a skilled birth attendant (SDG 3.1.2)	Women	88%	90%	92%	96%	98%	99%
Pregnant women with ANC contacts during the 1st trimester (before 24 weeks)	Women	41%	44 %	49 %	54%	59%	64%
Proportion of women with 8 or more Antenatal Care contacts	Women	64.2% (3 or more)	70% (4 or more)	80% (4 or more)	90% (4 or more)	95% (4 or more)	98% (4 or more)
Proportion of women and neonates Early Routine Postnatal follow-up care (within 2 days)	Women and Neonates	71.9%	75%	80%	85%	90%	95%
Caesarean section rate	Women	15%	15%	15%	15%	15%	15%
Proportion of pregnant women (15-49 years) tested for HIV	Women	99.5%	100%	100%	100%	100%	100%
Proportion of population covered by Emergency Obstetric Care (EmONC) health facilities within 2 hours of travel time	Women and Children	1 for 500 000 population	20%	40%	60%	80%	100%



INDICATORS	FOCAL GROUPS	Baseline 2024/2025	Year 1 2025-2026	Year 2 2026-2027	Year 3 (Mid Term Review) 2027-2028	Year 4 2028-2029	Year 5 (End Term Review) 2029/2030
OUTPUT INDICATORS							
HIV PMTCT	Women and Children	1%	0.5%	0.3%	0.2%	0.1%	<0.1%
Newborn Vaccination coverage [EPI] (SDG 3.b.1)	Neonates	80%	85%	90%	95%	Increase uptake by 60%	Increase uptake by 80%
Contraceptive prevalence rate	Women and Adolescents	No baseline data	Increase uptake by 25%	Increase uptake by 35%	Increase uptake by 50%	Increase uptake by 60%	Increase uptake by 80%
Care-seeking for symptoms of pneumonia	Children	No baseline data	Increase uptake by 25%	Increase uptake by 35%	Increase uptake by 50%	Increase coverage by 90%	Increase coverage by 100%
Coverage of diarrheal treatment	Children	No baseline data	Increase coverage by 50%	Increase coverage by 60%	Increase coverage by 75%	92%	95%
Vitamin A supplementation coverage	Children	79 %	82 %	85 %	90 %	100%	100%
Proportion of facilities providing ENC including skin-to-skin-approach	Neonates	No data	100%	100%	100%	100%	100%
Proportion of infants who were initiated prophylactic ART for HEB	Neonates	99%	100%	100%	100%	90%	95%
Proportion of facilities (hospitals) providing KMC for management of LBW babies nationally	Neonates	70%	75%	80%	85%	98%	100%
Proportion of HF implementing e-birth notification system (SDG 16.9.1)	Women and Neonates	36	36	36	38	42	45%
Proportion of women in preterm labor receiving at least one dose of antenatal corticosteroids	Women and Neonates	90%	92%	94%	95%	80%	90%
Proportion of pregnant women receiving magnesium sulfate and antibiotic prophylaxis for improved neonatal outcomes	Women and Neonates		Increase by 50%	60%	70%	100%	100%
Early routine PNC contact at HFs on Day 3, Days 7-14 & 6 weeks after childbirth	Women and Neonates	Data N/A	70%	80%	85%	90%	95%

TABLE 25: Core indicators for monitoring implementation of the Strategy (contd.)

INDICATORS	FOCAL GROUPS	Baseline 2024/2025	Year 1 2025-2026	Year 2 2026-2027	Year 3 (Mid Term Review) 2027-2028	Year 4 2028-2029	Year 5 (End Term Review) 2029/2030
OUTPUT INDICATORS							
Proportion of HF implementing prevention and management of childhood illnesses (IMNCI) (malaria, pneumonia, TB and diarrhea)	Children	100%	100%	100%	100%	100%	100%
Pediatric ARV coverage	Neonates	90%	95%	95%	97%	98%	98%
Proportion of U5 children who slept under insecticide-treated nets (ITNs) for malaria prevention	Children	8%	25%	50%	75%	90%	100%
Proportion of facilities introducing system for monitoring MR for children 5 - 9 years per 1000 (for facilitation of programming for this age group in future)	Children	No baseline	28 %	35 %	50%	70%	80 %
HIV PMTCT: Maternal ART coverage	Mothers	97%	98%	99%	99%	99.5%	100%
Proportion of schools with Integrated CSE curricula	Adolescents	10%	20%	30%	40%	50%	60%
Proportion of facilities providing health promotion programmes and BCC initiatives e.g., radio dramas and “edutainment” interventions	Adolescents	No baseline data	60%	70 %	80%	90%	95%
Proportion of facilities offering AFHS with integrated RMNCAH&N-related services	Adolescents	N/A	100%	100%	100%	100%	100%
Percentage of women of reproductive age (15-49) satisfied need for FP with modern methods	Women and Adolescents	80%	85%	90%	95%	100%	100%
Proportion of HFs introducing psychosocial assessment with HEADSSS (Home, Education and Employment, Activities, Drugs, Sexuality, Suicide/ Depression)	Adolescents	No data	10%	20%	30%	40%	50%



INDICATORS	FOCAL GROUPS	Baseline 2024/2025	Year 1 2025-2026	Year 2 2026-2027	Year 3 (Mid Term Review) 2027-2028	Year 4 2028-2029	Year 5 (End Term Review) 2029/2030
OUTPUT INDICATORS							
Routine HPV vaccination coverage	Adolescents	No baseline data	50%	60%	70%	80%	90%
Proportion of HFs offering integrated management of RMNCAH&N, and communicable & NCDs	Women and Adolescents	N/A	100%	100%	100%	100%	100%
Proportion of higher learning institutions introducing VIA, cervical cancer screening & LARC in curricula	Women and Adolescents	N/A	50%	70%	80%	90%	100%
Proportion of HFs with SRH refresher trainings conducted for health care providers (2 trainings per region, per year)	Women and Adolescents	N/A	50%	70%	80%	90%	100%
Proportion of PHC facilities with integrated SRHR/HIV/GBV	Women and Adolescents	N/A	50%	70%	80%	90%	100%
Proportion of adolescent girls (15-19 years) screened for HIV	Adolescents	94.4%	95%	96%	97%	98%	100%
Proportion of pregnant women (15-49 years) screened for HIV	Mothers and Adolescents	94.2%	95%	96%	97%	98%	100%
Number of sick and small newborn care units at district and referral level hospitals	Children	No baseline data	Increase by 30%	Increase by 40%	Increase by 50%	Increase by 60%	75
Proportion of quarterly maternal/perinatal death review meetings reports per year	Women and Neonates	No baseline data	50%	60%	70%	80%	90%
Regions reporting monthly number of maternal deaths to the national level	Women and Neonates	8/14	14	14	14	14	14
HFs providing Basic Emergency Obstetric Care (BEmONC)	Women and children	0	6	10	15	20	28 (2 per region)
Hospitals providing Comprehensive Emergency Obstetric Care (CEmONC)	Women and children	5	7	8	10	12	14 (1 per region)

TABLE 25: Core indicators for monitoring implementation of the Strategy (contd.)

INDICATORS	FOCAL GROUPS	Baseline 2024/2025	Year 1 2025-2026	Year 2 2026-2027	Year 3 (Mid Term Review) 2027-2028	Year 4 2028-2029	Year 5 (End Term Review) 2029/2030
OUTPUT INDICATORS							
Proportion of girls aged 9-15 vaccinated with HPV vaccine	Adolescent girls aged 9-15	4x	10	70	85	90	100
Proportion of facilities providing screening for, and management of cervical and breast cancer	Women and Adolescents	50%	65 %	70 %	75 %	85 %	95%
Percentage of women screened (using VIA, Pap smear, and HPV testing)	Women aged 20+ years	65%	75%	75%	85%	90%	97%
Percentage of eligible women screened with HPV DNA testing	Women aged 20+ years	0	15	35	50	65	80
Percentage of women screened and received the results	Women aged 20+ years	60	75	75	80	90	95
Percentage of women with abnormal screening results	Women aged 20+ years	15	15	20	15	10	5

7.1.4 Accountability mechanism

Accountability is a cyclical process to assess progress, recognise success, identify problems, take remedial action and hold all parties to account. Regular maternal and perinatal death review at various levels, Annual Joint Review of the State of Women, Children’s and Adolescents Health in Namibia will be conducted. It looks at commitments and what happened and, where appropriate, provides practical recommendations on what might be done better. In the context of this Strategy, accountability for the improved health of women, children, and adolescents shall be promoted and ensured through the following:

i. Strengthening the data systems for RMNCAH&N:

A sector-wide system strengthening effort is advocated, including improving human resources capacity; strengthening the system and processes for data collection to ensure accuracy, completeness, gender- and age- disaggregation and high degree of quality of data being reported; and, ensuring wide dissemination and easy accessibility of available data and results. In this respect DHIS2 shall be strengthened and expanded to cover all core RMNCAH&N indicators, and the results of the available data analysed, and disseminated online for easy accessibility, and reports on RMNCAH&N presented quarterly to the National IRMNCAH&N Technical Working Group.



ii. Improved monitoring, reporting, dissemination and utilisation of RMNCAH&N data at all levels:

Advocacy mechanisms will be harnessed to promote wide availability of gender-sensitive data to drive action at community, district, regional, and national levels to improve the health and well-being of women, children and adolescents. The use of dashboards, scorecards, and other innovative, attractive and low-literacy data presentation methods will also be promoted to increase the awareness of the appreciation for as well as utilisation of RMNCAH&N data for action.

iii. Joint Annual Review of RMNCAH&N status and performance:

Joint Review of RMNCAH&N status shall be carried out regularly on an annual basis – either independently or as part of the national health system review – to monitor the implementation of policy and programme actions relating to the health of mothers, children, and adolescents. The process should be transparent and involve a wide group of stakeholders, including CBOs, to enhance its impact. The report of the review shall be distributed widely at national and sub-national levels and launched annually to promote knowledge of its existence and potential for use.

iv. Development, printing and distribution/dissemination of an annual “State of Women, Children’s and Adolescents Health in Namibia” report:

This publication will present a critical analysis of the health status of women, children and adolescents, and serve as a tool for strengthening advocacy for improved funding and system performance for IRMNCAH&N and the health and well-being of women, children and adolescents. The publication will also encompass tracking and trend analysis of resources made available for RMNCAH&N activities at national and sub-national levels by government and its partners as it relates to RMNCAH&N, and present a report card of each region’s status and performance. The report will be launched nationally at the highest political level – by the President or Minister of Health – as part of an annual RMNCAH&N week that shall be commemorated by the country, and feature high level media engagement and partnership. Awards shall be publicly presented to geographical areas, institutions, and teams with outstanding performances and/or innovative approaches to improving the health status of women, children and adolescents. The RMNCAH&N Report card, which is part of the report, will also be personally presented by the Minister to the Member of Parliament representing each political constituency in the country.

v. Strengthening the system for Maternal, Perinatal and Neonatal Death Reviews:

Maternal, Perinatal and Neonatal Death Reviews have been conducted in Namibia but there are challenges with the periodicity, regularity, and availability of results as well as the optimal use of the report. The 2014 report of the review, for example, covered April 2010 to March 2012 (a two-year period), followed by another report two years later. Concerns have been raised about easily accessibility and the degree of use to positively impact the health system and maternal, perinatal and neonatal

deaths. Steps will be taken to ensure more regular reviews, the results of which shall be published in a timely manner and disseminated widely, including electronically to enhance its impact. Dialogues and professional discussions shall be promoted around the reviews and steps defined to use the result for improved impact. The result will also be disseminated through Policy Briefs, Review Summaries, infographics and other easy to read materials to promote wide dissemination and use of the results.

vi. Development of an accountability roadmap:

Specific efforts shall be made, in line with the call by the global community, to formally develop and optimally implement a national accountability map for RMNCAH&N for Namibia.



8. Introduction

Chapter 8 presents the financial blueprint for implementing the RMNCAH&N Strategy, detailing cost estimates, budgeting, and funding approaches over a five-year period. Using the One Health Tool, the chapter outlines a resource needs analysis that integrates service delivery,⁷¹ human resources, commodities, and program management. It estimates a total cost of NAD 8.55 billion, with the majority allocated to high-impact interventions. Financing strategies, emphasising sustainable domestic investment, innovative funding mechanisms, and phased implementation to maximize efficiency and impact are also explored.

8.1 Costing for the Implementation of the Strategy

The RMNCAH&N Strategy Plan resource requirements are estimated using the One Health Tool (OHT). OHT is a policy projection tool that allows users to create short- and medium-term plans for scaling up essential health services, including RMNCAH&N services. It is a bottom-up tool that enables modelling based on population demographics, disease and health profiles, clinical practices, service provision, and coverage. It helps to identify resource requirements for building and maintaining infrastructure, training, deploying, and retaining the health workforce, availing medicines and supplies, and addressing other aspects of health system management, including equipment, logistics, health information, health financing, and governance. OHT is a unified tool for joint planning, costing, budgeting, impact analysis, and fiscal space analysis. It helps link programs to health system strengthening platforms, integrates costing into the planning process, and considers the country's fiscal space for budgeting. The tool requires that planning is driven by an explicit analysis of the current health system, overall context, and what can realistically be achieved in the medium term.

8.2 Costing Results

8.2.1 RMNCAH&N Strategy Plan estimated cost

The resource requirements for the RMNCAH&N Strategy Plan were estimated based on: (i) available information on RMNCAH&N profiles documented as part of the Strategy Plan; (ii) official figures for base year population demographics from the Essential Health Service Package (EHSP); (iii) national protocols and expert opinions used for clinical practices; and (iv) expansion targets set to meet the standards, based on population figures and other criteria from the EHSP. The unit costs for human resources, commodities, and investment requirements were extracted from recent EHSP costing exercises, and each unit cost was verified by the Technical Working Group (TWG) of the RMNCAH&N Strategy Plan. The system priorities and targets were established by the team, and their unit costs were verified to be used in this resource requirement analysis.

8.2.1 Total intervention costs

Overall, the total resource requirement for implementing the RMNCAH&N Strategy Plan is estimated at NAD 8.55 billion over five years. Of this, the majority (90%) – approximately NAD 7.68 billion – is allocated to sustaining evidence-based, high-impact interventions in the form of service delivery. Meanwhile, programme management costs account for 10% of the total – around NAD 0.86 billion, as shown in Table 26.

TABLE 26: Cost of RMNCAH&N (NAD Billion)

Cost of RMNCAH&N	2025	2026	2027	2028	2029-30	TOTAL (NAD Billion)
Intervention cost	1.27	1.42	1.58	1.73	1.68	7.68
Program Management cost	0.04	0.08	0.20	0.27	0.27	0.86
Total Cost	1.31	1.50	1.79	2.00	1.95	8.55
Share from EHSP	40.4%	38.3%	36.4%	34.5%	30.9%	35.5%

The RMNCAH&N Strategy Plan aims to achieve universal coverage of various services delivered at different interventions (Table 27). In estimating service delivery costs by major interventions (excluding system strengthening costs), two cost elements were considered: human resources, and commodities.

Human resource costs were estimated based on the person-days required for each service, using the total time for each cadre through the One Health Tool (OHT), and the costs were apportioned according to annual salaries. Commodities costs were based on the targets set, and the required types and quantities of drugs and medicines, per intervention, necessary to reach the targeted population in need.

The total service delivery costs for all programs are estimated at NAD 7.7 billion. Of this, 25% is allocated to MNRH services, 16% to child health services, 12% to immunisation, 3% to Malaria, 5% to TB, 11% to HIV and AIDS, 7% to nutrition services, 5% to ENT (ear, nose, and throat) services, and 16% to NCDs. As shown in Table 27, 36% of the estimated resource requirement is for procuring and distributing health service commodities (such as medical supplies and vaccines), while 41% is allocated to financing the salaries of healthcare providers at different levels of care. Specific program system strengthening costs accounted for only 23% of the total service delivery cost

TABLE 27: Cost by types of services and major cost components (NAD Million)

Programme Areas	Service delivery		Total	Share
	Drugs ² Supplies	Labour		
Maternal/newborn and reproductive health	404.93	1,509.91	1,915	25%
Child and adolescent health	164.64	1,046.44	1,211	16%
Immunisation	901.62	49.70	951	12%
Malaria	203.97	2.82	207	3%
TB	186.80	193.66	380	5%
HIV/AIDS	436.17	416.90	853	11%
Nutrition	275.12	258.37	533	7%
Mental, neurological, and substance use disorders	-	-	-	0%
Neglected tropical diseases	-	-	-	0%
Ear, Nose & Throat	241.46	140.20	382	5%
NCDs: Cardiovascular Disease (CVD), Diabetes, Respiratory and Rheumatic heart diseases	-	-	-	0%
NCDs: Cancers: Breast Cervical & Colon	816.55	433.72	1,250	16%
TOTAL	3,631	4,052	7,683	100%
Share	47%	53%		

The RMNCAH&N Strategy cost constitutes 35% of the EHSP cost (Table 28), and the per capita cost of the RMNCAH&N services is estimated to be USD 28 (NAD 508) on average, for the next five years.

TABLE 28: Annual costs per intervention area from 2025 to 2030 (NAD Million)

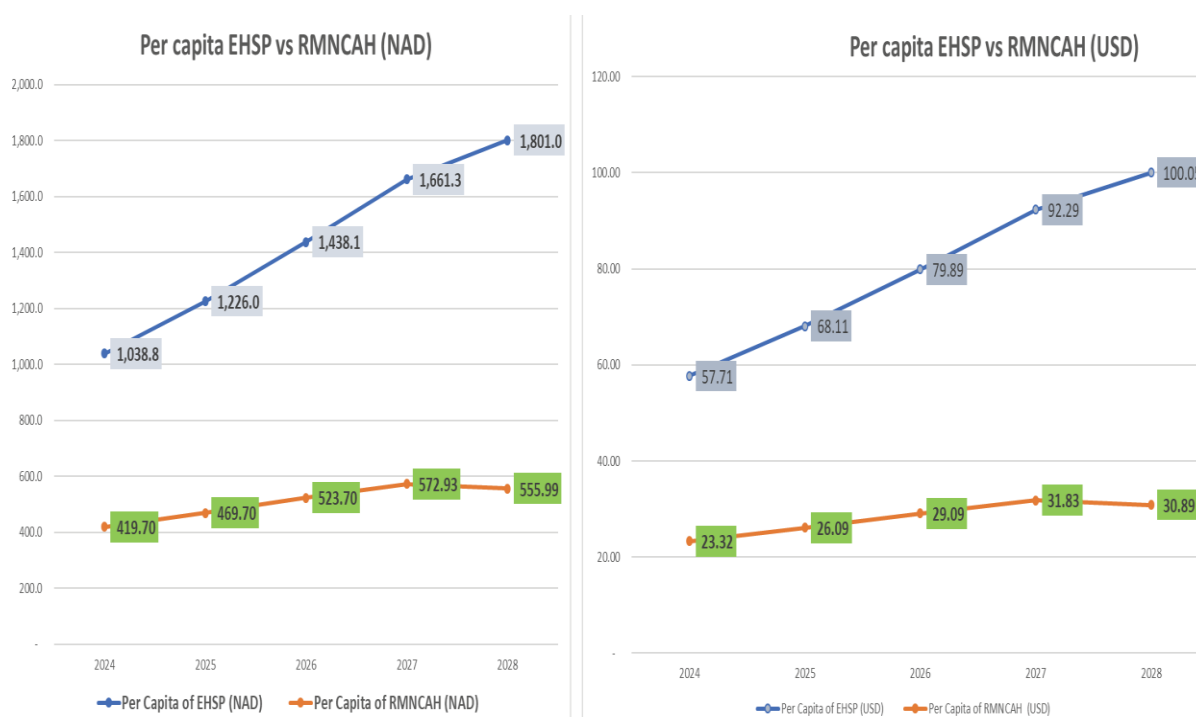
Programme Areas	2025	2026	2027	2028	2029-2030	TOTAL
Maternal/newborn and reproductive health	343	377	405	434	356	1,915
Child and adolescent health	192	217	242	269	292	1,211
Immunization	194	201	206	208	142	951
Malaria	33	34	49	45	45	207
TB	61	68	77	86	89	380
HIV/AIDS	141	154	169	186	203	853
Nutrition	102	107	112	115	97	533
Mental, neurological, and substance use disorders	-	-	-	-	-	
Neglected tropical diseases	-	-	-	-	-	
Ear, Nose & Throat	46	59	74	92	111	382
NCDs: Cardiovascular Disease (CVD), Diabetes, Respiratory and Rheumatic heart diseases	-	-	-	-	-	
NCDs: Cancers: Breast Cervical & Colon	157	202	248	297	346	1,250
TOTAL	1,268	1,420	1,583	1,732	1,680	7,683
Share of RMNCAH&N from EHSP	40%	38%	36%	34%	31%	35%

The projected annual costs for health intervention areas in Namibia from 2025 to 2030 reveal a strong financial commitment to maternal, newborn, and reproductive health, which holds the highest cumulative cost at NAD 1,915 million. Consistent growth is also evident in child and adolescent health, immunisation, and nutrition, reflecting a focus on preventive and essential health services for young populations. Spending on communicable diseases like Malaria, TB, and HIV and AIDS is steadily increasing, indicating continued prioritisation of these public health challenges. Rising costs in ENT services, as well as NCDs, particularly cancers, suggest an increasing need to address chronic illnesses and emerging health demands.

Overall, the total health budget is expected to grow from NAD 1,268 million in 2024 to NAD 1,680 million in 2028, totalling NAD 7,683 million over five years. Although the



FIGURE 27: Per capita cost of the RMNCAH&N services vs EHSP



share allocated to RMNCAH&N decreases from 40% to 31%, this shift likely reflects a balanced approach to supporting both communicable and non-communicable disease prevention. The planned expenditure growth across all areas indicates Namibia’s dedication to building a resilient healthcare system capable of meeting diverse health needs as they evolve over time.

8.3 Generic Annual Programme Management Costing

On completion of the identification and quantifications on activities and inputs, an appropriate costing template was developed which facilitates the computation of each of the activities and any adjustments. The template was then populated based on the available information from the quantification of inputs, assumptions and unit costs. The total cost of implementing would then be calculated as:

$$TC_i = \sum_{i=1}^8 TQ_i * UC_i$$

where TC, TQ and UC denote total cost, total quantity of input and unit cost of the associated input. The costs are then totalled for each type of cost such as meeting workshops, trainings, supervision, equipment etc. All costs have been calculated in local currencies. Depreciation of equipment was not considered in the calculation.

Based on the above approach, total cost of programme implementation of the RMNCAH&N Strategy over the five years is estimated to be NAD 862.64 million. On average, this is equivalent to an average annual investment need of NAD 172 million and a minimum and maximum annual cost of NAD 37 million (Year 1) to NAD 272 million (Year 5) respectively. The total cost for each year, as well as the investment needs under each strategy pillar, and cost categories, are given in Tables 29 and 30.

TABLE 29: Total estimated cost under each strategic pillar (NAD Million) for programme management

Strategic Pillar	Implementation Cost per Fiscal Year (NAD million)					
	Year1	Year2	Year3	Year4	Year5	Year5 Estimated Cost (NAD)
5.1.1 Strengthen Human Resources in Health for RMNCAH&N	2.87	11.80	20.41	10.75	17.98	63.82
5.1.2 Improve the Quality and Equity of RMNCAH&N Care	5.83	3.82	5.04	3.65	0.48	18.83
5.1.3 Increasing coverage and equity of cost-effective interventions.	0.34	1.14	5.94	5.94	5.94	19.29
5.1.4 Improve the funding for, and cost-efficiencies of public health and RMNCAH&N programming	0.33	1.17	1.17	1.17	1.17	5.01
5.1.5 Strengthen the logistics management systems for RMNCAH&N commodities	0.84	9.96	16.91	11.33	11.33	50.36
5.1.6 Strengthen partnership with community structures and systems	2.15	2.08	2.08	1.40	1.08	8.78
5.1.7 Improve multi-sectoral engagement and collaboration	1.51	1.18	2.35	2.60	2.35	10.00
5.1.8 Improve data generation and utilization for programming and accountability	6.14	11.14	10.51	10.38	9.96	48.14
5.1.9 Improve Research, Innovation and Knowledge Management	3.43	1.34	1.66	0.34	0.19	6.96
5.1.10 strengthen Response and Resilience	-	0.73	0.31	0.31	0.56	1.89
5.1.11 Reduce maternal mortality	4.45	13.50	114.31	204.21	203.45	539.92
5.1.12 Targeted neonatal, infant and child health Programming	6.48	15.33	18.46	16.52	14.27	71.05
5.1.13 Targeted interventions for Adolescent Sexual Reproductive Health and Rights	2.51	2.88	3.08	2.92	2.92	14.30
5.1.14 improve Detection, prevention and management of SGBV	1.08	0.90	0.74	0.74	0.74	4.20
Total Cost	37.95	76.96	202.96	272.24	272.42	862.54

TABLE 30: Total estimated cost under type of activities (NAD Million)

Programme Costing	Implementation Cost per Fiscal Year (NAD million)					
	Year1	Year2	Year3	Year4	Year5	Year5 Estimated Cost (NAD)
Meeting workshops	13.9	19.1	16.3	15.4	13.8	78.6
Advocacy	5.8	9.4	14.7	14.7	14.5	59.0
Training	11.7	31.1	32.9	29.6	23.4	128.6
Supervision	5.4	13.9	14.5	13.0	11.5	58.4
Infrastructure and equipment	1.3	1.3	105.1	188.5	197.6	493.8
Monitoring and Evaluation	-	-	5.0	-	-	5.0
Communication, media, and outreach	-	2.1	8.3	5.1	5.6	21.0
Others	0.0	0.1	6.2	6.1	6.0	18.4
Total Cost	38.1	77.0	203.0	272.4	272.4	862.8

8.4 Maternal and Child Mortality Impact

The RMNCAH&N Strategy is a core component of Namibia’s essential health services package, significantly contributing to reductions in maternal and child mortality. It aims to improve access to comprehensive healthcare services for mothers, newborns, and young children, addressing crucial gaps in prenatal, perinatal, and postnatal care. Through targeted interventions such as skilled birth attendance, emergency obstetric care, enhanced immunisation, and nutritional support, the RMNCAH&N Strategy is expected to play a transformative role in advancing maternal and child health outcomes.

As a direct result of this approach, Namibia’s maternal mortality ratio is projected to decline from 139 to 60 deaths per 100,000 live births over the next five years. This reduction underscores the impact of strengthened maternal healthcare services, improved quality of care, and wider access to essential health resources, ultimately enhancing safety for mothers throughout pregnancy and childbirth. Additionally, the U5 mortality rate is anticipated to decrease from 41 to 25 deaths per 1,000 live births. This decline highlights the effectiveness of RMNCAH&N child-focused interventions, including improved nutrition, disease prevention, and early childhood health programs. By addressing these health priorities, the RMNCAH&NS supports Namibia’s broader commitment to achieving sustainable health goals, reducing preventable deaths, and fostering a healthier future for women and children.

8.4 Financing Strategies

Affordability considerations and the need for further prioritisation are themes for frank discussion among stakeholders, given real-time fiscal realities. Phasic implementation of the national strategy interventions is recommended, weighting efforts in regions with the greatest burden of disease. Batched implementation of staff training and programme administration can better consolidate and reduce costs. Beyond the recommended 15% allocation for health, as a percentage of the Gross National Product for African countries (Abuja Declaration, 2001), strategic expenditure in the health sector often requires involvement of non-state actors, through partnership with the private sector. Innovative financing mechanisms such as platforms for the solicitation of micro-contributions through market-based financial transactions and selective taxation, such as the institution of a “sin tax” on cigarettes or alcohol have been successfully instituted by other countries to address any shortfalls in health financing.



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ANNEX

RMNCAH&N Strategy Acknowledgement

Name	Organisation/Directorate
Workshop for the development of the integrated RMNCAH&N Strategy, 16-20 October 2017, Altebrücke Hotel, Swakopmund	
MHSS	PHC(FHD, IEC)
MHSS-RMTs	Khomas, Erongo, Omaheke, Ohangwena, Zambezi, Oshikoto, Oshana, Otjozondjupa
MHSS-DCC	Erongo, Walvis Bay PHC
MHSS	NHTCT
UN Family	WHO, UNICEF, UNFPA Country Offices
USG	CDC/PEPFAR
Tertiary Education	UNAM School of Nursing, UNAM School of Medicine, IUM
UN Family	WHO, UNFPA, UNICEF
Dr Ene Nkem	Lead Consultant-WHO
Dr Muna Abdullah	UNFPA-ESA, Health Systems Strengthening
Dr Fatima Gohar	UNICEF - ESARO, Health Specialist, MNCH
Dr Teshome Desta Woldehanna	WHO
MHSS	PHC (FHD)
RMNCAH&N Strategy debriefing meeting, 02 November 2017	
MHSS	Office of the Deputy Permanent Secretary
MHSS	Khomas RMT
UN Family	WHO, UNICEF, UNFPA Country Offices
Anderqua Fatusi	WHO consultant
Namibian Police	GBV
NUST	
Workshop for building consensus and validating the draft integrated RMNCAH&N Strategy, 08-09 November 2017, Windhoek	
MHSS	PHC (FHD, IEC)
MHSS	Directorate Special Programmes
MHSS	HIRD
MHSS-RMTs	Khomas, Erongo, Omaheke, Ohangwena, Oshikoto, Otjozondjupa, Kavango East, Omusati
MHSS	WCH Maternity(Obs& Gynea)
MHSS	NHTCT
UN Family	WHO, UNICEF, UNFPA Country Offices
Anderqua Fatusi	WHO consultant
USG	CDC/PEPFAR
Tertiary Education	IUM
IMANA	
Namibian Police (NAMPOL)	
UN Family	WHO, UNFPA, UNICEF, UNAIDS Country Offices
Dr Tunde Mensah	
African Youth and Adolescents Network (AfriYAN)	



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