Namibia 2013

Millennium Development Goals

Interim Progress Report No. 4

PICTURE

National Planning Commission

Republic of Namibia

Produced with technical and financial assistance from UNDP

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September 2013

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Published by:
The National Planning Commission
Government Office Park
Private Bag 13356
Windhoek
Namibia
Tel: 264 61 283 4111

Produced with technical and financial assistance from UNDP

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Printed in Namibia by _____
Design and layout by _____
Photos courtesy of _____

FOREWORD

The Millennium Development Goals (MDGs) form an integral part of the global vision for a well-nourished, skilled, healthy populace, pursuing and sharing prosperity and wealth-creation in an equitable and environmentally sustainable manner. This agenda particularly resonates with Namibia as the country presided over the UN General Assembly and resultant Millennium Summit in 2000, which brought together the largest ever gathering of world leaders and articulated, through a set of eight goals and corresponding targets, that the "world as *it is* must give way to the world as *it could* be".

For Namibia, an arid landscape, enviably endowed with precious natural resources yet underdeveloped in human terms as a consequence of both inequitable distribution of resources by systems designed deliberately to deprive some segments of society, and ineffective measures to redress this in the post-Independence era, this global development agenda is fully in synch with her own aspirations.

Accordingly, Namibia's Vision 2030, as interpreted for action by successive periodic National Development Plans, domesticates this global vision for a better world. National Development Plan 4 is specifically anchored on the 1st Millennium Development Goal which speaks of reduction of poverty and hunger through "increased and sustained economic growth, creation of wealth and employment; and even distribution of that wealth".

In this regard, the compilation of this Report, the fourth for Namibia, is not only a reflection of how the world has fared on its commitments on human development but equally reflects how Namibia has progressed on her own agenda. The Report highlights key policies that have had a significant impact on the push towards the achievement of the MDGs. It also summarises where Namibia's challenges have inhibited the realisation of the Goals.

As an overview, Namibia, riding on a set of bold and targeted interventions to build the momentum and truly galvanise her people around the MDGs, notwithstanding the stubbornness of the challenges still faced, has a great deal to be proud of. Specifically, the country has made commendable progress in the areas of poverty reduction, education, gender equality, health and environmental sustainability. To flag a few successes in the area of poverty reduction, Namibia has succeeded in meeting or is on target to meet all but two indicators, namely those relating to the gini-coefficient and the 'share of poorest quintile in national consumption'.

Equally, in terms of universal access to primary education, Namibia had achieved or is expected to achieve all targets within the agreed timeline. In particular, there has been a tremendous expansion in the enrolment of children in primary schools and also the survival rate to Grades 5 and 8. With respect to gender equality and the empowerment of women and girls, the ratio of female to male students enrolled in secondary school and the literacy rate have been attained. Under the health area and specifically related to HIV, the reduction in the HIV prevalence among the 15 to 19 and 20 to 24 year olds has been realised. Equally, we are proud of our achievements around to incidence of malaria per 1 000 population.

In regard to access to clean, drinkable water, 'full access' has been attained, while in terms of environmental sustainability, the proportion of protected areas has increased. The increase in the number of conservancies and community forests under the Community Based Natural Resource Management programme deserves special mention because of its positive impact not only in increasing wildlife numbers but also because of the benefits that local communities derive.

Notwithstanding these successes, there is still more to be done to guarantee greater impact on the reduction of poverty, curtailment of the prevalence of HIV and infant mortality, improved maternal health and increased allocation of land to freehold conservancies for greater wealth creation and distribution.

To ensure success and guard against the reversal of these gains, Namibia – commended for her active participation in international partnerships and cooperation which contributes to peace-making and peace-building – must remain engaged on the global front. In particular, Namibia must continue to build solid and mutually beneficial partnerships with like-minded actors around the globe.

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Tom Alweendo
Director General, National Planning Commission

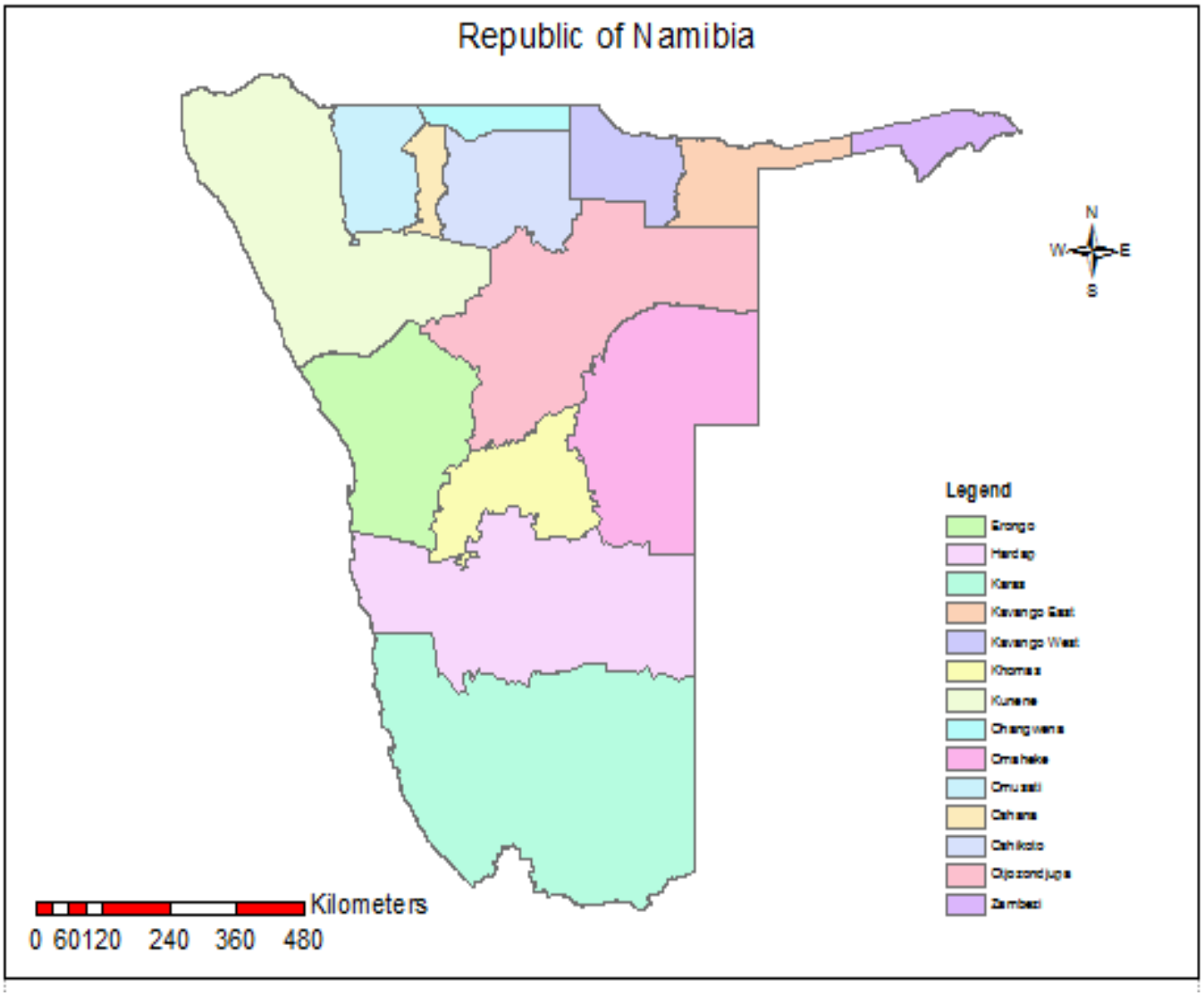
ACKNOWLEDGEMENTS

The fourth Millennium Development Goals Report, 2013 is a joint effort by the Government of the Republic of Namibia and the United Nations System in Namibia. This Report would not have been finalised without the support and leadership of the National Planning Commission (NPC) as well as the financial and technical support of the United Nations Development Programme (UNDP). Special thanks go to the Core Technical Team (NPC and UNDP) comprising of Ojijo Odhiambo, Mary-Tuyeni Hangula, Sylvanus Nambala, Nandi Mazeingo, Bertha Njembo, Leena Amukushu and Frieda Amwaala for assisting with the review of the report.

A total of 232 national and regional stakeholders made contributions to the report in relation to accuracy of data sources, accuracy of data and reporting of main challenges, milestones and post 2015 agenda items. Their contributions are appreciated wholeheartedly. The main stakeholders included government ministries, agencies and offices, development partners and civil society organisations.

A special word of gratitude goes to the main author of the report, Mr. Randolph Mouton, who prepared the report and facilitated national and regional consultations. He was support by Dr. Elizabeth Terry and Dr. Jon Barnes who provided extensive inputs into preparation of MDGs 3, 7 and 8. The Editor of the Report, Ms Megan Allardice is thanked for her editorial expertise in strengthening the report.

MAP OF NAMIBIA



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ACRONYMS

AFHS	Adolescent Friendly Health Service
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Treatment
CBNRM	Community Based Natural Resource Management
CBO	Community-Based Organisation
CFC	Chlorofluorocarbons
DAC	Development Assistance Committee
DAE	Directorate of Adult Education
DOTS	Directly Observed Treatment Short Course
DPTP	Decentralised Build Together Programme
ECD	Early Childhood Development
EFA	Education for All
EMIS	Educational Management Information System
EPI	Expanded Programme on Immunisation
EMA	Environmental Management Act
EmOC	Emergency Obstetric Care
ETSIP	Education and Training Sector Improvement Programme
EU	European Union
FAWENA	Forum for African Women Educationalists in Namibia
FBO	Faith-Based Organisation
FDI	Foreign Direct Investment
FSNP	Food Security and Nutrition Project
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GF	Global Fund
GPTF	Game Products Trust Fund
GR&AP	Gender Research and Advocacy Project
HAMU	HIV and AIDS Management Unit
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICT	Information Communication Technology
IPD	In-patient Department
ITN	Insecticide Treated Net
LAC	Legal Assistance Centre
MAWF	Ministry of Agriculture, Water and Forestry
MCA	Millennium Challenge Account
MCP	Multiple Concurrent Partnerships
MD	Millennium Declaration
MDG	Millennium Development Goal
MET	Ministry of Environment and Tourism
MGECW	Ministry of Gender Equality and Child Welfare
MLSW	Ministry of Labour and Social Welfare
MMR	Maternal Mortality Rate
MNH	Maternal and Neonatal Health
MOE	Ministry of Education
MOF	Ministry of Finance
MOHSS	Ministry of Health and Social Services

MRLGHRD	Ministry of Regional and Local Government, Housing and Rural Development
MTCT	Mother-to-Child Transmission
MTP	Mid-Term Plan
NACOP	National AIDS Control Programme
NAFIF	Namibia Alliance for Improved Nutrition
NDHS	Namibia Demographic and Health Survey
NDP	National Development Plan
NGO	Non-Governmental Organisation
NHIES	Namibia Household Income and Expenditure Survey
NID	National Immunisation Day
NIPAM	Namibia Institute of Public Administration and Management
NLP	National Literacy Plan
NPC	National Planning Commission
NSFP	National School Feeding Programme
NTCP	National Tuberculosis Control Programme
NTB	Namibia Tourism Board
NTCP	National TB Control Programme
NTD	National Testing Day
NTLP	National TB and Leprosy Programme
NVDCP	National Vector-Borne Disease Control Programme
ODA	Official Development Assistance
OPD	Out-patient Department
OPM	Office of the Prime Minister
OVC	Orphaned and Vulnerable Children
PLHIV	People Living with HIV
PMTCT	Prevention of Mother–to-Child Transmission
RACE	Regional HIV and AIDS Coordination for Education
SADC	Southern African Development Community
SACU	Southern African Customs Union
STI	Sexually Transmitted Infection
TB	Tuberculosis
TIPEEG	Targeted Intervention Programme for Employment and Economic Growth
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV and AIDS
UNAM	University of Namibia
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNICEF	United Nation Children's Fund
UPE	Universal Primary Education
USAID	United States Agency for International Development
VTC	Vocational Training Centre
WAD	Women's Action for Development
WFP	World Food Programme
WHO	World Health Organisation
WSASP	Water and Sanitation Sector Policy

EXECUTIVE SUMMARY

INTRODUCTION

The Namibia 2013 Millennium Development Goals Report (MDGR) is the fourth progress report prepared since the Millennium Declaration (MD) was adopted by 189 member states of the United Nations (UN) at the Millennium Summit in New York in September 2000. Following the adoption of the MD, eight smart, measurable, achievable and realistic goals and targets – the Millennium Development Goals (MDGs) – were developed and these have been implemented by developing member countries with the support of the developed member countries. The eight MDGs are:

MDG 1: Eradicate extreme poverty and hunger
MDG 2: Achieve universal primary education
MDG 3: Promote gender equality and empower women
MDG 4: Reduce child mortality
MDG 5: Improve maternal health
MDG 6: Combat HIV and AIDS, malaria and other diseases
MDG 7: Ensure environmental sustainability
MDG 8: Develop a global partnership for development

It should be noted that this is regarded as an interim report to be updated as soon as new data become available from the 2012/13 Demographic and Health Survey and 2013 Labour Force Survey. The final report should be available by early 2014.

GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER

Namibia managed to achieve the poverty reduction targets ahead of 2015, but is not on target to achieve equitable distribution of income or eradication of hunger. The proportion of Namibia's population who live in 'poor' and 'severely poor' conditions have decreased by more than half over the past 13 years. This is a commendable reduction in poverty and means that less than one third (28.7 percent) of the population currently lives below the poverty line. Namibia has at the same time, significantly reduced the poverty gap ratio, surpassing the target to halve the poverty gap by 2015. However, inequality remains a serious challenge, with high poverty levels in rural areas, and among female-headed households, older pensioners and subsistence farmers. Two regions had poverty levels of 50 percent or more, while increased poverty levels were experienced in Khomas region. The gini coefficient has fallen but remains one of the highest in the world. The unemployment rate of 27 percent is lower than the 52 percent in 2008 but it continues to be extremely high among Namibian youth (52 percent). Gross domestic product has grown modestly, hitting 5 percent per annum in 2012, while the share of the poorest decile more than doubled between 2003/04 and 2009/10. Hunger and malnutrition remain a serious concern for Namibia, especially with the current drought across many of the regions. Although Namibia has made great strides and achieved key milestones towards eradicating poverty and hunger, there are still challenges in terms of unemployment and unemployability, limited skilled and qualified human resources, limited research and development, food insecurity and malnutrition, and ongoing corruption and mismanagement of funds. Key interventions that should receive attention for the remaining period before the end of 2015 are the design of innovative ways to create employment, build Namibia's human capital, scale up a well-established social grant system, raise the budget allocation to education, health and food production programmes, speed up the processing of vital registration documents, and more effectively implement the Zero-Tolerance for Corruption strategy.

GOAL 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

Of the three MDG 2 targets that Namibia has set for herself to achieve by the year 2015, the net enrolment in primary education target has been achieved, the literacy rate is on target to be achieved, while the survival to Grade 8 target is not achievable if current trends continue. The net enrolment ratio in primary education stood at 99.6 percent in 2012. However, the gross enrolment rate for the past few years highlights inefficiencies in enrolling maximum numbers of children in age appropriate grades. The survival rate for Grade 7s was 86 percent

in 2012, 14 percentage points short of the 100 percent target. The literacy rate for 15 to 24 year olds was close to the 100 percent target at 94 percent in the year 2011. It is likely that the literacy rate target can be achieved by 2015. As with school enrolments, regional variations in literacy are evident, with Kunene having the lowest (59.4 percent) literacy rate in 2011, followed by Omaheke (70.7 percent) and Kavango (76.4 percent). The region with the highest literacy rate in 2011 was Khomas (97.4 percent), followed by Erongo (96.7 percent) and Karas (96.6 percent). This follows regional wealth trends, with the poorer regions having lower literacy rates and richer regions having higher literacy rates. One of the main thrusts of Vision 2030 is to transform Namibia into a high income, knowledge based economy. Such an economy would be expected to alleviate poverty, satisfy the labour market and ultimately support Namibia's transition into an industrialised nation. Namibia has consistently shown commitment to improved education with innovative interventions such as the Education and Training Sector Improvement Programme, continued curriculum development, free primary education, the official reinstitution of early childhood development, and infrastructural development. However, the following challenges persists poor school management, lack of motivation among many educators, poor physical learning environments, slow roll-out of early childhood development, poverty, malnutrition and high levels of domestic violence. Some of the interventions that could be considered to expedite MDG implementation are: improve school management structures at school, circuit, regional and national levels, strengthen procurement and distribution of textbooks especially to rural areas, continued improvement of physical learning environments, expedite roll-out of early childhood development centres, expand the school feeding scheme to include all children, enact the Child Care and Protection Bill, implement and enforce school codes of conduct for teachers and learners, and implement the teenage pregnancy policy. Key interventions to be considered for the remaining MDG period are: increase financial, material and human resources to implement legislation, policies and plans, ensure that gender-specific recommendations and significant action steps are included in the review of NDP 4, strengthen gender mainstreaming across different sectors, continue to expand nutritional programmes to support pregnant women and children, continue with awareness raising, and strengthen all interventions towards eradicating gender-based violence.

GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

Of the seven targets, three have already been achieved, two were on target to be achieved by the year 2015, while two were not on target. Gender parity targets have been reached for secondary education, literacy rates for 15 to 24 year olds and pre-primary education. The ratio of girls to 100 boys for secondary education was 112.3 in the year 2012, 101 for literacy in 2011 and 101.2 for pre-primary education in 2012. The target to have gender parity in primary education is on target to be achieved at 96.4 girls per 100 boys. Namibia was also on target to achieve 50 percent share of women in wage employment in the non-agricultural sector, having achieved 48 percent in 2008 and 35 percent in 2012. The gender parity target for tertiary education will likely not be achieved, taking current trends into consideration. The proportion of seats held by women in Parliament was 25 percent in 2013, still 25 percentage points from the targeted 50 percent. The Namibian Constitution is the starting point for gender equality in Namibia. Unlike many other national constitutions, Namibia's Constitution explicitly forbids sex discrimination. Numerous milestones toward gender equality can be mentioned, but the establishment of the Ministry of Gender Equality and Child Welfare was certainly one of the most significant, cementing Government's commitment to the cause of gender equality. A major bottleneck slowing down progress is the poor implementation of legislation, policies and plans, possibly due to low capacity and poor funding priorities. However, some key plans in Namibia, such as the NDPs, pay insufficient attention to gender issues. Other challenges include insufficient resources to mainstream gender equality adequately across different sectors, increased gender-based violence, the seeming inability of Namibia to translate gender parity on some levels into formal jobs and negotiation powers of women, inadequate disaggregation of data in national management information systems, and inconsistencies in data sources, research methodologies and data presentation.

GOAL 4: REDUCE CHILD MORTALITY

The target for MDG 4 is to ensure that, by 2015, under-five mortality rates are reduced by two-thirds. The three relevant indicators are to reduce both under-five mortality and infant mortality by two-thirds between 1990 and 2015, and to increase the proportion of one-year-old children immunised against measles. While the measles immunisation programme is on target, current data for Namibia show that it is unlikely to attain the reduction in child mortality targets by 2015. The infant mortality rate decreased from 57 deaths for every 1 000 live births in 1992 to 38 in the year 2000, but increased to 46 deaths per 1 000 live births in 2006/07. A similar trend was experienced for under-five mortality, which increased from 62 deaths per 1 000 live births in the year 2000 to 69

deaths in 2006/07. The challenges that contribute towards increased child mortality rates include, inefficient and ineffective health service provision, lack of basic emergency skills among some health workers, insufficient health infrastructure and difficulties of access to health services especially for severely poor and marginalised groups. The interventions urgently needed to expedite achievement of the 2015 targets are infrastructural development (including equipment and space at health centres and clinics), increased budget allocation, strengthened capacity of health management systems, improved skills and commitment of health workers, strengthened community health structures and roll-out of the Community Health Extension Officer programme. The proportion of one-year-old children immunised against measles has increased steadily from the early nineties, from 63.5 percent to 72.2 percent in the year 2000 and 78 percent in 2006/07. This shows that Namibia is on target to achieve the immunisation target of 85 percent by 2015.

GOAL 5: IMPROVE MATERNAL HEALTH

The targets for MDG 5 are to: reduce by three quarters, between 1990 and 2015, the maternal mortality ratio; and achieve, by 2015, universal access to reproductive health. The current data for Namibia (based on 2006/07 NDHS) shows that Namibia has already achieved the target for births to be attended to by skilled health personnel, is on target to reduce the unmet need for family planning to zero, but is unlikely to meet any of the other targets for this goal by 2015, such as 56 maternal deaths for every 100 000 live births, 100 percent contraceptive prevalence, the adolescent birth rate reduced by 100 percent and an antenatal coverage of 100 percent. As with child health, Namibia is committed to reducing child and maternal mortality. This is evident by the multi-sectoral institutional structures put in place, the Life Saving Skills/EmOC training of trainers, routine maternal death reviews, enhanced referral system, improved infrastructure and procurement of equipment, strengthened adolescent's sexual and reproductive health and rights, and improved PMTCT strategies among others. Namibia has developed a 'road map' with the aim of expediting achievement of maternal health targets, but needs to overcome the following challenges: shortage of skilled health workers, high attrition, non-availability of essential drugs especially in rural areas, inappropriateness of the health infrastructure to provide required skills, slow implementation of decentralisation, inadequate community outreach, and inefficient record keeping and use of the monitoring and evaluation system. It is essential, therefore, to develop a health professional human resource plan, improve retention of health professionals, accelerate training, build the capacity of all categories of reproductive health service providers, ensure availability and maintenance of essential medicines and equipment, design clinics to cater appropriately for all relevant health needs, speed up decentralisation, and strengthen community mobilisation and monitoring and evaluation.

GOAL 6: COMBAT HIV AND AIDS, MALARIA AND OTHER DISEASES

The three targets for this goal are, by 2015 to have halted and begun to reverse the spread of HIV, and the incidence of malaria and other major diseases, and by 2010, to have achieved universal access to treatment for HIV and AIDS for all those who need it. Of the six HIV and AIDS indicators that could be measured, trends from the early nineties show that Namibia had already achieved the ratio of 1.0 of school attendance of orphans to school attendance of non-orphans aged 14 years an below. Namibia is on target to achieve the 90 percent proportion of women aged 15 to 24 years with comprehensive and correct knowledge of HIV and AIDS, but not on target to achieve the same results for men of the same age group. The country is also on target to achieve the proportion (100 percent) of adults with advanced HIV infection who have access to antiretroviral treatment, although not target to achieve 95 percent of children with this access. The HIV prevalence target of 5 percent among the population aged 15 to 24 will also not be achieved, as it stood at 8.9 percent by 2012.

The overall national HIV and AIDS response in Namibia is guided by the respective short and medium term National Plans, the National Strategic Framework on HIV and AIDS and the National Policy on HIV and AIDS. In June 2011, Namibia committed itself to continuing its active response to HIV by endorsing the Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS, at the UN General Assembly High Level Meeting on AIDS. The Political Declaration on HIV and AIDS runs parallel to the MDGs, with ten targets to be achieved by 2015, which support the achievement of MDG 6. In 2013, a consultative mid-term review of progress against these targets was completed and outlined the way towards achieving them, while the NSF mid-term review and recommendations will pave the way forward. The challenges in the overall response to HIV include financial and technical sustainability, effectiveness of treatment due to adherence issues, resistance and inadequate nutrition for PLHIV on treatment, slow roll-out of PMTCT Prongs 1 and 2, difficulties in implementation of PMTCT Option B+, slow uptake of voluntary medical male circumcision, and not responding

appropriately to the key drivers of the epidemic, such as high risk populations. The overall monitoring and evaluation system is challenged by high staff turnover, inefficient use of available data, poor quality of data collected and absence of population based surveys and programme evaluations. Taking the above challenges into consideration, it is pertinent to continue with quality improvement activities for antiretroviral treatment, strengthen capacity of CSOs to support adherence to treatment, intensify efforts for elimination of MTCT by 2015, expedite implementation of the National Policy on Male Circumcision for HIV Prevention, continue with current prevention, treatment and care and support interventions for key populations, implement Government's sustainability plan for HIV response, and strengthen the overall monitoring and evaluation system.

In addition to targets set for HIV, MDG 6 strives to halt and begin to reverse malaria mortality by 2015. Namibia is on track to achieve this and has already achieved a reversal in the incidence of malaria. This Goal also aims to have universal coverage of children using insecticide-treated bed nets. According to current trends, Namibia falls short of achieving this target by 2015. In relation to other major diseases, available data show that Namibia is doing well and had already achieved, by 2010, the target of 85 percent of tuberculosis cases treated successfully and reducing the number of people who died from tuberculosis to less than five. However, Namibia is not doing well in achieving the target on notification of tuberculosis cases as this stood at 545 per 100 000 population instead of less than 300.

GOAL 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

The targets for MDG 7 are to: integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources; reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss; halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation; and by 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers. Progress to date includes three of these being met, two on target to be met and three not on target. Namibia has already achieved the targets to provide safe drinking water to urban (99 percent) and rural dwellers (90 percent), and to have 19.4 percent (against the targeted 15 percent for 2015) of land coverage in 2013 as communal conservancy areas. Namibia is on track to have 20 percent of land coverage as state protected and 5 percent as community forest areas. However, the target of halving the proportion of people without access to basic sanitation has not and will not be achieved by 2015. Related to this is a failure to meet targets for access to secure urban land tenure for poor people. Appropriate policies are in place but these need accelerated implementation. The constraints to environmental sustainability include slow implementation of the Water and Sanitation Policy (WASP) and a skills deficit to ensure access to basic sanitation, insecure access to land and tenure, slow and politicised efforts in conservation of fish resources, slow implementation of the Concessions Policy, environmental damage caused by mining, less than optimal use and management of groundwater, and slow promotion of good rangeland management and conservation farming. Recommendations for the period until 2015 include speedy implementation of WASP, addressing the skills deficit for sanitation provision, ensuring secure access to land and tenure, rebuilding the pilchard ocean stock, seizing the opportunity to exploit Namibia's diverse wildlife and scenic landscape for tourism, ensuring environmentally sensitive extraction of natural resources, sustainably managing the demand for and use of Namibia's underground water resources, and pursuing implementation of incentives for the promotion of sustainable rangeland management and conservation farming.

GOAL 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

The final Goal refers to a global partnership and has a range of targets and indicators, some of which apply to the developed nations and others that apply to nations in various states of development. Namibia has adopted four indicators of achievement for itself. One measures the net official development assistance (ODA) flows it receives, and the others measure the degree to which ICT has developed, in the form of internet access and use, cellular/mobile telephone subscriptions, and regular land line telephone use. Namibia has already achieved all the targets set for this Goal. Official development assistance increased from US$89 per capita in 1990 to US$131 per capita in 2011, surpassing the target of US$90 per capita. By 2013, 36 percent of Namibians had access to internet, against the 20 percent target of Goal 8. This could be attributed to increased cell phone subscribers and consequent internet access via cell phones. The proportion of cell phone subscribers increased from 31 percent in the early 2000s to 92 percent in 2010 and 115 percent in 2013. The proportion of land line subscribers increased steadily from 6.8 percent in 2005 to 8.1 percent in 2013 (surpassing the 7.5 percent target).

The government continues to engage vigorously in regional and international economic cooperation and groupings for mutual benefit and strives to effect structural transformation towards sustainable economic growth and development. It also recognises that regionally integrated markets are crucial for small economies like Namibia's to be able to grow and develop in the face of intensified economic globalisation. However, the following challenges prohibits optimal progress in global partnership development: non-availability of an adequately skilled labour force, accountability for improved public service delivery and elimination of corruption, labour inflexibility, ineffective public sector and civil society cooperation, and inadequate access to financing. Essential interventions for the remaining period before the end of 2015 are the identification of critical skills shortages for the economy to operate at a higher output level and consequently planning carefully for domestic skills development, strengthened institutional structures for public service performance and management accountability, making public key documents that would support the elimination of corruption and hold officials accountable for mismanagement of funds, government strengthening of the space for the private sector and CSOs to operate efficiently and in line with market forces, improved access to adequate financing, and provision of serviced land with tenure to ensure adequate collateral for the private sector to expand.

LOOKING BEYOND 2015

The 189 UN member states implementing the MDGs will meet at a Special Session at the UN General Assembly on 25 September 2013 to discuss two main issues: 1) how to accelerate progress towards achieving the MDGs; and 2) to agree on a new set of sustainable development goals (SDGs) for all nations and a timetable for implementation. The Rio+20 UN Conference of 2012 resolved to develop a set of SDGs for the timeframe beyond 2015. Many lessons can be learned from the MDGs that could influence the next set of SDGs, that is, the next set of SDGs needs to build on the successes and challenges of the current MDGs. Although UN member states have commenced discussions on a post 2015 agenda and have developed a draft international agenda, it is highly recommended that Namibia undertake an in-depth assessment closer to the end of 2015. The outcome of this assessment should be used to adapt the post 2015 SDG agenda for Namibia. The developmental focus should be more on women, children, youth, people with disabilities, marginalised people and the elderly. Based on the review of MDG achievements up to 2013, it is recommended that the following goals be considered for post-2015, in addition to the existing goals:

1 **Addressing inequality**
2 **Promoting good governance**
3 **Expediting the decentralisation process, including fiscal decentralisation**
4 **Promoting sustainable development and addressing climate change**
5 **Ensuring food security**

Achievement of these goals can be only be realised with the following enablers:

- Peace and security
- Good governance, transparency and efforts to fight corruption
- Strengthened institutional capacity
- Promotion of equality and access to justice and information
- Human rights for all
- Gender equality
- Domestic resource mobilisation
- Regional integration
- A credible participatory process with cultural sensitivity
- Enhanced statistical capacity to measure progress and ensure accountability
- Prudent macroeconomic policy that emphasises fair growth
- A democratic and developmental state
- An enabling global governance architecture.

MDGs 2013 Status at a Glance

GOALS AND INDICATORS	BASELINE	STATUS	TARGET (2015)	TARGET/ GOAL ACHIEVABLE?
MDG 1: ERADICATE EXTREME POVERTY AND HUNGER				
Halve the proportion of individuals classified as **poor** (consumption expenditure on food and non-food items of N$377.96 per adult equivalent per month)	69.3% (1993/94)	28.7% (2009/10)	34.7%	Achieved
Halve the proportion of individuals classified as **severely poor** (consumption expenditure on food and non-food items of N$277.96 per adult equivalent per month)	58.9% (1993/94)	15.3% (2009/10)	29.5%	Achieved
Gini coefficient	0.7 (2003/04)	0.5971 (2009/10)	0.5	Not on target
Halve the poverty gap ratio (%) - Poor	37.7% (1993/94)	8.8% (2009/10)	4.5%	Achieved
Halve the poverty gap ratio (%) - Severely Poor	28.1% (1993/94)	4.2% (2009/10)	4.5%	Achieved
Employment to population ratio	43.1 (1997)	47.9 (2009/10)	-	No target set
Growth rate of GDP per person employed (N$)				No target set
Proportion of own account and contributing family workers in total employment	7.7 (1997)	10.9		No target set
GDP growth (p.a.)	3.6 (1993)	5 (2012)	6.3	Not on target
Double the share of poorest decile in national consumption	1.07 (2003/04)	2.4 (2009/10)	5 (MDG+)	Not on target
Children under five stunted, in % of all children under five	28.4% (1992)	29% (2006/07)	14.2%	Not on target
MDG 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION				
Net enrolment ratio in primary education (%)	89% (1992)	99.6% (2012)	100%	Achieved
Proportion of pupils starting Grade 1 who reach last grade of primary (survival to Grade 8) (%)	59% (1992)	86% (2012)	100%	Not on target
Literacy rate of 15-24 years-olds, women and men (%)	76% (1991)	94% (2011)	100%	On target
MDG 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN				
Ratio of females to males in:				
• Primary education (girls per 100 boys)	102 (1992)	96.4 (2012)	100	On target
• Secondary education (girls per 100 boys)	124 (1992)	112.3 (2012)	100	Achieved
• Tertiary education (females per 100 males)	162 (1992)	85.25 (2011)	100	Not on target
• Ratio of literate females to males (15-24 years)	110 (1991)	103 (2011)	100	Achieved
• Pre-primary education (girls per 100 boys)	87.6 (2008)	101.2 (2012)	100	Achieved
Share of women in wage employment in the non-agricultural sector (%)	39 (1991) 49 (1997)	48 (LFS 2008) 35 (LFS 2012)	50	On target
Proportion of seats held by women in Parliament (%)	5.7 (1990-1995)	25.0 (2010-2013)	50	Not on target
MDG 4: REDUCE CHILD MORTALITY				
Infant mortality rate (deaths per 1000 live births)	56.6 (1992)	46 (2006/07)	19	Not on target
Under-5 mortality rate (deaths per 1000 live births)	83.2 (1992)	69 (2006/07)	28	Not on target
Proportion of 1-year-old children immunised against measles	75.7 (1992)	78 (2006/07)	85	On target

GOALS AND INDICATORS	BASELINE	STATUS	TARGET (2015)	TARGET/ GOAL ACHIEVABLE?
MDG 5: IMPROVE MATERNAL HEALTH				
Maternal health				
Maternal mortality ratio (deaths in 100 000 live births)	225 (1992)	449 (2006/07)	56	Not on target
Proportion of births attended by skilled health personnel (%)	68 (1992)	94.6 (2006/07)	95	Achieved
Universal access to reproductive health				
Contraceptive prevalence rate (%)	23 (1992)	46.6 (2006/07)	100	Not on target
Adolescent birth rate reduced by 100%	2 (1992)	15 (2006/07)	0	Not on target
Antenatal care coverage (at least one visit and at least four visits) (%)	56 (1992)	72 (2006/07)	100	Not on target
Unmet need for family planning (zero % unmet need)	24 (1992)	7(2006/07)	0	On target
MDG 6: COMBAT HIV AND AIDS, MALARIA AND OTHER DISEASES				
HIV and AIDS				
HIV prevalence among population aged 15-24 years (%)	8.2% (2006)	8.9% (2012)	5%	Not on target
Condom use at last high-risk sex for 15-49 years age group				
Women (%)	-	62.1% (2006/07)	85%	Lack of data
Men (%)	-	78.4% (2006)	90%	Lack of data
Alternative indicator Condom use with non-cohabiting partner (15-49 years)				
Women (%)	51% (2000)	62.1% (2006/07)	n/a	No target set
Men (%)	66% (2000)	78.4 (2006/07)	n/a	No target set
Proportion of population aged 15-24 years with comprehensive, correct knowledge of HIV and AIDS				
Women (%)	38.9% (2000)	64.9% (2006)	90%	On target
Men (%)	50.7% (2000)	61.9% (2006)	90%	Not on target
Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years	0.92(2000)[3]	1.02 (2006)	1.0	Achieved
Proportion of population (adults and children) with advanced HIV infection with access to ARV drugs (%)				
Adults (%)	56% (2006/07)	81.5% (2011)	100%	On target
Children (%)	88% (2006/07)	83.9% (2011)	95%	Not on target
MALARIA				
Malaria mortality per 100 000 population	31 (1996)	0.4 (2012)	Halt and begin to reverse	On target
Proportion of children under 5 sleeping under insecticide-treated bed nets	10% (2000)	34% (2009)	Universal coverage by 2010	Not on target
Incidence of Malaria in 1 000 population	207 (1996)	1.4 (2012)	Halt and begin to reverse	Achieved
TUBERCULOSIS				
TB cases notified per 100 000 population	657 (1997)	545 (2011)	<300	Not on target
% TB cases treated successfully	58 (1996)	85 (2010)	85	Achieved
Death rates (%) associated with TB	7 (2000)	4 (2010)	<5	Achieved

GOALS AND INDICATORS	BASELINE	STATUS	TARGET (2015)	TARGET/ GOAL ACHIEVABLE?
MDG 7: ENSURE ENVIRONMENTAL SUSTAINABILITY				
Areas protected to maintain biological diversity as percentage of all land				
State protected areas	12.5% (1995)	18.3% (2011)	20.0%	On track
Communal conservancies	0.0% (1995)	19.4% (2013)	15.0%	Achieved
Freehold land conservancies	5.0% (1990)	6.0 (2012)	10.0%	Not on target
Community forests	0.0% (2003)	4.0% (2012)	5.0%	On track
Proportion of households with access to safe drinking water (%)				
Urban	99% (2003)	99% (2010)	100%	Achieved
Rural	78% (2003)	90% (2010)	87%	Achieved
Proportion of households with access to basic sanitation (%)				
Urban	59% (2003)	57% (2010)	98%	Not on target
Rural	14% (2003)	17% (2010)	65%	Not on target
MDG 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT				
Official development assistance to Namibia (US$ per capita)	89 (1990)	131 (2011)	90[3]	Achieved
Internet users, percent of population	15% (2010)	36% (2013)	20%	Achieved
Cell phone subscribers, percent of population	31% (2006)	115% (2013)	61%	Achieved
Telephone lines, percent of households	6.8% (2006)	8.1% (2013)	8%	Achieved

INTRODUCTION

The Namibia 2013 Millennium Development Goals Report (MDGR) is the fourth progress report prepared since the Millennium Declaration was adopted by 189 member states of the United Nations (UN) at the Millennium Summit in New York in September 2000. The first report was prepared in 2004, followed by the second report in 2008 and the third in 2010. The 2013 MDGR will be the last report before 2015 when a final stocktake of progress towards the MDGs will take place.

Namibia played a key role in the formulation of the Millennium Declaration, with the then President of Namibia, Sam Nujoma, being the co-Chair of the Millennium Summit, while the current Speaker of the National Assembly was the President of the fifty-fourth session of the UN General Assembly. In the Declaration, world leaders committed themselves to "free all men, women, and children from the abject and dehumanizing conditions of extreme poverty". The Declaration outlines the key challenges faced by UN members, and a set of indicators and targets for addressing these challenges. Following its adoption, eight smart, measurable, achievable and realistic goals and targets – the Millennium Development Goals (MDGs) – were developed and these have been implemented by developing member countries with the support of the developed member countries.

The eight MDGs are:[1]

MDG 1: Eradicate extreme poverty and hunger
MDG 2: Achieve universal primary education
MDG 3: Promote gender equality and empower women
MDG 4: Reduce child mortality
MDG 5: Improve maternal health
MDG 6: Combat HIV and AIDS, malaria and other diseases
MDG 7: Ensure environmental sustainability
MDG 8: Develop a global partnership for development

"We will spare no effort to free our fellow men, women and children from the abject and dehumanizing conditions of extreme poverty, to which more than a billion of them are currently subjected. We are committed to making the right to development a reality for everyone and to freeing the entire human race from want." ***Millennium Declaration***

As the MDGs' target year of 2015 approaches, it is an opportune time to take stock of Namibia's progress. Namibia has, no doubt, made considerable progress towards many of the goals, already achieving some and being on target to achieve others but also not on target to achieve some. Significant challenges, however, remain in achieving the overall goal of development, especially as it relates to economic growth, distribution of wealth, employment, food security, governance, gender (especially gender-based violence), and the cross-cutting impacts of HIV and climate change on agricultural production, education, health and other social issues.

Namibia has adapted the MDG targets and indicators, based on local circumstances and reflecting national development objectives and aspirations. The national set of targets and indicators is rooted in the national milestones of Namibia's Vision 2030 and the National Development Plan (NDP) 4. This set of targets and indicators provided the framework for the development of the 2013 MDGR.

The methodology for preparing the report encompassed an extensive literature review and a qualitative and quantitative assessment of the achievement of goals and targets, arrived at by consulting key stakeholders in the different fields. Four regional (sub-national) workshops were facilitated involving stakeholders from all 14 regions, complemented by a national stakeholder validation workshop with the participation of representatives from government, civil society organisations (CSOs), development partners and the private sector.

An assessment of progress towards the targets was conducted using the characterisation 'achieved', 'on target', or 'not on target'. Judgments about which of these would apply were based mainly on the following factors: the observable trend; a change in trend for better or worse; the distance from the final target; and the existence or otherwise of policy and institutional frameworks to support the realisation of the goals.

[1] A full listing of the MDGs, associated targets and indicators for measuring progress towards the goals and targets are contained in Annex B.

Following this Introduction and a further introductory section covering the development context of Namibia, this report is organised into nine main sections, the first eight corresponding to the eight Goals and the last examining the post 2015 development agenda. Each of the main sections presenting progress on the MDGs provides an introduction to the relevant goal, followed by a review of trends in relation to progress made to date (to the extent that data are available), the key milestones that support progress towards the goal, challenges and opportunities to accelerate implementation during the remaining two years, and proposed priorities for post 2015. A table under the status and trends section provides quantitative indicators which highlight the progress towards achievement of targets from the 1990 baseline, the original reference year for each MDG indicator, and the current status. The ninth chapter discusses the evolving national post 2015 development agenda beyond and/or complementary to the MDGs.

This report still uses out of date data, especially on health indicators, from the 2006/07 Namibia Demographic and Health Survey (NDHS). The 2012/13 NDHS and 2013 Labour Force Survey are current being done, and should be ready for public use at the beginning of 2014. This version of the MDGR should, therefore, be regarded as an interim report to be updated with new data in early 2014.

THE DEVELOPMENT CONTEXT

Namibia is situated in the south-western part of Africa and is bordered by five countries: South Africa, Angola, Botswana, Zambia and Zimbabwe, as well as the Atlantic Ocean to the west. Namibia consists of 14 administrative and political regions. The regions with the largest population are Khomas Region, where the country's capital is situated, followed by one northern and one north-eastern region, Ohangwena and Kavango respectively. The region with the smallest population is Omaheke, situated on the eastern side bordering Botswana, followed by Hardap and Karas regions in the south. Namibia is vast, with a geographic size of 824 000km^2 and a population density of 2.6 people per km^2. It has a total population of 2.1 million. Two thirds of the population live in rural areas, 44 percent of households are headed by females, while 37 percent of the population are younger than 14 years of age. Namibia is generally an arid country with highly variable rainfall, resulting in many people depending on dryland cropping for subsistence. Namibia largely depends on her natural resources, which include gold, zinc, diamonds, uranium, copper, fisheries, wildlife and the 'wide open spaces' (tourism).

Vision 2030 is the inclusive guiding agenda for Namibia's development towards becoming an industrialised nation, developed by her human resources, enjoying peace, harmony and political stability. The five-year NDPs have guided socioeconomic progress that resulted in more people today having access to education, being wealthier, having better health and having access to diversified goods and services, in an environment that is generally politically peaceful. Since Independence in 1990, the provision of basic social services has improved in both urban and rural areas. Social services are more equitably distributed, despite the geographic vastness of the country. Income inequality in Namibia has decreased slightly, albeit still being regarded as one of the highest in the world. Namibia has developed good infrastructure, such as roads, water supply, electricity, telecommunications, and sea and air transportation, which support domestic trade and industrial development. The good infrastructure has also strengthened regional and global integration and trade. This progress towards development is a result of Namibia's commitment to sustainable economic growth, and reduced poverty and inequality.

Although Namibia has grown economically since Independence and has made great strides in the provision of basic social services while maintaining a generally stable economic and peaceful political environment, challenges in relation to key social indicators hamper the country's ability to achieve all goals set for Vision 2030. Namibia has been classified as an upper-middle income country, but ranked 120 out of 187 countries on the UNDP Human Development Index (HDI) in 2011. With this classification comes the responsibility and challenge to provide better for the needs of the people, especially the 'poor' and 'severely poor'. However, Namibia continues to be one of the most income skewed countries, with a Gini coefficient of 0.5971 in 2009/10. Although unemployment had decreased to 27.7 percent by 2012, unemployment among the youth (20 to 24 year olds) is still above 50 percent (MLSW, 2013:13). Namibia has increased access to education but the country falls short in terms of quality of education and responsiveness to the needs of the labour market. The lack of a skilled and adequately trained workforce has reduced potential investment opportunities, resulting in limited manufacturing in the country. Limited manufacturing may decrease the potential for employment and, thereby, increase poverty. Although overall poverty levels have decreased, some regions, such as Kavango and Caprivi, still report more than half of the population being poor and poverty is still increasing in some regions. The prevalence and incidence HIV have decreased at national level, although high, and in some cases rising, prevalence continues to be reported in some regions. A high incidence of gender-based violence, especially domestic violence and rape, disproportionately affects Namibian women and girls and has serious implications for the health and wellbeing of families and communities.

The National Development Plan 4 noted the following reasons for slow progress towards achieving planned development: "lack of proper execution, a lack of accountability, and spreading our efforts and resources too thinly" (NPC, 2013:x). With the implementation of NDP 4, Namibia endeavours to respond to these challenges with high and sustained economic growth, employment creation and increased income equality.

MDG 1: Eradicate Extreme Poverty and Hunger

Over the past 23 years, Namibia has experienced considerable reduction in poverty due to improved poverty reduction policies, strategies and plans, and the implementation thereof. Although great strides have been made in Namibia to reduce poverty, inequality in wealth distribution is being reduced only slowly and unemployment rates, especially among the youth, remain notably high. Hunger continues to be a serious challenge, especially in the wake of current droughts in many parts of the country which have resulted in increased malnutrition and reports of children and adults dying from hunger in two of the regions.

The three targets for MDG 1 are to halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day, and the proportion of people who suffer from hunger, and to achieve full and productive employment and decent work for all, including women and young people.

The MDG 1 indicators have changed over time. This Goal originally only included two indicators, but currently includes 11 indicators to meet the need for a better understanding of progress made towards the overall goal of eradication of extreme poverty and hunger. The millennium development target of eradicating poverty and hunger by 2015 is only two years away. Namibia has already achieved three of the main indicator targets for MDG 1 and one is on target to be achieved, but the remaining four are not on target to be achieved by 2015.

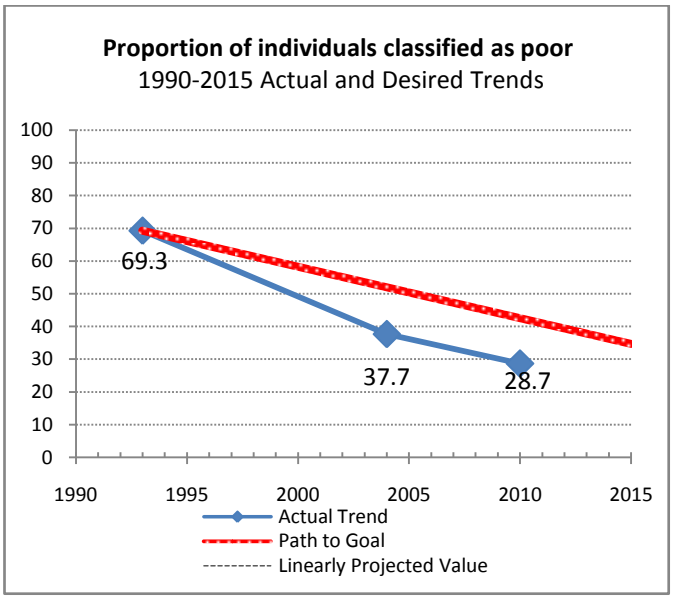
Status at a Glance

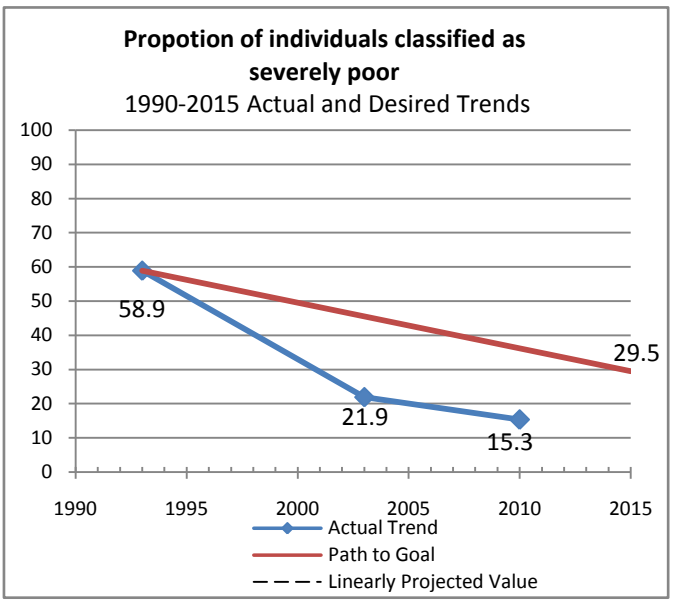
GOALS AND INDICATORS	BASELINE	STATUS	TARGET (2015)	TARGET/ GOAL ACHIEVABLE?
MDG 1: ERADICATE EXTREME POVERTY AND HUNGER				
Halve the proportion of individuals classified as **poor** (consumption expenditure on food and non-food items of N$377.96 per adult equivalent per month)	69.3% (1993/94)[1]	28.7% (2009/10)[1]	34.7%	Achieved
Halve the proportion of individuals classified as **severely poor** (consumption expenditure on food and non-food items of N$277.96 per adult equivalent per month)	58.9% (1993/94)[1]	15.3% (2009/10)[1]	29.5%	Achieved
Gini coefficient	0.7 (2003/04)[3]	0.5971 (2009/10)[2]	0.5	Not on target
Halve the poverty gap ratio (%) - Poor	37.7% (1993/94)[1]	8.8% (2009/10)[1]	4.5%	Achieved
Halve the Poverty gap ratio (%) - Severely Poor	28.1% (1993/94)[1]	4.2% (2009/10)[1]	4.5%	Achieved
Employment to population ratio	43.1 (1997)[8]	47.9 (2009/10)[2]	-	No target set
Growth rate of GDP per person employed (N$)				No target set
Proportion of own account and contributing family workers in total employment	7.7 (1997)[8]	10.9[5]		No target set
GDP growth (p.a.)	3.6 (1993)[8]	5 (2012)[8]	6.3	Not on target
Double the share of poorest decile in national consumption	1.07 (2003/04)[3]	2.4 (2009/10)[2]	5 (MDG+)	Not on target
Children under five stunted, in % of all children under five	28.4% (1992)[7]	29% (2006/07)[7]	14.2%	Not on target

[1] NSA, 2012b (2012 Poverty Dynamics Study)
[2] NSA, 2012c (2009/10 HIES)
[3] NPC, 2006 (2003/04 HIES)
[4] NPC, 1996 (Living Conditions Study)
[5] NSA, 2012d (2012 LFS)
[6] MOHSS, 2003 (2000 NDHS)
[7] MOHSS, 2008 (2006/07 NDHS)
[8] NPC, 2010b (2010 MDG Report)

Current Status and Trends

The proportion of poor individuals (consumption expenditure lower than N$377.96 per adult equivalent per month) who live under the poverty line[2] made up more than two-thirds (69.3 percent) of Namibia's population in 1993/94. This proportion of poor individuals dropped by 32 percentage points from 1993/94 to 2003/04, and 41 percentage points from 2003/04 to 2009/10. This is a commendable reduction in poverty and means that less than one third (28.7 percent) of the population currently lives below the poverty line. Fifteen percent of the population are categorised as 'severely poor',[3] because their consumption expenditure is lower than N$277.96 per adult equivalent per month. The proportion of severely poor households also decreased dramatically from 58.9 percent in 1993/04 to 15.3 percent in 2009/10. Thus Namibia had already surpassed the 2015 MDG of halving the number of severely poor individuals by 2002/03 (11 years in advance of the target date). The NDP 4 goal of reducing the proportion of severely poor individuals to below 10 percent by 2017 is likely to be achieved if the current trend of decline continues unchanged.





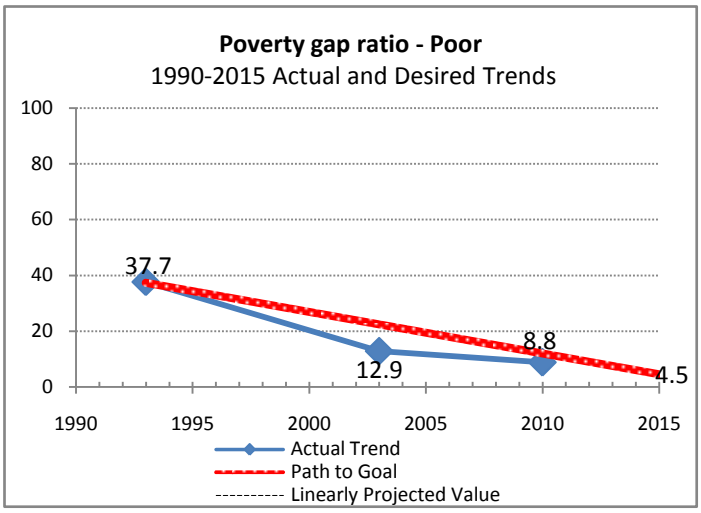
Alongside this success, it is equally important to look at other poverty determinants, such as the poverty gap and the severity of poverty[4] to understand better the nature of poverty in Namibia. The poverty gap for poor individuals has decreased from 37.7 percent in 1993/04 to 12.9 percent in 2003/04, and finally dropped to 8.8 percent by 2009/10. According to the Namibia Statistics Agency (NSA) (2012b), on average, poor individuals need an additional N$33.3 per month (2009/10) to their monthly income to move above the poverty line, while severely poor individuals need an additional N$11.7 to move out of severe poverty. This information is crucial to strategic planning and implementation. The poverty gap ratio target for poor individuals is likely to be achieved, while the target for severely poor households had already been achieved by 2009/10.

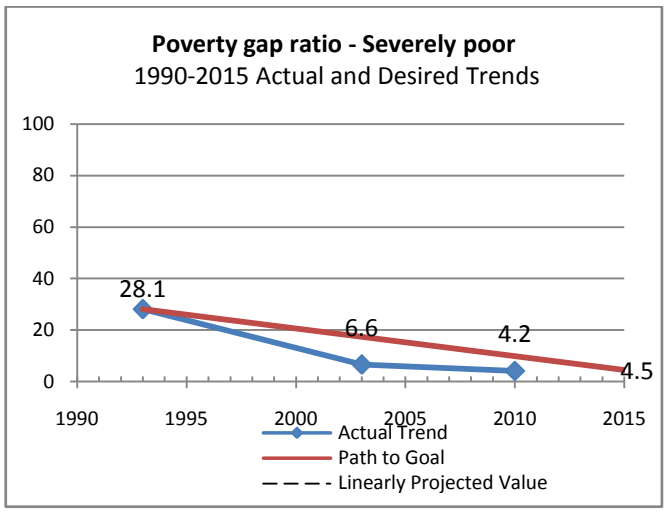
The poverty gap between the richest and poorest regions decreased between 1993/94 and 2009/10, from 54.8 percent to 48 percent (NSA, 2012b). However, it should be noted that half of the regions have poverty incidences that are above the national rate of 28.7 percent and more than half of the population falls below the poverty line in two regions. Although declines in poverty have been experienced, poverty remains high, given that Namibia is an upper-middle income country.

[2] "Poverty lines are cut-off points separating the poor from the non-poor, i.e., the predetermined level of consumption below which a person is considered 'poor'. Therefore, the incidence of poverty is measured as the proportion of the population whose consumption expenditure falls below this predetermined level" (NSA, 2012b:9).

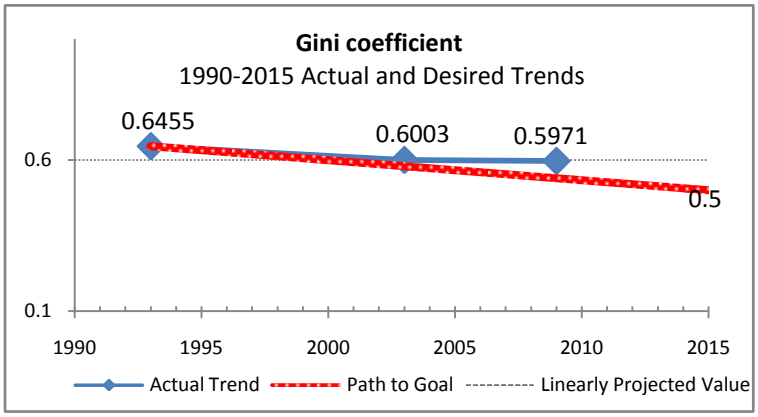
[3] "It is worth noting that the group of the severely poor is a sub-set of the poor" (NSA, 2012b:9), but still 15 percent of total population.

[4] NSA (2012b: 10) notes that the poverty gap "provides information on how far individuals are from the poverty line. Poverty severity looks at both the depth of poverty (how far off the poor are from the poverty line) and inequality within the poor (how deep or severe the poverty is), placing a higher weight on those further away from the poverty line, i.e. the poorest of the poor. Poverty gap and severity are important complements to poverty incidence and require different policy interventions."





The poor in Namibia are mostly found in rural areas, are concentrated in households with lower education levels, are often living in female-headed households with larger household sizes, and are mostly older pensioners and subsistence farmers. Variations in poverty across the thirteen administrative and political regions of Namibia have shifted slightly over the years. The regions with the highest poverty levels in 2009/10 were Kavango (55.2 percent), followed by Caprivi (50 percent) and Oshikoto (44 percent). The regions with the lowest poverty in 2009/10 were Erongo (7.1 percent) followed by Khomas (10.7 percent) and Omusati (19.1 percent). Omusati had the highest percentage poverty reduction over a 17 year period, reducing poverty by 61.2 percentage points. The poorest region in 1993/94 was Caprivi (81.6 percent), while the region with the lowest proportion of poverty was Khomas (26.8 percent). The poverty level in Caprivi is actually increasing slightly, although the national average shows a decrease.



Although Namibia has made considerable strides in poverty reduction, unequal distribution of wealth remains a major concern. Despite positive growth in overall gross domestic product (GDP) from the early nineties to 2011, there has been only minimal reduction in the Gini coefficient,[5] which decreased from 0.6455 in 1993/94 to 0.6003 in 2003/04 and 0.5971 in 2009/10 (NSA, 2012b). The likelihood of the Gini coefficient target of 0.5 being reached by 2015 is low and even the NDP 4 goal to reduce the coefficient to 4.8 by 2017 seems unlikely to be achieved. In addition, it is unlikely that the share of the poorest decile in national consumption will be increased to 5 percent by 2015 as the poorest 10 percent of the population in 2009/10 accounted for just 2.4 percent of total annual consumption, although this was an increase from 1.7 percent in 2003/04. In 2009/10 it was found that the per capita annual consumption for the richest 10 percent was N$96 262, while the poorest 10 percent consumed N$2 060. Inequality is highest in the Karas region (0.634) and lowest in the Ohangwena region (0.405). Inequality between 2003/04 and 2009/10 decreased most in Hardap, Omaheke, Erongo and Kavango regions, while it increased in Caprivi, Ohangwena, Khomas and Omusati regions. Inequality is higher in urban areas than in rural areas.

Unemployment was flagged as a serious challenge in previous MDG Reports for Namibia and it remains unacceptably high. Unemployment[6] increased from 33.8 percent in 2000 to 36 percent in 2004 and reached a high of 51.2 percent in 2008, after which it fell considerably to 27.4 percent[7] in 2012 (NSA, 2012d). Little variation

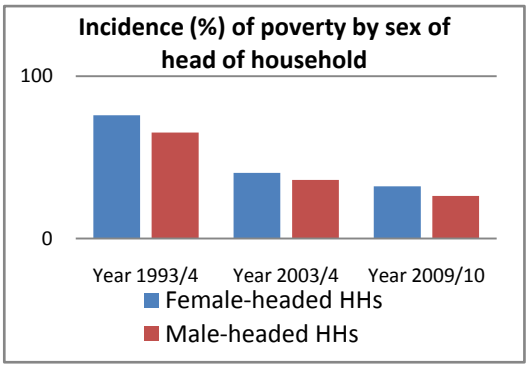
[5] Gini coefficient compares the actual distribution of income to a total equal distribution of income. The coefficient ranges from 0 to 1. An equal distribution of income gives a coefficient close to 0. The more unequal the distribution is the closer the coefficient is to 1. (NPC, 2006:24)

[6] Using the broad definition in which a person is unemployed if they are of employable age (15 years or over) and do not have a job, whether they are actively looking for employment or not.

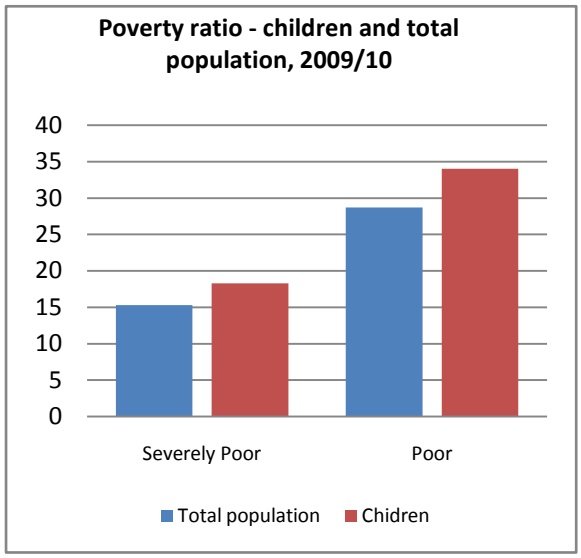
[7] It should be noted that the 2012 Namibia Labour Force Survey, on which the most recent unemployment statistic is based, employed a different methodology, asking totally different questions, from the 2008 Namibia Labour Force Survey. The increase to 51.2 percent in 2008 and the decrease reported in 2012 should, therefore, be regarded with caution.

was experienced for employment rates for urban and rural areas, whereas the employment rates for males and females in urban areas were 66.4 percent and 76.7 percent respectively, which is slightly higher than the gap in rural areas. Unemployment among the youth was above 50 percent in 2012.

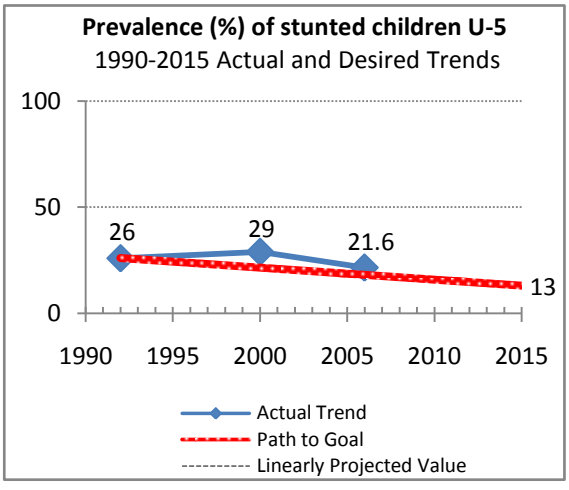
It is essential for poverty reduction policies, plans and programmes to have an in-depth understanding of age and gender in relation to poverty. The graph on the right shows higher proportions of female-headed households lived in poverty than male-headed households from the early nineties to 2010. Poverty is highest among the older population groups and lowest among the 21 to 29 years age cohort. Interestingly, poverty among the older age groups has declined by 11 percentage points for those between 50 and 54 years of age and by 17 percentage points for those 60+ years of age (NSA, 2012b: 30). This may be partly attributable to social grants.



Children are especially vulnerable to poverty when they experience social, economic and environmental circumstances and shocks, such as the death of one or both parents, divorce, labour migration and adverse weather events. Households with orphans (21.1 percent) or children (17.7 percent) were more often affected by severe poverty than those without children (2.9 percent) or without orphans (11.7 percent) (NPC, 2012a). Poorer households also tend to have more children than non-poor households. The NSA (2012a:5) notes that, "children are worse off in terms of what they use or consume than adult Namibians". Child poverty in Namibia has decreased from the early 2000s to 2010, from 43.5 percent in 2003/04 to 34.4 percent in 2009/10, but has stayed consistently above the general poverty line. Using the upper poverty line, similarly to national poverty trends, the Child Poverty Report finds the highest child poverty levels in Kavango (59.5 percent) followed by Caprivi (53.2 percent) and Oshikoto (48.7 percent). The lowest child poverty levels are found in Erongo (9.8 percent), followed by Khomas (14.4 percent) and Omusati (22.1 percent) (NSA, 2012a:7).



Neither has the nutritional status of children under the age of five improved over the years. "UNICEF spokesperson in Geneva, Patrick McCormick says more than 778 000 people affected by the drought including 109 000 children under five are at risk of malnutrition after almost three decades of low seasonal rainfall and a second year of failed rains in several regions of Namibia." (Kazondovi, 2013:3) "The general pattern indicates that regions with high levels of poverty, low literacy rates, high HIV prevalence, and with predominantly rural populations, have the highest levels of stunting…" (NAFIN, 2012:22). The proportion of stunted children under five years of age actually had increased slightly from 28.4 percent in 1992 to 29 percent in 2000, but decreased in the year 2006/07 (21.6 percent), meaning that Namibia is not on target to reduce stunting to 13 percent for under-five children. Close to one in five children under the age of five are underweight, and close to one in ten are wasted. It was also found that stunting is higher among male children (32 percent) than female children (26 percent), while children in rural areas were more likely (31 percent) to be stunted than children in urban centres (24 percent). Stunting was also more prevalent in poorer regions, such as Kavango (39 percent) than richer regions, such as Erongo (21.5 percent) and Khomas (22.6 percent). Children are less likely to be stunted when mothers are better educated and wealthier. Climate change in the form of droughts and floods has affected children severely, causing increased malnutrition. The Namibia Alliance for Improved Nutrition (NAFIN) reported that 6 000 child deaths per year can be attributed directly to malnutrition (NAFIN, 2010:6).



Milestones

Namibia inherited, from the apartheid regime of the Republic of South Africa, an economy with low economic growth, high rates of poverty, highly unequal distribution of wealth and income and high unemployment, among other challenges. The Government of the Republic of Namibia, immediately after Independence from the Republic of South Africa, put in place a set of plans for the social, economic, political and environmental development of the country. A Transitional Development Plan in 1990 was succeeded by the first short-term NDP of 1995. In 1998 Cabinet approved a Poverty Reduction Strategy that focused on three areas central to poverty reduction: 1) fostering more equitable and efficient delivery of public services, within the context of decentralisation; 2) accelerating equitable agricultural expansion, including an emphasis on food security; and 3) expanding options for non-agricultural employment, emphasising the informal and self-employment sectors which were seen as capable of employing larger numbers of the poor than formal sectors.

The country is currently implementing the fourth NDP. The five-year development plans are guided by the long-term vision of Namibia, Vision 2030, which strives for a prosperous and industrialised Namibia, developed by her human resources, enjoying peace, harmony and political stability. The NDP 4 seeks high and sustained economic growth, job creation and reduction of income inequality. This Development Plan is different from its predecessors in that it is a higher-level plan, focused on top priorities, and nurtures greater ownership by all stakeholders in development. Namibia has also been implementing a Poverty Reduction Strategy and Poverty Reduction Action Programme for the past ten years. The policy directions of NDP 3 and 4 were drawn from different documents and manifestos including the MDGs. For example, NDP 3 “presented targets for other socio-economic indicators as well as a qualitative assessment of the progress towards achieving MDGs by 2015” (NPC, 2008b:4).

Namibia has created an enabling environment and effective policy framework for the implementation of poverty reduction strategies and programmes. Acknowledging that health and education are key determinants of poverty alleviation, Namibia allocated substantial proportions of its annual budget to the Ministry of Education (MOE) and Ministry of Health and Social Services (MOHSS) with the aim of creating a healthy and well-educated population. Nationally, Namibia has created the economic and political stability that attracts domestic and foreign direct investment, thereby generating employment creation and economic growth. Namibia continues to invest substantially in development of infrastructure – telecommunications, electricity, water, roads and air transport – to ensure an enabling environment for private business sector growth. Employment creation is a key initiative, especially with the commencement of the Targeted Intervention Programme for Employment and Economic Growth (TIPEEG). The TIPEEG aims to promote employment creation via public works programmes and by addressing supply-side constraints. The fourth NDP advocates continued support to the TIPEEG’s strategic high-growth sectors.

Poverty alleviation is a cross-cutting issue that is mainstreamed across sectors. Developmental approaches spearheaded by different ministries, offices, agencies, development partners and civil society groups are geared towards alleviating poverty, among their other development goals. For example, the Ministry of Finance (MOF), in the 2013/14 budget, introduced progressive tax cuts that will put more money in the pockets of the poor, which can then be recirculated throughout the Namibian economy.

The provision of social grants is essential, especially for homes headed by pensioners and for orphaned and vulnerable children (OVC). Namibia is one of a limited number of African countries that provides social protection via non-contributory social grants. These include old age grants for people above 60 years of age, a maintenance grant for OVC, a foster care grant and a disability grant. Government’s contributory grants include social security and a war veterans’ grant. Social grants have had a positive impact on poverty and vulnerability according to a study based on the 2009/10 Namibia Household Income and Expenditure Survey (NHIES). The social grant aims to support the most vulnerable cohort of the population. “A previous analysis of the impacts of social grants (NHIES 2003/04) showed that these social grants already have had some effect on reducing poverty.” (NSA, 2012a:16) Money from social grants is usually spent on food and school fees. Abolishing family contributions towards the School Development Fund and making primary education free of charge frees up some money that can be reallocated to other basic needs.

After Independence, Namibia established a national Food Security and Nutrition Project (FSNP) with the goal of ensuring that all people in Namibia, at all times, have physical, economic, and social access to sufficient, safe and

nutritious food to meet their dietary needs and food preferences for an active and healthy life (NAFIN, 2012:11). The FSNP had four pillars: 1) food availability; 2) food access; 3) food utilisation and nutritional requirements; and 4) stability in equitable food provision. The Project ran from 1991 until 2006. In 2009, Namibia established the high level NAFIN headed by the then Prime Minister. Whereas FSNP included the public sector only, NAFIN brought together different stakeholders. Namibia joined the Scaling Up Nutrition movement in 2011 and the Prime Minister was chosen as a member of the Lead Group, comprising heads of state and other high ranking officials, to spearhead nutritional response policies and strategies.

The redistribution of land to the landless is an important initiative towards the alleviation of poverty. However, the beneficiaries of most resettlement farms and many affirmative action farms face a number of constraints to productive use of the land. Therefore, land distribution and reform interventions are currently focused on those farmers who have the capacity to use the farms productively and livelihood support programmes have been implemented to assist them to become self-sufficient farmers.

Programmes, projects and interventions that have played a key role over the years include the Green Scheme, food/cash-for-work programmes, micro-grants, the Equipment Aid Fund, small and medium sized enterprise development, community-based management of natural resources, rural water supply and sanitation programmes, mining, the German Special Initiative, the Rural Poverty Reduction Programme, the San Development Programme, the Constituency Development Fund, the Decentralised Build Together Programme (DBTP) and TIPEEG.

Challenges and interventions to expedite MDG implementation in the remaining two years

The causes and effects of poverty are extensive, complex and multifaceted. The challenges faced by Namibia in responding to poverty lie mainly in the implementation of existing policies, plans and strategies as Namibia has created an enabling policy environment for poverty alleviation. The test now is to make programmes work on the ground and in areas where the needs are urgent and concentrated. Serious attention, therefore, needs to be paid to those regions with the highest poverty and inequality levels, rural areas, female-headed households, children, the disabled and pockets within well-off regions such as informal settlements in urban settings. This section highlights key challenges and recommends interventions that would realistically support acceleration of MDG 1 implementation for the remaining period until the end of 2015. The recommendations would need consideration within the frameworks of NDP 4 and respective sectoral plans, and in conjunction with recommendations made for the remaining seven MDGs.

Challenges	Interventions to expedite MDG implementation
Unemployment and unemployability	• As well as reducing pressure on urban areas to provide employment, increased agricultural production and rural cash-for-work opportunities would both create employment and improve infrastructure for economic and social development • Provide more support to SMEs, especially start-up capital and technical support, accompanied by monitoring and evaluation • Due to the lack of skills in Namibia, import foreign skills with the aim of building the capacity of local people • Strengthen the implementation of labour laws, ensuring that the rights of employees and employers are respected • Implement the TIPEEG more effectively and efficiently to increase the number of employment opportunities • The private sector needs to invest more actively in education and higher learning, so that graduates are better prepared and can be matched to labour market needs • Strengthen the education system in order to provide for the needs of the labour market

Limited skilled and qualified human resources, limited financial capacity, and limited research and development reduce Namibia's ability to be proactive in terms of: implementation of policies, plans and strategies; risk management; community mobilisation; infrastructural development; financial mobilisation; etc.	• More research needs to be undertaken to understand better the continued causes and effects of poverty in order to inform policy, strategies and implementation • Monitoring and evaluation of poverty alleviation programmes need to be strengthened • Develop a regional development database, highlighting best practices and challenges • Strengthen infrastructural development, especially in the poorest regions • Expand decentralisation into devolution of power and resources to regional level • Strengthen constituency development by earmarking a special constituency development fund • Strengthen access to finances for poor and very poor people via development financing institutions such as the DBN • Continue to promote bottom-up development approaches
Food insecurity and malnutrition at household level have a negative effect on overall development, most specifically for children.	• Raise awareness of household food security programmes • Food aid in the form of drought relief food or food-for-work should be directed to the most vulnerable first • Scale up the school feeding programme to provide for all children and not only OVC • Raise budget allocations for food production programmes, such as the Green Scheme and Dry Land Agricultural Programme • Continue to raise awareness of the most appropriate breastfeeding practices and improved nutrition for children and their mothers • Raise awareness about the importance of consuming fortified foods • De-worm all children between 1 and 5 years of age
Namibia has a long-standing and well-established social grant system but the distribution of the number of grants and amounts paid per person are still relatively low. The coverage of social grants is affected by inefficient budgets, but also the inability of eligible persons to gain access to such grants. Additionally, poverty stricken children who are not classified as orphans and many extremely poor households are not covered by current social grants.	• Speed up the registration and issuing of vital documents to enhance access to social grants • "More social workers are needed and they need to be freed up from administrative work in order to focus on child protection issues" (NDP 4:63) • Expand the social grant system to include children in poor and severely poor households • Social grants should be increased annually as inflation increases and the increments need to be higher than inflation because the individual payments are small in number • Reconsider the commencement of the Basic Income Grant (BIG)
Ongoing corruption and mismanagement of public funds are serious challenges, given that theft of public funds takes away resources geared towards development of the nation, especially the poor.	• Implement the Zero Tolerance for Corruption strategy more effectively

Strategies need to be designed in such a fashion that beneficiaries of poverty reduction programmes are active participants in their own development. Programmes and projects need to be designed in such a fashion that they do not increase dependency on government and other external support, but enhance self-sufficiency.

Looking Beyond 2015

The recommendations below are geared toward decreasing overall inequality in Namibia.

Employment creation	Namibia needs to be more competitive globally and, at the same time, place special focus on population sectors facing particular challenges with work. Therefore: • Government and private sector organisations need to collaborate to increase long-term employment opportunities with adequate and flexible remuneration and working conditions • Unions need to play an active role in such developmental endeavours, ensuring a conducive environment for domestic and foreign direct investment • Special attention needs to be given to youth employment creation • There is a particular need for rural employment creation programmes
Improved education to provide for the labour market	Namibia has made great strides in increasing the number of schools, classrooms, tables, chairs, textbooks, teachers and other logistical support. Areas of focus now need to be ensuring that (particularly higher) education meets the needs of the labour market, and that education is available to all population groups. Therefore: • Continue to improve education by strengthening learning opportunities at school through the provision of learning support materials, continued teacher development in new and innovative teaching methods, and introduction of new technologies for learning, such as smart boards • Attention needs to be paid to the provision of quality education in order to satisfy the labour market with a qualified labour force, including through effective implementation of the Public Service Human Resources Policy and Plan, and building and stocking more vocational training centres • Special attention needs to be paid to vulnerable groups, such as San and OvaHimba, to ensure their inclusion in social and economic development • Namibia should focus on making secondary education free, as primary education already is, and providing more affordable tertiary education • Essential to improved quality education is monitoring and evaluation by principals, inspectors and quality control officers from central offices • Teacher and learner absenteeism could be curbed by enhanced monitoring and engaged school management
Eradicate child poverty and achieve universal access to basic services for all children	• Improve access to social grants for all children living in poor and severely poor households • Improve access to health, water and sanitation • Improve quality of education • Provide more employment opportunities for adults
More effectively respond to climate change	Climate change has severe impacts on macroeconomies, income and livelihoods, food security, gender, HIV, governance and social protection, Therefore: • Gather and monitor data on climate change and impacts of such variability on agriculture, the environment, social systems, fisheries and tourism • Government, development partners and CSOs need to make people aware of climate change and its potential impacts while allocating sufficient resources to those who are affected • Collaborative approaches are needed to design adaptation strategies across the different affected sectors • On the ground, extension services across different sectors such as agriculture, water, health, etc. need to work together to plan and implement response strategies to mitigate climate change impacts • Special attention needs to be paid to gender and climate change

Better access to land for private sector investment and low cost residential housing	• Identify the disincentives to the private sector expanding business opportunities to rural areas, in order to find solutions collaboratively and expand employment opportunities in rural areas • Local authorities need to ensure availability of serviced land for private sector development and possible innovative incentives to attract private investors • Encourage PPP to increase work opportunities and, consequently, economic growth • Strengthen low cost housing initiatives • Better control residential housing prices
Improve access to productive land	The redistribution of productive land needs to be reformed and expedited. Therefore: • Appropriate, cost effective and efficient capacity building programmes are needed, as well as resource support, and support structures that will allow new land owners to use their land productively and contribute to GDP • Find the most appropriate avenue to redistribute land to the landless for purposes of productive land use, subsistence and increased income.
Focused poverty alleviation strategies for children, women, youth and the uneducated, and the rural community	A study by NSA on social grants indicates that the costs of expanding the child grant system are "substantial but not astronomical, and that such policy changes could substantially reduce child poverty" (NSA, 2012a:25). Therefore: • In addition to employment creation for adults and decreased malnutrition among children and adults, it is important to continue with social grants and child protection and development programmes as an overall poverty alleviation strategy • Opportunities to expand the child grants need to be assessed • Innovative strategies are needed to focus on pockets of poverty, such as children, women, youth, those without education and the rural community, especially in the poorest regions
Expedite decentralisation	Namibia needs a functional, decentralised government with sufficient decision-making power and resources to implement programmes based on region specific needs. Therefore: • More equitable distribution of resources is needed across different regions, based on socioeconomic and environmental factors • Decentralisation should allow regions to have control over productive resources within their regions
Strengthen mainstreaming of HIV responses	Namibia is on target in terms of reducing HIV prevalence but some targets are yet to be achieved. It is essential for Namibia to mainstream HIV and AIDS across the different sectors and focus on key strategies around prevention, treatment, care and support and overall management and coordination of the epidemic.
Respond proactively to climate change	Climate change is an enduring, cross-cutting challenge with particular livelihood impacts. Therefore: • Continue to mainstream climate change in policies, plans and strategies across all sectors • Development partners, especially from the west, need to be mobilised to play a more active role in mainstreaming climate change and support efforts to reverse its negative impacts

MDG 2: Achieve Universal Primary Education

The provision of quality education with a consequently better equipped population is a fundamental contributor to the attainment of all the other MDGs. Namibia has made considerable progress towards achieving universal primary education (UPE), but continues to battle with high repetition and drop-out rates and low attendance and survival rates in primary education. Namibia regards education as one of the cornerstones of achieving Vision 2030 and strives to improve the provision of quality education by addressing key issues such as infrastructure, textbooks, teacher training, learner support, curriculum development, special initiatives for children from poor and very poor households, equity for girl and boy learners, and increased access in remote rural areas.

The target for MDG 2 is to ensure that, by 2015, children everywhere, boys and girls alike, are able to complete a full course of primary schooling. The first target towards MDG 2 had been reached by 2011, with practically all children enrolled in primary school, and the country is on target to achieve 100 percent literacy among the youth. However, the low survival of students into secondary education, teenage pregnancy and high levels of violence in schools and hostels remain challenges to be tackled if this target is to be met.

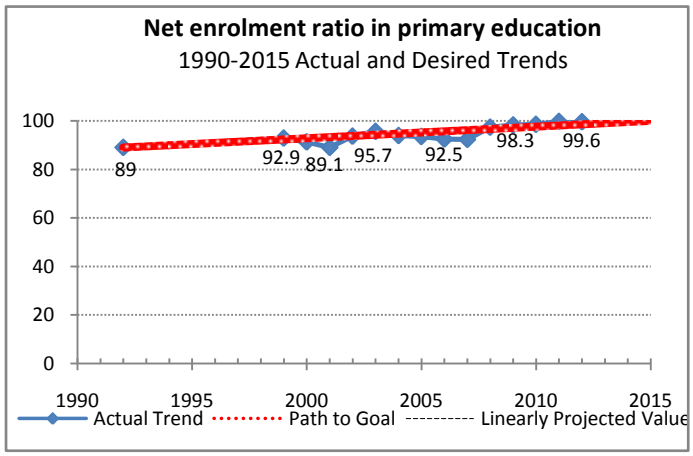
MDG 2: Status at a Glance

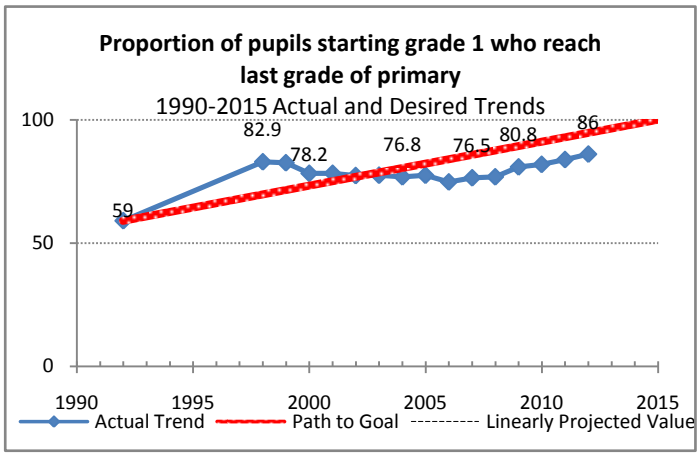
TARGETS AND INDICATORS	BASELINE	STATUS	TARGET (2015)	TARGET/ GOAL ACHIEVABLE?
MDG 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION				
Net enrolment ratio in primary education (%)	89% (1992)[1]	99.6% (2012)[2]	100%	Achieved
Proportion of pupils starting Grade 1 who reach last grade of primary (survival to Grade 8) (%)	59% (1992)[1]	86% (2012)[2]	100%	Not on target
Literacy rate of 15-24 years-olds, women and men (%)	76% (1991)[1]	94% (2011)[3]	100%	On target

[1] NPC, 2010b (Namibia 2010 MDG Report)
[2] MOE, 2013, MOE, 2012 (EMIS Reports)
[3] NSA, 2013 (2011 Census)

Current Status and Trends

Namibia experienced a general steady increase in primary school enrolment from the early nineties to 2012. The net enrolment rate in 1992 was 89 percent, which increased over 20 years to a high of 99.6 percent in 2012 (MOE, 2013).[8] The second target is to achieve 100 percent of pupils who start Grade 1 reaching the last grade in primary and progressing to Grade 8. The survival rate of Grade 7s (to Grade 8) has also increased from 59 percent in 1992 to 86 percent in 2012, but unfortunately is not on track to achieve the 2015 MDG target of 100 percent (MOE, 2013).

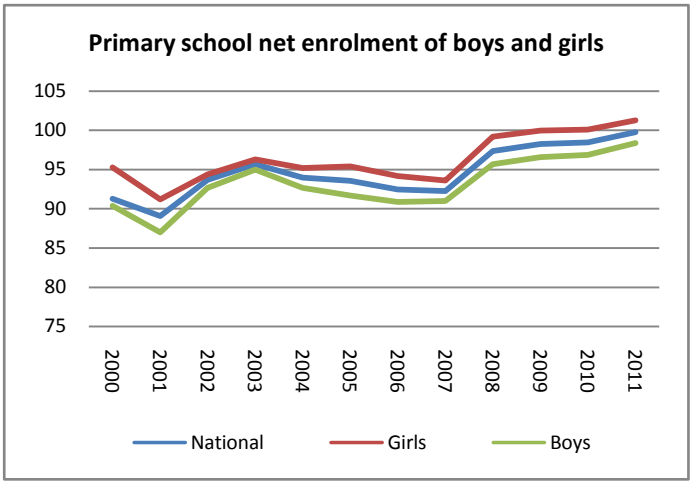




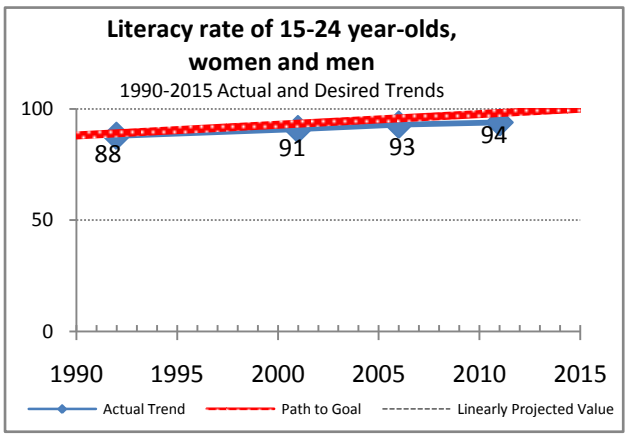
[8] It should be noted that the 2011 Population and Household Census (NSA, 2013) found an enrolment rate of 86 percent for children between 6 and 13 years of age. The discrepancy between the Census and 2011 EMIS data is currently being assessed. It seems that the 2011 Census corrected the denominator to calculate the Net Enrolment Rate.

Although good progress has been made in terms of enrolment and survival rates in primary schools, Ninnes (2011:10) states that the increasing gross enrolment rate suggests that the "primary school system is becoming less efficient in terms of enrolling maximum numbers of children in age-appropriate grades, suggesting higher levels of repetition, and hence lower quality of teaching and learning". The challenge is that repetition and school drop-out rates in Namibia have increased steadily, while promotion rates stagnated, with girls achieving lower repetition and higher promotion rates than boys. High repetition rates can be seen as a combined result of the quality of education, and the ability of learners to learn taking into consideration their physical and mental development and socioeconomic circumstances.

The net enrolment of girls in primary school continued to be higher than that of boys with 101.3 percent of girls and 98.4 percent of boys enrolling in 2012 (MOE, 2013:55). In general, girls have higher survival rates than boys as well. Regional disparities are evident and related to the relative wealth of the regions. The 2006/07 NDHS found that residents of Kavango, Kunene, Omaheke and Otjozondjupa are the least likely to have gone to school, while residents of Khomas, Erongo, Karas and Caprivi are the most likely (MOHSS, 2008). Caprivi is not necessarily a wealthy region in comparison to Khomas, Erongo and Karas, but historically has had a good education system.



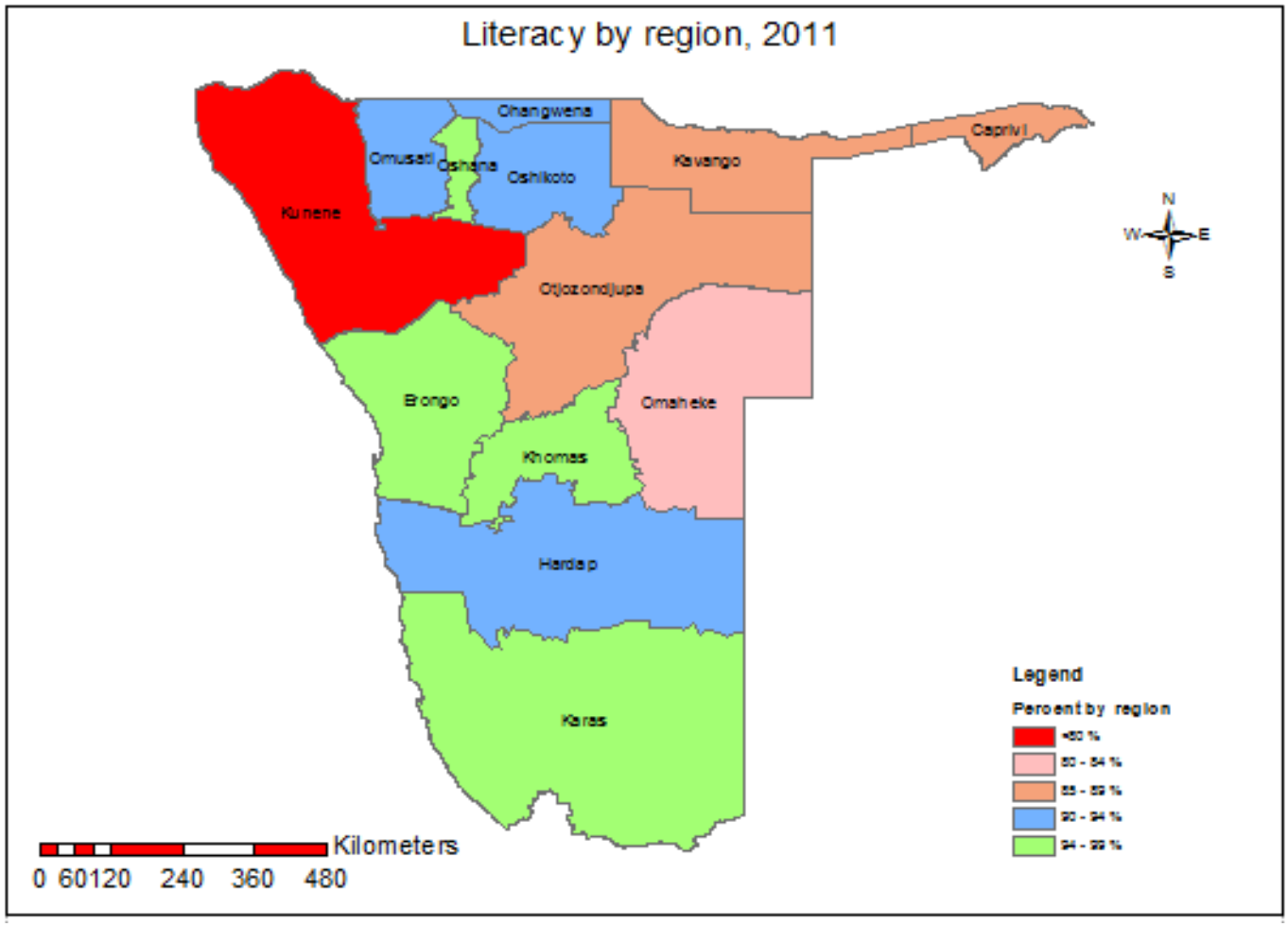
Of those primary children who are enrolled, 91 percent are attending school, which is an increase from 86 percent in 2000, (MOHSS, 2008:12). There is no variation between girls and boys in attending school once they are enrolled, although more children in urban areas attend schools than in rural areas. This could be a result of the long distances to schools and other competing household chores within rural settings. A Namibian study published in 2011, based on information from youth between the ages of 12 and 19 years in four northern regions, found that 8.7 percent felt fearful when travelling to and from school (Burton, Leoschut, and Popovac, 2011). A 2011 sms survey involving some 2 000 young people found that 45 percent of the learners (about evenly divided between girls and boys) generally did not feel safe at school and approximately half of learners surveyed in the 2004 Namibia school health survey reported being bullied in the previous month (Keulder, 2011). An Evaluation of School Counseling Services (2010), also highlights that corporal punishment in schools continues despite having been outlawed (UNICEF, 2010). The latest NDHS reported that OVC were as likely to attend school as non-OVC. The HIES (2009/10) also notes that "the poorest half of the population has either no formal education or only primary schooling, making them less able to gain access to livelihood opportunities in the modern economy" (RoN, 2012:18).



The target for Vision 2030 is to increase the overall literacy rate to 90 percent by the year 2015, and eventually to 100 percent by the year 2030. This coincides with the MDG target for literacy, although the MDG expedites the target to 100 percent by 2015 for those who are between 15 and 24 years old. Namibia is on target in terms of achieving the 100 percent[9] overall literacy target, as the overall literacy rate has increased steadily from two-thirds in 1991 to close to 100 percent in 2011. The literacy rate for youth (15 to 24 year olds) generally follows the same trend as the national literacy rate, although it was lower (at 94.4 percent) by 2012 (NSA, 2013:50). Although Namibia is on target in achieving 100 percent literacy rates among certain age groups, challenges remain in relation to practical literacy skills. A high proportion of people in rural areas cannot read or write in English, constraining their access to much needed information, especially with regard to social

[9] This refers to literacy of all appropriate ages. Literacy is measured based on the ability to read and write in one's own language.

issues and services such as social grants, development opportunities, and environmental threats. Literacy rates amongst marginalised groups such as the San are extremely low.



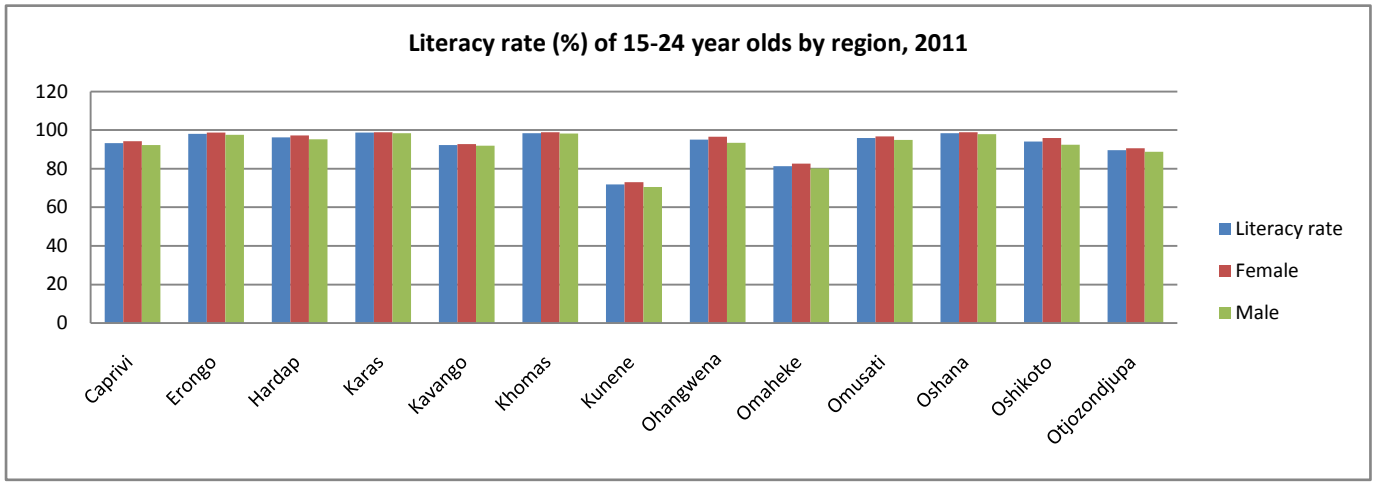
The big difference between the years 2001 and 2011 was the variation between urban and rural literacy. In 2001, three quarters of the rural population above 15 years of age was able to read and write. This increased dramatically in 10 years, with 92 percent of the rural population being able to read and write in 2011. The literacy rate among urban populations has always been relatively high. There are no major differences in literacy between male (85.4 percent) and females (85.1 percent). Youth in urban areas had much higher literacy rates (97.7 percent) than those in rural areas (91.9 percent) in 2011 (NSA, 2013).

Literacy rates, by urban, rural and combined for population 15 years and above, 2009/10

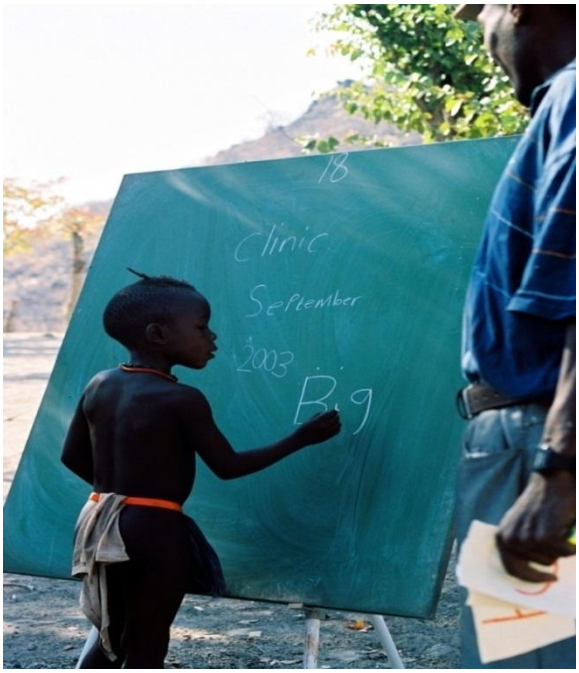
Category	Population	Female (%)		Male (%)		Combined (%)	
	Number	Literate	Not Literate	Literate	Not Literate	Literate	Not Literate
Total National	2 066 398						
Pop 15+ Total	1 297 840	87.1	12.9	88.4	11.6	87.7	12.3
Pop 15+ Urban	542 029	95.6	4.4	95.3	4.7	95.5	4.5
Pop 15+ Rural	755 811	81.3	18.7	83.1	16.9	82.1	17.9

Source: NSA, 2012c

As with school enrolments, regional variations in literacy are evident, with Kunene having the lowest (59.4 percent) literacy rate in 2011, followed by Omaheke (70.7 percent) and Kavango (76.4 percent). The region with the highest literacy rate in 2011 was Khomas (97.4 percent), followed by Erongo (96.7 percent) and Karas (96.6 percent) (NSA, 2013:49). This follows regional wealth trends, with the poorer regions having lower literacy rates and richer regions having higher literacy rates.



Milestones



One of the main thrusts of Vision 2030 is to transform Namibia into a high income, knowledge based economy. Such an economy would be expected to alleviate poverty, satisfy the labour market and ultimately support Namibia's transition into an industrialised nation. With this in mind and based on the commitment of the Government of Namibia, considerable funding has been allocated to the education sector over recent years, with a total of 23.7 percent (N$10.7 billion) of the total 2013/04 national budget being allocated to this sector (MOF, 2013:29). The role of education in supporting economic, health, environmental, political and other social targets in the country has continued to evolve based on lessons learned across the five short-term NDPs since Independence. Namibia has indeed made extensive inroads in improving overall access to quality education and is currently fifth in the literacy rankings out of 52 African countries, following Zimbabwe, Equatorial Guinea, South Africa and Kenya (UNESCO, 2011:264). Namibia also ranks third out of 28 African states on the Education for All (EFA) Development Index.

One of the key milestones in the education sector was Government's directive in 2002 to approach the World Bank to support educational reform, and 2005 saw the development and commencement of the Strategic Plan for the Education and Training Sector Improvement Programme (ETSIP) 2005-2010 (priced at N$2.4 billion), with support from the UN and other development partners. The Programme was based on an acknowledgement by Government and other stakeholders that the education sector was weak in terms of preparing Namibia to achieve the goals and targets of Vision 2013. Therefore, ETSIP was needed to reformulate the education sector in order to achieve the objective of EFA and the MDGs. The ETSIP Review noted that the important achievements were adoption of new policies, improved institutional efficiencies, curricula development, research, and provision of teaching/learning materials.

The latest Education Strategic Plan 2012-2017 and Performance Management Plans, as executing tools, aim to reform the education sector for the achievement of the education goals of NDP 4 and of Vision 2030. The goal is to "substantially enhance the sector's contribution to the attainment of strategic national development goals, and to facilitate the transition to a knowledge based economy. In the immediate future, it will improve the quality of education and skilled workforce required to improve knowledge-driven productivity and growth, and thus contribute to economic growth." (MOE, 2012b, Plan: 2) The targets of the plan are informed by NDP 4 and aligned to the MDG targets, such as those relating to net enrolment in primary schools and survival rates for Grade 7 for 2015.

Primary education enjoys an enabling policy environment with the following policies focusing on access, quality and equity: the Education Sector Policy for OVC, the Textbooks Policy, the School Cluster Policy, a draft Education Sector Policy for Inclusive Education, the Policy for Open and Distance Learning in Namibia, and the Special Needs Education Policy. Primary education in Namibia is also free, although parents had to contribute towards school development up to 2013 when Government abolished financial contributions towards the School Development Fund. Access to education, therefore, is likely to have increased, especially for poor and severely poor households as well as among marginalised communities such as the San who could not afford to contribute towards the School Development Fund.

Government, with its development partners, has designed innovative initiatives to enhance the quality of teacher education, although there is still room for improvement. Tertiary institutions and the Namibia Institute for Educational Development (NIED) play a key role in ensuring education quality. The NIED acknowledges this and in response has established a Continuing Professional Development Unit. Namibia also conducts standardised achievement tests in English and Mathematics, which most African countries cannot do due to lack of funds.

Early childhood development (ECD) has been reinstituted and rolled out under the auspices of the Ministry of Gender Equality and Child Welfare (MGECW). The fourth NDP retains ECD as one of the targeted sub-sectors and foresees increased ministerial capacity to support ECD centres (NPC, 2013:7). Training for ECD educators has been put in motion, with the plan being to have 75 percent of all educators trained for at least one month by 2017. By 2015, Namibia plans to support all ECD centres with school feeding. The MOE notes that, “while the target for 2012/13 was to subsidize 170 centres, 255 centres (with 293 edu-carers) began receiving a GRN subsidy in the last quarter of 2013/14. However, challenges remain with skills and finances to expand ECD in 2014/15” (NPC, 2013:6-7).

Other infrastructural development is also taking place with support from communities, such as building teaching structures, which includes cooking and accommodation structures. Infrastructural development in the form of more schools, classrooms and resource centres, as well as textbook provision, have received more attention over the past five years, especially with support from Millennium Challenge Account – Namibia (MCA-N) and other development partners. However, the increased quantity of infrastructure is not keeping up with population growth for either primary or secondary education.

The national school feeding programme (SFP) is an important milestone, not only because of its nutritional benefits, but because it encourages children to come to school, especially those from poor and marginalised households. The SFP was initiated in 1991 with support from the World Food Programme (WFP). Although there are still challenges, the programme has developed over the years to provide more nourishing food, better infrastructure for distribution, and enhanced monitoring and evaluation.

Other milestones have included support to gender equality in primary education, especially in Kavango and Caprivi regions, by the Forum for African Women Educationalists in Namibia (FAWENA), and the San Girls Education Programme under the Office of the Deputy Prime Minister, which has ensured increased enrolment for this marginalised group. The establishment of uniform teacher-learner ratios across the country has brought about increased equality of access, while mobile schools in some regions, such as Kunene, brought schools closer to the people. The introduction of the Prevention and Management of Teenage Pregnancy Policy is also regarded as a milestone.

Challenges and interventions to expedite MDG implementation in the remaining two years

The ETSIP Review conducted in 2011 reported that, "the country's education and training system suffers from various weaknesses despite high allocations from the Government budget: from low overall quality and internal efficiency to poor external efficiency of the tertiary level and of the vocational and training systems, from inequalities in the distribution of educational inputs and in learning achievements to the negative impact of HIV across the system" (MOE, 2011c:7). Although general improvements have been achieved across the education sector, below are some challenges and recommended responses that could potentially support acceleration of MDG implementation in the remaining two years.

Challenges	Interventions to expedite MDG implementation
Poor school management, in particular motivation of teachers and learners, innovation in teaching with limited resources, and monitoring and evaluation (including formative evaluation) of the entire educational process.	• Revisit the appointment criteria of Principals to ensure that the most highly qualified, experienced and mature candidates are selected, including those with management skills and experience • More active involvement by Circuit Inspectors in the evaluation of quality teaching and progress of learners • Management should not only focus on pass rates, but assess the quality of education received
The World Bank, MCA-N and other partners have contributed to procurement and distribution of textbooks over the past four years but the numbers of books and the procurement process remain inadequate.	• Continue to strengthen the textbook procurement process • Find additional finances to purchase more textbooks and other learning support materials • Facilitate more active involvement of the private sector
Poor physical learning environment, including infrastructure, especially in rural and poor areas. 93% of the education budget goes towards administration and operational costs, with little left for infrastructural development, such as schools, classrooms, libraries, sanitation facilities, electricity, ICT, roads, water, communication and teacher housing.	• Government needs to work closely with private sector organisations, motivating the private sector to become more involved in education infrastructure development • Communities should be mobilised to participate in the improvement of infrastructure, such as providing labour for construction of classrooms or teacher houses • Government to increase resources for infrastructure development with a focus on bringing schools closer to children • Strengthen and expand provision of water and sanitation, especially in disadvantaged areas • Monitoring systems at schools need to include monitoring of the state of school infrastructure • Appropriate teacher accommodation needs to be provided, especially in rural areas • Expand hostel accommodation, especially for rural children living long distances from schools • Infrastructure development needs to include pre-primary education
The roll-out of ECD is too slow, noting that the lack of a good educational foundation (linguistic, cognitive and social skills) before primary education can influence learning for the entire lifespan.	• Expedite ECD in all regions, with special attention given to rural areas and severely poor communities
Poverty and malnutrition are major barriers to achieving the MDGs.	• Expand the school feeding scheme to include all children in school
Enactment of the Child Care and Protection Bill has not taken place.	• Enact the Child Care and Protection Bill
High levels of violence and abuse at schools	• Implement and enforce school codes of conduct for teachers and learners • Implement teenage pregnancy policy

Looking Beyond 2015

Education for all has been advanced in Namibia and across Sub-Saharan Africa since the early 2000s and long-term development planning, implementation, and monitoring and evaluation will ensure that the global, international and national goals and targets set for educational achievement are reached. Namibia needs to continue implementing the Education Sector Strategic Plan and aspire to achieve internally set goals for 2016/17. In addition to what Namibia is currently doing, focused long-term interventions are needed in the areas discussed below.

Increase educational enrolment and access	Universal primary education is an excellent starting point and opportunity to increase enrolment and access. Therefore: • Continue with free UPE, but establish mechanisms so that it becomes totally free of charge • Expand the provision of universal education to secondary schools and tertiary education
Strengthen educational provision at all levels	A full cycle of decentralisation will strengthen educational provision at local, regional and national levels. Therefore: • Strengthen the decentralised system by establishing clear terms of reference for regional and national offices, and sufficient resource allocation based on such terms of reference • Capacitate regional and constituency offices with human resources, communications, training, transportation, etc. • Address regional capacity inequalities
Improve teaching quality and motivation	It is necessary to improve the interrelated factors of quality teaching (especially at lower primary levels) and teacher motivation. Therefore: • A long-term teacher development plan needs to be formulated and implemented, building on existing NIED teacher development approaches and methodologies • The University of Namibia (UNAM) needs to improve teacher training in terms of practical teaching and transfer of knowledge to learners • Pre-service and in-service training needs to meet teacher demands • Implement and enforce school codes of conduct for teachers and learners • Teacher training needs to concentrate on new developments, accompanied by ICT advances in the classroom • Teachers need to be provided with at least a basic appropriate teaching environment, especially in rural areas where there are no laboratories, libraries, electricity or other facilities • Teacher performance needs to be rewarded in various forms, such as salary increments for those with limited absenteeism, those who continuously improve their teaching skills and those with high learner success rates. Awards such as Teacher of the Month, or Teacher of the Year could be facilitated at the regional and national levels • Rural primary schools need special attention in terms of improved quality of teaching and learning, therefore, more emphasis could be placed on multi-grade teaching and learning within a resource limited environment • The standard of English language among teachers needs to be improved • Qualified teachers must be employed for all levels, including all primary schools • It should be compulsory for new graduates on government subsidies, scholarships and/or loans to teach in remote areas for the first year
Early learning in own language	All children in lower primary schools should be taught in their home language with a special focus on marginalised groups such as San and OvaHimba. Therefore: • National and regional education authorities need to ensure that the policy on national languages is implemented • Teaching materials need to be developed in various languages where shortcomings are experienced • More San and other marginalised groups need to be trained to become teachers with innovative strategies to allow them access to teacher training institutions

Mitigate the negative impacts of HIV, violence and poverty on the education sector	Strategies are already in place and need to be strengthened and expanded. Therefore: • Strengthen and HIV and AIDS Management Unit (HAMU) and Regional HIV and AIDS Coordination for Education (RACE) to coordinate mainstreaming of HIV more effectively at national, regional, circuit and school levels • Seek a better understanding of the effectiveness and efficiencies of current response strategies in the education sector in order to revise current programmes at national, regional and circuit levels as necessary • Expand the school feeding programme to include all children • Reduce bullying related to HIV stigma in schools
Mitigate the negative impacts of climate change on the education sector	Climate change hampers the ability of learners to gain access to schools and the ability of teachers to teach. Therefore: • Continue to study the impacts of climate change on the education sector, especially in the northern (flood prone) and southern (drought prone) areas to be better prepared with adequate prevention and response strategies
Amplify children's voices	Children's voices at national, regional and school levels need to be heard, and evaluations and research need to take into consideration the views and opinions of school children of all ages. Therefore: • Systematically employ formative research approaches in class to improve teaching and to provide sufficient opportunity for optimal learner participation • Include information about 116 helpline and child radio in curriculum • Strengthen platforms such as Junior Counsellor and Children's Parliament
Eradiate gender-based violence in education	Gender-based violence has serious implications for education. Therefore: • Continue to research the (sex disaggregated) impacts of GBV on the educational achievement of children and develop preventive and mitigatory measures based on sound evidence • Enhance involvement of men and boys • Reduce violence and abuse in schools and hostels and implement relevant policies and laws • Implement a learner code of conduct
Reduce teenage pregnancy	Teenage pregnancy remains a major challenge in Namibia, while the policy on Prevention and Management of Teenage Pregnancy is not fully implemented. Therefore: • Strengthen implementation of the Policy on Teenage Pregnancy • Mobilise communities and raise awareness of the dangers of teenage pregnancy
Increase resourcing and efficiency	It is necessary to both allocate more financial resources to education and strengthen the efficiency of resource use. Therefore: • Expand the Government contribution to education, gradually increasing the development budget to 20 percent of the total MOE budget, given that many development partners are reducing their educational support because Namibia has graduated to an upper-middle income country • Equally essential is prioritising spending and establishing mechanisms to ensure efficient utilisation of resources
Optimise the use of the Education Management Information System (EMIS)	The EMIS system potentially offers a range of valuable data for educational policy-making, planning, and monitoring and evaluation. Therefore: • Strengthen the EMIS system so that data are continuously analysed and used to inform policy, planning, programming and overall decision-making at the national, regional, circuit and school levels • Design a mechanism to track student mobility and progression to ensure alignment of phases and learner support efforts as well as to bring back into school those who drop out

MDG 3: Promote Gender Equality and Empower Women

Gender equality is about extending equal opportunities and rights to both women and men. This includes equal access to services, resources, and material welfare. Education at all levels is essential for girls and women to know their rights and to build their knowledge and skills, in order to obtain work, improve their standard of living and maintain a good quality of life. Women's interests must be taken into consideration at all policy-making levels, from the national to the local level. Women are empowered when they participate in decision-making at national, regional, community and household levels.

The original six MDG 3 indicators have not changed since 2000, and the trends for these and their current status are reported below. Namibia has already achieved two of the original six indicator targets for MDG 3. Two of the goals (an equal proportion of girls in primary education and women in wage employment in the non- agricultural sector) have worsened, but could still be achieved. The goal for tertiary education has not been on target for almost a decade and is unlikely to be achieved unless women are encouraged to study the traditionally male-dominated technical subjects at Vocational Training Centres (VTCs). The situation with respect to an equal number of seats being held by women in Parliament has also worsened and this target is unlikely to be achieved by 2015, unless all the political parties actually implement their 50:50 policies. While Namibia has not yet achieved full gender equality, there have been many meaningful and tangible accomplishments, including a change in the undercurrents surrounding gender, as can be seen in a finding in one study in which an overwhelming number of men and women agreed with the statement: "Really, things have changed in Namibia since Independence; women can stand up for their rights now" (Hubbard 2010:11 citing MGECW (2009).

MDG 3: Status at a Glance

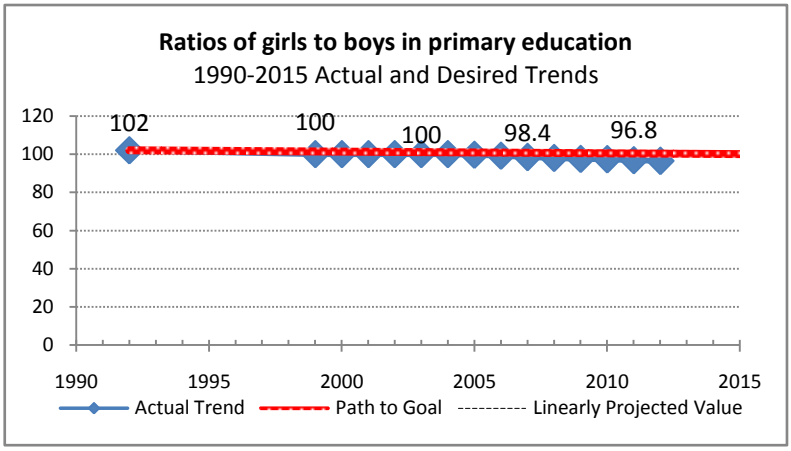
TARGETS AND INDICATORS	BASELINE	STATUS	TARGET (2015)	TARGET/ GOAL ACHIEVABLE?
MDG 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN				
Ratio of females to males in:				
• Primary education (girls per 100 boys)	102 (1992)[1]	96.4 (2012)[2]	100	On target
• Secondary education (girls per 100 boys)	124 (1992)[1]	112.3 (2012)[2]	100	Achieved
• Tertiary education (females per 100 males)	162 (1992)[3]	85.25 (2011)[4]	100	Not on target
• Ratio of literate females to males (15-24 years)	110 (1991)[5]	103 (2011)[5]	100	Achieved
• Pre-primary education (girls per 100 boys)	87.6 (2008)[2]	101.2 (2012)[2]	100	Achieved
Share of women in wage employment in the non-agricultural sector (%)	39 (1991)[6] 49 (1997)[6]	48 (LFS 2008)[7] 35 (LFS 2012)[7]	50	On target
Proportion of seats held by women in Parliament (%)	5.7 (1990-1995)[8]	25.0 (2010-2013)[8]	50	Not on target

[1] MDGs Reports for 2004, 2008, 2010.
[2] MOE's EMIS, 2009, Table 19, and EMIS, 2012, Table 8. [10]
[3] Namibia's MDGs Reports for 2004, 2008 and 2013. Note: the MDGs Report for 2010 indicates 175 for tertiary education as the baseline for 1992.
[4] Raw data from UNAM, PON, IUM and the five VTCs for 2011.
[5] MDGs Report, 2008, citing 1991 and 2001 Census; 2011 Census.
[6] MDGs Report, 2008 citing the 2001 Census and the MOLSW Labour Force Survey (LFS) for 1997.
[7] MOLSW LFSs, 2008 and 2012.
[8] Shejavali (2013:7) from IPPR.

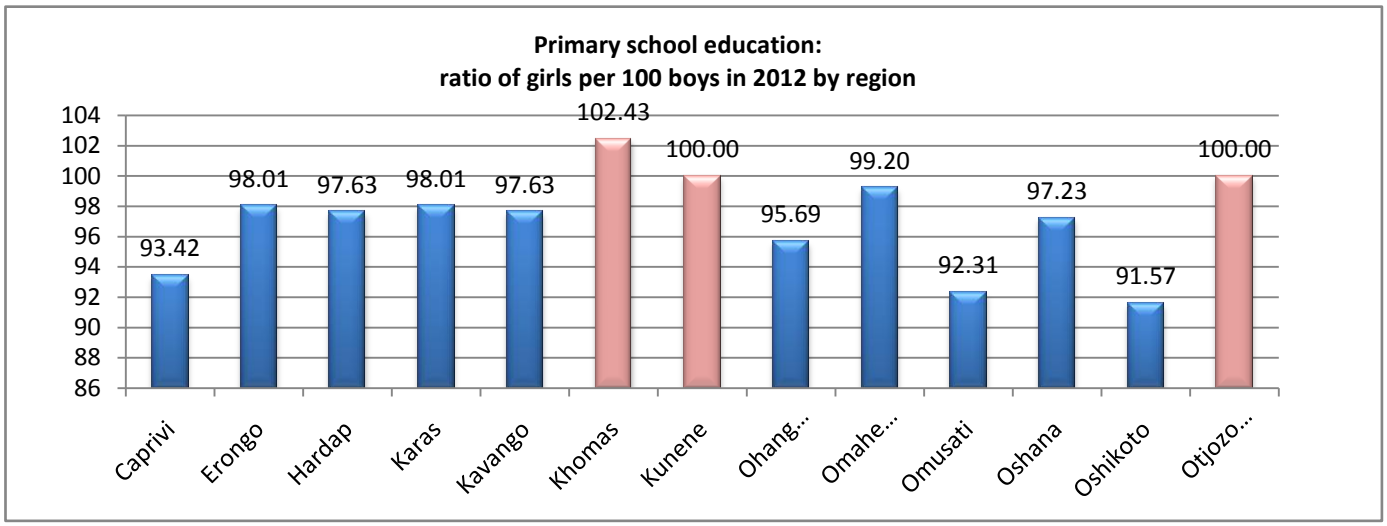
[10] From EMIS 2010 onward, separate data for pre-primary education were provided. For EMIS 2008 and 2009, the pre-primary data were reported within 'Other Grades'. Pre-primary was introduced in state schools between 2007 and 2008, after the implementation of the Early Childhood Development Policy in 2007 (EMIS, 2009, p.44).

Current Status and Trends

In the first decade of tracking the MDGs, Namibia had already achieved higher school enrolment rates for females than for males in all four levels of education – primary, secondary, tertiary, and adult literacy. As noted in the first MDG Report (NPC, 2004:13), one reason for the much greater access to education for girls and young women at Independence was the fact that more young men than young women fought in the war of Independence, so it took the next decade for the school enrolment of boys to catch up with that of girls. This greater presence of girls in primary and secondary school had also led to a higher literacy rate among female youth than among male youth. Unlike, many African countries facing the MDG education-gender challenge for females, Namibia actually needed to create a balance by encouraging a greater number of males to enrol in school, while maintaining the number of female students.



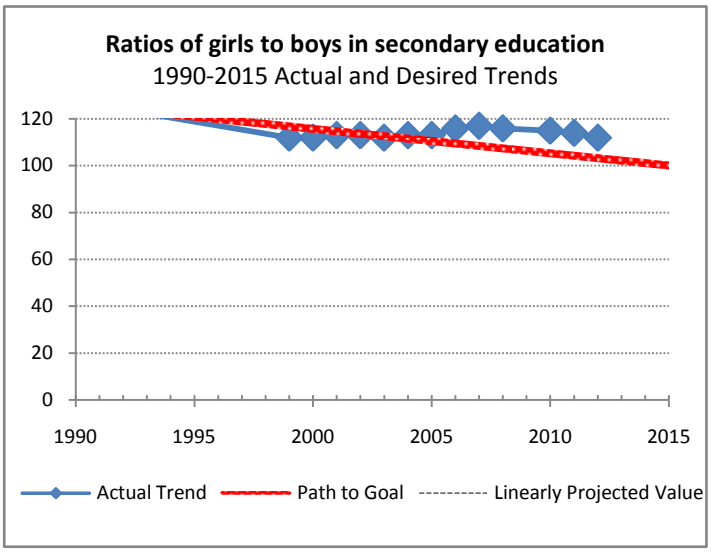
From 1999 to 2004, nationwide, there were 100 females for every 100 males in primary school, but this dropped slightly in 2005, and further decreased to the current (2012) figure of 96 girls per 100 boys. Despite this drop, it is still possible that the parity target for primary education can be achieved, but the strategy will have to include an analysis of the reasons for disparity in certain regions and make a commitment to raising the numbers of girls again to match the number of boys in school. There are regional variations, with girls still outnumbering boys in some regions. For example, in 2012, the female primary education enrolment ratio ranged from a low of 92 in Oshikoto to a high of 102 in Khomas (see graph below), with similar figures for the lower primary phase. This status diverged for the upper primary phase where the lowest ratio of girls to boys (89:100) was found in Caprivi Region and the highest ratios in Khomas and Otjozondjupa, both at 105:100.



Source: Author's calculations from EMIS 2012, p.28

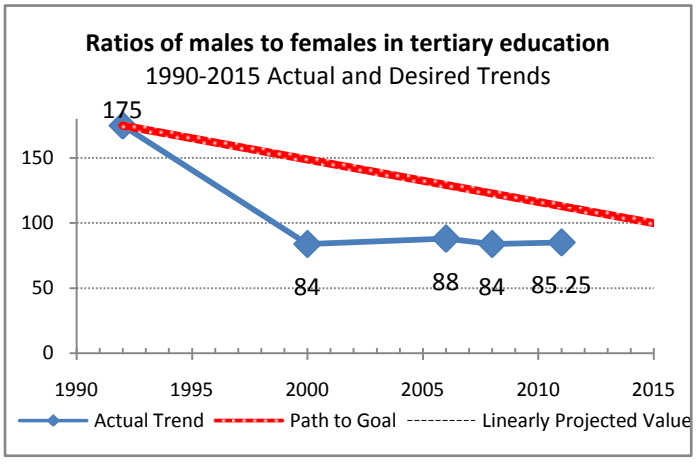
As can be seen in the graph below, since 1992, girls have always been in the majority in the nation's secondary schools, with the most recent figure (2012) standing at 112 females for every 100 males. However, there are significant differences in this ratio between regions, and also at different grades within secondary school. In 2012, female secondary education enrolment ranged from a low of 91 girls to every 100 boys in Kavango, to a high of 119:100 in Ohangwena with a similar regional situation for junior secondary. Only in the years 1995 and 2003 were there slightly fewer girls than boys nationally in Grades 11 and 12 (EMIS data, Table 19). In 2012, nationally, girls represented 53.7 percent (122:100) of all senior secondary school students, with six of the regions exceeding 55 percent (122:100), from a high of 57.6 percent (135:100) in Karas to a slightly lower figure of 55.3 percent (124:100) in Oshikoto. Despite great improvement over the years, four regions still have notably fewer than 100

girls to every 100 boys in the senior secondary phases. These regions are Kavango (76:100), Omaheke (86:100), Caprivi (90:100), and Kunene (93:100).



Nationally, while the main reason for girls dropping out of school is still teenage pregnancy, the incidence of this has declined since Independence, leading to the overall number of girls dropping out declining also (EMIS data, Table 65). With these points in mind, the fact that the proportion of girls dropping out because of pregnancy out of 'all reasons' has increased slightly from 23 percent in 2010 to 26 percent in 2012 (EMIS data, Table 65) would, therefore, need to be interpreted as a reduction in other reasons for dropping out. In the most recent data, Kavango and Ohangwena regions have the greatest number of girls dropping out because of pregnancy, followed by Omusati and Oshikoto regions (EMIS, 2012, Table 65). In 2012, Kavango and Khomas regions, compared to the other regions, had greater numbers of both girls and boys dropping out because of long distances between school and home (EMIS, 2012:103). Further analysis by the MOE and partners must be done at the regional level to determine the reasons for the disparity between regions, and a strategy needs to be implemented to ensure equal participation by both girls and boys in secondary education in all regions.

Although the MOE EMIS does not include 'violence in the school environment' as a category or reason for dropping out of school, two reports (MOHSS, 2008 and Burton *et al.,* 2011) point out that violence in schools can lead to fear and absenteeism, and does not create a productive learning environment. The 2004 Namibia School-Based Student Health Survey (MOHSS, 2008), which involved more than 6 000 learners, found that almost 38 percent of learners had missed at least one day of school in the 30 days prior to the survey because of feeling unsafe at school, or on the way to or from school. According to a survey conducted by Burton *et al* (2011:16, 18) of 319 learners aged 12 to 19 in four northern regions, 46 percent had experienced sexual assaults at school, 32 percent had been sexually assaulted two to five times, and almost one out of five (23 percent) had been sexually assaulted more than ten times while at school. Females were much more likely than males to experience most forms of bullying reported, and bullying was found to be intertwined with stigma around HIV. In summary, female learners face unique challenges in completing their education, including continued inadequate prevention and management of learner pregnancies, economic pressures on young girls from family members and financial dependence on older men (so-called 'sugar daddies').

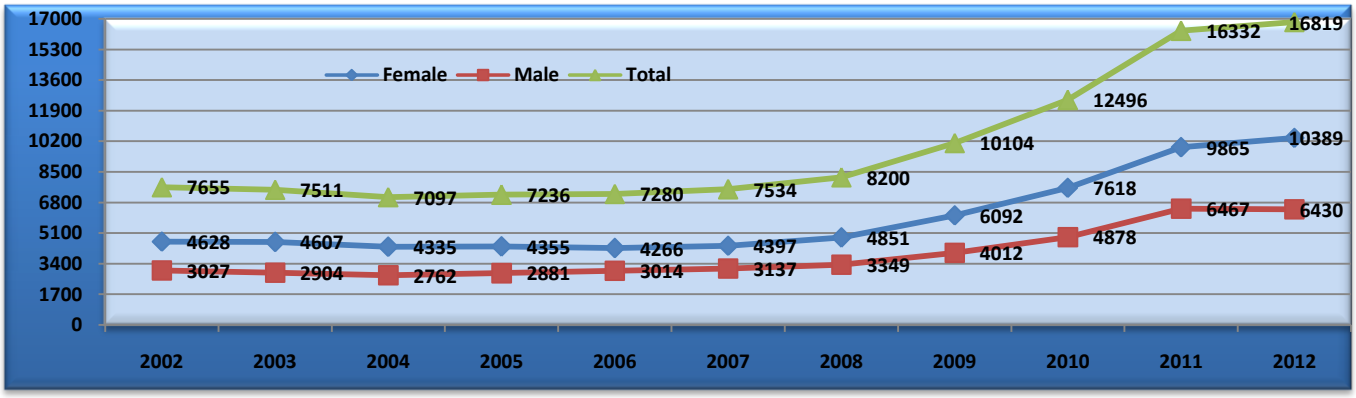


The significant drop in the ratio of females to males in tertiary education since 1991 may only be due to differing methods of calculating the figures or different definitions of 'tertiary education'.[11] From the most recent available data (2011) the average total enrolment ratio is 85, but a wide variation in the ratio exists among the institutions, as follows: University of Namibia (UNAM) at 153 females to 100 males, Polytechnic of Namibia at 127, IUM at 114, Zambezi Vocational Training Centre (VTC) at 82, Valombola VTC at 61, Windhoek VTC at 61, Rundu VTC at 45, and Okakarara VTC at 39. Both of Namibia's main tertiary institutions – UNAM and the Polytechnic – have

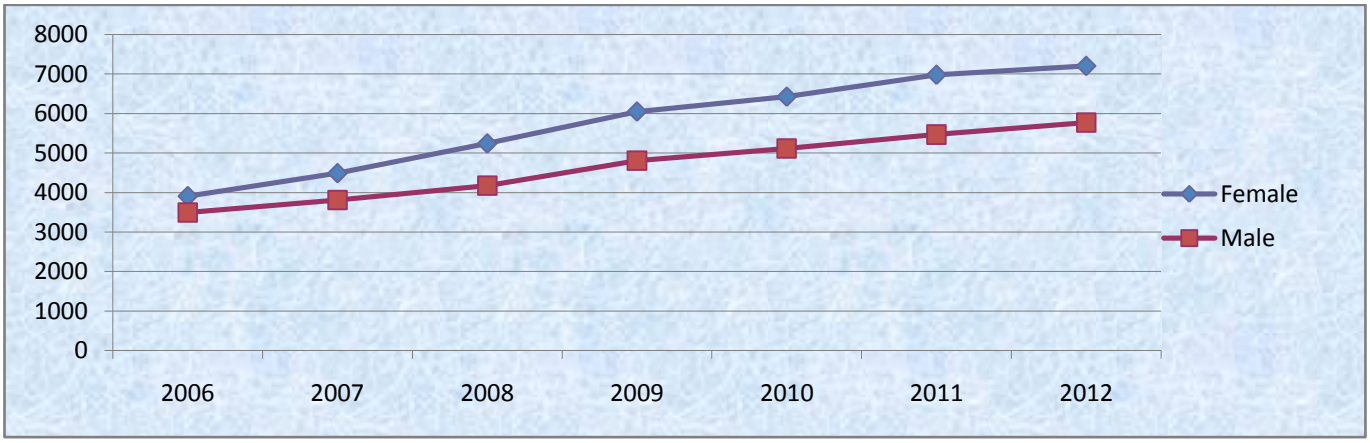
[11] Some reports seem to include only UNAM, the Polytechnic and IUM, while others include the VTCs also, and still others seem to include all of these plus other VET institutions, such as NamWater and NamPower. Unfortunately, none of the documents reporting these figures defines their methodology or exact sources of data. These methodological limitations put in doubt findings such as those of the MDGs Interim Report (Anon, 2013a), which reports a ratio of females to males at tertiary institutions above parity at 116 for 2011. The most recent figure used in the trend graph above has been calculated for 2011 from the most recent available raw data provided by UNAM, the Polytechnic, IUM and the five VTCs.

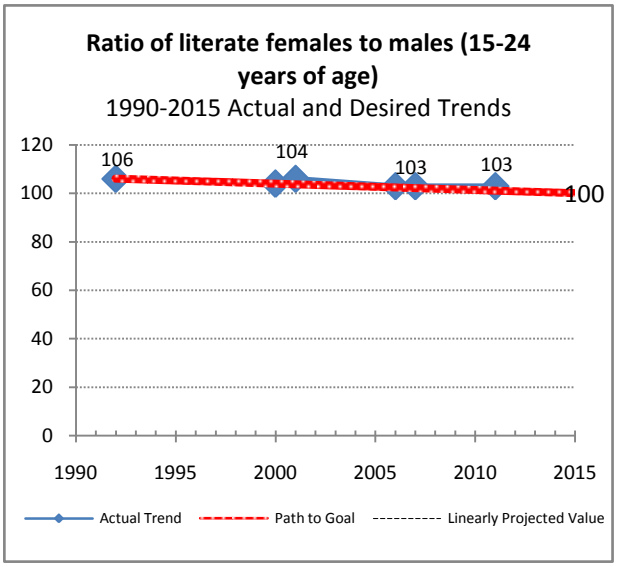
typically had more females than males enrolled, but this ratio varies by subject. For example, at UNAM, the Faculty of Engineering and Information Technology has had significantly fewer women than men since it commenced in 2008, with a ratio of 33:100 in 2011 and in 2012. From 2002, the faculties of Science, and Agriculture and Natural Resources had fewer women than men, but this reversed in 2010 and 2011 (UNAM, 2013:3). Similarly, the Polytechnic School of Engineering and School of Information Technology had significantly fewer women than men in 2011 and 2012 (PON, 2012a; PON, 2013). The ratio of female enrolment to male was 33:100 for Engineering and 54:100 for IT, in each year.

University of Namibia enrolment by gender 2002-2012 (UNAM 2013, p.3)



Polytechnic of Namibia enrolment by gender 2006-2012 (PoN, raw data, 2013)





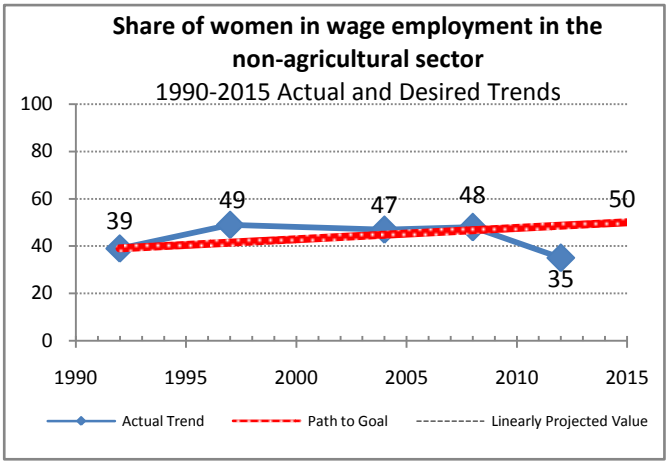
During the entire MDG reporting period, the female to male literacy ratio for youth (15 to 24 years) has been above parity. Adult literacy ratios moved into greater balance for male youth from 2006 onwards.

One important factor to ensure children's growth and development and their 'survival rate' in school is ECD, including receiving pre-primary education (MGECW, 2007a). Over the years, females have had a higher or almost equal rate of survival to males (MCECW, 2101d:17). Although the ratio of girls to boys in pre-primary education has never been a MDG indicator, the current report recommends that it be added as one and tracked to 2015 and beyond. Since EMIS (2008-12) has begun to record this level of education, the ratio has fluctuated from 88 in 2008 to above parity in 2010 (at 104) and in 2012 it stood at 101.

In summary, there is a need to improve access, equity and the quality of education at all levels and in all regions, particularly in science, mathematics and technological subjects, for girls and women. Other challenges and constraints, in relation to education, include cultural practices, bias, and stereotypes, which have a negative influence on the access, retention and development of

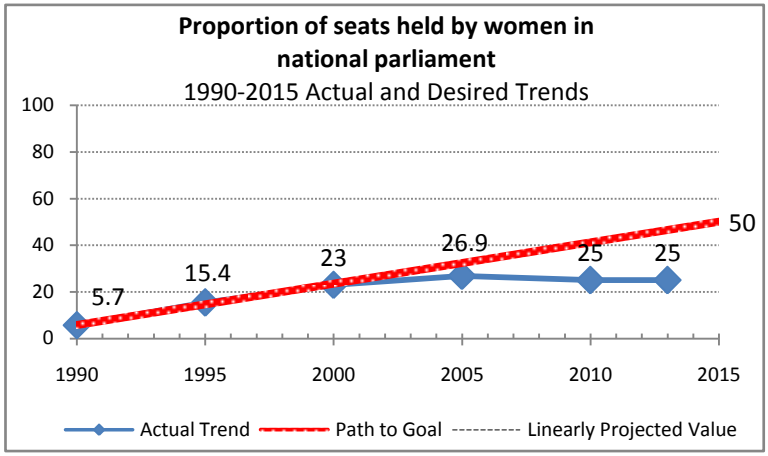
girls across the school curriculum; sexual harassment in educational institutions, which could result in pregnancies and exposure to HIV; and an inadequately gender-responsive pedagogy in primary, secondary and tertiary institutions.

Even though many females are educated in Namibia, the same challenge continues as it has been since Independence: how to translate this education of women into formal jobs, and further into higher-level positions of management, decision-making and political leadership. Women's representation and participation in these areas are critically important to ensure that their interests and voices are heard at a powerful and strategic level.



From the Labour Force Surveys (LFSs) of 1997, 2004, and 2008, the statistics reveal there were almost equal numbers of women and men working in the non-agricultural sectors, with the proportion of women indicated as 49 percent, 47 percent and 48 percent respectively. Thus, Namibia was close to parity for many years.

The most recent (2012) LFS, however, indicates a drastic drop to 35 percent for women. Until the Ministry of Labour and Social Welfare (MOLSW) and the Namibia Statistics Agency (NSA) can officially confirm this figure, this anomaly may be due to varying data collection methods.[12] If data from the 2011 Census (Table 5.6.4, p. 58) are utilised rather than the 2012 LFS, the drop is reduced to a not so severe 45 percent.[13] Beyond this indicator of parity in the non-agricultural sector, gender-related challenges in trade and economic empowerment include access to, and control of resources such as credit, land, market information, business skills and support services, as well as protective labour laws that benefit women and men equally.



The proportion of women in Parliament had increased substantially since Independence, from 6 percent in 1990 to 27 percent in 2005. However, during the most recent session (2010-13), this dropped to 25 percent (Shejavali, 2013:8-9). Government did commit itself to achieving gender equality by 2015, as a signatory to the SADC Gender and Development Protocol, but this target will only be achievable if this commitment and the ruling party's 2013 policy of 50:50 representation are put into action. Even if this should happen, huge challenges at regional and national Council levels will remain because these representatives are elected on a constituency basis. Achieving parity here would probably involve changes to the electoral system, which would likely require a constitutional amendment.

[12] Note: Caution must be taken when comparing 2008 LFS figures to 2012. In Table 5.2b 'Employed persons by industry, area and sex' in the 2008 LFS, 'Agriculture' is reported on separately, as is 'Fishing'. In contrast, in Table 3.4 'Employed persons by industry and by sex' in the 2012 LFS, 'Agriculture, forestry and fishing' are combined. To attempt comparison between the two years, the 'Fishing' figures for 2008 were added together with 'Agriculture' for 2008. For both years, these 'agriculture' figures were then subtracted from all the other industries to calculate the share of women in the non-agriculture sectors. Nevertheless, it is difficult to determine if this percentage of women in the non-agriculture sector has actually dropped so significantly from 2008 to 2012, or is due to LFS research methodology and reporting methods changing. Furthermore, several reports dispute the accuracy of the 2008 LFS indicating that, "it is widely believed that the 2008 LFS did not count subsistence farmers and simply made a mistake with the fishing sector by omitting a zero at the end of the number" (Anon. 2013b:16 from *Insight Namibia*). The same source notes that these oversights were rectified in 2012. This makes it difficult to compare the LFSs over time, making any trend analysis for MDGs reporting also problematic.

[13] Similar to the problem with the tertiary education indicator, the previous MDG reports do not cite the data source specifically (e.g. page or table number) and do not explain the exact methodology for determining the indicator score. For the percentage of women in non-agricultural employment, there is no explanation as to why the Census was not utilised after the 1991 Census, when it was used for the baseline reference point. Presumably, the LFSs were turned to because those surveys happen every four years while the census is conducted only every ten years.

In terms of other decision-making bodies, the most recent data (Shejavali, 2013:7 citing Gender Links, 2011) reveals that only local authorities are coming closer to parity (see Table below). This is attributable to the fact that affirmative action for women is mandated by statue at this level in the Local Authorities Act 23 of 1992. Furthermore, there are relatively few women reaching high-level positions in the public and private sectors. Representation of women in the management cadre of the public service improved from 25 percent in 2005 to 38 percent in 2010. In the private sector, women held only 21 percent of senior management positions (supervisors, section heads, managing directors and CEOs) in 2006 (MGECW, 2010d:35).

Women office holders in Namibia

Office	Members/Councillors	Number of Women	Percentage of Women
Cabinet	26	5	19
National Assembly MPs	78	19	24
National Council MPs	26	7	27
Regional Council	107	13	12
Regional Governors	13	3	23
Local Authority	323	135	*42
Mayors	30	8	27

Source: Shejavali, 2013:7 in IPPR citing Gender Links, 2011.

Other important gender issues are not reflected in the MDG indicators, notably the increasing level of gender-based violence (GBV) and continuation of harmful cultural practices. Attitudes towards domestic violence are an indication of how empowered women are. In the most recent study conducted by SIAPAC for the MGECW (2009:68) in 2007 and 2008, it was found that about 40 percent of women aged 18 to 49 years had been subjected to GBV, compared to 28 percent of men. Married women were significantly more likely to have been subjected to GBV than single women, regardless of age. In the same study (MGECW, 2009:49), about 35 percent of women and 37 percent of men in Namibia believed that a man is justified in abusing (slapping or similar) his female partner if she neglects the children, while 48 percent of women and 44 percent of men believed the same type of physical violence is acceptable if the male partner finds out the woman has been unfaithful. It should be noted that GBV and HIV are mutually reinforcing epidemics, with GBV being both a risk factor for HIV infection as well as a consequence of being HIV infected. Studies found that women who experience violence in intimate partnerships face a four times higher risk of HIV acquisition (Fleischman, 2012 citing Saul, 2012). In addition, fear of violence may keep individuals from being tested for HIV, disclosing their HIV status and seeking treatment and care, and may also deter them from negotiating safe sex.

Milestones

General

The goals and indicators in MDG 3 have guided the NDPs and Vision 2030, which in turn have guided ministerial sector planning and the Gender National Plan of Action. All have emphasised the need to mainstream gender in sectoral plans and interventions. However, more planners and decision-makers need to come to the realisation that gender mainstreaming must not be just a token concept, but actually lead to women and men having equal access to and control over resources, development benefits and decision-making at all levels of the development process, and in policy, programmes and projects.

The Namibia Constitution is the starting point for gender equality in Namibia. Unlike many other national constitutions, Namibia's Constitution explicitly forbids sex discrimination. According to Hubbard (2010:1), some countries do not even mention sex or gender, and many African countries make exceptions to the rules against sex discrimination in areas such as marriage, divorce and inheritance. Namibia's Constitution makes it clear that the provisions on discrimination take precedence over anything to the contrary in customary law. Namibia's Constitution also explicitly covers: affirmative action for women; "equal rights as to marriage, during marriage and at its dissolution" for women and men; and policies on equal pay for equal work and maternity benefits. Namibia's constitutional provisions on citizenship are completely gender-neutral, in contrast to the constitutions of many other African countries, which apply different citizenship rules for women and for men.

Vision 2030 (OPM, 2004) incorporated the gender and empowerment MDGs from 2000 and listed, in graph form: the current situation; things to do; things to avoid; a worst case scenario for 2030; and where we want to be in 2030. The development of Vision 2030, at the beginning of the millennium, like the Millennium Declaration, focused on the challenges related to gender equity in education and training, and emphasised the need to prepare women and men for the future labour market. This long-term planning document noted that the situation at that time included regional disparities in the enrolment of girls in schools and that opportunities for employment were more limited for women than for men. It also pointed out the high incidence of rape and other violence against women, and that many long-awaited laws affecting girls and women had not yet been finalised. Under 'things to do', Vision 2030 noted the need to ensure equitable access to resources, social services and facilities, including education and health, along with the removal of any limitations or barriers.

Numerous laws, policies and action plans have been developed and approved over the past thirteen years, some of which are mentioned below. Recent important ones have been the new National Gender Policy for 2010-2020 and the National Plan of Action on Gender-Based Violence, 2012-2016: Zero Tolerance for GBV. The revised National Plan of Action to link with the new National Gender Policy is still being developed within the MGECW in consultation with relevant stakeholders.

Namibia is a signatory to all relevant international and regional gender and human rights conventions and protocols, including: the Convention on the Elimination of all Forms of Discrimination Against Women in 1992, the Beijing Declaration and Platform for Action in 1995, the SADC Protocol on Gender and Development in 2009, the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, and the AU Solemn Declaration on Gender Equality in Africa in 2010.

Gender institutional milestones

The establishment and development of government bodies emphasising gender equality and women's empowerment began with the first Women's Desk in the Office of the President at Independence in 1990, then saw the establishment of the Department of Women Affairs in 1995, then the Ministry of Women Affairs and Child Welfare in 2000, and finally to the current government body, the Ministry of Gender Equality and Child Welfare (MGECW), Directorate of Gender Equality, which was established in 2005 (MGECW, 2010b). This Directorate works both at the regional level (MGECW has an office in each region's capital) and the constituency level. It sends Directorate of Gender Equality officers based in the regions' capitals into communities and utilises community activators, who are paid civil servants under the Directorate of Community and Early Childhood Development and are based at the constituency level. At this level the Directorate of Gender Equality mainly targets traditional authorities and other community leaders, such as school principals, especially to inform them where they and community members can go if gender-related problems occur in their communities, for example, to the police, nurses or social workers for GBV cases.

The Namibian government, via the MGECW as the lead agency, uses various mechanisms to ensure coordination of gender mainstreaming, but some of these have proven ineffectual and others are even inactive. On paper, in planning and policy documents, the first of these is the National Permanent Gender Task Force, which is supposed to be an advisory and consultative body, comprising stakeholders in government and academia, and among development partners, non-governmental organisations (NGOs), faith-based organisations (FBOs), media houses and civil society. The written objectives of the Task Force include: to ensure the achievement of policy objectives outlined in the NGP; to inform and educate the general public, while promoting gender equality; to assess proposed laws and their effects on women; and to lobby Parliament and development partners for sufficient funding to achieve the NGP objectives. Each region is supposed to have a similar body: a Regional Permanent Gender Task Force. At the parliamentary level, the Parliamentary Gender Caucus (PGC) is intended to enhance communication between Parliament and other stakeholders on gender issues, to ensure support for female Parliamentarians and to sensitise both female and male Parliamentarians to gender issues. The PCG is also supposed to scrutinise national budgets to ensure gender responsiveness in resource allocation, however this Caucus has been inactive for some time. There is also supposed to be a High-Level Strategic Inter-Ministerial Committee on Domestic Violence and Violence in General, which was inaugurated by the President of Namibia in November 2008. This Committee was mandated by Cabinet and functions as an advisory committee (LAC, 2008:7), but it has been inactive throughout 2013 and consistently fails to attract high-level government participation. Finally, Gender Focal Points/Units should have been in place since 1998 at senior levels in all sectors. The Focal Points are expected to make decisions regarding the implementation of the NGP, and to ensure

integration (mainstreaming) of gender concerns in the policies, programmes, budgets and annual work plans of line ministries and other state institutions. They are also supposed to play a supervisory role in departmental programmes to ensure that these are gender-aware and responsive, and to ensure that data and information collected and used is disaggregated by sex. The challenge has been to identify senior officers for these positions.

The government also works with NGOs and members of civil society. Over the years several NGOs have focused on capacity development and advocacy for gender equity and women's rights and empowerment. These include the LAC's Gender Research and Advocacy Project (GR&AP) (LAC, 2008 and 2012), Women's Action for Development (WAD) (Tjihenuna, 2013), Women's Leadership Centre (IKhaxas and Frank, 2011), Sister Namibia, the Forum for African Women Educationalists in Namibia (FAWENA), Women and Law in Southern Africa Project, Namibia Women's Health Network, and UNAM's Gender Training and Research Programme (Terry, 2012). As one specific example, the GR&AP at the LAC received funding from the Dutch government for 2.5 years to implement projects aimed at enacting MDG 3. This was a highly successful and high-impact programme, which included outreach to neglected communities and creative media with popular appeal (e.g. comics, films, animations) in a variety of languages to help popularise gender-related legislation.

For gender parity at all levels in education and training

As noted in the section on MDG 1, poverty alleviation is a cross-cutting issue that also effects education and the nation's ability to have a trained and experienced workforce. Therefore, any milestone for poverty reduction is equally a milestone for gender equality and women's empowerment. For example, the provision of social grants is essential, especially for homes headed by women or pensioners or caring for OVC, to ensure families have the money to feed and nourish both their girls and boys and to send them to school.

The ETSIP (2005-2020) and the Millennium Challenge Account for Namibia (MCA-N) Education Sector Support Programme have had a positive impact on all levels of education. Both programmes' funding has helped to improve Namibia's educational infrastructure and overcome resourcing problems by building new classrooms, renovating schools and supplying school furniture and textbooks. The MOE's Regional Integrated School Evaluation programme was introduced in 2010 to focus on improvements needed in the education sector in each region. All of these programmes emphasise giving equal opportunities and access to resources to all children, both girls and boys (Terry, 2012).

The Policy for the Prevention and Management of Learner Pregnancy in the Education Sector was introduced in 2009 and strongly emphasises prevention, along with support and encouragement to learners who are mothers (and fathers) to complete their education and to be good parents. This policy allows pregnant learners to remain in school until four weeks before their due date, encourages learners to keep up with their lessons and homework, and allows the mother to return to school as soon as the school is satisfied that both she and the baby are in good health and have a plan for the baby's care, while allowing for absence from school for a maximum of one year. The Legal Aid Centre (2008:4) points out that "Children born to educated mothers have a higher chance of enrolling and completing school. Children of less educated mothers are unlikely to complete school. Thus, the concern about improving the educational rights of girls who become pregnant is based in part on the knowledge that this will affect the fate of their children and future generations."

Under the Directorate of Adult Education (DAE), the MOE runs the National Literacy Programme (NLP) and the Adult Skills Development for Self-Employment Programme. From 20 000 to 30 000 adults attend literacy classes every year. More women participate in these classes than men. According to the DAE Director, "women are the driving force in the rural areas and are more interested to attend literacy classes". About 80 percent of the literacy promoters and about 70 percent of the students are women. Some of the literacy promoters use materials additional to those provided by the DAE to raise awareness and provide information on such topics as gender equality and HIV (Terry, 2012). From 1999 to 2012, on average about 64 percent of those tested at the end of one of the three adult literacy education phases were females. Of the females tested, on average 72 percent passed (EMIS data 1999 to 2012, Table 60). The overall literacy rate for all Namibians 15 years and older increased from 76 percent in 2001 to 81 percent in 2001, and to 89 percent in 2011.

It is still too early to assess the impact of the introduction in late 2012 of universal access to primary education and the abolition of School Development Fund fees under the same policy in terms of gender balance. However, it should ensure greater access to school and increased survival rates for both girls and boys.

For opportunities to obtain wage employment in the non-agricultural sectors

There has been an expansion of MOLSW's Employment Services, which provide vocational counselling and aptitude testing and help job seekers to link up with employers looking for employees, into most regions. More women than men seem to come in to register with Employment Services in Hardap Region, while the opposite is true for Kavango Region (Terry, 2012).

The Labour Act 6 of 1992 prohibited discrimination in any aspect of employment on the basis of sex, marital status, family responsibilities or sexual orientation, as well as forbidding harassment on the same grounds. It also provided for three months maternity leave for any woman who had been employed for at least one year by the same employer. In 1994, maternity leave was supplemented by maternity benefits in terms of the Social Security Act 34 of 1994. "This law represents one of the earliest lobbying successes for the women's movement" (Hubbard, 2010:2). The revised Labour Law of 1997 removed the clause about no discrimination on the basis of sexual orientation. The new 2007 Labour Act now promises maternity leave to all women who have worked more than six months for the same employer, and it prohibits discrimination on the grounds of pregnancy or HIV status as well as sex. It provides for compassionate leave for death or serious illness in the family, which should be of special benefit to women, who are often the caregivers in cases of illness. The Act also contains a strong new provision on sexual harassment, which "gives women a name and a remedy for a problem that has been around for a long time – and that in turn enables women to identify it and fight against it" (Hubbard, 2010:3).

The Affirmative Action (Employment) Act 29 of 1998 is intended to improve the representation of blacks, women and disabled persons in the formal workforce. According to recent reports of the Employment Equity Commission, women are only about 15 percent of executive directors and just over 25 percent of senior managers. However, women are approaching parity with men in middle management and specialised supervisory positions. Individual affirmative action provisions also apply to a number of statutory bodies and boards, reserving seats for women in bodies ranging from the Social Security Commission to the National Sports Commission (Hubbard, 2010:4).

For greater participation in decision-making including being a Member of Parliament

The Local Authorities Act 23 of 1992 requires that more than 30 percent of the people on every party list be women, as well as at least three women for councils of ten or fewer members, and at least five women for councils with 11 or more members. This law has worked extremely well in practice. At the moment, 42 percent of local council members are women. In contrast, Regional Councils (where there is no legal requirement for affirmative action) currently have only 11 percent women (Hubbard, 2010:4).

The Traditional Authorities Act 17 of 1995 required traditional authorities to "promote affirmative action among the members of that community," particularly "by promoting women to positions of leadership". In the Traditional Authorities Act 25 of 2000, the specific reference to 'women' was deleted in favour of a more neutral reference to "promoting gender equality with regard to positions of leadership" (Hubbard, 2010:5).

These two laws have been supplemented by advocacy from women and civil society for 50:50 representation at all levels of government and the use of 'zebra lists', which alternate women and men. Namibia became the first SADC country to ratify the SADC Protocol on Gender and Development in October 2009. The Protocol calls for a target of at least 50 percent women's representation in politics and other decision-making positions to be achieved by 2015, augmenting the AU Solemn Declaration on Gender Equality in Africa, to which Namibia is a party. Measures to provide for increased women's representation in politics are being implemented to ensure that the target of 50:50 set for 2015 is achieved, and that the share of the parliamentary seats occupied by women will increase during the regional elections to be held in November 2014. Specific recommendations for reform of the electoral law to guide political parties have been made in order to achieve 50 percent women's representation in politics as per the SADC Protocol. As recently as June 2013, SWAPO created a new mandate to implement and enforce a 50:50 system. The exact strategy is not yet clear.

Challenges and interventions to expedite implementation in the remaining two years

This section highlights key challenges and provides some suggestions for interventions that might encourage realisation of all the targets for MDG 3 by 2015.

Challenges	Interventions to expedite MDG implementation
Poor implementation of legislation, policies and plans, possibly due to low capacity and poor funding priorities, among other reasons.	• Increase financial, material and human resources to raise awareness of gender issues and to implement legislation, policies and plans fully • NPC and the Ministry of Finance (MOF) need to coordinate better concerning funding and plans • MOF needs to enforce the requirement of gender mainstreaming in all government ministries and programmes by denying general funds to ministries that do not comply • Streamline processes to achieve fewer plans and more action, noting that plans and commitments on paper can take energy away from day-to-day implementation • Prioritise realistically instead of trying to do everything at once, and then ensure that the priority tasks are accomplished fully • Continue advocacy by civil society
The NDPs give insufficient attention to gender issues, apart from lip-service to 'gender mainstreaming' and the absence of gender-disaggregated data in NDP 4 is glaring.	• Review NDP 4 to ensure gender-specific recommendations and significant action steps are included in the sectoral plans to address gender issues during the implementation of NDP 4, for example, a gender balance is needed in all training initiatives designed to develop marketable skills relevant to key economic growth areas • Increase NPC's capacity to include significant actions to address gender issues in future NDPs
Insufficient resources for mainstreaming gender, including too few line ministries identifying a senior management staff member as the GFP.	• Increase financial, material and human resources to raise awareness of gender issues, and to mainstream gender in all sectors and at all levels (national, regional and local) • Enforce the concept of having GFPs at senior management level in government and the private sector
Poverty is closely linked to low education levels, with the poor having fewer opportunities for quality education and consequently being vulnerable and susceptible to exploitation, including GBV and transactional sex	• Continue and expand nutritional programmes to support pregnant women, children under 5 years and young school learners (girls and boys), perhaps as a conditional grant linking money or food and nutritional supplements to clinic visits for immunisations or other maternal and child care • Awareness-raising on the importance of nutrition to pregnant women and the growing child could be included in literacy classes, women's empowerment groups and even in the rural sanitation programme • Expand skills training and income generation/SME support projects to all women, but especially single mothers and female heads of household
The tertiary education indicator varies widely between different institutions, with gender imbalances in favour of females in UNAM, the Polytechnic and IUM, and in favour of males in the five VTCs.	• More males need to be encouraged to apply to the academic institutions and more females to the technical trade institutions • Examine the impact of the Namibian Defence Force accepting more young men than young women on male enrolment in tertiary institutions • Establish more VTCs and other skills training centres/projects in the regions lacking sufficient training options and advocate for female technical instructors
Of all government ministries, MOE should be commended for its detailed and timely data collection and annual EMIS reports, however, there appears to be only limited and very basic analysis of these statistics *Primary education*: • Slight reduction nationally of the ratio from girls to boys to below parity since 2005	• Further detailed analysis at the national and regional levels to determine the exact reasons for the slight reduction in gender parity in primary schools • Further analysis by MOE and its partners at the regional level to determine the exact reasons for disparities between regions, and implementation of a strategy to ensure equal participation of both girls and boys in secondary education • Ensure that all schools adhere to the Teenage Pregnancy Policy to ensure that no girl is forced to drop out of school because of pregnancy

Challenges	Interventions to expedite MDG implementation
• In 2012, only Kunene and Otjozondjupa at 50:50 and Khomas at 50.6% for girls were at or close to parity. *Secondary education*: • While secondary schools overall have always had more girls than boys, there have been significant differences between regions and by grade levels • The top two reasons for dropping out have been teenage pregnancy and long distances from home to school. In 2012, more than 1 400 females left school because of pregnancy compared to only 25 boys because of parenting obligations; while, in 2012, 392 girls dropped out because of long distances compared to 424 boys.	• Starting from the primary school level, create awareness among school-going girls and boys, and their parents of both the prevention and human rights aspects of the Teenage Pregnancy Policy • Address the psychosocial issues that lead to teenage pregnancies, e.g. poverty, transactional sex, gender inequality and peer pressure • Continue with 'My Future, My Choice' programmes and clubs • Increase the number of school counsellors and regional-level social workers, especial in rural areas • Reduce violence, abuse and exploitation at schools and school hostels • Implement and enforce school codes of conduct for learners and teachers • Enforce relevant laws and policies and create mechanisms to hold those who violate accountable, including dismissing any school teacher who impregnates a school girl • Raise awareness among learners and adults that cross-generational sex is totally unacceptable • Increase the MOE budget for building more schools, establishing mobile schools, or the provision of free transportation in areas where children are dropping out of school because of long distances • Implement the National Plan of Action to Eliminate Child Labour (ILO and MOLSW 2008), the Convention on the Rights of the Child (CRC) and the Namibian Constitution's clauses pertaining to children's rights to education
There are inadequate proportions of women in all governing bodies except local authorities.	• Create new legislation to enforce 50:50 representation within political parties and disqualify parties that do not comply from participating in elections at all levels • Establish a regulatory framework and monitoring and implementation system for a 'zebra' or 50:50 system to enable equitable representation • Alternatively, develop and implement similar legislation for other governing bodies, such as Regional Councils and Parliament to the Local Authorities Act 23 of 1992, which requires that more than 30 percent of the people on every party list be women • Provide training, awareness, and advocacy for young women to increase the number of women who might be interested in a political career, in order to enhance their self-confidence • Establish an organisation (similar to 'Emily's List' in the United States) that encourages and mentors women to become candidates and supports female candidates through funding, capacity development and awareness-raising
A recognisable achievement in Namibia is the high female literacy, school enrolment and survival rates but it is a challenge to translate this level of education into formal jobs, particularly higher-level positions, and especially wage employment in the non-agricultural sector.	• Implement many of the recommendations indicated above for MDG 1 for employment creation and capacity building, but with an emphasis on a 50:50 balance for all training and employment opportunities • MGECW, OPM, MOLSW, Ministry of Trade and Industry, and Namibia Institute of Public Administration and Management (NIPAM) need to coordinate to advocate for women's capacity development and employment at senior levels • Every company/institution over a certain size should be required to have its own gender policy and gender mainstreaming plan, which should include steps to implement and monitor how it promotes gender equality e.g. 50:50 female:male training opportunities • The Affirmative Action (Employment) Act of 1998 needs to enforced be more rigorously • Whether or not VET institutions and companies fall under definition of 'relevant employer' in the AA Act, each institution should consider following the Voluntary Affirmative Action Clause 22, which states: "Any employer who is not a relevant employer may adopt and implement an affirmative action plan with this Act."

Challenges	Interventions to expedite MDG implementation
	• Consider revisiting the law that provides for maternity leave to extend maternity leave from three months to six months in order to avail more options to working women, while encouraging exclusive breast feeding • Within each organisation's corporate social responsibility programme, there should be a component to promote awareness among women and girls of the advantages of technical skills training programmes and to support women with bursaries • Discourage traditionally-held views that certain types of jobs are for women and other jobs are only for men • Break gender-based norms that separate women and men in all educational and employment sectors, including the traditionally female-dominated sectors such as teaching and nursing • Further capacitate MOLSW's Employment Services into all regions to enhance vocational counselling and aptitude testing for girls and boys • Expose girls and boys at an early age to non-traditional role models as teachers/trainers and in the labour market, including female role models in the engineering, mining and technical trade sectors • Follow through on the 2011 recommendation that the MOE re-introduce vocational subjects in the school curriculum and encourage girls to participate in the technical training • Every company/institution should have a sexual harassment policy
Continuing high levels of gender-based violence.	• Implement the National Plan of Action on Gender-Based Violence, 2012-16 • Meaningful coordination and collaboration between ministries and at various decision-making levels will need to be developed for successful implementation of the NPA on GBV • Review, if necessary, implement fully and enforce all the relevant legislation to reduce GBV, including the Combating of Rape Act of 2000, Combating of Domestic Violence Act of 2003, the Criminal Procedures Amendment Act of 2003 and the Correctional Service Act • Provide training to relevant officers issuing protection orders to better serve those seeking protection • Increase the number of Women and Child Protection Units, and strengthen the existing ones by ensuring adequate human and financial resources at all levels • Establish more 'places of safety' (e.g. shelters for women and children) in all regions • Rehabilitate incarcerated offenders/perpetrators of GBV and utilise them to create awareness among their peers • Implement the recommendations in the MGECW (2009:xv-xviii) report by SIAPAC, particularly to build the capacity of traditional and religious leaders and the community to address GBV, and legislative and policy action linked to national and local advocacy • Implement the numerous recommendations in the GR&AP reports, 'Rape in Namibia' (LAC, 2006) and 'Seeking Safety' (LAC, 2012b:553-574) • Strengthen the linkages between HIV and GBV services • Sexual harassment, exploitation or coercion of girls by male students and teachers is a form of GBV that can no longer be tolerated in Namibia's schools and training institutions
Inconsistencies in data sources, research methodologies and data presentation make it very difficult to identify gender trends and conduct analysis.	• GRN through NSA consultations with the relevant post-Grade 12 institutions should take a clear stand on how to define 'tertiary education' and which institutions to include in the definition • All studies reporting on these data must provide their methodology for calculations and exact sources of data

Looking Beyond 2015

The recommendations below are aimed at increasing overall gender equality in Namibia.

Collect evidence to understand better the reasons for school drop-out	It is necessary to improve analysis of existing data and conduct any necessary new research on the reasons for school drop-out, including exploring possible reasons in relation to water and sanitation, health and personal hygiene needs, poor nutrition, violence in schools and poor quality of some schools. For example, in some countries a lack of proper sanitation and the availability of sanitary pads for girls coming into puberty can cause girls to drop out of school. Therefore: • A study should be conducted by the MOE, MOHSS, MAWF's Directorate of Rural Water Supply and MGECW to determine the status of this correlation for Namibia • Greater emphasis must be placed on the provision of proper sanitation in schools • Use existing and new data to plan and monitor schools drop-outs better (and create mechanisms to track and encourage vulnerable learners)
Track and analyse the girls:boys ratio of children enrolled in pre-primary, along with quality control of non-government ECD centres	The importance of ECD, including pre-primary attendance, cannot be underestimated in terms of its impact on the future development of Namibia's girls and boys. Therefore: • Focus on improving the infrastructure in certain regions (e.g. Karas) and increasing training of pre-primary teachers (e.g. Erongo, Otzojondjupa and Kunene) to ensure implementation of compulsory pre-primary education • Consider requiring the registration of all ECD centres and programmes for 5 to 6 year olds (and later for 0 to 4 years olds) with Government to provide a monitoring and oversight mechanism for quality control • Design and implement a quality control programme for all ECD centres
Women's non-traditional skills training and the labour market	The education and labour sectors recommend the reintroduction of vocational subjects in the formal education system. Therefore: • Follow this recommendation, while emphasising that all subjects are suitable for both girls and boys, and all labour sectors are suitable for both women and men • Utilise the gender-sensitive and gender-aware role models and best practices found currently in some private VET institutions
Employment creation for women and men	MDG 1 recommends collaboration towards adequately paid, long-term opportunities. Therefore: • Government and private sector organisations need to collaborate to increase long-term employment opportunities with adequate remuneration and working conditions, equally for women and men • Special attention needs to be paid to youth employment creation, inclusive of both female and male youth
50:50 representation in Parliament and other governing bodies	Although Namibia has done well with female representation at some levels and generally compares well to many other African countries, the country is still far from achieving 50:50 representation. Therefore: • Broaden the indicator on proportion of seats held by women in Parliament to include other governance levels, such as regional, local and constituency authorities • Consider not only tracking 50:50 representation of Members of Parliament and other governing bodies, but also adding 'a skills indicator' in the next round of MDGs to track the capacity of both female and male leaders • Develop and implement skills training as required

Reduction in GBV	Despite indications of empowerment among women and shifts in attitude to domestic violence among both women and men, GBV is still unacceptably high. Therefore: • Long-term awareness and education programmes need to be introduced in Namibia, starting at pre-primary and carrying on through all the school levels • Prioritise comprehensive sexuality education in families, communities and in and out of school settings, taking into account the specific needs of girls and young women, e.g. goal-setting, decision-making, communication, assertiveness, and negotiation skills, as these can prevent and mitigate relationship violence and promote safe sex • Male involvement in family planning and child-raising should be promoted • Training and awareness-raising is needed for traditional authorities and other community leaders to enable them to understand that violence towards girls and women and boys and men should not be tolerated, even if certain aspects are currently culturally or traditionally accepted • Strengthen and expand comprehensive services for GBV survivors
Impact of climate change on women's empowerment	Climate change will have different impacts on girls and women to those on boys and men. Therefore: • Continue to mainstream climate change into the policies, strategies and plans across all sectors in a manner that recognises gender-differentiated impacts • Give attention to necessary gender-sensitive strategies and interventions
Data collection and analysis methodologies	There is a need for consistent data collection and analysis methodologies to enable sound evidence-based policy-making, planning and implementation. Therefore: • NSA, NPC and UNDP should provide explicit instructions for best data sources and analysis methodologies • All indicators for MDGs should be gender disaggregated

MDG 4: Reduce Child Mortality

Namibia is considered one of the top ten high-mortality countries with the sharpest increase in the annual rate of reduction in under-five mortality in Sub-Saharan Africa (UNICEF, 2012:8). The opportunity represented by child mortality is that almost all cases can be prevented, especially with well-equipped health professionals and infrastructure. However, the child health programme in Namibia is challenged by weak health systems and limited human resources (MOHSS, 2010a:1). Several interventions to decrease child mortality have been implemented but the MDG targets are not being met. In response, the MOHSS and development partners have adopted a road map to accelerate interventions towards both achieving the MDGs and maintaining response beyond 2015.

The target for MDG 4 is to ensure that, by 2015, under-five mortality rates are reduced by two-thirds. The three relevant indicators are, to reduce both under-five mortality and infant mortality by two-thirds between 1990 and 2015, and to increase the proportion of one-year-old children immunised against measles. While the measles immunisation programme is on target, current data for Namibia show that it is unlikely to attain the reduction in child mortality targets by 2015.

MDG 4: Status at a Glance

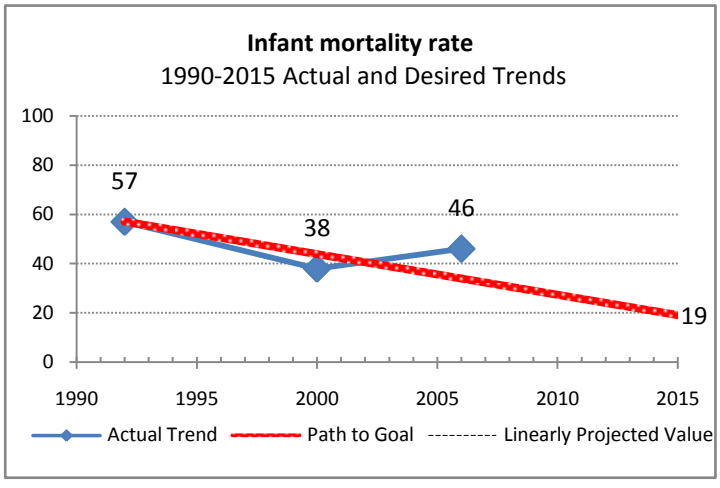
GOALS AND INDICATORS	BASELINE	STATUS	TARGET (2015)	TARGET/ GOAL ACHIEVABLE?
MDG 4: REDUCE CHILD MORTALITY				
Infant mortality rate (deaths per 1 000 live births)	56.6 (1992)[1]	46 (2006/07)[2]	19	Not on target
Under-5 mortality rate (deaths per 1 000 live births)	83.2 (1992)[1]	69 (2006/07)[2]	28	Not on target
Proportion of 1-year-old children immunised against measles	75.7 (1992)[1]	78 (2006/07)[2]	85	On target

[1]MOHSS, 1993 (2000 NDHS) [2]MOHSS, 2008 (2006/7 NDHS)

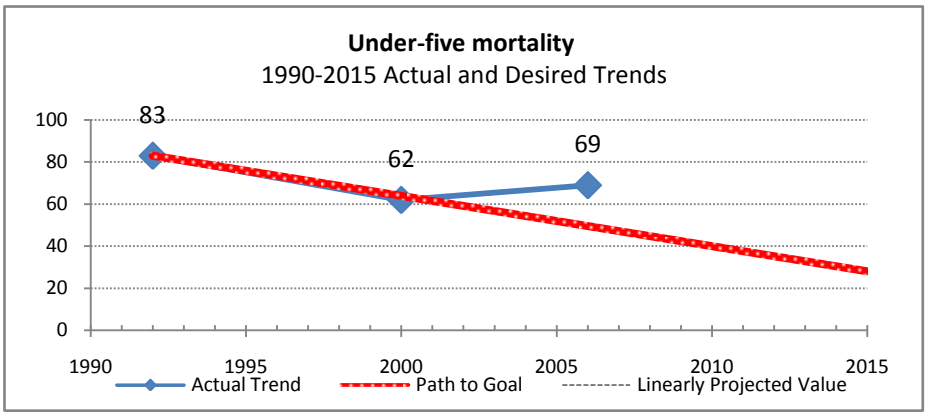
Current Status and Trends

The graphs on the right and on the next page show that Namibia is not on target to achieve a reduction in infant mortality[14] to 19 deaths per 1 000 live births by 2015. Likewise, the under-five mortality target of 28 deaths per 1 000 live births is unattainable. However, Namibia has made great strides in achieving 78 percent coverage of children under one year of age immunised against measles by 2006/07 and is on track to achieve the goal of 85 percent by the year 2015.

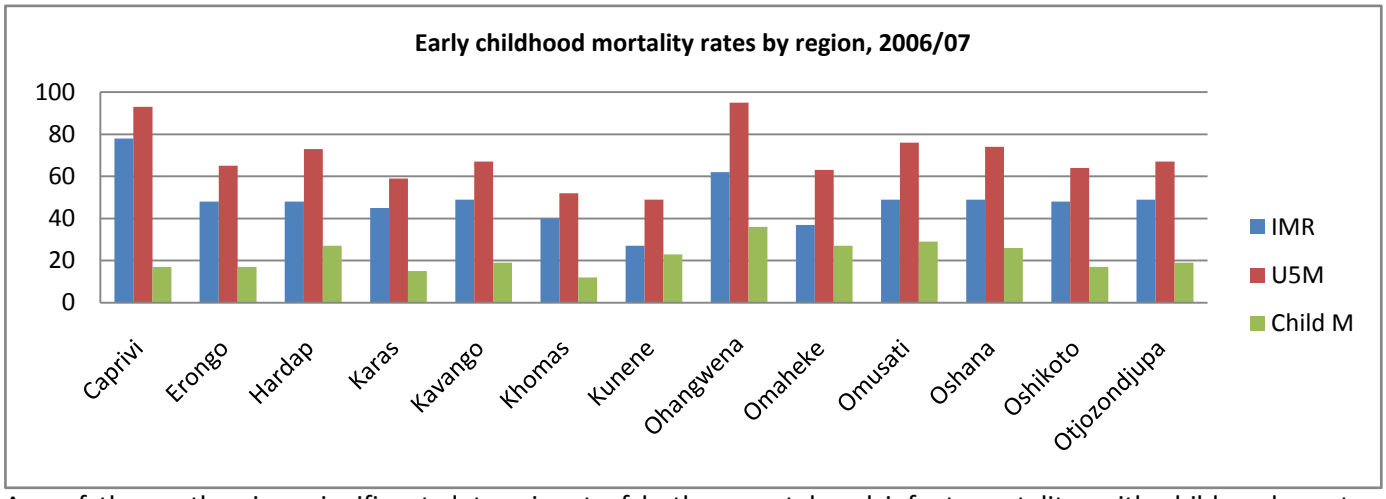
Extrapolating the 1992 to 2006/07 rate of reduction in infant mortality towards the 2015 goal, the number is expected to be 33 deaths per 1 000 live births, which is about 1.7 times higher than the target of 19. Namibia experienced a decline in infant mortality between 1992 (57 per 1 000 live births) and 2000 (38 per 1 000 live births) and a sudden increase from the year 2000 to 2006/07 (46 per 1 000 births). The UNICEF 2012 Progress Report indicated that the infant mortality rate was 30 per 1 000 live births, while the under-five mortality rate was 42 per 1 000 live births in 2011 (UNICEF, 2012:34). Although these latest figures for 2011 show declines in both mortality rates, the 2015 targets would still be unattainable.



[14] 'Infant mortality' states the probability of dying before the first birthday. 'Under-five mortality' is the probability of dying between birth and the fifth birthday. 'Child mortality' is the probability of dying between the first and fifth birthday.

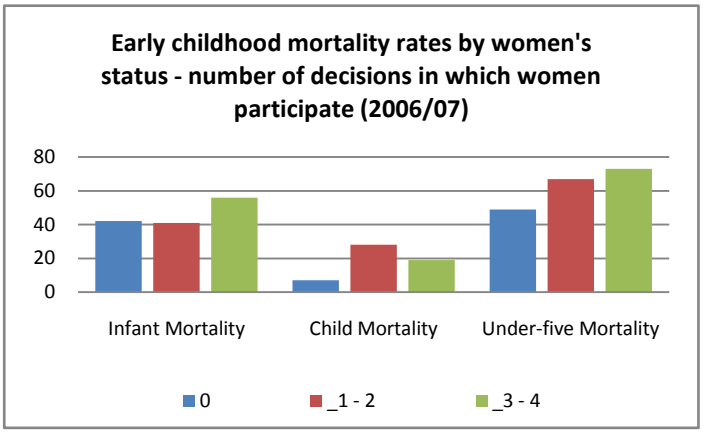


The under-five mortality rate decreased from 83 per 1 000 live births in 1992 to 62 in 2000 and increased to 69 per 1 000 live births in 2006/07. Extrapolating the 1992 to 2006/07 rate of reduction in under-five mortality towards the 2015 goal, the number is expected to be 57 deaths per 1 000 live births, which is about 2 times higher than the set target of 28. It is safe to say, therefore, that Namibia will need innovative interventions in its pursuit to reach the 2015 MDG. The geographic trends for child mortality over the past ten years were fairly constant, with higher mortality rates in rural areas than in urban areas. The rate in rural areas was 52 deaths per 1 000 births in 2006/07, compared to 43 deaths in urban areas, mainly because of better access to health and information services in urban settings. Infant mortality was highest in Caprivi (78 per 1 000 live births) in 2006/07, while under-five mortality was highest in Caprivi and Ohangwena. The lowest rates for both infant and under-five mortality were found in Kunene region, at 27 per 1 000 live births as a measure of infant mortality. Ohangwena and Caprivi are also among the poorest regions, while Kunene was considered the sixth poorest among the thirteen regions. In relation to gender, female children across all age groups had a higher probability of survival than male children.



Age of the mother is a significant determinant of both neonatal and infant mortality, with children born to younger mothers (under 20 years of age) and those born to older mothers (40 years and older) having higher mortality levels. The risk impact of the mother's age for infant and child mortality is markedly more significant for older than for younger mothers. Other factors that contribute to infant and child mortality are birth intervals, the number of children a mother has, where the particular child appears in this order, the child's size at birth and the mothers' level of empowerment.

The 2006/07 Namibia Demographic and Health Survey (NDHS) measured child mortality by women's participation in household decision-making, attitudes towards a wife's right to refuse to have sex with her husband, and attitudes towards wife beating. Interestingly, it was found that mortality rates were lower for children born to women who had no household decision-making power and for women who did not agree with any of the reasons for refusing sex with their husbands (MOHSS, 2008:103). Infant mortality was highest among women who agreed with all three reasons for refusing to have sexual intercourse with husbands. Infant mortality, child

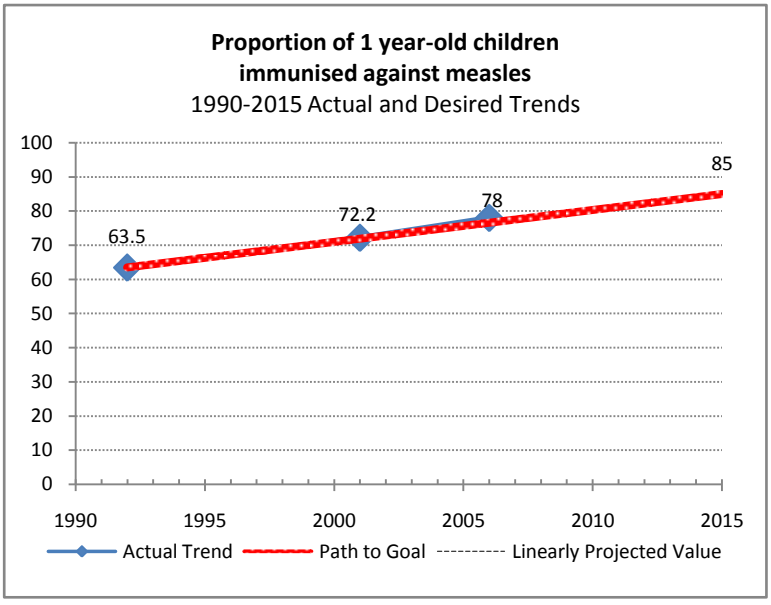


mortality and under-five mortality was also highest for women who could give five reasons for which wife beating is justified and lowest (child mortality and under-five mortality) for women who could not give any reason for which wife beating is justified.

A significant correlation was found between the education and wealth of mothers and mortality, with more highly educated and wealthier mothers having lower child mortality rates. The NDHS 2006/07 found that, "children born to mothers in the lowest wealth quintile are at much higher risk of dying before the fifth birthday (92 deaths per 1 000 births) than those born to mothers in the highest wealth quintile (29 deaths per 1 000 births)" (MOHSS, 2008:101). Under-five mortality for children in the lowest wealth quintile is nearly double that of children in the highest wealth quintile. Some of the causes of child mortality are:

- Acute respiratory infections
- Diarrhea
- HIV related illness
- Neonatal causes
- Congenital abnormalities.

A further cause is lack of immunisation. A slight increase has been reported in children between 12 and 23 months who have been vaccinated fully, from 65 percent in the year 2000 to 69 percent in 2006/07. The coverage for MCG (vaccine against TB) and DPT vaccines is much higher than for polio and measles (MOHSS, 2008:135). The 2015 target of 85 percent for measles vaccination for children 12 months old and younger is on target to be reached, as it already stood at 78 percent by 2006/07. Female children have slightly higher vaccination coverage than male children, as was also found in the two previous Demographic and Health Surveys in 1992 and 2000. Children in urban areas are more likely to be vaccinated (72 percent) than children in rural areas (67 percent). Kunene region had the lowest level (35.3 percent) of immunisation, although this region's infant mortality rate was also the lowest. Omusati had the highest immunisation rate (81 percent) in 2006/07. Children born to poorer mothers were less likely to be immunised and the 2006/07 NDHS found that mothers with higher education levels are more likely to have their children immunised. "Fourty-four percent of children of mothers with no education are fully immunised, compared with 86 percent of children of mothers with at least some secondary education" (MOHSS, 208:136). Immunisation coverage for children one year of age and older has also improved over time.



Milestones

Namibia acknowledges that newborn, infant and child health are essential for the sustainable development of the nation, as the children of today will lead the nation of tomorrow. Namibia, therefore, adopted MDG 4 to strive towards the reduction of child mortality through policy development, building human resource capacity, establishing an enabling environment and allocation of resources.

The National Task Force on Maternal and Child Health leads a multi-sectoral response to maternal and child health issues. The multi-sectoral response strategy brings together stakeholders from ministries, development partners, NGOs, FBOs and community-based organisations (CBOs).

Child medical care has been provided via the Reproductive and Child Health sub-division in the Primary Health Care department of the MOHSS. Good progress has been made towards improved child health and access to health services, but child mortality continues to grow, according to available official data. Several assessments have been conducted to identify the bottlenecks and to develop strategies for improvement. One such was the Needs Assessment for Emergency Obstetric Care (EmOC) and the resultant development of the Guidelines on Essential and EmOC in 2009. Namibia also adopted the Road Map for Accelerating the Reduction of Maternal and Neonatal Morbidity and Mortality in 2010. The Road Map (MOHSS, 2010a:4) aims to:

1 Provide quality maternal healthcare services at all levels of healthcare delivery
2 Increase utilisation of maternal and neonatal health services
3 Provide quality neonatal care services at all levels of healthcare delivery
4 Provide adolescent friendly health services (AFHS) at all levels of healthcare delivery

Several improvements have been achieved in terms of child health, such as high antenatal care coverage and relatively high frequency of visits to health facilities, which provides an excellent opportunity for information sharing, education and communication. Increased immunisation coverage using the Reaching Every District (RED) approach and National Immunisation Days (NIDs) are components of the Expanded Programme for Immunisation. The NID has grown significantly since it was first rolled out in 1996. Since 2009, regional implementation of Maternal and Child Health Days has improved immunisation coverage of under-five children as well. Improved antiretroviral coverage and putting children on prevention of mother-to-child transmission of HIV (PMTCT) treatment have prevented new HIV infections and prolonged lives among infants and children infected with HIV.

Several key guidelines have been prepared including: Guidelines for Completing the Maternal and Peri/Neonatal Death Review Form; National Standards for Adolescent Friendly Health Services; National Guidelines on Infant and Young Child Feeding; and Guidelines on Essential and EmOC. These guidelines and standards have played a key role in strengthening provision of quality health services to children under five years of age.

In addition, capacity building programmes have been put in place covering, for example: a Nutrition Assessment and Counselling Support Programme; an EmOC Life Saving Skills Training; Integrated Management of Neonatal and Childhood Illnesses; Integrated Management of Acute Malnutrition; distribution of oral rehydration salts; distribution of mosquito nets; health education on nutrition; and prevention of diarrhea campaigns. Central to these programmes has been capacity building among health professionals, especially nurses, in basic emergency responses. Many health professionals across the regions now serve as trainers as well, ensuring sustainability and skills transfer on a continuous basis.

The establishment of Regional Stakeholders' and Home-Based Care Forums created a platform for all regional stakeholders to contribute to resolving pressing health issues and to engage directly and indirectly with community members. In the Omaheke Region, a sub-committee for food security was established.

Strengthening internal and external capacities by recruiting health professionals from outside the country and engaging Community Health Extension Officers (currently piloted in Kunene and Kavango only) have been shown to improve overall quality and access to health services. Infrastructural development and the procurement of much-needed equipment have also improved.

Challenges and interventions to expedite MDG implementation in the remaining two years

Several road maps have been developed and workshops facilitated to accelerate the reduction of child mortality in the country's effort to reach MDG 4 by 2015. These have resulted in the design of strategies and the current implementation of a number of initiatives. Some of the key challenges and a set of recommendations towards expediting implementation and improving Namibia's chances of achieving this Goal within the remaining two year period are outlined below. The overall recommendation is based on the need for the public health sector to become more proactive in its responses.

Challenges	Interventions to expedite MDG implementation
The state of health infrastructures is such that there is a public outcry for improvement in buildings, equipment, water, sanitation, electricity and other facilities	• Urgent attention needs to be paid to the condition of infrastructure in public hospitals, health centres and clinics • An increased budget allocation is needed for regular maintenance of health infrastructure but such funds need to be well used, starting with a tendering process that is efficient and provides value for money • Increase the number of maternal waiting homes near major hospitals
While generally a good quality service is provided, some ineffective and inefficient management of health service provision at national, regional, district and local levels has contributed to lower quality health provision, especially as it relates to child health. This includes management of staff shortages.	• Strengthen the capacity of health management teams to plan, manage, implement, monitor and evaluate • An in-depth assessment is needed to determine the qualifications of health managers, with recommendations to strengthen overall management • Strengthen the Reproductive and Child Health sub-division • Enhance the capacity of personnel and infrastructure to provide AFHS • Strengthen follow-up mechanisms, including tracking of mothers and children through the health system
Lack of basic skills among some nurses to prevent child mortality, noting that a large proportion of newborn deaths is preventable. In addition, the undesirable attitude of some health personnel towards patients, discourage some from seeking medical support unless absolutely necessary.	• In-service training needs to be strengthened • Self-assessment tools that are already in place need to be utilised
Referral systems are weakened by poor communication between health service providers and patients, and lack of transportation to referral health facilities	• Establish community health committees and emergency committees to support access to health facilities and referrals • Such committees need to establish appropriate communication and transportation mechanisms relevant to an area and based on local resources • Roll out the Community Health Extension Officer programme currently being piloted in five regions
Difficult access to health services, especially for severely poor and marginalised groups	• Planning for infrastructure development needs to be based on current and projected future geographical distribution of people • Sufficient allocation of public funds needs to be allocated to infrastructure development • All health service providers need to be informed about the exemption of OVC so that is applied consistently • The exemption needs to be revised to include the severely poor as well, especially as some OVC are better off than some severely poor • Community Health Committees need to be established to improve access through better coordinated transportation and communication with health service providers

Low awareness of maternal and child health, especially in remote and poor areas, contributes to higher mortality rates in such regions.	• Promote maternal and child healthcare • Promotion of the involvement of the entire family in maternal and child health, especially involvement of males • Develop and disseminate culturally sensitive information, education and communication (IEC) materials on child health, prenatal care, postnatal care, PMTCT and family planning • A rights-based approach to awareness raising is needed, ensuring that parents know their own and their children's health rights • Continue to raise awareness of the importance of child immunisation • Expand health extension workers services to all thirteen regions to bridge the gap between facilities and the communities needing access
Illegal and unsafe abortions and baby-dumping contribute to increased child and maternal mortality.	• Raise awareness about abortions and baby-dumping, while current legislation is reviewed to decrease unsafe abortions and baby dumping
The existing M&E system is not used optimally to plan for child health.	• Strengthen the M&E of the Health Management Information System (HMIS) to make data more frequently available • Capacitate health professionals and administrators to apply available data from HMIS

Looking Beyond 2015

Improve skills, experience and the work environment	It is necessary to empower health professionals with skills and experience, and to provide a conducive working environment that will decrease the attrition levels of health professionals. Therefore: • Child-centred health approaches need to be understood and adopted across the healthcare system • Equip paediatric health professionals and semi-professionals with adequate knowledge and skills, including the interpersonal skills appropriate to working with children and parents • Equip ancillary workers, such as cleaners, with the knowledge and skills appropriate to a health facility through adequate training on the linkages between cleanliness and spread of viruses, and other relevant issues • Continuous evaluation of staff performance is needed and performance should be disciplined or rewarded on the basis of merit, including a system based on evaluation by patients • Involve the private sector in contributing to training of health professionals, as the public health sector plays an essential role in ensuring a healthy workforce • Strengthen local training institutions to prepare and provide qualified nurses for the sector, to reduce the cost of sending nurses to other countries for training • Provide housing to nurses who work in rural areas • Increase remuneration to decrease attrition of health professionals
Maintain 100% immunisation of under-fives	An immunisation programme is in place and has had a positive impact on infant and child mortality, but immunisation coverage is uneven in terms of diseases combated and geographical area. Therefore: • Continue to implement the Extended Programme for Immunisation (EPI) • Concentrate more on those regions that show lower numbers, while maintaining the higher numbers in others
Make optimal use of HMIS	It is necessary to strengthen the M&E system of the HMIS to ensure that data are available on request. Therefore: • Produce and make available reviews of every child death to inform future prevention, care and support • Data should be used at all levels, but special efforts should be made to get regional, district and hospital/clinic/health centre levels to use such data to improve services • The M&E system should be used to identify priority areas for improvement in relation to available resources • Importantly, data should be used to engage the community in preventive measures

Revise health budget allocation	Currently 88 percent of the MOHSS budget is allocated to operational costs (mostly salaries), and only 2 percent to primary healthcare. Therefore: • The budget needs to be results-driven, focusing on key priorities, and internal budget allocations also need to be linked to results • Budget allocations should be needs-driven
Provide alternative health services	Provision of alternatives to the current public and private services would increase the availability of healthcare generally and enhance user access and options. Therefore: • Assess opportunities for public-private partnerships • Assess opportunities to use NGOs and FBOs to provide health services, thereby reducing pressure on public health service infrastructure • Build on existing best practice for involving NGOs, FBOs and CBOs in strengthening the national health outreach programme
Strengthen coordination between sectors and with CSOs	Responding to child health cuts across different sectors, requires multi-sectoral coordinated approaches. Coordination of different sectors continues to be a challenge. Therefore: • Strengthen coordination between vital sectors such as health, water, sanitation and education • Enhance collaboration and coordination with CSOs, for outreach and support services
Respond to poverty and HIV	Many constraints to healthcare provision and access occur as a result of either poverty or HIV, and as a result of the interrelationship between these two factors. Therefore: • Continue to provide HIV prevention, treatment, and care and support services in collaboration with civil society organisations • Strengthen the social protection systems to include all poor and severely poor children
Respond proactively to the impacts of climate change	The impacts of climate change are increasingly visible, particularly evident as recurring droughts in southern regions and floods in northern regions. Therefore: • Proactively prepare for and be ready to respond to negative impacts imposed by climate change, such as changing to drought resistant grains, moving vulnerable population before floods commence, etc. • Emergency programmes of food aid in times of drought need to be continued, with more efficient distribution mechanisms.

MDG 5: Improve Maternal Health

Maternal mortality, which is the death of women during pregnancy, childbirth, or in the 42 days after delivery, remains a major challenge to health systems in many parts of the world. The Government of the Republic of Namibia provides sexual and reproductive health services, including maternal and neonatal healthcare, and has implemented numerous safe motherhood strategies in various regions and districts of the country. Despite this, maternal mortality has continued to rise (MOHSS, 2010a). As with child health, almost all cases of maternal mortality can be prevented with well-equipped health professionals, infrastructure and increased access to health facilities. The operational challenges are imbedded in the 'three delays'[15] to treatment. In response to the main challenges and to accelerate implementation towards achieving MDG 5, Namibia and her development partners have designed a road map as a guide to implementation up to 2015.

The targets for MDG 5 are to: reduce by three quarters, between 1990 and 2015, the maternal mortality ratio; and achieve, by 2015, universal access to reproductive health. The current data for Namibia (based on 2006/07 NDHS) shows that Namibia has already achieved the target for births to be attended to by skilled health personnel, is on target to reduce the unmet need for family planning to zero (the final indicator for universal access to reproductive health), but is unlikely to meet any of the other targets for this Goal.

Status at a Glance

GOALS AND INDICATORS	BASELINE	STATUS	TARGET (2015)	TARGET/ GOAL ACHIEVABLE?
MDG 5: IMPROVE MATERNAL HEALTH				
Maternal health				
Maternal mortality ratio (deaths in 100 000 live births)	225 (1992)[1]	449 (2006/07)[2]	56	Not on target
Proportion of births attended by skilled health personnel (%)	68 (1992)[1]	94.6 (2006/07)[2]	95	Achieved
Universal access to reproductive health				
Contraceptive prevalence rate (%)	23 (1992)[1]	46.6 (2006/07)[2]	100	Not on target
Adolescent birth rate reduced by 100%	2 (1992)[1]	15 (2006/07)[2]	0	Not on target
Antenatal care coverage (at least one visit and at least four visits 4) (%)	56 (1992)[1]	72 (2006/07)[2]	100	Not on target
Unmet need for family planning (zero % unmet need)	24 (1992)[1]	7(2006/07)[2]	0	On target

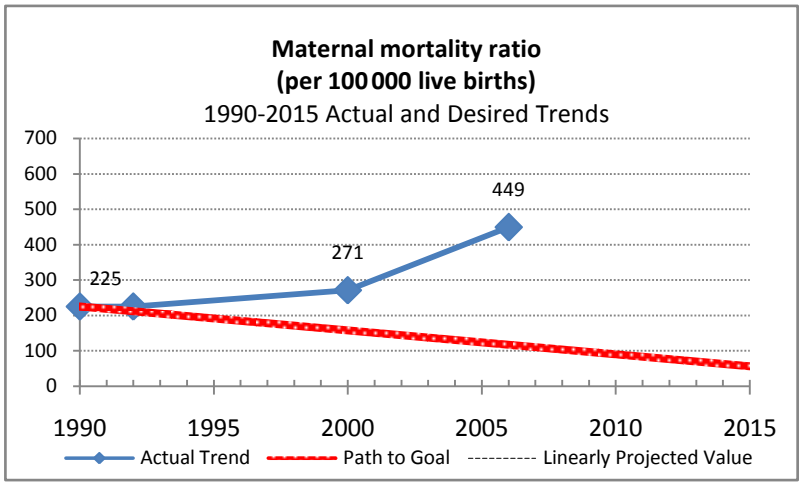
[1]MOHSS, 2003 (2000 NDHS) [2]MOHSS, 2008 (2006/07 NDHS)

Current Status and Trends

The graph below shows that the maternal mortality ratio (MMR) has increased from 225 deaths per 100 000 live births in 1992 to 449 deaths per 100 000 live births in 2006/07 (MOHSS, 1993; MOHSS, 2008). The ratio has almost doubled instead of decreasing significantly and this trend occurred despite the fact that in urban and rural areas, births increasingly take place at health facilities and are attended by skilled health personnel. The MDG target for 2015 of reducing maternal mortality to 56 deaths per 100 000 live births will not be achieved if the current increase in MMR is not halted and reversed. The World Health Organisation (WHO), UNICEF, UNFPA and the World Bank estimated that maternal mortality for Namibia in 2010 was 200 deaths per 100 000 live births (WHO, UNICEF, UNFPA, World Bank, 2012:34). With this estimated number of maternal deaths five years out, the 2015 target is still not achievable.

[15] 1) delay to decide to seek healthcare; 2) delay in getting to the health facility; and 3) delay in receiving appropriate medical care.

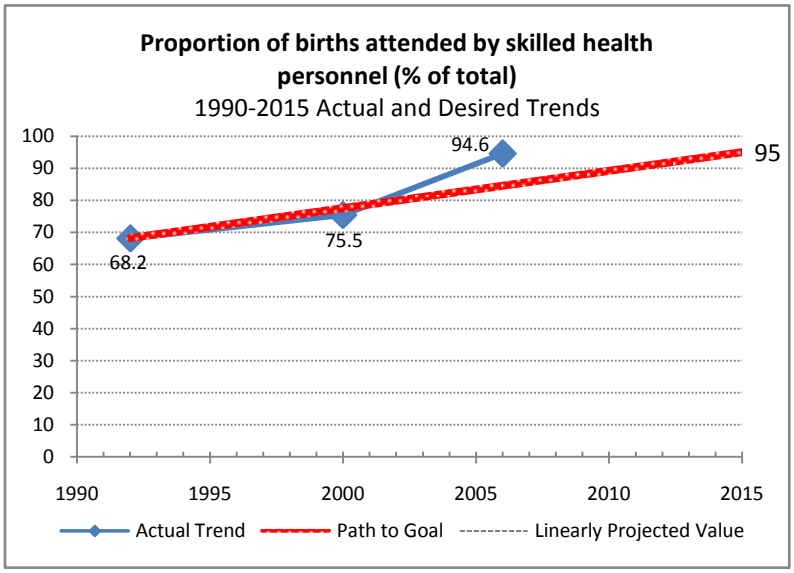
More than 75 percent of maternal deaths occur during childbirth or within 72 hours after delivery. Therefore, this is clearly the time for which improved care needs to be provided for women in Namibia. High mortality rates can be attributed to the following operational challenges, known as the 'three delays':



- Delay in deciding to seek care, which may be caused by limited understanding of complications, low trust in the healthcare delivery system, acceptance of maternal death as the norm in the context of low status accorded to women, and sociocultural barriers to seeking care
- Delay in reaching care, due to lack of transportation and/or communications, and physical, cultural, financial and other barriers to service access
- Delay in receiving care because of a lack of skilled personnel, supplies, equipment, and blood transfusion and other services.

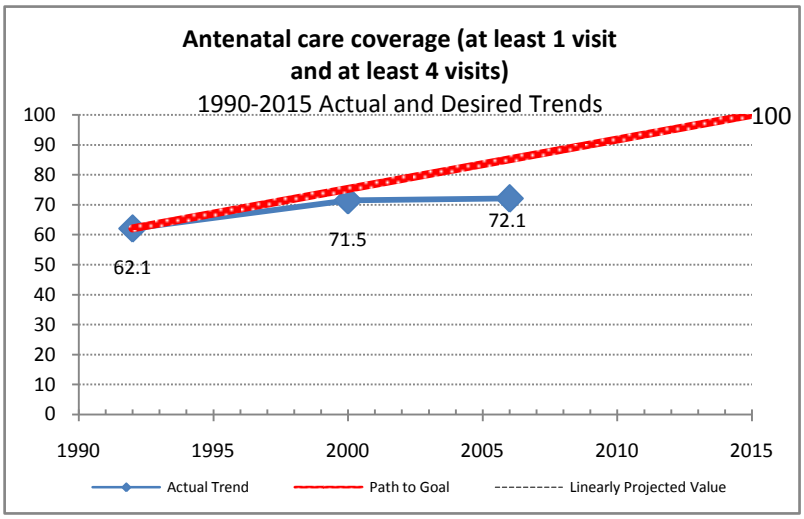
The increase in MMR in Namibia is also partially attributable to the high HIV prevalence in the country. This is the leading indirect cause of maternal mortality, accounting for a significant proportion (37 percent) of maternal deaths in health facilities, among others such as malaria, TB, meningitis and pneumonia. (MOHSS, 2010a:3).[16] The major direct causes of maternal mortality are eclampsia (33 percent), haemorrhage (25 percent) and obstructed labour (25 percent) (MOHSS, 2010a:3). Evidence also shows that women who are anaemic have a higher risk of dying from bleeding during pregnancy, child birth and the postpartum period than those who have an acceptable standard of haemoglobin (MOHSS, 2010a:3).

As noted, the increase in maternal mortality comes against an increase in the number of births attended by skilled health personnel. The graph below reveals that there was a steady increase in the proportion of births attended by trained health personnel from 68 percent in 1992 to 94.6 percent in 2006. It is necessary to analyse closely why the increase in proportion of births attended to by trained health personnel has not translated to a reduction in the MMR. One area to assess is the effectiveness of care received at health facilities before and after birth, and the follow-up care at home. Namibia has made great strides in increasing births attended to by skilled health personnel to 94.6 percent in 2006/07. Thus the MDG target has already been achieved. More than 90 percent of pregnant women aged 15 to 49 across twelve of the thirteen regions[17] received antenatal care from a skilled provider but in Kunene the figure was only 81.4 percent.



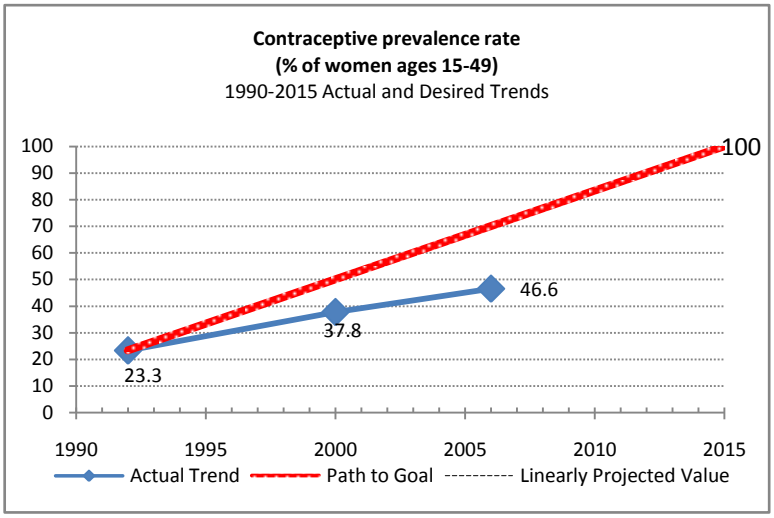
Only slight differences were reported between birth attendance by skilled health personnel coverage in rural areas (93 percent) and in urban areas (96 percent) (MOHSS, 2008) but a significant difference was reported for mothers who received antenatal care from a doctor in urban areas (27 percent) compared to rural areas (7 percent) (MOHSS, 2008). The MOHSS (2008:15) further notes that "nurses and midwives provide antenatal care for 86 percent of

[16] The 2012 WHO, UNICEF, UNFPA and World Bank Report on maternal mortality estimated that AIDS related indirect maternal mortality was 59.4 percent for 2010 (p. 34).
[17] The NDHS unfortunately does not provide data on maternal mortality disaggregated by region to compare with antenatal care by region.



mothers in rural areas but only 69 percent of mothers in urban areas". Women are more likely to visit antenatal clinics with their first child (96.6 percent), compared to 92.2 percent for their fourth to fifth child. Pregnant women between the ages of 20 and 34 are more like to seek skilled services, followed by those younger than 20 years old. Those 35 to 49 years old are the least likely to seek skilled services, probably because they have had more children than the younger age groups. The wealthier and more educated the mother, the more likely she is to seek skilled services. Only 79 percent of mothers with no education obtain skilled services, compared to 97.4 percent among those women who have completed secondary education (MOHSS, 2008).[18] Underlying these findings is the fact that the coverage of antenatal care generally improved in the period 1990 to 2006/07, from 62 percent to 72 percent (see graph above). However, at this rate of improvement, the target of 100 percent coverage by 2015 will not be achieved.

The contraceptive prevalence rate (see graph below) doubled from 23 percent in 1992 to 47 percent in 2006. This is a significant increase but is unlikely to result in the 100 percent target for 2015 being achieved. Almost all women and men are likely to have heard of at least one method of fertility regulation. Nearly equal proportions of women (72 percent) and men (71 percent) reported having used a contraception method. This represents an increase of approximately 10 percent since 2000. There was also a substantial increase in women using any method of family planning, from 23 percent in 1992 to 47 percent in 2006/07, while "Use of modern contraceptive methods increased from 21 percent in 1992 to 46 percent in 2006-7." (MOHSS, 2008:59) Sexually active women of all ages in urban settings are more likely (74 percent) to use modern[19] contraceptives than those in rural areas (55 percent). It was also found that the prevalence of contraceptive use increases with education levels and wealth quintiles. Those in Erongo and Khomas regions were also more likely to use condoms than those in Kavango. Kavango is the poorest region in Namibia while Erongo and Khomas are among the richest. It was also found that women start using contraceptives at a young age, while contraceptive use decreases the more children they have and the older they get. The age group for women with the highest contraceptive prevalence in 2006/07 was the 25 to 29 years group (57.8 percent), followed by 30 to 34 year olds (54.7 percent), and 20 to 24 and 35 to 39 year olds at 52.6 percent (MOHSS, 2008:58). The age group with the lowest contraceptive use prevalence was the 15 to 19 year olds.



Unmet needs are influenced by women's empowerment and negotiating authority on the use of contraceptives and whether to have children. Nevertheless, the proportion of currently married women with an unmet need for family planning decreased from 24 percent in 1992 to 7 percent in 2006, suggesting that it is likely the target of zero unmet family planning needs will be met by 2015 (MOHSS, 2008:253).

The overall trend of adolescent births has been on the increase from 1990 to 2000, to 2006/07 and there was a 56 percent increase from 1992 to 2006. The MDG target is to have zero adolescent births by 2015, but the

[18] These figures represent at least one visit to an antenatal care clinic.

[19] Modern contraceptives refer to female and male sterilisation, the pill, the intrauterine device, injectables, implants, male condom, female condom, lactational amenorrhoea and emergency contraception (MOHSS, 2008:53).

adolescent fertility trend over the fifteen years to 2006/07 shows Namibia is not on track to achieve this target. The current adolescent fertility rate is 78 births per 1 000 women between 15 and 19 years of age. Fertility is higher in rural areas than in urban areas for all ages, with child bearing commencing relatively early in Namibia (MOHSS, 2008). Adolescent fertility is much higher in rural areas (92 births per 1 000 women) than in urban areas (58 births per 1 000 women). Adolescent fertility was lowest in Khomas region followed by Omusati and Oshana, and highest in Kavango followed by Omaheke and Caprivi.

Milestones

The Government of Namibia is particularly concerned about an increase in maternal mortality. To respond to the increasing numbers of maternal deaths, the MOHSS facilitated the establishment of the Maternal and Child Health Committee in 2008 under the Primary Health Care Department. The mandate of this committee is to coordinate and harmonise the speedy implementation of "evidence based maternal and child health interventions in the country" (MOHSS, 2011a:6). Represented on the committee are government departments, UN agencies, development partners, NGOs, FBOs, tertiary hospitals and training institutions.

Maternal health services are based on four pillars: 1) antenatal care; 2) clean and safe delivery; 3) post natal care; and 4) family planning. Given the evidence that Namibia and many other countries will not be able to achieve the MDG on maternal mortality, the WHO in collaboration with the African Union (AU) and member states prepared a Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality in Namibia. The first Road Map for Namibia was launched in 2008, followed by a second one in 2010.

A significant milestone in response to increased maternal mortality was the Life Saving Skills/EmOC training-of-trainers course for doctors, nurses and midwives. The main purpose was to upgrade the skills and knowledge of health professionals in the provision of emergency obstetric and neonatal care. Representatives from all thirteen regions were trained, ensuring that training can be rolled out to others in the regions. Eighteen health workers were also trained as trainers on Community-Based Maternal and Neonatal Care in Kavango Region. Other achievements have included:

- Availability and provision of quality maternal and neonatal healthcare services
- Institutionalisation of Routine Maternal Death Reviews overseen by a National Maternal and Peri-Natal Death Review Committee, established in 2010 and following the WHO guideline, 'Beyond the Number Reviewing Maternal Deaths and Complications to Make Pregnancy Safer'
- Establishment of a National System for Confidential Enquiry into Maternal Deaths
- Empowerment of individuals, families and communities to improve reproductive health, and maternal and neonatal health (MNH)
- Regional campaigns, such as the Accelerated Reduction of Maternal Mortality launched in Gobabis in 2010, to raise awareness of maternal and child health issues
- Establishment of a referral system between communities, clinics, health centres and district hospitals
- Creation of an enabling operational environment to respond to maternal health issues
- Strengthening of the capacity of national, regional and district health systems in planning, implementing, monitoring and evaluating maternal and neonatal care services
- Resource development for strengthening MNH services
- Integration of neonatal care within other health programmes
- Strengthening of services that address adolescents' sexual and reproductive health and rights
- Improved recruitment of health professionals from within and outside Namibia
- Improved health infrastructure, coupled with improved procurement of equipment
- Improved male involvement in prevention of parent-to-child transmission of HIV.

Namibia has responded well to HIV, especially with regard to PMTCT strategies, which have a direct impact on maternal and child health. The PMTCT programme commenced in 2002 and, by 2011, 314 out of 340 health facilities provided PMTCT, including all state hospitals and health centres (MOHSS, 2009:2). Prevention of mother-to-child transmission has been integrated fully into routine antenatal, maternity and postnatal care services, and safe motherhood and newborn care interventions, "with established linkages to antiretroviral treatment (ART), tuberculosis management and other related services" (MOHSS, 2009c:2). The National Elimination Plan for MTCT

was launched in 2012 on World AIDS Day and spells out Namibia's strategy and plan for how to eliminate MTCT and keep mothers alive. Namibia has continued to update its national guidelines and registers based on lessons learned and WHO recommendations. Thus Namibia has managed significant, although not sufficient, achievements towards better maternal health.

Challenges and interventions to expedite MDG implementation in the remaining two years

Namibia needs to continue with the implementation of the above-mentioned Road Map with the aim of ensuring a continuum of care connected by effective referral links and supported by adequate skills, supplies, equipment, drugs and transportation. The challenges outlined and recommendations made here are also relevant to the child mortality goal (MDG 4).

Challenges	Interventions to expedite MDG implementation
The human resource challenges include shortage of skilled health workers, high attrition, language barriers between patients and some health professionals, and shortage of basic lifesaving skills among nurses.	• Design a health professional human resources development plan • Improve retention of health professionals with strategies such as scarce skills allowance, rural hardship allowance, and staff housing especially in rural areas • Accelerate training of all health workers, and design a long-term training plan • Build capacity of all categories of reproductive health service providers, including traditional birth attendants, nurses, midwives, etc.
Essential medicines including ergometrine, oxytocin, $MgSO_4$ and others are unavailable at lower levels of healthcare delivery.	• Ensure the availability and maintenance of essential medicines and equipment at all MCH centers
Health infrastructure is not appropriate to providing all required services.	• Design clinics that cater appropriately for all health needs • Expand maternal waiting rooms
Slow implementation of decentralisation.	• Speed up the decentralisation and devolution of power to regions and districts, with appropriate budget allocation
Community outreach is challenged by limited male involvement, weak referral systems and the difficulty of maintaining momentum.	• Strengthen male involvement in sexual and reproductive health • Strengthen the already established AFHSs, Namibia Planned Parenthood Association, Multi-Purpose Youth Centres, etc., which provide a wide range of reproductive health services • Expand access to midwifery care in the community and use midwives as an avenue for awareness raising • Raise the level of family planning uptake, especially long-term methods, and continue reducing the prevalence of unmet need for contraceptives • Improve the referral system for responding to maternal emergencies • Institutionalise regular monitoring and evaluation at all levels of the healthcare delivery system
Monitoring and evaluation	• Emphasise the routine collection and processing of data on process indicators for monitoring progress towards maternal mortality reduction, in the context of Namibia's Road Map for Accelerating the Reduction of Maternal and Neonatal Morbidity and Mortality, using indicators set out in the Road Map and the Neonatal Health HMIS

Looking Beyond 2015

Infrastructure development and maintenance	The development and maintenance of infrastructure is a major challenge that will require continuous focus. Therefore: • Promote and increase public and private financial investment in infrastructure for maternal healthcare, particularly clinics and health centres in rural and remote areas, including procurement of EmOC equipment, expansion of health posts in rural areas, construction of accommodation in remote areas and provision of maternal waiting rooms • Support infrastructure enhancements by improving provision of water and sanitation
Improve skills of health professionals responsible for maternal health	The fact that nurses and nurse midwives are not allowed to provide basic EmOC has proven to be restrictive in the provision of maternal healthcare. Therefore: • Revise and implement the long-term human resource strategy with key stakeholders such as line ministries, tertiary institutions and national and international development partners • With training and acquisition of improved knowledge and skills by nurses and mid-wives, change policy that would allow them to take on additional EmoC services • Continue to expand the cadre of community health extension officers
Strengthen community outreach	Community health extension officers programmes piloted in some regions have improved the quality of and access to health services. Therefore: • Extend the Community Health Care Extension Officers initiative • Enhance collaboration and coordination with CSOs, including co-financing their support services
Respond proactively to the impacts of climate change	The impacts of climate change are increasingly visible, particularly evident as recurring droughts in southern regions and floods in northern regions. Therefore: • Proactively prepare for and be ready to respond to negative impacts imposed by climate change, such as changing to drought resistant grains, moving vulnerable populations before floods commence, etc. • Emergency programmes of food aid in times of drought need to be continued, with more efficient distribution mechanisms
The combined impact of HIV and poverty in Namibia is severely undermining Government's efforts to reduce maternal mortality	With low immunity caused by HIV and poor nutrition due to poverty, many women succumb to diseases such as malaria and tuberculosis (TB). Therefore**:** • Strengthen integration of reproductive health, HIV and AIDS and PMTCT, TB and malaria services • Provide family planning as a component of the maternal, newborn and child health service package • Integrate recommendations from MDG1 for poverty alleviation

MDG 6: Combat HIV and AIDS, Malaria and Other Diseases

"Five years ago, when the international community committed to Universal Access, there were many who believed it was only a dream. Namibia has shown that this dream can become reality", Michael Sidibe, UNAIDS Executive Director (MOHSS, 2010g:4). Namibia, although having among the highest adult HIV prevalence in the world, is considered a country that has championed responses to HIV and AIDS. This is evident in trends showing that the adult prevalence has decreased and stabilised, new infections are decreasing, targets for treatment have already been achieved and impact mitigation is on course. However, new challenges have emerged with the progression of the epidemic, while some recurrent challenges continue to hamper further progress.

The three targets for this goal are, by 2015 to have halted and begun to reverse the spread of HIV, and the incidence of malaria and other major diseases, and by 2010, to have achieved universal access to treatment for HIV and AIDS for all those who need it.

The indicators for MDG 6 have changed since the inception of the MDGs in 2000. The first MDGR 2004 included three indicators that dealt with HIV prevalence and successful treatment of TB; the MDGR 2008 included nine indicators that dealt with HIV prevalence, incidence, condom use, access to ART, TB cases detected, successful treatment of TB and incidence of malaria; the MDGR 2013 was expanded to include 12 indicators across HIV and AIDS, TB and malaria. For targets 6A and 6B, Namibia has reached the target on one indicator and is on target for two others. The country is not on target for three of the indicators.

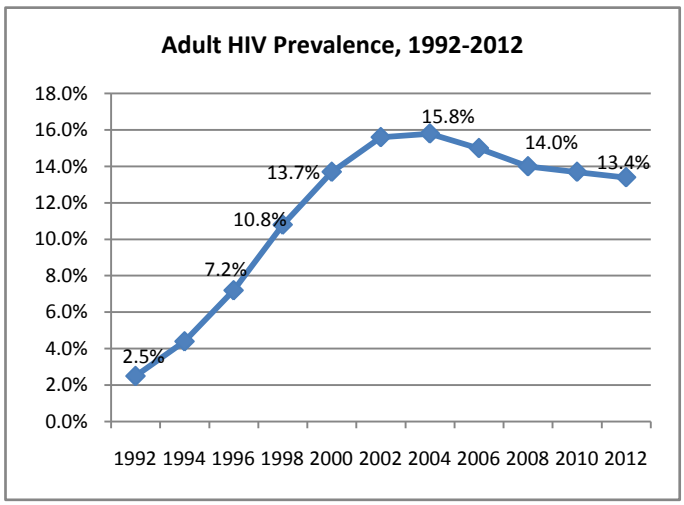
Status at a Glance

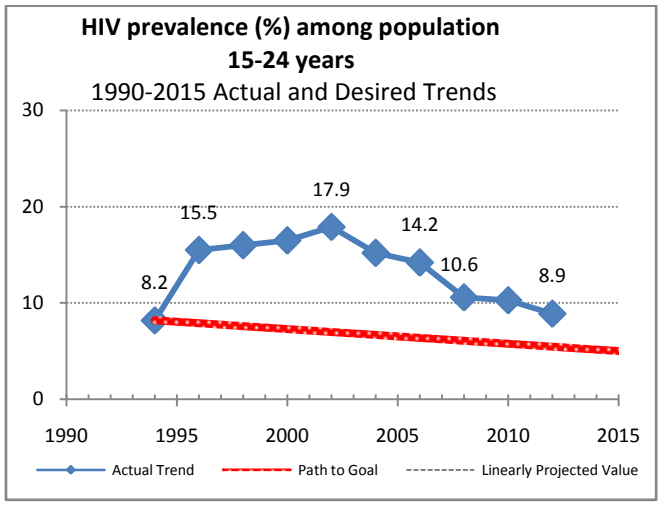
TARGETS AND INDICATORS	BASELINE	STATUS	TARGET (2015)	TARGET/ GOAL ACHIEVABLE?
MDG 6: COMBAT HIV AND AIDS, MALARIA AND OTHER DISEASES				
HIV and AIDS				
HIV prevalence among population aged 15-24 Years (%)	8.2% (2006)[1]	8.9% (2012)[1]	5%	Not on target
Condom use at last high-risk sex for 15-49 years age group				
Women (%)	-	62.1% (2006/07)[2]	85%	Lack of data
Men (%)	-	78.4% (2006)[2]	90%	Lack of data
Alternative indicator Condom use with non-cohabiting partner (15-49 years)				
Women (%)	51% (2000)[3]	62.1% (2006/07)[2]	n/a	No target set
Men (%)	66% (2000)[3]	78.4 (2006/07)[2]	n/a	No target set
Proportion of population aged 15-24 years with comprehensive, correct knowledge of HIV and AIDS				
Women (%)	38.9% (2000)[3]	64.9% (2006)[2]	90%	On target
Men (%)	50.7% (2000)[3]	61.9% (2006)[2]	90%	Not on target
Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years	0.92(2000)[3]	1.02 (2006)[2]	1.0	Achieved
Proportion of population (adults and children) with advanced HIV infection with access to ARV drugs (%)				
Adults (%)	56% (2006/07)[2]	81.5% (2011)[4]	100%	On target
Children (%)	88% (2006/07)[2]	83.9% (2011)[4]	95%	Not on target

[1] MOHSS, 2012c:12 (2012 HIV Sentinel Survey)
[2] MOHSS, 2008 (2006/07 NDHS)
[3] MOHSS, 2003 (2000 NDHS)
[4] MOHSS, 2012B:69 (NSF Progress Report, 2010/11

Current Status and Trends

Namibia has a mature, generalised HIV epidemic with a high adult (15-49) HIV prevalence[20] of 13.4 percent in 2012 (MOHSS, 2012d:33). Similarly to some other African countries, Namibia experienced a rapid increase in HIV prevalence following the first reported infection in 1986. Adult prevalence reached its peak in 2002 (close to 16 percent) and plateaued at around 13 percent by 2012. The first indicator under MDG 6 is to have halted by 2015 and begun to reverse the spread of HIV and AIDS. Although good progress has been made in the reduction of new HIV infections (incidence), reduction of the prevalence among 15 to 24 year olds to 5 percent is not on target. Prevalence in this age group reached its peak at 17.9 percent in 2002 and declined by 50 percentage points in the following ten years to the current (2012) 8.9 percent (MOHSS, 2012c).[21] The graph below shows that the prevalence among 15 to 24 year olds consistently decreased from 17.9 percent in 2002 to 14.2 percent in 2006, 10.3 percent in 2010 and 8.9 percent in 2012 (MOHSS, 2012c).



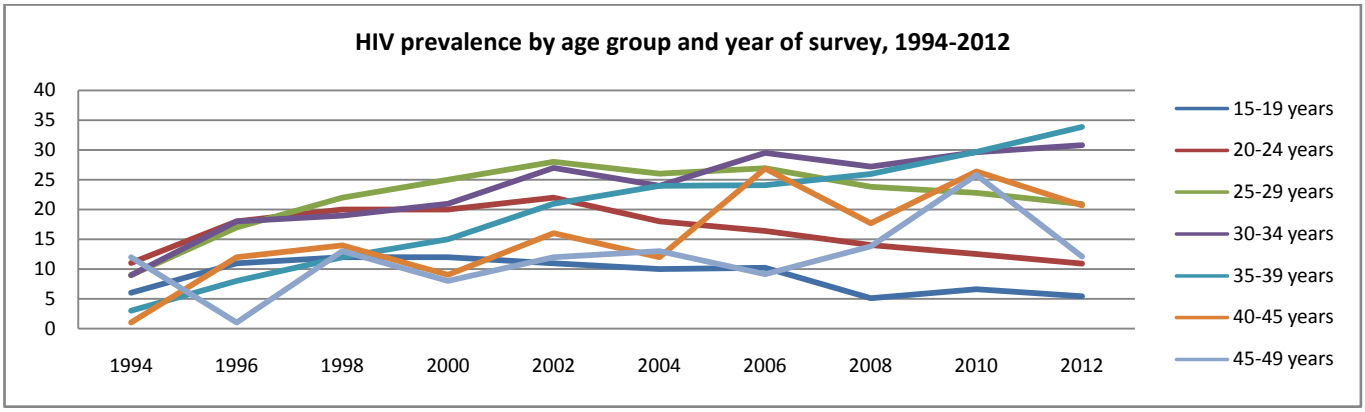


Although the prevalence among 15 to 24 year olds seems relatively low in 2012, considerable variations were reported across sentinel survey sites. In 2008, Katima Mulilo had the highest prevalence for this age group at 24.1 percent, followed by Tsandi (23.7 percent), Okahao (18.5 percent) and Walvis Bay (15.4 percent). In 2008, the site with the lowest reported prevalence for this age group was at Windhoek Central Hospital (1.4 percent), followed by Opuwo, (4.6 percent), Tsumeb (5.2 percent) and Khorixas (5.5 percent). In 2012, Katima Mulilo still reported the highest HIV prevalence (21.5 percent) among pregnant women between the ages of 15 and 24, followed by Rundu (17.4 percent), Luderitz (14 percent) and Oshikuku (12.2 percent). Windhoek Central Hospital continued to have the lowest prevalence at 0.0 percent in 2012, followed by Karasurg (1.2 percent), Nankudu (1.7 percent) and Usakos (3.3 percent). It is worth noting that prevalence, among pregnant women who participated in HIV sentinel surveys, increased significantly in areas such as Luderitz from 4 percent two years ago to 14.1 percent in 2012. The sentinel survey in 2012 found that in 22 out of 35 sites more than one quarter of the women tested HIV positive. It further reported that "among women for all ages (15 -49 years), from 2010 to 2012 a decline in HIV prevalence rate was observed at 10 (54%) out of 35 sites and an increase was observed at 14 (40%) out of 35 sites. No change was observed at 2 (6%) sites" (MOHSS, 2012c:23).

Variations were reported between age cohorts, with prevalence decreasing for some and increasing for others. The graph below shows that the highest observed prevalence, based on sentinel surveys, was among the 35 to 39 year olds and 30 to 34 year olds, at 33.9 percent and 30.8 percent respectively. The lowest prevalence was found among the 15 to 19 year olds (5.4 percent) followed by 20 to 24 year olds (10.9 percent). Trends show that prevalence continues to rise for the older age groups 30+, while it seems to be declining for the younger age groups, and stabilising for 25 to 49 year olds. Increased prevalence among older age groups is expected, because people on ART are healthier and live longer, while new infections enter the pool of those already infected.

20 Prevalence is based on HIV sentinel surveys carried out every two years among adult pregnant women visiting antenatal clinics. "To calculate national prevalence the ANC prevalence must be adjusted to account for males and other women that are not represented in the ANC surveillance hence the importance of modeling." (MOHSS, 2012d:7). The Spectrum Group of Models is used to give estimates of adult prevalence used here in the report.

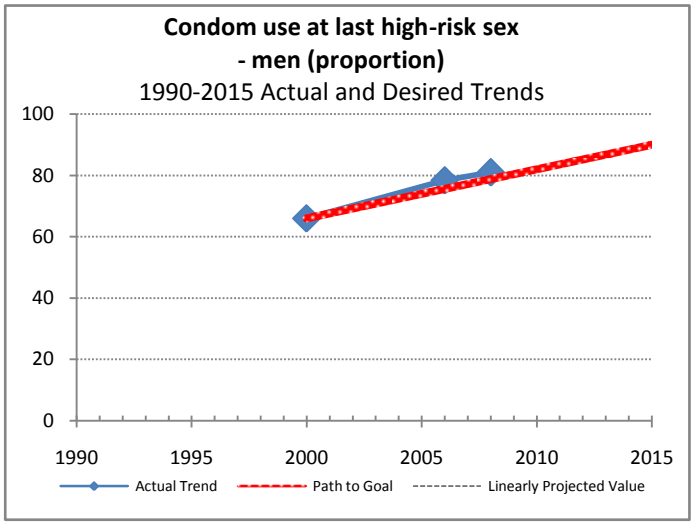
21 Based on the 2012 Sentinel Survey as the 2011/12 Estimate and Projects did not provide prevalence broken done by age category in the main report.

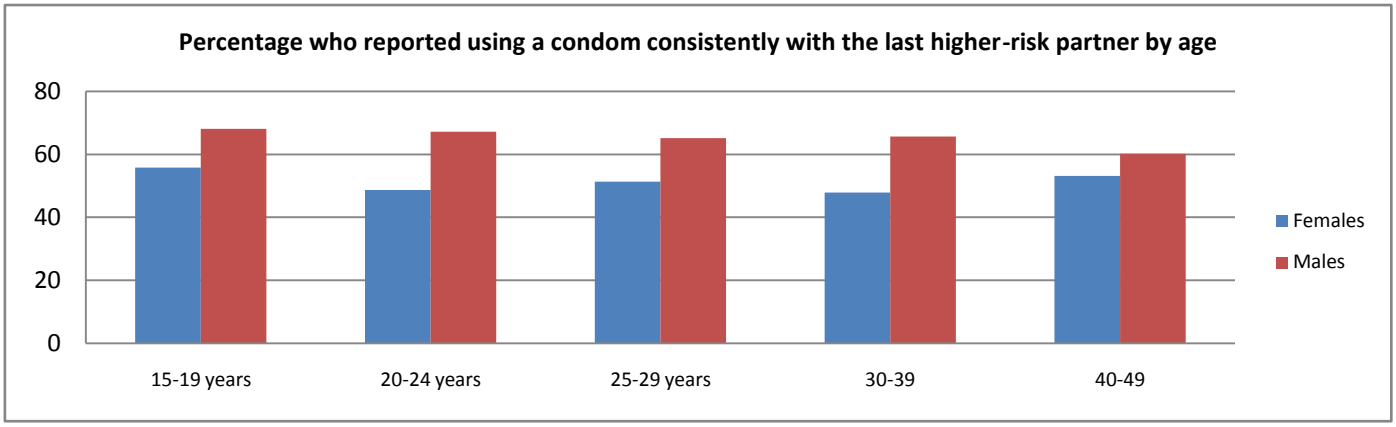


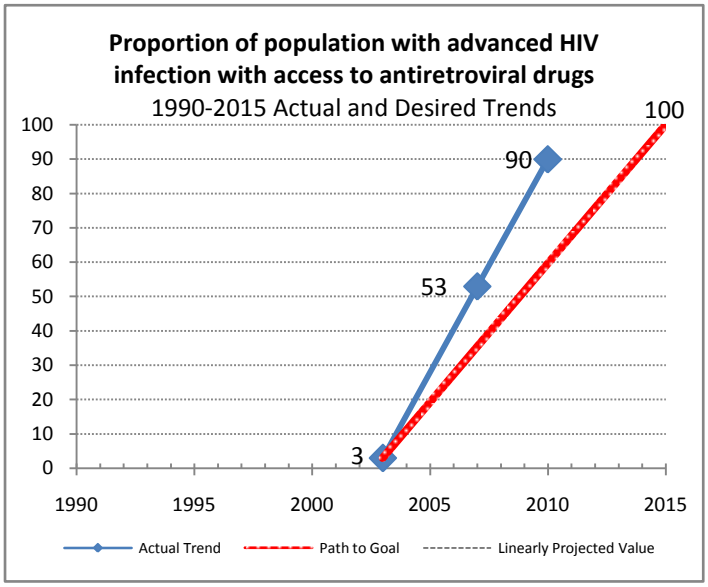
New infections continue to decline to 22 infections per day, totalling 8 177 infections in 2011/12. This is a significant achievement. Current trends in new infections show that Namibia is very likely to achieve the NSF target of reducing new infections by 50 percent by 2015/16. Five percent of new infections are estimated to be among children under the age of 15. Two thirds (67 percent) of the new infections among 15 to 24 year olds are among women (MOHSS, 2013a).

Comprehensive, correct knowledge of HIV is essential for prevention. Comprehensive knowledge includes knowledge about incorrect beliefs and misconceptions about HIV transmission. The 2015 MDG target was for 90 percent of women and men to have comprehensive knowledge of HIV. With only two data sources, NDHS 2000 and 2006/07, it was difficult to determine trends. The 2011/12 NDHS will provide more accurate and relevant data. However, based on the two available sources, women are on target while men are not on target in relation to having comprehensive knowledge of HIV. There seems to be no significant variation in age in women and men's knowledge, although those with higher education, in the highest wealth quintiles and living in urban areas had more comprehensive knowledge. Among regions, women in Caprivi and Kunene and men in Ohangwena were subject to the most misconceptions about HIV transmission.

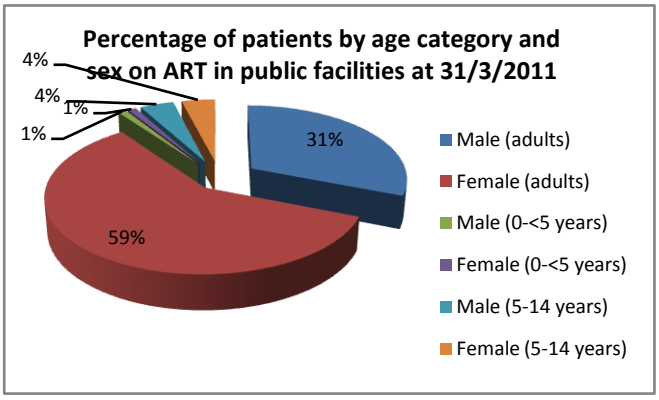
Condom use at last high-risk sexual encounter for 15 to 49 year olds was higher for men than for women across all age groups. The MDG target for 2015 is to achieve 85 percent condom use by women and 90 percent by men. Current trends show that condom use among women is not on target to be achieved, while condom use amongst men is on target. It should be noted that, in 2006/07, 3 percent of women and 16 percent of men reported having had two or more partners in the previous 12 months; while 49 percent of women and 60 percent of men had had higher-risk sexual intercourse over the same period (MOHSS, 2008). Women and men who are not married or cohabitating and those in younger age groups were more likely to engage in high-risk sexual relations and 15 to 19 year old men and women were more likely to engage in high-risk sexual activities than any other age group. Condoms are most likely to be used by younger people and those outside marriage or cohabitation. Three in four men and one in three women in 2006/07 reported having used a condom at last higher-risk intercourse. Women (31 percent) and men (42 percent) in Kavango were the least likely to have used a condom at last high-risk sexual encounter, while women (73 percent) in Khomas and men (84 percent) in Oshana were the most likely (MOHSS, 2008:206-208).







The MDG target for ART provision is similar to that of the National Strategic Framework for HIV and AIDS 2010/11 – 2015/16 (NSF). Namibia strives to achieve 100 percent access to ARV drugs for adults with advanced HIV infection and 95 percent for children. The provision of free ART was initiated in 2002 in reaction to alarmingly high AIDS related morbidity and mortality. Significant progress has been made, with an initial coverage of 3 percent in 2003, rising to 53 percent in 2007 and 90 percent in 2010 (MOHSS, 2010g:16). In 2011, 83.9 percent of children between birth and 14 years of age and 81.5 percent of adults with advanced HIV were on ART. Overall, 81.7 percent of HIV positive people were still on treatment 12 months after treatment initiation. With the adoption of the WHO criteria for ART, which saw the CD4 count level for initiation of treatment raised from 200 to 350 in 2010, the number of people on ART will continue to increase. Based on past trends, Namibia is on target to achieve access to ART for adults, but not on track to achieve access to ART for children. The MOHSS (MOHSS, 2012a:69) notes that the number of people on ART increased by 16 453 between April 2010 and March 2011 compared to 11 044 between April 2009 and March 2010. "Of those on ART, 59% were female adults, 31% were male adults, 4% were male children aged 5-14 and 4% were female children aged 5-14 while 1% were male children under 5 years and another 1% were female children under 5 years" (MOHSS, 2012a:72).



The MDG goal was to achieve a ratio of 1 for school attendance of orphans and non-orphans aged 10 to 14 years old. Namibia has already achieved this goal by increasing the ratio from 0.92 in the year 2000 to 1.02 in 2006. There is no variation in school attendance between OVC and non-OVC.

Milestones

The overall national HIV and AIDS response in Namibia is guided by the respective short and medium term Five Year Plans, the National Strategic Framework on HIV and AIDS and the National Policy on HIV and AIDS. The policy and the plans are based on Namibia's commitment towards the wellbeing of all people, as enshrined in the Namibia Constitution. To respond to the overwhelming challenges posed by HIV, Namibia established the National AIDS Control Programme (NACOP) immediately after Independence in 1990. Over the years, Namibia has learned that HIV is not only a health challenge but a developmental challenge across different sectors, giving rise to the National AIDS Coordinating Programme in 1999. A high level HIV and AIDS Committee, chaired by the Minister of MOHSS and co-chaired by the Minister of then Ministry of Regional Local Government and Housing, signified the urgency attached to responding to the epidemic. The commitment of government was stated in a speech by the Prime Minister of Namibia in 2000 when he said, "…the battle against AIDS is a shared responsibility for all Namibians and all people must take responsibility for orphan children to ensure that the disease that kills their parents does not continue to lay waste to their future" (*New Era*, 2000). Ten years later, the President of Namibia, H. E. President Pohamba at the UN MDG Summit in New York in September 2010 made a commitment to ensuring that in Namibia no child will be born with HIV and no woman will die giving birth (MOHSS, 2012a:102-103).

A coordination structure was established for a multi-sectoral HIV response at national, regional and local levels and in workplaces. The overall multi-sectoral approach concentrated on prevention, treatment, care and support, impact mitigation and management and coordination. The medium terms plans called on all sectors to mainstream HIV in their plans, strategies, programmes and projects. The Office of the Prime Minister (OPM) coordinates and provides guidance on the Public Sector Response to HIV and AIDS. There are 33 public service offices, ministries and agencies (OMAs); all OMAS are guided by the Public Service HIV and AIDS Workplace Policy, with about ten out of 28 having specific Workplace HIV and AIDS Policies. All OMAs have plans to implement their activities, while 18 budget for their plans. Total population targeted with the Public Service Workplace programmes is 240 000 (staff members and dependents). The development of comprehensive national policy on employee wellness, for both the private and public sectors, will increase the scale of financial investment and contribution towards employee wellness and improved service delivery. The extension of the HIV and AIDS Workplace Programmes to Comprehensive Employee Wellness Programmes will assist in the elimination of discrimination and stigmatisation, and ensure effective management of chronic diseases at the place of work, including ART.

In June 2011, Namibia committed itself to continuing its active response to HIV and AIDS by endorsing the Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS, at the UN General Assembly High Level Meeting on AIDS. The Political Declaration on HIV and AIDS runs parallel to the MDGs, with ten targets to be achieved by 2015, which support the achievement of MDG 6. In 2013, a consultative mid-term review of progress against these targets was completed and outlined the way towards achieving them.

The M&E system for HIV has expanded over time, with a well-established framework and effective organisational structure that includes different stakeholders, encompassing development partners, CSOs, FBOs and the private sector. Routine monitoring of the epidemic, such as through the HIV Sero Surveillance Survey, has been conducted every two years since 2002, and triangulation of data from different sources is carried out.

The paradigm shifts in HIV prevention have been based on lessons learned from the early stages of the epidemic. Namibia acknowledges that effective prevention strategies are as essential as all other components of the overall HIV response, and should continue to receive attention and resources equal to those for treatment and support. The overall prevention response is guided by evidence-based strategies to prevent STIs, reduce multiple concurrent partnerships (MCPs), promote voluntary medical male circumcision (VMMC) (rolled out to 30 district hospitals), promote condom use, home-based care, involvement of people living with HIV (PLHIV), and social and behaviour change. The programmes implemented have included information, IEC and use of the mass media at local, regional and national levels. Some interventions included MFMC, Window of Hope, FAWENA programme, Wings of Life, Communications for Behavioural Impact Strategy for HIV and AIDS (COMBI), interpersonal communication at workplaces, the Break the Chain (BTC) campaign (the first campaign to address MCP), NawaSport, the Stand Up campaign against alcohol misuse, VCT campaigns such as the National Testing Day, the Be Strong Get Tested campaign, the Condom Social Marketing and Distribution Programme (NASOMA), HIV

control activities for commercial sex workers, prevention activities with men who have sex with men (MSM), special programmes for women and men in uniform, voluntary medical male circumcision and creating demand for it, PMTCT as well as male involvement in PMTCT, prevention of sexually transmitted infections (STIs), Bophelo! mobile wellness screening initiative, and safety of blood transfusion products. The BTC, implemented by Nawalife on behalf of the joint venture between the Ministry of Information and Communication Technology, MOHSS, the UN, United States Agency for International Development (USAID) and NGO partners, was the first runner up in the category Best Multi Channel Campaign at the AfriCOMNET 2010 Annual Awards of Excellence in HIV/AIDS Strategic Communication in Africa.

In addition to several interventions to encourage men and women of different ages to be tested for HIV, Namibia also has National Testing Days (NTDs) for HIV. Three have been held and at the first one in 2008, 30 000 people were tested and received their results. The number of people tested increased to 80 000 on NTD in 2009. In 2010 the NTD exceeded its target by 129 percent (MOHSS, 2010h:2).

Namibia has accelerated ART scale-up with high coverage, the adoption of the WHO 2010 guidelines for a CD4 count threshold of 350, replacement of AZT by Tenofovir as a first line drug, and achievement of a low percentage of the need for second line treatment (MOHSS, 2012a,:77). Antiretroviral treatment is now provided in 181 decentralised sites, which include 40 full ART sites, 111 outreach and 30 Integrated Management of Adult Illnesses sites, and reaches over 75 000 people (MOHSS, 2010g:9). Commendable strides have been made with PMTCT, HIV testing and community outreach as well. Furthermore, the recently launched National Elimination Plan for MTCT (2012) provides the way towards achieving zero new infections among children and keeping mothers alive.

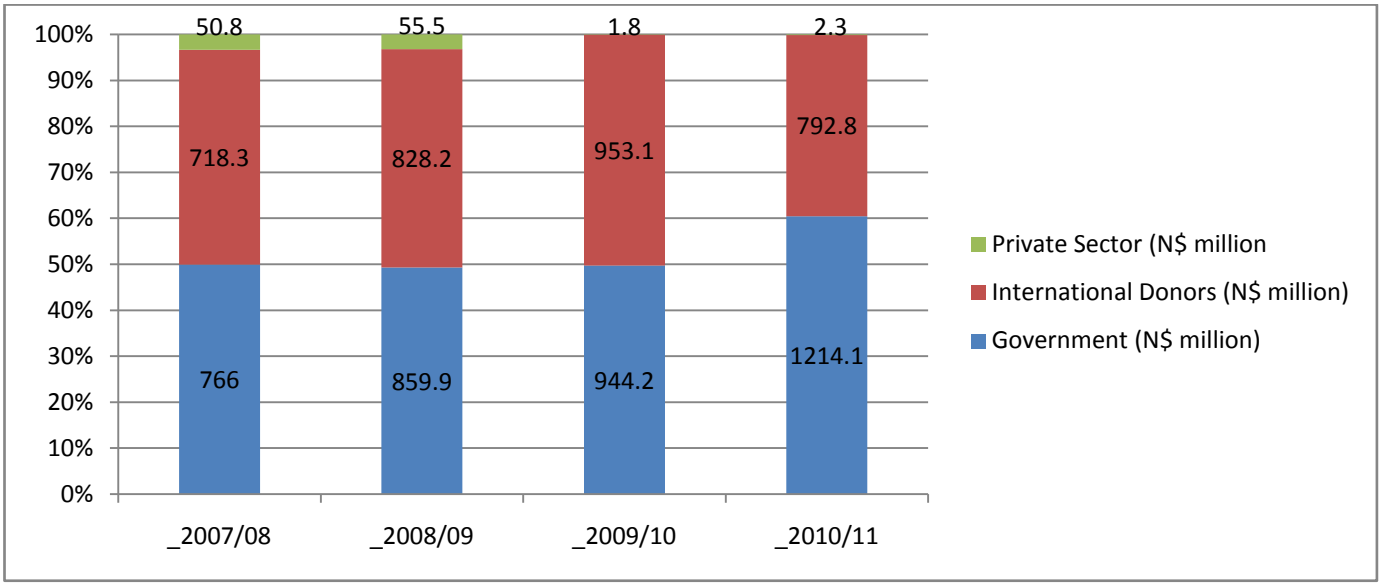
The relationship between TB and HIV creates challenges and meeting these continues to be a high priority of Namibia's HIV treatment care and support programme. This has led to the establishment of the TB/HIV Technical Working Group, responsible for coordinating TB and HIV response activities. The achievements in the coordinated TB/HIV response include the establishment of ART and TB guidelines and revisions thereof, trainings especially in co-management of HIV and TB, making prophylaxis for opportunistic infections available at all health centres, improvement in Isoniazed Preventive Therapy provision, and roll-out of HIV Quality Care (HIVQUAL) to more ART facilities.

Namibia is one of only a few countries in Africa that has a well-established social support system for children orphaned and made vulnerable by HIV and other social determinants. Monthly social grants have supported OVC to gain access to vital social services. Taking overall child poverty into consideration, Namibia is reviewing the current child grant system with a plan to expand it to include all vulnerable children.

Development partners have contributed extensively in the form of financial and technical support, which is greatly appreciated by the Namibian people. The two main external sources for funding and technical support are the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the President's Emergency Plan for AIDS Relief (PEPFAR). Other external support is provided by the UN, European Union/GIZ, and Spanish Cooperation for International Development. However, with the re-categorisation of Namibia as an upper-middle income country in 2009, several donor-funded concessional grants and loans will be reallocated to other countries, resulting in a scale-down of financial and technical support that is already beginning to be felt. Taking this into consideration, Namibia has drafted a Sustainability Plan based on the study Sustainable Financing for HIV/AIDS in Namibia: Managing the Transition towards a New AIDS Financing Strategy. The sustainability plan is based on Namibia using existing scarce resources more efficiently, strengthening partnerships with CSOs and engaging more actively in public-private partnerships. This will require the use of an investment approach which focuses on high impact interventions that deliver the greatest returns and reach key populations and those who are most vulnerable to and worst affected by HIV.

Namibia's commitment to responding effectively to HIV is evident in the increased proportion of Government's share of funding of the overall response. Namibia's share of funding increased from 49.7 percent of total HIV and AIDS expenditure in 2009/10 to 60.4 percent in 2010/11 (MOHSS, 2013c:32). International assistance for HIV response decreased from 50.2 percent of total spending in 2009/10 to 39.5 percent in 2010/11 (MOHSS, 2013c:32). Overall sustainability is, therefore, strengthened by this increased financial commitment by Namibia.

Funding by donor type from 2007/08 to 2010/11



Source: MOHSS, 2013c:33

Challenges and interventions to expedite MDG implementation in the remaining two years

Namibia is currently preparing the NSF mid-term review which will look at current progress, key successes, and challenges, and make recommendations for prioritised interventions based on lessons learned. It is essential for all stakeholders to focus on the recommendations from the mid-term review as this will pave the way for expediting achievement of the targets set in the NSF, but also other commitments such as the MDGs and UNGA Political Declaration targets from 2011. It is assumed that high impact interventions for prevention, treatment care and support for key, marginalised and severely poor population groups will be prioritised for scale-up. Furthermore, it will be important to manage strategically the integration of HIV into broader sexual and reproductive health and overall primary healthcare without jeopardising the progress and gains that have been made.

Challenges	Interventions to expedite MDG implementation
While extensive progress has been made with provision of ART, care and support, challenges remain with adherence, effectiveness of treatment due to inadequate nutrition for PLHIV who are on treatment, staff shortages, inadequate capacity of CSOs, and community outreach.	• Strengthen task shifting/sharing by increasing numbers of IMAI trained nurses with knowledge and skills to initiate ART • Use of point-of-care diagnostics needs to be expanded • Enhance scale-up towards increased geographical coverage to health centres and larger clinics • Continue with quality improvement activities, enhancing adherence to treatment and improving retention in care • Strengthen capacity of CSOs to deliver adherence support, such as an umbrella body for PLHIV organisations
Key challenges experienced by the PMTCT programme include slow roll-out of PMTCT Prongs 1 and 2, HIV and infant feeding, effective implementation of PMTCT Option B+, quality of services and adherence of clients to PMTCT services.	• Expand PMTCT to remaining health facilities with ANC facilities • Intensify efforts set for elimination of MTCT by 2015/16 • Improve quality of service for each of the four PMTCT prongs as well as critical enablers and synergies • Special focus on “undeserved and most at risk populations”, such as PLHIV, sero-discordant couples, adolescents and rural populations (MOHSS, 2013:16) • Build community systems critical for PMTCT performance in collaboration with CSOs • Roll out implementation of the national HIV and infant feeding guidelines

Slow uptake of voluntary medical male circumcision (VMMC) with a coverage of 21 percent in 2008.	• Expedite implementation of the National Policy on Male Circumcision for HIV Prevention of 2010 • Finalise the VMMC Draft Strategy and Implementation Plan to operationalise the policy
Although Namibia has a generalised epidemic, key populations (MSM, commercial sex workers, prisoners) are significant drivers of the epidemic due to stigma and discrimination, high risk behaviours, and poor access to services.	• Continue with current prevention, treatment, and care and support interventions for MSM, CSWs and prisoners
Due to Namibia's upper-middle income country status, donor funding is decreasing.	• The sustainability plan needs to be finalised and put into action to ensure increased efficiencies and effectiveness in the national response, and sufficient funds to keep the existing momentum in the country's HIV response • This is especially important for civil society contribution to the response • Integrate investment approaches based on clear evidence of greatest impact • Strengthen cost effectiveness and efficiency
Namibia has a functional M&E framework but there is high staff turn-over and inefficient use of available staff, the quality of data collected is poor and there is a lack of HIV population based survey and programme evaluations to provide evidence for programme design, planning, implementation and M&E.	• Provide more attractive incentives for qualified M&E officers to remain in regions, for example, performance award incentives such as M&E Officer of the Year with a prize that could include additional training, a scholarship or money • Triangulation and verification measurements need to be strengthened at all levels • Carry out HIV population based bio-behavioural surveys • Surveys need to be carried out to inform the NSF, MDGs and 2011 UN Political Declaration

Looking Beyond 2015

Prevention	• Invest in high impact interventions, such as VMMC, treatment as prevention, PMTCT (option B[22]), social condom marketing and contribution, HIV counselling testing, social and behaviour change communication, and alcohol abuse programmes, and strive for the elimination of MTCT • Enhance involvement of PLHIV • Target most at risk populations, such as men having sex with men, commercial sex workers, mobile populations, uniformed people, and those in MCPs • Strengthen male involvement in prevention interventions, such as PMTCT and couple counselling and testing for HIV • Strengthen community mobilisation, using local NGOs, FBOs, and CBOs • Integrate HIV into SRH and primary healthcare and phase out vertical programmes • The condom procurement and promotion strategy should be finalised and implemented, while it is essential for condom promotion and distribution to be part of reproductive health and family planning
Treatment, care and support	• Scale up ART provision, especially with the WHO guideline to increase the CD4 count for treatment enrolment to 350, including recruitment and training of more health workers, and giving the utmost importance to quality of care during scale-up • Strengthen early warning indicators for HIV drug resistance at facility level • ART literacy needs to be expanded, especially in rural and remote areas • Engage local NGOs, CBOs and FBOs to expand care and support, which will require financial support from central government to CSOs • Revise home-based care policy and align it with other relevant interventions at community level, given that many PLHIV are no longer chronically or terminally ill • Expedite the plan to appoint Community Health Care Extension Officers at constituency levels

[22] This PMTCT programme enrols all pregnant women who are HIV positive, regardless of CD4 count.

Impact mitigation	• The most vulnerable and susceptible households need to be targeted first, including the poor and severely poor, child-headed households, households caring for OVC, the disabled, households headed by the elderly and households in remote areas • Expand income-generating activities for PLHIV and other vulnerable population groups • Expand the social grant system to include all poor and severely poor households and increase the value of the social grants to bring them into line with the current economic situation • Recruit and train more social workers, and use lay persons to reduce the pressure on social workers • Improve services provided at Namibia Children's Home, but at the same time strive to place children in need in conducive family home environments • Expedite the plan to appoint Community Health Care Extension Officers at constituency levels • Strengthen ECD, especially in rural and remote areas
Management of coordination	• Strengthen networking, collaboration and coordination between all sectors • Strengthen mainstreaming of HIV responses across sectors, ensuring that Focal Persons are those who have decision-making authority to influence effective mainstreaming • Put in place effective workplace programmes and structures • While wellness issues are included in sectoral strategic plans, a national Wellness Policy for the public sector is needed to guide mainstreaming and workplace programming • HIV and AIDS units need capacity building and more authority to influence decision-making • Motivate the finalisation and passing of the Child Care and Protection Bill • Strengthen child care and protection forums • Strengthen the overall M&E system to monitor and evaluate mainstreaming of HIV responses • The sustainability plan needs to be finalised and put into action to ensure increased efficiencies and effectiveness in the national response and sufficient funds to keep the existing momentum in the country's HIV response, especially to motivate continuing civil society contribution to the response • The private health sector and other private sector companies need to strengthen their investment in HIV responses • Re-establish an umbrella body for PLHIV with strong monitoring, evaluation and quality control mechanisms • Integrate HIV into overall SRH, maternal health and primary healthcare

Malaria

Namibia has done well in terms of malaria prevention, treatment and support, having exceeded the targets set in Abuja at the World Health Assembly, as well as the Roll Back Malaria targets. Namibia is well on its way to eliminating the local transmission of malaria and consequent morbidity and mortality. These achievements are the result of a comprehensive programme for improving access to health facilities, increasing prevention services, improving the quality of services, and providing more effective diagnosis and treatment. Due to the above achievements, Namibia is now able to reorient the national malaria programme from a control programme to an elimination programme.

The MDG is to halt and begin to reverse malaria mortality by 2015. Namibia is on track to achieve this and has already achieved a reversal in the incidence of malaria. MDG 6 also aims to have universal coverage of children using insecticide-treated bed nets. According to current trends, Namibia still falls short of achieving this target by 2015.

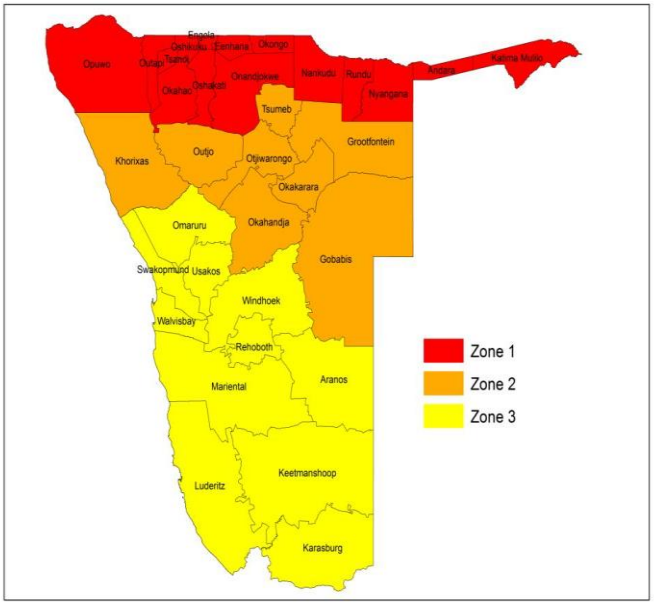
Status at a Glance

GOALS AND INDICATORS	BASELINE	STATUS	TARGET (2015)	TARGET/ GOAL ACHIEVABLE?
MALARIA				
Malaria mortality per 100 000 population	31 (1996)[1]	0.4 (2012)[2]	Halt and begin to reverse	On target
Proportion of children under 5 sleeping under insecticide-treated bed nets	10% (2000)[3]	34% (2009)[1]	Universal coverage by 2010	Not on target
Incidence of Malaria in 1 000 population	207 (1996)[1]	1.4 (2012)[2]	Halt and begin to reverse	Achieved

[1] Ohahandja Meeting Report, 2013
[2] MOHSS, 2013a (2012/13 National Vector-Borne Diseases Control Programme Annual Report)
[3] MOHSS, 2003 (2000 NDHS)

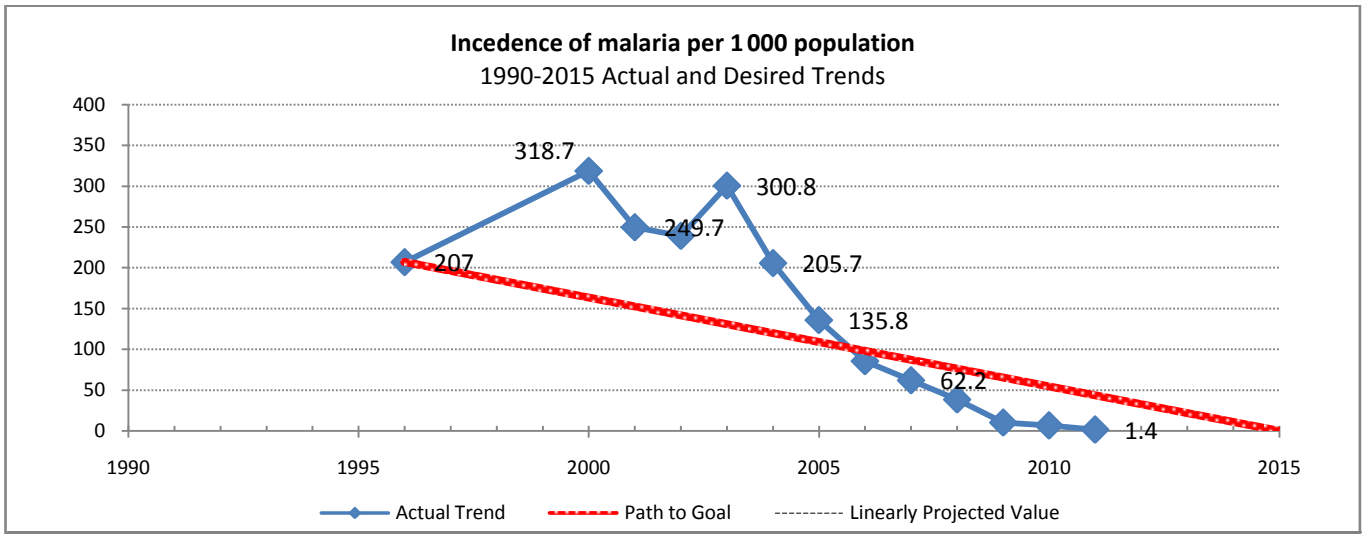
Current Status and Trends

The table above shows that Namibia is on track to halt and reverse malaria mortality, not on track with universal coverage of children under five years old sleeping under insecticide-treated nets (ITNs), and has already achieved the target to halt and reverse the incidence of malaria. The MDG goals are in line with the goals set in the MOHSS Strategic Plan 2010-2016 to reduce incidence of malaria to below 1 case per year per 1 000 people in all regions by 2016. Based on current trends, this target will be surpassed, with deaths being halted completely.



Namibia has done notably well in responding to malaria by reducing the number of people infected with malaria and treating those already infected. The current malaria incidence of 1.4 per 1 000 population is considerably lower than in 1996 (207 per 1 000 population) and 2000 (318 per 1 000) and 2004 (205 per 1 000). The graph

below show a significant reduction of 99 percent in malaria incidence from 2001 to 2012. In addition to the above, severe malaria cases had already dropped by 98 percent over the eleven year period to 2012. Reported cases dropped from 521 067 to 3 163 over this period (MOHSS, 2013:2).



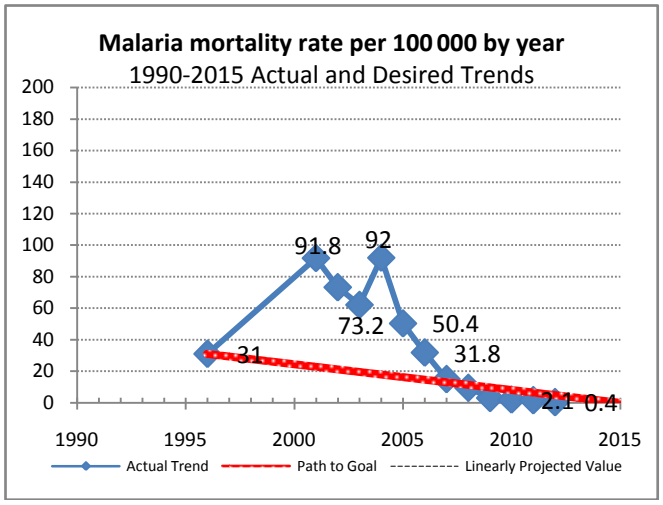
Based on the table below, the only region with increased out-patient department cases of malaria was the Karas Region. All other regions reported decreased out-patient department malaria cases, with the largest decrease reported in Kavango (91 percent). Caprivi has the highest number of reported cases, followed by Kavango and Omusati. The regions with the lowest reported cases are Hardap and Karas, which are not typically malaria-prone areas, and Omaheke. On the other hand, none of the regions reported an increase in in-patient department reported cases of malaria. The region with the highest number of in-patient malaria cases was Omusati, followed by Otjozondjupa and Caprivi. Since 2011, out-patient malaria cases reported have reduced by 78 percent, while there has been a 94 percent decrease in in-patient cases.

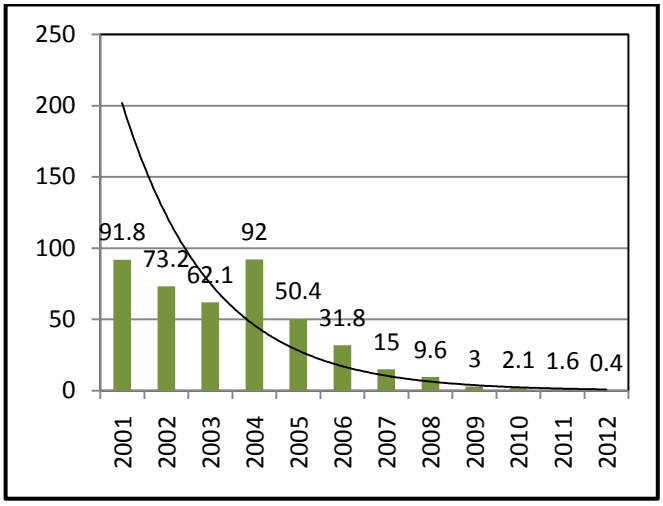
Out-patient department and in-patient department cases of malaria by region, 2012

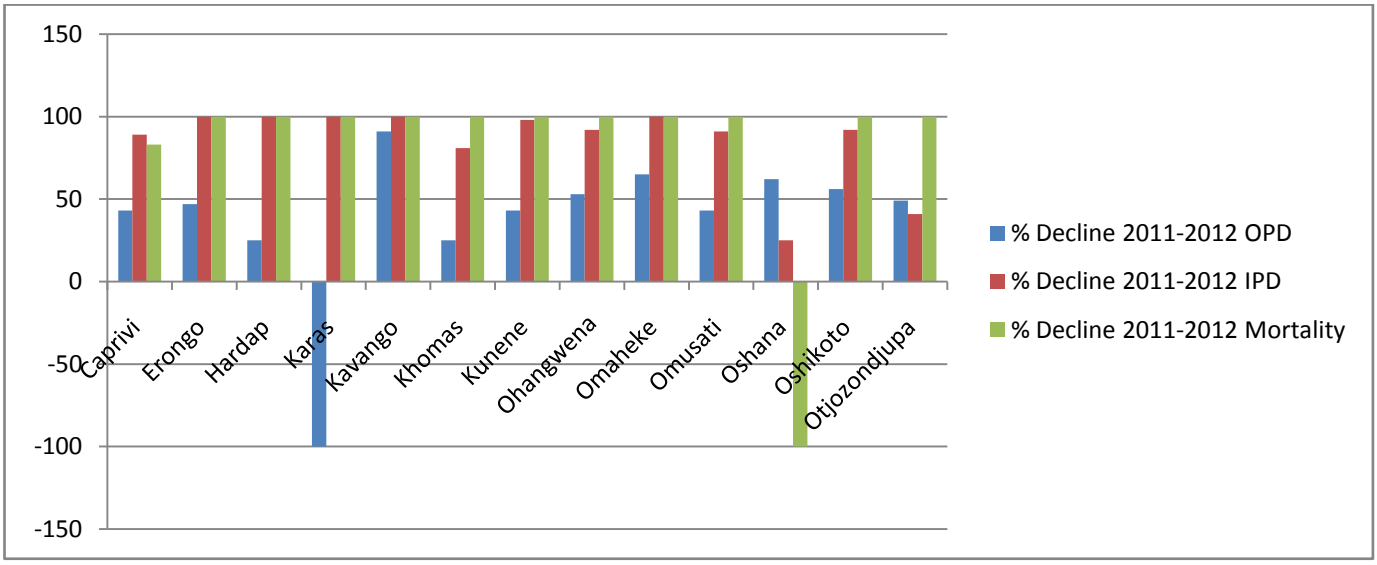
Region	OPD Cases			IPD Cases		
	2011	2012	% Decline	2011	2012	% Decline
Caprivi	2 218	1 274	43	81	9	89
Erongo	34	18	47	9	0	100
Hardap	4	3	25	2	0	100
Karas	2	4	-100	4	0	100
Kavango	10 501	965	91	515	2	100
Khomas	57	43	25	43	8	81
Kunene	136	77	43	56	1	98
Ohangwena	413	196	53	48	4	92
Omaheke	37	13	65	3	0	100
Omusati	673	381	43	173	15	91
Oshana	128	49	62	4	3	25
Oshikoto	139	61	56	24	2	92
Otjozondjupa	67	34	49	22	13	41
Total	14 409	3 512	78.4	984	50	94.2

Source: MOHSS, 2013a:6

Malaria mortality follows the same trend as incidence, with significant declines over the past 11 years, falling from a high of 91.8 deaths per 100 000 population per year in 2001 to 50.4 in 2005 and 0.4 in 2012. Deaths fell by 89 percent between 2011 and 2012 (MOHSS, 2013a:6). Regional reductions vary considerably, with Kavango showing an out-patient department malaria case reduction of 91 percent and Hardap showing a reduction of 25 percent. As noted above, Khomas and Hardap are not malaria-prone. Oshana experienced three malaria deaths, while Caprivi reported one death and the remaining eleven regions did not report any deaths.







Milestones

With the prioritisation of malaria as a serious health risk, the National Vector-Borne Disease Control Programme (NVDCP) was established a year after Namibia's Independence under the auspices of the Primary Health Care Directorate. The NVDCP was later integrated into the Directorate of Special Programmes, with other leading diseases, HIV and TB. It is guided by an Integrated Malaria Policy, the Malaria Epidemic Preparedness and Response Plan, and the Integrated Vector Control Policy.

The NVDCP recently expanded its human resources in order to accelerate plans to eradicate malaria. Namibia has had no major malaria epidemics since 2005 and has now changed its overall response to malaria from a control programme to an elimination programme, a stage that only one in four SADC countries have been able to reach. Key to this approach is being more context-appropriate and focused on key areas, such as tackling districts with high infection rates first. This is evident in the shift of focus from the previous strategic plan to the current one. The previous malaria strategic plan (2003-2007) aimed to reduce malaria morbidity and mortality to a point where it would no longer be a major public health problem (MOHSS, 2010:5), while the aim of the current strategic plan (2010-2016) is to reduce the incidence of malaria to below 1 per 1 000 population in every district by 2016.

Recognising that malaria is a major developmental challenge and that gains can very easily be reversed through intermittent responses, the Government of Namibia funds the bulk of the NVDCP initiatives, including N$65 million per year for preventive and control activities, also covering administrative costs. In 2012, the Global Fund approved the Rolling Continuation Channel phase 2 and allocated US$9.8 million for three years. In addition to this, the Government of Namibia allocated an additional N$22 million for malaria elimination over the next three

years. Strong partnerships have also been built with other development partners and international NGOs, such as the Society for Family Health (SFH), Development Aid from People to People, and Anglican Diocese/Nets for Life. Development partners who provide technical and programme support include the WHO, UNICEF and the Southern Africa Malaria Elimination Support Team.

Namibia has been implementing annual indoor residual spraying of houses since 1965, and has maintained a high coverage of 90 percent across eight malaria-prone regions. With support from the Global Fund, Namibia started using long lasting insecticide-treated nets from 2005 and has since distributed 600 000 of these nets free to those in need across nine regions.

As case management of malaria is extremely important, the NVDCP continues to build the capacity of staff. A training-of-trainers exercise was carried out with the intention that an additional 141 health workers would be trained by the original trainees. The NVDCP recruited four clinical mentors and two surveillance officers to support the malaria prone regions. One of these mentors was stationed in Caprivi due to the high number of cases there (MOHSS, 2013a).

Frequent and regular supervisory visits are undertaken for monitoring purposes. In addition, continuous research investigating malaria epidemiology is carried out at selected sites. A study on the prevalence of Schistosomiasis was carried out in two regions, Caprivi and Kavango, and showed that the prevalence in the two regions was between 10 and 49 percent.

Namibia plays a key role in the regional malaria response as it is spearheading the elimination campaign in the SADC region. Significant progress has been made towards the establishment of the Trans-Kunene Malaria Initiative along the border with Angola.

Challenges and interventions to expedite MDG implementation in the remaining two years

The main challenges facing the NVDCP are unsustainable financial, logistical and technical support, especially in malaria zones[23] 1 and 2. Below are key the challenges and sets of recommendations, which complement the Malaria Strategic Plan (2010-2016) and should be used as a guide to accelerating implementation.

Challenges	Interventions to expedite MDG implementation
Shortage of staff at national, regional, district and health facility levels, and lack of training of all health workers in case management and diagnosis.	• Accelerate the proposed restructuring process for NVDCP specifically, including Malaria Elimination Officers • Employ additional spray operators • Expand annual training in case management and diagnosis to all health workers
Information challenges, including lack of a proper GIS for malaria specifically, no effective information management system for malaria, poor reporting from regions, and no active surveillance system.	• Purchase GIS hardware and provide most appropriate training via internal technical support • Establish, with the support of HMIS, an effective information management system for malaria • Establish an active surveillance system
Absence of annually updated Malaria Epidemic Preparedness Plan.	• Annual updates of the malaria preparedness plan, especially for district levels
Expiration of ITNs delivered more than three years ago.	• Expand and strengthen the procurement and distribution of insecticide-treated nets • Establish a procurement and supply management system
Limited IEC materials at regional, district and community levels	• Design standardised clinical algorithms (procedures) and posters for health workers • Design, produce and disseminate IEC materials that are age, sex and culturally appropriate

[23] See map on p.68 Malaria Zone 1: moderate transmission risk; Malaria Zone 2: Low transmission risk; Malaria Zone 3: malaria risk 'free'.

Shortage of community support programmes.	• Health extension workers could take on some of the community mobilisation tasks • Continue with national advocacy days • Appoint a focal person responsible for health promotion and communication • Harmonise malaria messages developed by different partners • Improve awareness raising on risk perception and prevention methods • Improve awareness of appropriate ways of using nets
Logistical challenges overall, but most specifically for spraying activities.	• Strengthen logistical support in relation to transportation and supervision
Lack of cross-border initiatives with Zambia, Botswana, Angola and Zimbabwe.	• Establish other cross-border initiatives similar to the Trans-Kunene Malaria Initiative

Looking Beyond 2015

With the programme re-orientation from malaria control to elimination, it is essential sustain and scale up malaria prevention, treatment and management at all levels.

Review indicators	• The second indicator with regard to mosquito nets needs to be changed to use of mosquito nets by under-five year olds and not universal coverage because nets have been distributed extensively but the actual use of the nets is still a challenge • The incidence of malaria indicator should also be revised to bring it into line with the elimination strategy
Strengthen advocacy	It is necessary to continue to sensitise and mobilise all partners to support the malaria elimination campaign. Therefore: • Strengthen high-level advocacy to sustain and scale up malaria interventions towards elimination • Sustain current partnerships as these are essential for technical and programmatic interventions • Strengthen partnerships with community organisatons and campaigns
Improve information and surveillance	An information and surveillance system should be able to, “accurately estimate the burden of disease, to measure trends over time, to evaluate coverage and quality of interventions, to identify geographical and seasonal distribution of cases and to detect epidemics in a timely manner” (MOHSS, 2010d:8). Therefore: • Design, establish and implement a comprehensive information and surveillance system
Sustain financial and human resources	• Continue with mobilisation of additional domestic funds to assist in the implementation of malaria elimination • Strengthen the overall health system to reduce attrition • Strengthen public-private-partnerships
Mitigate climate change impacts on malaria programming and access to services	• Respond proactively to climate change and climate shocks, and continue to conduct assessments to determine impacts

Tuberculosis

Namibia is among the countries worst affected by the communicable disease TB, which remains a serious health challenge and the second leading cause of death, after HIV related deaths. In Namibia, TB is one of the three most frequent reasons for attendance at an out-patients' clinic and causes of hospitalisation. The current trend in TB indicators shows that TB control has improved considerably and that steps towards national and international targets are being made. Namibia has made progress in systematic monitoring of drug-resistant TB, but social determinants and operational challenges continue to be the main bottlenecks in prevention and treatment.

Target 6 C strives to halt and begin to reverse, by 2015, the incidence of TB. The three indicators are to reduce the TB cases notified per 100 000 population to less than 300; increase the proportion of TB cases treated successfully; and decrease the proportion of deaths associated with TB to less than five. Available data show that Namibia is doing well in terms of achieving the target of 85 percent of TB cases treated successfully and reducing the number of people who die from TB. However, Namibia is not doing well in achieving the target on notification of TB cases as it stood at 545 per 100 000 population instead of less than 300.

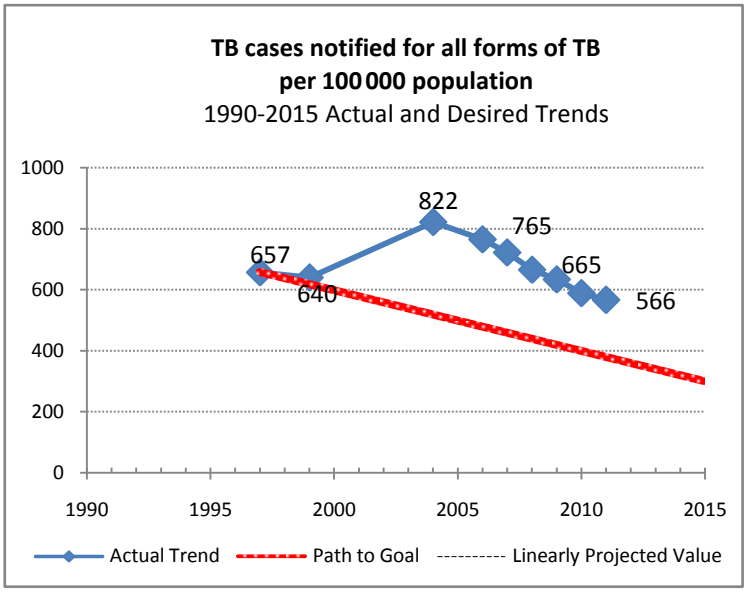
Status at a Glance

GOALS AND INDICATORS	BASELINE	STATUS	TARGET (2015)	TARGET/ GOAL ACHIEVABLE?
TUBERCULOSIS				
TB cases notified per 100 000 population	657 (1997)[3]	545 (2011)[1]	<300	Not on target
% TB cases treated successfully	58 (1996)[2]	85 (2010)[1]	85	Achieved
Death rates (%) associated with TB	7 (2000)[1]	4 (2010)[1]	<5	Achieved

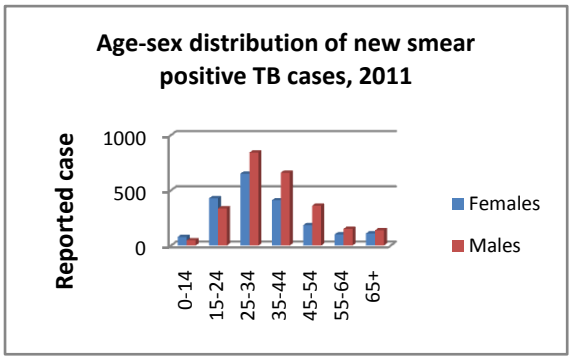
[1] MOHSS, 2011b (2010-2011 Annual Report, NTLP)
[2] NPC, 2010b (2010 MDGR)
[3] NPC, 2008d (2008 (MDGR)

Current Status and Trends

The overall incidence of TB has been reduced in many countries including Namibia. The current TB incidence in Namibia is 723 per 100 000 population after steadily declining since the early 2000s (WHO, 2012). In 2011, there were 566 TB cases notified per 100 000 population (MOHSS, 2011b). Namibia reported an increase in TB cases notified from the mid-nineties to the early 2000s, after which a steady reduction was reported from 2004 (822 per 100 000 population) to 2011 (566 per 100 000 population). The overall decline in notified cases is slowing down from a decline of 10 percent between 2007 to 2008 to 5 percent between 2009 and 2010. The MOHSS noted that, "the decline in the number of cases notified over the past five years…suggests a decrease in TB incidence in the country, although this cannot be confirmed in the absence of TB disease prevalence surveys" (MOHSS, 2011b:2). The graph on the right shows that Namibia is not on track to achieve the 2015 MDG of 299 TB notified cases per 100 000 population. In addition, multi-drug resistant TB and extensively drug resistant TB across all regions exacerbate the challenges faced by public and private health facilities in prevention and treatment.

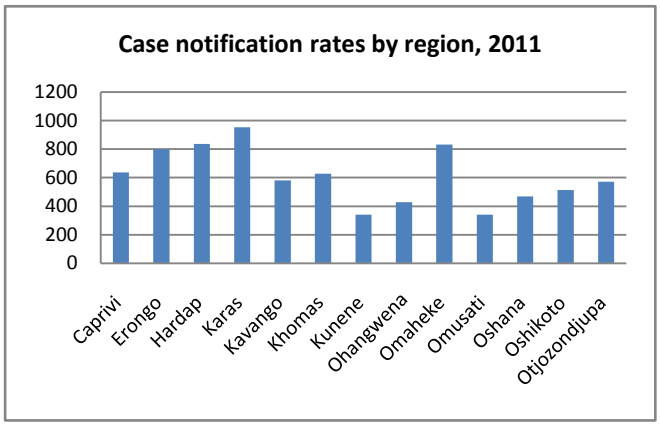


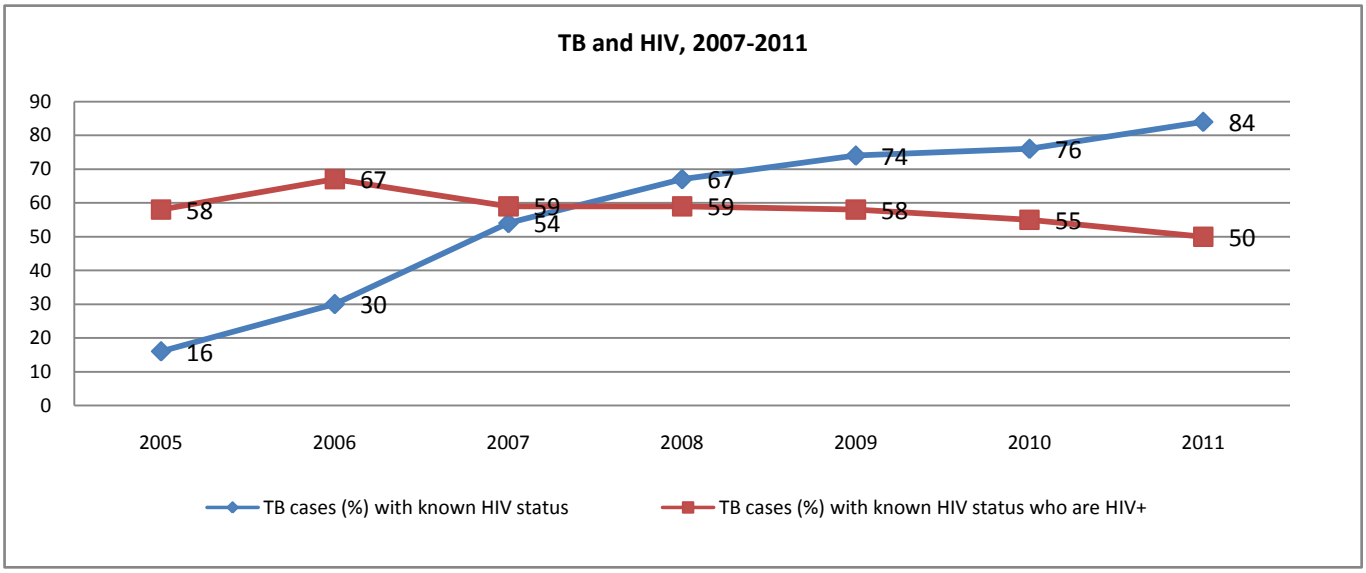
Slightly different trends have been observed for different types of TB – new sputum smear negative TB, smear positive TB and extra-pulmonary TB (EPTB). The decrease in new cases of sputum smear negative TB is higher than that of smear positive TB, which is a concern, especially taking into consideration the high HIV prevalence in the country. "The number of cases of EPTB has remained relatively constant between 2006 and 2011, possibly as a result of scale up of ART with the consequent decrease in the risk of developing EPTB." (MOHSS, 2011b:2.)



In 2011, it was found that more males (56 percent) than females (44 percent) were tested positive, while those aged between 25 and 34 were more prone to infection than younger (0 to 14 years) and older (55+ years) people. However, more females than males tested positive in the 0 to 24 years group, following similar trends noted in HIV infection. The regions with the highest case notifications were Karas (953 per 100 000 population) followed by Hardap (837) and Omaheke (833). The lowest TB case notification was reported in Omusati (340 per 100 000 population), followed by Kunene (341) and Ohangwena (428).

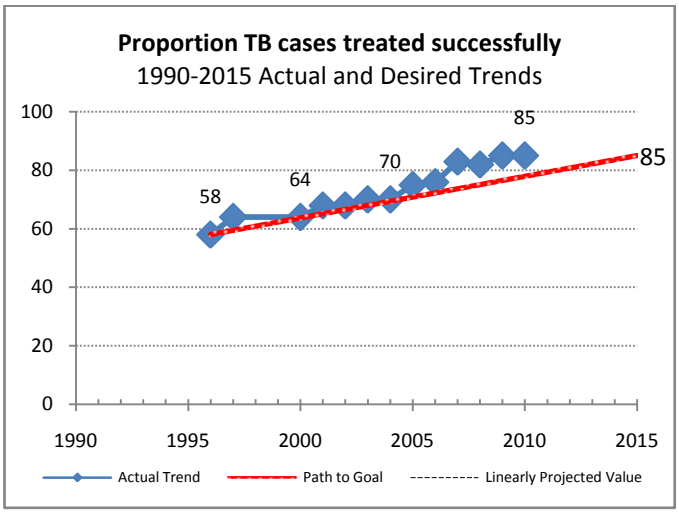
TB is the most common life-threating opportunistic disease amongst HIV positive people. The graph below shows that more people who are diagnosed with TB are tested for HIV and know their status, while the proportion of people with TB who are HIV positive has been on a steady decline from 59 percent in 2007 to 50 percent in 2011. "Kunene maintained the highest regional HIV testing rate among TB patients (99 percent), while Khomas and Caprivi (region with the highest HIV prevalence) had the lowest proportion of patients with a known HIV status." (MOHSS, 2011b:13)

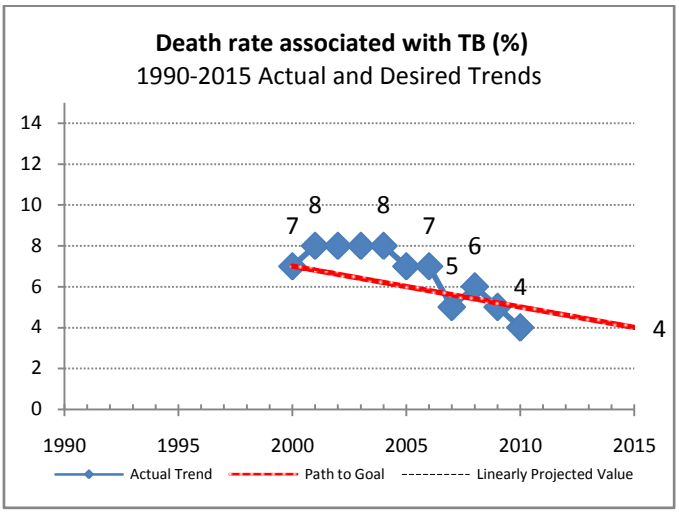




The international target for TB case management is a treatment success rate of at least 90 percent among new patients with infectious TB. However, the MDG for Namibia is 85 percent by the year 2015. Namibia reached a TB treatment success rate of 85 percent in this category of patients for the patients who commenced treatment in 2009, six years ahead of the 2015 target, and remained constant for 2010. The defaulter rate was 3 percent, while the treatment failure and death rates were 4 percent and 5 percent respectively (MOHSS, 2011b:x). However, it should be noted that the success rate for retreatment was low, at 71 percent in 2010, "necessitating greater efforts towards screening for TB drug resistance both at the beginning of treatment as well as at any point during treatment should the patient remain smear-positive" (MOHSS, 2011b:6). The failure rate for those on retreatment was 11 percent in 2010, while 10 percent died. The death rate associated with TB follows similar

trends to those for TB cases notified, with a steady reduction from 2001, from eight deaths to four deaths in 2010. This means that Namibia had achieved the MDG goal of less than five deaths associated with TB by 2010, five years ahead of the 2015 target.





Milestones

After the Independence of Namibia in 1990, the MOHSS included the TB programme under the broader Primary Health Care Framework. Tuberculosis is highlighted as a health priority under the current MOHSS Strategic Plan 2009-2013. The National TB and Leprosy Programme (NTLP) sits strategically in the Directorate of Special Programmes of MOHSS together with the NACOP due to the interrelationship with HIV and resultant collaborative activities. "Mainstreaming TB in HIV/AIDS planning and management and vice versa is now more prominently reflected in the respective strategic documents" (MOHSS, 2010c:14) while implementation is commendable. Tuberculosis is regarded as a development challenge and requires a multi-sectoral response similar to the response to HIV. Therefore TB responses have been included in existing multi-sectoral coordinating structures for HIV.

The WHO, one of the key strategic partners in the fight against TB, supported Namibia to carry out the first situation analysis shortly after Namibia's Independence. Based on the findings of this analysis, the National Tuberculosis Control Programme (NTCP) was established. In 1991, NTCP adopted the WHO's Directly Observed Treatment-Short Course (DOTS) and reached national coverage by 1996. Several policy documents and guidelines for the management of TB have been and continue to be developed to respond to TB effectively, especially in relation to multiple drug resistance and the development of new medical regimes, such as fixed dose tablets. Drug resistance has been managed since the 1990s, with the first guidelines being released in 1995.

Government's commitment to drive TB responses effectively and efficiently is evident in the importation of health specialists and technical assistance. Namibia continued to build an interactive relationship with key development partners such as WHO, KNCV TB Foundation, USAID, PEPFAR, UNAIDS, Centers for Disease Control, ITECH, IULTD, the Global Fund, MSH and TLMI. These relationships have played a key role in continued efforts to devise innovative responses for an ever changing epidemic. They are supported through inter-programme, inter-divisional and inter-agency collaboration, multi-sectoral collaboration, and international collaboration. The national coordinating structure follows a multi-sectoral approach, with the first coordinating body, the National Steering Committee for Tuberculosis, being established in 2005. Through this multi-sectoral committee, Namibia was able to solicit funding from several sources, such as WHO, USAID and the Global Fund. However, with external funding slowly decreasing, the Government of Namibia is assessing various avenues to continue to fund TB programmes from within.

Namibia has done well in terms of engaging the community in TB response strategies. Sensitisation and mobilisation of communities have paid off in terms of early case identification and adherence to treatment. The latest strategic plan acknowledges the important role of community-based DOTS services and community workers in the significant improvement in treatment success rates, while the work of community workers contributed to reduction in stigma and discrimination. The Community Health Committees are active in most cases, but need

technical support to maintain momentum. “The use of community field workers, especially ‘field DOTS promoters’ and ‘lifestyle ambassadors’ as part of community TB care scale up has been remarkable and critical to the expansion of patient-centered delivery of treatment, including DOTS at community level.” (MOHSS, 2010c:50)

Based on lessons learned and in line with the current strategic plan of the MOHSS as well as international commitments such as the MDGs, the Second Medium Term Strategic Plan for Tuberculosis and Leprosy 2010-2015 aims to achieve the following:

- High quality TB DOTS and leprosy services expanded and enhanced
- Increased access to high quality TB/HIV treatment and care interventions
- Programmatic management of drug resistant TB improved and scaled up
- General health systems strengthened and effectively supporting TB and leprosy services
- Partnerships for TB control and leprosy eradication strengthened
- Communities and people with TB and leprosy empowered.

Challenges and interventions to expedite MDG implementation in the remaining two years

Although NTLP has laid a strong foundation for TB control in Namibia, innovative interventions are needed to reach targets such as reducing TB cases notified for all forms of TB to 299 or less per 100 000 population. Innovation will also be needed to keep the momentum for other TB related targets already met, such as 85 percent of TB cases treated successfully, and reducing the death rate associated with TB to four by the year 2015. Therefore, the implementation of the Medium Term Plan (MTP) II for TB and Leprosy (2010-2015) is essential. Below are some challenges and recommendations, which are complementary to the MTP II.

Challenges	Interventions to expedite MDG implementation
Inadequate institutional and human resource capacity (including specialists), and high staff turnover.	• The Public Commission needs to create a position at hospitals specifically catering for TB • Import specialist health skills, while Namibians are being capacitated • Reintroduce the bush allowance for those working in remote areas • Get laboratories to provide surveillance as well as clinical functions such as diagnosis
Limited TB workplace safety measures for health workers.	• Provide adequate ventilation in wards and other areas • Provide appropriate infrastructure to protect those not infected (including nurses) from becoming infected
Inadequate health infrastructure and equipment to offer effective services.	• Construct appropriate health facilities that are responsive to current health needs • Build accommodation for healthcare providers at each health facility, especially in remote rural areas
IEC materials are mostly confined to health facilities and not in the community.	• Urgently roll out Community Based Health Care Extension (currently at pilot stage in Kavango and Kunene) • Continue to mobilise and involve CBOs and NGOs, while Government should seek avenues to support CSOs financially • Training needs to be provided to Community Health Committees
Suboptimal functional collaboration between TB and HIV programmes.	• Strengthen coordination of responses between TB, HIV and other vector diseases
Poor accessibility of TB diagnostic services and DOTs observers due to distance from clinics.	• Bring medical care closer to the people with innovative strategies such as the use of Community Health Extension Workers
Unaddressed social factors, such as poverty, unemployment, overcrowding, smoking, silicosis, alcoholism, overcrowding and unemployment.	• Apply recommendations under MDGs 1, 2 and 3

Looking Beyond 2015

The main themes to focus on beyond 2015, in line with the MTP II for TB and Leprosy, are detailed below.

Strengthen human resources	Continued availability and efficient use of qualified and competent staff at all levels of the programmes will contribute to their success. Therefore: • Efficient use of existing staff is paramount, taking into consideration the continued shortage of skilled personnel in specialised fields • Design innovative ways in which to attain specialists, such as better remuneration and incentives for working in remote rural areas • Staff on development partner support need to be converted to fulltime government funded positions • Dedicated positions at regional and district levels need to be created for TB and leprosy
Increase financial resources	Financial resources need to be provided in a proactive and timely manner. Therefore: • With projected reduced funding from external forces, Government needs to increase internal funding • Ensure more efficient use of scarce financial resources
Continue political commitment	• Continued political commitment is needed to create appropriate institutional structures, especially for an ever changing health profile
Effective programme governance	• Continue to strengthen management structures and systems for human, financial, infrastructural and technological development
Negative impacts of climate change	Climate events such as droughts and floods have negative impacts in two different ways: 1) droughts may affect a person's ability to continue treatment with decreased availability of nutritious foods; and 2) floods not only increase susceptibility to infection, but also hinder access to health facilities for treatment, care and support. Therefore: • Respond proactively to climate change and continue to conduct assessments to determine impacts

MDG 7: Ensure Environmental Sustainability

Over the past twenty years, Namibia has made great strides in integrating the principles of sustainable development into country policies and programmes, to reverse the loss of environmental resources. This has been achieved with a suite of national policy instruments and international agreements. Important among these has been the adoption of policies and legislation empowering landholders to invest in natural resources and to benefit from them in terms of livelihood and income. A case in point is the national community-based natural resource management (CBNRM) programme, which has expanded hugely the area of Namibia in which wildlife resources are thriving. Backing this up has been a programme of natural capital accounting and economic valuation of natural and ecosystem services, which pointed the way for economically efficient investment in sustainable conservation. In addition, new environmental management legislation has formalised environmental impact and strategic environmental assessment, which greatly increase the chances of environmental sustainability.

The targets for MDG 7 are to: integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources; reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss; halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation; and by 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers.

Progress to date includes three of the planned achievements being met, two on target to be met and three not on target. In particular the target of halving the proportion of people without access to basic sanitation has not and will not be achieved by 2015. Related to this is a failure to meet targets for secure urban land tenure for poor people. Appropriate policies are in place but these need accelerated implementation.

MDG 7: Status at a Glance

GOALS AND INDICATORS	BASELINE	STATUS	TARGET (2015)	TARGET/ GOAL ACHIEVABLE?
MDG 7: ENSURE ENVIRONMENTAL SUSTAINABILITY				
Areas protected to maintain biological diversity as percentage of all land				
State protected areas	12.5% (1995)[1]	18.3% (2011)[2]	20.0%	On track
Communal conservancies	0.0% (1995)[3]	19.4% (2013)[3]	15.0%	Achieved
Freehold land conservancies	5.0% (1990)[4]	6.0 (2012)[4]	10.0%	Not on target
Community forests	0.0% (2003)[3]	4.0% (2012)[3]	5.0%	On track
Proportion of households with access to safe drinking water (%)				
Urban	99% (2003)[5]	99% (2010)[5]	100%	Achieved
Rural	78% (2003)[5]	90% (2010)[5]	87%	Achieved
Proportion of households with access to basic sanitation (%)				
Urban	59% (2003)[5]	57% (2010)[5]	98%	Not on target
Rural	14% (2003)[5]	17% (2010)[5]	65%	Not on target

[1] Tarr, 1996
[2] MET, 2010:17, EIS Namibia, www.the-eis.com, 2013, NACOMA, www.nacoma.org.na, 2013
[3] NACSO, 2004, 2006, 2008, 2010, 2013, EIS Namibia, www.the-eis.com, 2013
[4] EIS Namibia, www.the-eis.com, 2013
[5] World Bank Data, www.trading economics.com, 2013

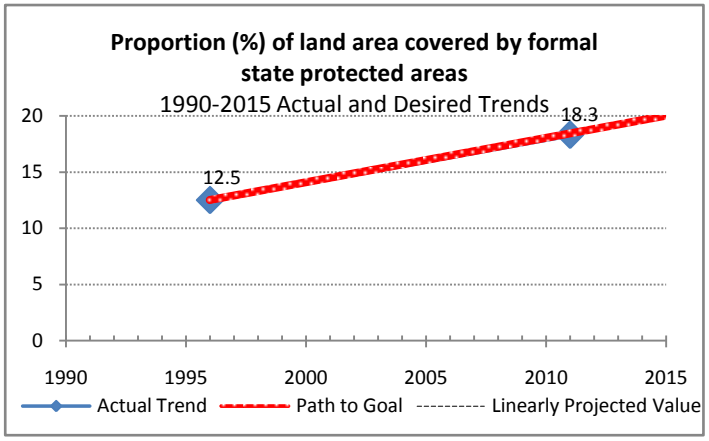
Current Status and Trends

Namibia's natural resource base supports around 52 percent of the country's economic activity. Much of the population is reliant on natural resources, especially land, and biological resources such as vegetation, wildlife and fisheries, for their livelihood. It follows that achievement of MDG 7 will go a long way towards alleviating poverty and ensuring sustainable development. Namibia's development philosophy is characterised by the integration of environmental sustainability in its national planning. Namibia recognises that sustainable utilisation of natural resources is a prerequisite for the sustained generation of income and creation of employment. The sixth objective of Vision 2030 is to, "Ensure the development of Namibia's natural capital and its sustainable utilization for the benefit of the country's social, economic and ecological well-being" (GRN, 2004).

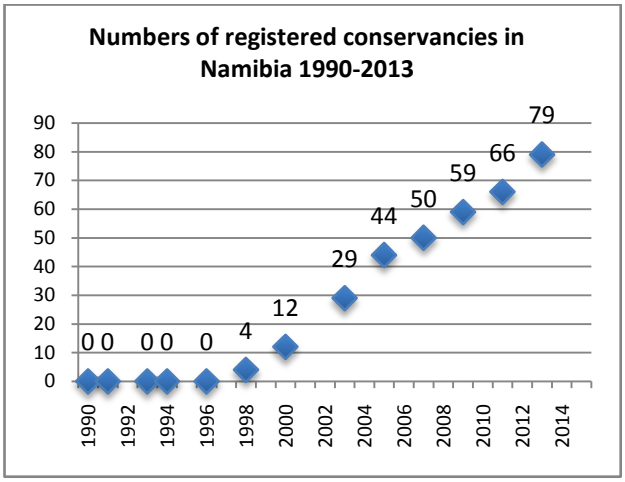
Namibia's commitment to the environment was further evident in its identification of environmental sustainability as one of the Key Results Areas that had indicators, targets and programmes with specific outcomes and outputs in NDP 3 (2008-2012). The four economic priorities adopted for the NDP 4 (2012-2016) (NPC, 2013) include agriculture and tourism, both of which are primary sectors heavily dependent on environmental sustainability for their growth.

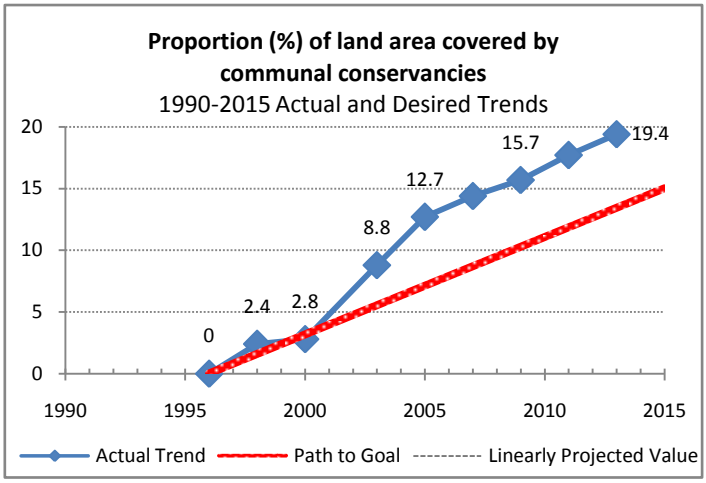
Namibia has adopted the proportion of terrestrial, and marine areas protected as the primary indicator for targets 7A and 7B. Some nineteen state protected areas, ranging in extent from 25 hectares to 5 million hectares, form the core of the protected area system. The state system is complemented by registered zones where landholders protect and use wildlife and natural resources, within the national CBNRM programme. In addition landholders on freehold properties protect and utilise wildlife communally in freehold land conservancies, and individually in formal and informal private game reserves. One marine park of 1.2 million hectares has been established, extending along 400 kilometres of the coast. The indicators, detailed in the table above, consist of state parks, communal land conservancies, freehold conservancies, and community forests (some of which overlap with communal conservancies).

The graph on the right shows the progress that Namibia has made in achieving its MDG target of 20 percent of land under state protection by 2015. The core protected areas estate inherited at the time of Namibia's Independence amounted to some 12.5 percent of the total land area of 11 million hectares (Tarr, 1996). It had increased to 18.3 percent of the total land area, or some 14 million hectares, by 2011. This was documented by MET (2011) and was as result of the proclamation of the Sperrgebiet and Dorob National Parks, both of which extend the protected area system to cover the whole of the Namibian coastline and to link with parks in Angola and South Africa. Also included in this total is Namibia's first major marine park, which extends protection previously limited to several small coastal islands to a belt 40 kilometres offshore along 400 kilometres of the coast – some 1.2 million hectares. The projection of this overall expansion suggests that the target of 20 percent of Namibia's land area by 2015 could be met. However, this will depend on whether it makes sense for Namibia to exapand its state protected areas. It may be more sustainable for expansion to take place within the other multiple use protected area categories.

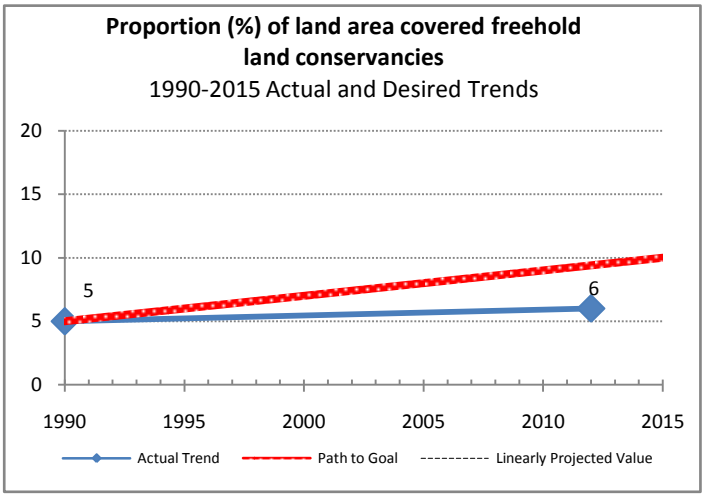


The two graphs that follow and the Table above show how the number and extent of communal land conservancies have increased since 1996, when enabling legislation was enacted. Although there were no registered communal conservancies between 1990 and 1996, by 2013, there were 74, covering 19.4 percent of the country's land area. Thus the target of 15 percent by 2015 had been well exceeded by 2013. The CBNRM programme in Namibia is considered to be a significant success, as it has secured conservation of wildlife resources for livelihood and economic gain as a legitimate form of communal land use, which complements the established use of rangeland for livestock and crops. By extending protected land beyond the core, it has more than doubled the extent of land on which wildlife and natural resources are protected in Namibia (NACSO, 2004, 2006, 2008, 2010, 2013).

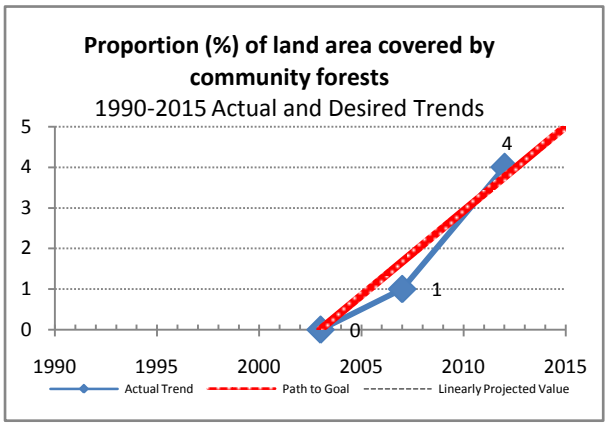




The amount of land under freehold conservancies, where landholders in freehold farmland group together to manage wildlife resources communally, has not expanded dramatically and is not expected to reach the target of 10 percent of total land area (see graph on the right and table above). The use of 'freehold conservancies' as an indicator is unsatisfactory in that wildlife conservation and use on freehold land now takes on a number of additional forms. These have become the driving force in the expansion of protection of and investment in wildlife (Barnes and Jones, 2009). Thus, economic incentives have driven dramatic expansion on freehold land of individually owned private game reserves, individual hunting and game farms, and combined wildlife and livestock farms, none of which are captured under the indicator as formulated. Inclusion of all these in the freehold conservancies indicator would almost certainly show significant positive achievement. No comprehensive data sets are available to enable this, however.



The establishment and registration of community forests in the communal lands began after 2003. Here, as with the communal conservancies and often linked to these, communities conserve and manage forest resources for use. Given that Namibia's forest resources are limited due to its dry climate, thirteen community forests covered only 4 percent of Namibia by 2012 (NACSO, 2013). The rate of expansion however, looks set to meet or exceed the target of 5 percent by 2015.



Generally the approach that Namibia has adopted to the development and expansion of protected areas has been highly successful and has resulted in about half the land in the country being under some form of biodiversity protection. The approach provides for custodial rights over natural resources which, in turn, provide income and an incentive for protection and investment. It has harnessed the capital and management skills of landholders in communal and freehold land for the active conservation of wildlife and other natural resources. This bodes well for the future of the environment and for key development sectors such as tourism. Namibia's policies and legislation embracing property rights are arguably the most important drivers of environmental sustainability in the country.

An important natural resource base for the country is that which supports the marine fishing sector. Here the up-welling of the Benguela current system supports a rich marine fauna. Excessive fishing, in the years before Namibia's exclusive economic zone was established at Independence, seriously depleted the stocks. Since Independence, Namibia has generally managed the use of its stocks wisely, resulting in some recovery of some

species, including the important hake resource. But a period of adverse environmental conditions during the 1990s prevented a major recovery. The pilchard (sardine) stocks are of much concern to the nation. These have not been able to recover from severe depletion. As they formed the basis of the food chain in the whole marine system, supporting almost all the other resources, the fishing industry and the marine ecosystem have not been able to recover to their full potential (Barnes and Alberts, 2007).

Overall, Namibia is on course to meet its MDG 7A and 7B targets. An important element underpinning this successful picture has been management of natural resources for sustainable use. Underpinning this, in turn, has been a commitment to the development of natural resource asset accounts, in which economic values for natural resource use and natural capital are integrated with national economic planning. Between 1994 and 2008, natural resource accounts for fish, minerals, water, energy, rangeland, forest and wildlife were developed in the Ministry of Environment and Tourism (MET) (Lange, 2001a, 2001b; Barnes *et al*., 2010, 2013). These were backed by a programme of economic analysis aimed at determining the economic efficiency of investment in natural resources and their use. Work by Turpie *et al*. (2010a, 2010b) and Barnes *et al*. (2010) on the value of investment in protected areas, work on the economic efficiency of investment in CBNRM, and work on wildlife use on private land (Barnes 2008; Barnes and Jones, 2009) have all shown the economic efficiency of sustainable natural resource use and the economic merits of natural resource conservation and husbandry. Similarly the economic contribution of tourism, as measured in tourism satellite accounts (WTTC, 2006; NTB, 2008, 2013), has shown the merits of investment in the tourism sector, and the sustainable use of tourism natural assets.

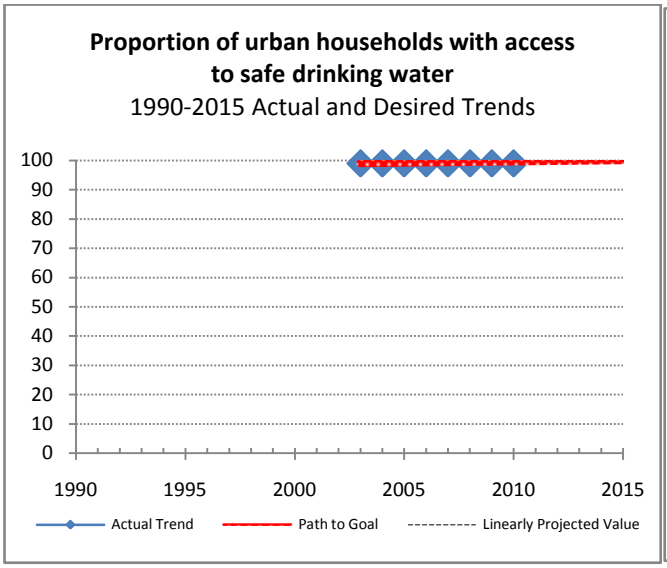
The approach described above has enabled successful mobilisation of increases in government and donor contributions to investing in natural resources and avoiding losses of natural resources and biodiversity. The passing of the Environmental Management Act (EMA) of 2007 (MET, 2008), and the appointment of an Environmental Commissioner in 2012, have institutionalised the requirements for environmental impact assessment for development projects, as well as broader scale strategic environmental assessment. This helps further to ensure environmental sustainability and avoid loss of environmental resources. The Climate Change Policy was published in 2011 (MET, 2011). This was guided by several research and analytical studies which pointed to the need for flexibility in future development to enable adaptation to climate change.

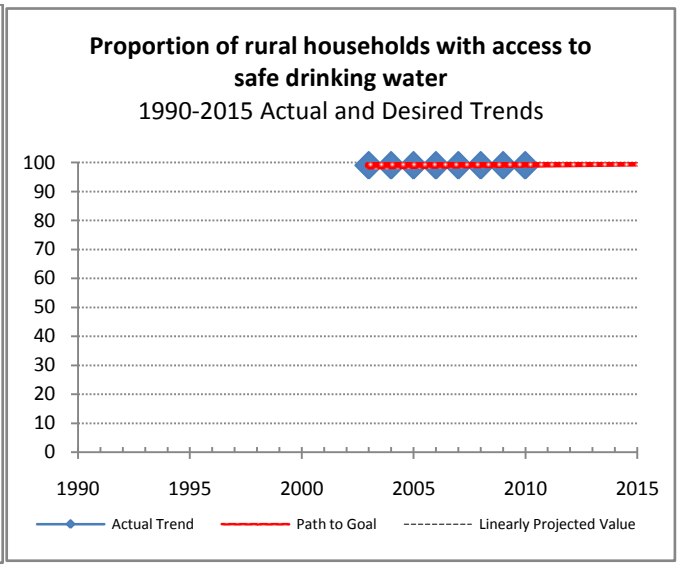
Namibia, with its small population, very low human density, and general lack of industrialisation, has had a relatively small impact internationally in terms of carbon dioxide emissions and consumption of ozone-depleting chlorofluorocarbons (CFCs). Nevertheless, under the Montreal Protocol, Namibia is obliged to reduce substances that deplete the ozone layer, known as ozone depleting substances (ODSs). Namibia has made a commitment to reducing its ozone depleting potential (ODP) from 20 ODP tonnes in 2002 to zero in 2010 (http://ozone.unep.org). Lack of data makes it impossible to determine whether this commitment has been met.

The Import and Export Control Act of 1994 (Act No. 30 of 1994), which prohibits importation into Namibia of ODS, in compliance with the obligation under the Montreal Protocol, has facilitated reduction of ODSs, and in particular CFCs. In order to achieve such a significant reduction, Cabinet approved a request from the Ministry of Trade and Industry for an incentive scheme to subsidise (by about 60 percent) the conversion cost to Namibian companies that intend to convert their refrigeration installations from CFC based technologies to non-CFC based technologies.

Nearly all Namibians living in urban areas have access to safe drinking water. Progress on this indicator is shown in two graphs on the next page, and the table above. It relies on World Bank data,[24] which are available only from 2003 to 2010 (http://www.trading economics.com/namibia). From 2003 to 2010, about 99 percent of households in urban areas had access to safe drinking water and it is expected that, by 2015, all households in urban areas will have access. The proportion of rural households with access to clean and safe drinking water increased from 45 percent in 1991 to 78 percent in 2003 and to 90 percent in 2010. Thus the target for 2015, that 87 percent of households in rural areas should have access to safe drinking water, had been exceeded by 2011.

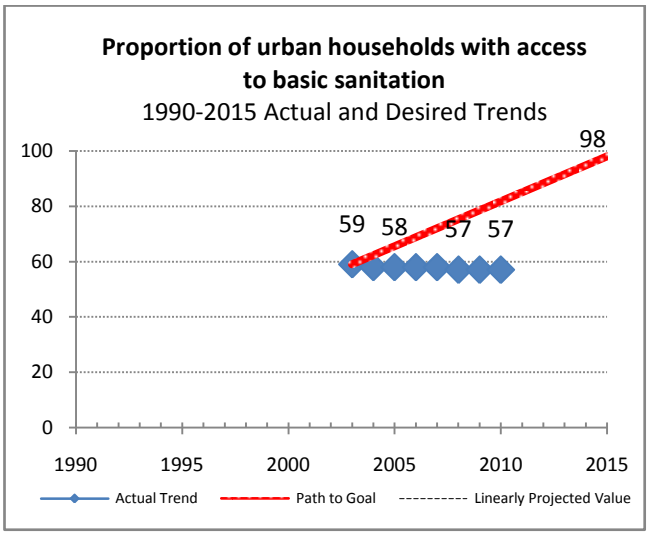
[24] There is a problem with conflicting and inconsistent data on water supply and sanitation, as data from the 2001 and 2011 national censuses indicate that the proportion of people with access to safe drinking water has actually declined and, in the case of sanitation, the proportion of urban households with access to basic sanitation is notably higher. World Bank data were used, as they appear to better reflect evidence from the Directorate of Water Supply and Sanitation Coordination and UN (2012).

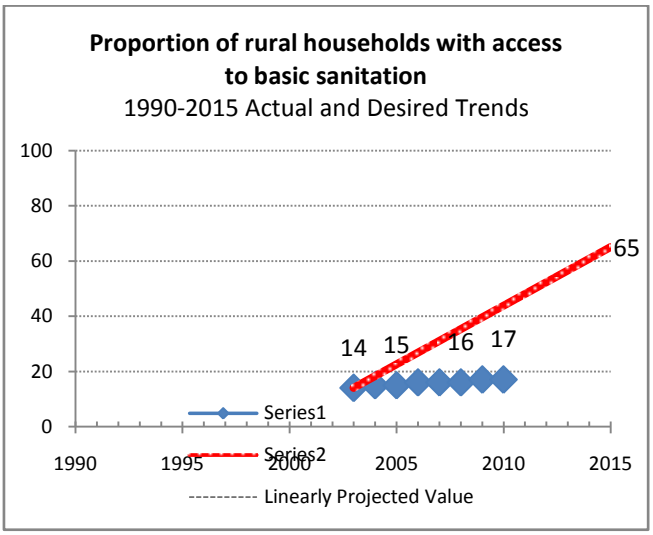




According to the UN Special Rapporteur's mission to Namibia on the human right to safe drinking water and sanitation (UN, 2012b) the situation of access to sanitation in Namibia is dire, with about two thirds of the population lacking access to improved sanitation and more than half practicing open defecation. The allocation of attention and resources to the issue of sanitation has been limited. The adoption in 2009 of the National Sanitation Strategy represented an important shift.

The proportion of households in rural areas that have access to basic sanitation increased slightly from 14 percent in 2003 to 17 percent in 2010. However, access to basic sanitation is worsening for people living in urban areas. The proportion decreased from 59 percent in 2003 to 57 percent in 2010. The targets of 98 percent and 65 percent access to basic sanitation for families in urban and rural areas respectively are extremely unlikely to be achieved by 2015. In urban areas, the decrease in the proportion of residents with access to sanitation may partly be due to the high rural-urban migration and the formation of informal settlements on the outskirts of cities and towns. Poverty in rural areas is one of the driving forces for the high rate of urban migration as poor people move to urban areas to seek employment. There are regional disparities in access to basic sanitation in Namibia. For example, in Khomas Region almost 80 percent of households have access to basic sanitation, while in Ohangwena and Caprivi Regions only 10 percent of households have this access.





Namibia uses access to secure land tenure as a proxy for assessing improvement of livelihoods of slum dwellers and is one of the first countries to introduce secure tenure in informal settlements. The Flexible Land Tenure System (FLTS) allows for flexible land titles in cities and towns. The objective is to offer some sort of formal security to landholders. The measure especially targets the residents of informal settlements, and survey standards were adapted to accommodate this specific clientele. Demand for access and title to serviced plots in the urban areas has exploded in the face of rural-urban migration, while supply of these has been very slow and

large backlogs have accumulated. This problem is closely linked to the poor performance in respect of the indicator, access to basic sanitation in urban areas.

Milestones

A number of Acts of Parliament have been passed which represent milestones in Namibia's progress towards sustainable resource use and the achievement of MDG 7. The first was the Nature Conservation Amendment Act of 1996, which formalised the development and expansion of conservancies, and forms the basis of the CBNRM programme. The Game Products Trust Fund (GPTF) Act of 1997 was established to ensure reinvestment of incomes from wildlife back into the resource. This was followed by the Namibia Forest Act of 2001, which ultimately made possible the establishment of community forestry and community forests. The broad-based Namibia EMA of 2007, enabled formalisation of the environmental assessment policy, ensured environmental impact assessment, strategic environmental assessment and the establishment of the Environmental Commissioner's Office. It also forms the umbrella Act for the range of environmental legislative instruments currently being drafted, such as the Parks and Wildlife Bill. Most recently, the Flexible Land Tenure Act of 2012 aims to overcome the far-reaching problems in achieving MDG Target 7D concerning improvement of the lives of slum dwellers.

In terms of policy for environmental sustainability, 1994 saw the development of the first policy on CBNRM, encapsulating the practical principles acquired by NGOs in the previous 15 years. The revised Water and Sanitation Sector Policy of 2008, was approved by Cabinet and paved the way for the development in 2009 of the National Sanitation Strategy Plan for 2010/11-2014/15, which was approved by Cabinet. The Cabinet also mandated the Directorate of Water Supply and Sanitation Coordination (former Directorate of Rural Water Supply) within the Ministry of Agriculture, Water and Forestry (MAWF) to take over rural sanitation and overall national coordination of the sector. Namibia's Climate Change Policy was published in 2011 and focuses on adaptation to climate change to ensure sustainability. The National Rangeland Policy and Strategy, launched in 2012, aims to reverse long-term degradation of the vital rangeland resource, employing economically sound sustainable rangeland management and community management principles.

These legislative instruments and policies are supported by institutional arrangements, including those made in cooperation with the private sector. For example, the MCA-Namibia compact was signed for significant investment in the conservation and tourism sector in Namibia in 2008. This was the first time that the Millennium Challenge Corporation had invested in this sector. The Environmental Investment Fund (EIF) was established in 2011 and launched in 2012. It performs a complementary role to government and other investing partners in the environment sector, and is soon to incorporate the GPTF. At the same time, the restructuring of the MET incorporated the establishment of the Office of the Environmental Commissioner in 2012.

Challenges and interventions to expedite MDG implementation in the remaining two years

Challenges	Interventions to expedite MDG implementation
Slow provision of sanitation in urban and rural areas.	• Speedy implementation of the WSASP will expedite provision of sanitation services to most people • The skills deficit needs to be addressed to ensure access to basic sanitation that meets the requirements of health, hygiene and dignity for the whole population in an acceptable, affordable and sustainable manner
Insecure access to land and tenure.	• Secure access to land and tenure will allow local people, especially the marginalised poor and the vulnerable, including women, to invest in and use the land to diversify their livelihoods • The redistribution of land needs to be reformed and expedited, with an appropriate, cost effective and efficient capacity building programme and resource support and support structures to allow new land owners to use such land productively and contribute to GDP • Redistribution of land needs to be planned and undertaken in a way that minimises uncertainty, which causes aversion to investing resources in land use and conservation, among current landholders • Redistribution of land needs to incorporate tourism and wildlife land uses where these make economic sense
Slow and politicised efforts in conservation of fish resources.	• Government should make every effort to rebuild the pilchard stock, which would include strict adherence to scientific principles, at the expense of political considerations
Slow implementation of the Concessions Policy.	• Namibia needs to seize the opportunity to exploit its diverse wildlife and scenic landscape for tourism as it has a great potential to contribute to both the GDP and poverty reduction for local communities, who can be employed in the industry or enter into eco-tourism ventures. Particularly this applies to currently underutilised state protected areas, but also to communal land conservancies on which it will be necessary to find ways of ensuring security of tenure and collateral for communities and investors in tourism and other natural resource use joint ventures
Environmental damage caused by mining.	• Mining corporations, Government and civil society have a responsibility to ensure environmentally sensitive extraction of natural resources • Adherence to and compliance with the provisions and requirements of the EMA will contribute to environmental sustainability
Less than optimal use and management of groundwater.	• The increasing demand for and use of Namibia's underground water resources, for example in mining, agriculture and tourism, and for a growing population, requires management to ensure they are used optimally
A need for promotion of good rangeland management and conservation farming.	• Government and donors should pursue implementation of incentives for, and projects promoting both the national rangeland policy and strategy, which provides for a programme to reverse rangeland degradation, and conservation farming principles, which can be applied to arable production at little cost to improve production

Looking Beyond 2015

The recommendations below are geared towards increasing environmental sustainability in Namibia's long-term development process.

Adaptation to climate change	The National Climate Change Policy, Strategy and Action Plan are already in place and are a welcome intervention that will address climate change adaptation and mitigation in Namibia. Therefore: • Government, donors, NGOs and private sector organisations need to collaborate on ensuring that long-term development is not vulnerable to climate change • This implies ensuring more flexibility to cope with the uncertainties of effects, as well as likely more dramatic variation in climate
Policies on water use and sanitation within a framework of secure tenure	The fact that Namibia is now an upper-middle income country belies the actuality that targets for ensuring access to basic sanitation are not being met, and indeed the situation is worsening in urban settings. Appropriate policies and strategies are in place and the challenge is to ensure their implementation. Therefore: • An immense effort is needed to assist people moving to the towns and cities, to acquire tenure security, housing, water and sanitation, including through provision of space and incentives for households to participate in their own improvements • Optimise the use of existing policy, for example the National Housing Policy, which aims to make decent housing available to all Namibians, including ultra-low and low income households, and to provide safe water and basic sanitation, ensuring dignity, for the entire population • Support organisations such as the Shack Dwellers Federation of Namibia (SDFN), the DBTP, and other NGOs and CBOs which provide plot and house loans to low income households • Consideration should be given to the establishment of a high level committee, possibly at Cabinet level, to deal with sanitation challenges, to ensure the urgent implementation of appropriate existing policies
Institutionalised natural resource accounting and natural resource economics	Much of the Namibia's success in wildlife and natural resources conservation is due to economically efficient strategies to achieve this. Tourism satellite accounts are satisfactorily handled by the Namibia Tourism Board. However, the natural resource accounting programme (embracing satellite accounts for natural assets such as water, fish, forests, rangeland and wildlife, and measures the economic contribution of these resources, as well as their value as capital assets) is not yet institutionalised satisfactorily. The valuation of natural resources, biodiversity, and ecosystem services needs to be mainstreamed and integrated into the national accounts. Therefore: • The revamped National Statistical Agency (NSA) should provide the demand and the mandate to ensure that natural resource accounts development and updating is supported
Development of legislation	The EMA provides the umbrella for a number of legislative instruments related to the environment and conservation, some of which are outdated, for example the Nature Conservation Ordinance of 1974. Therefore: • Speed up the Revision of the Nature Conservation Ordinance of 1974, which has been ongoing for some 15 years • Finalise and enact the long-awaited Parks and Wildlife Bill
Development and implementation of government-private-community partnerships	The CBNRM programme is a rights-based policy and legislation founded on the premise that if resources have sufficient value to local people and they are allowed exclusive rights of use, management and benefit, this creates incentives for people to use resources sustainably (NACSO, 2007). The CBNRM has been successful in Namibia mainly in respect of sustainable wildlife management and use. Therefore: • Further develop the options for community management of resources other than wildlife, for example forest resources through community forests, water resources through water committees and rangelands through community-based rangeland management

MDG 8: Develop a global partnership for development

Namibia is an active participant in the international family of nations. The country is engaged in promoting south-south relations generally, as well as relations within Africa and particularly Southern Africa. Namibia has established a business-friendly economic framework, which generally welcomes foreign investors. However, its position on the global competitiveness index, and its position in the World Bank 'ease of doing business' ranking, have become marginally less favourable in recent years. Classification of the country by the World Bank in 2009 as an upper-middle income country could be expected to have reduced the amount of net official development assistance and official aid received by Namibia but, so far, this has not happened and the trend is towards a continued increase. This is possibly because of the realisation that Namibia still faces a number of challenges on its way to becoming a prosperous nation. It is suggested that Namibia's standing as a global partner in development will be best served through initiatives aimed at increasing its own global competitiveness.

MDG 8 refers to a global partnership and has a range of targets and indicators, some of which apply to the developed nations and others that apply to nations in various states of development. Namibia has adopted four indicators of achievement for itself. One measures the net official development assistance (ODA) flows it receives, and the others measure the degree to which ICT has developed, in the form of internet access and use, cellular/mobile telephone subscriptions, and regular land line telephone use. The level and extent to which the population is able to communicate at home and internationally is considered to be a good indicator of its commitment to the global partnership.

Status at a Glance

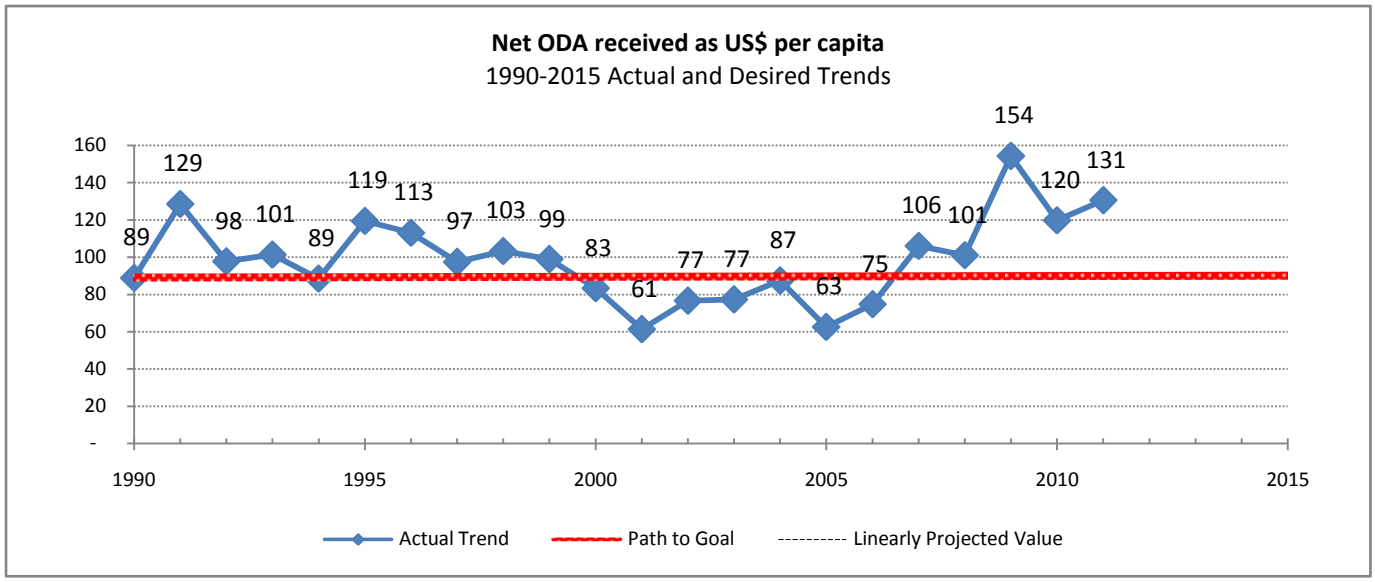
GOALS AND INDICATORS	BASELINE	STATUS	TARGET (2015)	TARGET/ GOAL ACHIEVABLE?
MDG 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT				
Official development assistance to Namibia (US$ per capita)	89 (1990)[1]	131 (2011)[1]	90[3]	Achieved
Internet users, percent of population	15% (2010)[2]	36% (2013)[2]	20%	Achieved
Cell phone subscribers, percent of population	31% (2006)[2]	115% (2013)[2]	61%	Achieved
Telephone lines, percent of households	6.8% (2006)[2]	8.1% (2013)[2]	8%	Achieved

[1] IndexMundi, www.indexmundi.com, 2013
[2] World Bank, www.tradingeconomics.com and CRAN, 2013
[3] NPC, 2008c

Current Status and Trends

Since Independence, Namibia has always understood that it needs to engage actively with the global community of nations in order to develop itself effectively. Socioeconomic development and an improvement in the standard of living of all Namibians cannot be realised without engagement with and the participation of development partners. To this end, Vision 2030 aims to achieve, among other things, stability, full regional integration and democratised international relations, the transformation from an aid-recipient country to a provider of development assistance, and Namibia's transformation into an industrialised country of equal opportunities, which is globally competitive, realising its maximum growth potential on a sustainable basis, with improved quality of life for all Namibians.

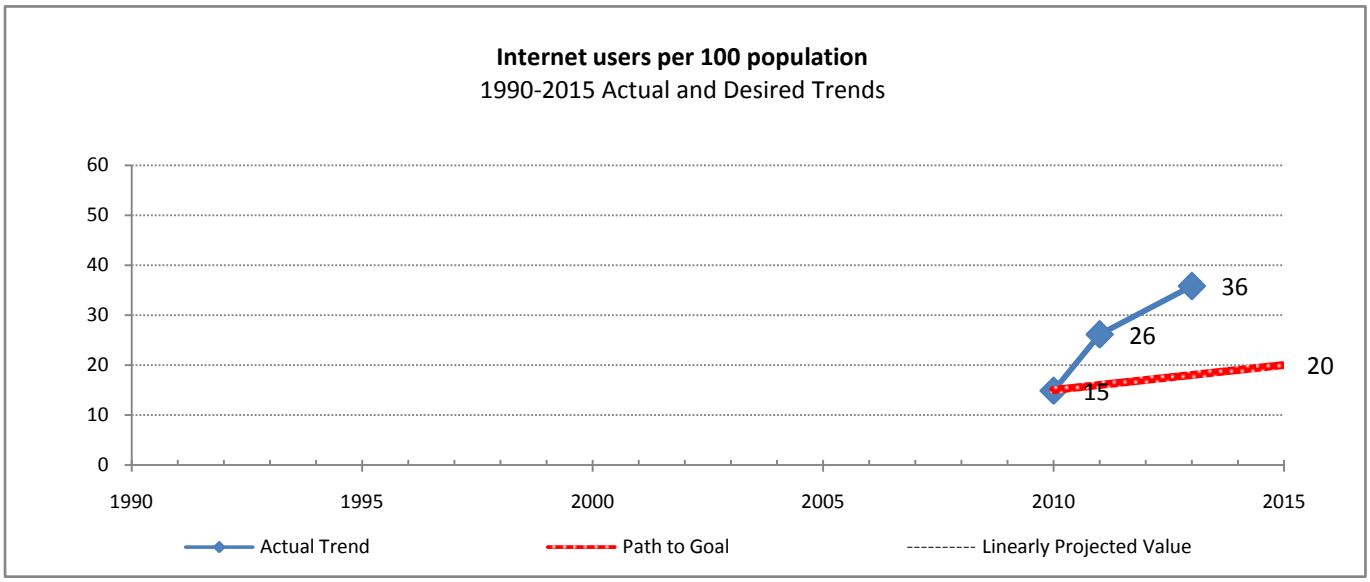
The graph below shows the World Bank database (www.worldbank.org/indicator) estimates of net ODA, in current US$ per capita, received by Namibia between 1990 and 2011. Here, net ODA refers to disbursements of loans made on concessional terms (net of repayments of principal) and grants by official agencies of the members of the Development Assistance Committee (DAC), by multilateral institutions and by non-DAC countries to promote economic development and welfare in countries and territories on the DAC list of ODA recipients. It



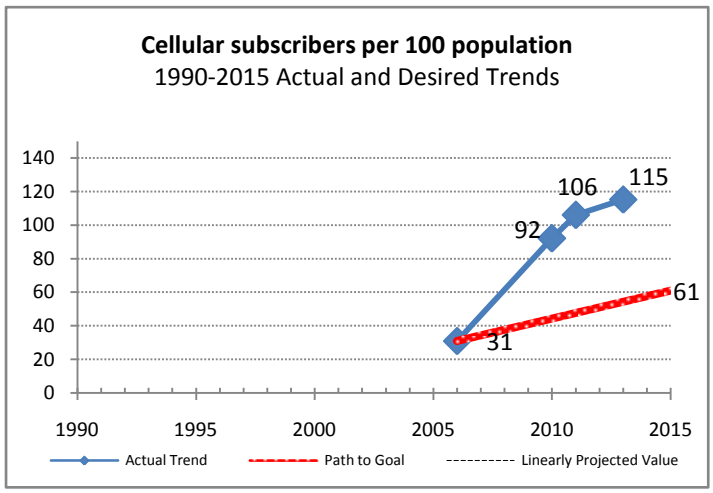
includes loans with a grant element of at least 25 percent (calculated at a rate of discount of 10 percent). The 2015 target reflects the target for NDP3 and is the same as the net ODA received in 1990.

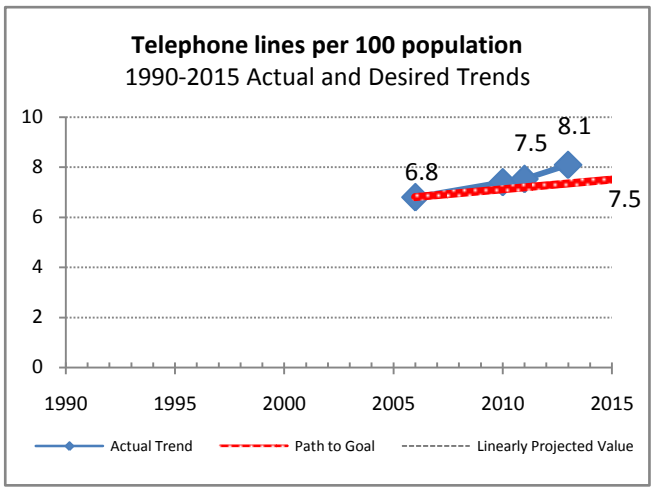
The graph showing net ODA per capita also shows a trend line, which indicates slowly increasing ODA receipts up to 2011. The trend line suggests that the target of US$90 per capita will be exceeded. This is despite the fact that Namibia in 2009 was reclassified from a lower-middle income country to an upper-middle income country. That reclassification and the fact that a number of traditional bilateral donors gave notice that they were withdrawing from Namibia, gave rise to the expectation that ODA would decline. Given that Namibia's increase in per capita income belies disparities in income that are still very high, and that a number of pressing development problems remain, some argue that the reclassification was unfortunate. The finding that the 2015 ODA target will likely be exceeded suggests that there is recognition among the donor community that development assistance for Namibia can still be very effective. However, much of the current ODA reflects multi-year commitments made earlier that are running to the end, and announcements of expected cuts have been made by a number of donors. Thus the trend shown is unlikely to persist for long. Some have noted the positive side of upper-middle income status, in that it provides positive publicity and will result in greater foreign direct investment (FDI) in the country.

The other indicators in the table above relate to the degree to which the population of Namibia has adopted the use of the Internet, and use of fixed and mobile telephone technology. The status of these is shown in graphs on this and the following page. Here, data were drawn and combined from both the Communications Regulatory Authority of Namibia (CRAN) and the World Bank database (http://www.tradingeconomics.com). The percentage of the population that uses the internet was 15 percent in 2010, and this had risen to 36 percent by 2013.



The number of cellular telephone subscriptions has risen from 31 percent of the population in 2006 to 115 percent of the population by 2013. This implies that some people have more than one cellular subscription. Only 6.8 percent of households were in possession of a fixed telephone line in 2006, and this had risen by a small proportion to 8.1 percent in 2013. It seems that many households are moving directly from having no telephone, into cellular phone use, and this appears to be the case particularly for the less well-off segments of the population who have ready access to cellular networks but would find it difficult and increasingly unnecessary to acquire a landline. This is an area of development in which all the targets, (which coincide with those in the NDP) are being achieved and, indeed, exceeded.





Milestones

Namibia has endeavoured to establish a business-friendly economic framework, which generally welcomes foreign investors. The table below shows how Namibia's global competitiveness and ease of doing business rankings have compared with those of its neighbours. Namibia's competitiveness ranking, according to the 2012-13 World Economic Forum Global Competiveness Report (Schwab, 2012), is still relatively good at 92nd out of 144 nations, and is among the best scores for countries in the Southern Africa region. However, it has declined from 74 in each of the last two World Economic Forum reports and this is of concern. Despite this, Namibia continues to benefit from a relatively well-functioning institutional environment, with well-protected property rights, an independent judiciary and reasonably strong public trust in the political system. It also has good transport infrastructure by regional standards, and the financial markets are well developed with notable confidence in financial institutions. Namibia is doing well in terms of political stability, and it has the infrastructure in place to ensure global competitiveness. Where it remains relatively weak in terms of competitiveness is in the fields of education and health (Schwab, 2012), and the size of its domestic market.

Global competitiveness ranking and ease of doing business rankings for 2012 and 2013 for Namibia, South Africa, Botswana and Angola

World Ranking	Namibia			South Africa			Botswana			Angola		
	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013
Global Competitiveness	74	83	92	54	50	52	76	80	79	-	-	-
Ease of Doing Business	-	81	87	-	41	39	-	58	59	-	174	172

Sources: World Economic Forum (Schwab, 2012); World Bank, 2013

The World Bank Doing Business report (World Bank, 2013) ranks countries according to ease of doing business and here Namibia ranks 87th out of 183 countries. However, its position on this index has also slipped several places. The most problematic factors for doing business are given as: an inadequately educated workforce; limited access to financing; corruption; restrictive labour regulations; and inefficient government bureaucracy. The Ministry of Trade and Industry has been working proactively to eliminate these constraints.

As described in the 2008 MDG report, Namibia participates actively in international cooperation, is a member of over 46 international organisations and has diplomatic relations with most countries in the world. In Africa and

the Southern Africa Region, Namibia is a member of the African Union (AU) and of the Southern African Development Community (SADC). Namibia is a signatory to the New Partnership for Africa's Development (NEPAD) initiative as well as the SADC Free Trade Area launched in August 2008, and hosts the Secretariats of the Southern African Customs Union (SACU) and the SADC Parliamentary Forum. The country has taken part successfully in several peace-keeping missions, for example to Angola, Liberia and East-Timor, and also contributed military observers in Sudan/Darfur and Cote d'Ivoire. Namibia believes in and advocates for greater African and Southern African regional cooperation and integration. The country signed the Convention on Cluster Ammunitions adopted in the Diplomatic Conference in Dublin in 2008 and, as member of SADC, Namibia sent observers who oversaw the presidential run-off elections in Zimbabwe, parliamentary elections in Angola and Swaziland, and presidential by-elections in Zambia.

The Government continues to engage vigorously in regional and international economic cooperation and groupings for mutual benefit and strives to effect structural transformation towards sustainable economic growth and development. It also recognises that regionally integrated markets are crucial for small economies like Namibia to be able to grow and develop in the face of intensified economic globalisation. This is primarily because such cooperation is fundamental for Africa's economic integration in particular and eventually the integration of Namibia into the broader world economy. Hence, in order to create an economic space for industrialisation, economic growth, poverty reduction and sustainable development, the Government has adopted global partnerships and regional economic integration as vehicles for overcoming the constraints of a small local market and as a means to facilitate the structural transformation of the country's economy. Therefore, Namibia's involvement in the regional integration initiatives is a strategic response to the growing demand for market enlargement and risk cover against economic marginalisation.

Namibia has concluded double taxation agreements with a number of important trading partner countries, welcomes direct foreign investments, as described above, and actively pursues these via an investment code that offers a range of incentives to foreign investors with companies from South Africa, Europe, North America and China leading as foreign investors. To strengthen African and international south-south cooperation, Namibia as part of SACU, concluded preferential trade agreements with some African, Asian and Latin American countries in 2008. Besides being a member of SACU, the country is part of the Common Monetary Area (CMA) together with Lesotho, South Africa and Swaziland.

The country's economy has been growing positively over the past twelve years, with annual growth rates consistently over 4 percent, and it proved relatively resilient in the face of the world financial crisis in 2008/09 from which the negative effects were only temporary. Even though the country's growth rate has tended to exceed the SADC development targets, its performance falls short of the required rate to lift many poor households out of poverty. One major challenge is to implement programmes that will address specifically the structural weaknesses of the economy. Skills and institutional capacity development must be enhanced and accelerated in order adequately to address the supply side constraints faced by the economy, thereby promoting a sustainable growth path to achieve economic emancipation. The need to maintain a high growth rate, sufficient to create gainful employment and generate increased income that would address poverty, cannot be overemphasised.

Namibia is actively involved in trans-boundary natural resources issues. To cite a few examples, Namibia is a member of three Trans-Frontier Conservation Area (TFCA) initiatives that are expected to produce substantial socioeconomic and environmental benefits from shared resources, as well as the Orange-Sengu Basin Commission (ORASECOM) and the Okavango Basin Commission (OKACOM), both of which aim to manage shared rivers and ensure equitable allocation of water.

Namibia considers the achievement of the MDGs as one of the core targets of all her economic and social policies for the benefit of the Namibian people. Namibia is a signatory to UN environment conventions, including the United Nations Convention to Combat Desertification (UNCCD), the Convention on Biological Diversity (CBD) and the United Nations Framework Convention on Climate Change (UNFCCC). Government recognises the vital role played by NGOs, CBOs and FBOs in the economic development of the country and has generally adopted a friendly stance towards them.

Challenges and interventions to expedite MDG implementation in the remaining two years

The MDG 8 indicators adopted show positive achievements and generally Namibia is well on track to achieving the overall Goal. Nevertheless, certain factors that tend to weaken Namibia's international competitiveness have emerged and these need to be addressed in the near and long-term future.

Challenges	Interventions to expedite MDG implementation
Non-availability of an adequately skilled workforce.	• It is necessary to identify the critical skills needed for the economy to operate at a higher output level • If not available in the domestic market, skills must be imported rapidly and efficiently • Domestic skills development needs to be carefully planned, focused and directed at addressing the skills gaps in the economy over the short and long term • Namibia needs to implement the current Human Resources Plan efficiently, and also to transform this into a comprehensive Human Resources Development Plan
Accountability for improved public service delivery and elimination of corruption.	• Strengthen institutional structures and hold officials accountable for performance and management of resources • Make public key documents that would support the elimination of corruption and hold officials accountable for mismanagement of funds
Labour inflexibility.	• There is a need for more flexibility while adequately protecting the rights of workers
Ineffective public-private sector and civil society cooperation.	• Government needs to give the private sector and civil society the space to operate efficiently in line with market forces and avoid attempting to micro-manage the economy • Cooperation with the private sector should be strengthened through public-private partnerships
Inadequate access to financing.	• Improve access to adequate financing and provide serviced land with tenure to ensure adequate collateral for the private sector to expand

Looking beyond 2015

The recommendations below are geared toward improving Namibia's role as an international partner for development.

Management of ODA	A concern for Namibia is the sustainability of development programmes initiated with support from development partners. Efficient use of ODA inflows requires increased national capacity for absorption and monitoring and evaluation. Therefore: • Government and donors need to coordinate planning in a way that extends programme assistance over time and ensures greater sustainability
Secure access to international markets	Namibia, with its small domestic market, needs to acquire and secure access to international markets for its products. Therefore: • Efforts to secure global trade agreements should be made to, as far as possible, ensure long-term predictability • Efforts could be stepped up to end the ongoing standoff regarding the Economic Partnership Agreement (EPA) with the European Union while ensuring that World Trade Organisation rules are applied

Increased international competitiveness	The same considerations aimed at ensuring that Namibia is internationally competitive in the global community, mentioned above, should be the focus of proactive attention in the long-term. Therefore: • Secure sufficient skills, initially through importation and, as and when possible, through local skills development • Ensure that government failure and corruption are minimised • Ensure adequate and appropriate financing • Ensure market flexibility for labour
Expansion of MDG 8 targets and indicators for Namibia	Namibia has done well according to the adopted targets, but these are narrow and the addition of several targets which are more specific to Namibia's needs could be useful. Therefore: • Include indicators that can track Namibia's ability to attract investment, such as global competitiveness and ease of doing business indicators • Include broadband access as an indicator • Include gender disaggregation in as many indicators as possible

The Post 2015 Agenda

The 189 UN's member states implementing the MDGs will meet at a Special Session of the UN General Assembly on 25 September 2013 to discuss two main issues: 1) how to accelerate progress towards achieving the MDGs; and 2) agreement on a new set of sustainable development goals (SDGs) for all nations and a timetable for implementation. The UN member states have already developed a draft set of SDGs to be adapted by all countries in the world and to be achieved within a given timeframe. It is, therefore, essential to learn from the achievements and challenges towards achieving the current MDGs.

The overall importance of the MDGs in Namibia is evident, when one compares development improvements since the year 2000 to the era before the year 2000. Significant changes have occurred since 2000, such as the proportion of the population living in poverty and severe poverty being reduced by more than half, 100 percent enrolment in primary education, improved gender parity, stabilisation of HIV prevalence, decreased incidence of HIV, extensive roll-out of ART and PMTCT, near elimination of malaria, close to no deaths associated with TB, an improved environmental sustainability, and expanded global partnerships. This progress report shows that great strides have been made by Namibia towards achieving the MDGs, although more needs to be done, especially in areas of health (MDGs 4, 5 and 6). Certainly not all progress can be attributed to the MDGs, although it is safe to say that the articulation of these Goals has contributed towards approaching development with more urgency.

The MDGs have influenced, to some extent, the manner in which Namibia planned and implemented development initiatives over the past 13 years. One example is the development of the Road Map for Accelerating the Reduction of Maternal and Neonatal Morbidity and Mortality, which specifically had 2015 in mind. Some MDGs were used to set priorities and to enhance the accountability of ministries and development partners. General ODA support has also increased since the early 2000s, partly due to the agenda setting of the MDGs. However, the MDGs have not been integrated fully into overall national and sub-national planning, implementation and monitoring and evaluation. For example, no reference to the MDGs was made in the NDP 4, while alignment to the MDGs has been missing from some sectoral plans. Stronger alignment of the national agenda to the MDGs would have been realised with the development of an MDG implementation plan accompanied by a monitoring and evaluation framework.

The Rio+20 UN Conference in 2012 resolved to develop a set of SDGs for the timeframe beyond 2015. Many lessons can be learned from the MDGs that could influence the next set of SDGs beyond 2015, that is, the next set of SDGs needs to build on the successes and challenges of the current MDGs. Although UN member states have commenced discussions on a post 2015 agenda and have developed a draft international agenda, it is highly recommended that Namibia undertake an in-depth assessment closer to the end of 2015. A rigorous consultative process should be undertaken as part of the assessment including children, youth, people with disabilities, women, men, marginalised groups, government ministries, government agencies, development partners, NGOs, CBOs and FBOs. The consultations should focus on the type of future Namibians want. The outcome of this assessment should be used to adapt the post 2015 SDG agenda for Namibia. Below, are recommendations from the MDG progress report process, which should be used as an initial starting point for further discussions.

Review MDG 1	The poverty trends show that Namibia has already achieved many of the MDG targets towards eradication of poverty and hunger. Namibia was classified as an 'upper-middle income country' in 2009, because the country's GDP had increased at a higher rate than its population growth. Current thresholds for consumption expenditure for poor and severely poor adult equivalents were regarded as too low based on the above. Therefore: • Revisit the threshold for 'poor' (consumption expenditure lower than N$377.96 per adult equivalent per month) and 'severely poor' (consumption expenditure lower than N$277.96 per adult equivalent per month) to bring them into line with the economic realities of the country • Include specific indicators for promoting child wellbeing, especially in relation to social protection of OVC.

Review MDG 2	Namibia is doing very well in achieving targets under this Goal. However, the targets exclude the provision of quality education and the extent to which the education system provides for the labour market. It is, therefore, important to include indicators that focus on quality education and the needs of the labour market. It is also recommended that the following targets be included: • All children are enrolled in pre-primary schools • All children are enrolled in secondary schools • Increased gross enrolment • Decreased repetition • Increased survival rates.
Review MDG 3	Since Namibia has already achieved half of the MDG targets towards gender equity and women's empowerment, the MDG targets should be reviewed and new indicators added that link to the performance of the existing indicators, but also go beyond only the most basic equity and equality issues. For example, new indicators could be included for: • ECD and pre-primary education • The ratio of girls and women in specific non-traditional subjects and jobs, such as in science, engineering and IT, the technical trades, and the mining and fishing industries • A reduction in GBV • Increased participation of marginalised girls and women, such as those with disabilities or members of minority ethnic groups, in training opportunities and decision-making platforms.
Review MDG 4	MDGs 4 and 5 are clustered because of the close ties between the two. The MDG could be called 'Improve Child and Maternal Health'. It is suggested that a target on non-communicable diseases be included as well. An indicator could be added to focus on universal access to all health services, including treatment for substance abuse, mental health and other emerging health hazards.
Review MDG 5	
Review MDG 6	Revise the target and indicators for malaria to bring them into line with the elimination of malaria strategy.
Review MDG 7	Overall, Namibia has been very successful in mobilising investment in natural resources conservation and in the use of these resources. With use of the right policies, it has provided incentives to landholders to complement Government in its conservation efforts. Then it has demonstrated the economic value in such investments, thereby attracting donor inputs. The MDG targets for land under conservation through CBNRM could be revised upward, while a new set is advised for freehold land to embrace private game reserves and other land under wildlife and tourism use in addition to the freehold land conservancies. Mainstreaming of environmental sustainability should also be strengthened across the different sectors.
Review MDG 8	It is recommended that Namibia examine its adopted MDG 8 indicators and targets to determine whether these are adequate for the future. Namibia's effectiveness as a global partner will depend on its development progress. It may be useful to include as indicators some of the factors that constrain Namibia's international competitiveness.

Proposals for New Goals – Post 2015

The dignity of all human beings should be at the heart of the MDGs. It is, therefore, paramount that a human rights approach be followed across all MDGs. The post 2015 agenda should focus on 'pockets' of vulnerability, susceptibility and deprivation. The developmental focus should be more on women, children, youth, people with disabilities, marginalised people and the elderly. Based on the review of MDG achievements up to 2013, it is recommended that the following goals be considered for post-2015, in addition to the existing goals:

6 Addressing inequality

- Promote industrialisation, economic development and pro-poor growth
- Promote more equitable access to productive resources and assets, principally agricultural land, housing, credit, and education and skills

7 Promoting good governance

- Intensify the fight against corruption
- Enhance transparency and accountability

- Improve conditions for investment, conditions for doing business and overall competitiveness of the economy

8 Expediting the decentralisation process, including fiscal decentralisation

- Introduce and implement a poverty incidence and deprivation index weighted fiscal transfer mechanism for transferring development resources from national to regional governments
- Introduce and implement constituency development funds (initially N$1 million per constituency), which is ring-fenced for SME development, and job creation and economic empowerment for women and youth

9 Promoting sustainable development and addressing climate change

- Promote sustainable economic, social, political and environmental development
- Introduce and implement sustainable urbanisation policies, while capacitating local authorities to manage the rapid influx of people into cities and towns, but also include rural development
- Proactively engage the various sectors to be prepared for natural disasters such as droughts, floods and earthquakes, and have climate change adaptation policies and plans in place
- Strengthen the promotion of the use of clean renewable energy as it would limit future warming of the earth

10 Ensuring food security

- Improve food production, agricultural modernisation, land distribution reform, capacity building and integration of subsistence farmers into agri-business value chains.

Achievement of the above will be only be realised with the following enablers (UNDP, n.d.):

- Peace and security
- Good governance, transparency and efforts to fight corruption
- Strengthened institutional capacity
- Promotion of equality and access to justice and information
- Human rights for all
- Gender equality
- Domestic resource mobilisation
- Regional integration
- A credible participatory process with cultural sensitivity
- Enhanced statistical capacity to measure progress and ensure accountability
- Prudent macroeconomic policy that emphasises fair growth
- A democratic and developmental state
- An enabling global governance architecture.

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ANNEX A: LIST OF KEY INFORMANTS AND WORKSHOP PARTICIPANTS

List of National Level Key Informants

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3. Vekondja Tjikuzu	NPC	Deputy Director, Regional, Sectoral Planning and Coordination
4. Stark Katokele	MOHSS	Senior Health Programme Advisor - TB
5. Francina Tjituka	MHOSS	NACOP HIV and AIDS Deputy Director
6. Anna Jonas	MOHSS	Chief Health Programme Officer
7. Farai Mavhunga	MHOSS	Chief Medical Officer - TB
8. Rosa	MOHSS	M & E Officer - TB
9. Sister Diergaadt	MOHSS	Chief Health Programme Advisor
10. Francina Rusberg	MOHSS	Senior Health Programme Administrator
11. Abner Goagub	OPM	Deputy Director
12. Fiona Sikabongo	MOLSW	Acting Deputy Director - Employment
13. Joab Muozamapabwe	MOLSW	Chief Psychologist
14. Ojijo Odhiambo	UNDP	Senior Economist
15. Myo-Zin	UNICEF	Chief, Maternal, Child Survival and Development
16. Charles Avelino	UNICEF	Education Programme Officer
17. Melanie Seto	UNESCO	Education Programme Specialist
18. Marcuss Thiobald	EU	Head of Social Economic Trade Section
19. Susan Lewis	EU	Press/Information Officer
20. Lucia Lapalle	EU	Cooperation Officer
21. Lora Imbuwa	EU	Programme Officer/Rural Development Officer
22. Jaques de Boer	EU	Attaché Rural Development
23. Melissa Jones	USAID	Director of Health
24. Brad Corner	USAID	Health Specialist
25. Olga Martin	AECID	Programmes and Gender Specialist
26. Zack Makari	NANASO	Information Specialist
27. Jackson Malundanga	NANGOF	Sector Coordinator
28. Anna Shifotoka	GF	M&E Manager
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30. Sister Marega	CAA	Programmes Manager
31. Madga Robalo	WHO	Representative
32. Andemichael Ghirmay	WHO	Maternal and Child Health Officer
33. Desta Tiruneh	WHO	Disease Prevention Control Officer
34. Loide Amkongo	UNFPA	National Programme Office - Reproductive Health
35. Dianne Hubbard	LAC	Project Manager
36. Rachel Coomer	LAC	Researcher

National Validation Workshop

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41. John Walters	Ombudsman
43. Johannes Haufiku	SFH
45. Ndapona Schleberger	NTB
47. S. Simenda	MRLGHRD
49. Tanncy Shililifa	Penduka
51. Ebba Shidiue	Penduka
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55. Petra Hoelscher	UNICEF
57. Zack Makari	NANASO
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65. Desta Tiruneh	WHO
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69. N. Nghishekwa	MHAI
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73. Clarence Rupingena	City of Windhoek
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77. Peter J. van Wyk	NABLOA
79. V. Shipoh	MGECW
81. Francina Tjituka	MOHSS
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50. Carmen Sendino	AECID
52. Christine Liswaniso	ACC
54. Olimpio Nhuleipo	MET
56. Aina Shikukumwa	MLR
58. Lusia N. Shitundeni	ACT
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62. Sarita Seehgal	UNAIDS
64. Linus S. Nahole	MHA
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72. Fabian Mubana	UNDP
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122. J. Kuhanga	OTRC
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171. Selma N. Iipinge	MYNSSC
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197. Michael Mwinga	Governor Office

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162. Saltiel Mbimbo	Min of Veteran Affairs
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168. Jan Platt	MAWF - DEES
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176. Lucia Hamutenya	AAP
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180. Fransina Kanana	Oshana ELCIN Aids Action
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230. Junias Endjala	MAWF, DOF

ANNEX B: MDGS, TARGETS AND INDICATORS

Millennium Development Goals (MDGs)	
Goals and Targets (from the Millennium Declaration)	**Indicators for monitoring progress**
Goal 1: Eradicate extreme poverty and hunger	
Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	1.1 Proportion of population below $1 (PPP) per day[i] 1.2 Poverty gap ratio 1.3 Share of poorest quintile in national consumption
Target 1.B: Achieve full and productive employment and decent work for all, including women and young people	1.4 Growth rate of GDP per person employed 1.5 Employment-to-population ratio 1.6 Proportion of employed people living below $1 (PPP) per day 1.7 Proportion of own-account and contributing family workers in total employment
Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	1.8 Prevalence of underweight children under-five years of age 1.9 Proportion of population below minimum level of dietary energy consumption
Goal 2: Achieve universal primary education	
Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	2.1 Net enrolment ratio in primary education 2.2 Proportion of pupils starting Grade 1 who reach last grade of primary 2.3 Literacy rate of 15-24 year-olds, women and men
Goal 3: Promote gender equality and empower women	
Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	3.1 Ratios of girls to boys in primary, secondary and tertiary education 3.2 Share of women in wage employment in the non-agricultural sector 3.3 Proportion of seats held by women in national parliament
Goal 4: Reduce child mortality	
Target 4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	4.1 Under-five mortality rate 4.2 Infant mortality rate 4.3 Proportion of 1 year-old children immunised against measles
Goal 5: Improve maternal health	
Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	5.1 Maternal mortality ratio 5.2 Proportion of births attended by skilled health personnel
Target 5.B: Achieve, by 2015, universal access to reproductive health	5.3 Contraceptive prevalence rate 5.4 Adolescent birth rate 5.5 Antenatal care coverage (at least one visit and at least four visits) 5.6 Unmet need for family planning
Goal 6: Combat HIV and AIDS, malaria and other diseases	
Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV and AIDS	6.1 HIV prevalence among population aged 15-24 years 6.2 Condom use at last high-risk sex 6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV and AIDS 6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years

Target 6.B: Achieve, by 2010, universal access to treatment for HIV and AIDS for all those who need it	6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs
Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	6.6 Incidence and death rates associated with malaria 6.7 Proportion of children under 5 sleeping under insecticide-treated bed nets 6.8 Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs 6.9 Incidence, prevalence and death rates associated with tuberculosis 6.10 Proportion of tuberculosis cases detected and cured under directly observed treatment short course
Goal 7: Ensure environmental sustainability	
Target 7.A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources Target 7.B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss	7.1 Proportion of land area covered by forest 7.2 CO2 emissions, total, per capita and per $1 GDP (PPP) 7.3 Consumption of ozone-depleting substances 7.4 Proportion of fish stocks within safe biological limits 7.5 Proportion of total water resources used 7.6 Proportion of terrestrial and marine areas protected 7.7 Proportion of species threatened with extinction
Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	7.8 Proportion of population using an improved drinking water source 7.9 Proportion of population using an improved sanitation facility
Target 7.D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	7.10 Proportion of urban population living in slums[ii]
Goal 8: Develop a global partnership for development	
Target 8.A: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system Includes a commitment to good governance, development and poverty reduction – both nationally and internationally Target 8.B: Address the special needs of the least developed countries Includes: tariff and quota free access for the least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction Target 8.C: Address the special needs of landlocked developing countries and small island developing states (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly)	*Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked developing countries and small island developing States.* <u>Official development assistance (ODA)</u> 8.1 Net ODA, total and to the least developed countries, as percentage of OECD/DAC donors' gross national income 8.2 Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation) 8.3 Proportion of bilateral official development assistance of OECD/DAC donors that is untied 8.4 ODA received in landlocked developing countries as a proportion of their gross national incomes 8.5 ODA received in small island developing states as a proportion of their gross national incomes <u>Market access</u> 8.6 Proportion of total developed country imports (by value and excluding arms) from developing countries and least developed countries, admitted free of duty 8.7 Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries 8.8 Agricultural support estimate for OECD countries as a percentage of their gross domestic product 8.9 Proportion of ODA provided to help build trade capacity

Target 8.D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	<u>Debt sustainability</u> 8.10 Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative) 8.11 Debt relief committed under HIPC and MDRI Initiatives 8.12 Debt service as a percentage of exports of goods and services
Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	8.13 Proportion of population with access to affordable essential drugs on a sustainable basis
Target 8.F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	8.14 Fixed telephone lines per 100 inhabitants 8.15 Mobile cellular subscriptions per 100 inhabitants 8.16 Internet users per 100 inhabitants

[i] For monitoring country poverty trends, indicators based on national poverty lines should be used, where available.

[ii] The actual proportion of people living in slums is measured by a proxy, represented by the urban population living in households with at least one of the four characteristics: 1) lack of access to improved water supply; 2) lack of access to improved sanitation; 3) overcrowding (3 or more persons per room); and 4) dwellings made of non-durable material.