2ND MILLENNIUM DEVELOPMENT GOALS REPORT | NAMIBIA 2008

REPUBLIC OF NAMIBIA

PROGRESS AT MID-TERM
SEPTEMBER 2008

2ND MILLENNIUM DEVELOPMENT GOALS REPORT | NAMIBIA 2008

PROGRESS AT MID-TERM I SEPTEMBER 2008

NATIONAL PLANNING COMMISSION

Private Bag 13356
Government Office Park
Luther Street
Telephone +264 61 2834111
Fax +264 61 226501

layout & design: OFFICE OF THE UNITED NATIONS RESIDENT COORDINATOR
photographs: UN/LEITAGO /NARIB

ACKNOWLEDGEMENT

This second progress report on the Millennium Development Goals was produced with financial assistance from the United Nations Development Programme (UNDP). The report is a joint effort by the Government of the Republic of Namibia and the United Nations in Namibia. The preparation of the report was led by the National Planning Commission Secretariat (NPCS) which provided the overall direction and coordination.

The report benefited from the guidance and contributions from the following United Nations agencies: UNDP, UNFPA, UNICEF and UNESCO in particular. The National Planning Commission gratefully acknowledges substantive inputs received from all members of the Steering Committee and all other individuals that were interviewed in several ministries, offices and agencies including those in the private sector and NGOs.

We would especially like to acknowledge the Namibia Economic and Policy Research Unit (NEPRU) for their hard work and dedication on the research, data collection, analysis and write-up of this report.

Data are still not available for all indicators related to the MDGs, nevertheless, this report has been completed with hard work and great effort from all concerned. For this, we thank all those who were involved in producing and preparing it.

FOREWORD

The year 2008 is critical for the Millennium Development Goals – half way towards the target date of 2015. This is therefore a good point to take stock whether we are half way towards meeting the goals. This second progress report addresses this question for Namibia, assessing how successful we have been in moving towards each of the goals and their associated targets, and signaling what would be required to turn this historical moment into historical opportunity to fulfill the spirit and the promises of the Millennium Declaration.

Some targets under poverty and gender have been achieved way before 2015. The education goal is likely to be achieved soon and, progress is being made in reaching the targets for HIV/AIDS, as well as environmental sustainability. Not satisfied with these achievements, Namibia has commited itself to a set of more ambitious targets under the Third National Development Plan (NDP3) through to 2012. This bold agenda is a tribute to Namibia's results-based approach to accelerating and deepening rural development for poverty reduction.

In spite of progress in some goals, serious issues and challenges remain. To meet all the MDGs targets by 2015, Namibia will have to achieve GDP growth of 5 to 6% per annum or even higher as proposed in our NDP3, ensure continuity and sustainability of prudent policies, allocate additional resources and ensure their effective use, and above all increasingly involve communities in the development process.We should realise that although the MDGs are global they can most effectively be achieved with the active and continuous involvement of national and regional levels of government, civil society and local communities at large. National plans and actions are critical. But experience has shown that national plans must be linked with both local realities and the people they serve in order to be successful.

The Government sees the MDGs as rallying points for development efforts and resource allocation for optimal outputs. This report will be used as a tool for policy dialogue and advocacy, at all levels of government and civil society. It should influence national decision-making on socio-economic investment, public resource allocation and management, focusing on national, regional, and local communities.

As greater fiscal space becomes available, even more resources will be allocated to the social sectors. Equally, we expect our development partners to provide enhanced resources to help us achieve the MDGs. Let me reiterate that the Government of Namibia is fully committed to achieiving the MDGs by 2015.

Nahas Angula,

PRIME MINISTER

PREFACE

The second progress report on the MDGs in Namibia has been produced in 2008, thus mid-way between 2000 and 2015. It is intended to provide a mid-term review of both the encouraging achievements and the challenges that remain, and on the way towards the full realisation of the MDGs by 2015. Like the first report in 2004, this report emphasises certain policy changes and gives a picture of where we are and where we are going.

It indicates our profound commitment to working towards achieving the goals in order to eradicate poverty and to cooperate with other governments and international institutions as part of a broader global campaign for a prosperous world with peace and security, the ultimate aim of the MDGs.

It is of vital importance that this report coincides with the implementation of Namibia's Third National Development Plan (NDP3). The NDP3 serves as the first systematic attempt to translate the Vision 2030 into concrete programmes and activities to improve the quality of life for our people to the level of the developed world. Therefore, the NDP3 serves as the country's road map for sustainable social and economic development in which the Millennium Development Goals have been fully and systematically integrated with vigour and enthusiasm.

This report shows that good progress has been made towards the achievement of most of the set targets. This is clear particularly to poverty reduction, primary education and gender equality. Some progress has been made on environmental sustainability, while a slight improvement has been made on HIV/AIDS prevalence. However, with respect to the global partnership for development (Official Development Assistance), our achievement so far is unfortunately less encouraging.

It is worth noting that this report provides information on core development issues of the country. Accordingly, it is a source of information of critical importance and interest. Therefore, we would like to present this report to planners, policymakers, researchers and academics for their indepth discussion and deliberations. An intesive consultative process based on efforts, resources and inputs from a wide group of stakeholders from Government institutions and the United Nations Agencies in Namibia, laid the foundation for this collaborative endeavour.

The preparation of the report was led by the National Planning Commission, assisted by a Steering Committee whose members were drawn from a group of different stakeholder across the country. The United Nations Development Programme (UNDP) provided technical and financial support to the production of this report.

Hon. Prof. Peter H. Katjavivi
DIRECTOR GENERAL

NATIONAL PLANNING COMMISSION

MAP OF NAMIBIA

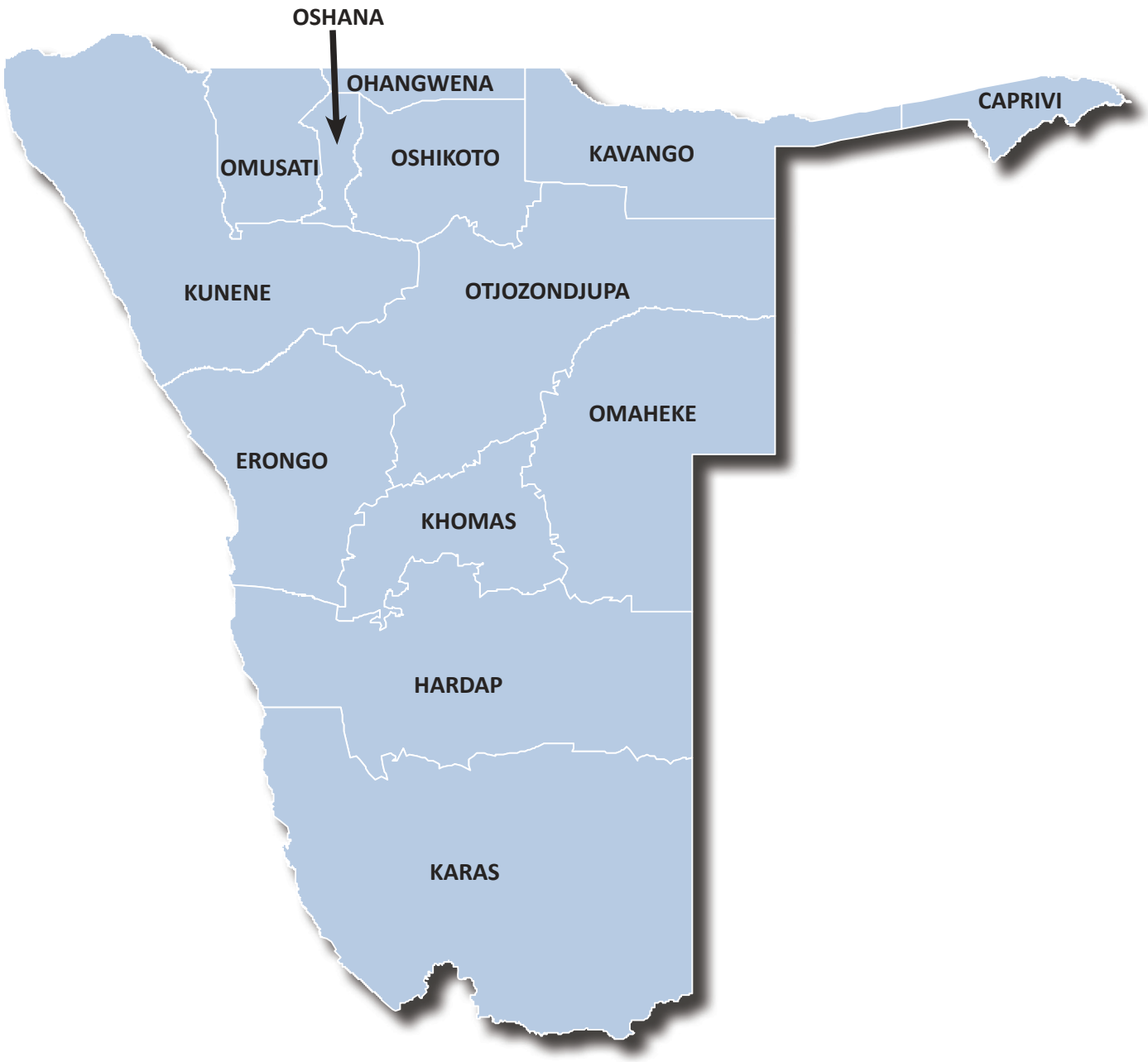


TABLE OF CONTENTS

LIST OF ABBREVIATIONS

AFASS	Accessible, Feasible, Affordable, Safe and Sustainable
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-natal Care
ART	Anti-Retroviral Treatment
ARVs	Anti-Retrovirals
BEmOC	Basic Emergency Obstetric Care
BTP	Build Together Programme
CBS	Central Bureau of Statistics
CDR	Case Detection Rate
CMA	Common Monetary Area
CMR	Child Mortality Rate
CBO	Community Based Organisation
CNR	Case Notification Rate
CEMoC	Comprehensive Emergency Obstetric Care
DBTP	Decentralised Build Together Programme
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment Short Course
EPA	Economic Partnership Agreement
EPI	Expanded Programme on Immunisation
EmoC	Emergency Obstetric Care
EU	European Union
GDP	Gross Domestic Product
HIV	Human Immuno-deficiency Virus
HRDC	Habitat Research and Development Centre of Namibia
IMR	Infant Mortality Rate
IRS	Indoor Residual Spraying
ITN	Insecticide Treated Net
MAWF	Ministry of Agriculture, Water and Forestry
MTCT	Mother-to-child Transmission
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
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
n.a.	not available
NDP	National Development Plan
NEPAD	New Partnership for Africa's Development
NGO	Non-Governmental Organisation

NHE	National Housing Enterprise
NHIES	Namibia Household Income and Expenditure Survey
NPC	National Planning Commission
NTCP	National Tuberculosis Control Programme
PHC	Population and Housing Census
PMTC	Prevention of Mother-to-child Transmission
PNC	Post-natal Care
SACU	Southern African Customs Union
SADC	Southern African Development Community
STI	Sexually Transmitted Infections
SDFN	Shack Dwellers Federation of Namibia
TB	Tuberculosis
UN	United Nations
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
NANASO	Namibia Network of AIDS Services Organisations

EXECUTIVE SUMMARY

To reduce and overcome the challenges and bottlenecks encountered on the way to a modern and prosperous society, Namibia has made some far-reaching strategic development policy decisions which are guided by the document "Vision 2030" and are implemented through National Development Plans and specific sector plans. However the achievement of the MDGs which otherwise would have been relatively easy to reach are challenged by high levels of regional income disparities, the impact of HIV/AIDS on public sector service delivery and relatively new fledging institutions that need consistent and quality technical support. The main observations and conclusions under each Millennium Development Goal are summarised below and in Table A.

GOAL 1 – ERADICATE EXTREME POVERTY AND HUNGER

Poor and severely poor households currently make up around 28% and 4% of all households respectively. Both figures have decreased significantly since the beginning of the 1990s. The 2012 target for severely poor households has already been achieved, and meeting the target for the poor households is possible. The Gini-coefficient, a measure of the inequality of the distribution of income, has improved considerably but remains unacceptably high. The growth of gross domestic product has beenmodestalthough the trend is increasing somewhat. However, the unemployment rate remains high and rising. It currently stands at around 37% (including people who are unemployed and not looking for jobs), while the youth unemployment figure is even higher. The proportion of undernourished and stunted children has been declining since the 1990s and is now around 24%. Meeting the target of 18% for 2012 is possible.

GOAL 2 – ACHIEVE UNIVERSAL PRIMARY EDUCATION

The net primary school enrolment rate stands at around 92%. Since 2003 enrolment has been on a downward trend. The target of 99% will be difficult to meet. The survival rate to grade 8 has increased from 75% in 2000 to 81% in 2006, and the target of 80.2% has already been achieved. The survival rate to grade 5 is improving, so even if the rates in 2000 and 2006 were the same (94%), the target (99.2%) can possibly be achieved. The literacy rate (93%) has not experienced much progress, and it is not likely that the target of 100% will be reached. Furthermore, the general competence level of learners in Namibia is low compared to other southern and eastern African countries.

GOAL 3 – PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

The ratio of females to every 100 males in primary education stands at 98, in secondary education at 117, and in tertiary education at 88. The target to have gender parity in education has been achieved in secondary education; it is likely to be achieved for primary education, and it will possibly be achieved in tertiary education. Nationally, there are 103 literate women to a 100 men, and the gender parity goal has thus been achieved. The proportion of women employed in the non-agricultural sector is 47%, and the target of 50% is likely to be achieved. During 2007 women occupied 27% of seats in Parliament, and the 2015 target of 50% can only be achieved if the political will is there. Before gender equality can be a reality, issues such as gender-based violence, harmful cultural practices and female poverty must be dealt with.

GOAL 4 – REDUCE CHILD MORTALITY

Infant mortality as well as under-five mortality was decreasing until 2000, but has been on an upward

trend since then. Currently the infant mortality rate stands at 46 deaths per 1,000 live births, while under-five mortality is at 69 deaths per 1,000 live births. The increase is mainly due to the combination of HIV/AIDS and inadequate nutrition. Given the rising trend for infant and under-five mortality, it is unlikely that the targets concerning infant and under-five mortality set for 2012 of 38 and 45 respectively can be met.

Immunisation of children against measles has made steady and uninterrupted progress since the early 1990s and currently stands at around 84% of all one-year-old children. The target for immunisation of one-year-old children coverage for 2012 is likely to be met. However, there are considerable regional disparities in immunisation coverage.

GOAL 5 – IMPROVE MATERNAL HEALTH

Maternal mortality has been on a rising trend since the beginning of the 1990s. At present, it stands at around 450 deaths per 100,000 live births. It is unlikely that the target of 337 deaths in 100,000 live births will be met. At the same time, the proportion of births attended by trained health personnel is steadily increasing and is currently at around 80%. It is likely that the target of 95% will be achieved by 2012. However, this latter development could not compensate for the combined effects of limited access to emergency obstetric care, HIV/AIDS as well as poverty on maternal health, offering an explanation for the rise in maternal mortality.

Reproductive health indicators have improved accross the board, and reaching the set targets is likely for most of the indicators. The contraceptive prevalence rate for married women is on a steady increase from 38% in 2000 to currently 47%. The adolescent birth rate is still high, currently at 15%, but is steadily decreasing on national level. Antenatal care is increasing and at present covers 70% of all births. It is possible that the target of 80% will be met. Only 7% of families in need of family planning have not received assistance. Meeting the target for 2015 of 6% is likely.

GOAL 6 – COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

The HIV prevalence rate has gone down from 12% in 2000 to 5.1% in 2008 for the age group 15-19 years, and from 20% to 14% for the age group 20-24 years. The 2012 targets of 8% for the age group 15-19 has been exceeded while the 12% target for the age group 20-24 could possibly be reached if these declining trends continue. The number of people living with HIV is however increasing as ARV treatment has been rolled out in the public sector. Women are more at risk of getting HIV than men, both due to physical attributes and trans-generational and transactional relationships. Furthermore young women's condom use during higher-risk sexual intercourse is much lower than men's.

The prevalence of tuberculosis has decreased since 2004 and currently stands at 765 cases per 100,000 people. Programmes and policies are in place, which are likely to further contribute to the lowering of TB cases. This is also reflected in treatment success which has increased from 64% to around 76% currently.

Cases of malaria have considerably declined over the past 15 years to the current ratio of 48 cases per 1,000 people. The target for 2012 – to halt and reverse the trend – has been achieved. This development is the result of an intensive anti-malaria campaign.

GOAL 7 – ENSURE ENVIRONMENTAL SUSTAINABILITY

The area of protected land has increased and currently stands at 18%. The target set for 2012 of 20% is likely to be achieved. Communal conservancies have expanded considerably and at present cover 14%

of the total area. The target for 2012 is likely to be achieved. However, less progress has been made in expanding freehold land conservancies which currently cover 6% of the land area. It is nevertheless possible though that the target set for 2012 of 10% will be met.

Access by urban households to safe drinking water is only slightly less than 100%, but is slightly decreasing. It is possible that the target set for 2012 of 100% will be achieved. Access of rural households to safe drinking water is increasing and currently stands at 80%. The target set for 2012 of 87% is likely to be achieved. Access of urban households to basic sanitation is decreasing and stands at 58%. The target of 98% is unlikely to be met. For rural households the access to basic sanitation is stagnating at 14%. The target set at 65% is likewise unlikely to be met. Urban migration makes it difficult for municipalities to provide sufficient drinking water and sanitation.

GOAL 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 and relations in Africa and Southern Africa specifically. Namibia has established a business-friendly economic framework which welcomes foreign investors.

The Namibian people use increasingly modern techniques of communication within the country as well as with the rest of the world. Currently, 4.8% of the population are internet users. Cellular phone subscribers account for 49% of the population. Around a third of households possess a fixed telephone line.

The classification of the country by the World Bank as a "lower middle income" country has disadvantageous consequences for the amount and concessionality of multilateral and bilateral aid flows to Namibia. The Namibian Government regards this as inappropriate in the context of the legacy of the colonial past and the remaining challenges confronting Namibia on its way towards becoming a prosperous nation.

TABLE A THE QUANTITATIVE INDICATORS AT A GLANCE

GOALS AND INDICATORS	1990/1993 BASELINE	CURRENT STATUS (2008)	2006 TARGET	2012 TARGET	TARGET/ GOAL ACHIEVABLE?
ERADICATE EXTREME POVERTY AND HUNGER					
Poor HH (including severely poor HH), % of all HH	38**	28	28	19*	POSSIBLE
Severely poor HH, % of all HH	9**	4	4	3.5*	ACHIEVED
Unemployment rate, broad concept, nationwide in percent	34. 5 (1997)	36.7	33.8	33.3	POSSIBLE
Employment growth, % p.a., average in period	-	-	2.6	2.6 -- 3.2	POSSIBLE
GDP growth rate p.a., average percent in period	3.6	4.7	4.3	5.0 - 6.5	POSSIBLE
Gini-coefficient	0.701	0.604	0.6	0.58	LIKELY
Children under five, malnourished, stunted, in % of all children under five	28.4	24.2	-	18	POSSIBLE
ACHIEVE UNIVERSAL PRIMARY EDUCATION					
Net primary school enrolment (percent)	89	92.3	95	99.1	UNLIKELY
Youth literacy rate (percent)	88	93	94	100*	UNLIKELY
Survival rate grade 5 (percent)	70	94	95	99.2	POSSIBLE
Survival rate grade 8 (percent)	59	81	-	80.2	ACHIEVED
PROMOTE GENDER EQUALITY AND EMPOWER WOMEN					
Females per 100 males in					
Primary education	102	98	100+	100	LIKELY
Secondary education	124	117	100+	100	ACHIEVED
Tertiary education	175	88	100+	100	POSSIBLE
Literacy	106	103	100	100	ACHIEVED
Share of women employed in non-agriculture (percent)	39	47	-	50	LIKELY.
Share of seats held by women in parliament (percent)	6.9	26.9	26.9	50	POSSIBLE
REDUCE CHILD MORTALITY					
Infant mortality rate deaths per 1,000 live births	56.6	49	36	38	UNLIKELY
Under-five mortality rate deaths per 1,000 live births	83.2	69	54	45	UNLIKELY
Share of one-year old children immunized against measles (percent)	75.7	83.8	80	85	LIKELY
IMPROVE MATERNAL HEALTH					
Maternal mortality rate, deaths per 100,000 live births	225	449	268	337	UNLIKELY
Birth attendance by trained health personnel (percent)	68	81	88	95	LIKELY
Use of contraceptives (percent)	23	47	50	56.6	LIKELY
Adolescent birth rate (percent)	22	15	-	13	LIKELY
Ante-natal care coverage (percent)	56	70	-	80	LIKELY
Unmet need for family planning (percent)	24	7	-	6*	LIKELY

COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES					
HIV/AIDS					
HIV prevalence, 15 – 19 years (percent)	6	5.1	9	8	**ACHIEVED**
HIV prevalence, 20 – 24 years (percent)	11	14.0	15%	12	**POSSIBLE**
People living with HIV, 15 – 49 years (percent)	-	15.3	-	-	**LACK OF DATA**
Condom use at the last higher-risk sex, women 15 – 24 years (percent)	-	64	45	-	**LACK OF DATA**
Condom use at the last higher-risk sex, men 15 – 24 years (percent)	-	81	-	-	**LACK OF DATA**
Proportion of population with advanced HIV infection with access to ARV drugs (per cent)	-	66	-	75	**LIKELY**
TUBERCULOSIS, MALARIA					
TB cases detected per 100,000 population	656	765	-	<300	**POSSIBLE - LIKELY**
TB cases treated successfully (percent)	64	76	75	85	**LIKELY**
Incidence of malaria per 1000 population	207	48	-	Halt and begin to reverse	**ACHIEVED**
ENSURE EVIRONMENTAL SUSTAINABILITY					
Protected areas	14	18	15	20	**LIKELY**
Communal conservancies	0	14	11	15	**LIKELY**
Freehold land conservancies	5	6	9	10	**UNLIKELY**
Community forestry (ha)	0.0	460000	300000	2.5 mio	
PERCENT HOUSEHOLDS WITH ACCESS TO SAFE DRINKING WATER					
Urban	99	97	95	100	**POSSIBLE**
Rural	74	80	80	87	**LIKELY**
PERCENT HOUSEHOLDS WITH ACCESS TO BASIC SANITATION					
Urban	86	58	-	98	**UNLIKELY**
Rural	14	14	50	65	**UNLIKELY**
DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT					
Official development assistance to Namibia (per capita US$)	80	88 (2006)	-	90	**LIKELY**
Internet users, per 100 population	-	4.8	-	-	**LACK OF DATA**
Cell phone subscribers, per 100 population, 16 years and older	-	49	-	-	**LACK OF DATA**
Telephone lines, per 100 households	-	34.6	-	-	**LACK OF DATA**

* NDP3, **1993/1994

DEVELOPMENT CONTEXT

Namibia covers 824,000 km2 with a population of around 2 million. The population growth rate is around 2.5% per annum and is slowly declining. Although relatively sparsely populated, 60% of the population lives in six northern regions of the country where the population density is much higher than the average density would suggest. Two-thirds of the population live in rural areas. Apart from the northern regions which benefit from perennial rivers, the rest of the country has an arid climate which permits cattle ranching – if it is cautiously managed – but little rain-fed agriculture. Namibia is blessed with a wealth of mineral resources comprising diamonds, uranium, copper, zinc and gold. The cold Benguela current on Namibia's Atlantic shore contains rich – albeit varying – quantities of marine resources.

Namibia's developmental aspirations are explicitly formulated in the national long-term plan "Vision 2030". All development policy decisions are guided by "Vision 2030" and are implemented through National Development Plans. Education, much neglected in colonial times, has turned into a cornerstone of development policy with about 25% of the budget allocated to education.

Namibia shares many developmental challenges with the partner countries of the Eastern and Southern African region. These include poverty of large strata of the population, natural disasters such as floods, drought or cyclones, the HIV epidemic, quality education for all and exposure to the forces of globalisation, with fluctuating prices for raw materials and rising food and fuel prices. Attempts are being made to correct the inherited highly uneven distribution of land through a relatively moderate approach of land reform, which follows the principle of "willing buyer, willing seller". For several years now the country has embarked on a programme of decentralisation, intended to strengthen the decision-making power of regional and local authorities. Providing a social safety net is a policy priority. Government provides a monthly social pension to all residents beyond the age of 60 years and a social grant to all vulnerable children. Targeted food aid is provided to schools and orphanages. In case of natural catastrophes, Government distributes food to those affected.

Namibia pursues sound macroeconomic policies and has a past record of stable economic growth rates. The foreign public debt stock of 5.4% of GDP is relatively low by international comparison. According to the UN classification, Namibia is a "middle income" country with per capita GDP of around US$3,000. This classification is however simplistic and misleading, because income and wealth are very unevenly distributed in Namibia. A sizable proportion (28%) of the population is poor and about 4% are severely poor. At the same time, a segment of the society is very wealthy even by international standards. The consumption of the richest 10% of households is more than 20 times higher than that of the poorest 10%.

MDG 1

ERADICATE EXTREME POVERTY AND HUNGER

"Poverty is the worst form of violence."

Mahatma Gandhi

The Collected Works of Mahatma Gandhi, New Delhi, 1960.

MDG 1: ERADICATE EXTREME POVERTY AND HUNGER

Namibia uses the food consumption ratio to define the poverty status of households. A household which spends 60% or more of its total consumption on food is regarded as "poor", and a household which spends more than 80% on food is regarded as "severely poor". This measurement criterion defines poverty in relative rather than absolute terms.

STATUS AND TRENDS

TABLE 1.1 ERADICATE EXTREME POVERTY AND HUNGER

INDICATOR	1993/94	2003/04	2006/07	2006 TARGET	2012 TARGET	TARGET ACHIEVABLE?
Poor HH (including severely poor HH), % of all HH *	38	27.8	-	28	19 (2015)	POSSIBLE
Severely poor HH, % of all HH *	9	3.9	-	4	4.5 (2015)	ACHIEVED
Unemployment rate, broad concept, nationwide **	33.8 (2000)	36.7 (2004)	-	33.8	33.3	POSSIBLE
Average employment growth rate, percent p.a. **	-	-2.7	-	2.6	2.6 - 3.2	POSSIBLE
GDP growth p.a. ***	3.6	4.5	4.7	4.3	5.0 - 6.5	POSSIBLE
Gini-coefficient **	0.701	0.604	-	0.6	0.58	LIKELY
Children under five, malnourished, stunted, in % of all children under five ^	28.4	23.6 (2000)	24.2	-	18	POSSIBLE

NOTES: HH: Households
SOURCES: * Central Bureau of Statistics (CBS) (1996) & (2006), ** National Planning Commission (NPC) (2001) & (2008), *** CBS (2007), ^ MoHSS (2008d).

The proportion of poor households decreased considerably during the ten year interval between the first and the second household survey (1993/94 and 2003/04)1. The target set by the Government for 2006 (28%) had already been achieved in 2003/04. The global target for 2015, however, namely to realise a reduction of the 1990 value by 50%, is still some way ahead – though not unreachable. The proportion of severely poor households was and is much smaller than that of all poor households. The figure decreased considerably, from 9% to 4%. The Government target for 2006 was met ahead of time. The UN target for 2015 (reduction by 50% the 1990 value) has likewise already been achieved.

1 However, due to a change of definitions and survey technique, the results of the two reports are not fully comparable. Moreover, a new method of measuring poverty – the cost of a basic needs basket of goods – has been recently developed by CBS.

Poverty and inequality have an urban/rural as well as a gender dimension. In urban households, consumption per capita is more than three times as high as that of rural households. Consumption per capita in male-headed households is 40% higher than in female-headed households.

Unemployment is a main cause of poverty. The broad measurement concept of unemployment includes those citizens who are no longer looking for a job, although they are unemployed and would like to have a job. The unemployment rate according to this broad definition is 36.7% (2004). Since 2000 the rate has increased by around 3 percentage points. The increase is mirrored in the negative figure for employment growth (-2.7%). The targeted employment rate of 66.7% by 2012 implies an unemployment rate of less than 33.3%. This is a modest target which can possibly be achieved. The NDP3 target of an annual employment growth of 2.6% - 3.2% implies a change of the current trend. This seems to be possible if the promotion of labour-intensive small and micro enterprises, including the informal sector, is continued.

Unemployment is highest in the youngest age group, and lowest in the older age groups. Young persons (15 – 19 years) face an unemployment rate of 67%. The rural-urban divide in unemployment is moderate. While the rural unemployment rate (in 2000) was around 36%, the urban rate is about 31%. More significant is the difference in unemployment amongst men (28%) and amongst women (39%).

Women, specifically when they have to head a household, as well as their children, are specifically vulnerable to poverty and malnutrition. The number of female-headed households has much more increased between 1993/94 and 2003/04 than that of male-headed households.

Annual GDP growth increased slightly from the end of the 1990s to the early 2000s. The NDP2 target for 2006 has been achieved. Further GDP growth depends on many factors, most of which are not under the control of the Government. International developments such as the demand for raw materials play a critical role. However, there is still much to be done to reduce red tape and improve the growth-conducive environment. If this is done the targeted GDP growth rate can possibly be achieved.

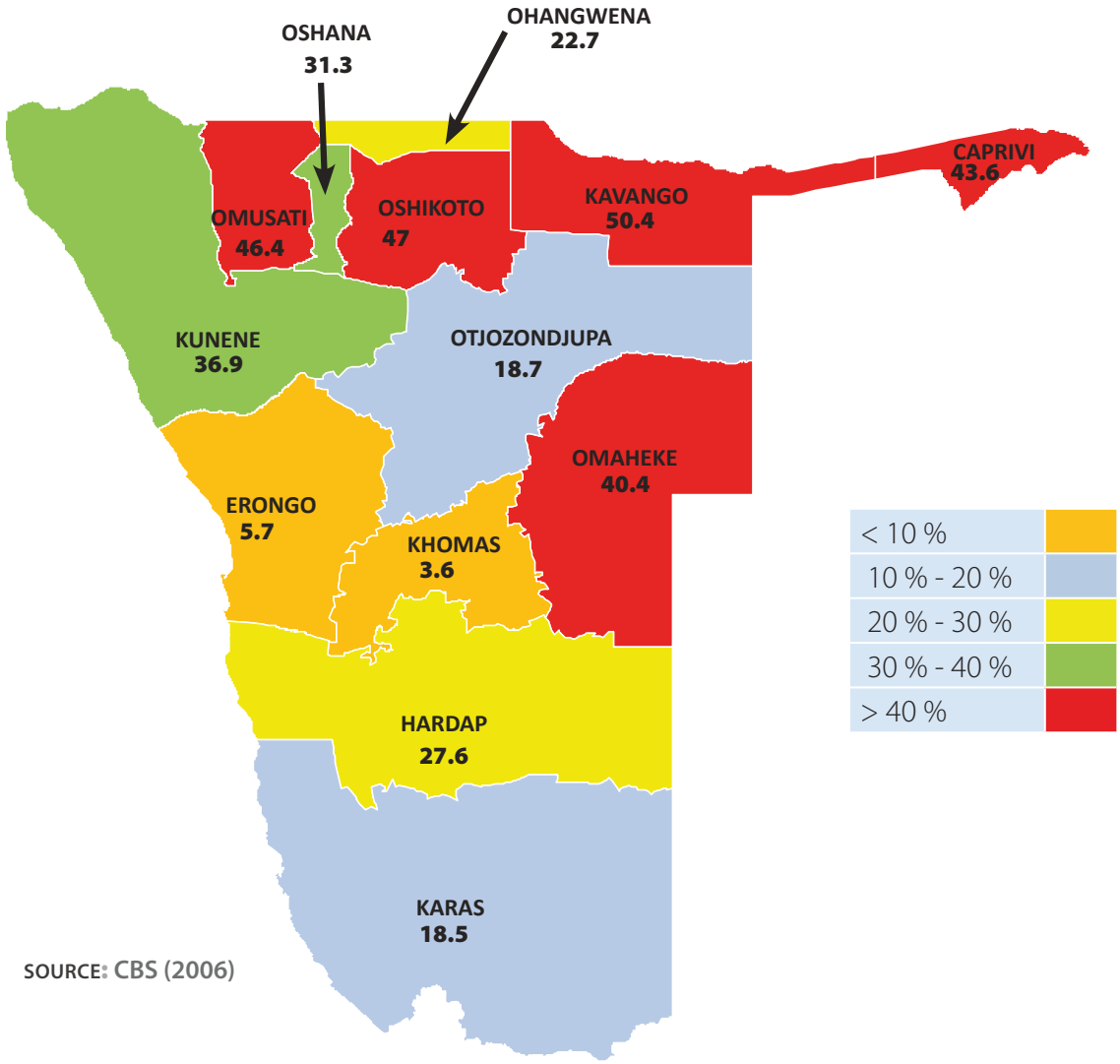
The Gini-coefficient, expressing the inequality of income, is a common measure of relative poverty. A completely equal distribution of income results in a value of 0, while a completely unequal distribution has a value of 1. Namibia's Gini-coefficient of around 0.6 indicates a relatively uneven distribution of income, specifically in comparison with poorer African countries. However, income inequality in neighbouring countries Botswana and South Africa is similarly high (a Gini-coefficient of 0.60 and 0.58, respectively). The reduction by about 15% of the Gini-coefficient in Namibia is encouraging and a further, reduction aimed at for 2012 is likely to be achieved.

Child poverty is difficult to measure because children are generally not wage earners. Malnutrition of children and per capita consumption in households with many children can serve as a proxy. Other indicators such as access to schooling and illiteracy rates are discussed in other chapters of this report.

Malnourished children under five years of age constitute more than a quarter of all children in this age group. After 1990, the percentage decreased considerably but later increased slightly to 24.2%. The national target for 2012 – to bring the figure down to 18% - is ambitious, but it could possibly be met. Child poverty, at least in relative terms, is also mirrored in the fact that households with two and more children and relatives have a per capita income of only around 15% of households without children and relatives.

The regional incidence of poverty is shown in the map. In Kavango region, more than half of all households are poor (including severely poor households). Somewhat lower is the percentage in Oshikoto and Omusati regions. By contrast, in Khomas and Erongo regions the poor households amount to only around 5% of all households. This demonstrates the skewed regional disparities in terms of levels of poverty.

FIGURE 1.1 POOR HOUSEHOLDS, INCLUDING SEVERELY POOR, BY REGION, IN PERCENT OF ALL HOUSEHOLDS, 2003/04



SOURCE: CBS (2006)

The MDGs, specifically numbers 2 to 7, contain significant causal chains responsible for the existence and persistence of poverty. Besides unemployment, of central influence is the prevalence of HIV/AIDS. On the one hand it is a core cause of poverty, while on the other, it renders many efforts to eradicate poverty futile. This is the reason why combating HIV can be rightly regarded as a cross-cutting issue of national development policy.

CHALLENGES AND OPPORTUNITIES

- The first of the main challenges to eradicate poverty is its many faces and complex causation. Persistent hunger, starvation and malnutrition are only some of the features, albeit the gravest, of poverty. Unemployment is a central root of poverty, but it may be also be caused by poverty and accompanying lack of employability.
- A cause for as well as an effect of poverty is when households with children are not led by a couple but are single-headed. In Namibia 41% of households are female-headed. This situation makes child poverty more widespread, more severe and more persistent. To develop a poverty index specifically for children may be helpful as a policy information tool.
- Not all vulnerable children currently have access to child welfare funds and grants. Hence social sector budgeting needs to introduce mechanisms and measures that will ensure that elegible children receive their fair share of allocations in critical sectors and the achieved results matches the investment.
- A direct fight against poverty and its many faces is unavoidable when deprivation and starvation occur, for instance after a catastrophic flood or absence of the usual seasonal rains. However, the long-term goal of eradication of poverty can only be achieved with long-term measures, the most important of which is a policy that

stimulates economic growth. A cornerstone of such a policy is proven to be high-quality education provided to every child. Lack of quality education is one of a major causes of poverty.

- With regard to employment and reduction of poverty, the labour-intensive sector of small and medium-sized enterprises, including informal businesses, contains a still not fully exploited potential of additional employment opportunities.
- Experience from other developing countries shows that strong growth processes lead relatively quickly to a decrease in absolute poverty, while relative poverty (i.e. inequality) may increase for a while. Long-term economic growth together with good governance is ultimately pro-poor, in that absolute poverty is relatively rapidly eradicated, and relative poverty is reduced in the longer term.
- A national conference on poverty would provide the opportunity to relate past efforts to current achievements and to draw strategic conclusions with regard to the remaining challenges in the achievement of MDG targets.

INTERVENTIONS

- A number of ministries are running programmes to combat poverty. There are programmes for social protection, social welfare, rural water supply, poverty reduction, title security, housing and rural development. Most of these ministries have included specific indicators for poverty reduction in their performance indicators.
- In 1998 the Namibian Government launched a Poverty Reduction Strategy which was later expanded and integrated into the National Development Plans 2 and 3 as well as into Vision 2030. Participatory Poverty Assessments were conducted from 2003 to 2006 in all 13 regions of the country. Bilateral as well as multilateral donors also follow this orientation in most of the projects they support.
- In five regions livelihood improving and income generating activities are being supported through programmes of the Ministry for Gender Equality. Examples relate to the support of vegetable gardens which increase opportunities for vulnerable groups to access adequate nutrition as well as of small and medium enterprises which improve employment opportunities.
- In instances of natural catastrophes, the Namibian Government, sometimes together with development partners, provides relief of various kinds to the population in need. In reaction to the floods and food price increases, the Government decided to set the Value Added Tax at a rate of 0% for some basic food items, such as wheat, maize and cooking oil. Moreover, the Government increased the monthly old-age pension, and is considering expanding the coverage of child welfare grants.
- In one community in Namibia (Otjivero/Omitara) the population of around 1,200 people receives a "Basic Income Grant" of N$100 per person per month, excluding pensioners. This is intended to improve the standard of living and to stimulate demand-driven investments, and in turn, economic growth and employment. The project was initiated by civil society and is regarded as a test case which could be expanded to other communities if the anticipated positive results materialise.
- Donors could do more to support initiatives for sustaining livelihoods and building national expertise in the area of monitoring and evaluation of programmes aiming at reducing poverty.

MDG 2

ACHIEVE UNIVERSAL PRIMARY EDUCATION

Education is (…) an avenue for poverty alleviation, human development and social advancement. To this end, education is a fundamental human right and all are entitled to receiving an education of good quality.

Government of the Republic of Namibia

MDG 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

An educated population is a central priority in achieving the MDGs. Educated people are in a better position to create work for themselves and others, and also to obtain formal employment. This is likely to reduce poverty and hunger, and in turn increases the standard of living. Furthermore, education gives a good foundation for life-long learning, which is fundamental in a knowledge-based society. Education is especially important for women to have knowledge about nutrition and hygiene since this leads to better health for their children. Furthermore education puts women in a stronger position to take part in decision-making.

STATUS AND TRENDS

TABLE 2.1 UNIVERSAL PRIMARY EDUCATION

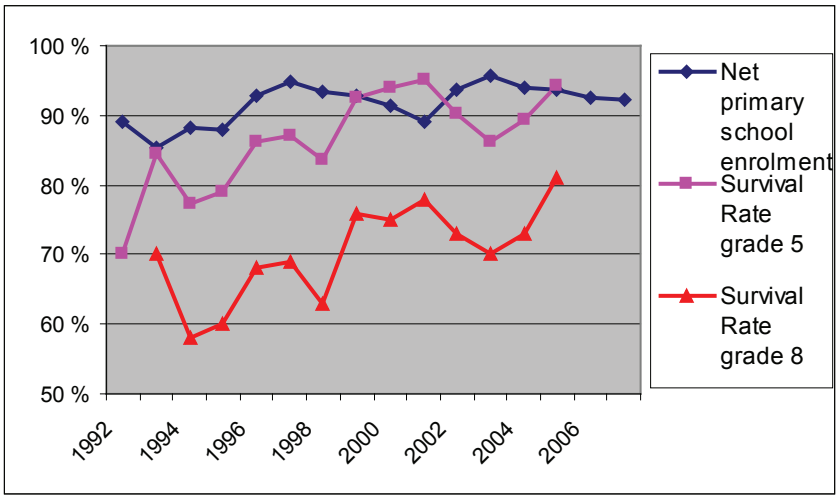
INDICATOR	1992	2000	2006	2006 TARGET	2012 TARGET	TARGET ACHIEVABLE?
Net primary school enrolment (%)*	89	91	92.3	95	99.1	LIKELY
Youth literacy rate (% aged 15-24 years)	88**	91**	93***	94	100 (2015)	LIKELY
Survival Rate grade 8 (%)*	59	75	81	-	80.2	ACHIEVED
Survival Rate grade 5 (%)*	70	94	94	95	99.2	POSSIBLE

SOURCES:* = Ministry of Basic Education and Culture (1996c), Ministry of Basic Education, Sport and Culture (2002b) and Ministry of Education (MoE) (2008a), ** = National Planning Commission (1994) and (2003), ***= Ministry of Health and Social Services (MoHSS) (2008d).

From 2000 to 2006 there was a slight increase in the net primary school enrolment rate (from 91% to 92%). However, it must be noted that the net primary school enrolment rate has been on a downward trend since 2003, although it is still above 90%. In the same period, the survival rate to grade 5 has stayed the same (94%), while the survival rate to grade 8 has increased from 75% to 81%. As can be seen in Figure 2.1, the survival rate to grade 5 is currently improving, so it is possible that the 2012 target will be reached. For the survival rate to grade 8, the goal has already been achieved. However, one area of concern is that about 10% of children between 6 and 16 years of age have never attended school. Therefore, efforts should be intensified to ensure that all children of school-going age attend school. Government should further strive to identify the inhibiting factors in reaching 100% enrolment rates.

Namibia compares well with her neighbours. In Botswana and South Africa, the survival rate to grade 5 was 90% and 82% respectively, compared to 86% in Namibia in 2003-2005. Namibia lies in the middle range compared to its neighbours, and in an African context Namibia performs well. On the other hand, in many developed countries the survival rate is close to 100%. While the net enrolment rate is encouraging at above 90%, this rate should be maintained and more resources should be allocated to improving the survival rates.

FIGURE 2.1 NET PRIMARY SCHOOL ENROLMENT AND SURVIVAL RATES

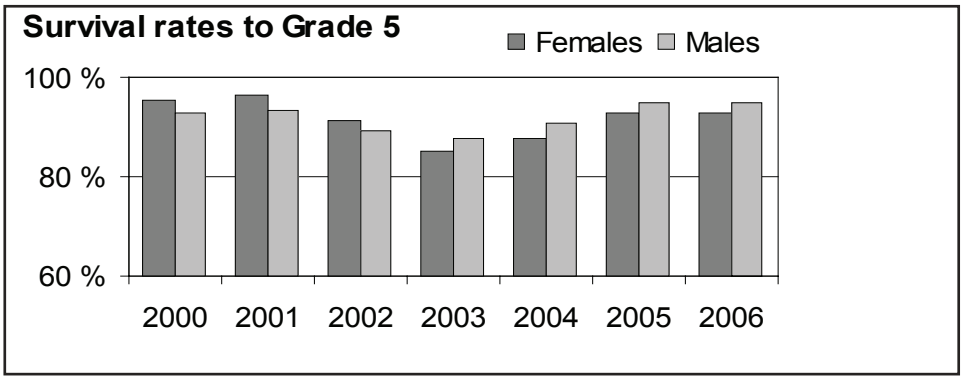


SOURCE: MoE: EMIS 1992-2007.

As shown in Figure 2.1, there appear to be positive developments in survival rates. If one compares the survival rates and the net primary enrolment rates from 1998 onwards, these two variables seem to move in opposite directions thus when the net primary school enrolment decreases, the survival rates increase.

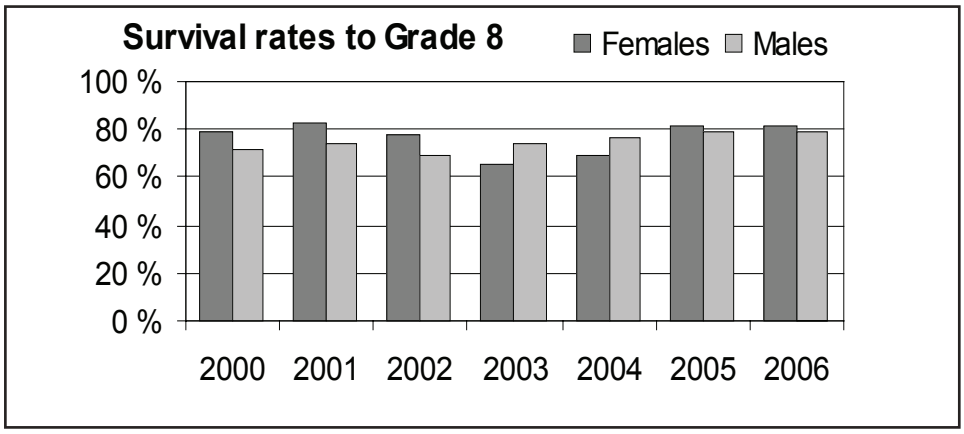
The net primary school enrolment rate for females is higher than for males. This is a positive achievement, since from an international perspective there is a tendency towards more males than females being enrolled in school. Enrolment is not the sole significant factor however; completion of schooling is also crucial to achieve a satisfactory level of education. Survival rates provide information about the likelihood of learners reaching a given grade; thus the survival rate for grade 8 tells us the likelihood of learners passing grade 7. An interesting feature of Namibia's survival rates is that they tend to be higher for females than males. In 2005 the survival rates for females were higher than for males from grade 6 to grade 12. Thus at a national level, no tendency of more males than females completing schooling can be found. Figures 2.2 and 2.3 show the survival rates for grades 5 and 8.

FIGURE 2.2



SOURCE: MoE: EMIS 1992-2007.

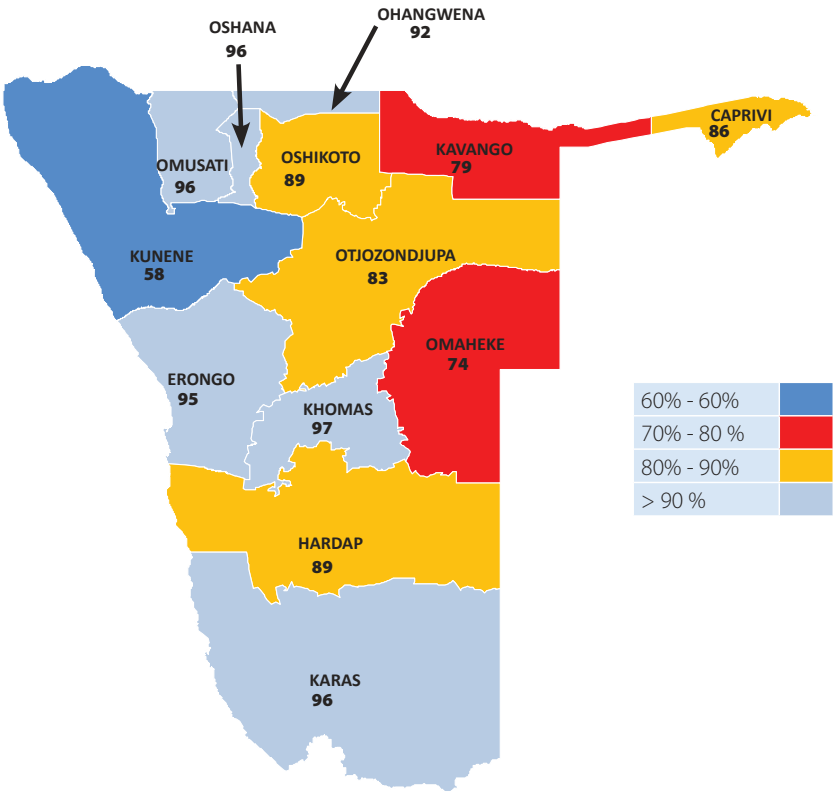
FIGURE 2.3



SOURCE: MoE (2008a)

Though literacy rates increased slightly from 2000 to 2006 (from 91% to 93%), this is one of the targets that could easily be achieved through improvements in survival rates. In 2006 the national level of the literacy rate was higher for females (94%) than for males (91%), which should be expected given the general higher enrolment and survival rate for females than males. Furthermore, the literacy rate is higher in urban than rural areas, and this holds for both females and males . There are more literate women than men in all regions except in the Kavango region. There are however large regional disparities in literacy rates. As can be seen in Figure 2.4, Kunene, Omaheke and Kavango have the lowest literacy rates, while Karas, Khomas, and Oshana have the highest.

FIGURE 2.4 LITERACY RATES IN 2006/ 2007 BY REGION



SOURCE: MoHSS (2008d)

CHALLENGES AND OPPORTUNITIES

- The Government has invested in the educational sector over many years, and about 25% of the national budget is allocated to education in 2008/2009. For the same period 50% of the education budget is allocated to pre-primary and primary education affairs and services. This investment has led to higher accessibility of schools and better facilities. However teachers' salaries absorb most of the funds. Despite the investment in education, the number of learners dropping out of school and the repetition rates are a cause for concern. In 2000 more than 54% of learners had repeated a grade, and in 2006 about 10,000 learners dropped out of school. The main reasons for dropping out of school are pregnancy, demands from parents and distance to school. This requires urgent attention from Government as it affects overall educational achievement and thereby renders Government's investments in education ineffective. There are considerable regional differences concerning drop-outs, while the numbers of females and males dropping out is about the same. Furthermore, the low net primary school enrolment and youth literacy rate is a hindrance towards achieving universal primary education.
- Poverty and hunger are two important aspects in relation to both drop-out rates and performance at school. The effect of proper nutrition on learners' results in school cannot be overestimated. Learners are calmer and have better concentration when they have eaten properly. Furthermore, hunger may lead learners to drop out of school because they need to work in order to provide food. Poor households might not send their children to school because the household is dependent on the child's labour, or because the direct costs of schooling, such as school uniforms and transport are too high. Poverty is thus commonly seen as a major reason for children being denied adequate education.
- HIV/AIDS has a significant impact on the education sector, and has taken its toll both on teachers and pupils. There are about 121,000 orphans enrolled in school, accounting for 21.2% of total learners. These learners may face greater challenges in general, and in particular concerning the financial demands of schooling. When a teacher becomes sick, the consequences are severe especially when it comes to class teachers as opposed to subject teachers. Therefore, primary education is likely to be more affected thereby affecting the achievement of education targets. Absenteeism among teachers is an obstacle to the provision of quality education.
- School facilities differ widely from region to region, with Kavango region in general being the most poorly-equipped. At a national level, about 78% of schools have toilet facilities for learners; 81% have water supply, and only 56% have access to electricity. It is clear that the availability of equipment will affect the quality of training, such as training in basic computer skills.
- The national learner-teacher ratio is 28.1, well below and thus better than the set ratios of 35 at primary level and of 30 at secondary level. Furthermore, teachers' qualifications have increased over time and should contribute to increasing learners' skills. However, there are concerns about the pupils' skills when leaving school. The Southern and Eastern Africa Consortium for Monitoring Educational Quality (SAQMEQ)'s study of the quality of education in Namibia in 2000 showed that the general competence levels of learners and teachers in Namibia are low compared to other southern and eastern African countries. In Namibia there were large differences between rural and urban areas, with learners living in large towns tending to perform better. Of major concern is the low competency in mathematics demonstrated by teachers in Caprivi, Kavango, Ohangwena, Oshikoto, Oshana and Omusati regions. About two thirds of all primary schools are found in these regions, and thus about 65% of Grade 6 learners were taught by teachers with low competency in mathematics. Therefore, these regions should be given assistance by the Government in order to improve the quality of

education.

- An important factor in children's learning outcome is parental involvement in their education. If parents help with homework and make education a priority in their children's lives, it is more likely that children will succeed better at school. However it is often a challenge to get parents more involved.
- The 2001 Population and Housing Census showed that 32% of children between 3 and 6 years of age were enrolled in some form of Early Childhood Development (ECD) programme. It is a challenge that not more children are being enrolled in a ECD programme. ECD and pre-primary education are widely recognised as having a significant effect on children's performance in basic education. They reduce drop-out and repetition rates, and they lay the foundations for acquiring skills. This must be seen in connection with the repetition rate for grade 1 being almost 20%, and the drop-out rate almost 5%. Therefore, getting more children involved in pre-primary education and ECD is crucial in achieving universal education.

INTERVENTIONS

- Education is stated as crucial to development in Vision 2030, the National Development Plans and the Poverty Reduction Strategy. Policy frameworks are in place, contained in documents such as the Education for All National Plan of Action 2001-2015, the Early Childhood Education Policy, and the National Policy on HIV/AIDS for the Education Sector.
- The Education and Training Sector Improvement Programme (ETSIP) represents the education and training sector's response to Vision 2030, and is addressing the problems of the education system. It provides a detailed and broad-based plan of action for the development of the educational sector and aims to improve the quality and the range of skilled workers. The Government has increased the number of pre-schools in order to enhance the preparedness of a learner before entering school.
- The School Feeding Program is an important tool to keep learners in school. There are about 85,000 children participating in this programme, and this is expected to increase due to the Government's expansion of the programme as a reaction to increasing food prices. The programme is also intended to protect children from the effect of natural disasters such as droughts and floods.
- The Government has invested in boarding schools in order to provide education for children in remote areas. Boarding schools are an expensive means of providing schooling when compared to the alternatives in densely populated areas, but are necessary in order to achieve universal education.
- Development Assistance could focus on support to orphans and vulnerable children, strengthening early childhood education, the training of teachers and management of schools. Furthermore, in areas where teachers' absenteeism is high or competence is low, assistance could be provided in the form of qualified personnel and capacity building.
- There is need for government to focus more on reducing drop-out rates, and improving survival rates.

MDG 3

PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

"Women's equal participation in decision-making is not only a demand for simple justice or democracy, but also ought to be seen as a necessary condition for women's interests to be taken into account and for social and economic development"

National Gender Policy

MDG 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

Women's participation in decision-making is an important step towards women's empowerment. It is crucial that their interests be taken into consideration both at the national political level and at grassroots level, especially at home and in the local surroundings. Education is essential in order for women to know their rights, and also to obtain formal work, which again is likely to increase their standard of living. Therefore, indicators providing information about women in education, employment and politics have been selected to describe the progress towards gender equality and the empowerment of women.

STATUS AND TRENDS

TABLE 3.1 GENDER EQUALITY AND EMPOWER WOMEN

INDICATOR	1992	2000	2007	2006 TARGET	2015 TARGET	TARGET ACHIEVABLE?
Ratio of females to males in:						
- Primary Education (females per 100 males)*	102	100	98	100+	100+	LIKELY
- Secondary Education (females per 100 males)*	124	112	117	100+	100+	ACHIEVED
- Tertiary Education (females per 100 males)**	175	84	88 (2006)	100+	100+	POSSIBLE
Ratio of literate females to males (15-24 years) (females per 100 males)	106***	104***	103^	100	100	ACHIEVED
Share of women employed in the non-agricultural sector (%)	39***	49^^	47^^	-	50	LIKELY
Proportion of seats held by women in parliament (%) **	6.9	22.2	26.9	30	50	POSSIBLE

SOURCES: * = Ministry of Basic Education and Culture (1996c), Ministry of Basic Education, Sport and Culture (2002b) and Ministry of Education (2008a) ** = UN Statistics, *** = National Planning Commission (1994) and (2003), ^ = Ministry of Health and Social Services (2008d), ^^ = Ministry of Labour and Social Welfare (2001) and (2006).

In 2007 there were 98 females for every 100 males in primary school, and 117 females for every 100 males in secondary school. Furthermore, female literacy is higher than male literacy. The targets for the ratio of females to males in secondary education and the female to male literacy rate have thus been achieved.

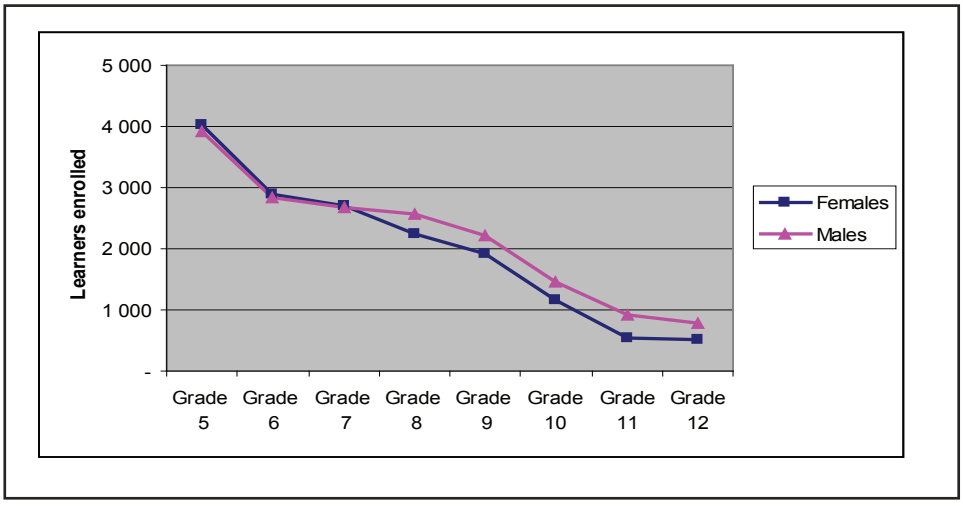
Furthermore, it is likely that the target for the same ratio in primary education will be achieved. The ratio of females to males in tertiary education has fluctuated greatly since 1991 with no clear trend. In 2006 there were 88 females to every 100 males, so there is still some way to go in reaching the goal of gender equality in tertiary education.

From a regional perspective, the female to male ratio in primary and secondary education in Namibia is good. In primary education, many countries in Southern Africa have gender equality in enrolment rates, while this is not so in secondary education. This is true for Mozambique, Zambia and Zimbabwe. Botswana on the other hand features the same trend as Namibia, with the female/male ratio increasing from primary to secondary education.

The proportion of women in Parliament has increased substantially since Independence from 7% to 27% in 2007. The Government has committed itself to achieving gender equality by 2015 as a signatory to the SADC Gender Protocol. Thus, the target is achievable if this commitment is implemented. In regional and local authorities, averages of 36% were women. At the local level in particular more women are engaged in politics compared to the national level.

There are large differences in the ratio of women to men enrolled in secondary school between regions. In the Khomas region there are more women than men enrolled in total, while the opposite is true for the Kavango region. Figure 3.1 shows enrolments in the Kavango region, and reveals that the enrolment for girls and boys in upper primary school is almost the same, while in secondary school the number of girls is declining compared to the number of boys. Nationally, the main reason for girls dropping out of school is teenage pregnancy, which in the Kavango region is rated at almost 35%. The rate of teenage pregnancy among secondary school graduates is 5% compared to 45% amongst girls with pre-primary or no education. Girls with incomplete primary education are more than twice as likely to have sex with men 10 or more years older (8%) compared to 3% of girls with completed secondary education.

FIGURE 3.1 FEMALE AND MALE SCHOOL ENROLMENT IN THE KAVANGO REGION



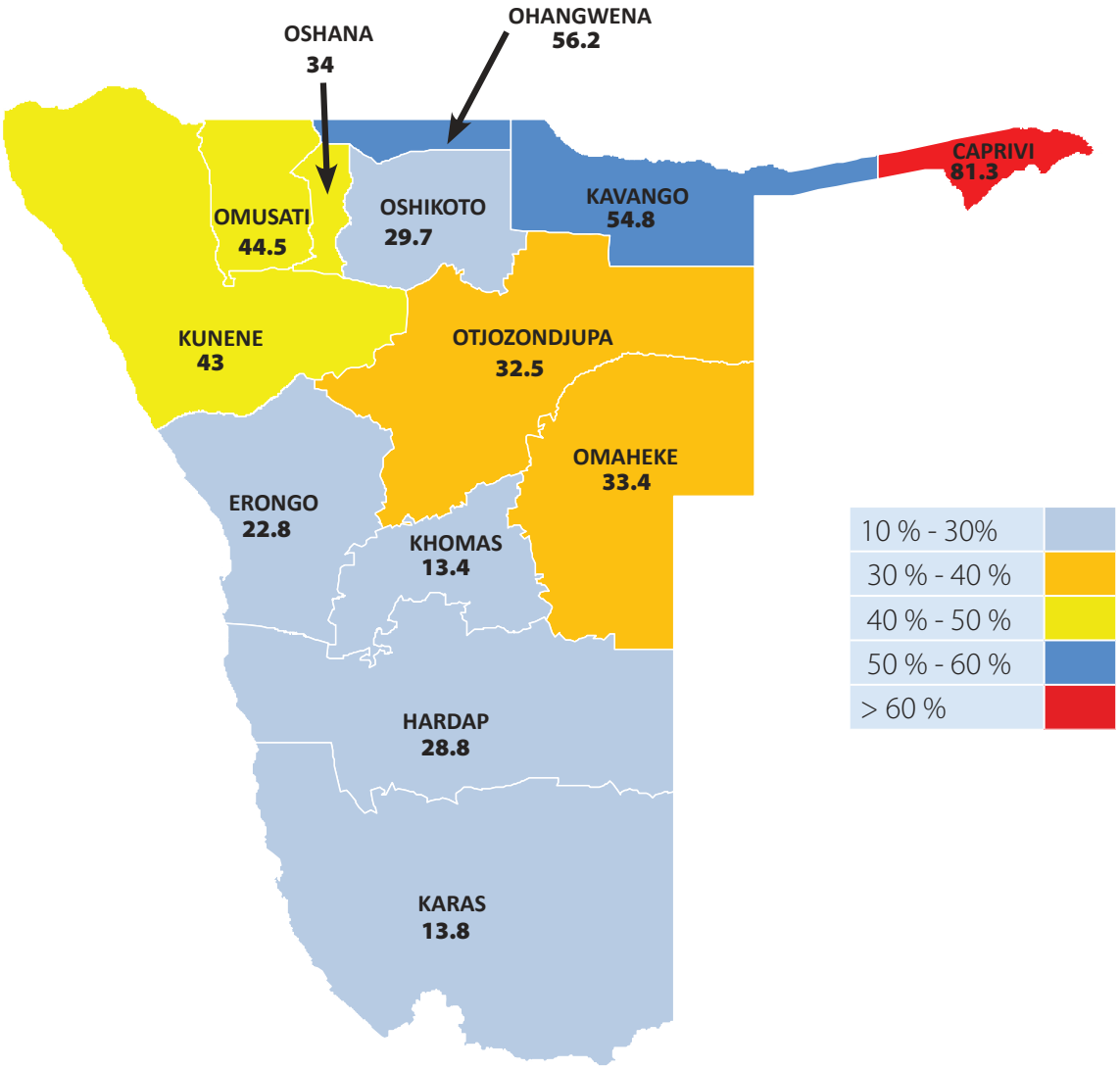
SOURCE: MoE (2008a)

Even though Namibia is doing well with the targets set for gender equality and empowerment of women, this does not mean that the goal has been reached. There are several important aspects of gender issues that are not reflected in the indicators, such as gender-based violence, the low level of women reaching high-level positions, and harmful cultural practices.

Female-headed households account for 41% of all households, but for only 29% of total income. It may be that women tend to engage in non-paid work such as child-care and home-making. Furthermore, there are relatively few women reaching higher-level positions. In the private sector, women held 33% of senior management positions in 2005 . In the same year women comprised 29% of the Parastatal Boards of Directors, while on the Boards of Directors in the private sector, 18% were women. In the public sector the proportion of women in management positions in government offices, ministries and agencies varies from 5% in Ministry of Defence to 75% in the Ministry of Gender Equality and Child Welfare. Overall, it is quite encouraging to observe that 47% of people taking up employment in the non-agricultural sector are women.

Attitudes towards domestic violence are indications for how empowered women are. In 2006 about 26% of women in Namibia believed that a husband is justified in abusing his wife if she neglects the children. However, there are considerable regional differences, and the Caprivi region stands out as the most accepting of wife-abuse. Caprivi women believe that abuse can be justified if the wife: burns the food (38%), argues with the husband (55%), goes out without telling him (60%), neglects the children (63%) or refuses to have sexual intercourse with him (38%). Interestingly, Caprivi men appear to agree less to wife-abuse than the women themselves.

FIGURE 3.2 PERCENTAGE WHO AGREE WITH AT LEAST ONE SPECIFIED REASON FOR WIFE BEATING



SOURCE: MoHSS (2008d)

Attitudes about sexual practices can offer insights into the extent to which women are empowered to exercise control over their bodies. About 25% of Ohangwena men believe that when a woman refuses to have sex with him, the husband has the right to use force to have sex. The national average is much lower, at 5%. Furthermore, about 54% of men in Omusati believe they have the right to have sex with another woman if the wife refuses sex, while the country average is 16%. This must be seen in the context of the spread of HIV, where having one faithful partner reduces the risk of infection dramatically.

CHALLENGES AND OPPORTUNITIES

- Policies supporting gender equality and women's empowerment are by no means lacking in Namibia. The problem is rather how to implement these policies, and to change perceptions about women and their roles in society. Patriarchal attitudes are central in forming perceptions about women. Such attitudes tend to see men as leaders and women as subordinates.
- An achievement in Namibia is the high female school enrolment rates, the high female survival rates and the high female literacy rates. The 2006 statistics show that in higher primary and secondary schools, more females than males are completing school. Even though many females are educated in Namibia, it is a challenge to translate this education into formal jobs, and further into higher-level positions.

- Cultural practices such as widow inheritance, widow cleansing, dry sex and initiation practices can be seen as obstacles to women's empowerment. Furthermore they contribute to the spread of HIV. To empower women to be able to exercise control over their bodies is crucial in order to achieve gender equality. Furthermore, inheritance practices where the husband's family as opposed to the wife inherit the husband's possessions when the husband dies place women and children in a vulnerable position.
- There is a vicious circle between poverty and women's empowerment. Poverty is closely linked to low education levels, and being poor and with low education contributes to a person's vulnerability. Lack of education may lead people not to be aware of basic human rights, and thus more vulnerable to exploitation. Furthermore, poverty may turn women into sex workers in order for them to make a living. Additionally, the low status of particularly poor women is a hindrance to achieve gender equality. Education is an important tool in order to achieve women's empowerment, since more females than males are poor.
- Indicators of women's empowerment in the Namibia Demographic Health Survey 2006/07 show that women who participate in decision-making at home are less likely to justify wife abuse, and they are also more likely to receive proper health care when pregnant. Therefore getting women involved in decision-making is important for the empowerment of women and furthermore likely to increase women's engagement in politics.

INTERVENTIONS

- The Namibian Constitution acknowledges the rights of women as equal to men in society, and it outlaws all discriminatory practices. In NDP3, one of the goals is to achieve gender equality. Gender equality is seen as a goal in itself, but it is also advocated that it be mainstreamed in all key result areas in NDP3. The stated objectives include advocating for equal representation of women at all power sharing levels, building capacity for women in management and leadership positions, changing negative attitudes towards gender equality and increasing awareness of negative cultural practices that hinder women's participation in power sharing at all levels of society.
- The Government is committed to ensuring that gender issues are integrated into all laws, policies and programmes. This process is guided by the National Gender Policy (now being revised by the MGECW) and the National Gender Plan of Action. Namibia is a signatory to the Convention on Elimination of all Forms of Discrimination against Women, and also to the SADC Protocol on Gender, which are indicative of the Government's commitment to work towards women's empowerment.
- Many laws and policies have been developed to support gender equality and women's empowerment, such as the Combating of Domestic Violence Act (No. 4 of 2003), the Married Persons Equality Act (No. 1 of 1996), the Combating Rape Act (No. 8 of 2000), the Affirmative Action (Employment) Act (No. 29 of 1998) and the Education Act (No. 16 of 2001).
- Several gender-related non-governmental organisations can be found in Namibia. To name a few, Namibia National Women's Organisation (NANAWO) is working on gender issues. The Legal Assistance Centre is a driving force behind gender-specific law reforms. Sister Namibia is an organisation focusing on women's rights, and has as its mandate to eliminate patriarchy and to encourage gender equality. Namibian Men for Change was the first male-driven initiative addressing gender issues in Namibia. Since then other organisations such as the White Ribbon Campaign Namibia has followed. The White Ribbon Campaign Namibia is a men's organisation that is working to end men's violence against women and children through education, discussions and actions.

MDG 4

REDUCE CHILD MORTALITY

The future of any society depends on its ability to foster the health and well-being of the next generation. Stated simply, today's children will become tomorrow's citizens, workers, parents and leaders. When we fail to provide children with what they need to build a strong foundation for healthy and productive lives, we put our future prosperity and security at risk.

Marlene Mungunda, Honourable Minister of Gender Equality and Child Welfare

MDG 4: REDUCE CHILD MORTALITY

The overall level of children's health is reflected in a number of indicators, such as infant and child mortality ratios as well as immunisation coverage against preventable diseases. More importantly, since the children of today need to grow into healthy, productive adults, a poor current health status poses the threat of developmental constraints not only for the individual, but also for society at large. To prevent a vicious cycle of poverty and social marginalisation it is essential that the health of the Namibian child is adequately addressed.

STATUS AND TRENDS

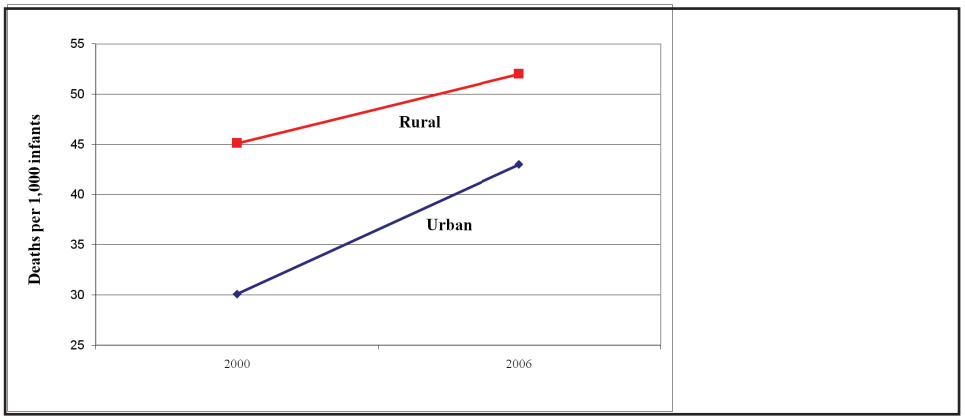
TABLE 4.1 CHILD MORTALITY

INDICATOR	1992	2000	2006	2006 TARGET	2012 TARGET	TARGET ACHIEVABLE?
Infant mortality rate (deaths per 1,000 live births)	56.6	38.1	46	36	38	UNLIKELY
Under-five mortality rate (deaths per 1,000 live births)	83.2	62.2	69	54	45	UNLIKELY
Proportion of one-year-old children immunized against measles	75.7	80.4	83.8	80	85	LIKELY

SOURCE: Ministry of Health and Social Services (MoHSS) (1993), (2003) & (2008d).

Amongst Sub-Saharan African countries Namibia is performing well. Namibia has a lower infant mortality rate than its large neighbour South Africa, for example. However, since 2000, infant mortality rate has increased from 38.1 to 46 deaths per 1,000 live births. This stands in contrast to marked progress made during the 1990s in reducing this rate. The under-five mortality rate deteriorated in a similar way. Therefore, for both indices the 2006 target was not achieved. As shown in Figure 4.1, although the mortality rate has increased in both rural and urban areas, the child mortality rate has deteriorated more in urban than in rural areas although the figure remains lower than in rural areas.

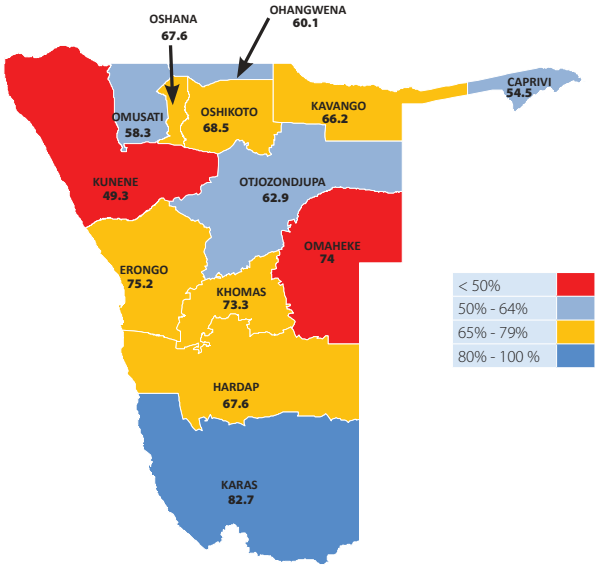
FIGURE 4.1: TRENDS IN URBAN AND RURAL MORTALITY 2000 - 2006



SOURCE: MoHSS (2003) & (2008d)

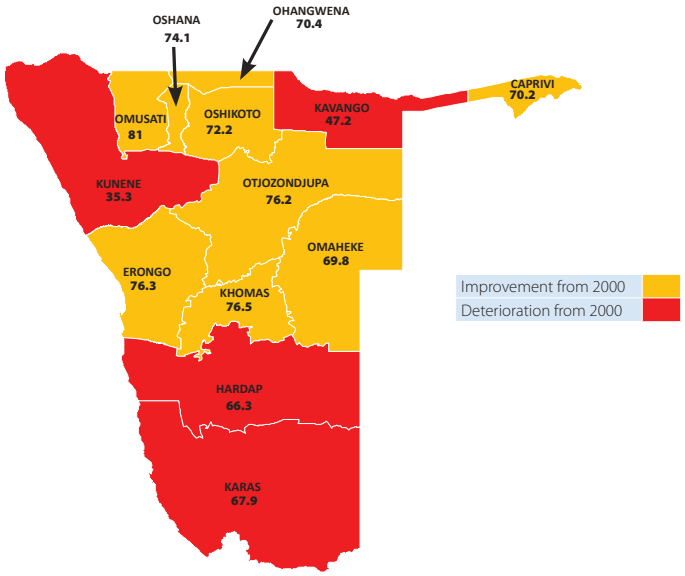
National coverage of immunisation against measles increased from 80% in 2000 to 84% during 2006. The set target for 2006 was not only met, but was surpassed. Moreover, progress in terms of an increase from 65% in 2000 to about 70% in 2006 for children who have received all their vaccinations (and not only vaccinations against measles) can also be reported. If this trend continues, it is very likely that the health authorities will meet the 2012 target of 85% regarding immunisation coverage of children. The overall progress in the immunisation programme makes it probable that fewer children will die or have to carry the burden of disabilities caused by preventable diseases. Unfortunately, the performance of the immunisation programme is not equally effective in all regions. For example, as shown in figures 4.2 and 4.3, while in Omusati and Omaheke coverage increased by 39% and 53% respectively, the Kunene and Karas region experienced a reduction in immunisation figures.

FIGURE 4.2: OVERALL IMMUNIZATION COVERAGE, 2000



SOURCE: MoHSS (2003).

FIGURE 4.3 OVERALL IMMUNIZATION COVERAGE



SOURCE: MoHSS (2008d).

The indicators discussed above show a mixed picture regarding the overall health status of the Namibian child. On the one hand, health authorities are determined to improve child health and to reduce child mortality. On the other hand, the figures concerning mortality suggest a long road ahead before children are placed on a secure path towards a prosperous future. Overall, challenges need to be overcome and

opportunities seized in order for Namibia to reach the goal of reduced child mortality. Considering these challenges, the 2012 target for infant mortality was revised upwards, making it realistically more attainable.

CHALLENGES AND OPPORTUNITIES

- Most diseases children die of can be related to a weak immune system. Children's health is weakened by a number of factors, of which poverty and hunger are important contributing features. Parents without work are seldom able to adequately provide their family with adequate food, shelter and clothing. Also, in many cases parents are hesitant to incur the cost of treatment and only take their child to a health facility once an illness has progressed. Often this visit comes too late. Aggravating this is the fact that in rural areas parents often have to travel long distances to take their child for medical treatment. Overcoming the challenges of poverty and unemployment will play a significant role in reducing child mortality.
- An important cause for the high morbidity of children younger than five years of age can be found in the low nutritional status amongst Namibian children. According to the Namibia Demographic and Health Survey of 2006/07, acute malnourishment can be identified in about 7% of children in which wasting is recognised. Almost a quarter of young children are stunted. Moreover, more than 20% of children are underweight. These indices show that about one in five children younger than five years of age are chronically and acutely undernourished. For an infant to develop its general cognitive abilities, a good diet is essential especially during the first six years of its life. In addition to sufficient food, for the development of a child it is important that the nutrition contains the relevant micronutrients and vitamins. Vitamin A, iodine and iron are essential. If undernourished during the first six years, the child is burdened by the effects of bad nutrition for the rest of its life. These effects are observable later in life, often reflected in weaker physical health and intellectual competence. The long-term implications of this situation, besides the inability of the individual to live up to his or her potential and lead a socially and economically productive life, are that such a large proportion of undernourished children poses an important constraint on Namibia's future ability to develop in accordance with Vision 2030.
- Related to the prevalence of malnourished children is the predicament facing HIV -positive mothers in feeding their babies. Since the disease is transmittable from mother to child through breastfeeding, mothers may want to feed their children with supplementary food. This type of food is often expensive and not all women can afford it. Moreover, supplementary food needs to be prepared in clean conditions. In general, women living in an impoverished environment may not have the facilities to sterilise food implements. Preparing the food also takes time. Few mothers will be able to feed their babies more than three times a day on the basis of prepared food. As a consequence, mothers may not be able to feed their infants adequately and regularly. Many babies receiving substitute food therefore suffer from hunger and diarrhoea, which in turn result in malnourishment, a compromised immune system and general ill health. In addition to these disadvantages of supplementary food, the child does not benefit from the nutritional value of mother's milk. The official policy concerning breastfeeding and HIV-positive mothers is to give the mothers information about feeding options. The mother is recommended to either exclusively breastfeed for four months, or exclusively use replacement feeding where this is acceptable, feasible, affordable, safe and sustainable (AFASS). Mixed feeding increases the probability of transferring HIV to the baby, and should thus be avoided.

INTERVENTIONS

- Namibian health authorities employ an extensive policy framework aimed at promoting child health. The Extended Programme for Immunisation (EPI) in particular has shown encouraging results in rolling out vaccination to all children, although regional disparities are observable. In terms of general health, community initiatives, mobile clinics and clinics as well as hospitals aim to provide quality health services to children, treating diseases and ailments. Vitamin A is provided by the health authorities. Moreover, it is stipulated by law that salt, even if sold for animal consumption, is enriched with iodine in order to ensure that children receive the required amount of iodine in their diet.
- The Ministry of Health and Social Services has been efficient in responding to outbreaks in diseases in general. The polio campaign of 2006 as well as measures to control cholera outbreaks during the same year proved successful.
- The importance of breast-feeding for the overall physical well-being of children is acknowledged and also

promoted. HIV-negative mothers are encouraged to practice exclusive breast-feeding for six months. After six months, breast-feeding should be continued until the infant is two or more years old, but in addition fed with complementary food. Mother's milk provides the children with essential nutrients and also strengthens the immune system of the baby. Children that are not breastfed often suffer from diarrhoea and other sicknesses which may have negative long-term implications for the child's health.

- Although the programmes are in place to attend to the well-being of the child in terms of health and general welfare, the burden of poverty as well as diseases such as HIV/AIDS place severe constraints on the health and welfare authorities. Although the efforts are supported by a significant number of NGOs as well as development partners and faith-based organisations, the need is great and challenging to meet.
- The accountability and quality of health service delivery may benefit from improvements in terms of implementation and enforcement of the stipulated policies. This is true especially for remote regions. In conjunction with successful economic growth and poverty reduction programmes, the effective implementation of the national programmes and policies will go a long way in leading the country towards the achievement of the goal of child health and also the creation of an environment supportive of achieving the goal.

MDG 5

IMPROVE MATERNAL HEALTH

The tragedy of maternal death is that almost all the causes of maternal death can be prevented if only all pregnant women had access to a skilled attendant at child birth and emergency obstetric care when pregnancy related complications occur.

Kahijoro Kahuure, Permanent Secretary Ministry of Health and Social Services

MDG 5: IMPROVE MATERNAL HEALTH

Good maternal health reflects on the quality of and access to maternal health care, while also offering evidence regarding the health status of women at reproductive age and that of their children. To policymakers and donor agencies, maternal health can therefore be a very useful barometer concerning the health status of the female population, and also of socio-economic conditions in general.

STATUS AND TRENDS

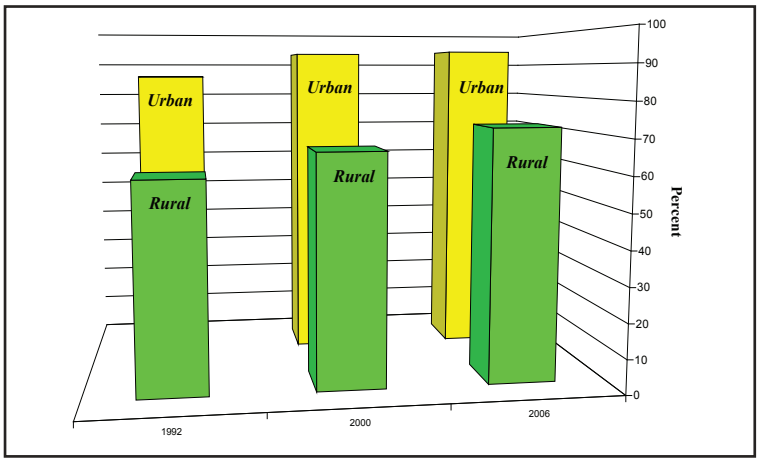
TABLE 5.1 MATERNAL HEALTH

INDICATOR	1992	2000	2006	TARGET 2006	TARGET 2012	TARGET ACHIEVABLE
Maternal Mortality Ratio (deaths in 100,000 life births)	225	271	449	268	337	UNLIKELY
Proportion of births attended by trained health personnel in percent	68	76	81	88	95	LIKELY

SOURCE: Ministry of Health and Social Services (MoHSS) (1993), (2003) & (2008d).

Compared to Sub-Saharan African countries, Namibia is performing well in terms of the maternal mortality ratio (MMR). For example, during 2005 the MMR in Namibia was lower than in Botswana, Kenya as well as Mozambique. On the other hand, compared to other lower-middle income countries the Namibian MMR of 449 deaths per 100,000 live births is high. Moreover, by 2006 the MMR had increased from 271 to 449 deaths in 100,000 live births. This trend occurred despite the fact that in urban as well as rural areas, births are increasingly attended by doctors or nurses (Figure 5.1).

FIGURE 5.1: ASSISTANCE AT BIRTH IN RURAL AND URBAN AREAS



SOURCES: MoHSS (2003) & (2008d).

It has become clear from studies conducted that a determinant of the high levels of maternal mortality is the limited capacity of health service providers and facilities to provide key emergency obstetric care services (EmOC), which are critical in saving the lives of mothers in cases of complications and emergencies during birth. The direct causes of maternal death are severe eclampsia (high blood pressure) (33.3%), bleeding (25%), obstructed or prolonged labour (25%), post-partum sepsis (8.3%) and complications of abortions (8.3%). Given adequate emergency obstetric care, in many instances these complications are treatable and maternal deaths hence in many cases preventable.

Contributing to the high and escalating trend observable in maternal mortality is the prevalence and incidence of HIV/AIDS. With about 20% of pregnant women infected, the disease affects their general health and possibly weakening the women, thus making them susceptible to complication during pregnancy and delivery. With more than 50% of deaths indirectly caused by the disease, HIV/AIDS offers some explanation for the increasing MMR. Against this background, the raising of the 2012 target of 337 maternal deaths in 100,000 from the 2006 target of 268 in 100,000 live births instead of lowering it is a realistic adjustment to the achievability of the goal of improving maternal health.

UNIVERSAL ACCESS TO REPRODUCTIVE HEALTH

STATUS AND TRENDS

TABLE 5.2 REPRODUCTIVE HEALTH

INDICATOR	1992	2000	2006	TARGET 2006	TARGET 2013	TARGET ACHIEVABLE?
Contraceptive prevalence rate (percent)	23	38	47	50	56.6.	LIKELY
Adolescent Birth Rate (percent)	22	18	15	-	13*	LIKELY
Antenatal Care Coverage at least four visits (percent)	56	69	70	-	80	LIKELY
Unmet Need for Family Planning (percent)	24	25	7	-	6**	LIKELY

SOURCE: MoHSS (1993), (2003) & (2008d).
* Target for 2012
** UN Target

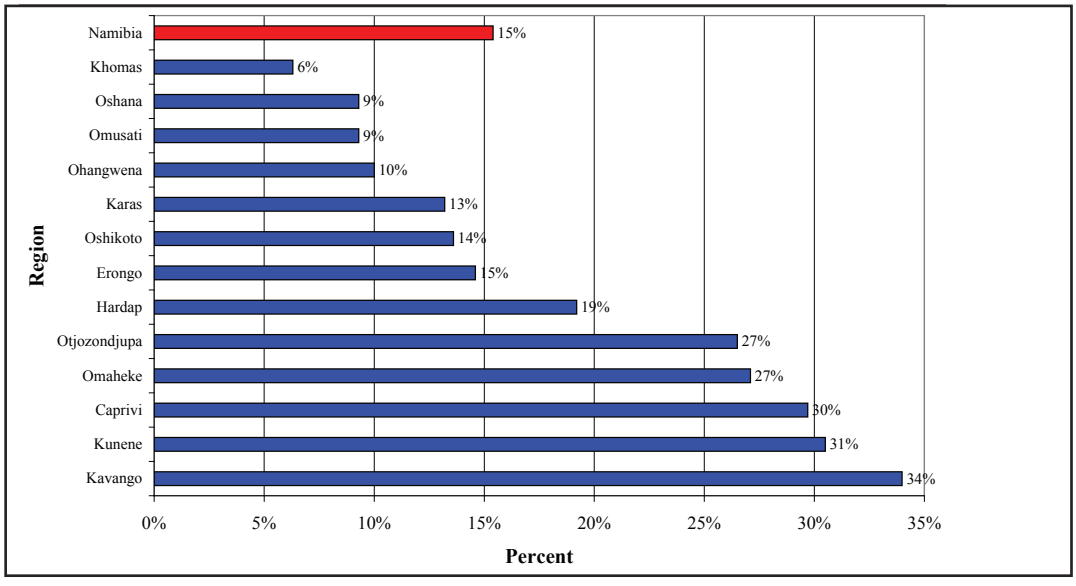
The care women receive during and after pregnancy is an important contributing factor in lowering morbidity of pregnant women and mothers, but also of children. As is indicated by the trends in percentages of pregnant mothers visiting health facilities for ante-natal care check-ups, women are increasingly utilising the available maternal health services. While sixteen years ago only 56% of pregnant women sought ante-natal care four or more times, by 2006 this figure had increased to more than 70%. Post-natal care

provided to the mother after delivery aims at diagnosing any complications arising from the delivery, while at the same time providing the mother with important information on how to care for herself and her child. Proper post-natal care reduces the risk of maternal mortality, with the service optimally provided within four days of delivery, since it is during this period that most maternal and neonatal deaths occur. During 2006, 65% of women received a post-natal check up within 2 days after delivery, while about 10% received a post-natal check up between 3 to 41 days after delivery. About 22% of women did not visit health facilities to receive a post-natal check up.

A contributing factor to reproductive health is that of meeting married women's family planning needs. Only about 7% of women found their family planning needs were not met. Besides indicating improved access and quality of family planning services, this trend also suggests that women are increasingly aware and make use of the available options relating to the spacing and limiting of pregnancies. Experience shows that this may have a very positive effect on the health of mothers, since family planning allows the body to properly recover after pregnancy.

The teenage pregnancy rate in Namibia is high. Although declining, during 2006 more than 15% of girls between fifteen and nineteen years of age became pregnant with their first baby, or had already given birth to a child. During 2006 64% of women 15 – 19 years have never used a contraceptive. Young mothers are especially at risk of encountering complications during birth, since their bodies are often not yet fully developed. Moreover, since teenagers tend to discontinue their schooling due to the pregnancy, it is likely to have long-term effects on their future economic opportunities. In addition, the (often) unwanted pregnancy is evidence of unsafe sex practices, with implications for transmitting HIV/AIDS and other sexually transmitted diseases. Figure 5.2 indicates that in Kavango almost 35% of girls in the age group 15 to 19 are pregnant or had at least one child before turning 20. At six percent, in the Khomas region teenage pregnancies are not as common.

FIGURE 5.2 PERCENT OF TEENAGERS (15-19 YEARS) WHO HAVE BEGUN CHILD-BEARING, 2006



SOURCE: MoHSS (2008d).

In spite of this, the message regarding safe sex appears to be reaching the nation. Although the 2006 target of 50% contraceptive prevalence rate amongst all women was not quite met, the use of contraceptives has more than doubled from 23 % in 1992 to 47 % in 2006. Together with injectable contraceptives, male and female condoms are the most widely used contraceptives. While obvious effects on fertility can be observed with a reduction of the total fertility rate from 4.2 in 2000 to 3.6 in 2006, increased contraceptive use

further reflects the increased self-confidence of women to determine their reproductive wishes, as well as an increasingly accommodating stance on the side of their partners. In addition, a conscious and prepared sex life is the first step towards victory over the HIV/AIDS pandemic.

The trends in reproductive health indicators as well as attendance during delivery by a skilled health worker are improving. In spite of this, maternal mortality is deteriorating. Considering the figures, it is rather unlikely that maternal mortality will improve to a level of 337 deaths per 100,000 live births by 2012.

CHALLENGES AND OPPORTUNITIES

- The high MMR is a clear indication that, in spite of increased utilisation and provision of health services designed to improve maternal health, the Namibian mother is burdened with ill health. The effects of HIV/AIDS are taking their toll on the physical strength of pregnant women and mothers. Moreover, in addition to pregnancy-related factors, future mothers are particularly receptive to diseases such as malaria or tuberculosis due to the immune deficiency caused by the syndrome.
- In addition to the burden of HIV/AIDS, many women live in a poor socio-economic environment. Unemployment and hunger result in a weakened physical condition which increases the health risk for the mother as well as her unborn child.
- Three delays aggravate maternal mortality. These include delays in recognising the need to seek health care, getting to an appropriate facility and also delays in receiving care when at the facility.
- Service delivery is challenged by the vast distances and sparsely populated areas of Namibia. This makes per capita service delivery expensive, and management and logistical co-ordination demanding. This is aggravated by shortages of qualified nurses and doctors. Due to a lack of incentives, especially in rural areas, a shortage of qualified staff exists. To increase the number of qualified staff in rural areas it should be considered to enhance the attractiveness of jobs through enabling work environment and salaries.
- Lack of support from women themselves and the communities in which they live can also contribute to high maternal mortality. Although women know that childbirth is not without health risks and that the presence of a nurse or doctor during delivery will improve her chances of a successful delivery, birth assistance services are of-ten underutilised. Moreover, increased post-natal care utilisation will reduce mater-nal morbidity where of particular relevance are the immediate days after delivery. Increased utilisation of post-natal care services is likely to reduce maternal mortality. Therefore, to provide pregnant women with sufficient information about the risks pregnancy may entail should be a focus of the Government.
- A strong contributor to maternal mortality in Namibia is limited access to public emergency obstetric care services. While Comprehensive Emergency Obstetric Care (CEmOC) facilities do exist, these are concentrated in the Oshikoto, Khomas and Otjozondjupa regions. Pregnant women and young mothers residing in remote areas have limited access to emergency services because Basic Emergency Ob-stetric Coverage (BEmOC) is non-existenting. In case of an emergency, the woman has to be sent to health facilities which are equipped to offer the required treatment. Since such facilities are often far, it takes some time for the woman to reach the hospital. This delay is likely to worsen her condition. Exacerbating this is the fact that ambulance services are limited, which makes transportation problem-atic. Increasing access to emergency obstetric care facilities as well as improving referral systems will show marked results in reducing maternal mortality.

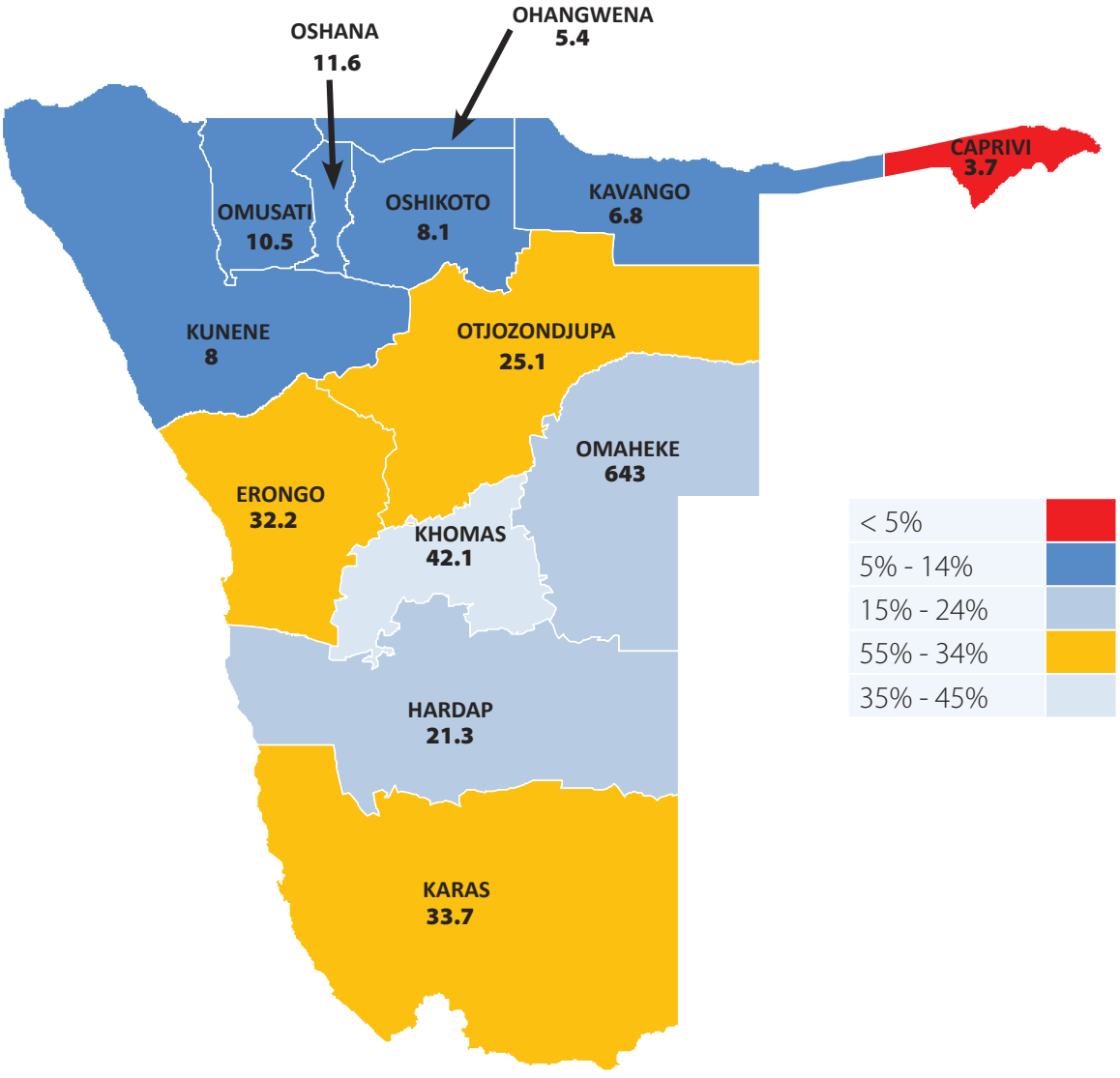
INTERVENTIONS

- The Namibian health authorities have established a framework of policies and programmes aimed at ensuring maternal and reproductive health. Useful to men-tion are the Reproductive Health Policy which aims to protect and support pregnant women and mothers. The policy is supported by a number of programmes and in-itiatives, underlining the commitment of Government to improve maternal health. Furthermore, it is also important to mention the Adolescent Friendly Health Services approach as well as the Population Policy for Human Development. In addition, the Ministry of Health and Social Services has published a roadmap to maternal and infant health which outlines the strategies, measures and guidelines required and intended to improve maternal

health.

- The regulation of medical practitioners and nurses as well as the job descriptions under which nurses are employed prohibit nurses from performing certain tasks in assisting women during childbirth and attending to complications. In the event of an emergency, instead of providing help, the nurse is required to refer the patient to a doctor. Due to the low number of doctors working in rural areas and the consequential low percentage of births attended by doctors (Figure 5.3) women experiencing complications during delivery often have to be sent long distances to receive treatment from a doctor. The effects of the delays due to the long distances and often bad roads are likely to further worsen the health status of the woman. Adjusting the job descriptions of nurses by expanding their responsibilities and task shifting together with adequate training could significantly contribute to improved treatment and assistance during delivery.

FIGURE 5.3: PERCENT BIRTHS ATTENDED BY DOCTORS IN EACH REGION, 2006/07



SOURCE: MoHSS (2008d).

- The set framework of health policies needs to be improved upon by expanding maternal and reproductive health care services whilst implementing general improvements in the quality of service delivery. In addition to facilitating the implementation of programmes and regulations in all health facilities by increasing the supervision of management, health workers need to be held accountable for the service they deliver. In combination with programmes sustaining poverty reduction and employment creation, the expansion, enforcement and proper management of given health policies will provide a supportive environment for reaching the goal of reduced maternal mortality.

MDG 6

COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

HIV/AIDS is the single largest threat to the development of Namibia. Its impacts are felt at every level of our society, and affect all individuals, families and communities, who are the fundamental building blocks of our social and economic development.

His Excellency Hifikepunye Pohamba, President of the Republic of Namibia

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

This goal aims at combating HIV/AIDS, malaria and other diseases. In addressing it, this chapter is divided into three sections. The first is devoted to HIV/AIDS, followed by tuberculosis and malaria.

HIV/AIDS

HIV/AIDS is negatively influencing economic and social development in a broad range of aspects. The epidemic is affecting health, livelihoods, economic perspectives, demographic futures as well as many individual lives. HIV has reduced life expectancy in Namibia significantly, and has left many families economically vulnerable. After dec-ades of decreasing mortality rates for children under the age of five, HIV is currently contributing to a reversal of this trend. AIDS has left about 66,000 children orphaned, and has therefore increased the burden of responsibility on children to put food on the table. HIV and tuberculosis are closely interlinked; most HIV positive people are also TB infected. Monitoring the HIV epidemic is particularly important in informing policy-makers of the challenges and needs facing a large proportion of the Namibian popula-tion.

STATUS AND TRENDS

TABLE 6.1 HIV/AIDS

INDICATOR	1994	2000	2006	2007 TARGET	2012 TARGET	TARGET ACHIEVABLE?
HIV prevalence rate[1], 15-19 years (%)*	6	12	5.1	9	8	ACHIEVED
HIV prevalence rate , 20-24 years (%)*	11	20	14.0	15	12	POSSIBLE
People living with HIV, 15-49 years old (%)***	-	14.6	15.3	-	-	-
Condom use at last higher-risk sex 15 – 24 years						
women[2] (%) **	-	48	64	45	-	-
men 15-24 years (%)**	-	69	81	-	-	-
Proportion of population with advanced HIV infection with access to ARV drugs (%)***	-	3[3]	66 (2007)	-	75[4]	LIKELY

SOURCES: * = Ministry of Health and Social Services (MoHSS) (1995), (2001b) and (2007b), ** = MoHSS (2003) and (2008d), *** = MoHSS (2008e)

As can be seen in Table 6.1, the HIV prevalence rate has declined in the 15-19 and 20-24 age groups, from 12% in 2000 to 5.1% in 2008, and from 20% to 14.0% respectively. The 2007 targets on the prevalence rate among different age groups by 2007 have been achieved in respect of the 15-19 and 20-24 year gae groups. The 2012 target for the age group 15-19 has

1 HIV prevalence rate in pregnant women.

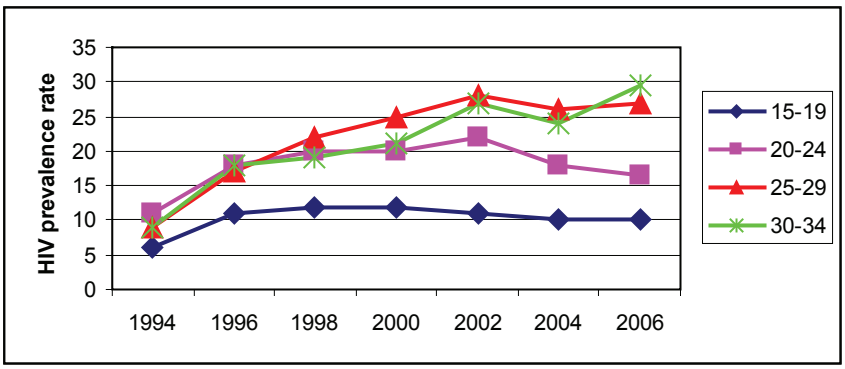
2 Higher risk sex refers to sexual intercourse with a partner who is neither the spouse nor live-in partner of the respondent.

3 This figure is corresponding to before the roll out of ARV treatment in 2003.

4 This target is for the age group 15 years and above. For children 0-14 the target is 91%.

also been achieved. The target for condom use at last higher risk sex was exceeded. If the prevalence rates continue to drop at the rate observed between 2000 and 2008, the 2012 targets may be achievable. On the other hand, the number of people living with HIV is on the increase because HIV-positive people are living longer as treatment programmes are expanded in the public and private sectors. As seen in Figure 6.1, the prevalence rate among 35-39 year olds has been increasing. New infections in this age group plus the fact that people living with HIV are getting older both contribute to this increase. There are considerable differences in the prevalence rates across the various testing sites in Namibia. Katima Mulilo has the highest prevalence rate in pregnant women in the country at 31.7%. Katima Mulilo is a transit town, and such towns tend to have higher HIV prevalence rates.

FIGURE 6.1: TRENDS OF HIV PREVALENCE RATE BY AGE GROUP AND YEAR OF SURVEY



Source: MoHSS (2007b)

The first four cases of HIV/AIDS were reported in Namibia in 1986, and now it is estimated that about 200,000 people are living with HIV in Namibia. 60% of these are women. Women are more prone to contract HIV during sexual intercourse than men due to the biological make up of women. Furthermore, as seen in Table 6.1, women's condom use during higher-risk sex is much lower than men's in the same age group. This may be explained by women having older partners, and/or that they may not feel empowered to demand the use of a condom. Intergenerational and transactional sex and multiple concurrent partners are both factors contributing to the spread of HIV.

It was estimated that about 57,500 people were in need of anti retroviral treatment (ART) in 2007, while about 38,000 people were receiving ART. This means that there is about 66% ART coverage, compared to below 3% before 2003 – which must be seen as an impressive expansion of ARV usage within a few years. Future projections of coverage is estimated to be about 80%, thus the set target of 75% is likely to be achieved.

Knowledge about HIV is important, both in reducing infections and getting appropriate treatment. About 64% of people between 15 and 24 years of age have comprehensive knowledge about HIV. Comprehensive knowledge means knowing that consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting the AIDS virus, but also knowing that a healthy-looking person can have the virus, and rejecting the two most common misconceptions about HIV transmission or prevention. The two most common misconceptions are that AIDS can be transmitted by mosquito bites and a person can become infected by shar-ing food with a person who has AIDS.

The introduction of rapid testing in 2005 has improved the efficiency of health service personnel, and is now offered at 110 public health facilities around the country. Rapid testing provides quicker test result to the client, and is also cost efficient. Furthermore, it has reduced the non-return of clients.

Mother-to-child transmission occurs when an HIV positive woman passes the virus to the baby. This can

happen through pregnancy, labour and delivery, or through breastfeeding. Without treatment around 15-30% of babies may become infected with HIV during pregnancy and labour. Another 5-20% may become infected through breastfeeding. In developed countries, effective Prevention of Mother-to-Child Transmission (PMTCT) of HIV has reduced the risk of transmission of HIV to less than 2%. This prevention includes ARV prophylaxis given to women during pregnancy and labour and to the infant in the first weeks of life, safe obstetrical practices, and the complete avoidance of breastfeeding.

In March 2002, PMTCT services were introduced in the Katutura and Oshakati State hospitals. Since then services have been extended to all 35 hospitals and to 153 health centres and clinics, out of 335 public health facilities. Although this must be seen as a considerable achievement, in order for PMTCT to be effective the highest possible number of pregnant women must be tested for HIV, and if found positive, ARV treatment should be provided and taken. It could be assumed that most pregnant women would want to be tested for HIV in order to protect the baby, but the fear of stigma and rejection if they test positive may lead them not to. Also, long distances to travel may prevent women from getting tested.

CHALLENGES AND OPPORTUNITIES

- HIV prevalence in the country remains high despite all the interventions. In 2007, the estimated total number of new infections was 15,700. This implies an average of 43 new infections per day. Of the new infections, 43% occurred amongst young people between 15 and 24 years, and of these, 77% are women Trans-generational relationships in combination with unsafe sex increase the risk of becoming infected. Furthermore, poverty may lead young women to seek relationships with older, wealthier men. Young and poor women may not be in the position to demand the use of a condom, and are hence at risk of becoming HIV-infected. This suggests that prevention efforts must be targeted at young people, and particularly women, who are at the point of becoming sexually active and forming their sexual behaviours and habits.
- The HIV prevalence rate is measured in pregnant women, and hence excluding men form being included in the sample. This may lead to a skewed picture of the epidemic. Therefore, complementary data sources for the prevalence rate where a broad-based sample of the population is included, should be considered. Such data could be created by collecting data from all HIV testing sites where both men and women are being tested.
- In 2006, 92% of women who started antenatal care (ANC) took an HIV test. 79% of the pregnant women who delivered knew their HIV status, and of all the HIV positive mothers who delivered, 64% took ARV prophylaxis. These numbers show that there is room for improvement in getting more pregnant women tested for HIV, and also if found to be positive, to ensure that ARV treatment is taken. Even though the roll out of ARV treatment and PMTCT services has been extensive, there is a need for a further scaling up of these services in order to reach all persons in need of such treatment.
- Many people do not know their HIV status. The fear of stigmatisation, if found positive, has a profound detrimental impact on the numbers of people volunteering for testing. Some 21% of women who have given birth do not know their HIV status. The stigmatisation of HIV positive people must thus be seen as a challenge in itself, as it is clearly a hindrance to widespread HIV-testing. Interventions targeting the reduction of stigmatisation of HIV positive people are therefore required. To make HIV testing easily available and reducing the risk of exposure of going to a testing site or clinic, providing voluntary and anonymous HIV testing at the work place should be considered. Such a service should aim to enhance prevention, treatment, care and support mechanisms at the work place.
- In Namibia, HIV testing is voluntarily, but in Swaziland it is mandatory. To know one's status is likely to reduce the spread of the disease, and thus mandatory, confidential testing should be considered as an option for curbing the spread of HIV. Also, to knowingly spread the disease will in many countries lead to imprisonment, and a similar practice could be considered for Namibia.
- Sexually transmitted infections (STIs) continue to pose a major health challenge in Namibia. Failure to adequately diagnose and treat STIs has contributed to increases in the HIV infection rate.
- There is a need for change in sexual behaviour in order to curb the spread of HIV. Official policies are an important

tool for doing so, but even more important is work that aims to change people's perceptions and behaviours at an individual level. Taking responsibility for your own and your partner's health should be emphasised when targeting behaviour change.

- Having multiple concurrent partners increases the likelihood of spreading HIV. In Uganda, a campaign for limiting your sexual partners to only one partner to avoid spreading HIV has been moderately successful. A similar campaign should be considered for Namibia.
- Concerning PMTCT, there is no public provision of formula milk to HIV-infected mothers with babies. With such a programme in place, MTCT is likely to decrease, given the accessible, feasible, affordable, safe, sustainable (AFASS) principles. ARV medicines have very strong side effects, and sufficient nutritious food is necessary in order for the body to handle the medicines. Therefore a feeding programme for poor HIV-positive people should be considered.
- Donors could assist in improving the implemention of international best practices, capacity building, and strengthening national monitoring and reporting systems. Also, supporting feeding programmes for babies with HIV-infected mothers and for HIV-positive people in need of ARV treatment would help babies to remain HIV-negative, and people living with HIV to live healthier and longer lives.

INTERVENTIONS

- The Namibian Constitution acknowledges the importance of human rights through the Bill of Rights. Furthermore, the Namibian HIV Charter of Rights and the Code on HIV/AIDS define the legal rights of people living with HIV/AIDS.
- The political leadership of Namibia is committed to combating HIV/AIDS, as seen in the Third Medium-term Plan under the National Strategic Plan on HIV/AIDS and NDP3. The former was created in order to guide the national programme for curbing and treating the disease. In the latter, the prevention of new HIV infections and treatment of people living with HIV/AIDS is established as a top national priority. This is followed by basic care for those infected or affected, especially orphans and vulnerable children. Furthermore, Namibia is receiving assistance from the Global Fund for AIDS, TB and Malaria. In several application processes Namibia has received funding for all three diseases.
- A National Policy on HIV/AIDS has been developed to serve as a guide for all sectors in their response to the epidemic. The document mainly focuses on creating an enabling environment free of discrimination and stigma for HIV positive people, on prevention, and on treatment and care.
- The MoHSS recognises the importance of blood transfusion in the health delivery system, and in 2007 a National Blood Policy was published. MoHSS further appreciates the threat to life in the face of insufficient blood stocks and the risk of transfusion transmissible infections such as HIV. Therefore the need for adequate and safe blood supplies to all who may need it is emphasised.
- There have been many policy documents developed to help society deal with HIV/ AIDS issues. Some important documents are the National Policy on HIV/AIDS for the Educational Sector, Guidelines for the Prevention of Mother-to-Child Transmission of HIV, the Report on the Estimation and Projection of the Impact of HIV/AIDS in Namibia and the Response Needed and the National Policy on Orphans and Vulnerable Children.
- A National Male HIV conference was held in 2008, the first of its kind in Namibia. The meeting looked at low male involvement in HIV/AIDS treatment and prevention activities, and aimed to provide a platform where male leaders could contribute to fight against the pandemic.
- There have been comprehensive programmes targeting vulnerable groups conducted in the National Defence Force, the Namibian Police and to some extent in prisons.
- The after-school voluntary life skills programmes: My Future My Choice, and Windows of Hope, have been rolled out nationwide through the Ministry of Education in order to target behavioural change at young people.
- There are many private HIV/AIDS initiatives from different sectors such as churches, voluntary organisations, community-based organizations and the private sector.

TUBERCULOSIS

The 2007 Global Tuberculosis Report ranks Namibia second in the world in terms of the incidence of tuberculosis. This well-known disease often coincides with poverty and malnutrition, overcrowded living conditions and alcoholism. Long spells of sickness mark the tuberculosis (TB) patient while at the same time the often highly infectious germ is spread amongst families and communities. To make matters worse, the prevalence and incidence of TB is fuelled by the HIV/AIDS pandemic.

STATUS AND TRENDS

TABLE 6.2 TUBERCULOSIS

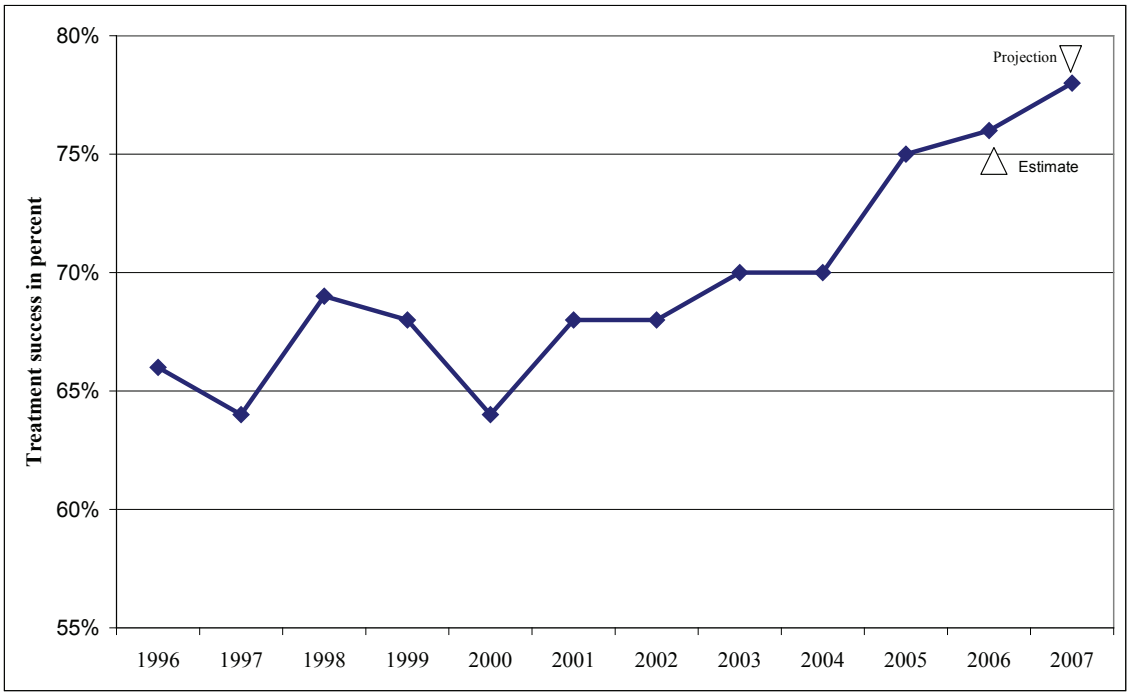
INDICATOR	1997	2004	2006	TARGET 2007	TARGET 2015	TARGET ACHIEVABLE?
TB cases in 100,000 detected	656	822	765	n/a	< 300/100,000	POSSIBLE -LIKELY
Percent TB cases treated successfully	64	70	76*	75	85	LIKELY

SOURCE: MoHSS.

*** This figure is an estimate by the Directorate Special Programmes (MOHSS). The figure for 2005 was 75%**

While TB remains a health problem in Namibia, under the reviewed national TB control programme (NTCP) the Ministry of Health and Social Services succeeded in implementing a range of practices and guidelines which have the potential to reduce the incidence of TB. The trends indeed indicate a turning point concerning the prevention and treatment of tuberculosis. The number of TB cases detected in 100,000 people (Case Notification Rate) shows a decreasing trend since 2004, while it increased between 1997 and 2004. Although the CNR is high, the continued establishment of the reviewed tuberculosis programme promises to reduce the number of infections. Optimism exists that the 2015 target set for the CNR, namely less than 300 notified cases per 100,000 people, can be reached. Figure 6.2 shows that the percentage of TB cases successfully treated under DOTS (directly observed treatment short-course) has increased. DOTS is a globally applied system adapted to Namibian conditions, under which patients are directly observed and monitored by a tuberculosis treatment supporter. Projections for 2007 indicate that health officials expect the success rate to reach 78%. The target of 85% could therefore realistically be reached by 2015.

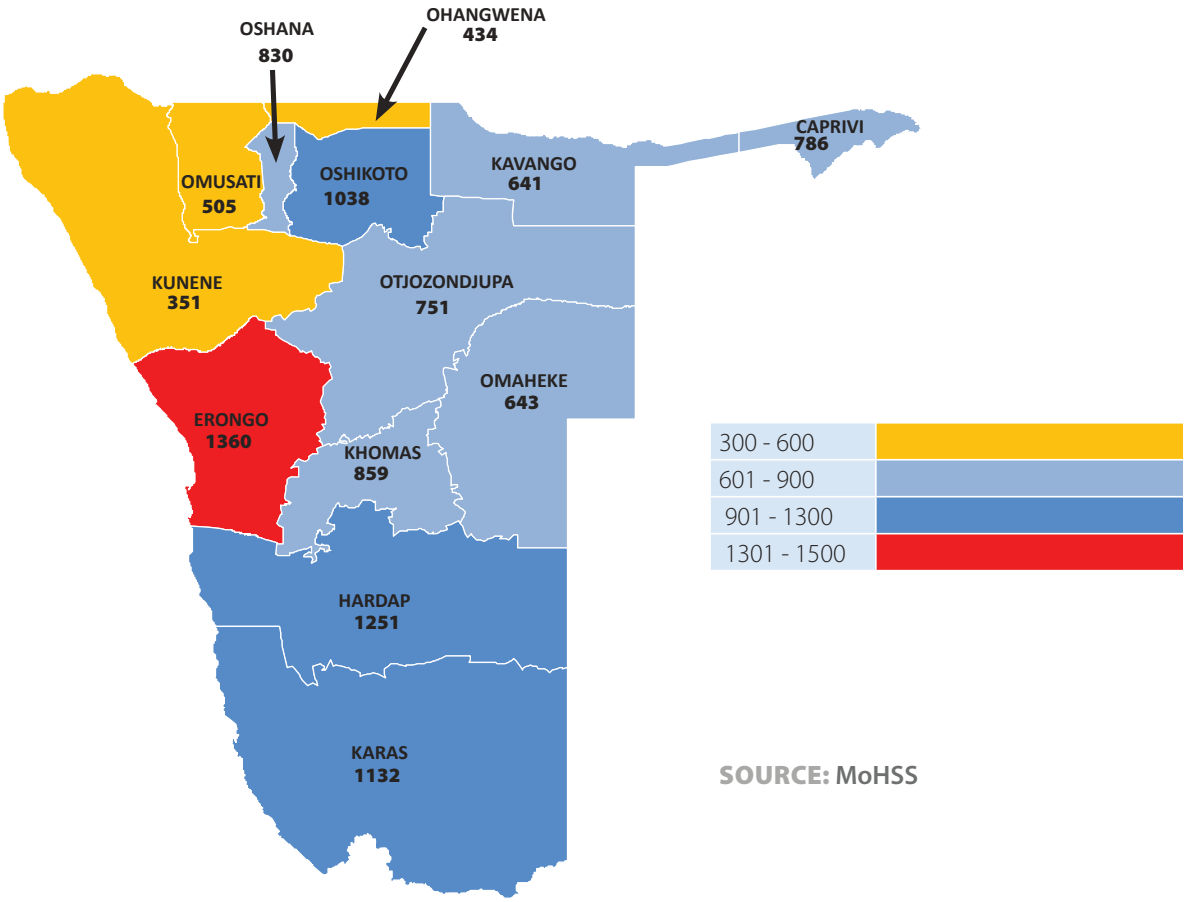
FIGURE 6.2: TREATMENT RESULTS FOR NEW SPUTUM SMEAR POSITIVE CASES 1996 - 2007



SOURCE: MoHSS.

Figure 6.3 Shows the sharp differences in the CNR between regions, with the highest prevalence ratio occurring in the Erongo region, and the lowest in Kunene.

FIGURE 6.3: TB CNR PER 100,000 BY REGIONS DURING 2006



SOURCE: MoHSS

CHALLENGES AND OPPORTUNITIES

- The nature of the tuberculosis treatment makes it difficult to bring the disease under control. Patients have to take four tablets of TB medication daily for up to 18 months. Although non-compliance should be reduced through this fixed Dose Combined medication, non-compliances remains a challenge to TB prevention and cure. Non-compliance leads to increased resistance to the medication, making future treatment more difficult and costly. Medicines used in the past required that up to 15 different pills had to be taken daily, which was a major cause of non-compliance. In addition to challenges related to medication, detection and treatment are hindered by a lack of awareness regarding TB.
- A very promising opportunity to increase HIV outreach is offered by the DOTS stations. The regular contact these centres have with TB patients holds the opportunity of extending services to provide councilling and treatment to HIV/AIDS patients at little additional cost. Officials at DOTS stations currently encourage TB patients to take HIV tests when tested or treated for TB.
- Although public and also private involvement is already highly commendable, as is the co-operation and collaboration between the MoHSS and DOTS supporters, there is room for programme expansion, especially beyond urban areas. NGOs and also private businesses and individuals can support this functioning system by contributing to the establishment, improvement and management of DOTS centres in terms of finance, materials or just time spent helping out.

INTERVENTIONS

- The objectives of the National TB Control Programme (NTCP) not only include reducing morbidity and mortality resulting from the incidence and prevalence of TB, but also interrupting the transmission of the disease and preventing the increasing resistance of the TB germ to medication. Early detection is imperative to limit infections, and hence health workers routinely diagnose the symptoms of TB when individuals visit health facilities and validate results through laboratory tests. If confirmed, the TB patient is registered with the DOTS programme.
- The Government has clearly demonstrated that it is committed to controlling and eliminating TB by 2015. The epidemic is declining, albeit from high levels. Even though the reviewed NTCP was only established about four years ago, its success is encouraging. Activities of TB prevention and cure are supported by various information and awareness campaigns. In addition, the MoHSS has focussed on increasing human resources through the training and recruitment of suitable staff.
- A number of NGOs and faith-based organisations assist the NTCP, especially through the DOTS efforts. In the Ohangwena and Omusati region the Red Cross is present, while in Otjozondjupa the DOTS programme is supported by Health Unli-mited. TB CAP monitors the Erongo region. CoHeNa is present in the Omaheke and Hardap region, while Penduka is an active NGO in the Khomas region. In the Kavango region TB patients are supported by the Johanniter, a faith-based organi-zation. The global fund is supporting the MoHSS in the Oshikoto, Oshana, Karas, Caprivi as well as the Kunene region.

MALARIA

Malaria remains one of the main health problems in the world, killing up to 3 million people annually. The disease is caused by the Plasmodium Falciparum parasite and is transmitted by the Anopheles mosquito. Compared to some African countries, transmission of malaria in Namibia is relatively low and is largely of a seasonal nature, with a peak transmission period that corresponds with annual rainfall patterns. Nevertheless, Malaria remains a major public health concern in Namibia, affecting more than 60% of the population.

STATUS AND TRENDS

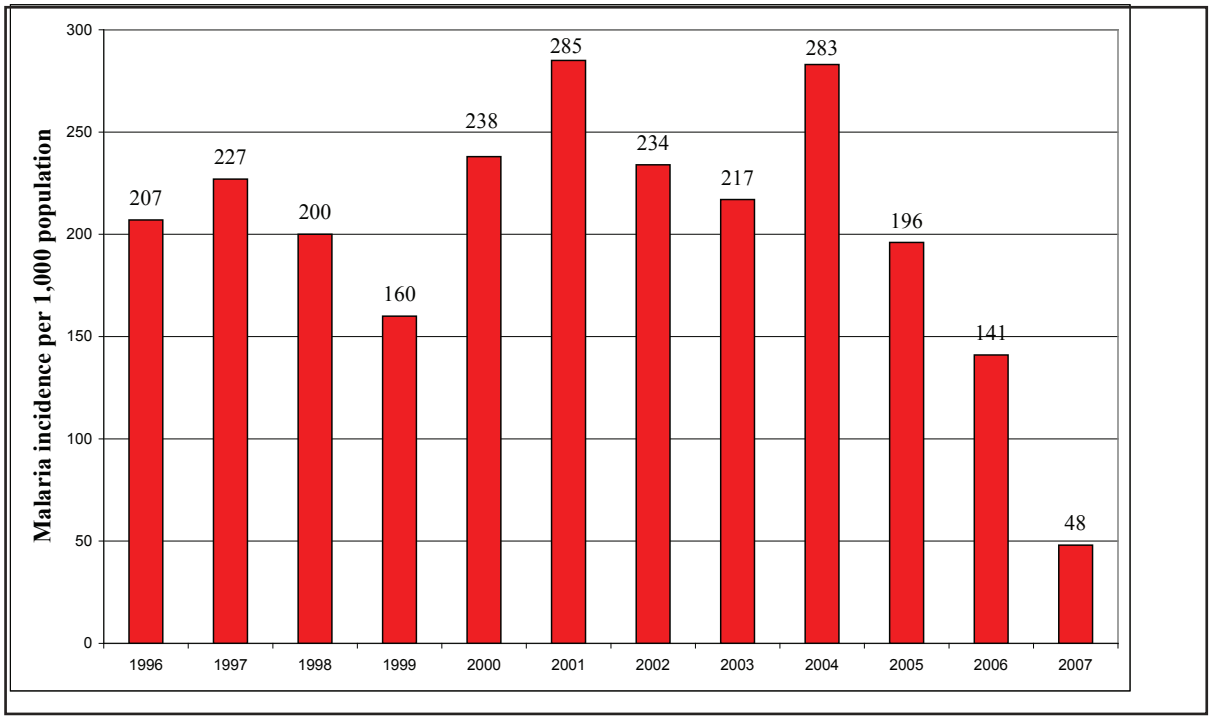
TABLE 6.3

INDICATOR	1996	2000	2007	TARGET 2006	TARGET 2015	TARGET ACHIEVABLE?
Incidence of Malaria in 1,000 population	207	238	48	-	Halt and begun to Reverse	ACHIEVED

SOURCE: MoHSS (2008d).

The incidence of malaria during 2007 is markedly lower than it was during 2000. As shown in Figure 6.4 the annual malaria incidence between 1996 and 2004 fluctuated without indicating a clear trend, although reaching a high of 285 in 2001. After 2004 malaria incidence shows a clear decline and the lowest trend mark was reached in 2007 with an incidence of 48 cases per 1,000 people. The disease has thus been set on a firm downward trend.

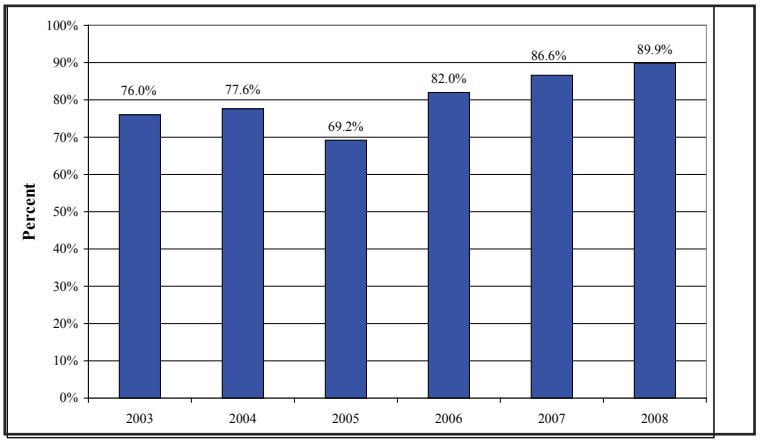
FIGURE 6.4: MALARIA INCIDENCE BY YEAR, 1996 – 2007



SOURCE: MoHSS (2008a).

Amongst others, this trend can be attributed to improved training of officials, spraying insecticides to reduce the mosquito population as well as the expansion of the indoor residual spraying (IRS) strategy (Figure 6.5).

FIGURE 6.5 INDOOR RESIDUAL SPRAYING: NATIONAL COVERAGE 2003 -2008



SOURCE: MoHSS (2008a).

Furthermore, mosquito nets are increasingly utilised as a preventative measure. While in 2000 a mere 7% of children under the age of five slept under mosquito nets, and only about half of those nets were treated with insecticide, in 2006 about 11% of children slept under an insecticide-treated net (ITN). The use of malaria nets is most common in Caprivi, Kavango, Omusati and Oshana where malaria is a significant threat.

Malaria in Namibia is a regional occurrence. The incidence ranges from 618 per 1,000 people in some districts in the Kavango region to as low as less than 1 per 1,000 people per year in the southern parts of the country where there is no indigenous malaria transmission. The regional nature of malaria is further reflected in causes of death. During 2007 more than 40% of deaths in the Caprivi, Omusati and Kavango regions can be related to malaria.

CHALLENGES AND OPPORTUNITIES

- Expanding the distribution of ITNs to all people living in affected areas has the potential to significantly reduce the incidence of malaria.
- Malaria programme activities are hampered, at regional and district levels in particular, by a lack of expertise in the epidemiological or parasitological areas of malaria control.

INTERVENTIONS

- The main priorities of the Ministry of Health and Social Services are the prevention of malaria transmission and the treatment of infected patients. Measures in place to achieve this objective include the reduction of the Mosquito population by spraying insecticides and distributing ITNs in affected areas. Malaria treatment is provided to patients. If required, Malaria patients are treated in hospitals. Vulnerable groups such as pregnant mothers, children and HIV/AIDS patients enjoy priority in the provision of treatment.
- The objectives of the health authorities are supported by the World Health Organisation as well as the Global Fund for HIV/AIDS, TB and Malaria in terms of financial assistance, but also with equipment such as vehicles and with technical advice. In addition, a number of communities are involved in the production of mosquito nets. These nets are distributed with the help of the Red Cross.
- The efforts of health authorities are showing positive results in the reduction of malaria. It has to be borne in mind, however, that the occurrence of malaria depends not only on the degree of intervention from the health authorities and on the behaviour of the citizens, but also on rainfall received.

MDG 7

ENSURE ENVIRONMENTAL SUSTAINABILITY

The Ministry of Environment & Tourism faces two important challenges: one is to ensure the conservation of Namibia's ecosystems and biodiversity and the other is to contribute to national development goals such as poverty reduction and economic growth.

Honourable Minister Willem Konjore

MDG 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

The sustainable utilisation of Namibia's natural resources is a prerequisite for the sustained generation of income and creation of employment. The sustainable management of these resources provides the basis for industries within the secondary and tertiary sectors. Within the context of climate change and global warming this is of particular relevance. To determine whether utilisation is conducted in a manner conducive to environmental sustainability, environmental management, the agricultural sector, forestry, mining, and fishing industries are all considered as well as water and sanitation.

STATUS AND TRENDS

TABLE 7.1 INDICATORS FOR ENVIRONMENTAL SUSTAINABILITY

INDICATOR	1990	2000	2006	TARGET 2006	TARGET 2015	TARGET ACHIEVABLE?
Land area protected to maintain biological diversity, as percentage of all land*						
• Protected Areas	14	17	18	15	20**	LIKELY
• Communal Conservancies	0.0	5	14	11	15**	LIKELY
• Freehold Land Conservancies	5	6	6***	9	10**	UNLIKELY
• Community forests(ha)	0.0	0.0	460000	300000	2500000	POSSIBLE
Proportion of households with access to safe drinking water (percent) ****						
urban	99	98	97	95	100	POSSIBLE
rural	74	68	80	80	87	LIKELY
Proportion of households with access to basic sanitation (percent) ******						
urban	86	85	58	-	98	UNLIKELY
rural	14	20	14	50	65	UNLIKELY

*SOURCE: Ministry of Environment and Tourism (MET) (2008).
**Target suggested by MDG technical committee (2008).
*** 2005 figure
**** Ministry of Health and Social Services (MoHSS) (1993), (2003) & (2008d).

SUSTAINABLE ENVIRONMENTAL MANAGEMENT

Central to the goal of ensuring environmental diversity is the objective of promoting biodiversity. For plant and animal species to flourish, large areas of land are necessary where plant and animal life is not under threat of being harvested or hunted in an unsustainable manner. Protected areas have consistently been extended since 1990. Currently 18% of all land in Namibia is designated as public protected areas, ranging from game reserves to national parks. Likewise, communal conservancies have been expanded from 5% in 2001 to 14% of the total land. Moreover, communal forests are likewise quickly expanding. The area for conservancies on freehold land showed a slight increase between 1990 and 2001, but remained at about 6% of freehold land. The objective of promoting biodiversity is further supported by extensive wildlife management conducted by the Ministry of Environment and Tourism. These efforts have shown a remarkable degree of success. Game counts indicate that Namibia has the largest number of free-roaming cheetahs as well as the biggest population of black rhinos in the world.

SUSTAINABLE AGRICULTURE

Namibians increasingly derive their livelihoods from agriculture. In 2000 11% of women and 19% of men stated their occupation as related to the agricultural sector. In 2006 this figure had increased to 17% and 27% respectively. This trend reflects an increasing demand on the sector to provide work places and sources of income. A consequence of this pressure on land is the tendency of farmers to overstock the grazing available to them, causing erosion and bush encroachment and overall land degradation.

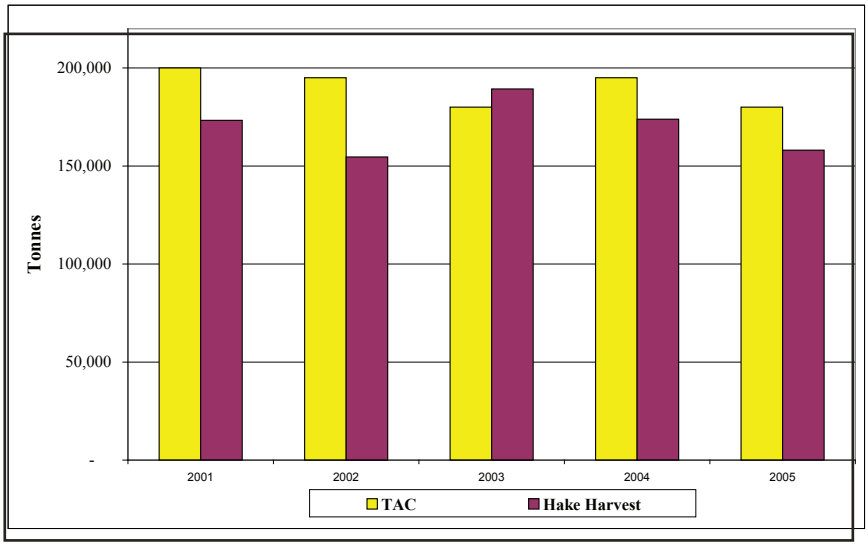
ENVIRONMENTALLY CONSCIOUS MINING

The recent sharp commodity price increase has resulted in heightened activities in exploration for raw materials such as uranium, copper, gold and other zinc. While two new mines in the Erongo Region have commenced operations, further promising prospects in other parts of Namibia are being investigated. Mining operations can offer increased income by creating employment opportunities. In addition, state revenues increase through taxes and royalties paid by the mining companies. However, if mining operations are not conducted in an environmentally sensitive manner, damage done to the environment can include surface and groundwater pollution, stream sediment and soil contamination and noise pollution. In addition, since mines require large quantities of water for their operations, the increase in mining activities in turn heightens water demand, putting pressure on this scarce resource.

SUSTAINABLE MANAGEMENT OF MARINE RESOURCES

Fishing is a significant sector in Namibia's economy. The sustained production of the sector requires the proper management of this natural resource. While on the one hand over-fishing results in long term damage to fish stocks, underutilisation on the other hand implies forgone income and employment opportunities. Scientists determine the available biomass twice a year that forms the basis for the total allowable catch (TAC) finally announced by the Ministry of Fisheries and Marine Resources. The TACsfor most commercial fish have been reduced between 2001 and 2005.

FIGURE 7.1: TOTAL ALLOWABLE CATCH AND HARVEST OF HAKE 2001 - 2005



SOURCE: Ministry of Fisheries and Marine Resources (2006).

WATER AND SANITATION

As indicated in Table 7.1, most Namibians living in urban areas have access to safe drinking water. Although some reduction was reported in 2000 and again in 2006, the decrease was small and levels of safe drinking water remained high. The target for 2006 has been surpassed. The proportion of rural households with access to safe drinking water has increased by 12 percentage points since 2006, and with that the 2006 target of 80% was also met. There is no clear trend for access to basic sanitation in rural households. Although access increased for the period from 1992 to 2000 during which access increased from 14% to 20%, this improvement was lost after 2000 with access to basic sanitation dropping to 14% currently. The 2006 target was not met, nor is Namibia likely to meet the 2015 target. The number of urban households with access to basic sanitation has deteriorated markedly since 2000, showing a decrease from 85% to 58%. It is unlikely that the set target for 2015 will be met. A significant contributing factor to this development is urban migration, especially to Windhoek.

SUSTAINABLE SHELTER FOR ALL

The global MDG Goal 7, Target 11 is to monitor and gradually attain the "Cities/Towns without Slums". Target 11 is: "By 2020, to have achieved a significant improvement in the lives of at least 100 million slum/shack dwellers"

The expected results are that, Namibia needs to provide an overview of the shelter situation with the emphasis on security of tenure, right to adequate housing (sufficient living area-not more than two people sharing the same room), access to land, access to credit, and access to basic services such as sanitation, water, energy, and roads.

CHALLENGES AND OPPORTUNITIES

- Namibia's landscapes and wildlife diversity present extensive opportunities to the tourism industry. Tourism is already an important sector to the Namibian economy, contributing more than 3% to total GDP and creating 5% of Namibia's jobs. The significance of the tourism industry becomes even more evident if the indirect contribution to Namibia's economy is considered: the Namibia Tourism Satellite Accounts calculated the overall impact of tourism at almost 15% of GDP. Moreover, the industry is estimated to grow by 7% over the next year. Considering this trend, not only is it likely that the area of protected land will be maintained or increased in response to these expected trends, but also that growth in tourism, and wildlife tourism in particular, will contribute to employment creation and income generation, with poverty reduction the final result. It has to be kept in mind though that in order for tourism to make a positive contribution to employment creation and poverty reduction, employment opportunities created through this industry are not merely to replace existing jobs in, for example, the agricultural sector, but the total number of employment opportunities has to increase.
- Forest protection from natural and man-made causes is essential. Limiting factors are inadequate control of deforestation, lack of coordinated fire detection and inadequacy of forest classification.
- Tourism in Namibia has significant room for expansion. Nevertheless, facilities and tourist attractions have capacity limits. If the industry is to sustain its high and internationally competitive standard the number of visitors may not exceed this capacity.
- Mining is a threat to environmental sustainability, in terms not only of visual destruction, but also to pollution as a consequence of mining which may render an area unhealthy for humans. Mining corporations, government as well as civil society have a responsibility to ensure the environmentally sensitive extraction of natural resources.
- Considering the significance of agriculture to livelihoods in Namibia, the sustainable management of land is critical to secure the provision of basic needs. The high demand for land often results in the over-utilisation of available land and forests. Over-utilisation, usually observable by desertification or bush encroachment, results in the reduction of productivity of the land that in turn can lead to further over-utilisation in order to compensate for reduced productivity.
- A major challenge in the Namibian fishing industry is the limited pool of personnel qualified to calculate the size of the various fish populations, and in turn to determine the Total Allowable Catch. While a number of factors, such as logistical obstacles, late announcements or high fuel prices could explain the fact that fishing companies have not filled their quotas, the lower than granted total harvests could be an indication that fish stocks are lower than estimated, implying that for fishing to be sustainable, quotas would have to be significantly lower.
- The supply of basic sanitation and safe drinking water is especially challenging on account of the low population density. This results in high costs and considerable logistical difficulties.
- Shortcomings in the provision of basic sanitation and safe drinking water have far-reaching consequences for the health status of the population. Drinking water is often contaminated due to poor sanitation. Especially in the case of children, consumption of contaminated drinking water often leads to diarrhoea. According to the Ministry of Health and Social Services (2008d), this ailment is responsible for 35% of deaths amongst children younger than five years of age. It is further suspected by the Ministry that poor sanitation was one of the underlying causes of the polio and cholera outbreaks in 2006.
- Migration to urban areas and especially to Windhoek proves to be a taxing challenge for municipal authorities. Large numbers of settlers live in informal settlements, often without access to safe drinking water and basic sanitation. Funds are insufficient to meet the demands for housing and sustainable shelter. In addition, migrants seldom have sufficient income to buy a plot or house, and again are seldom eligible for loans with which to acquire property. Moreover, the system of acquiring secure tenure is a somewhat complex and expensive system, involving the payment of various fees and charges to public and private institutions. Consequently people build their own informal structures on land that is not registered in their name and does not officially belong to them thereby living with the constant treat of being evicted. Basic sanitation and drinking water are rarely available, resulting in unhygienic living conditions. Municipalities struggle to provide the facilities required to meet demand, particularly given the high rate of influx to the urban areas.
- Mining activities, agriculture, tourism and a growing population require increasing amounts of water, which is mainly extracted from groundwater. This increasing demand on Namibia's underground water resources

is a threat to the country's water reserves. Management and replenishment of the reserves is a difficult task, dependent in part on surface water and rainfall. The situation is similar with available surface water reserves. The sporadic rainfall is not always enough to replenish Namibia's dams. Staff and resources are required to raise awareness amongst the Namibian population to use water sparingly, but also to encourage co-operation between farmers and water authorities in order to build surface water dams at geologically and geographically appropriate locations, ensuring deep dams to limit evaporation and porous ground so that rain water can replenish ground water reserves. Alternatively, tariffs on water use may contribute to more considerate water use.

- Last but not least, a long-term challenge for Namibia's environmental sustainability is the danger of global climate change which may affect Africa and specifically Namibia and may increase the ecological but also the economic vulnerability of the country. Vulnerability studies with respect to climate change are warranted.

INTERVENTIONS

- For forest protection the gazetting of community forest regulations in 2006 was an important step. It empowers stakeholders to sustainably manage their forests.
- Authorities are aware of the problems resulting from the shortcomings in the provision of basic sanitation. The Directorate of Rural Water Supply under the Ministry of Agriculture, Water and Forestry has the infrastructure in place to supply water in most areas of the country. The responsibility for the provision of basic sanitation has been transferred to the Ministry of Agriculture, Water and Forestry from the Ministry of Health and Social Services. Instead of only managing water supply and maintaining existing infrastructure, staff of the Ministry of Agriculture, Water and Forestry will now also provide for and maintain sanitation. This transfer is expected to contribute to advances in the provision of basic sanitation in rural areas.
- The objective of providing safe water and basic sanitation to the entire population is supported by the National Housing Policy which aims to make decent housing available to all Namibians by also including ultra-low and low income households. The Shack Dwellers Federation of Namibia (SDFN), the Decentralised Build Together Programme (DBTP), NGOs and Community Based Organisations (CBO) provide plots and house loans to low income households, which are households with average earning up to about N$3,000 per month. Loans to lower middle income households with an average combined monthly income of between N$5,000 to N$9,759 are provided by the National Housing Enterprise (NHE). Loan applicants earning a monthly income exceeding N$9,759 but less than N$28,288 are serviced by the NHE as well as commercial banks, while households earning more than the latter amount are catered for by commercial banks. As Table 7.2 shows, loan applicants with income between N$3,000 and N$5,000 are not included in a house loan programme with the implication that lower middle income households are not eligible for loans. Hence they do not have the opportunity to acquire a plot or a house.
- A target of 300,000 houses is set to be built by 2030. Due to constraints in terms of human resources and finances this target is unlikely to be met.

TABLE 7.2: GAPS IN LOANS OFFERED

AVERAGE INCOME	MAXIMUM LOAN	POPULATION	MARKET SEGMENT	HOUSING LOAN PROVIDER
N$100	N$40,000	89,200	Low	SDFN & DBTP
N$3,000		92,917	Higher Low	
N$3,000	N$40,000	92,917	Lower middle	DBTP
N$3,000-5,000	N$6,000	55,750	gap	MRLGHRD
N$9,759	N$228,779	18,583	Higher middle	NHE
N$15,269	N$357,945	14,866	High	NHE
N$28,288	N$522,350	7,433	High	NHE, Commercial Banks

SOURCE: Adapted from Habitat Research and Development Centre (HDRC) (2008).
Please note that the requirement to participate in the DBTP, the income should not exceed N$ 3, 000 per month. The Ministry is currently busy addressing the gap between DBTP and the NHE (between N$ 3, 000-N$5, 000)

- Local authorities are not able to meet the demand for land and services, in particular for the low-income groups in informal settlements. The main reason for this can be found in financial constraints faced in developing virgin land. The set up of basic infrastructure such as sanitation and street lighting is very expensive and local authorities often do not have access to funds sufficient to develop the land. The situation is aggravated by a shortage in town and regional planners. These constraints make it difficult for local and regional government authorities to support the 2015 target set in terms of the NDP3 to build 300,000.
- The Ministry of Agriculture, Water and Forestry monitors water resources in terms of quality, utilisation and available reserves. Especially in terms of the Water Policy for Namibia, guidelines are provided on the use and management of available water resources.

MDG 8

DEVELOP GLOBAL PARTNERSHIP FOR DEVELOPMENT

The State of Namibia shall endeavour to ensure that in its international relations it adopts and maintains a policy of non-alignment; promotes international co-operation, peace and security; creates and maintains just and mutually beneficial relations among nations; fosters respect for international law and treaty obligations; encourages the settlement of international disputes by peaceful means.

Constitution of the Republic of Namibia, Art. 96

MDG 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

Namibia is an active participant in the international community of nations. The country is member of 46 international organisations and has diplomatic relations with most countries in the world. Namibia's engagement in Africa and Southern Africa is particularly pronounced. As a member of the African Union and of the Southern African Development Community (SADC), Namibia is a vocal advocate for greater African and Southern African regional co-operation and integration. Namibia's membership of the SADC Free Trade Area launched in August 2008 reflects this commitment. Namibia has signed the New Partnership for African Development (NEPAD) initiative. Namibia hosts the Secretariat of the Southern African Customs Union (SACU), the SADC Parliamentary Forum and the SADC Tribunal. The country has been successfully engaged in several peace-keeping missions, for example to Angola, Liberia and East-Timor.

Namibia's involvement in international and regional economic exchange and co-operation is intensive. An Economic Partnership Agreement (EPA) with the European Union is being negotiated in order to adhere to the World Trade Organisation rules. Namibia has concluded double taxation agreements with a number of important trading partner countries. Foreign direct investments are welcomed and are actively pursued by an investment code which offers a range of incentives to foreign investors. Companies from South Africa, Europe, North America and China lead the foreign investors. To strengthen African and international South-South co-operation, Namibia as part of SACU has concluded preferential trade agreements with some African, Asian and Latin American countries. Besides being a member of SACU, the country is part of the Common Monetary Area (CMA) together with Lesotho, South Africa and Swaziland.

Last but not least, Namibia considers the achievement of the Millennium Development Goals as one of the core targets of all her economic and social policies for the benefit of the Namibian people. This is well documented in the country's guiding document "Vision 2030". Moreover, the Government adopts a friendly stance towards Civic Organisations.

An indicator for the global partnership is the extent to which the population of a country is able to communicate internationally. Currently, 4.8% of the Namibian population are internet users, compared to 1% to 2% in most other African countries. However, in the neighbouring countries of Botswana and South Africa the rates are 4.3% and 11.6%, respectively. Cellular phone subscribers (16 years and older) account for 49% of the population though there is a considerable urban/rural divide. Around a third of all households currently possess a fixed telephone line.

Namibia's general orientations and policies, as mentioned above, are regarded as a contribution to global partnership, peace and prosperity. Furthermore, the fruitful relations with development partners and their commitments to the country are acknowledged as a valuable factor to accelerate Namibia's economic and social development. Namibia is also partner of large bilateral and multilateral development programmes which base the eligibility of countries on democracy and good governance. The increasing focus on budget and programme instead of project support signifies the trust of the development partners in Namibia's institutions.

The total volume of per capita official development assistance received by Namibia fluctuates greatly and is thus difficult to plan. The inflow of aid more than doubled during the first 10 years of Independence, before dropping significantly for three years. The year 2006 saw a strong increase of foreign assistance. The target of aid inflow has been met in most years and is likely to be met in the years to come, specifically when one looks at the figure for 2006. The per capita figure for 2007 (see Table 8.1) amounts to around 3% of GDP, which is low when compared with other African countries.

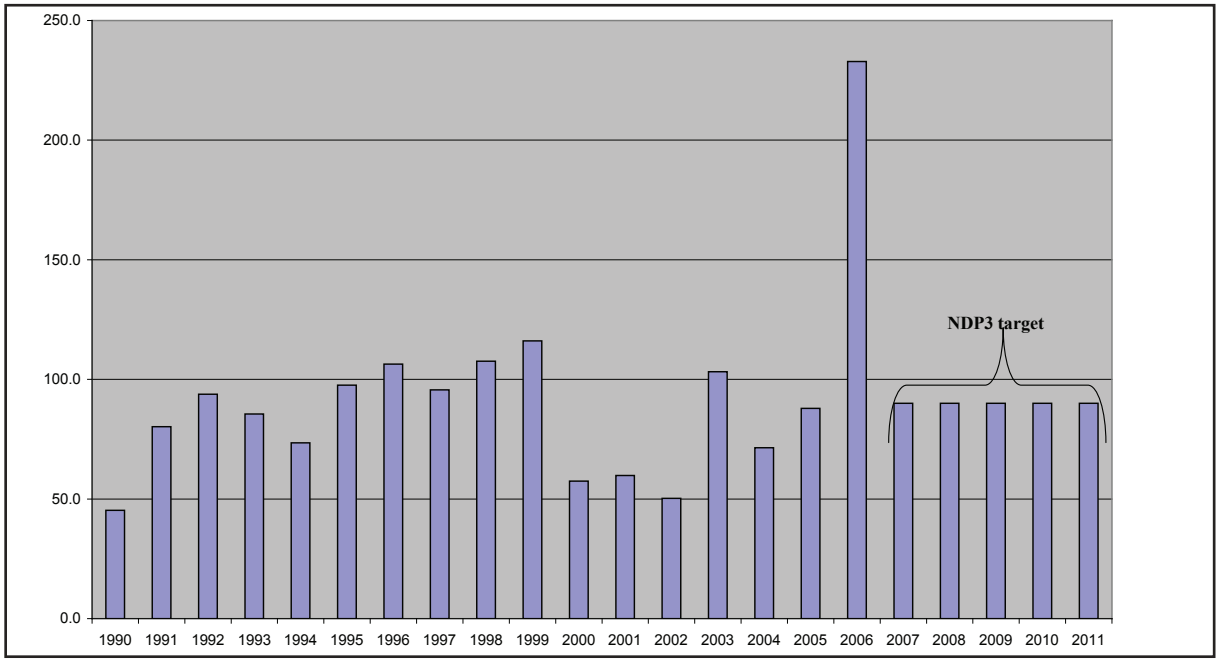
Moreover, access to concessional loans of the World Bank's International Development Agency (IDA) is

barred. The reason for this is Namibia's classification by the World Bank and the International Monetary Fund as a "lower middle income" as opposed to a "poor" country, and some development partners apply this characterisation similarly to their assistance. However, this measurement tool is based on a single criterion, namely annual GDP per capita – which, at around US$3,000, is indeed not low in international comparison. But this hides the challenges the country continues to face and which could not be easily reversed during the past 18 years of Independence.

A concern for Namibia is the sustainability of development programmes which have been started with the support of the development partners. Moreover, an efficient absorption of the inflowing funds needs increased national capacity for monitoring and evaluation.

It is not only assistance in the form of money and expertise that is needed. What is still relatively restricted is access to developed countries' markets. Without adequate access, the chance to develop and prove an ability to compete successfully in the international economic arena remains limited.

FIGURE 8.1 PER CAPITA OFFICIAL DEVELOPMENT ASSISTANCE TO NAMIBIA IN US$, 1990 – 2011 (TARGET)



SOURCES: UNDP, Development Cooperation Report Namibia, 2000; NPC database; NEPRU calculations.

REFERENCES

- Central Bureau of Statistics. (2008). A Review of Poverty and Inequality in Namibia. Windhoek: National Planning Commission.
- Central Bureau of Statistics. (2007). National Accounts 1996 – 2006. Windhoek: National Planning Commission.
- Central Bureau of Statistics. (2006). 2003/2004 Namibia Household Income & Expenditure Survey, Windhoek: Author.
- Central Bureau of Statistics. (1996). 1993/94 Namibia Household Income and Expenditure Survey, Windhoek: Author.
- Defino, D & Simmons, P.J. (1999). Infectious disease and economic growth: the case of tuberculosis. Heslington: University of York.
- Department of Women's Affairs. (1998). National Plan of Action on Gender. Windhoek: Author.
- Department of Women's Affairs. (1997). National Gender Policy. Windhoek: Author.
- Directorate of Primary Health Care (2005). Sexual and Reproductive Health in Namibia, Namibia Country Paper Presented to the Sub regional meeting on reproductive health for Southern African Countries, Windhoek 21 – 25 February 2005. Windhoek: Directorate Primary Health Care.
- Government of the Republic of Namibia. (2008a). Estimates of Revenue and Expenditure for the years 1 April 2008 – 31 March 2011.
- Government of the Republic of Namibia. (2008b). Medium Term Expenditure Framework for 2008/2009 to 2010/2011.
- Government of the Republic of Namibia. (2007a). Education and Training Sector Improvement Programme (ETSIP): Planning for a Learning Nation: Programme Document: Phase I (2006-2011).
- Government of the Republic of Namibia. (2007b). National Policy on HIV/AIDS. Windhoek: Author.
- Government of the Republic of Namibia. (2006). Children's Status Act. Windhoek: Author.
- Government of the Republic of Namibia. (2003). Combating of Domestic Violence Act (No. 4 of 2003). Windhoek: Author.
- Government of the Republic of Namibia. (2002). Education for All. National Plan of Action 2001-2015.
- Government of the Republic of Namibia. (2001). Education Act (No.16 of 2001). Windhoek: Author.
- Government of the Republic of Namibia. (2000a). Combating of Rape Act (No.8 of 2000). Windhoek: Author.
- Government of the Republic of Namibia. (1998). Affirmative Action (Employment) Act (No. 29 of 1998). Windhoek: Author.
- Government of the Republic of Namibia. (1996). Married Persons Equality Act (No. 1 of 1996). Windhoek: Author.
- Government of the Republic of Namibia & Unicef. (2006). Country Programme Action Plan 2006 – 2010.
- Inter-Ministerial Task Force on ECD. (1995). National Early Childhood Development Policy.
- Joint United Nations Programme on HIV/AIDS. (2008). 2008 Report on the global AIDS epidemic.

» Habitat Research and Development Centre of Namibia. Retrieved 7 October from http://www.interact.com.na/hrdc/index.htm.

» |Khaxas, E. (Ed.). (2008). We must choose life: Writings by Namibian women on culture, violence, HIV and Aids. Windhoek: Women's Leadership Centre.

» Levine, S. (2007). Trends in Human Development and Human Poverty in Namibia: Background paper to the Namibian Human Development Report. Windhoek: United Nations Development Programme.

» McCarthy, D., Wolf, H., & Wu, Yi. (1999). The growth costs of malaria.

» Mendelsohn. J. (2006). Farming Systems in Namibia. Windhoek: Research & Information Services of Namibia (RAISON).

» Ministry of Agriculture, Water, and Forestry. (2006). Annual Report 2006. Windhoek.

» Ministry of Education (2008a). Education Management Information System (EMIS): Education Statistics 2007. Unpublished Document.

» Ministry of Education. (2008b). Education Management Information System (EMIS): Education Statistics 2006. Windhoek: Author.

» Ministry of Education. (2007). Education Management Information System (EMIS): Education Statistics 2005. Windhoek: Author.

» Ministry of Education. (2006). Education Management Information System (EMIS): Education Statistics 2004. Windhoek: Author.

» Ministry of Education. (2005). Education Management Information System (EMIS): Education Statistics 2003. Windhoek: Author.

» Ministry of Basic Education and Culture. (1999). Education Management Information System (EMIS): Education Statistics 1998. Windhoek: Author.

» Ministry of Basic Education and Culture. (1998). Education Management Information System (EMIS): Education Statistics 1997. Windhoek: Author.

» Ministry of Basic Education and Culture. (1997). Education Management Information System (EMIS): Education Statistics 1996. Windhoek: Author.

» Ministry of Basic Education and Culture. (1996a). Education Management Information System (EMIS): Education Statistics 1995. Windhoek: Author.

» Ministry of Basic Education and Culture. (1996b). Education Management Information System (EMIS): 1993 School Statistics.. Windhoek: Author.

» Ministry of Basic Education and Culture. (1996c). Education Management Information System (EMIS): 1992 School Statistics. Windhoek: Author.

» Ministry of Basic Education and Culture. (1995). School Statistics – 1994. Windhoek: Author.

» Ministry of Basic Education and Culture. (1993). Toward Education for All; A Development Brief for Education: Culture and Training.

» Ministry of Basic Education, Sport and Culture. (2005). Education Management Information System (EMIS): Education Statistics 2002. Windhoek: Author.

» Ministry of Basic Education, Sport and Culture. (2002a). Education Management Information System (EMIS): Education Statistics 2001. Windhoek: Author.

» Ministry of Basic Education, Sport and Culture. (2002b). Education Management Information System (EMIS): Education Statistics 2000. Windhoek: Author.

» Ministry of Basic Education, Sport and Culture. (2002c). Education Management Information System (EMIS): Education Statistics 1999. Windhoek: Author.

» Ministry of Basic Education, Sport and Culture & the Ministry of Higher Education, Training and Employment Creation. (2003). HIV/AIDS for the Education Sector.

» Ministry of Finance (2008). The Government's Accountability Report for 2006/07. Windhoek.

» Ministry of Fisheries and Marine Resources. (year not stated). Annual Report 2005.

» Ministry of Gender Equality and Child Welfare (2007a). Ministerial Annual Report 2006. Windhoek.

» Ministry of Gender Equality and Child Welfare (2007b). National integrated early childhood development policy Namibia.

» Ministry of Gender Equality & Child Welfare. (2007c). Statistics on Men and Women in Management Positions in the Parastatals of Namibia.

» Ministry of Gender Equality & Child Welfare. (2006a). Statistics on Men and Women in Management Positions in the Private Sector of Namibia.

» Ministry of Gender Equality & Child Welfare. (2006b). Statistics on men and women in management positions in the Public Sector of Namibia.

» Ministry of Gender Equality & Child Welfare (2005). Women in Politics. Retrieved September 10, 2008 from www.mgecw.gov.na/

» Ministry of Health and Social Services. (2008a). Document provided by Doctor P. Uusiko. Unpublished Document.

» Ministry of Health and Social Services (2008b). Guidelines for the prevention of mother-to-child transmission of HIV. Windhoek: Author.

» Ministry of Health and Social Services (2008c). Health and Social Services Review. Draft 3.

» Ministry of Health and Social Services (2008d). Namibia Demographic and Health Survey 2006/2007. Windhoek: Unpublished Document.

» Ministry of Health and Social Services. (2008e). Report on the Estimation and Projection of the Impact of HIV/AIDS in Namibia and the Response Needed. Unpublished document.

» Ministry of Health and Social Services. (2008f). Sanitation Extracts. Ministry of Health and Social Services Review 2008. Unpublished Document.

» Ministry of Health and Social Services (2007a). National Policy on Infant and Young Child Feeding. Windhoek: Author.

» Ministry of Health and Social Services (2007b). Report of the 2006 National HIV Sentinel Survey. Windhoek: Author

» Ministry of Health and Social Services (2007c). Roadmap for accelerating the reduction of maternal and newborn morbidity and mortality. Windhoek: Author.

» Ministry of Health and Social Services. (2006/2007a). The national tuberculosis and leprosy control programme, annual report 2006/2007.

» Ministry of Health and Social Services (2006/2007b), United Nations General Assembly Special Session (UNGASS): Country Report: Reporting Period April 2006 – March 2007. Windhoek.

» Ministry of Health and Social Services (2006a). Report on Needs Assessment for emergency obstetric

care (EmOC). Windhoek: Author.

» Ministry of Health and Social Services. (2005a). National malaria policy. Windhoek: Author.

» Ministry of Health and Social Services. (2005b). PMTCT Annual Report. Period 1 April 2004 – 31 March 2005. Windhoek: Author.

» Ministry of Health and Social Services. (year not stated). The National Strategic Plan on Tuberculosis (TB), Medium Term Plan I (TB-MTP 1) 2004 – 2009.

» Ministry of Health and Social Services (2003). Namibia Demographic and Health Survey 2000. Windhoek: Author.

» Ministry of Health and Social Services, Family Care International & Unicef Namibia. (2002). Safe Motherhood & Adolescent Reproductive Health Needs Assessment in Namibia.

» Ministry of Health and Social Services. (2001a). National Policy for Reproductive Health. Windhoek: Author.

» Ministry of Health and Social Services. (2001b). Report of the 2000 National HIV Sentinel Survey. Windhoek: Author

» Ministry of Health and Social Services. (2000). National TB control programme (NTCP) Review, August 2000.

» Ministry of Health and Social Services (1998). Towards achieving Health and Social Well Being for Namibians: A Policy Framework. Windhoek: Author.

» Ministry of Health and Social Services. (1995). Report of the 1994 National HIV Sentinel Survey. Windhoek: Author

» Ministry of Health and Social Services. (1993). Namibia Demographic and Health Survey 1992. Windhoek: Author.

» Ministry of Labour and Social Welfare. (2007). Labour Statistics Bulletin 2005. Windhoek: Author

» Ministry of Labour and Social Welfare. (2006). Namibia Labour Force Survey 2004: Report of Analysis.

» Ministry of Labour and Social Welfare. (2001). The Namibia Labour Force Survey 1997: Final Report of Analysis. Windhoek: National Planning Comission.

» Ministry of Regional, Local Government and Housing and Rural Development (2008): Sustainable shelter for all. Unpublished Document.

» Ministry of Regional, Local Government and Housing and Rural Development (2007): Namibia "Build Together" National Housing Programme – Implementation Guidelines and Procedures. Fourth Revised Edition. Windhoek: Author.

» Ministry of Regional, Local Government and Housing and Rural Development. (2006). Report on Secure Land Tenure and Housing Conditions of low-income groups in Namibia. Windhoek: Author.

» Ministry of Regional, Local Government and Housing and Rural Development. (2002). National Plan of Action.

» Ministry of Women Affairs and Child Welfare (2004). National Policy on Orphans and Vulnerable Children.

» Ministry of Women Affairs & Child Welfare, Ministry of Health and Social Service, NGO Partners, & Unicef Namibia (2003). Integrated Early Childhood Development, A Baseline Study on Maternal &

Child care practices & resources in Namibia. Windhoek: Author.

» Makuwa, D. (2005). The SACMEQ II Project in Namibia. A Study of the Conditions of Schoolig and the Quality of Education, Harare: SACMEC.

» Namibia Nature Foundation. (2008). Namibia's Communal Conservancies: A review of Progress. Windhoek: Namibian Association of CBNRM Support Organisations (NASCO).

» National Planning Commission. (2008). Third National Development Plan (NDP3): 2007/2008-2011/12, Volume 1. Windhoek: Author & the Government of the Republic of Namibia.

» National Planning Commission. (2004). Namibia 2004 Millennium Development Goals. Windhoek: Government of the Republic of Namibia

» National Planning Commission. (2003). 2001 Population and Housing Census. Windhoek: Central Bureau of Statistics.

» National Planning Commission. (2001). Second National Development Plan (NDP2): 2001/2002-2005/2006. Windhoek: Author & The Government of the Republic of Namibia.

» National Planning Commission. (1994). 1991 Population and Housing Census. Windhoek: Central Bureau of Statistics.

» Namibian Economic Policy Research Unit. (2005). Namibia E-Access and Usage Index Survey. Windhoek.

» Office of the President. (2004). Namibia Vision 2030: Policy Framework for Long-term National Development. Windhoek: Author.

» Omulolu, O. (2008). Improving the Maternal and Child Health Services in Namibia. University of Ibadan.

» Republic of Namibia (1990). The Constitution of the Republic of Namibia.

» Rodgers, P.A. (2004). Nutrition in under five year old children in Namibia. Windhoek.

» Pakleppa, R. (2005). Report on Enquiry into socio-economic conditions and needs of some San communities in the Ohangwena and Otjokoto regions of northern Namibia. Commissioned by the Working Group of Indigenous Minorities in Southern Africa.

» Schade, K. & Naimhwaka, E. (2004). Public Expenditure Tracking Survey (PETS) and Quantitative Service Delivery Survey (QSDS): The Education Sector. Windhoek: NEPRU.

» Southern African Research and Documentation Centre & University of Namibia. (2005). Beyond Inequalities 2005: Women in Namibia. Windhoek and Harare: Authors.

» Telecom Namibia. (2007). Annual Report 2005/06, Windhoek: Author.

» UNESCO Institute for Statistics. (2007). Global Education Digest 2007. Comparing Education Statistics Across the World. Quebec: Author.

» United Nations website for the MDG indicators. Data retrieved September 12, 2008 from http://unstats.un.org/unsd/mdg/

» United Nations Development Program. (2008). United Nations development Reports 2007 /2008.

» United Nations Development Program. (2007). Human Development Report 2007/08. New York. Retrieved 10 September 2008 from http://unstats.un.org/unsd/mdg/.

» Visser, K. (2005). A study to assess the school feeding coverage in Namibia's regions and cost its targeted expansion based on defining efficiency measures. Windhoek: Oshipala Trust

» World Bank (2005). 2005 World Development Indicators. Washington.

» World Bank. (2000). World Development Report 2000/01: Attacking Poverty. Washington.

» World Health Organisation. (2002). A Guideline for Tuberculosis Treatment Supporters, Geneva: Author

» World Travel and Tourism Council (2008). The 2008 Travel & Tourism Economic Research.

NATIONAL PLANNING COMMISSION

Private Bag 13356
Government Office Park
Luther Street
Telephone +264 61 2834111
Fax +264 61 226501

REPUBLIC OF NAMIBIA

NATIONAL PLANNING COMMISSION

Private Bag 13356
Government Office Park
Luther Street
Telephone +264 61 2834111
Fax +264 61 226501

REPUBLIC OF NAMIBIA