Namibia

KEY FACTS

Joined Commonwealth:	**1990**
Population:	**2,324,000 (2011)**
GDP per capita growth:	**1.9% p.a. 1990–2011**
GNI per capita:	**US$4,700 (2011)**
UN HDI 2011 ranking:	**120 out of 187 countries**
Life expectancy:	**62 years (2011)**
Under-five mortality rate (per 1,000 live births):	**42 (2011)**
Maternal mortality ratio – reported (per 100,000 live births):	**450 (2007–11)**
Maternal mortality ratio – adjusted (per 100,000 live births):	**200 (2010)**
Largest contribution to mortality:	**Communicable diseases, maternal, perinatal and nutritional conditions**
HIV prevalence rate for people aged 15–49 years:	**13% (2011)**
Government health expenditure:	**4% of GDP (2010)**

General information

Namibia in south-west Africa is one of the driest and most sparsely populated countries on Earth. It is bounded by the South Atlantic Ocean on the west, Angola to the north, Botswana to the east and South Africa to the south. The Caprivi Strip, a narrow extension of land in the extreme north-east, connects it to Zambia. Namibia comprises 13 regions: (from south to north) Karas, Hardap, Khomas, Erongo, Omaheke, Otjozondjupa, Kunene, Oshikoto, Okavango, Omusati, Oshana, Caprivi and Ohangwena.

Climate: Arid, semi-arid and sub-humid. Prolonged periods of drought are characteristic. There is little precipitation apart from rare thunderstorms in the arid zone of the Namib Desert coast, with rainfall rising to 600 mm or more in the sub-humid north-eastern border with Angola and the Caprivi Strip. Rain falls in summer (October–April). The cold Benguela current gives the Namib Desert thick coastal fog.

Environment: The most significant environmental issues are the scarcity of natural freshwater resources and desertification.

Population: 2,324,000 (2011); density is extremely low overall and 38% lives in urban areas; growth 2.4% p.a. 1990–2011; birth rate 26 per 1,000 people (43 in 1970); life expectancy 62 years (53 in 1970 and 61 in 1990).

The Ovambo and Kavango together constitute about 60% of the total population. Other groups are the Herero, Damara, Nama and the Caprivians. The San (Bushmen), who are among the world's oldest surviving hunter-gatherers, have lived in this territory for more than 11,000 years. The Basters, who settled in Rehoboth in 1870, stem from marriages between white farmers and Khoi mothers in the Cape. The 'Cape Coloureds', immigrants from South Africa, tend to live in the urban areas. Of the white group of approximately 90,000, about 50% are of South African and 25% of German ancestry, about 20% is Afrikaners with a small minority of UK ancestry.

Economy: Namibia is classified as an upper-middle-income economy by the World Bank.

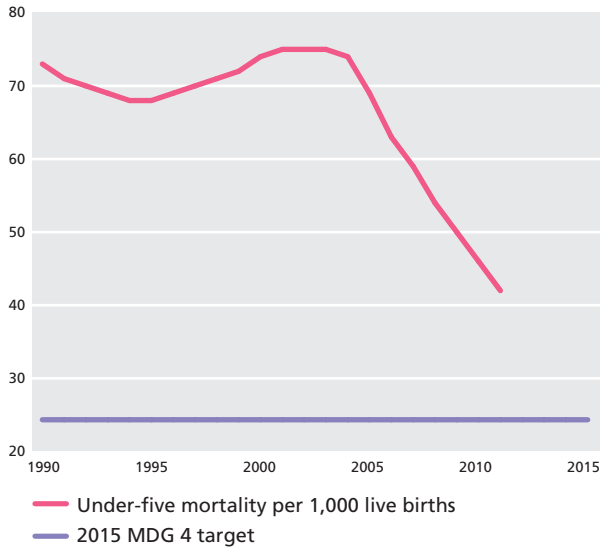
Mental health

Morbidity: There is a lack of data concerning the most commonly diagnosed mental illness in Namibia. However, studies have shown links between mental illness in the country and HIV/AIDS: an estimated one-third of all those who are HIV positive have exhibited symptoms of depression. Neuropsychiatric disorders contributed an estimated 6.9% of the global burden of disease in 2008.

Health systems: The most recent Act relating to mental health in Namibia is the Mental Health Act (1973), and mental health receives specific mention in general health policy. There is an officially approved mental health policy (2005) and plan (2009). In

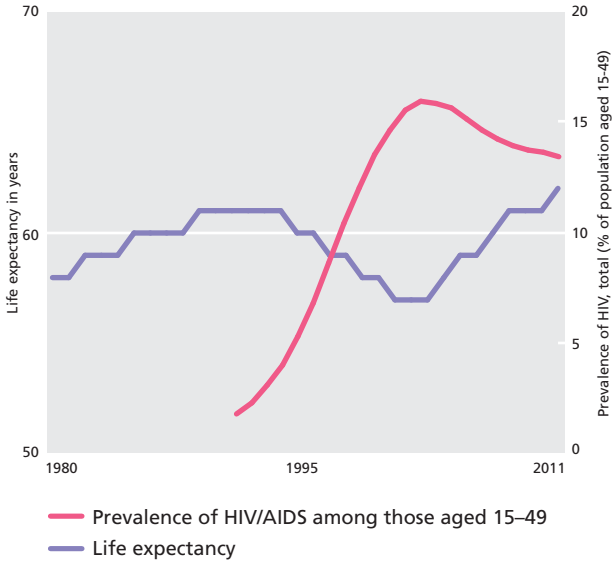
GRAPH 1

Under-five mortality



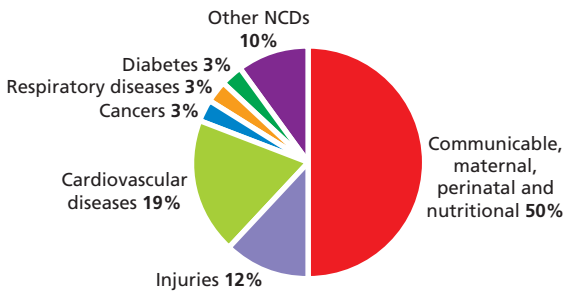
GRAPH 2

Life expectancy and HIV/AIDS



GRAPH 3

Mortality by cause of death (% of all deaths), 2008



2011 the Mental Health Act was being updated through a draft bill that had yet to be finalised at the time of writing. Mental health does not have a separate budget from general health expenditures by the government.

There is widespread stigmatisation and a traditional understanding of mental illness in Namibia. This coupled with the vast land area and a concentration of healthcare provision in the north of the country means that access to medical mental health care, particularly for those in rural communities, is poor. Between 2006 and 2011, the majority of primary healthcare doctors and nurses had not received official in-service training in mental health.

There are 0.1 mental health outpatient facilities (of which half were reserved for children and adolescents), 8.3 psychiatric beds in general hospitals (of which approximately one in eight were reserved for children and adolescents), 0.1 community residential facilities per 100,000 people (2011). There were no community residential facilities, psychiatric hospitals or beds in psychiatric hospitals.

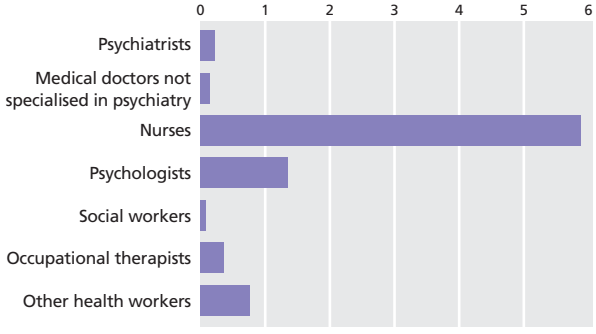
Health

Child and maternal health: Infant mortality in Namibia was 30 deaths per 1,000 live births in 2011, with an under-five mortality rate of 42 deaths per 1,000 live births. As shown in Graph 1, while the under-five mortality figure has fallen since the early 1990s, it is not yet in line with the target of 24 deaths per 1,000 live births, as defined by Millennium Development Goal 4 (MDG 4). In 2010 the three most prominent causes of death for children below the age of five years were prematurity (19%), HIV/AIDS (14%) and pneumonia (12%). Other contributory causes were birth asphyxia (11%), congenital anomalies (9%) and diarrhoea (5%). In the period 2007–11, Namibia reported a maternal mortality ratio of 450 deaths per 100,000 live births (this figure was estimated at 200 deaths per 100,000 live births by UN agencies/World Bank in 2010).

Burden of disease: Communicable diseases together with maternal, perinatal and nutritional conditions in Namibia accounted for an estimated 50% of all mortality in 2008. The prevalence of HIV in Namibia, as a percentage of population aged 15–49 years, was 13% in 2011. HIV prevalence has fallen slightly since 2002.

GRAPH 4

Health professionals working in the mental health sector per 100,000 of the population



There were 556 reported cases of malaria in 2010. There was a dramatic overall reduction in confirmed cases of malaria and deaths from the disease in the period 2001–11. There has also been a notable decline in estimated incidence of, and estimated mortality (when mortality data excludes cases co-morbid with HIV) from, tuberculosis (TB) in the period 2003–10, although both figures are presently higher than they were in 1990. There were 4,076 reported cases of measles, 159 reported cases of cholera and 27 reported cases of rubella in 2009.

The most prevalent non-communicable diseases (NCDs) in Namibia are cardiovascular diseases, which accounted for 38% of total deaths across all age groups in 2008. Cancers, non-communicable variants of respiratory diseases and diabetes each contributed 3% to total mortality (2008).

Health systems: Namibia's public spending on health was 4% of GDP in 2010, equivalent to US$361 per capita. In the most recent survey conducted between 1997 and 2010 there were 37 medical doctors and 278 nurses and midwives per 100,000 people. Additionally, 81% of births are attended by qualified health staff (2007–12), and 74% of one-year-olds are immunised with one dose of measles (2011). In 2010 93% of the Namibian population had access to improved water sources, and 32% had access to adequate sanitation facilities. In the most recent survey conducted in the period 2000–11, Namibia had 18 pharmaceutical personnel per 100,000 people.

The country has around 50 public and private hospitals, the majority of which are found in the north of the country and in the larger towns where most of the population lives (2009). Windhoek Central Hospital is Namibia's largest referral hospital. While there is some local pharmaceutical manufacturing, this is largely small-scale, and the majority of the country's pharmaceutical requirements are imported.

Progress towards the MDGs: Namibia is currently working towards achieving the Millennium Development Goals. To achieve the targets for the reduction of child mortality, which forms MDG 4, Namibia should reduce under-five deaths per 1,000 live births to 24, and increase measles immunisation to 100% by 2015. At present under-five mortality is approximately 42 deaths per 1,000 live births and measles immunisation is 74%, which suggests that there is some way to go if the country is to achieve these targets by 2015.

The global MDG 5 target for maternal health is to reduce the number of women who die in pregnancy and childbirth by three-quarters between 1990 and 2015. When applying this target to Namibia, the maternal mortality should fall to 50 cases per 100,000 live births. In the period 2007–11 Namibia had reported a maternal mortality ratio of 450 deaths per 100,000 live births (this figure was estimated at 200 deaths per 100,000 live births by UN agencies/World Bank in 2010). According to this data, Namibia is very unlikely to meet the maternal mortality goal by 2015. MDG 5 also stipulates that 100% of births must be attended by a skilled health professional. In the period 2007–12, this figure stood at 81%, and so dramatic progress must be made if this target is to be achieved.

MDG 6 aims for a reduction in the prevalence of HIV, malaria and other diseases. Namibia has demonstrated a decline in the percentage of the population with HIV, although the figure remains very high. Deaths from malaria declined, while estimated rate of mortality from TB (when mortality data excludes cases co-morbid with HIV), is approximately double that of 1990. With good progress, the country can achieve some of the targets set by MDG 6.

For definitions, sources and explanations on the Millennium Development Goals see page 355.

Further information

Ministry of Health and Social Services: www.mhss.gov.na

Commonwealth Health Online: www.commonwealthhealth.org/health/africa/namibia