A different kind of family

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CHAPTER 6

Health

Article 26

Nurses at the Outjo hospital in action. *Photo: David Mutani Xoagub*

KEY POINTS

- Namibia's SGDI for the health sector is 68%, which places the country at number five out of the 15 SADC countries in the region.
- Namibia is among the SADC countries with the most comprehensive health systems.
- Citizens were slightly more critical rating the country 55% based on their perceptions of the country's progress towards meeting the health targets in the SADC Gender Protocol set for 2015. This is slightly lower than the 56% regional average.
- The maternal mortality rate for Namibia is 449 deaths per 100 000 live births.
- About 46% of the population access contraception.
- Abortion is illegal unless on specific medical grounds.
- Skilled personnel attend to 81% of births.
- On average, there is 32% total coverage of sanitation facilities in rural and urban areas. However, the gap between rural sanitation coverage - 17% and urban coverage 57% is worrisome.

Table 6.1: CSC scores on health		
	SGDI	*CSC*
Scores	68%	55%
Ranks	5	12

Table 6.1 shows that at 68%, the SGDI ranks the country fifth in the region. The SGDI measures the percentage of women aged 15 to 49 years who use a modern form of contraception; the maternal mortality ratio and births attended by trained midwives or nurses.

The CSC score of 55% is considerably lower than the SGDI and is one of the lowest in the region at number 12. Government is making efforts to improve the health of mothers, young children and adolescents. Some initiatives have begun to target men more successfully too. However, citizens probably took into account some of the challenges. For example, the SGDI does not take into account that abortion remains illegal in Namibia. Authorities permit abortion only on certain medical grounds. Two practitioners must approve abortion after rape or incest in writing. The written approval can take time leaving the girl and women more vulnerable to unsafe abortions.

It is something to ponder on that women in rural areas travel long distances to access health services. Rebecca and Bertha of Tsumeb village discuss issues affecting them. *Photo: Susan Tolmay*

Also, many women are unaware and do not have access to the female condom, particularly in the peri-urban and rural areas. It is expensive too.

Background

The Government is committed to improving maternal health, as shown in Vision 2030, the third National Development Plan and practical guidelines such as the Roadmap to Maternal, Newborn and Child Health.[1]

The Government places maternal and child health at the centre of sustainable development of the nation. A holistic approach to health management has been adopted with multi-sectoral involvement to create an environment in which the right to universal health is ensured for every woman and child.[2]

The Ministry of Health and Social Services National Health Programme is aimed at promoting, protecting and improving the health of families and individuals with special programmes designed for women and children.

The Government provides pre-natal care, deliveries and postnatal care services through its Safe Motherhood programme. These services are provided at all health facilities countrywide. Government provides mothers with antenatal care services during pregnancy, safe midwifery, delivery services during labour and post natal care services.

Sexual and reproductive health

The Protocol provides for state parties to by 2015, adopt and implement legislative frameworks, policies, programmes and services to enhance gender sensitive, appropriate and affordable quality health care; reduce the maternal mortality ratio by 75% and ensure the provision of hygiene and sanitary facilities.

[1] World Health Organisation. (2009). *Maternal and child health in Namibia*. Second edition. Namibia: World Health Organisation. At page 29.
[2] Ministry of Health and Social Service. (2008). *Health and social services system review*. Windhoek, Namibia: Ministry of Health and Social Services. At page 12.

Table 6.2: Key sexual, reproductive and health indicators	
Indicators	**Country statistics**
Current maternal mortality rate (out of 100 000)	449
% Births attended by Skilled Personnel	81%
% Contraceptive use among sexually active women 20-24 (in case of Namibia is 15-24 men and women)	46%
Total coverage of sanitation facilities	32%
Urban coverage	57%
Rural coverage	17%

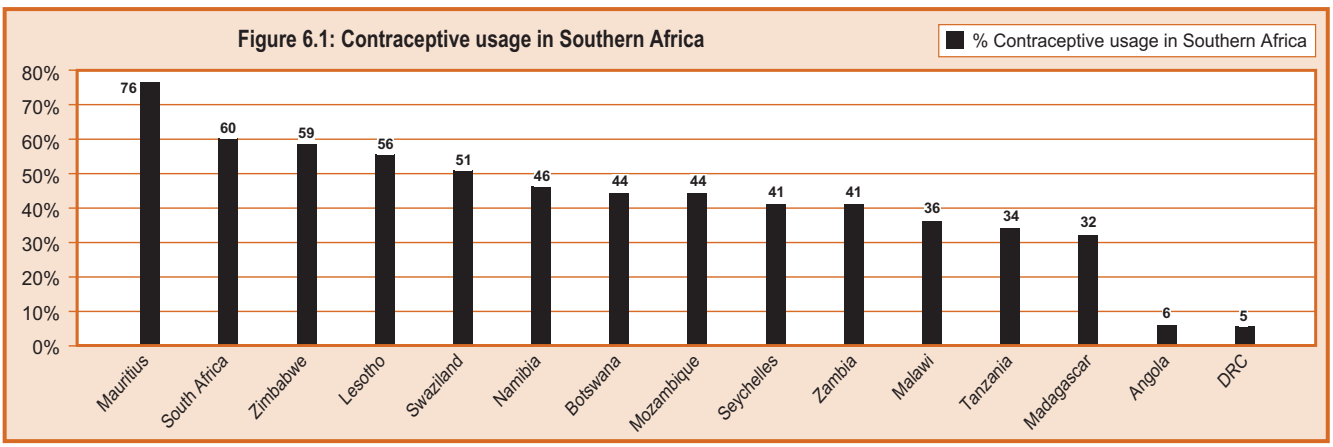
Source: 2012 SADC Gender Protocol Barometer.

Maternal mortality has risen from 271 out of 100,000 in 2000 to 449 out of 100 000 in 2006, despite high ante natal coverage (95.6%) and almost 81% of births being attended by a skilled professional. Namibia now has 44 health centres (an increase of seven), 265 clinics (an increase of 19) and 1150 mobile clinics (no mobile clinics were previously reported) since the second and third MDG report.[3] The mobile clinics are of particular importance in ensuring that women in rural areas have access to healthcare. However the average distance to a fixed government health facility is 73.5 minutes. The mean distance in urban areas is 24.6 minutes, and the mean distance in rural areas is 114.4 minutes.[4]

The 2006-2007 Demographic and Health Survey reports that 70.4% of women report at least one of seven specified problems accessing healthcare services: (1) getting permission to go for treatment; (2) getting money for treatment; (3) distance to a health facility; (4) having to take transport; (5) not wanting to go alone; (6) concern that no female service provider will be available; and (7) concerned that no service provider will be available at all.[5]

Nurses attending to a baby in an infant incubator. *Photo: David Mutani Xoagub*

Family planning and contraceptive Usage



Source: SADC Gender Protocol Barometer, 2012.

[3] Ministry of Health and Social Services. (2008). *Namibia Demographic and Health Survey 2006-2007*. Windhoek, Namibia: Ministry of Health and Social Services. At page 3.
[4] Ministry of Health and Social Services. (2008). *Namibia Demographic and Health Survey 2006-2007*. Windhoek, Namibia: Ministry of Health and Social Services. At page 242.
[5] Ibid at page 128.

As highlighted by Figure 6.1 Namibia ranks six in SADC, with only 46 % of the population using contraception. Knowledge of at least one family planning method continues to be nearly universal (98.3% of women know of at least one method of contraception, an increase from 97%).[6] A total of 65.7% of sexually active women use a form of modern contraception.[7]

The percentage of men involved in family planning campaigns is rising. On family planning, there is 81% of condom use. The male condom is the contraceptive method used the most and profile of the users is aged between 15-24 yrs and beyond.

Contraceptive campaigns do include information on the female condom, namely the femidom. In 2000 an NGO, Women's Action for Development (WAD) selected some women from some regions to test the femidom. Although there were reservations about the usage, many agreed to make use of it.

The Government distributed 30,314,800 condoms and 1,162,000 femidoms during the 2008-2009 financial year. National Social Marketing Programme (NASOMA) also distributed 1,595,277 condoms and 19,446 femidoms.[8]

Education on family planning has been included in Safe Motherhood programmes (discussed below). The importance of family planning and sex education has also been recognised in the Ministry of Education policy for the prevention and management of learner pregnancy.

Maternal health

Research shows that approximately 95% of women receive antenatal care from a skilled service provider, an increase from 91% as previously reported. The greatest improvements have been seen in the Omaheke (19 percentage points) and Kavango and Caprivi regions (10 percentage points).

Although the number of women accessing healthcare in rural and urban areas is similar (96.1% and 93.4% respectively), the type of service accessed differs as 27% of mothers in urban areas receive antenatal care from a doctor compared with 7% of women in rural areas. However whilst 69% of mothers receive antenatal care from nurses and midwives in urban areas, 86% of women in rural areas receive such care from nurses and midwives.

Access to antenatal care has been correlated to education - 15% of women without education fail to access antenatal care compared with only 4% of women with education.[9]

Women make their first antenatal visit in either their first or second trimesters (32.6% and 38.3% respectively). A slight improvement in the timing of visits is seen since 2000 with 71% of women receiving antenatal care before six months compared with 69% of women in 2000. Seventy percent of women make the WHO-recommended four antenatal visits.[10]

The percentage of women receiving assisted deliveries by trained personnel has risen from 75% in 2000 to 81.4% in 2006-07. Postnatal services were provided to 65% of women within two days of birth. Approximately 20% of women did not receive any post-natal care.[11]

Factors and difficulties in accessing maternal health

Whilst free maternal healthcare is available, only 11.7% of women do not pay for the delivery of their child.[12]

Immunisation against communicable and the killer diseases before getting pregnant is one way of combating maternal deaths.

Photo: Laurentia Golley

Although access to maternal healthcare has increased, the maternal mortality rate has also risen from 271 out of 100,000 in 2000 to 449 out of 100 000 in 2006. However the data must be viewed with caution due to the small sample size (the data has large sampling errors as the 95 percent confidence intervals indicate that the maternal mortality ratio varies from 341 to 557). Despite this caveat, the confidence intervals between the 2000 and 2006-7 data do not overlap thus indicating with reasonable confidence that maternal mortality has risen.[13] The MoHSS conducted a needs assessment for

6 Ibid at 54.
7 Ibid at 58.
8 Directorate of Special Programmes. (2009). *Progress report on the third medium term plan on HIV/AIDS*. Windhoek, Namibia: Ministry of Health and Social Services. At pages viii-ix.
9 Ibid at 115-117.
10 Ibid at 118-119.
11 Ibid at 123-124.
12 Ibid at 131.
13 Ibid at 113.

emergency obstetrics care in 2006. The report concluded that there are insufficient emergency care facilities available. The distribution of current services is also inequitable across the country.

Reports also suggest that associated conditions, such as HIV and malaria must be addressed as HIV positive mothers are more susceptible to malaria, tuberculosis and other diseases due to immunodeficiency and these diseases contribute to the increase in maternal mortality.[14]

UNICEF has recommended more training for birth assistants, a more equitable distribution of trained staff between urban and rural areas, and incentives for healthcare professionals to work in the public rather than private sector.[15] As many people in Namibia live in poor socio-economic conditions, unemployment and hunger can also have adverse effects on the weakened mothers.[16]

Health and Social Services System review

In 2008 the Ministry of Health and Social Services conducted a Health and Social Services System review. The review recommends the roll out of the road map for reducing maternal mortality and improving newborn health. This includes conducting a maternal death audit and improving data recording, scaling up the availability of emergency obstetrics care, antenatal clinic attendance and the prevention of mother to child HIV transmission, and promoting family planning education, including a focus on reducing teenage pregnancies.[17]

Termination of Pregnancy

Abortion in Namibia is illegal under the Abortion and Sterilisation Act of South Africa (1975), which Namibia inherited at the time of Independence from South Africa in March 1990.

Abortions are allowed only when continuing the pregnancy will "endanger the woman's life or constitute a serious threat to her physical or mental health or there must be a serious risk that the child to be born will suffer from a physical or mental defect so as to be irreparably seriously handicapped. The act also allows for the termination of a pregnancy in cases of rape or incest. In addition to the woman's doctor, two other doctors are required to certify the existence of grounds for an abortion and the operation must be performed by a medical practitioner in a State hospital or an approved medical facility. Supporting statement by government: (Namibia).

In a statement at the 1994 International Conference on Population and Development in Cairo, then Minister of Health and Social Services Nicky Iyambo stated that, "On the question of abortion, the position of Namibia is that it can only be performed under strict medical supervision within the confines of the laws, which state that consent to abortion can only be given in cases of rape, incest and when the life of the mother is in danger. Mr. President, ladies and gentlemen it must be clearly understood that Namibia does not promote abortion as a means of family planning but as a public health issue."

Namibia has had some debates and campaigns on the termination of pregnancy. Sister Namibia, a women rights feminist organization, lobbied for safe abortions in Namibia. It was tabled in National Assembly but voted against by the majority of members. This vote was based on the grounds of religion and certain cultures.

Sanitation

The SADC Gender Protocol requires that by 2015 member states ensure the provision of hygiene and sanitary facilities and nutritional needs of women, including women in prison.

The provision of sanitation and hygiene facilities is integral to improving women's health throughout the region. Poor sanitation results in increased spread of communicable diseases such as tuberculosis and malaria which women are particularly vulnerable to.

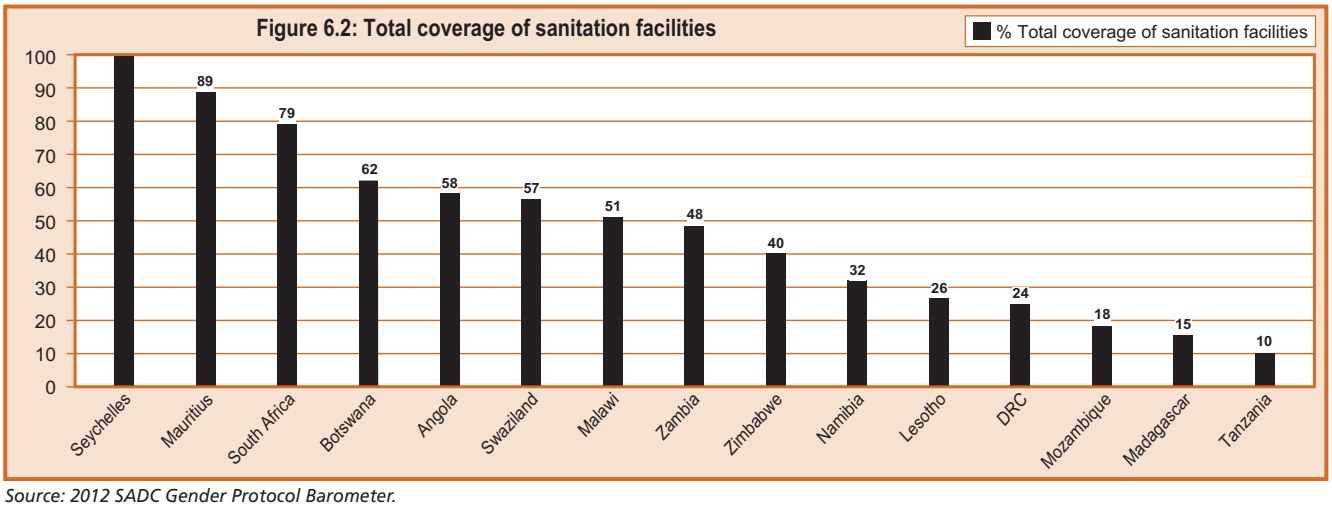
Furthermore, menstruation, pregnancy, and post-natal care become increasingly difficult for women without proper hygiene and sanitary facilities, as does caring for family and community members living with HIV. According to the World Health Organization, almost

[14] Ministry of Health and Social Services. (2006). *Report on needs assessment for emergency obstetrics care. Windhoek: Ministry of Health and Social Services*. Windhoek, Namibia: Ministry of Health and Social Services. At page 87 Directorate of Special Programmes. (2009). *Progress report on the third medium term plan on HIV/AIDS*. Windhoek, Namibia: Ministry of Health and Social Services. At page xi.
[15] UNICEF. (2009). *A time of joy, a time of challenge*. The health of mothers and newborns in Namibia. Windhoek, Namibia: UNICEF. At page 7.
[16] National Planning Commission. (2008). *Second Millennium Development Goals Report*. Namibia. Windhoek, Namibia: National Planning Commission. At page 29.
[17] Ibid at 13.

one tenth of all global deaths can be avoided by providing clean drinking water, better sanitation and improving water resources management to provide reduce incidence of water-borne diseases and cases of accidental drowning.

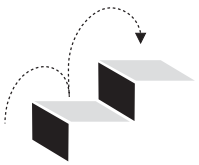
Household sanitation is everyone's responsibility, but the reality is that women, especially those in rural areas, bear a disproportionate burden of household responsibilities. Tasks such as cooking, cleaning, care giving and caring for children are easier where there is running water. Inadequate sanitation also impacts on women and girls' personal safety. Women's risk of experiencing rape and sexual assault are reduced when toilets and water supplies are located close to home, and where they do not have to leave their homes at night to access these. Women thus have a vested interest in ensuring that there are developments in sanitation in their countries, and their energies should be harnessed to implement national and community projects to improve sanitation. Although providing hygiene and sanitation facilities are provisions of the protocol, the developments have been slow.

Improved coverage of sanitation facilities will lead to a healthy nation. *Photo: Trevor Davies*



Source: 2012 SADC Gender Protocol Barometer.

Figure 6.2 shows that overall the coverage of sanitation facilities in Namibia is 32%. On closer analysis, rural coverage is 17% compared to 57% urban coverage of sanitation facilities. There is a need to accelerate efforts by putting in human, financial and technical resources to improve the facilities if the country is going to meet the targets of the SADC Gender Protocol by 2015.



Next steps

- Promote a robust public debate and advocacy for a review of current legislation on abortion.
- The government needs to continue to encourage men to be more involved in reproductive health.
- An increase of emergency obstetrics care as a means to reduce the current Martenal mortality of 449 per 100 000 live births
- Improved training for birth assistants and a more equitable distributation of trained staff between urban and rural areas. This could include an introduction of incentives for healthcare professional to work in the public rather than private sector.
- Mobilise resources to improve coverage of sanitation facilities particularly in rural areas.