Republic of Namibia
Ministry of Health & Social Sevices

GLOBAL FINANCING FACILITY

Countdown to 2030
Women's Children's & Adolescent's Health

African Population and Health Research Center
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2026

# NAMIBIA

# SYNTHESIS REPORT

## Analysis of Reproductive, Maternal, Newborn, Child and Adolescent Health Indicators for 2020-2025


**Countdown to 2030 in partnership with Namibia`s Ministry of Health, Global Financing Facility, WHO, WAHO & UNICEF**


## Team Members

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# KEY FINDINGS

## 1. Health Facility Data Quality Assessment: Numerators and Denominators

**NUMERATORS:** Routinely reported health facility data are an important data source for health indicators. The data are reported by health facilities on events such as immunizations given, or live births attended. As with any data, quality is an issue. Data are assessed for completeness of reporting by health facilities, extreme outliers and internal consistency. Appropriate adjustments are made to the data before use to compute statistics.

**Summary of reported health facility data quality, DHIS2, 2020-2025**

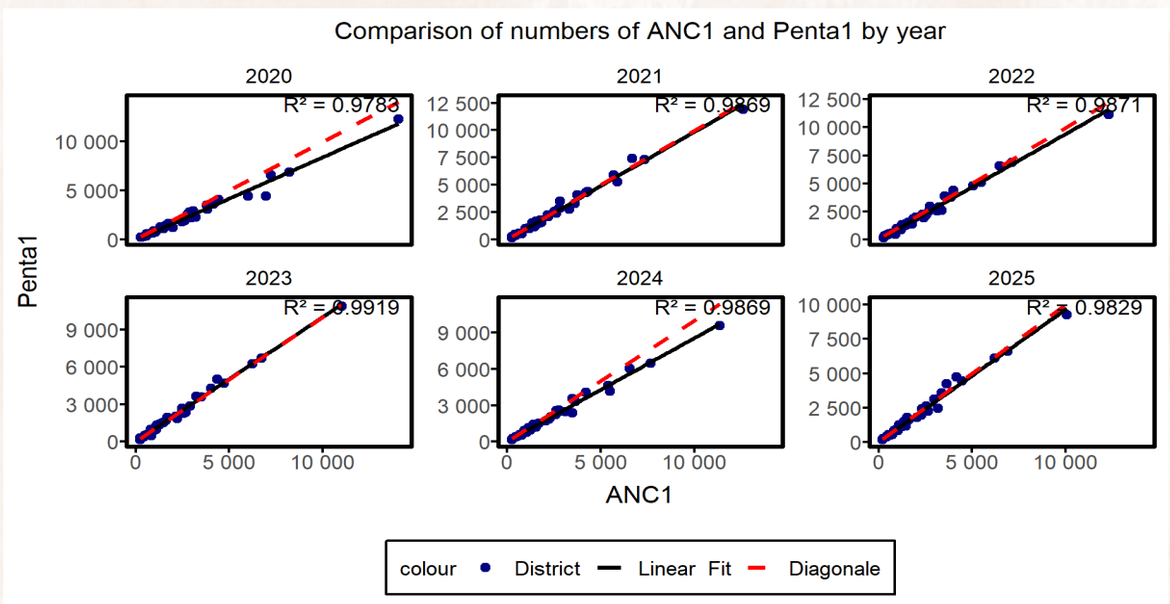
| | Data Quality Metrics | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|---|---|---|
| **1. Completeness of monthly facility reporting (mean of ANC, delivery, immunization)** | | | | | | | |
| 1a | % of expected monthly facility reports (national) | 89 | 92 | 93 | 95 | 97 | 97 |
| 1b | % of districts with completeness of facility reporting >= 90 | 68 | 75 | 79 | 83 | 94 | 89 |
| 1c | % of districts with no missing values for the 4 forms | 83 | 85 | 85 | 85 | 85 | 85 |
| **2. Extreme outliers (mean of ANC, delivery, immunization)** | | | | | | | |
| 2a | % of monthly values that are not extreme outliers (national) | 100 | 100 | 99 | 100 | 100 | 99 |
| 2b | % of districts with no extreme outliers in the year | 87 | 90 | 87 | 91 | 90 | 86 |
| **3. Consistency of annual reporting** | | | | | | | |
| 3a | Ratio anc1/penta1 | 1.21 | 1.03 | 1.08 | 0.99 | 1.16 | 1.03 |
| 3b | Ratio penta1/penta3 | 1.09 | 1.07 | 1.07 | 1.06 | 1.08 | 1.04 |
| 3c | % district with anc1/penta1 in expected ranged | 89 | 59 | 81 | 41 | 92 | 65 |
| 3d | % district with penta1/penta3 in expected ranged | 70 | 76 | 70 | 78 | 78 | 65 |
| **4** | **Annual data quality score** | **84** | **82** | **85** | **82** | **91** | **84** |

### Interpretations

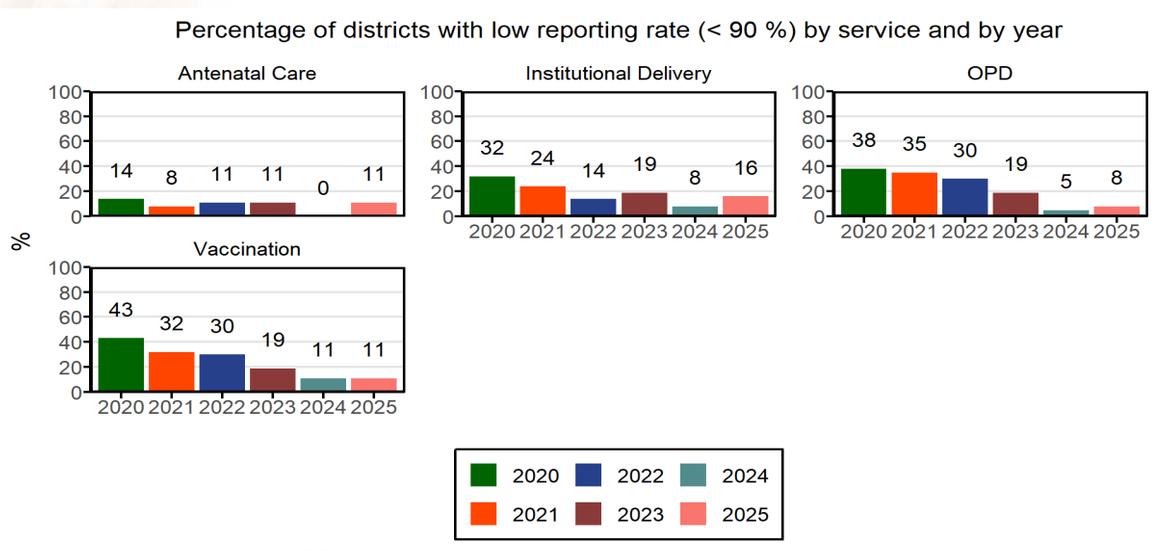
- The annual data-quality score indicates generally good with scores from 82% to 91% in 2020 and 2025 respectively. Data quality improved to its highest level in 2024 (91%), but declined to 84% in 2025
- The decline in 2025 was linked to fewer districts achieving at least 90% reporting completeness, more districts with outliers, and lower consistency for both ANC1/Penta1 and Penta1/Penta3
- Is there a data quality pattern by year for which there is an explanation? Due to system outage, high staff turnover leads to late and sometimes no reports
- Engela, Okongo and Opuwo have the lowest completeness rates over the years

- The main concern appears to be consistency across ANC, delivery and immunization reporting, rather than national completeness the adjustment value was K adjusted to 0.25.
- There is overall consistency at national level. However, district-level consistency was weak and unstable: only 41% of districts were within the expected range in 2023 and **65% in 2025 this could be due to population movement they attend ANC at one facility and go for immunization in another districts.

Numerator: Data quality appears strongest in 2021, 2022, 2023 and 2025, where the fitted line closely follows the diagonal, larger deviations are visible in Khomas and Oshana Region.

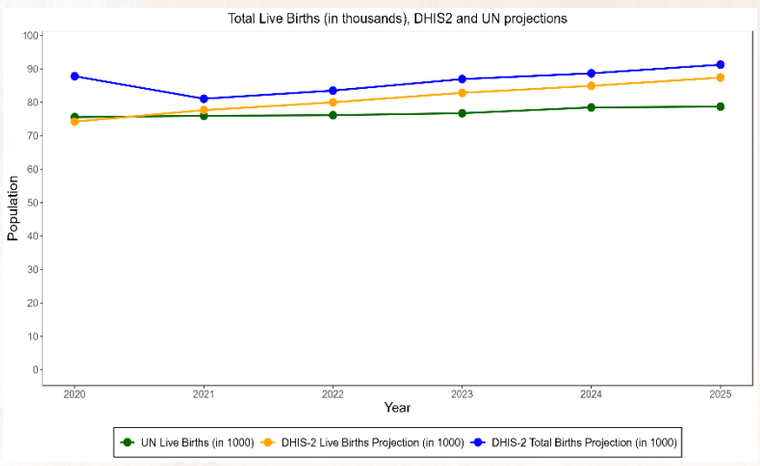



Numerator: facility data quality - example 2 Explain the observation on data quality (one bullet)

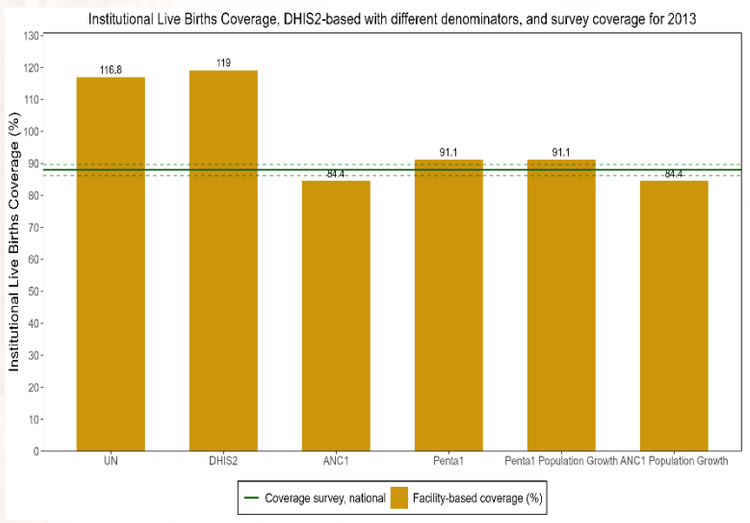



**DENOMINATORS:** Service coverage is defined as the population who received the service (numerator) divided by the population who need the services: (the denominator). We test four options for denominator measures using institutional live births and Pent-3 immunization coverage (Figures 2c and 2d). The quality of the population projections in DHIS2 is assessed through consistency over time and comparison with the UN projections. Two denominators are also derived using near universal service such as ANC-1 and Penta-1. The most plausible is identified for use to generate other statistics.

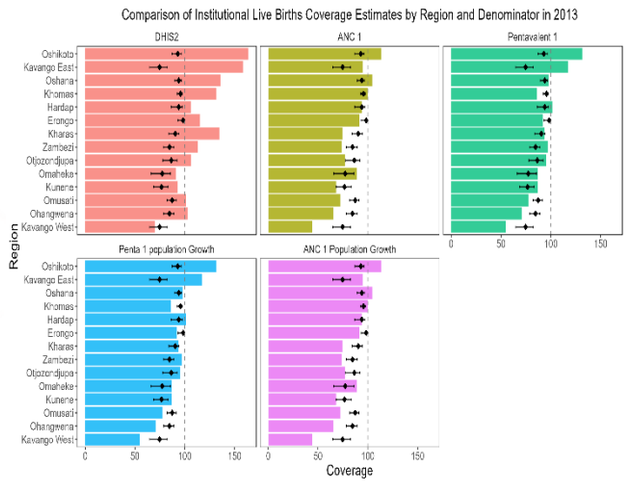
### Total Livebirths




### National Institutional Live Births




### Subnational Institutional Live births



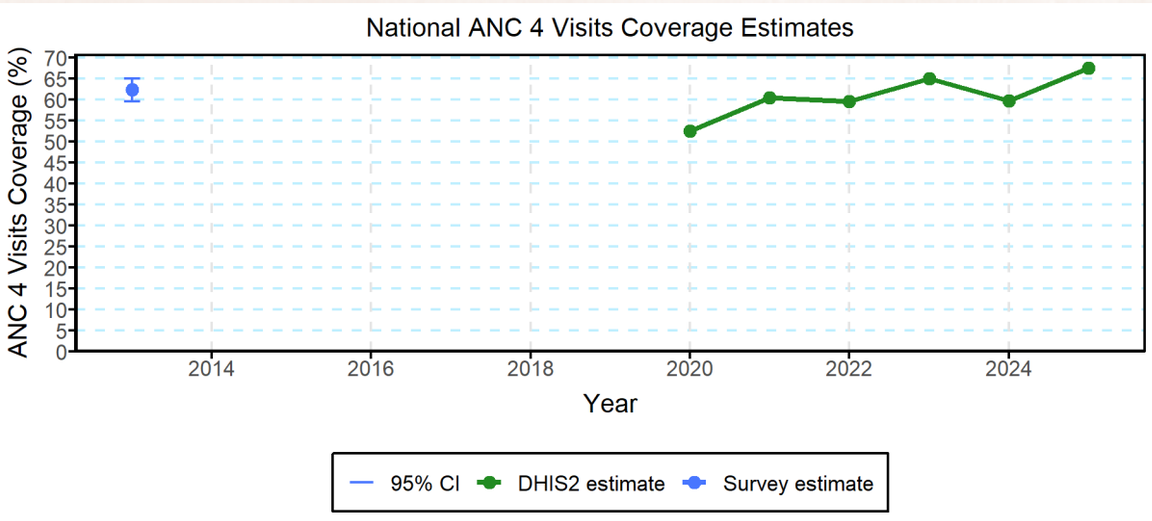

### Interpretations

- The DHIS2 live-birth projection is close to the UN estimate in 2020–2021, but the two series increasingly diverge thereafter. DHIS2 projects a steady increase from about 74,000 births in 2020 to approximately 87,000 in 2025, while the UN estimate rises only slightly to around 78,000.
- UN and direct DHIS2 denominators produce implausible coverage above 100%, at approximately 116.8% and 119%, respectively. The service-derived denominators perform much better. The Penta1 and ANC1 population-growth methods produce coverage of about 91.1%, while the ANC1 and Penta1 population-growth alternatives shown at about 84.4% are also reasonably close to the survey estimate of roughly 88%.
- ANC1-derived denominator, preferably with the population-growth adjustment where it gives the closest agreement with survey coverage.
- Penta1-derived denominator, subject to confirmation from the Penta3 national and subnational comparison results.

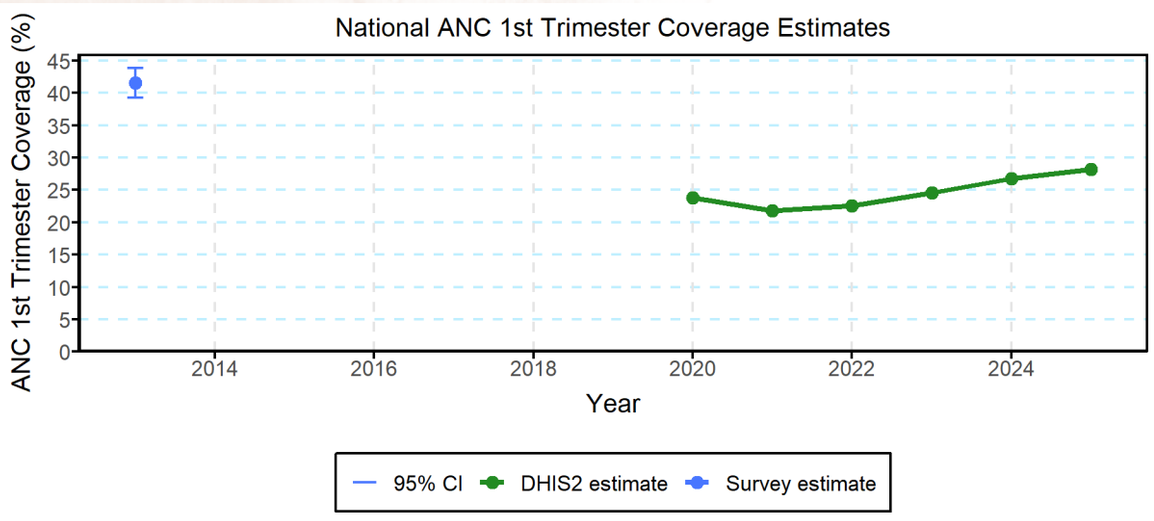
## National Coverage Trends: Facility Data and Surveys

**Antenatal care: ANC4, ANC early visit, first trimester of pregnancy**

### ANC 4



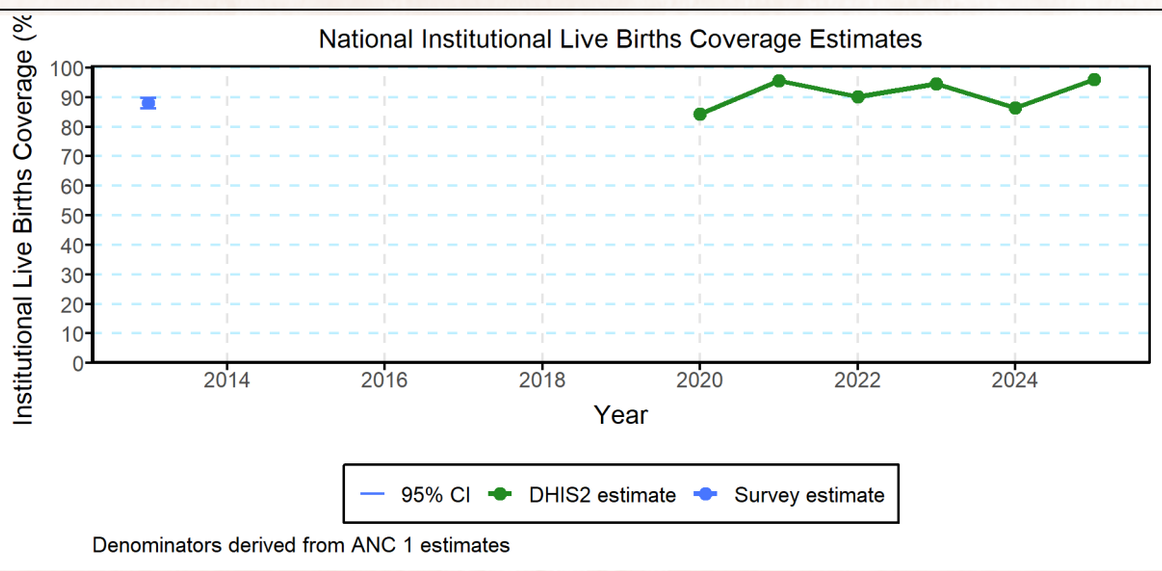

### ANC early visit




### Interpretations

- Facility-based ANC4 and ANC1 1st trimester coverage increased from about 53% and 24% in 2020 to 68% and 28% in 2025, respectively. The most recent survey estimate shown, from 2013, was approximately 63%, which is very close to the 2025 DHIS2 estimate. This suggests that Namibia may have made progress after 2013, but some of those gains may have been lost in recent years. The consistently low coverage could reflect real challenges such as late ANC booking, missed follow-up visits, transport barriers, staff shortages, or pressure on services

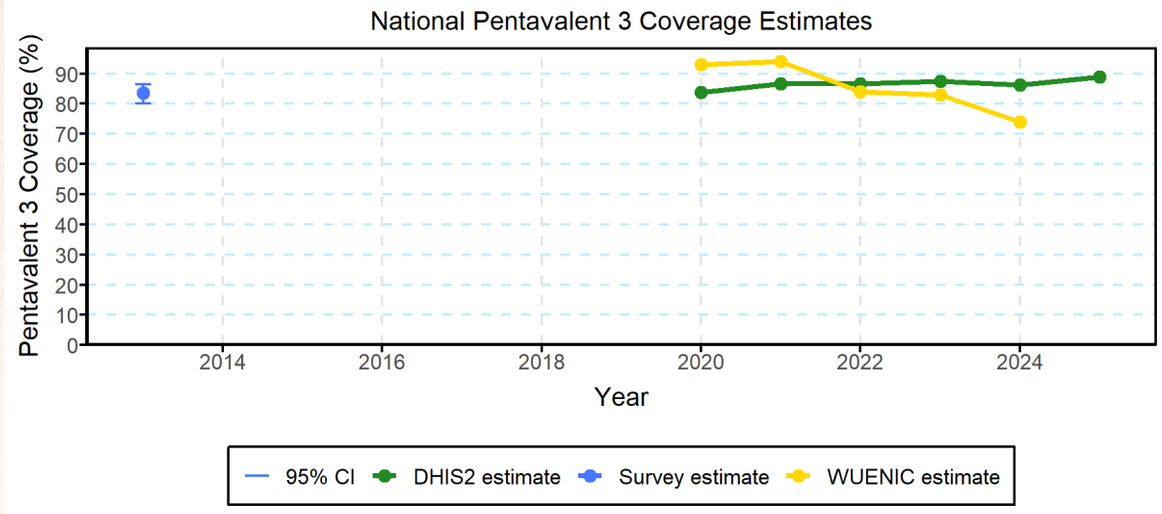
### Institutional delivery

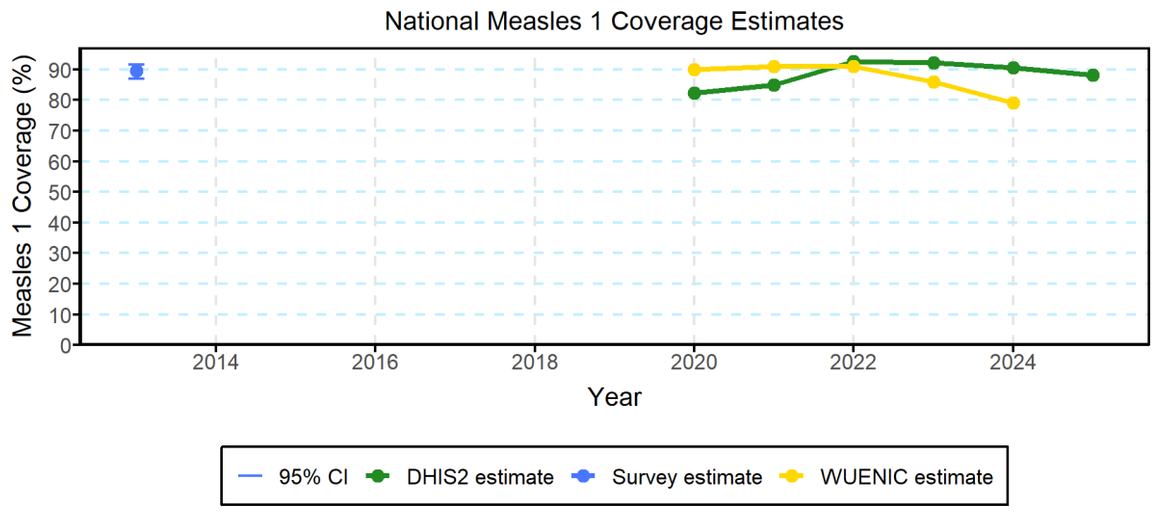



### Interpretations

- Namibia's routine DHIS2 data show very high institutional live-birth coverage, ranging from about 85% in 2020 and 95% in 2025. The 2025 DHIS2 estimate is close to the survey estimate of about 88%, suggesting improved consistency between facility and survey data in the later years. However, the survey is much older, so a direct comparison should be made cautiously.

### Immunization: Penta 3, Measles 1



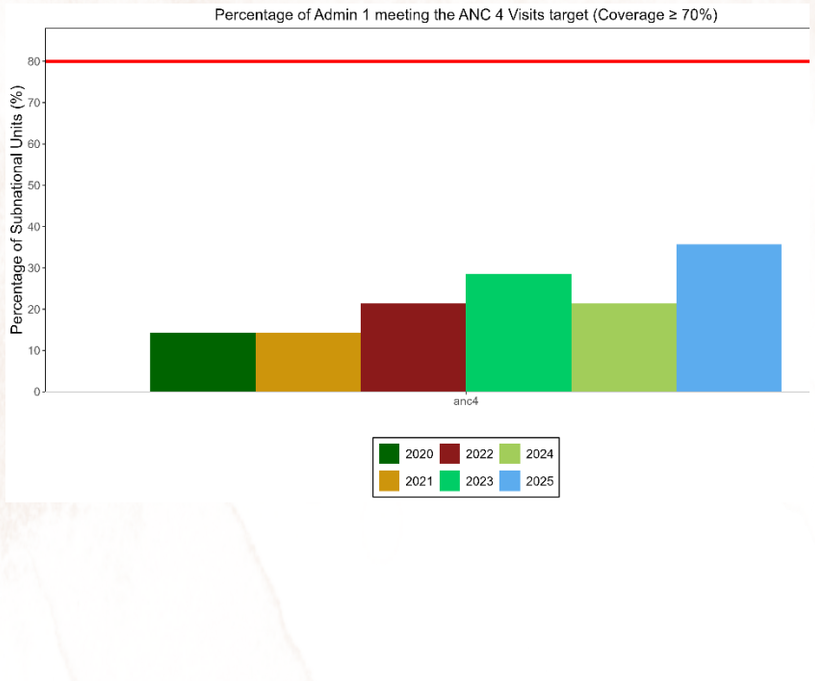




### Interpretations

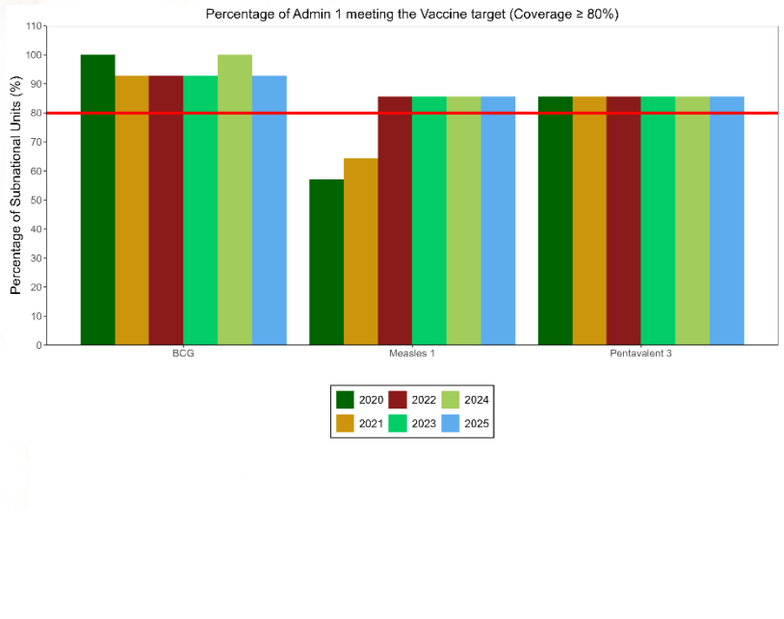
- The Pentavalent 3 estimates show relatively high but divergent coverage across data sources from 2020–2025. The DHIS2 estimate increased from approximately 84% in 2020 to 89% in 2025, with a modest dip around 2022 and subsequent recovery. In contrast, the WUENIC estimate declined from about 93% in 2020–2021 to 74% in 2024, indicating a widening discrepancy between administrative and modelled estimates in the later years. The 2013 survey estimate was approximately 83% (95% CI: ~80–87%), providing an earlier empirical benchmark. The divergence, especially after 2022, suggests that the two sources may be capturing different aspects of vaccination performance and should not be interpreted as directly interchangeable measures of true coverage.
- Measles 1 follows a similar trend, where DHIS2 coverage increased from approximately 82% in 2020 to 93% in 2022, followed by a gradual decline to about 88% in 2025. WUENIC estimates were relatively stable at around 90–91% in 2020–2022, before declining to 79% by 2024. The 2013 survey estimated coverage at approximately 89% (95% CI: ~87–91%). Overall, both antigens demonstrate substantial discrepancies between administrative and WUENIC estimates, with DHIS2 generally producing higher estimates in recent years. These differences should be interpreted cautiously because administrative coverage depends on reported doses and denominator quality, while WUENIC incorporates survey and other evidence.

### Percent of districts achieving high coverage targets

#### ANC 4




#### Child Health Indicators



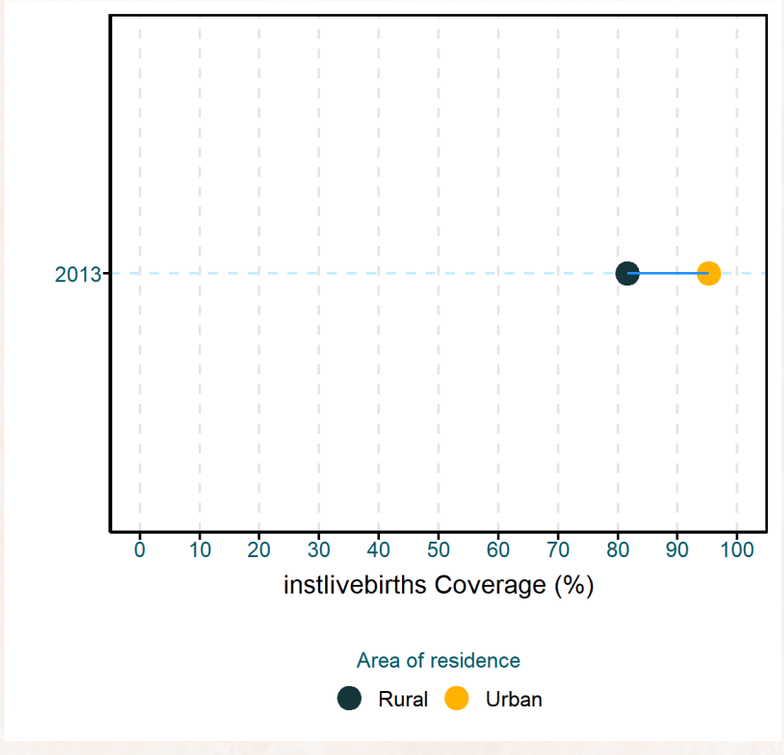

### Interpretations

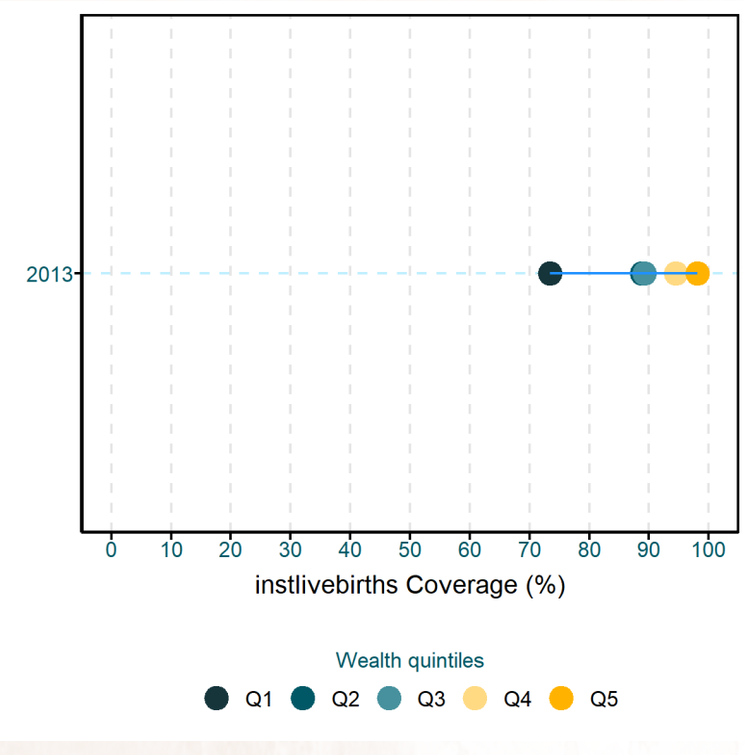
- For vaccination, performance was stronger in earlier years but declined across all three vaccines. In 2020, more than 90% of districts met the 80% coverage threshold for BCG and Penta3, while about 86% did so for Measles1. By 2025, this had fallen to roughly 51% for BCG, 60% for Measles1, and 65% for Penta3.

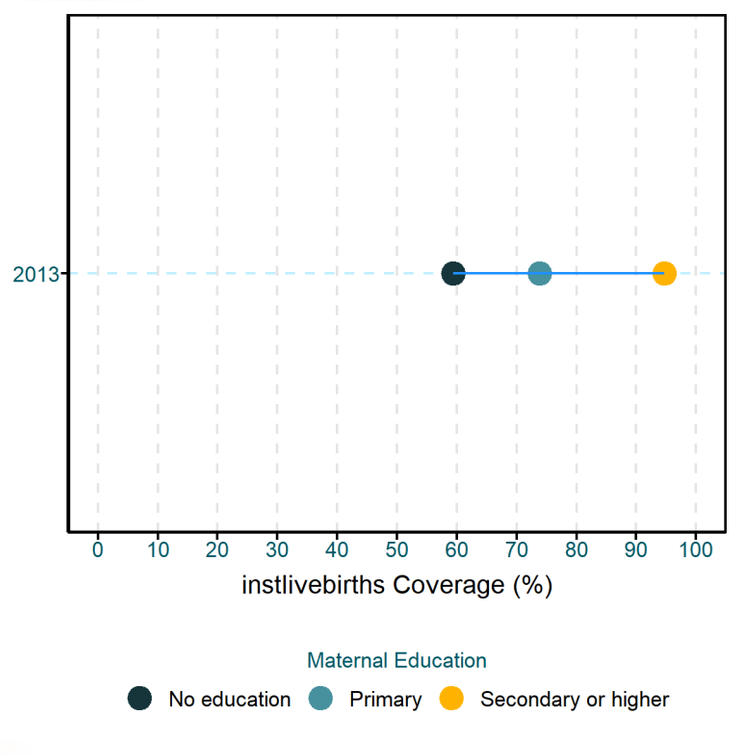
## 3. Equity

**Equity by wealth, education, rural-urban residence (from surveys)**

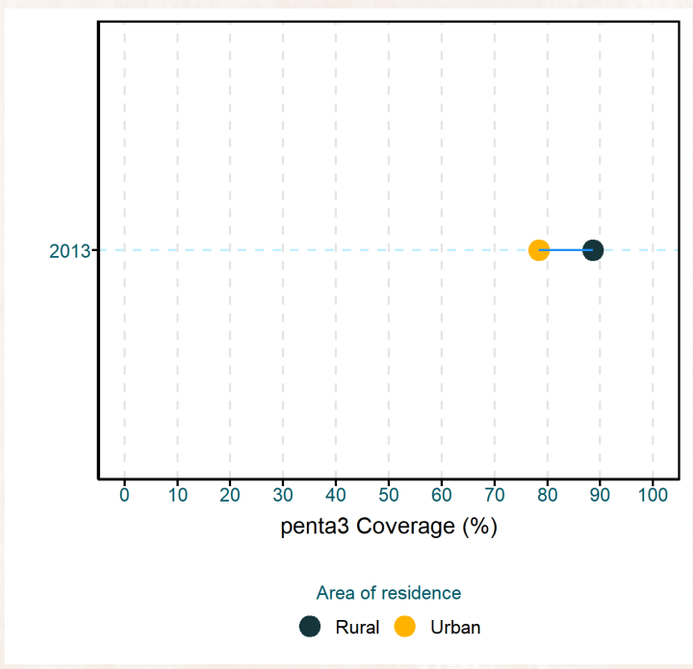
### Institutional Live Births

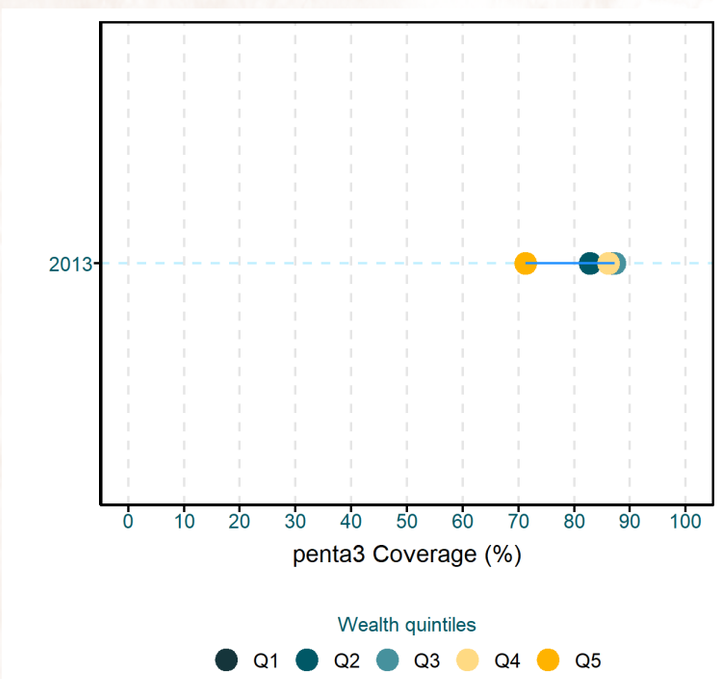


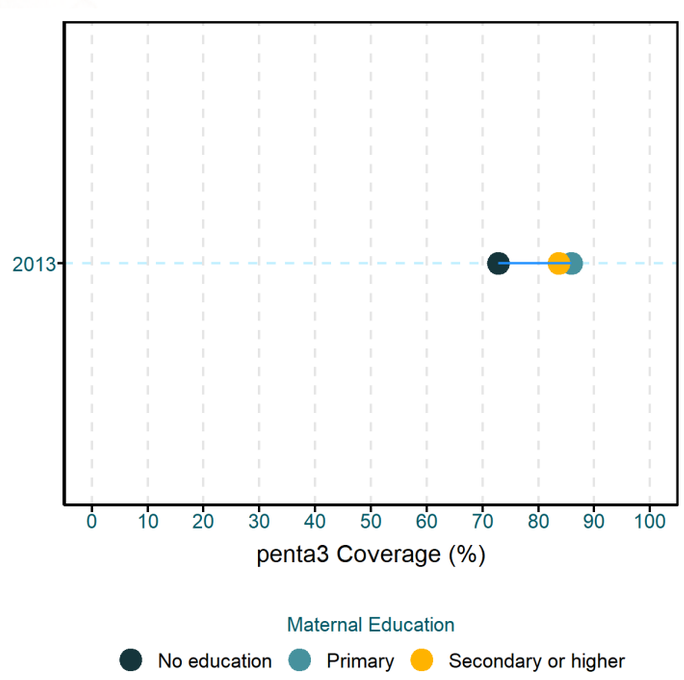




### Pentavalent 3rd Dose



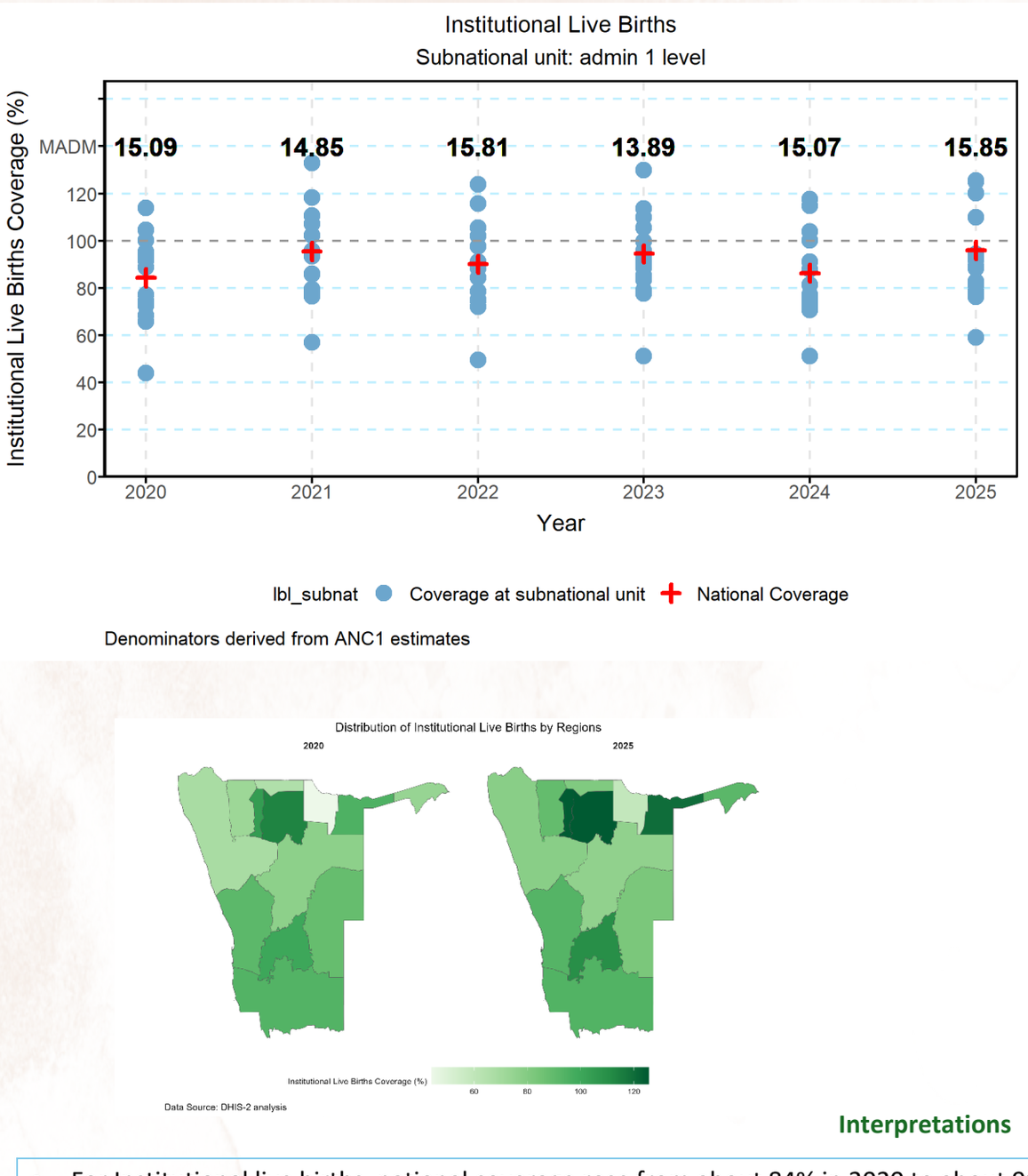




### Interpretations

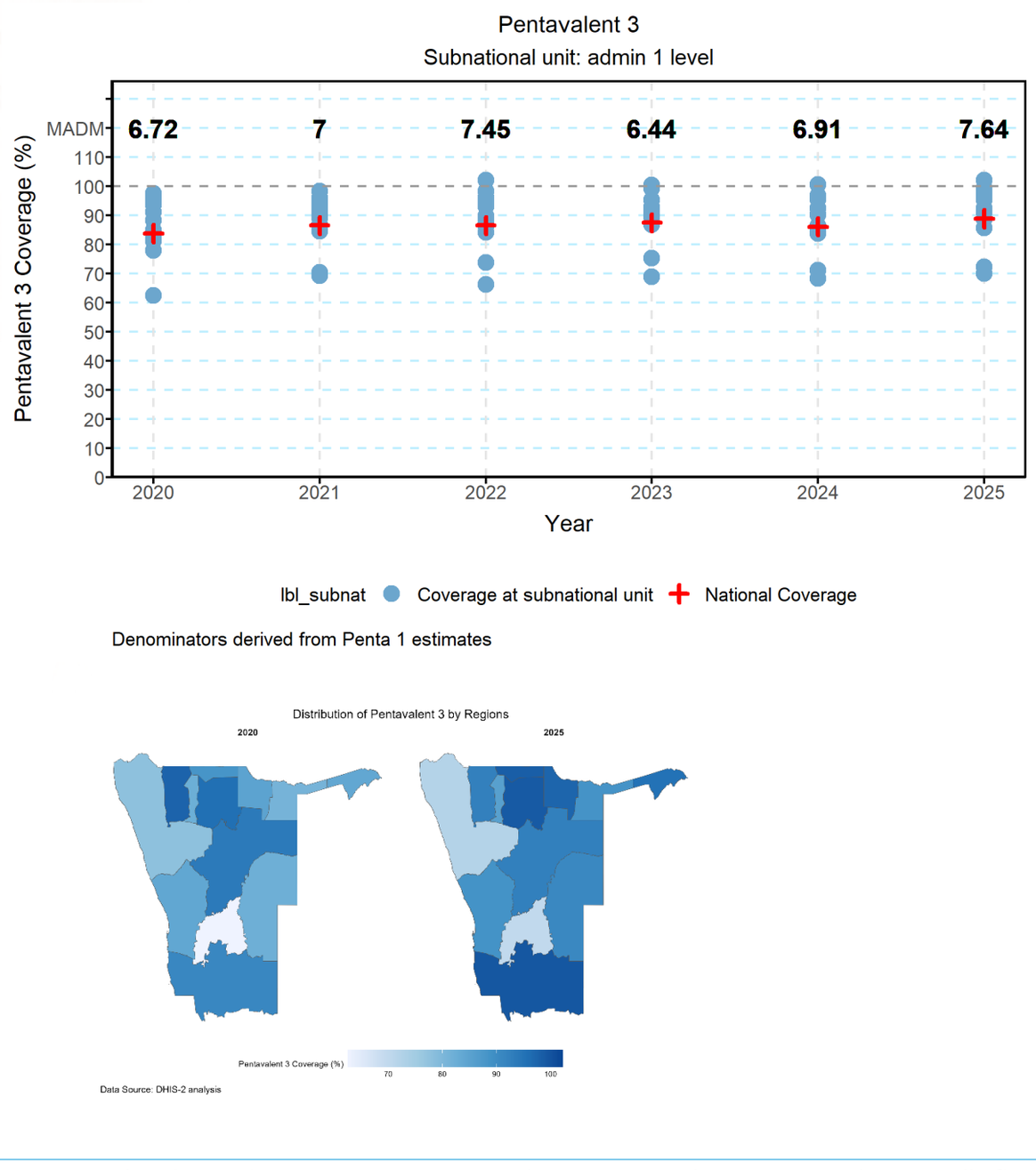
- Persistent disparities are evident by wealth, maternal education and place of residence. Institutional delivery coverage is lower among rural women, poorer households and women with little or no education, while women with secondary or higher education are much more likely to deliver in health facilities. For Penta3, the pattern is less typical: urban residents, wealthier groups and women with higher education show lower recorded coverage. This may partly reflect greater use of private health facilities among wealthier households and people with medical aid. Because private-sector vaccination records may not be fully captured in DHIS2, their true coverage could be underestimated in the routine information system. No time trend can be assessed because the survey was conducted only once, in 2013. Interventions should continue to target rural and low-income communities through transport support, maternity waiting homes, community mobilization and improved outreach. At the same time, private-sector reporting should be strengthened

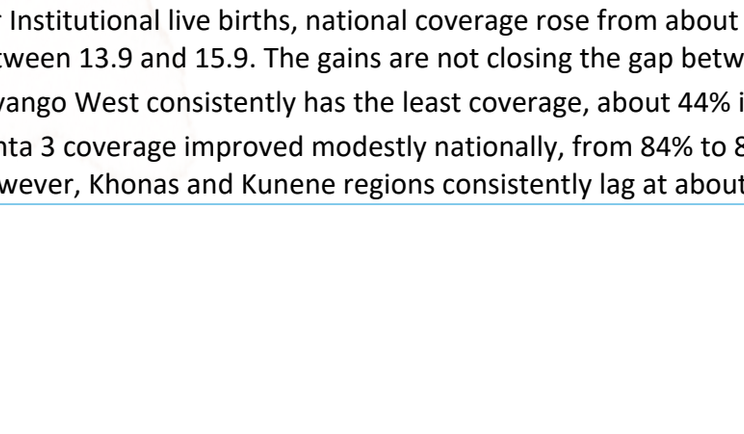
**Geographical inequalities: Health facility data**

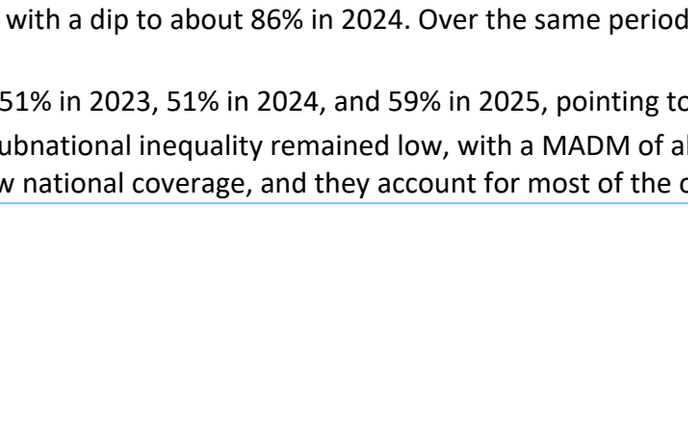
### Institutional Live Births




### Pentavalent 3rd Dose



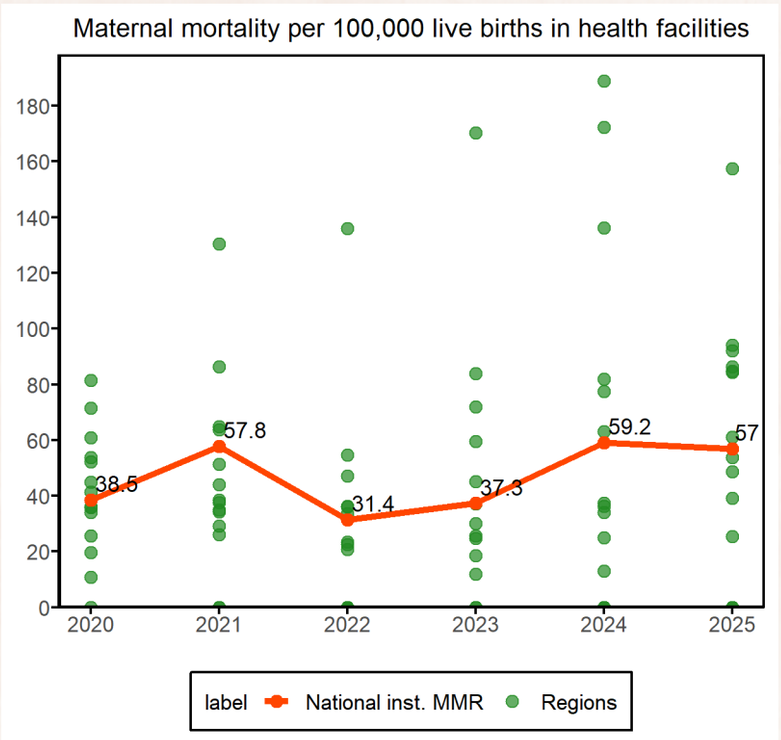

### Interpretations

- For Institutional live births, national coverage rose from about 84% in 2020 to about 96% in 2025, with a dip to about 86% in 2024. Over the same period MADM stayed essentially flat, between 13.9 and 15.9. The gains are not closing the gap between subnational units.
- Kavango West consistently has the least coverage, about 44% in 2020, 57% in 2021, 49% in 2022, 51% in 2023, 51% in 2024, and 59% in 2025, pointing to a clear priority target.
- Penta 3 coverage improved modestly nationally, from 84% to 89% between 2020 and 2025, and subnational inequality remained low, with a MADM of about 6–8 percentage points. However, Khonas and Kunene regions consistently lag at about 62–77%, about 15–20 points below national coverage, and they account for most of the observed inequality.

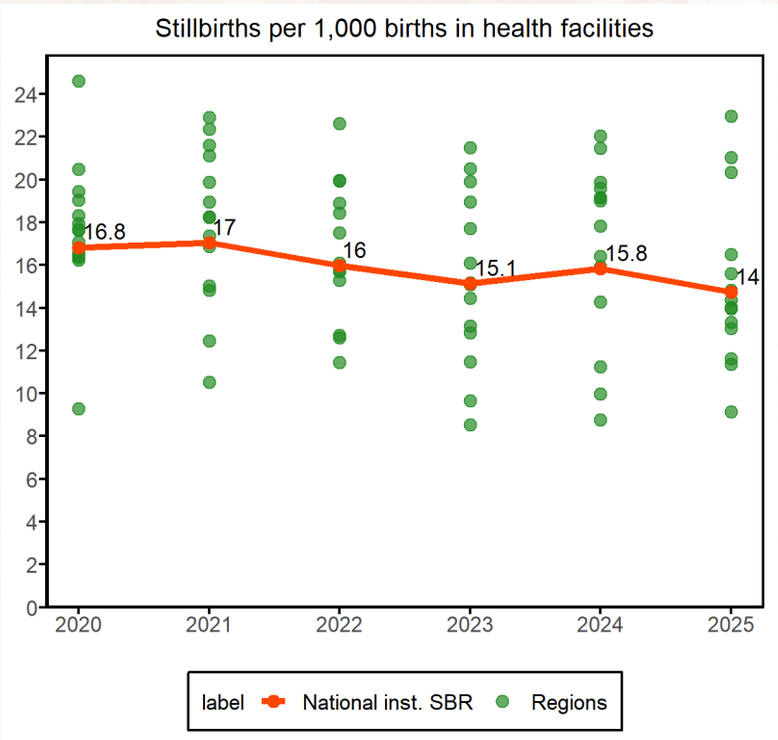
## 4. Institutional mortality

### Institutional Mortality trends (iMMR, iSBR)

**iMMR**



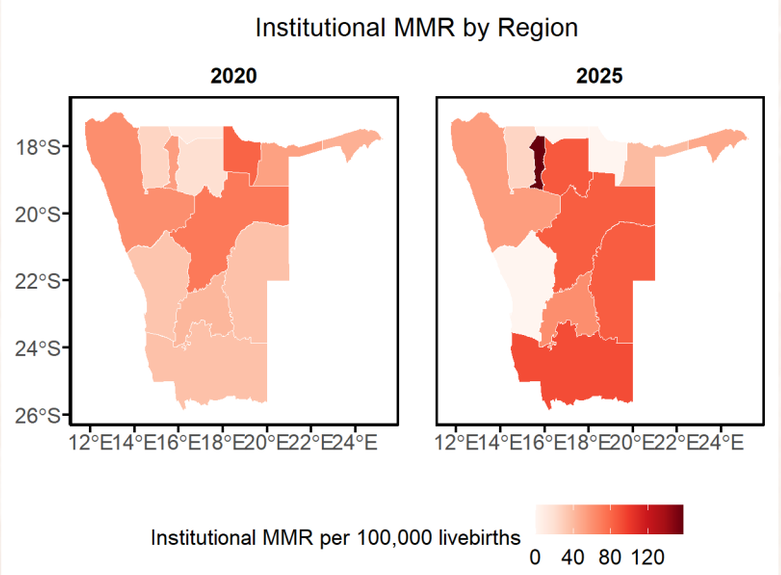

**iSBR**

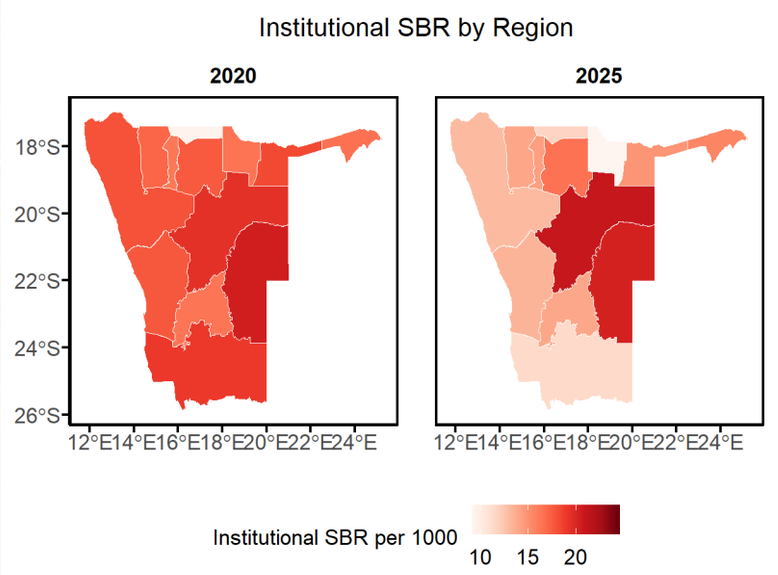



**Interpretations**

- The institutional maternal mortality ratio fluctuated between 39 and 59 deaths per 100,000 live births from 2020 to 2025, with no clear sustained decline. These facility-based levels are much lower than the UN-related estimate reported for Namibia of about 215 maternal deaths per 100,000 deliveries in 2020. This large difference suggests that the facility data does not capture all maternal deaths, particularly deaths occurring outside maternity wards, after discharge, in the community or in facilities with incomplete reporting. The national facility stillbirth rate is close to the global UN estimate of 13.9 per 1,000 births, but lower than the estimated sub-Saharan African average of about 21.7 per 1,000.

### Institutional Mortality by admin1 units



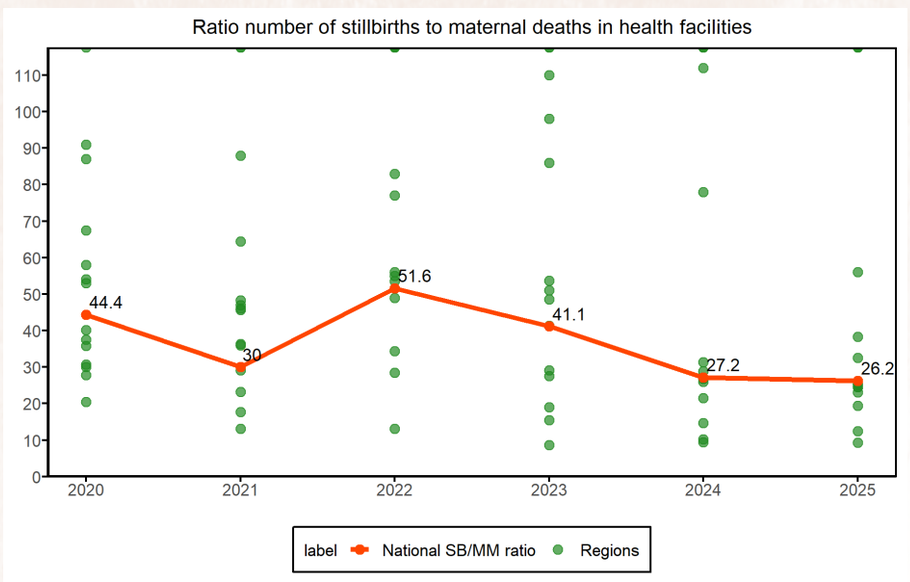




**Interpretations**

- From the colour intensity, the highest institutional maternal mortality appears to be concentrated in Oshana, at approximately 157 maternal deaths per 100,000 live births, followed by selected southern and eastern regions, likely //Kharas and Hardap OR Omaheke, at roughly 85–95 per 100,000 live births. For stillbirths, the highest rates in 2025 appear in the central and eastern regions, at approximately 20–23 stillbirths per 1,000 births. The lowest regional rates are around 9–11 per 1,000 births, mainly in some western and southern regions.

### Data quality metrics

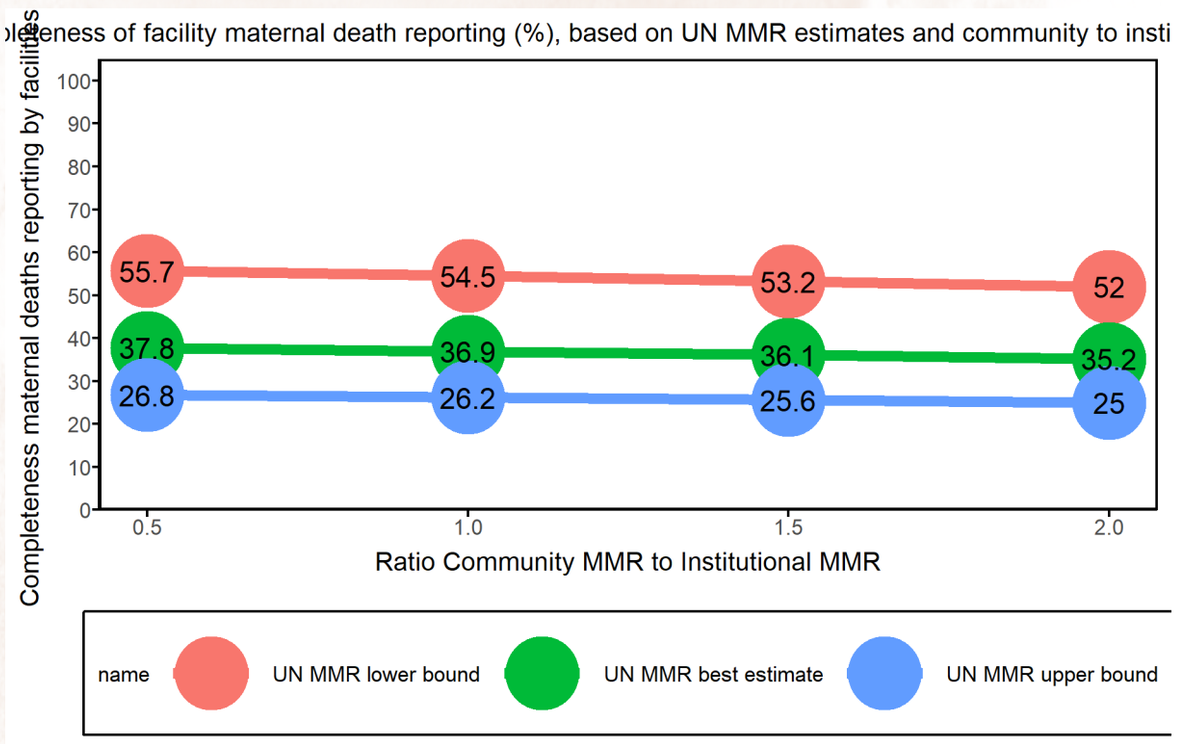
Ratio stillbirth to maternal deaths in the health facility data at national level

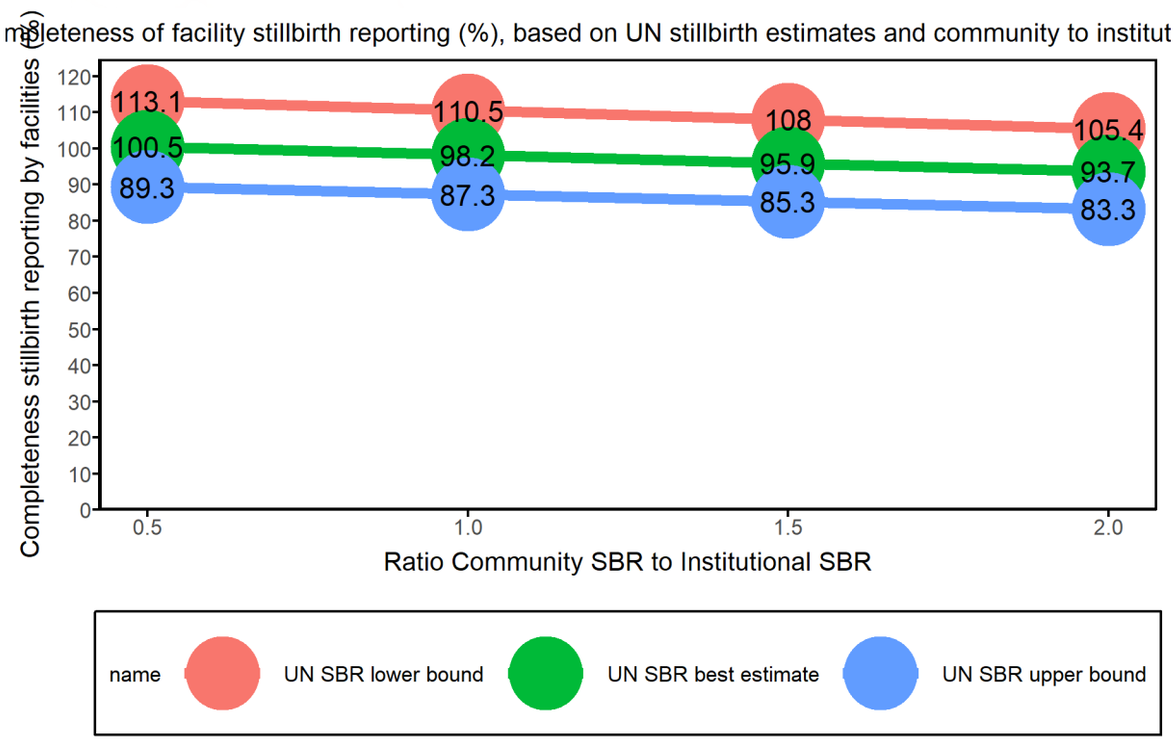



**Interpretations**

- The national ratio was above the plausible range of 5–25 in every year
- The regional level, the highest ratios are above 100 stillbirths per maternal death. These are highly implausible and strongly suggest that very few or no maternal deaths were reported despite recorded stillbirths. The lowest regional ratios are approximately 9–15 in recent years and fall within the plausible range.
- If the ratio is above 25, this may mean that maternal deaths are more underreported than stillbirths. If it is below 5, stillbirths are likely underreported. If the ratio is within the range, the reporting may be good if the mortality levels are in the expected range. If not, then both maternal deaths and stillbirths are underreported. No regional ratio appears to be below **5**, so the graph does not provide strong evidence that stillbirths are more underreported than maternal deaths

Estimated completeness of facility maternal death and stillbirth reporting



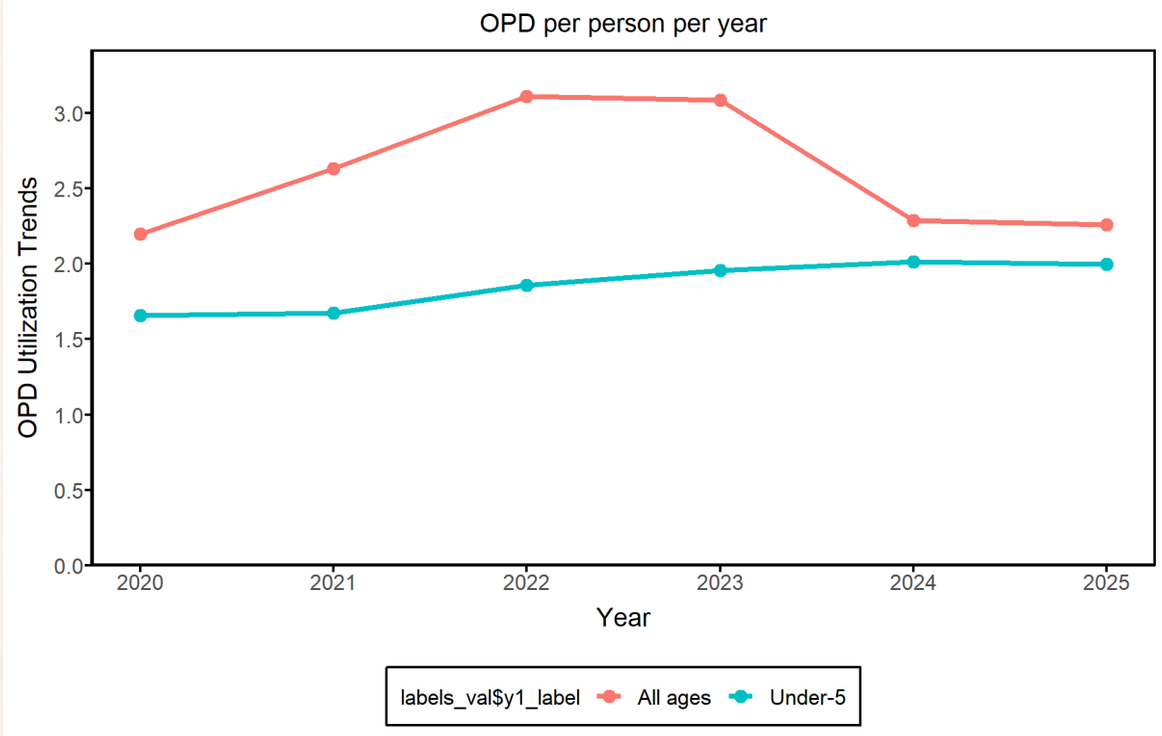

**Interpretations**

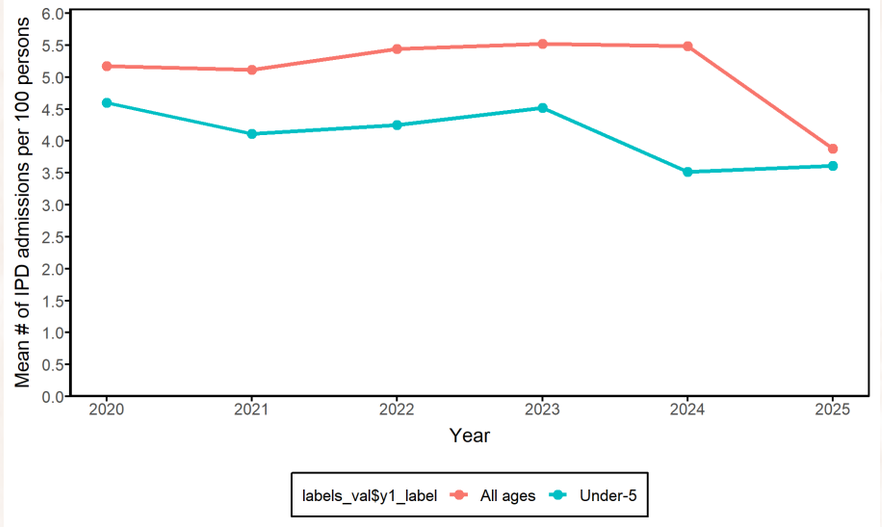
The analysis indicates that maternal deaths are substantially underreported in health facilities, while stillbirth reporting appears much more complete. There is still an issue in Namibia on coding of causes of deaths, some maternal deaths could have occurred but coded under a wrong cause of death, the other reason is that MMR in Namibia are bound to reduce because there are several programs targeting maternal care and very few target the reduction of still births.

The national neonatal mortality rate is 7.07 deaths per 1,000 live births. However, there is no separate record of neonatal deaths occurring before discharge. This limits the assessment of the completeness and plausibility of facility-based neonatal mortality reporting.

## 5. Curative Health Service Utilization for Sick Children

### Outpatient and inpatient service utilization

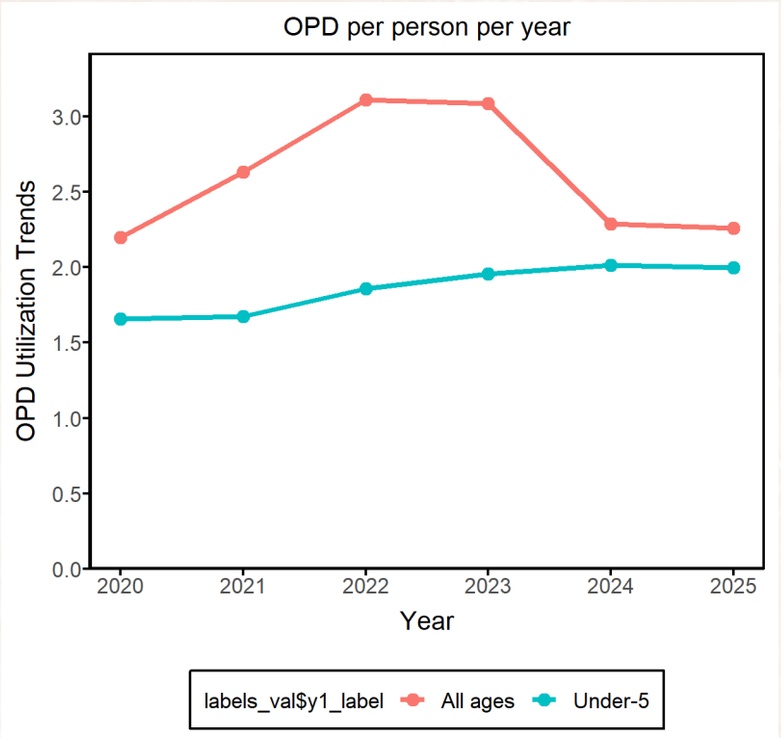


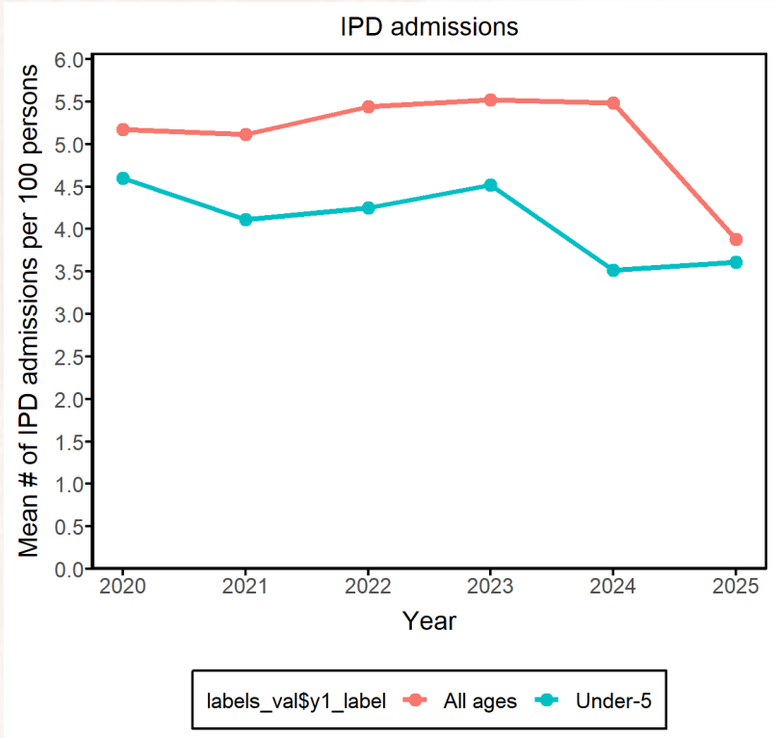




**Interpretations**

- In 2024, the mean number of OPD visits per child under five was just under 2 visits/year. This represents a recovery from the sharp drop in 2021, where visits declined, likely due to COVID-19 impacts.
- While higher than 1, the number is still below pre-2020 levels (~3.5), suggesting access has not fully rebounded.
- Gradual improvements post-2021 indicate stabilizing service use and plausible reporting.
- The year-to-year trajectory is smooth, with no suspicious spikes, supporting good data quality.
- The IPD admission rate per 100 under-5 children was about 1.1 in 2024, rising from a low of 1.0 in 2022.
- Ensure availability of essential medicines and staff at primary care facilities to rebuild public trust and demand for outpatient services.
- Monitor regional trends in service utilization to identify areas where recovery has lagged and tailor interventions accordingly.

### Regional/provincial service utilization



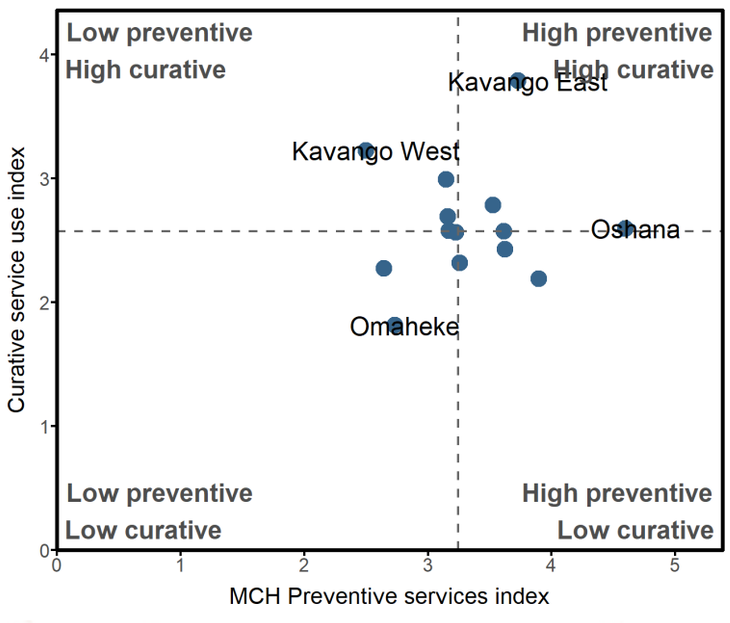




**Interpretations**

- Nationally, under-five OPD use increased from about 1.65 visits per child in 2020 to around 2.0 in 2024–2025. All-age OPD use rose to just over 3 visits per person in 2022–2023, then dropped to about 2.3 in 2024–2025.
- Under-five IPD admissions fluctuated between approximately 3.5 and 4.6 admissions per 100 children, while all-age admissions remained around 5.1–5.5 per 100 people until 2024, before dropping sharply to about 3.9 in 2025. The sharp decline in all-age OPD after 2023 and in all-age IPD in 2025 may reflect real reductions in service use, but it could also indicate incomplete reporting, delayed data entry, changes in denominators, facility closures, or changes in service classification.

### MCH Preventive vs Curative Index

MCH preventive index compared to curative service index, under5




**Interpretations**

- The figure compares regional performance in maternal and child health preventive services with the use of curative services for children under five. The dashed lines divide regions into four performance groups based on the average preventive and curative service indices.
- Kavango East is the strongest-performing region, falling clearly within the high preventive and high curative quadrant. This suggests comparatively good access to both routine preventive services and treatment services for sick children.
- Kavango West has relatively high curative service use but lower preventive performance. This pattern may suggest that children are accessing treatment after becoming ill, while preventive services such as immunisation, growth monitoring or other routine MCH services are comparatively weaker. Omaheke is located in the low preventive and low curative quadrant and is therefore one of the poorest-performing regions
- The remaining regions are clustered close to the average values, indicating moderate performance with relatively small differences between them.

# 6. Health System Progress and Performance

## Health system inputs

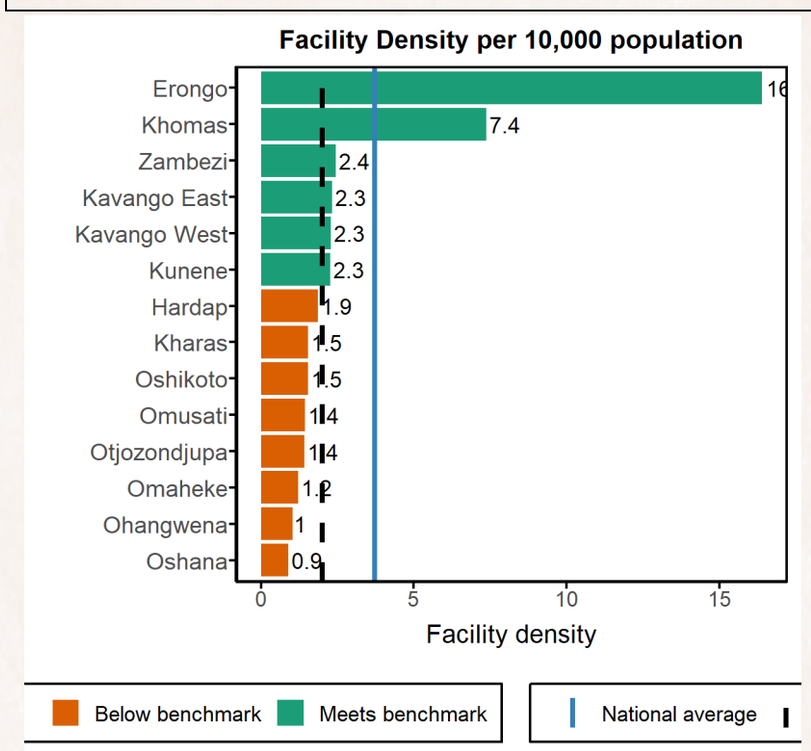
| 2024 | | |
|---|---|---|
| **Indicator** | **Value** | **Unit** |
| **Health infrastructure** | | |
| Health facility density | 3.7 | per 10,000 |
| Share of facilities that are hospitals | 4.6 | % |
| Hospital density | 1.7 | per 100,000 |
| Inpatient bed density | 25.6 | per 10,000 |
| **Health workforce** | | |
| Health workforce density | 34.0 | per 10,000 |
| Skills mix ratio nurse-midwives per physician | 5.3 | |
| **Role of private sector** | | |
| Share of Private facilities | 77.1 | % |
| Share of NGO facilities | 2.0 | % |

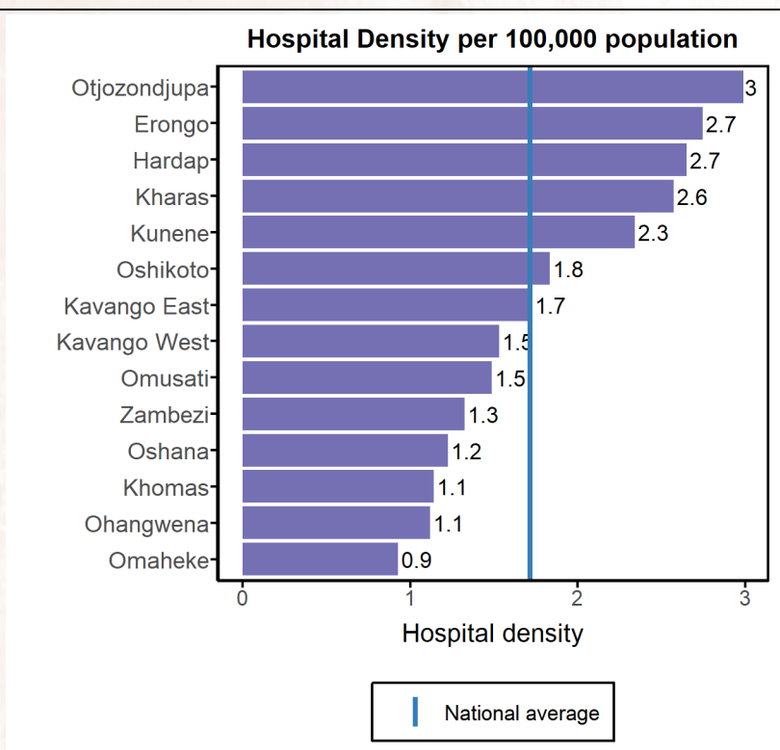
### Interpretations

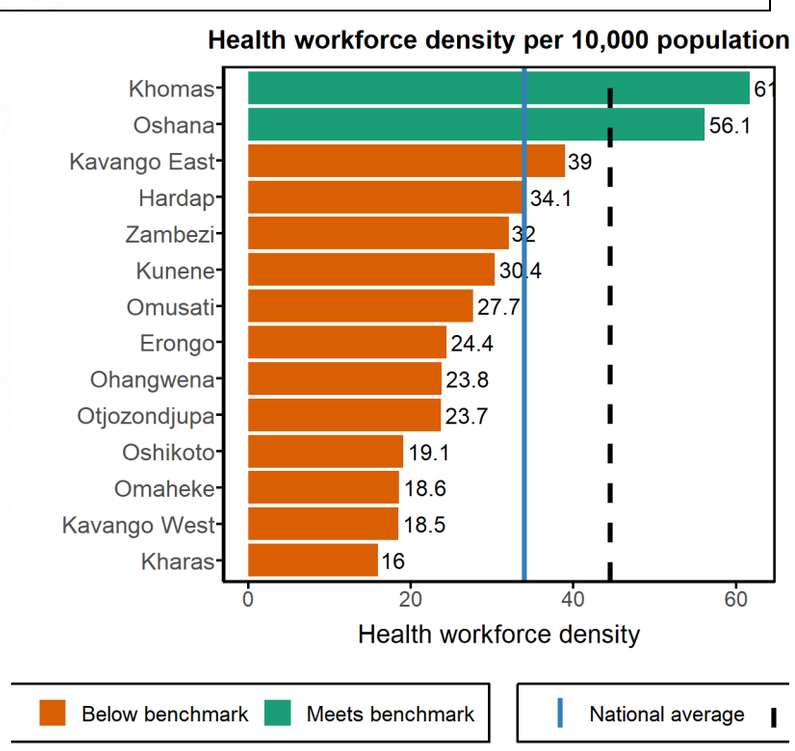
At national level, Namibia recorded 3.7 health facilities per 10,000 population, 1.7 hospitals per 100,000 population, 25.6 inpatient beds per 10,000 population, and 34 health workers per 10,000 population in 2024. The results show substantial regional inequalities, particularly in workforce and bed availability. Inpatient bed density: Namibia's inpatient-bed density of 25.6 beds per 10,000 population is close to the approximate global average of 27 per 10,000 reported in WHO health-facility analysis guidance and considerably higher than the approximate African regional average of 10 per 10,000.

Health Workforce density: Namibia's health-workforce density of 34 per 10,000 population is below the indicative WHO-related threshold of approximately 44.5 doctors, nurses and midwives per 10,000 population associated with achieving the health-related Sustainable Development Goals

## Health system inputs by region/province



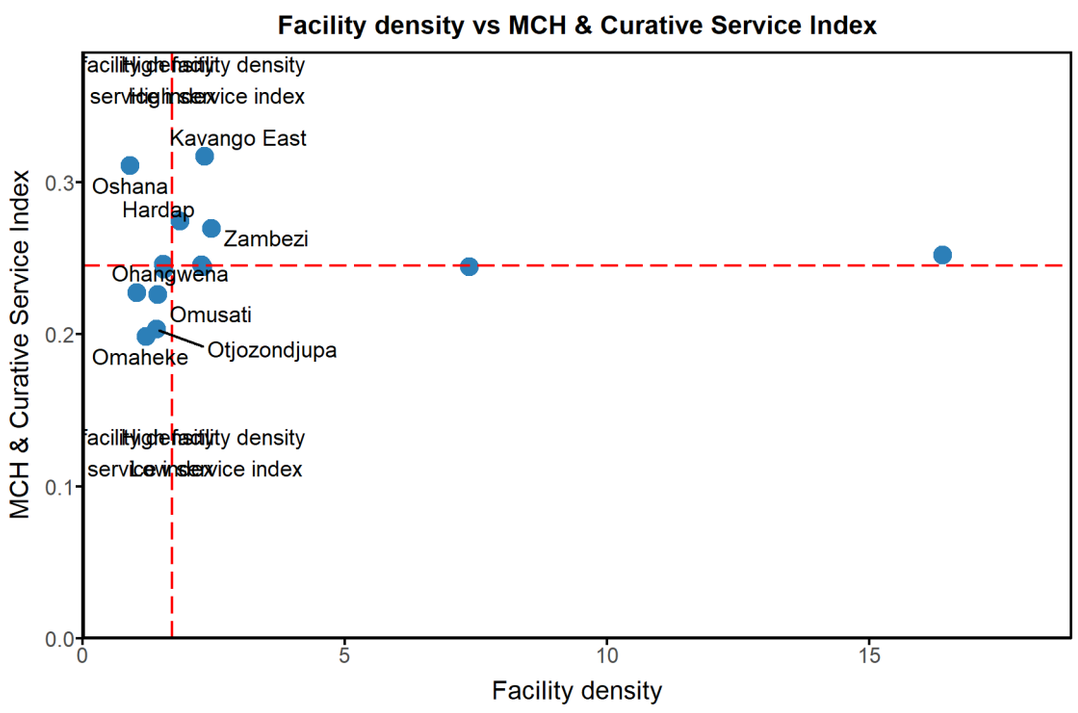




Erongo reports 16.4 facilities per 10,000 population, more than twice the level in Khomas and several times the national average. This is due to the numerous private consulting rooms, small clinics, occupational-health facilities or other service points. Khomas has the highest workforce density at 61.7 per 10,000, followed by Oshana at 56.1. However, The concentration of workers in Khomas is expected because Windhoek hosts national referral hospitals, specialist services, central administration, training institutions and a large private sector. Oshana's high density is also plausible because Oshakati serves as an important referral and service hub for northern Namibia. Although, the density of health workers is high they regions still suffer overcrowding and long patient waiting hours before service. The national figure therefore suggests an overall workforce shortage combined with marked geographic maldistribution. Kavango East is third at 39.0, while //Kharas, Kavango West, Omaheke and Oshikoto have the lowest densities.

Hospital density: Otjozondjupa has the highest hospital density at 3.0 per 100,000, followed by Erongo and Hardap at 2.7, and //Kharas at 2.6. Omaheke has the lowest hospital density at 0.9, while Khomas and Ohangwena each record

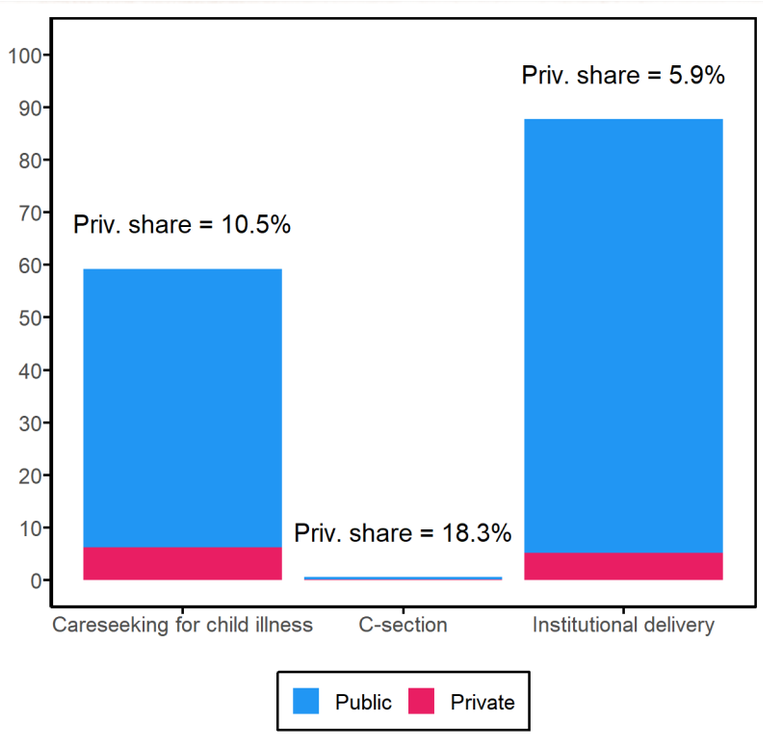
## Health system outputs by inputs at the subnational level

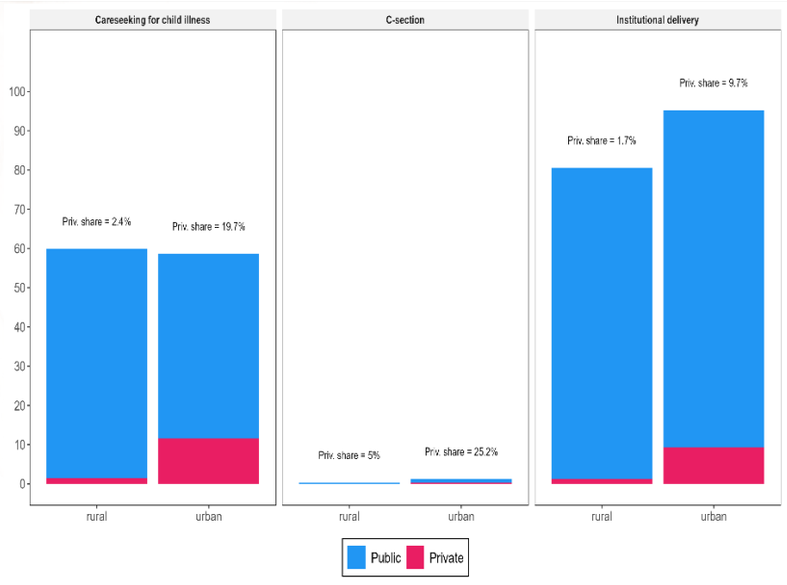



### Interpretations

- When it comes to better performing region like kavango East, Oshana ,Hardap and Zambezi they have low to moderate facility density and they at are above the national average line, and the poor performing like Omaheke, Otjozondjupa and Oshikoto they are at the bottom Y-axis with a low index and they are below the national average line Good perfoming region is Kavango west with 0.35-0.40 index followed by Oshana. Hardap with 0.30-0.35 and Zambezi with above average ranging between 0.28-0.30 index.

## Private sector and RMNCAH services

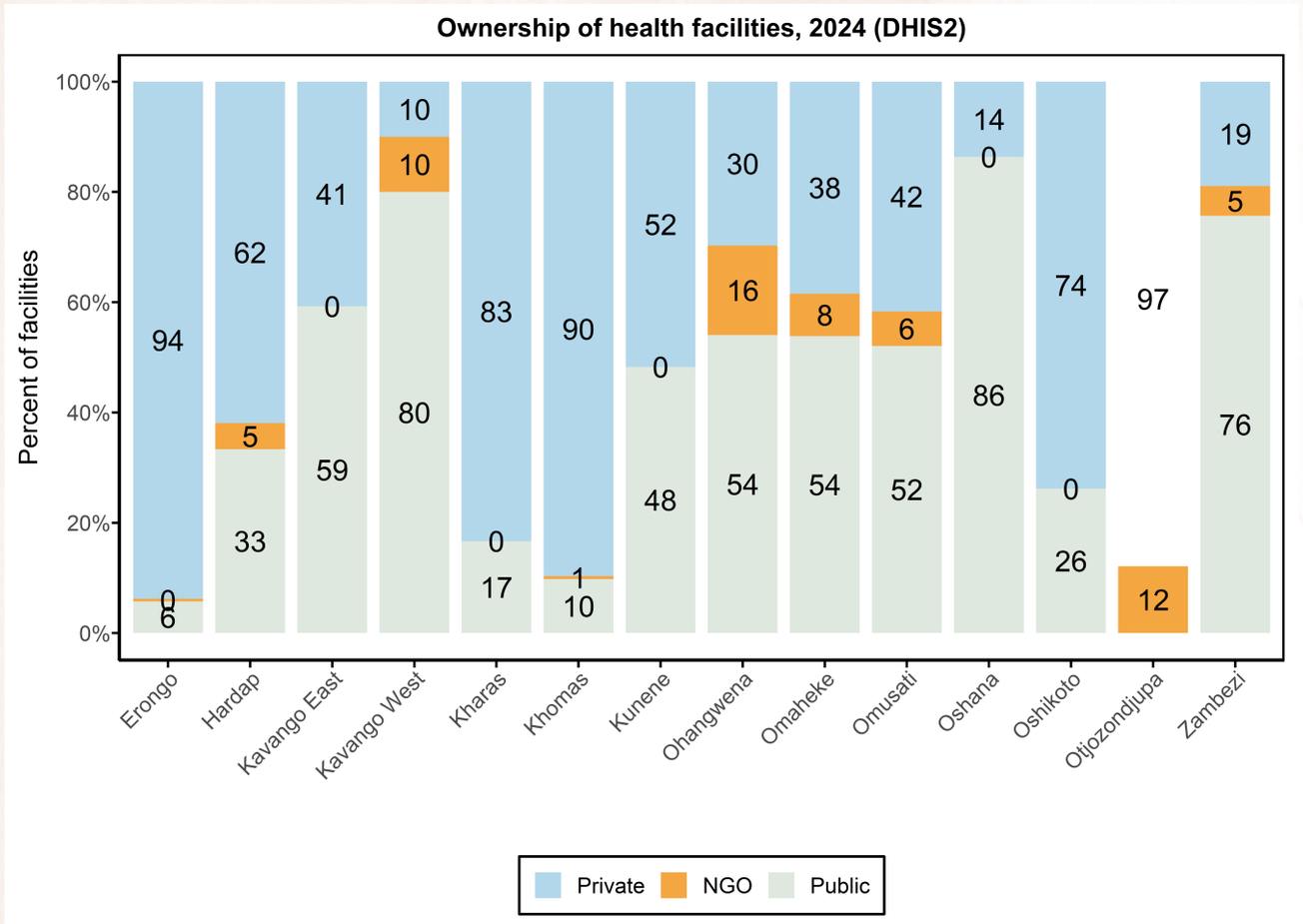



### Interpretations

- Despite the large number of privately owned facilities, the public sector remains the main provider of the selected health services nationally,the urban private has the highest share with 25% compared to rural private with only 2% C-section and if we look at institutional delivery urban private share has the highest with17% followed by Rural private with only 3%

## National Ownership of Health Facilities




## CONCLUSION

Namibia has made important progress in strengthening routine health reporting, with high national completeness and relatively few extreme outliers, but data-quality challenges remain at district level and in the selection of appropriate denominators. Coverage of maternal and child health services remains relatively high in some areas, yet recent declines in ANC4, institutional delivery and vaccination coverage indicate that earlier gains may not be fully sustained. Regional, wealth, education and rural–urban inequalities continue to affect access to essential services, while incomplete private-sector reporting may distort some coverage estimates. Maternal deaths appear to be substantially underreported, in contrast to stillbirth reporting, which is comparatively more complete. Continued investment in data validation, private-sector reporting, maternal death surveillance, equitable workforce distribution and targeted support to underserved regions will be essential for Namibia to improve RMNCAH outcomes and remain on track toward the 2030 targets.

# COUNTDOWN TO 2030

## COUNTRY ANNUAL MEETING

# CAM 2026

JUNE 2026