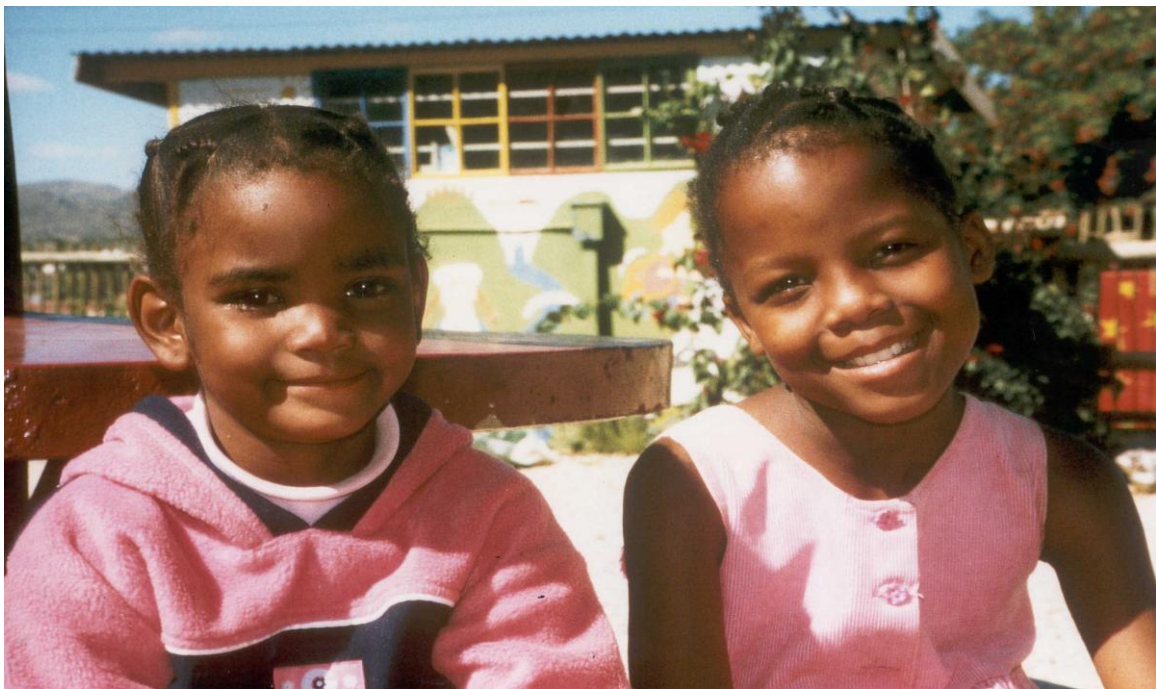




**REPUBLIC OF NAMIBIA**

**Ministry of Health and Social Services**



**HEALTH AND SOCIAL SERVICES REVIEW  
2008**

## **FOREWORD BY THE MINISTER**

The National efforts to attain health and Social wellbeing of the Namibian population is based on the Ministry of Health and Social Services health care system that aims to ensure equal access to quality health care to all of its citizens.

The Ministry has made noteworthy progress towards attaining this status and has made significant achievements in our health care delivery services. As we have progressed positively in a number of areas of our health development, we have however also met challenges that have slowed down our efforts.

In furtherance of improving the health of the nation, the ministry continues to steer the national health priorities through the control of communicable and non- communicable diseases, improvement of maternal health care services and the development of human resources as articulated in National Development Plan 3.

The ministry is one of the public sectors that are to conform to the public sector reforms and initiatives led by the Office of the Prime Minister. One of the reforms is the health sector's Strategic Plan. The Health and Social Services System Review is the first step in the process of the development of this Strategic Plan as it provides the situation analysis.

As noted, in this report, the review's findings highlight the health systems performance, weaknesses, strengths and challenges in all five reviewed areas. The strategic plan, which is the first step in phase two of this process, will thus serve as a road map for the Ministry's health care system performance management system towards better performance.

I am therefore pleased to present this Health and Social Services System Review report findings. I sincerely hope that the report will unite all of us in our endeavours to serve the people of Namibia to the outmost of our abilities.

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**DR. RICHARD NCHABI KAMWI, MP**  
**MINISTRY OF HEALTH AND SOCIAL SERVICES**

# PREFACE

The Health and Social Services System Review is the first report, which attempts to take stock of the Ministry's performance, reflects on the success and challenges of the Namibian public health sector, and outlines likely approaches and strategies in addressing the challenges.

Although the report covers the period since independence, the majority of the information contained is of the past five years. As this report highlights the progress made and the challenges faced in achieving the, "*Health for All*" goal, the findings in this report give ground for both optimism and concern. Much progress has been made in the improvement of key health indicators since independence. However, recent statistics show a reversal in gains in the under-five mortality and maternal mortality rates.

The information in this report was gathered over a three-month period through data collection from stakeholders, health facilities, health workers, and the public. The report is further informed through various policies, reports, administrative records, and research projects.

The review was seen as the top priority undertaking and during the time of the implementation all ministerial resources being technical expertise, financial resources and time were pooled together to make this exercise a success. This review was also made possible through the technical support of UNICEF, WHO, USAID, UNFPA, ITECH and SYNERGOS. Specifically the Ministry would like to acknowledge UNICEF consultant Dr. Vincent Orinda who was the lead resource person, and Health Systems 20/20 consultants supported by USAID, Mr. Gabriel Abraham and Mr. Damascene Butera. In addition, financial support was given by UNICEF and SYNERGOS.

My sincere appreciation goes to the consumers of our health services, youth and women groups, Village Development Committee members, individuals, and stakeholders who provided us with valuable information and suggestions. Furthermore, my sincere gratitude to all ministry officials from national, regional and district level for their contribution in providing information and logistical services especially the work done by the Directorate: Policy, Planning and Human Resource Development, and Primary Health Care Services.

I also like to thank the various government offices, development partners, civic organizations who manifested their commitment by attending the feedback Conference and for their valuable input and comments. As reflected in this report, those input have culminated into refined final product. Thanks to all the members of the two committees listed in Annex A for the role they played in steering the process.

It is my sincere hope that health and social services review findings will be put to good use by planners, policymakers, and stakeholders to achieve the "*Health for All*" goal.

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**MR. K. KAHUURE**  
**PERMANENT SECRETARY**

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## Abbreviations

<b>ADT</b>	ARV Dispensing Tool
<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>ALS</b>	Average Length of Stay
<b>ANC</b>	Antenatal Care
<b>ARI</b>	Acute Respiratory Infections
<b>ART</b>	Anti-retroviral Therapy
<b>ARV</b>	Anti-retroviral
<b>BREC</b>	Biomedical Ethical Committee
<b>BTR</b>	Bed Turnover Ratio
<b>CAA</b>	Catholic AIDS Action
<b>CDC</b>	Centre for Disease Control
<b>CDD</b>	Control of Diarrhoea Diseases
<b>CDP</b>	Continuing Professional Development Programme
<b>CHBC</b>	Community Health Based Care
<b>CMS</b>	Central Medical Store
<b>CNR</b>	Case Notification Rate
<b>CO</b>	Civic Organizations
<b>COMBI</b>	Communication-for-Behavioural-Change
<b>CRS</b>	Constant Returns to Scale
<b>DHS</b>	Demographic and Health Survey
<b>DPR</b>	Disease Prevention & Rehabilitation
<b>DRS</b>	Decreasing Returns to Scale
<b>EC</b>	European Commission
<b>ELCIN</b>	Evangelical Lutheran Church in Namibia
<b>EmOC</b>	Emergency Obstetric Care
<b>EU</b>	European Union
<b>FBO</b>	Faith Based Organisation
<b>FDC</b>	Funds Distribution Certificates
<b>FDI</b>	Federation Dentaire International
<b>FMM</b>	Facilities Management and Maintenance
<b>FP</b>	Family Planning
<b>FY</b>	Financial Year
<b>GDP</b>	Gross Domestic Product
<b>GNP</b>	Gross National Product
<b>GSFAF</b>	Government Students Financial Assistance Fund (GSFAF)
<b>HDI</b>	Human Development Index
<b>HIS</b>	Health Information System

<b>HIV</b>	Human Immunodeficiency Virus
<b>HPSI</b>	Health Promotion School Initiative
<b>HRD</b>	Human Resource Development
<b>HRH</b>	Human Resource for Health
<b>HRM</b>	Human Resource Management
<b>HRMIS</b>	Human Resource Management Information System
<b>IAEA</b>	International Atomic Energy Agency
<b>IEC</b>	Information Education and Communication
<b>IFMS</b>	Integrated Financial Management System
<b>IMCI</b>	Integrated Management of Childhood Illness
<b>IMR</b>	Infant Mortality Rate
<b>IRS</b>	Indoor Residual Spraying
<b>IT</b>	Information Technology
<b>ITN</b>	Insecticide Treated Net
<b>IYCF</b>	Infant and Young Child Feeding
<b>KAP</b>	Knowledge, Attitude and Perception
<b>LB</b>	Live birth
<b>M&amp;E</b>	Monitoring and Evaluation
<b>MDR-TB</b>	Multi-Drug Resistant Tuberculosis
<b>MGECW</b>	Ministry of Gender Equality and Child Welfare
<b>MoHSS</b>	Ministry of Health and Social Services
<b>MoLSW</b>	Ministry of Labour and Social Welfare
<b>MoVA</b>	Ministry of Veterans Affairs
<b>MSH</b>	Management Science for Health
<b>MTEF</b>	Medium Term Expenditure Framework
<b>N\$</b>	Namibian Dollars
<b>NAEC</b>	National AIDS Executive Committee
<b>NAMBTS</b>	Blood Transfusion Services of Namibia
<b>NAMlist</b>	Namibian Essential Medicines List
<b>NAPPA</b>	Namibia Planned Parenthood Association
<b>NCDs</b>	Non-Communicable Diseases
<b>NDP</b>	National Development Plan
<b>NHA</b>	National Health Account
<b>NHIES</b>	Namibia Income Household & Expenditure Survey
<b>NHTC</b>	National Health Training Centre
<b>NID</b>	National Immunization Day
<b>NMPC</b>	National Medicines Policy Co-ordination
<b>NPEC</b>	National Polio Eradication Committee
<b>NSFAF</b>	Namibia Students Financial Assistance Fund
<b>ORT</b>	Oral Dehydration Therapy
<b>OTS</b>	Orthopaedic Technical Services
<b>OVC</b>	Orphans and Vulnerable Children

<b>PDE</b>	Patient Day Equivalent
<b>PEPFAR</b>	President's Emergency Plan for AIDS Relief
<b>PHC</b>	Primary Health Care
<b>PLWHA</b>	People Living with HIV/AIDS
<b>PMS</b>	Performance Management System
<b>PMTCT</b>	Prevention of Mother to Child Transmission
<b>PSIP</b>	Public Sector Investment Programme
<b>PWD</b>	People Living with Disability
<b>RAG</b>	Research Advisory Group
<b>RED</b>	Reach Every District Approach
<b>RHTCS</b>	Regional Health Training Centres
<b>RMC</b>	Research Management Committee
<b>RMT</b>	Regional Management Team
<b>SADC</b>	Southern African Development Community
<b>SD</b>	Standard Deviation
<b>SSA</b>	Sub-Sahara Africa
<b>STI</b>	Sexual Transmitted Infections
<b>SWIS</b>	Social Welfare Information System
<b>TBA</b>	Traditional Birth Attendants
<b>TE</b>	Technical Efficiency
<b>TFR</b>	Total fertility rate
<b>THE</b>	Total Health Expenditure
<b>TTI</b>	Transfusion Transmissible Infections
<b>U5MR</b>	Under five mortality rate
<b>UNAM</b>	University of Namibia
<b>UNDP</b>	United Nations Development Programme
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children Fund
<b>US\$</b>	United States Dollars
<b>USAID</b>	United States Agency for International Development
<b>USG</b>	US Government
<b>VRS</b>	Variable Returns to Scale
<b>WASCOM</b>	Wages and Salaries Commission
<b>WHO</b>	World Health Organisation
<b>XDR-TB</b>	Extensively Drug Resistant Tuberculosis

## Executive Summary

This health and social services system review is the first major attempt by the Ministry of Health and Social Services (MOHSS) to take stock of its performance following the restructuring of the health sector that started soon after independence in 1990. It has enabled the sector to reflect on the successes, challenges, and failures of the Namibian public health and social welfare system, especially in view of the new challenges facing Namibia including emerging and re-emerging diseases such as HIV/AIDS, tuberculosis and malaria.

The main objectives of the review were identified by the ministry as follows:

- Conduct a comprehensive review and analysis of the health and social services system, including the Policy Framework of 1998 and all management systems and structures;
- Make a comprehensive review of the Primary Health Care Approach, its implementation, relevance, and impact on improving access to services;
- Assess the provision of social services by the Ministry of Health and Social Services; and
- Utilise the findings and recommendations of the review to redefine existing management and organizational structures, propose national policy changes and develop a national strategic plan for health and social services.

A national task force was established to steer this review. The task force developed a framework for the review that identified five key focus areas: ***Governance, Human Resources, Service Provision, Infrastructure and Health Financing.***

The review was part of a two-phase exercise aimed at improving health and social services in Namibia. In the first phase, a comprehensive review and analysis of the health and social welfare system, including the Policy Framework and management systems and organisational structures was conducted from mid-March to mid-June 2008. This document represents the output of Phase one, and with its finalization, the second phase will begin.

The second phase will involve the revision of the Policy Framework (including the Mission and Vision Statement of the MOHSS), and the development of a five-year Strategic Plan. This will be followed by the development of organisational interventions; revision of the organisational structure; a strategy to reform hospital services including nursing services, which was separately considered prior to this review; elaboration of policy/strategy for health care financing; and strategies for primary health care and for social welfare services.

In first phase data gathering was done in three stages:

1. Desktop review and literature review of relevant policies, guidelines, and reports;
2. Interviews with key informants and focus group discussions in communities, and information collected from eight target groups through interviews and focus group discussions; and
3. Submissions from individuals through a call for submissions advertised in The Republikein and New Era.

A one-week analysis and report-writing workshop was held after completion of the fieldwork, bringing together national level directors and programme managers as well as regional directors from all the thirteen regions and key staff from the four referral hospitals. Subsequently, a national stakeholders workshop was held to share preliminary findings of the review and to seek input from the stakeholders. This report outlines the key findings and recommendations in the five component areas identified in the review framework.

## **Key Findings and recommendations**

### **1. Governance**

The Policy Framework of 1998 states the goals, objectives, and principles for each sector within the Ministry of Health and Social Services as well as strategies for achieving these goals. In line with this framework, the ministry is organised into seven (7) directorates at the national level and 13 regional directorates and 34 districts. The national directorates are: 1) Primary Health Care, 2) Developmental Social Welfare Services, 3) Special Programmes, 4) Tertiary Health and Clinical Support services, 5) Finance and Logistics, 6) Human Resource Management and General Services, and 7) Policy, Planning and Human Resource Development.

## **Key Findings**

### **A. Leadership, Structure and Functions**

#### Leadership

The Organisational Performance survey and interviews revealed problems in the area of system leadership, clinical leadership and capacity and mindset of individuals.

With regard to system leadership, the following were found to be weaknesses:

- Clarity of direction fades at lower levels in the organization
- Perception gap in the effectiveness of the provided direction, e.g. directors have a more positive view than the rest of staff.
- The executive leadership team's contribution to the organization is not visible
- Current managers do not role model desired behaviours.
- No clear performance indicators or metric tracking system to give feedback on how well goals are met.

Clinical leadership was found to be lacking due to the following:

- Formal systems hamper development of clinic leadership e.g. limited incentive to choose a leadership position, and lack of mentoring.
- Leadership capability among clinicians is not systematically nurtured.
- Beliefs that clinical leadership is of low value, e.g. limited data to show impact, not perceived as core to the clinicians professional identity.

With regard to capabilities and mindset, the interviews revealed that there is lack of confidence due to insufficient management and leadership training which hampers the effectiveness of individuals in pivotal roles.

Other prevalent mindsets that were found to inhibit performance were distrust, lack of accountability and demotivation.

Strategic plan

There is a lack of a national strategic plan for the health sector. There is also no clear national strategy for social services.

Duplication of structures and functions

In spite of the efforts made in the restructuring of the sector over the years, the review found that there was fragmentation and duplication of functions in a number of divisions within various directorates including the following:

- Human Resource Management in Directorate of Human Resources and General Services whereas Human Resource Development is in Directorate of Policy Planning and Human Resource Development.
- Disability Prevention in Primary Health Care Directorate and Rehabilitation is in Developmental Social Welfare Directorate.
- Licensing of health facilities is in the Human Resources Management and General Services whereas another licensing and inspection function is in the PHC Services Directorate.
- Facility Planning is in Policy Planning and Human Resource Development Directorate whereas Facility Management is in Human Resources and General Services Directorate.
- General Services in Human Resources Management and General Services whereas Logistics is in Finance Directorate.
- The Directorate Policy Planning & HRD is responsible for the preparation of MTEF documents while the Sub-division on budgeting and budget control under Finance and logistics also have a budgeting responsibility.

This duplication has resulted in little sharing of information and poor coordination. It was found that divisions within one directorate often fail to realize the interrelationship of their functions and hardly cooperate with each other or coordinate their plans and activities. In some cases, certain activities are allocated to a certain directorate but the functions are carried out in another Directorate.

Further, the responsibility for social welfare is spread among different government ministries, notably Health and Social Services, Gender Equality and Child Welfare and Labour and Social Welfare. This has added confusion on the roles and responsibilities in the social welfare sector with duplication of services and lack of coordination in service delivery.

In addition, the MOHSS has many stand-alone information systems managed by different divisions in different directorates and running on different software. These systems include Health Information System (HIS) which is in Primary Health Care Services Directorate; Social Welfare Information System (SWIS) in Developmental Social Welfare Directorate; Management Information and Research in Policy Planning and Human Resource Development Directorate; and Monitoring and Evaluation in Special Programmes Directorate. This fragmented structure has created overlaps and duplication between the various systems.

**B. Policies**

The review revealed that most health facilities had copies of the most important guidelines, including clinical, ART, cholera, pharmaceutical, IYCF, school health, Vitamin A, CHBC, ARI, EPI, RH, TB, malaria, HIV, PMTCT, FP, and mental health guidelines. Over 80 percent of the 76 health facilities visited during the review had guidelines for PMTCT, HIV, Malaria,

and TB. However, less than 60 percent of the facilities had guidelines for nutrition and HIV/AIDS, infant and young child feeding and reproductive health. Overall, most health workers showed that they were familiar with these guidelines and utilized them in the delivery of services.

On the other hand, it was found that as much as 50% of managers at all the levels were not aware of the existence of some national policies.

An analysis was done to identify policies that needed to be finalised, those that needed to be updated and yet others which need to be developed. Among the policies that needed to be updated is the Public Health Act (as the country is currently using that of 1919) to provide guidance for sanitation and hygiene amongst others. The policies, which needed to be amended, include the policy and guidelines on working hours of clinics (in order to provide 24-hour operation after hours and public holidays – taking into account the Labour Act provisions). There was a strong feeling from the community that the health facilities should be opened during weekends and public holidays. Currently, all clinics and health centres are closed during weekends and holidays. The policies, which needed to be developed, include a clear national policy and strategy for health promotion and for behaviour change communication.

#### Decentralization

The review found that there was a delay in decentralization of services to the regional councils. However, there has been some deconcentration of the planning process, management and implementation of services and programmes from the central level to the regional and district levels. The issuance of Funds Distribution Certificates (FDCs) and payments are undertaken at national level.

#### Health extension work in communities

The formal structure of the health system ends at the clinic level and outreach points. Although the ministry has put emphasis on the implementation of community based health care and has trained about 5,000 community health workers, there are no clear structures to support community based health care services. The volunteer community health workers have no incentives and have inadequate support from communities and health workers.

### **C. Coordination**

#### Internal coordination

The review found that there was poor coordination within the Ministry among various programmes such as between HIV/AIDS & PHC in particular HIV/AIDS and RH, Health promotion and CBHC. Also there was a lack of coordination among vertical programmes involved in supporting community-based interventions was found.

#### Donor Coordination

The review found that there was a lack of over-arching coordination of the various partners involved in the health sector. The current approach of donor coordination, for example, is built on a number of structures that bring stakeholders with common interest together. These include the quarterly review meetings of the MOHSS and UN Agencies; MOHSS – USG Agencies (PEPFAR) Review meetings; and Inter-Agency Coordination Committee that bring stakeholders together on immunization, and NACCATUM, the Country Coordinating Mechanism for Global Fund.

Overall, it was found that there is inadequate coordination with, and involvement of, stakeholders in policy formulation and implementation.

### **Recommendations**

Among the key recommendations made by the review are the following:

1. Develop a national strategic plan for the health and social services sector that promotes coordination and synergy among the various programmes and pays a special attention to reaching the difficult to reach areas.
2. Review the core functions of the health sector and clarify roles and responsibilities of various levels of the health system.
3. Update the 1998 Health Policy Framework.
4. Restructure the ministry's organization structure to be responsive to new challenges. Develop an integrated M&E system for all programs under one roof to coordinate health, social services and management information (Research, MIS, HIS, Epidemiology, M&E). There is a need to immediately address overlaps in the following divisions and harmonize their functions: a) HRM and HRD; b) Disability Prevention and Rehabilitation in separate directorates; c) Facility Planning and Facility management/maintenance; d) logistics and general services; e) health facility licensing and inspections; and f) Management information separate directorates.
5. Establish community based health care providers as the lowest level of health services delivery, in collaboration with Regional Councils and develop a clear policy on health promotion.
6. All social services should be coordinated under one sector.
7. The Hospital Health Facility Act in collaboration with private sector should be revised in order to foster relationship that will commit the private practitioner to have a social responsibility to provide some of their services to the public sector and to ensure that they also provide HIS data to the Ministry.
8. Decentralise some components of PHC to Regional Councils (e.g. spraying programmes, sanitation, distribution of water purification tabs, CBHC, etc).
9. Improve the internal coordination between programmes through the establishment of Steering Committees and establish a coordination mechanism for partners in the health sector.
10. Revise the policy/directives on after-working hours, working during weekends and holidays in clinics and remote areas to make service available to the population at these times.
11. Hold an Annual Health Assembly to bring together all key stakeholders to review progress made by the sector, major constraints faced and the steps necessary for further improvement of the provision of health and social services.
12. Engage in an on-going policy analysis and review process to ensure that all policies and guidelines remain relevant to emerging challenges.
13. Ensure active participation of all stakeholders at all levels, including citizens' groups, in the formulation of health sector policies.
14. Build regional leadership capabilities and cross regional collaboration.
15. Ensure leadership renewal through ongoing development and succession planning.
16. Put a clear tracking system in place to clarify responsibilities and give feedback on how well people are meeting goals.
17. Elevate importance of clinical leadership, and enable talent (both MOHSS and other stakeholders) to thrive by putting a support structure in place, e.g. clear career paths incentives, training opportunities, etc.
18. Develop replicable model for hospital-based clinical leadership (e.g. Oshakati)

19. Extend clinical leadership programme across the PHC network and remaining referrals hospitals.
20. Assess and improve specific capabilities across pivotal roles through training.
21. The revision of the National Medicine Policy has started but needs to be completed as a matter of urgency and a second National Pharmaceutical Master Plan developed to guide pharmacy services in future years.

## **2. Human Resources**

The MOHSS drafted a Long-Term Human Resource (HR) strategic framework forecasting on the future needs and supply of required staff in the country for a period of thirty years (1997-2027). Subsequently, a Medium-Term Human Resources Plan (1997-2007) and Five-year Human Resource Development Plans (2000-2005; 2008-2012) were developed to serve as guidelines for HR planning.

### **Key Findings**

Although Namibia's health worker capacity is above the WHO benchmark of 2.5 health workers per 1000 population (with 3.0 health workers per 1000 population), there is a marked disparity in health workers capacity between the public and private sectors. While the private sector has 8.8 health workers per 1000 population, the public sector barely has 2.0 health workers per 1000 population (below the WHO benchmark). Within the public sector, the situation is compounded by chronic staff shortages amongst frontline workers (doctors and nurses) which - if addressed - could result in Namibia reaching the WHO benchmark of 2.5 health workers (in the public sector) per 1000 population.

### **A. Shortage of health professionals**

There is a general shortage of health professionals in Namibia due to a number of reasons highlighted below:

- Inadequate number of graduates are produced by the Ministry's Health Training Centres, the University of Namibia (UNAM), and the Polytechnic of Namibia to meet the demand; hence the unavailability of enough HRH professionals and sub professionals in the labour market.
- There are not enough Namibian high school graduates (Grade 12) entering health related study fields mainly due to lack of availability of good candidates with strong sciences and mathematics background to meet entrance requirements for health related study; particularly the pre-medical and pre-pharmacy programs.
- The lack of any medical school or institution for training pharmacists in country also has contributed to the acute shortage of key health professionals like doctors and pharmacists.
- The private sector's tendency to attract the few graduates produced by the local training institutions, including the few available doctors and pharmacists that the country had invested in by training them abroad.

### **B. Vacancy Rates**

Namibia has good ratios of health personnel to the total population compared to other Southern African Countries. However, additional health and social welfare personnel are still required to effectively deliver needed health and social services in this vast country. The vacancy rate in the overall public sector stands at 27% and the MOHSS institutional records reveal that the shortage of all categories of staff is a recurring problem in most of the facilities. Out of the total 5,509 established posts for key health programmes 1,482 (26.9%) remain vacant. Most categories are characterized by very high vacancy rates ranging from

20% to 63%, most significantly doctors at 36%, registered nurses at 21% and enrolled nurses at 24%. This situation is due to the following:

- The current staff establishment is outdated and is non-responsive to accommodate new developments and new programs (e.g. increased demand in HIV/AIDS, outreach staff, school health staff, CBHC staff, Pharmacist Assistants, Medical Rehabilitation Workers, radiographic assistants, mental health, etc.).
- There is a long recruitment process for government positions. Recruitment through the Public Service Commission (PSC) is a lengthy process, requiring several steps.
- The long process for issuing work permits to foreign nationals does not easily facilitate the hiring of much needed expatriates.
- Students financial assistance quotas received from the Ministry of Education are insufficient. Therefore, some health related students at the local and foreign academic institutions and UNAM are not beneficiaries of the Namibia Students Financial Assistance Fund (NSFAF), and continue to study in very difficult conditions.
- Students supported through the Namibia Students Financial Assistance Fund (NSFAF) are not obliged to work for the Government after completion of their training. They can take up employment with any sector provided that they pay back to the Fund. This contributes to the shortage and a high turnover of health professionals in the public sector.
- Salary scales/grades are not correlated to educational levels or years of training. This is evidenced by the high vacancy rates among Physio/Occupational Therapists.

### **C . Attrition Rates**

The public health sector has suffered high levels of attrition for the past ten years. A cumulative loss of 3,309 health professionals has been registered. The annual average attrition rate for the health professionals is about 5%. Radiographers have the highest attrition rate at 16%; followed by dentists 11%; pharmacists 10%; environmental health officers 9%; doctors 8%; social workers 8%; and registered nurses and enrolled nurses 4%.

The main reasons for human resource losses from the public health service during the year 2005/2006 were resignations with 51%, followed by retirements 20%, death (17%) and transfer to other sectors (5%). These very high rates are threatening the sustainability and efficacy of the health system.

### **D. Lack of HR Retention Strategy**

There is limited career movement in the public health sector leading to a high staff turnover. The Public Service Management Circular No. 32 of 2002 stipulates that staff members in public service may only apply for promotional posts one grade higher than their own. However, applicants who are not in the public service are allowed to apply for posts at any level. There is a lack of a career ladder in some type of health professionals/sub professionals who are condemned to remain in an entry position until retirement or to have not more than one promotion in their whole life.

There is also a lack of Performance Management System (PMS). The PMS is not yet functional; the staff appraisal is still being done in a traditional manner, where performance is not necessarily rewarded.

Further, incentive packages are not sufficient to encourage staff retention.

### **E. Staff Burn Out**

Generally, there is high workload in the ministry as a result the Ministry staff is experiencing burnout. This is more evident in health facilities due to high disease burden especially HIV/AIDS. Although this is the situation, the Ministry has not yet implemented Employee Assistance Programme, which is aimed at enhancing the health, well-being and performance of the workforce. EAP is dedicated to supporting and strengthening the workplace environment by providing professional help for employees whenever they need it, placing emphasis on prevention, treatment, support, care and confidentiality.

### **F. National Health Training Centre (NHTC)**

It was found that NHTC is having inadequate human capacity to cope with its demand especially in the area of pre-services training and continuous education. While the NHTC and the RHTC offer pre-service training, there in-service training which is predominantly in HIV rather than the other program areas. Furthermore, due to the high intake of students, the available training space is far from adequate. This is especially noticeable in the regions at the Training Networks. It was also noted that there is a mismatch between the NHTC staff responsibilities and their levels of grading.

### **Recommendations**

1. Review the staff establishment to accommodate posts for emerging needs.
2. The staffing of health facilities should be based on population, distance and workload.
3. The filling of vacant posts should be accelerated.
4. The MoHSS should seek from the Ministry of Home Affairs and Immigration a special treatment for health workers and if possible to become part of the Immigration Board to speed up the process.
5. A compulsory community service by all new health related graduates should be enforced before registered as independent practitioners. These regulations should be enforced by various health professional councils.
6. Private health professionals should be encouraged to offer part time services in public health facilities.
7. The MoHSS should lobby with the Ministry of Education (MOE) to implement the conversion of the study loans received by health related students from the Namibia Students Financial Assistance Fund (NSFAF) into grants.
8. Capacity of local training and academic institutions should be strengthened to increase the intake of students in the various professions this is to include NHTC and to align its salary grading with responsibilities.
9. Expedite the establishment of a medical school.
10. The community health workers should be made extension workers of the Ministry of health in order to strengthen the primary care approach and incentives provided to them.
11. Better career marketing & promotion of the health related professions through intensive career guidance should be conducted by the MoHSS in collaboration with the MOE in high schools.
12. Strengthening and improvement of Human Resource Management Systems.
13. The Performance Management System (PMS) should be implemented
14. Establish Performance indicators for service personnel and a comprehensive monitoring and verification system.
15. Consider career path development of all job categories, which is not attached to competitive promotional positions at least once or twice in each job category e.g.

senior and principal level and also recommend review Circular No. 32 of 2002 not to restrict especially the health professionals.

16. Review and adjust of salary grades to harmonize remuneration packages of staff members in same occupational categories and carrying out the same functions.
17. Review and re-introduce the deprivation packages for staff working in remote areas, in order to improve their conditions of service. As part of this, health workers should be exempted from the renting fee in rural areas.
18. Consider the creation of new specialist cadres of nurses to address the current constraints and improve on their career paths.
19. There is an urgent need to revise the current MoHSS staff establishment for pharmaceutical services so that it can cater for the additional services that are now being provided – at both operational level and national level. An investigation should also be done into the feasibility of starting a pharmacy diploma course in Namibia.
20. Implement Employee Assistance Programme.
21. Recommend the review of WASCOM decision.

### **3. Service Provision**

In spite of the apparent increase in infant and under-five mortality rates and maternal mortality ratio between 2000 and 2006, there has been a significant increase in the coverage of various services in Namibia. The public health system has a network of health facilities consisting of approximately 1,150 outreach points, 260 clinics, 40 health centres, 30 district hospitals, 3 intermediate hospitals and 1 national referral hospital, as well as various social welfare service points.

#### **Key Findings**

##### **A. General Findings**

###### Health Services Packages

The review found that the national essential package is yet to be finalized and that there was a need to define a district health Package

###### Access to Services

The vastness of country causes geographical accessibility challenges, high opportunity cost and lack of transport. Out of the 295 clients interviewed upon exit from the 76 health facilities, 41.5% had travelled for less than 5 kilometres, 27% travelled for 5-10 kilometres, 8% 11-20 kilometres and 13% travelled for greater than 21 kilometres.

###### Satisfaction with Services

Consumer perception about quality of services received was very favourable with less than 10 percent rating the services as poor in all regions except in Hardap where 12.5% rated services as poor. About 60 percent of respondents in exit interviews rated the services they received as good and above showing that there was a general satisfaction among communities with the services provided. However, many respondents were unhappy with the closure of health facilities during weekends and holidays.

###### Participation of Communities

Overall, 72% of health facilities visited during the review had health committees which included community members. In Oshana, had the highest percentage (100%) followed by Oshikoto with 92% whereas in Khomas only 17% all health facilities visited had committees

with community members. This relatively high participation of community members may have contributed to the relative satisfaction with the services provided.

There has been an increasing number of community based organisations and larger NGOs and FBOs that have become involved in delivering CBHC at the household level. In 2007, 290 organizations and around 20,000 volunteers have been involved in delivering CBHC. About 5000 community based health care providers have been trained in provision community health services (such as hygiene, home based care, prevention of diarrhoea,). In total, 11,000 HBC kits have been purchased and distributed to all regions for HBC and palliative care. An assessment has been carried out on community volunteers and community based health care programmes

#### Supportive Supervision

Support supervision from the regional levels to the 76 health facilities sampled in the review was generally weak. Overall, 30% of the health facilities were visited once in the 3 months before the review visit. 67% of facilities in Khomas, 66% in Kunene, 20% in Kavango, 27% in Oshana, 25% in Oshikoto, 23% in Otjizondjupa were visited once in the previous three months. It is evident that support supervision is poor in most of the regions.

#### Outreach/Mobile Health Services

The review found that outreach/mobile services are not functioning optimally as most of the regions reported having no transport for outreach services. This impact negatively on a number of health indicators such as EPI coverage and Infant mortality rate – it is therefore not surprising that IMR has increased over the years.

#### Referral System

The referral system is poor as a result there is no continuity of care is provided. This is mainly due to lack of transport in particular the number of ambulances. On average just above 20% of the facilities had ambulances available. Furthermore, it was observed that the referral policy of the Ministry is not working well. It was observed that some facilities are over-crowded as a result of self-referrals; patients are bypassing the lower level facilities and access hospitals directly.

#### Health Promotion

Overall, health promotion is inadequate at all levels. In the focus group discussions as well as in the exit interviews, respondents indicated that apart from HIV/AIDS, they receive little or no information on health issues. The capacity at the national and regional levels for adequate support to health promotion and for effective behaviour change communication was found to be weak. Community based health care (CBHC), which is aimed to empower communities to increase awareness and knowledge does not have a clear health promotion strategy.

### **B. Impact of PHC**

The review found that the primary health care approach has been successfully implemented over the past decade. Progress has been made in various areas as detailed below.

The proportion of children vaccinated against measles by age 12 months slightly increased from 76% in 1992 to 84% in 2006, slightly surpassing the national district target of 80%. Immunisation programme has had a major impact in Namibia resulting in virtual elimination of neonatal tetanus by 2005, and significant reduction of measles cases between 2003 and 2007. However, recent surveillance data indicates a re-emergence of neonatal tetanus cases.

The implementation of Integrated Management of Childhood Illness has been implemented in 47% of health facilities. A total of 577 (70%) out of eligible 828 health workers have been trained in IMCI case management. In addition, pre-service IMCI training was introduced into University of Namibia (UNAM) nursing curriculum since 2002. A total of 545 final year nursing students have now been trained in IMCI case management in Windhoek and Oshakati campus. The health workers have been deployed in various regions and districts including those where IMCI was not formally introduced. The review has found that the implementation of IMCI has been slow and that follow-up as well as supportive supervision were inadequate.

The management of acute respiratory infections as well as of diarrhoea are part of the IMCI strategy. However, in the districts where IMCI has not been implemented efforts needed to be made to continue implementation of ARI and ORT activities. The ORT rate has stagnated with a slight increase between 2000 and 2006 according to DHS findings.

Although acute respiratory infections are among the leading causes of morbidity and mortality in children under-five, not enough has been done to improve the management of acute respiratory infections. The MOHSS essential indicators report of 2006/07 show that diarrhoea (29%), pneumonia (29%) and HIV/AIDS (8%) are the major causes of infant mortality. The same three conditions are the leading cause of child mortality (age 1 to under 5 years) with diarrhoea causing 35% of reported deaths and pneumonia and HIV/AIDS causing 24% and 8% of reported deaths respectively. The high prevalence of diarrhoea is largely due to poor sanitation and hygiene practices especially in some regions such as Caprivi, Kavango and Ohangwena. Community based treatment for pneumonia has not yet been introduced in Namibia.

The ORT rate has increased slightly between 2000 and 2006 according to DHS findings. There is regional variation with Erongo and Ohangwena regions having over 80% ORT rate whereas Kunene, Caprivi and Omaheke less than 60% ORT rate.

Malnutrition rates remain high in Namibia aggravating diarrhoea and infant mortality as a whole. Seventeen (17%) of children were found to be underweight (NDHS 2006), including 4% severely underweight (below -3SD) from the median of reference population. The prevalence of underweight status was highest in Oshikoto (22%), Oshana (21%), and Hardap (20%) regions. About one-third of children (30%) were found to be stunted (Height-for-age), while 10 percent were severely stunted (DHS 2006). There has been an improvement in nutritional status of children as compared with previous findings. The proportion of children younger than 5 years of age who are underweight has declined from 26 percent in 1992 to 17 percent in 2006. Similarly, the proportion of children who are younger than 5 years who are stunted has declined slightly from 28% in 1992 to 24% in 2000, but increased to 29% in 2006. The caring and feeding practices also contribute to the high malnutrition rates in Namibia. Exclusive breastfeeding at 5 months has declined from 26% in 2000 to 24% in 2006 with most of the hospitals with delivery facilities declared baby friendly.

Sanitation coverage in Namibia is poor with a national coverage in 2006 of less than 40%, aggravating the prevalence of diarrhoea. Ohangwena, Omusati, Caprivi and Kavango all had less than 20% sanitation coverage in 2006. Sanitation is not always receiving its due attention because of it is a cross cutting service between Health, Agriculture and Housing. From a health point of view, sanitation is a very mechanism to prevent disease outbreaks but other

sector may have a comparative advantage with regard to the constructions of toilets, but the collaboration in this regard is weak.

Antenatal care (ANC) attendance in Namibia is very high at 94.6 percent in 2006 for first visits to antenatal care clinics showing a slight increase of 1.6 percent compared to 2000 DHS. Although most women tend to delay first visit to ANC, rural women are more compared to urban women. A significant percentage (23.4 %) of women only visit ANC after six months of pregnancy, which may lead to late detection of pregnancy complication.

PMTCT is implemented in an integrated manner with ANC services. By March 2007, PMTCT services had been rolled out to 189 (57%) out of the 331 health facilities (all 35 hospitals and 153 health centres and clinics). During the period of March 2006 to March 2007, 94% of women starting ANC services were pre-test counselled and 91% of them accepted to be tested for HIV. Seventy percent (70%) of all HIV positive women had a CD4 count done in 2006/2007.

Maternal mortality has almost doubled from 225 maternal deaths per 100,000 live births in 1992 to 449 in 2006.

The 2006 DHS found that a high proportion of deliveries (81%) take place in health facilities. There are slight regional disparities with Khomas having 95% of women delivering in health facilities followed by Karas and Erongo at 91% then Hardap at 90%, Oshana, and Omusati at 88% and 87% respectively. Kavango and Kunene have the lowest proportion of women delivering in health facilities at 62% and 53% respectively.

On the other hand, a survey of all hospitals, health centres conducted in all 13 regions in 2005/06 found that only 4 (11.8%) out of 34 hospitals provided comprehensive emergency obstetric care, i.e., provision of the following services: a) administration of parenteral antibiotics; b) administration of parenteral oxytocics; c) administration of parenteral anticonvulsants; d) manual removal of placenta; e) removal of retained products; f) assisted delivery; g) blood transfusion; and h) caesarean section. These are the live saving functions which must be provided by all hospitals to ensure that the 15% of pregnant women expected to have complications are adequately cared for. On the other hand, no health centres provided the basic emergency obstetric care, i.e. the provision of all the above services except for blood transfusion and caesarean section. Only 17.6% of women expected to have obstetric complications are treated in EmOC facilities. This means that there is a big unmet need for EmOC of over 80%.

Thirty eight percent of all women in Namibia are currently using a contraceptive method, with 37% using modern contraceptive methods. Marked differences are found among regions. Contraceptive prevalence among sexually active women is highest in Erongo, followed by Otjozondjupa and Karas regions, where around two-thirds of women are currently using modern contraceptives. At the other end of the spectrum, one in five sexually active women in Ohangwena Region is currently using family planning methods.

### **C. HIV/AIDS/TB/Malaria**

Namibia has performed well in the provision of anti-retroviral treatment. The total number of clients on anti-retroviral therapy as of March 2008 stands at 47,963.

There was a remarkable increase in condom use between 2000 and 2006. During the 2000 DHS, more than one-quarter of women said they used a condom the last time they had sex. In 2006, this practice has improved drastically with about two-thirds of the women reporting use of condoms. However, condom usage among women in nine out of the 13 regions was below 60%.

Tuberculosis is a major public health problem in Namibia, a situation that is compounded by the HIV epidemic. In 2006, 15,771 tuberculosis cases were reported in the country, with a case notification (CNR) of 765 cases per 100,000 population. Although there has been a downward trend in the number of notified cases, from 790 in 2005 to 722 in 2007, the CNR is one of the highest in the world.

The monitoring of Multi Drug Resistant Tuberculosis (MDR-TB) and Extensively Drug Resistant TB (XDR TB) in the country have resulting in finding of 8 cases of XDR TB. The emergence of XDR TB imposes additional challenges for improved infection control in health facilities, including the provision of isolation wards, improved capacity for the management of the identified cases, strengthened surveillance, and reporting.

Malaria is one of the leading causes of illness among under-five children and adults in Namibia. Nine of the 13 regions and 22 of the 34 districts, mainly in the northern and central parts of the country are affected, with approximately 67% of the population living in the malaria endemic areas.

The annual number of malaria cases has declined consistently since 2000, except in 2004. In 2006 and 2007, the outpatient malaria cases dropped by 35% and 79% respectively when compared with the 2000 level. Similarly, malaria deaths declined by 41% and 82% in 2006 and 2007. Namibia practices indoor residual spraying and promotes use of insecticide treated nets.

#### **D. Non-communicable diseases**

Although population-based data are lacking, there is concern that Non-Communicable Diseases (NCDs) are emerging as important causes of morbidity and mortality in the country. Health facility based data indicate hypertension and diabetes as the first and second causes of disability among adults respectively. From HIS reports, heart failure, hypertension, and stroke collectively were responsible for 5% of all health facility deaths in 2005. The proportion of these NCDs deaths grew to 6% in 2006 and 8% in 2007. Mental, neurological, substance abuse and psychosocial related disorders are considered a problem, although reliable data are not available. Cancers are also on the increase, constituting 0.6% of hospital deaths between 2005 and 2007.

#### **E. Hospitals**

Hospitals play a critical role in the delivery of health services in Namibia. Their availability, spatial distribution, accessibility to the population, range of services delivered, management, and attitudes of health workers providing services in them go a long way in determining the perception of the quality of services by the utilizing population.

The survey found that hospitals in the country provide a full range of medical services including diagnostic, treatment, pharmaceutical, care, counselling, rehabilitation, and emergencies. They also serve as referral centres for the lower level facilities (health centres and clinics) and are available for 24 hours of the day. However, hospitals suffer from a

general paucity of transport logistics for service delivery to facilitate movement of drugs and supplies, and staff for outreach services and supervisory visits. The frequent breakdown of some critical equipment and machines, coupled with the absence of equipment replacement plans were identified as a constraint to the delivery of quality services.

With respect to hospital management, the survey found that most hospitals are currently being managed by medical personnel who may not necessarily be skilled or trained in hospital management. The management/organizational structures in the national and intermediate hospitals are not well defined. Most hospital management teams do not hold regular management meetings. There is a lack of supervision of subordinates by managers in most hospitals. Some doctors do not adhere to working hours. Crucially, there is a practice among some doctors of leaving the hospitals to do other remunerative activities such as locums and part time private practice during working hours, with the attendant adverse effect on service delivery.

### **F. Mental Health**

Mental illness is a major cause of morbidity as well as some mortality amongst the population of Namibia. Major constraints include lack of adequate skilled labour and mental health facilities and equipment, and inaccessibility of services by majority of the population particularly those in rural areas.

### **G. Social welfare**

The social welfare sector provides treatment and rehabilitation to abusers of drugs and alcohol. The treatment is provided at treatment centres and is followed by after-care services which are essential in minimising relapses.

The provision of family welfare services by the ministry has decreased following the transfer of key functions, such as child welfare and social assistance to other Ministries.

The Directorate Social Welfare Services has a statutory responsibility to register homes for older people and develops the requirements and minimum standards for registration, including guidelines, and provides quality assurance through inspection and investigations of complaints. The homes for older people registered at the MOHSS are Hardap (1), Omaheke (1), Karas (2), Khomas (3), Otjozondjupa (4) and Erongo (5).

The ministry also provides services for people with disability. The 2001 Population and Housing Census, shows that the number of people with disabilities in Namibia is around 85,567 or 4.7 % of the total population. The population is almost equally distributed between females and males, but higher in rural areas than urban areas.

Family Welfare has been severely compromised following the transfer of key functions, such as child welfare and social assistance to other Ministries. Despite this, the Ministry intervenes in order to ensure that the family functions as an integrated unit. It provides marriage counselling, bereavement counselling, suicide, family violence, unwanted pregnancies, prostitution, property grabbing and links families to appropriate resource systems. Much emphasis is placed on promoting the well-being of older people.

Alcohol abuse is among the contributors to ill health in Namibia. Research conducted in the Nation-wide KAP Baseline Survey on Alcohol and Drug Use in Namibia, published in 2002,

by MOHSS, suggest that the 55.6% of Namibians that currently drink, 47.9% felt that they had drunk more that was good for them and 11.3% had sought treatment.

## **H. Support Services**

### Transport

There is currently no replacement plan although vehicles has to replaced when the running cost per kilometre exceed N\$ according to the Transport policy. A lack of funds has hampered continues replacement of vehicles especially ambulances and outreach services. There is also no system in place that assured the availability of funds such as what happening in Ministries of Agriculture and Works and Transport which use a Trade Account for the replacement of Vehicles.

Due to the no replacement plan of vehicles, transport officers tend to keep vehicles for a period way past their life span and the running cost as a result become very expensive. There is no policy in place to indicate that if a vehicle reaches a certain kilometres or after depreciation over a certain number of years the vehicle has to be written off.

### Laundry Services

The ministry is faced with ageing laundry equipment which is in most cases dysfunctional or semi-functional marred by regular breakdowns. As a result, a substantial number of hospitals are transporting the lined to other hospitals or making use of private laundry suppliers. This in turn means that the staff at the Ministry who are employed for this function are not utilized.

### Cleaning Services

The Ministry is responsible for the cleaning of all hospitals and other facilities with the exception of Head office, which is cleaned by personnel of the Department of Works. It was noted that in many facilities there is poor supervision of cleaners because the cleaning staff do not fall directly under the nurse in-charge, as it was the case before. It was further noted that cleaners have bad attitudes/lack of commitment and tend to disappear from work before their knock off time.

### Contract management

The Ministry spends large sums of money on the provision of catering, cleaning, laundry services, security and equipment maintenance. However, there is evidence that the Ministry is losing substantial amounts due to the weak management of contracts with private sector suppliers. There is a general lack of knowledge of the contract contents amongst Ministry administrative staff.

## **Recommendations**

1. Strengthen and extend maternal and child health services at all levels.
2. Roll out the Road Map on reducing maternal mortality and improving newborn health.
  - a. Establish maternal death audit and make maternal deaths notifiable.
  - b. Scale up EMOc services: Scale up Basic EmOC in health centres and large clinics and ensure all hospitals provide comprehensive EmOC: Equip health centres and large clinics with basic EmOC equipment to do routine deliveries.
  - c. Scale up PMTCT and promote timely ANC attendance.
  - d. Promote family planning and develop strategies for reducing teenage pregnancies.

3. Scale up cost effective child survival interventions: Roll out and support the “Reach Every District” (RED) Approach and strengthen routine immunization coverage; introduce new vaccines; scale up ORT, ITN use and breast-feeding.
4. Implement Child Days to facilitate bi-annual supplementation of Vitamin A and to accelerate childhood immunisation.
5. Promote caring practices through effective communication for behaviour change.
6. Revive the baby Friendly Hospital Initiative and promotion of exclusive breastfeeding in communities.
7. Extend the health services into communities, through the recruitment of paid community health workers.
8. Reach consensus on a minimum package of an essential health service provision and cost it to inform resource allocation and HR deployment.
9. Ensure availability of a separate vote for outreach services.
10. Improve the ambulance and the referral system.
11. Supportive supervision is essential and must be done regularly, with an accepted supervisory checklist, aimed at improvement of service delivery.
12. Continually update knowledge and skills of health workers including on interpersonal communication.
13. Regions, especially in remote areas must be encouraged to establish more welfare organisations, while existing welfare organisations must be encouraged to extend their services to remote areas.
14. Strengthen the hospitals’ managerial capacity through relevant training for current manager in Hospital Management, and in future employ suitable CEOs for the job (medical or non-medical).
15. Clearly define the management/organizational structures of the National and Intermediate Hospitals.
16. Create autonomy and enhance governance of hospitals through the creation of Hospital Management Boards and introduction of professional managers.
17. Establish an umbrella structure for Health Service Management at national level to specifically support the hospitals with the following divisions:  
Quality Improvement, Nursing services and Hospital services
18. Strengthen the capacity to deliver PHC services at health centres and clinics level to reduce over-crowding at hospitals and instances of patients accessing the health system directly at the hospital level.
19. Conduct public education to increase TB case detection and retention and strengthen community-based DOT programme in all regions.
20. To establish a comprehensive mental health service structure for appropriate mental health services at national, regional and district and community level.
21. Strengthen of rehabilitation programs e.g. gardening, sewing, at the Mental Centre (Occupational therapy department) by sufficient budget allocation.
22. Improve the monitoring of multi-drug resistant TB in all regions.
23. Accelerate HIV/AIDS prevention in all regions and improve collaboration between HIV/AIDS and PHC programmes at all levels.
24. Explore the possibility of outsourcing the non-medical services and strengthen the current contractual arrangements that are in place.
25. Strengthen Health Promotion including establishing structures at the regional and district levels to cater for the assigned functions.
26. Decentralise Sanitation Services in line with the awaited recommendations from WASP Review Committee.
27. Update and finalise the national developmental social welfare policy through a participatory process.

28. Sensitise the top structure in the MOHSS on the need for merging of social welfare services, establish stakeholders forum on social welfare to lobby for the merging of social welfare services.

#### **Social Services**

29. Revise Transport Policy.
30. Develop a vehicle fleet management system.
31. Develop a vehicle replacement plan.
32. Introduce Trade Account for vehicles replacement.
33. Separation of ambulance services from general transport service at referral hospital.
34. Gradual replacement of all laundry machines in facilities.
35. Outsourcing of laundry services.
36. Strengthen the contract management on catering.
37. Outsource cleaning services

## **4. Infrastructure**

### **Key Findings**

Public health facilities are poorly maintained. This can be attributed to several causes including inadequate funding, failure of material and finishes poor supervision, and unclear lines of responsibilities between the MOHSS and the MOWTC.

The most significant constraint within the infrastructure component is the lack of professional staff and maintenance staff within the facilities and maintenance areas. There are no architects, clerk of works, quantity surveys or even accountants. The facilities planning department is run by a very small staff and a clerk who manages an annual budget of over N\$ 200 million. Because of the lack of technical staff, the projects are managed wholly by the Department of Works and at their schedule and often duplicating activities within the construction process. The MOHSS does not have the staff to vet architectural/construction drawings, nor does it have the staff to monitor ongoing work, or the completed facility. The lack of an empowered institution that can properly plan, manage and maintain facilities is the primary weakness in the infrastructure sector. This deficiency affects all other sectors of health delivery. For instance, the lack of ventilation affects the morale of staff. The lack of properly planned facility forces many facilities to use the outside as the waiting room.

The other constraint identified by the survey in infrastructure is the inadequacy of the existing criteria for the establishment of health facilities. While some facilities are over-subscribed, some others only see a handful of patients daily. Most key informants also identified the lack of involvement of users in planning process, designing, and construction project as impacting negatively on service delivery in the country.

The low priority given to capital projects as reflected in the budget allocation, compounded by the centralization of the budget for construction/maintenance of health facilities were also noted as major constraints.

The survey noted that the heavy bureaucracy and multiple centres of decision-making unnecessarily constrain the quick completion of construction projects as well as delays in carrying out routine maintenance. This occurs principally with the existing procedures for construction and maintenance that involve the MOHSS, the parliament and the Department of Works. The cumbersome procedural requirements create major backlogs in maintenance and new construction.

The survey noted some significant successes in respect of increasing the stock of health infrastructure in the country in the past years, resulting in a decrease in the population per health facility. However, regions population per fixed health facilities has remained high in Khomas and Ohangwena due to in-migration and high population growth rate respectively. Area per fixed facilities has changed tremendously in some regions but has changed little in the regions in such as Omaheke and Karas. In some regions, people are travelling for more than 300km to get to the closest hospital. The review noted that the current criteria for establishment of new facilities put more emphasis on population and less on distance.

## Recommendations

The MOHSS must take a few critical and proactive steps to streamline the procedures for construction and maintenance of the health facilities.

1. Integration of Facility Planning and Physical Facilities Management Unit (with combined competencies of maintenance and capital planning) bring it one roof as Asset Management.
  - a. Create new positions within the Facilities Planning Unit with technical staff including architect, engineer, quantity surveyor and accountant.
  - b. In line with Cabinet decision, a building maintenance unit should be established at the National level and a strategy to decentralize this function to the regional and district levels.
2. Review the criteria for establishment of health facilities and subsequently revise the relevant standards and norms policy document for establishment of health facilities
3. Increase the budgetary allocation to capital projects and decentralize the major and minor capital projects with its budget to the regions.
4. Actively involve all stakeholders in planning process, designing, and construction of projects at regional, district and clinic levels.
5. Construction of all new facilities should cater for all essential services and programmes, while attempts should be made to refurbish existing facilities to provide space for the essential services.
6. Expand space for Central Medical Stores.

## 5. Health Care Financing and Finance Planning

### A. Health Care Financing

Namibia's health care system is a mix of public and private financing. The public system provides universal coverage and is predominantly funded through general taxation while the private health care system which provides either comprehensive or partial health care coverage is funded largely through employee and employer contributions.

Namibia's Total Health Expenditure (THE) as a percentage of GDP for 2005 was 6.7%. Over a ten-year period, the expenditure as percentage of GDP has averaged 6.7%. In terms of per capita expenditure for the period 1996–2005, the range is N\$ 580 – N\$ 1264. The total health expenditure as a percentage of GDP compares favourably with countries in Southern and Eastern Africa, however the per capita total expenditure of Namibia is almost less than half of Botswana and South Africa.

The budgeting process in the ministry involves all levels at national, regional and district: There is a need to ensure that the budget allocations match priorities at the specific levels. User fees structure and administration has not been reviewed in recent years.

## **B. Financial Planning**

### Budgeting

There is no clear demarcation of responsibilities when it comes to the preparation of Medium Term Expenditure; while this functions structurally under Directorate Finance and Logistics the actual work is being done by the Directorate Policy, Planning & HRD. This creates some bottlenecks in terms of the smooth finalization of the budget. In the MTEF, the budget allocation to programmes does not take the cost element into account; the costing exercise is not done due to lack of skills. Currently the programmes reflected in the MTEF is a clustering of the Main Divisions of the old line item budget with a percentage included of National Directorate budgets calculated based on staffing. The current budget process is a top-down approach whereby MTEF is only done at the National Level.

### Budget control

The budget forward plans, which are forwarded by the FDC holders, do not always correlate with the activities or statutory payments resulting in delays. There is lack of accountability of FDC Holders. There is poor budgeting system and poor management accounting system. In order to control funds the Ministry of Finance developed an Integrated Financial Management System. Because this system is Windhoek based it has created problems for the FDC holders who have to travel to Windhoek on regular basis for commitment of requisitions.

## **Recommendations**

1. Review of budget preparation responsibility
2. Review budget process in the Ministry to accommodate a more bottom-up approach
3. Review the programmes in the MTEF
4. Allocate more financial resources (transport, & outreach services)
5. Monitoring tools for resource allocation and utilization
6. Delegation of FDC to districts
7. Review of budget preparation responsibility
8. Policy on retention of user fees at point of collection
9. Institutionalize policy on exemption for those unable to pay
10. Implement feasibility studies for universal coverage (free health services through universal insurance scheme).
11. Develop proper system of procurement and payment of suppliers; review the staff structure at both National and Regional Levels. Roll out of IFMS to regions, hospital and other directorates.

The above findings and recommendations will enable the Ministry of Health and Social Services to improve service delivery and reduce inequity in access to services in all regions of Namibia. These recommendations will be considered by the ministry as it develops a national strategic plan for the sector.

Overall, this review would result in a major reform that would position the Ministry of Health and Social Services as an effective and progressive public institution that is able to optimize

its ability and contribute significantly towards the attainment and realization of Namibia's Vision 2030.

## **6. Conclusion**

It is evident from this report that the objectives of phase one of the report have been met. In this report, major findings and recommendations have been made in each section of the report and summarised in the Executive Summary. From these findings, it can be concluded that the sector has made major progress since independence to address the health needs of Namibians, although major challenges remain. According to the results of the Demographic and Health Surveys, there was remarkable progress in key indicators between 1992 and 2000 following the introduction of Primary Health Care Approach soon after independence. However, the 2006 DHS has found a reversal in a number of these key indicators as already highlighted in the report.

In phase two of this exercise, the MOHSS will develop a *Five-Year Strategic Plan* which will address these and other challenges. In addition, the policy framework (including Mission and Vision Statement) will be updated to enable the ministry to respond to the challenges faced. Further, strategies for primary health care and for social development will be updated with active involvement of key stakeholders.

In conclusion, it is evident that the review has re-energised the health sector and that the leadership in the sector is fully committed to reforming the sector.

## CHAPTER 1. INTRODUCTION AND BACKGROUND

### 1.1 Background

At independence in 1990, the Government of Namibia inherited a fragmented health care and social welfare system which was administered by Second Tier Authorities that created eleven different administrations and parallel programmes<sup>1</sup>. One of the first tasks of the new Government was to bring together these Second Tier Authorities, leading to the creation of the Ministry of Health and Social Services. The primary health care approach adopted by the new government provided an opportunity for the restructuring of the public health sector based upon the principles of equity, affordability, involvement of communities and participation of other sectors in the provision of services. This resulted in a rapid transformation of the sector with the creation of new structures including new directorates that enabled the Ministry of Health and Social Services (MOHSS) to unify the fragmented services and to pay special attention to disadvantaged regions and difficult to reach communities. All these changes were embodied firstly in the Policy Statement of 1990<sup>2</sup> and subsequently in the Policy Framework of 1998<sup>3</sup>.

At its inception, the Directorate of Social Services within the MOHSS was responsible for the professional social welfare services, as well as social assistance. However, the problem of fragmentation that was experienced before independence, continued when the child welfare functions (statutory- and non-statutory services, residential care services, grants and allowances with regard to children) and social assistance (old age pensions, disability grants, war veteran grants and administrative functions) were transferred to the Ministry of Gender Equality and Child Welfare (MGEWCW), and the Ministry of Labour and Social Welfare (MoLSW) respectively. In 2005, the Division of Disabilities Prevention and Rehabilitation responsible for social integration of people with disabilities was transferred from the Ministry of Lands and Resettlement to the MOHSS to harmonise services. With the establishment of the Ministry of Veteran Affairs (MoVA) in 2007, the functions of war veteran subvention administration were transferred from the MoLSW to the MoVA.

During the first ten years after independence, major progress was made in all regions in Namibia with the improvement in key health indicators<sup>4</sup>. However, recent statistics point to a reversal in the gains made<sup>5</sup>.

This health and social services system review is the first major attempt by the ministry to take stock of its performance especially in view of new challenges including emerging and re-emerging diseases such as HIV/AIDS, tuberculosis and malaria. It is an attempt to reflect on the successes, challenges, and failures of the Namibian public health sector since independence and to outline possible new approaches and strategies to address these challenges.

The review was comprehensive covering five areas namely *governance, health financing, human resources, service provision, and infrastructure*.

The main objectives of this exercise were to:

1. Conduct a comprehensive review and analysis of the health and social welfare system, including the Policy Framework of 1998 and all management systems and structures.
2. Make a comprehensive review of the Primary Health Care Approach and Strategy, Developmental Social Welfare Approach and Strategy, their implementation, relevance, and impact on improving access to services and promoting equity.
3. Utilise the findings and recommendations of the review to redefine existing management and organizational structures.
4. Propose national policy changes.
5. Revisit other key strategies that are of paramount importance to health care delivery in the country; and
6. Develop a strategic plan.

Overall, through this review, the ministry set out to, inter-alia:

1. Gain a better understanding of the functionality and inter – relationships among different levels of the health and social and social welfare system;
2. Identify internal and external factors that have contributed to success and failures of the system;
3. Better understand and articulate the mandate, aims and objectives of the Ministry of Health and Social Services;
4. Develop appropriate strategies and responses to address critical challenges; and
5. Identify core and non-core functions, and eliminate duplications and overlaps.

The result of this two-phase process will help to position the ministry as an effective and progressive public institution that is able to optimize its ability and contribute significantly towards the attainment and realization of Vision 2030<sup>6</sup>.

## **1.2 Methodology**

The health and social services review was conducted from mid-March to mid-June 2008. The review was coordinated by a national task force chaired by the Director of Policy Planning and Human Resource Development. The task force reported to a Steering Committee chaired by the Permanent Secretary and in his absence the Deputy Permanent Secretary in the Ministry of Health and Social Services.

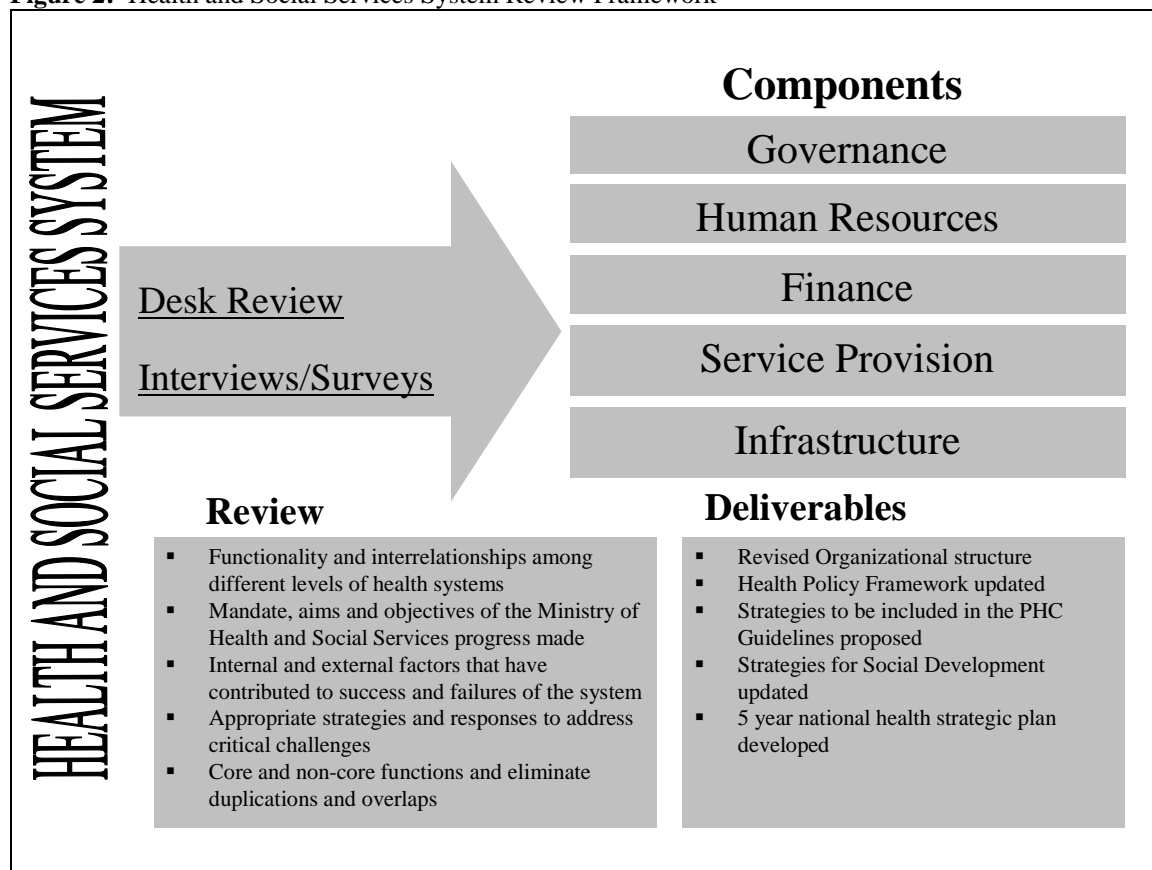
The Task Force agreed on a framework for the review that is highlighted in figure below.

Data gathering was done in three stages: 1) Desktop review and literature review of relevant policies, guidelines, and reports. 2) Information was collected from eight target groups through interviews and or focus group discussions. 3) Submissions from individuals through a call for submissions advertised in the *Republikein* and *New Era*.

The following ten data collection instruments were developed, pre-tested and applied to collect qualitative and quantitative data for the review: a) health facility checklist; b) health worker questionnaire; c) youth focus group discussions guide; d) women focus group discussions guide; e) village development committee focus discussions guide; f) consumer exit interview questionnaire; g) social welfare facility checklist; h) hospitals' questionnaire; i) questionnaire for discussions with health and social welfare stakeholders (including key sectors, donors and NGOs); j) Social Welfare Consumer Exit Interview Questionnaire and k) Social Welfare Stakeholder Focus Group Discussions. Among the key reference documents

utilised to guide the development of a number of key questions as well as the overall review methodology was the USAID Health Systems Review tool<sup>7</sup>.

Figure 2: Health and Social Services System Review Framework



A sampling frame was developed and used in two stages to select a representative sample of regions and health facilities from 13 regions of the country. The first stage was to stratify the region into four clusters; the Northwest, Northeast, Central and South and then to randomly select regions in these clusters. In the second stage, a list of all the health facilities in the country was used to select a representative sample of health facilities. Before the selection, the facilities were clustered according to the type: namely hospital, health centre, and clinic. The facilities were then selected to give an urban and rural representation, also taking into account their levels of performance based on the Health Information System (HIS) reports.

In total, seven out of the 13 regions were selected. These were Kavango, Oshana, Oshikoto, Kunene, Otjozondjupa, Khomas, and Hardap. A total of 17 hospitals, 14 health centres, 49 clinics, and 13 social welfare offices were selected proportional to the size of the population. Private facilities in the selected regions also formed part of the sample.

The pre-testing of the survey tools was conducted in two districts which were not sampled. Seven survey teams were then constituted and trained for two days following which the fieldwork was undertaken from 22 April to 12 May 2008.

A one-week analysis and report writing workshop was held bringing together national level directors and programme managers as well as the regional directors from all thirteen regions. Subsequently, a national stakeholders workshop was held to share preliminary findings of the review and to seek their inputs.

## CHAPTER 2. OVERVIEW OF THE HEALTH AND SOCIAL SERVICES SYSTEM

### 2.1 Macroeconomic Context

Namibia has an estimated population of 1,991,747 and a population growth rate of 1.8%. It has a large surface area of 824,116 square kilometres with some very sparsely populated areas. With a GNP per capita of US\$ 2,990, Namibia is classified as a lower middle-income country. The table below shows per capita GNP of selected Southern and Eastern Africa countries with Namibia as second highest to that of South Africa which is classified as an upper middle-income country. Although Namibia's GNP per capita is relatively high at US\$ 2,990, the Namibia Income Household & Expenditure Survey (NHIES) reveals large disparities between urban and rural areas where 67% of the population live<sup>8</sup>. The average per capita income is N\$ 5,141 in rural areas, whilst in urban areas it is N\$ 15,810. The disparity in income distribution is further illustrated by the finding that the 25% households in the lowest quartile, representing 35% of the population account for only 7% of total income, while the top most 2% of households representing 1% of the population account for 16% of total annual income. The GINI-coefficient for Namibia is 0.604<sup>9</sup>.

**Table 1:** Per capita GNP of selected countries in USD<sup>10</sup>

Country	Per capita GNP 2005 USD
Kenya	530
Mozambique	310
Namibia	2,990
South Africa	4,960
Zambia	490
Zimbabwe	340

The Namibian economy is mainly dependant on primary commodities which largely consist of precious metals and minerals such as diamond, uranium, gold, and copper. The economy expanded at a relatively robust pace of 6.6 percent in 2004, but slowed down to 4.8 percent in 2005 and to 4.1 percent in 2006. Economic growth is projected to decelerate to 4.0 percent in 2007 mainly because of weaker performance of the primary industries, in particular mining<sup>11</sup>.

Despite a satisfactory economic growth, the unemployment rate, estimated at 36.7% in 2004, remains high<sup>12</sup>. There is a growing threat to the economy largely due to inflationary pressures attributed to rising and volatile oil and food prices. The annual average inflation rate for 2007 is estimated at 6.8%, higher than the annual average rate of 5.1% recorded in 2006 and 2.2% in 2005<sup>13</sup>.

### 2.2 National Health Policy Framework

#### Vision

The MOHSS' vision, as stated in the Health Policy Framework of 1998, is the attainment of a level of health and social well-being by all Namibians, which will enable them to lead economically, and socially productive lives. In line with this, the main objective of the Government is the provision of relevant preventive, promotive, curative, and rehabilitative

health services, which are affordable and accessible to all Namibians. The Primary Health Care approach is the platform through which this vision has to be realised.

### **Health and Social Services Targets**

The Third National Development Plan (NDP3)<sup>14</sup> has outlined the following national health targets based on the epidemiological profile prevailing in the country:

1. Ensure that life expectancy is at 51 years by 2012.
2. Reduce the infant mortality rate from 46/1000 to 38/1000 by 2012.
3. Reduce the under-five child mortality from 77 per 1000 to 45/1000 by 2012.
4. Reduce the maternal mortality rate from 449/100,000 to 337/100,000 by 2012.
5. Reduce the total fertility rate (TFR) from 4.18 to 3.6 per woman by 2012.
6. Reduce under-nutrition among the under-fives from 17% to 8%.
7. Continue to improve the quality of life and environmental impact through the promotion of environmental health at all levels.
8. Ninety-five percent (95%) disability coverage.

In the long-term perspective, the health and social welfare related targets envisioned by the Government's Vision 2030 include the following:

1. Reduction in the infant mortality rate from 53 per 1000 live births in 2001, to 30 per 1000 live births by 2015; 15 per 1000 in 2025; and 10 per 1000 in 2030;
2. Reduction in the total fertility rate from the 2002 level of 4.2 to 3.5 by the year 2015; 3.0 by 2025, and 2.0 by 2030;
3. Full immunization coverage from 65% in 2002, to 70% in 2015, to 75% in 2025, and 80% in 2030;
4. Increase contraceptive prevalence rate from 37.8% in the year 2002 to 50% by the year 2015; 65% by 2025; and 80% by 2030;
5. Reduce the number of substance use/abuse related cases among youth by 40% by 2030. Achieve full social integration for 10 000 people with disabilities by 2030.
6. Develop a legal framework for policy, monitoring, and evaluation for the social welfare sector by 2030;
7. Establish a National Disability Council by 2012; and
8. Develop and implement plans that meet the needs of people with disabilities in at least six of the regional councils by 2012.

### **Health Sector Reforms**

The main reform initiatives that have taken place since independence include the following:

1. Restructuring and re-orientation of the health sector in line with the Primary Health Care approach. As part of this, new programmes were introduced and implemented. These included, EPI, CDD, ARI, Safe Motherhood, nutrition and HIV/AIDS. Steps were undertaken to build capacity at national level and in the regions for planning, implementation, and monitoring of these programmes.
2. There has been a shift in orientation of social services from curative and remedial social work to a developmental approach with emphasis on prevention of social ills and empowerment of individuals, groups, and communities. As part of this, the Developmental Social Welfare Services directorate is structured into the following 5 subdivisions to reflect the focal areas of developmental social welfare services in Namibia:
  - a. Family Welfare Programme
  - b. Substance Abuse, Prevention, Drug Control and Rehabilitation
  - c. Specialised Social Welfare Services

- d. Human Security Promotion and Prevention of Social Problems
- e. Social Welfare Information Services
3. The Performance Improvement of the Civil Service, through the establishment of the Wages and Salaries Commission (WASCOM) that among other things introduced an improved appraisal system and application of performance-related pay, as well as the introduction of Public Service Charter.
4. Broadening of health financing options through the introduction of user-fees policy at all facilities both for private patients holding private medical aid schemes, including government employees, and state patients. An exemption mechanism for the poor is in place.
5. Introduction of Managed Competition: the Ministry applies the principle of managed competition in the area of buying-in support services, such as catering and security services and maintenance and repair of equipment. These services are procured by competitive tendering through the National Tender Board<sup>15</sup>.

## 2.3 Epidemiological Profile

The MoHSS conducted its first ever Demographic and Health Survey in 1992. The results were used to set up goals and draw strategic plans for the sector. In 2000 and 2006, the MoHSS conducted two more DHSs which have made it possible to analyse trends in essential indicators such as fertility rates, child mortality rates, maternal mortality rates, etc. Overall, these trends show dramatic improvement in key indicators between 1992 and 2000, but a reversal in some indicators in 2006.

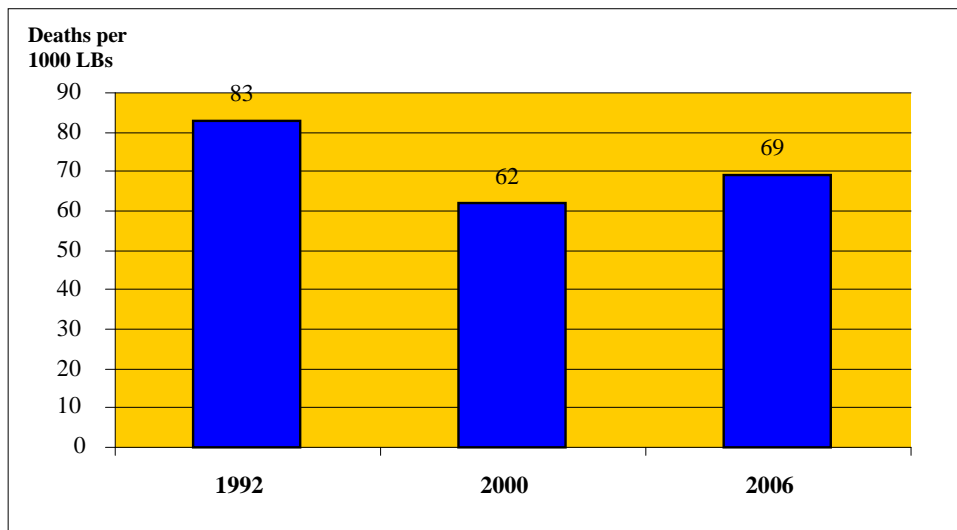
**Infant Mortality Rate:** There was a noticeable drop in the IMR from 58 per 1000 live births in 1992 to 38 per thousand live births in 2000. However, the preliminary findings of 2006 DHS show a dramatic increase in IMR to 46 per 1000 live births. There are considerable variations in infant mortality by region. Infant mortality is highest in Caprivi and Ohangwena regions at 78 and 62 per 1000 live births respectively, compared with less than 50 for the remaining regions. Kunene region reported the lowest infant mortality rate of 27 per 1000 live births (LBs) in 2006. In general, IMR in Namibia are much lower than those reported for most other DHS countries in Sub-Saharan Africa (SSA) – as illustrated in the table below.

**Table 2:** Infant and Under-5 Mortality Rates (Per 1,000 Live Births), 1990 and 2006<sup>16</sup>

Country	Infant Mortality Rate		Under-5 Mortality Rate	
	1990	2006	1990	2006
Angola	154	154	260	260
Botswana	45	90	58	124
Lesotho	81	102	101	132
Namibia	60	46	86	69
South Africa	45	56	60	69
Swaziland	78	112	110	164
SSA	109	94	184	157

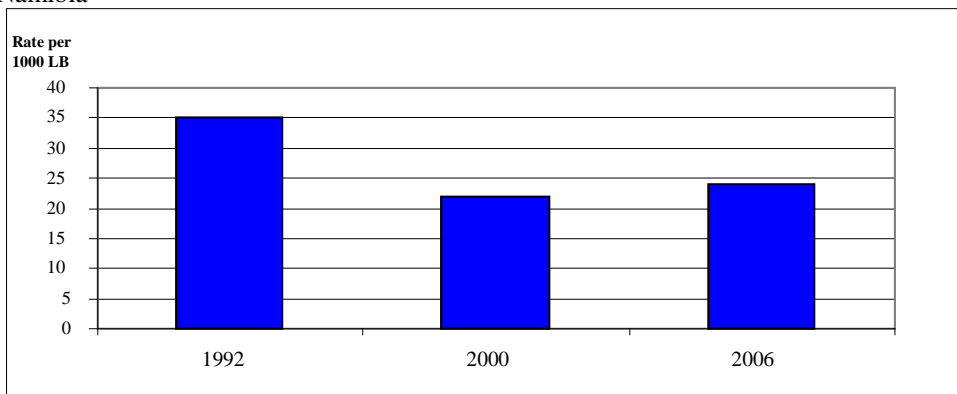
**Under-five Mortality Rate:** The under-five mortality rate (U5MR) dropped from 83 per 1000 live births in 1992 to 62 per 1000 live births in 2000 but has slightly increased to 69 per 1000 live births in 2006. Ohangwena (95 per 1000 births) and Caprivi (93) regions have the highest U5MR, whereas Kunene region reported the lowest U5M (49 per 1000 births) in 2006. Namibia, followed by South Africa, has the lowest under-five mortality rates when compared to selected DHS countries in Sub-Saharan Africa.

**Figure 3:** Under-Five Mortality Rates for the 5-year periods preceding the survey, 1992, 2000 & 2006



**Neonatal Mortality Rate:** In general, there was a considerable drop in the deaths of neonates between 1992 (35 deaths per 1000 live births) and 2000 with 22 deaths. However, a slight increase (24 per 1000 live births) has been observed during 2006. Ohangwena, Caprivi, and Omusati regions reported the highest neonatal mortality rates (39, 37, and 31 deaths per 1000 live births).

**Figure 4:** Neo-Natal Mortality rate per 1000 lbs doe the 10-year period preceding the survey, 1992-2006, Namibia



The causes of the high infant and under-five mortality include immediate causes such as diarrhoea, pneumonia, malaria, and perinatal causes with malnutrition and HIV/AIDS as major underlying factors. The relative stagnation of the infant and under-five mortality rates could also be explained in part by the relative lack of progress in key child survival interventions.

**Top Causes of Morbidity and Mortality**

Data from the Health Information System (HIS) show that other respiratory system diseases, diarrhoea without blood, common cold, nose/throat disease/disorder, and malaria were the top five main causes of OPD visits among under-5 children. The other causes are skin diseases, pneumonia, other syndrome/diagnosis, other gastrointestinal disease/disorder, and trauma/injury. This has been the same pattern for the past three years, with the importance of malaria declining from the top cause in 2005 to the fifth position in 2007. The figure below shows the major cause of OPD visits in 2007.

**Table 3:** Top 10 first outpatient visit diagnosis for children under-five, 2007<sup>17</sup>

Rank	Diagnosis	No. of Cases	% of all Cases
1	Other respiratory system disease	115,323	24.06%
2	Diarrhoea without blood	82,845	17.28%
3	Common cold	61,486	12.83%
4	Nose/throat disorder	54,785	11.43%
5	Malaria	48,684	10.16%
6	Other skin diseases	37,332	7.79%
7	Pneumonia	24,669	5.15%
8	Other syndrome/diagnosis	18,918	3.95%
9	Other gastrointestinal disorder	18,205	3.80%
10	Trauma/Injury	17,046	3.56%
	<b>Total</b>	<b>479,293</b>	

When all age groups are considered, malaria was the highest cause of illness, followed by respiratory system disease in 2005. The HIS report shows that in 2007, other respiratory system disease, musculo-skeletal system disease, skin diseases, common cold and nose/throat disease/disorder were the top causes of morbidity in Namibia.

Over the last few years, HIV, diarrhoea, pulmonary tuberculosis, pneumonia, and malaria have been the top causes of deaths in all health facilities in the country. The other leading causes of mortality are other respiratory system diseases, anaemia, heart failure, malnutrition, and hypertension. The data reveal a growing threat of non-communicable diseases deaths.

**Table 4:** Inpatient Cause of Death, 2007<sup>18</sup>

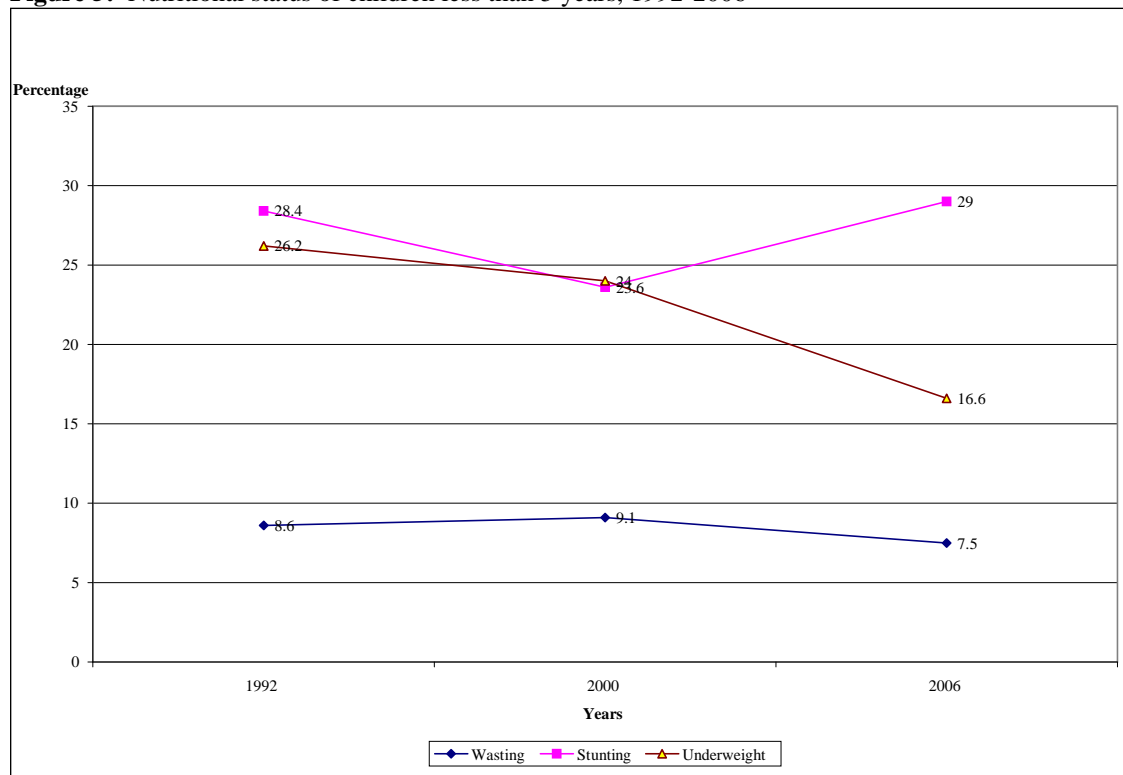
Rank	Cause of Death	No. of Deaths	% of all Deaths
1	HIV	1608	24.76
2	Diarrhoea	1269	19.54
3	Pulmonary TB	1092	16.82
4	Pneumonia	990	15.24
5	Other Respiratory system disease	332	5.11
6	Heart failure	310	4.77
7	Anaemias	263	4.05
8	Malnutrition	217	3.34
9	Malaria	209	3.22
10	Hypertension	204	3.14
	<b>Total</b>	<b>6494</b>	

### Nutritional status

The nutritional status of children under five is a measure of a country's status of development and an indication of its potential economic growth and poverty reduction. According to the NDHS conducted in 2006, the rates of malnutrition among children aged 6 months to 5 years show consistent declines in levels of underweight from 24% in 2000 to 16.6% in 2006.

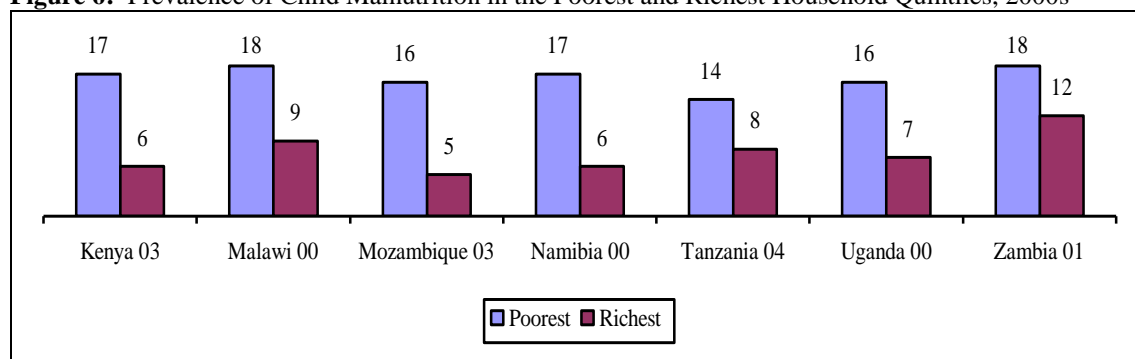
The regional differences in malnutrition levels are striking. Children in the northern regions, where the majority of the country's population live, are experiencing nearly twice the level of wasting and stunting than those in the central regions.

Figure 5: Nutritional status of children less than 5 years, 1992-2006<sup>19</sup>



**Malnutrition/Underweight:** Seventeen (16.6%) of children were found to be underweight (NDHS 2006), including 4% severely underweight (below -3SD) from the median of reference population. The prevalence of underweight status was highest in Oshikoto (22%), Oshana (21%), and Hardap (20%) regions. There has been an improvement in nutritional status of children as compared with previous findings. The proportion of children younger than 5 years of age who are underweight has declined from 26 percent in 1992 to 17 percent in 2006. Generally, the prevalence of under nourishment in the population as a whole is high as compared to other countries in the region (*see figure below.*)

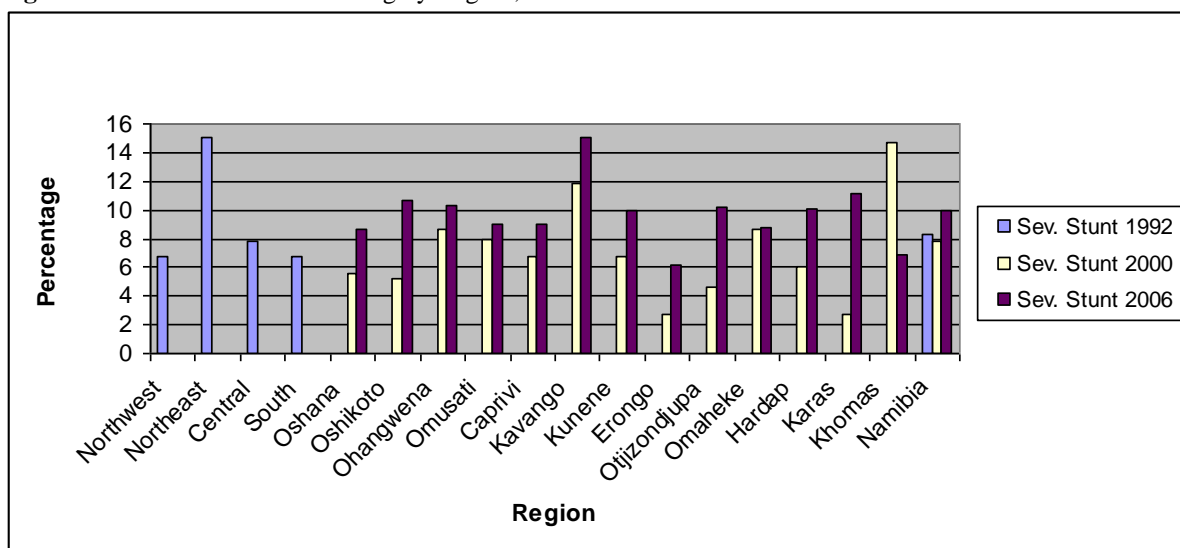
Figure 6: Prevalence of Child Malnutrition in the Poorest and Richest Household Quintiles, 2000s<sup>20</sup>



**Stunting:** About one-third of children (30%) were found to be stunted (Height-for-age), while 10 percent were severely stunted (NDHS2006). Marked differences were observed by region. Stunting levels were much higher in Kavango region (39%), followed by Ohangwena region (34%). Both regions reported severely stunted levels of 15 and 10 percent respectively. Both Erongo and Khomas Regions recorded lowest stunting levels of about 22% with 7% severely stunted children. Overall, the proportion of children under 5 years who are

severely stunted has decreased from 8.3% in 1992 to 7.8% in 2000, but has increased to 9.9% in 2006 as illustrated in the figure below.

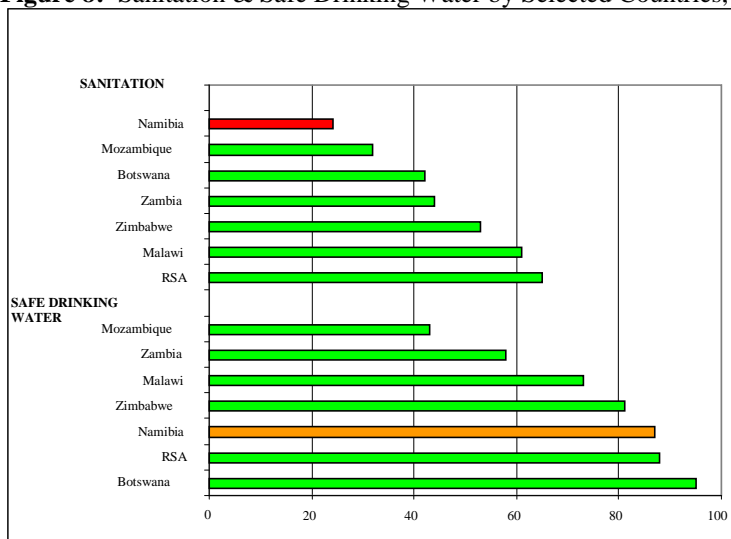
Figure 7: Trends of Severe Stunting by Region, 1992-2006



**Wasting:** About one in eight (7.5%) children were found to be wasted (i.e. below -2SD), while 2% were severely wasted (below -3SD). Wasting was most common in Hardap, Omusati, and Oshana Regions with about 10% of children. There is no improvement in wasting rates between 1992 and 2006.

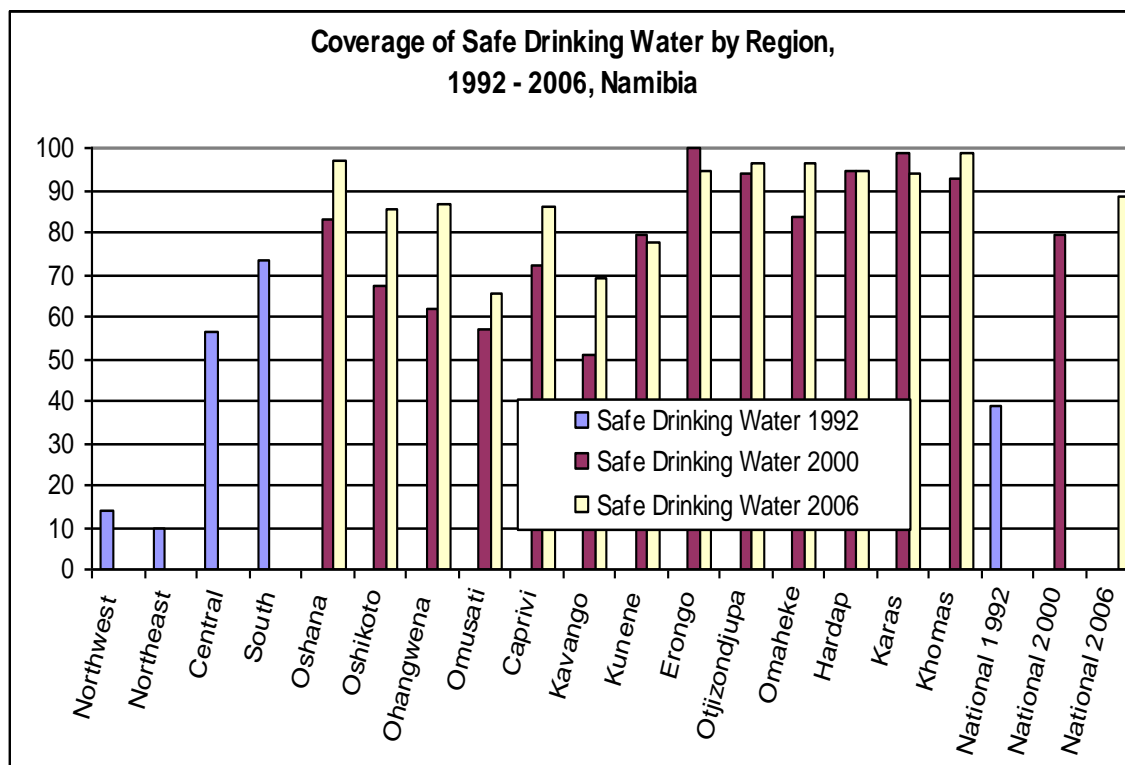
**Sanitation and Safe Drinking Water:** Sanitation coverage has increased twofold from 16% in 1992 to 34% in 2006. There are however large regional variations, with households in Ohangwena, Omusati and Caprivi regions being the least advantaged in terms of sanitary facilities whereas those in Erongo and Khomas regions have better sanitation coverage. Namibia has the poorest sanitary toilets compared to other DHS countries in sub-Saharan Africa (see figure below.)

Figure 8: Sanitation & Safe Drinking Water by Selected Countries, 2004



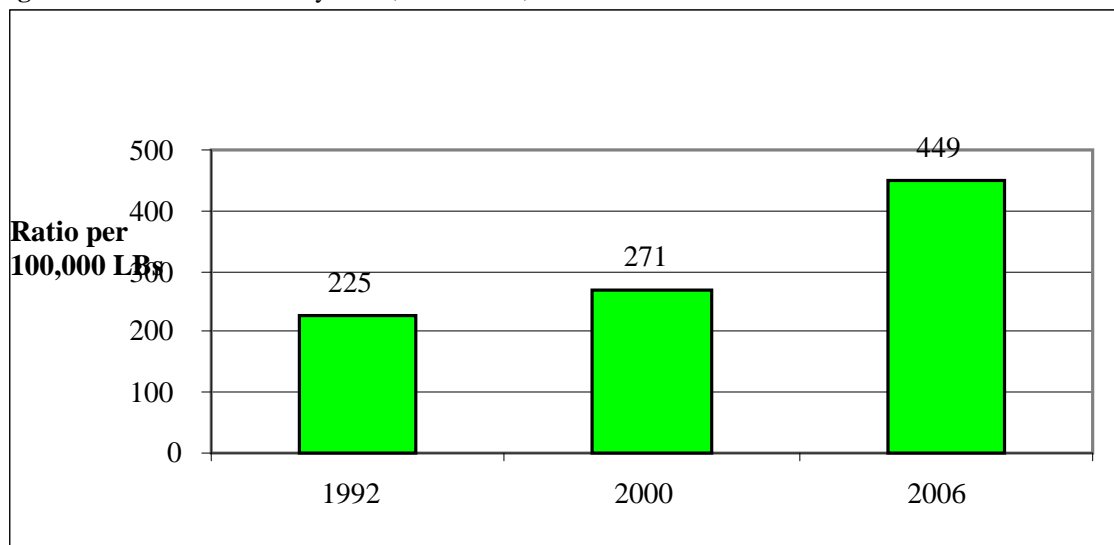
**Safe drinking water:** 80 percent of households in Namibia have access to safe drinking water. When compared to selected DHS countries in sub-Saharan Africa Namibia was the third best country in terms of coverage of safe drinking water.

**Figure 9:** Coverage of Safe Drinking Water by Region 1992-2006,



**Maternal Mortality Ratios:** Maternal mortality has almost doubled from 225 maternal deaths per 100,000 live births in 1992 to 449 in 2006.

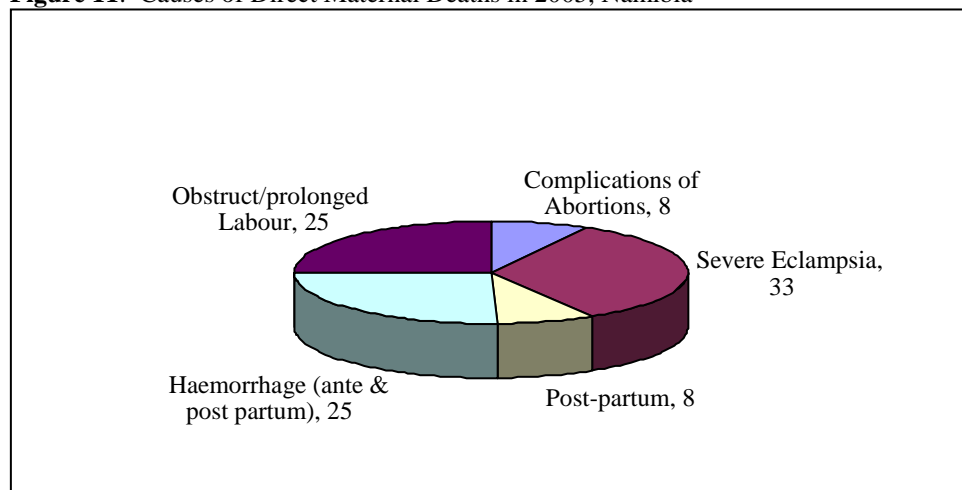
**Figure 10:** Maternal Mortality Ratio, 1992-2006, Namibia



The main direct causes of maternal mortality in Namibia are haemorrhage, eclampsia, obstructed labour, and sepsis whereas indirect causes include HIV/AIDS<sup>21</sup>.

From a study done in 2005 (EmOC study, 2006, MoHSS) it was found that Severe Pre-eclampsia /eclampsia (33.3) was the leading cause of direct maternal deaths in Namibia, followed by haemorrhage (ante & post partum), obstructed/ prolonged labour at 25 %, complications of abortion and post-partum sepsis at 8.3 %.

**Figure 11:** Causes of Direct Maternal Deaths in 2005, Namibia<sup>22</sup>



This high maternal mortality is in spite of the high deliveries by skilled attendants and in health facilities. There has been a notable increase in the proportion of deliveries attended by skilled personnel (medical professionals - doctors, nurses/midwives) between 1992 (68.2%) and 2006 (81.4%). It is worth noting that women in those regions who recorded the highest neonatal, infant and under-five mortality rates (Ohangwena, Caprivi, Kavango, Omusati) were less likely to deliver with assistance of a health professional particularly a doctor.

**Emergency Obstetric Care:** A survey of all hospitals, health centres and 27 out of 263 health clinics conducted in all 13 regions in 2005/06<sup>23</sup> found that only 4 (11.8%) out of 34 hospitals provided comprehensive emergency obstetric care, i.e., provision of the following services: a) administration of parenteral antibiotics; b) administration of parenteral oxytocics; c) administration of parenteral anticonvulsants; d) manual removal of placenta; e) removal of retained products; f) assisted delivery; g) blood transfusion; and h) caesarean section. These are the live saving functions which must be provided by all hospitals to ensure that the 15% of pregnant women expected to have complications are adequately cared for. Among the reasons, why health workers did not carry out these procedures were lack of awareness of their indication and lack of training.

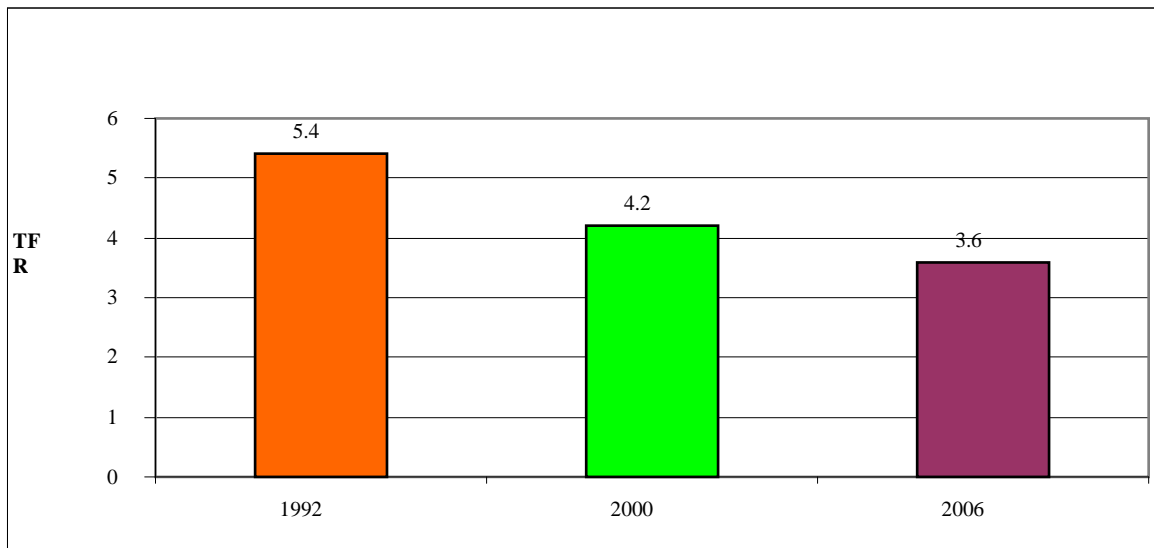
On the other hand, no health centres provided the basic emergency obstetric care, i.e. the provision of all the above services except for blood transfusion and caesarean section.

Given that 81% of women deliver in health facilities (DHS 2006) there is a great potential to reduce deaths due to pregnancy complications if the observed gaps in the provision of EmOC services are adequately addressed and efforts made to improve technical support supervision to hospitals and health centres

**Total Fertility Rate (TFR)** in Namibia has declined considerably from 5.4 in 1992 to 3.6 in 2006. If fertility remains constant at current levels (3.6), a Namibian woman would give birth to an average of 3.6 children. There are however, large regional differences where women in

Omaheke wanting on average 5.1 children compared to those in Khomas wanting 2.6 children.

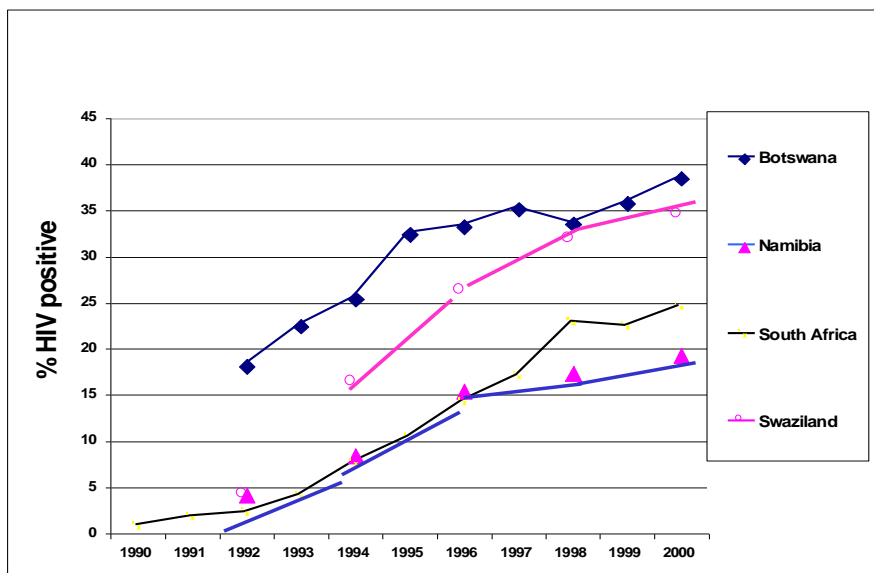
Figure 12: Total Fertility Rates for 3 years preceding the Survey, Namibia 1992, 2006, & 2006



**HIV/AIDS**

The HIV/AIDS epidemic in Namibia continues to threaten the socio-economic fabric of the country. Overall, HIV prevalence has continued to rise since the first infection in the country 23 years ago as highlighted in the National AIDS Coordination Programme Mid-Term Review report<sup>24</sup>.

Figure 13: Trends in HIV prevalence<sup>25</sup>

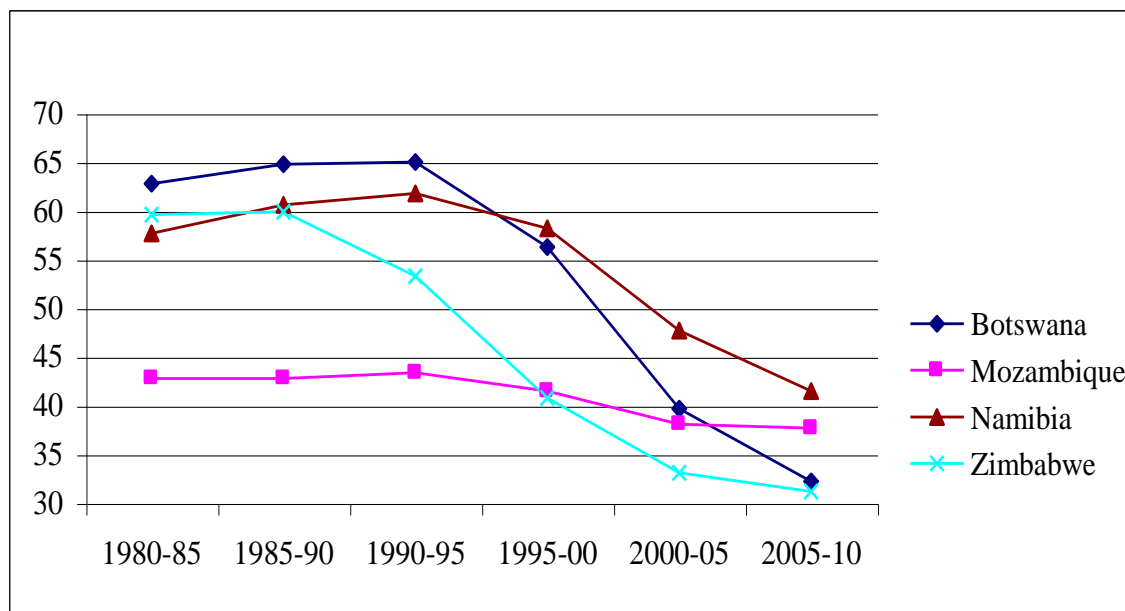


The figure above shows how the epidemic has expanded in comparison to other countries in the region. The epidemic has had a major impact on the life expectancy of Namibians. It has resulted in a growing number of orphans and made women especially young girls most vulnerable as they are most affected by the scourge.

The 2006 national HIV sentinel survey<sup>26</sup> found a national HIV prevalence of 19.9% with major regional variations. The sentinel sites at Katima Mulilo showed the highest prevalence of 39.4%. Oshakati, Engela, and Onandjokwe in northern Namibia had prevalence rates of 27.1%, 27%, and 23.7% respectively. On the other hand, Opuwo, Gobabis, Windhoek Central Hospital, and Mariental sentinel sites had the lowest prevalence rates of 7.9%, 7.9%, 9.1%, and 10.2% respectively.

Overall, life expectancy in Namibia, as is the case in many countries in the region, has significantly reduced over the past 2 decades (*see figure below.*)

**Figure 14:** Changes in life expectancy in four countries 1980-1985 to 2005-2010<sup>27</sup>



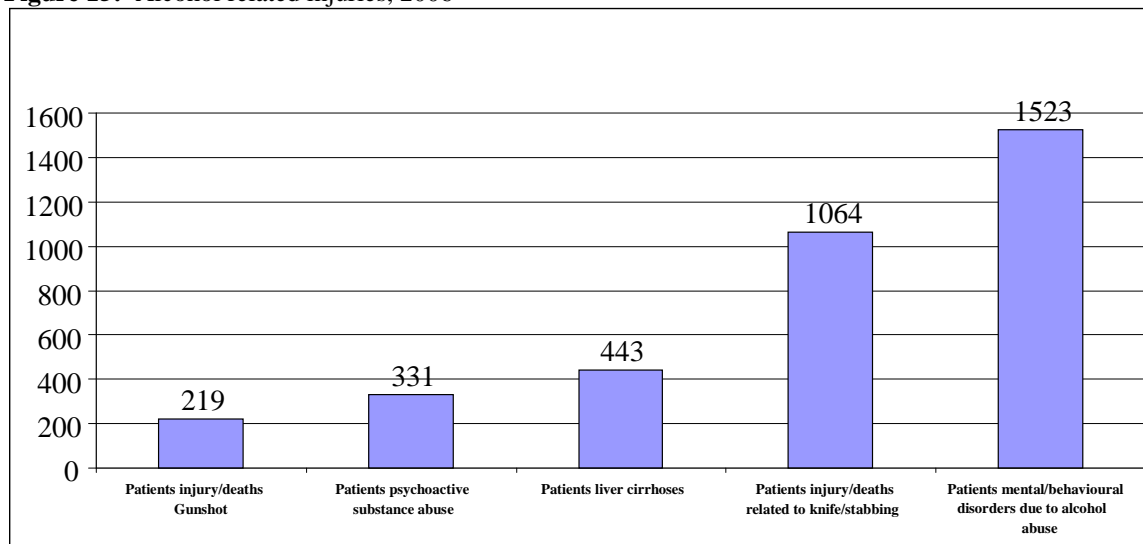
**Alcohol and Substance Abuse**

Alcohol abuse is among the contributors to ill health in Namibia. Research conducted in the Nationwide KAP Baseline Survey on Alcohol and Drug Use in Namibia, published in 2002, by the MOHSS, suggests that the 55.6% of Namibians that currently drink, 47.9% felt that they had drunk more that was good for them and 11.3% had sought treatment.

The consumption level in Namibia is more than 10 units per drinking occasion among 56% of the population and 10 litres per week. This is very hazardous and harmful to their health.

According to the Human Development Report (1999). *“There are more liquor outlets compared to other types of businesses in most Namibian towns. Numerous shebeens also supply alcoholic beverages to customers on a 24-hour basis.”*

The graph below indicates the number of patients admitted at state hospitals and the type of injury or illness because of alcohol and other drug abuse.

**Figure 15:** Alcohol related injuries, 2006

The Nationwide KAP Baseline Survey (2002) demonstrated that **health workers** are the *first point of contact* for people seeking help with regard to alcohol use/misuse. This finding highlights the need to ensure that front line health staff have adequate knowledge, skills, and resources to respond to requests for interventions.

In a report by Farahani et al (1997) that analyzed suicides in the North West of Namibia between 1990 and 1995, alcohol reportedly featured widely among the random sample covered by the study. Alcohol use featured highly both in terms of regular use among those committed suicide (68%) but alcohol use just before the suicide took place also reportedly a common feature.

Abuse of alcohol often leads to fights, domestic violence, and even murder. The WHO Multi-Country Study on Women's Health and Domestic Violence shows that 1 out of 3 women in Namibia suffer domestic violence.

According to the Nationwide KAP Baseline Survey (2002), 19.7% of the respondents had a broken relationship with a friend or spouse due to alcohol consumption. The national average was 19.7% the percentage for the Rural South of Namibia was 28.5%.

There is a link between alcohol abuse and sexual behaviour among the youth, and drinking increases the risk behaviour by a factor of 3.53 (UNICEF KAPB Study, 2006).

- Majority of youth have multiple sexual partners (UNICEF, 2006)
- Sexual initiation at the age of 15 years: 29% boys and 41% girls (UNFPA, 2007)
- Knowledge ability about HIV/AIDS among the youth: 95-99% (MOHSS-DHS-2000)
- Syphilis among under 17 years is 6% and 18 years above 94% (25000 infected cases reported in Khomas Region) (STI Report, 2006)

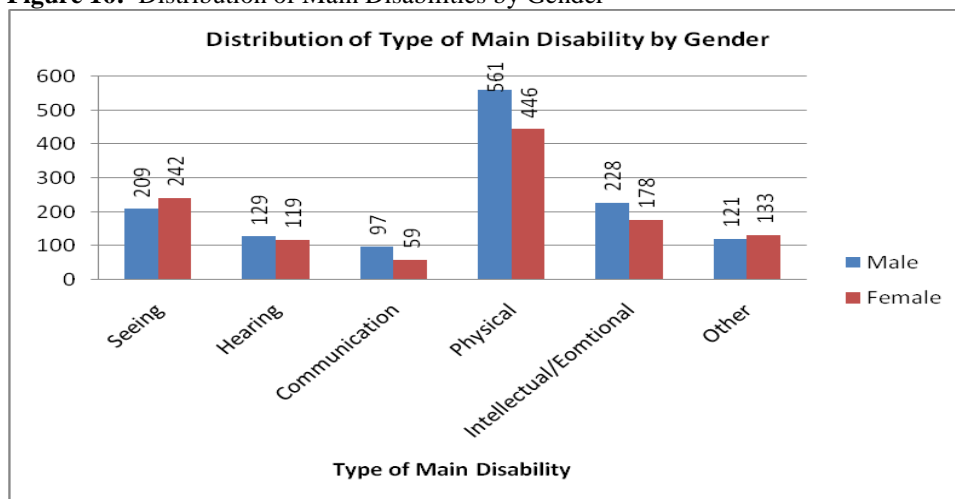
Strijdom and the MOHSS (1999) conducted a survey "Substance Abuse among young people" with young people (13-30 years) on their substance use. The survey showed that 53.5% of young people reported that they currently used alcohol.

The UNICEF 2007 Report - **A Future in Doubt: Youth Alcohol Abuse in Namibia** states that 10 – 14 year old children receive their first alcohol drink from their own parents or guardians and 45% are exposed to drunken behaviour in their homes.

**Disabilities**

The 2001 Population and Housing Census, shows that the number of people with disabilities in Namibia is around 85,567 (4.7 % of the total population.) The population is almost equally distributed between females and males, but higher in rural areas than urban areas. According to this Study, poverty and disability go hand in hand, people with disabilities experience compounded high health cost. The main types of disability are blind, deaf, impaired speech, impaired of legs and mental disability.

**Figure 16:** Distribution of Main Disabilities by Gender



**2.4 Stakeholders in Health and Social Services**

The Primary Health Care and Community Based Health Care guidelines of the Ministry of Health and Social Services clearly stipulated that the health sector alone cannot change the health status of the community. It needs the involvement of other public and private sectors, faith base non-governmental organizations, and the community at large. To address morbidity and mortality, other sectors are playing a crucial role in reducing poverty and underlying causes of ill health. They have resource and technology needed for economic development. The government focuses on decentralization of services and multi-sectoral approach to enhance efforts, avoid duplication, minimize expenditure and ensure sustainability.

**2.4.1 Other Sectors**

Improving the health of all citizen as one of the government objective sectors such as Ministry of Agriculture, Water and Forestry plays a major role in addressing food security, hence the ministry established a “Food Security and Nutrition Council” in 1995, inaugurated by the former President of Namibia, Dr. Sam Nujoma. The Ministry not only is co-ordinating this Food Council, but many other specific programme related task forces and multi-sectoral committees such as National AIDS Executive Committee (NAEC). The Ministry of Gender Equality, and Child welfare, coordinates and developed a plan of action for the Orphans and Vulnerable Children, which includes issues on HIV/AIDS, reproductive health and nutrition. It is also responsible for all child welfare functions, e.g. statutory and non-statutory services, residential care services, children’s grants and allowances, as well as gender issues. The

Ministry of Labour and Social Welfare is responsible for all labour issues, old age pensions and disability grants (only adults).

The Ministry of Education plays a key role in promoting life skills, supporting school health programs, administering the Namibian Students Financial Assistance Fund, training health cadres and contributing to HIV prevention among school going children. The Ministry of Youth, Sport, National Service and Culture also provides support for life skills, sports and other recreational and cultural activities for the youth, as well as employment preparation and creation. The Ministry of Defence has a specific division overseeing the health of its workers and soldiers and collaborates with the MOHSS on national events. In contributing to the general public health and environmental hygiene, all the municipalities provide services in urban areas while the Ministry takes full responsibilities of rural areas. Further, the Ministry of Justice has the responsibility over children's courts, juvenile courts, criminal courts, maintenance court, high and supreme courts, legal aid, and estate allowances.

These are just a few out of many sectors that are complementing the work of the Ministry. The mechanisms used to coordinate these efforts often they are initiated by the Ministry of Health and Social Services and the Ministry policies has identified various roles to be played by different sectors including development partners who are providing technical and financial support.

#### **2.4.2 Private sector**

The private health sectors are regulated by 1994 Hospital and Health Facilities Act, of the Ministry of Health and Social Services. Such private facilities are licensed to provide health services to private patients as a result they contribute to the reduction of morbidity and mortality.

To date a total number of 844 private health facilities are registered or licensed with the MoHSS. These facilities are among others 13 hospitals, 75 primary care clinics, 8 health centres, 557 medical practitioners which is inclusive of dentists, psychologists and physiotherapist and 75 pharmacies. However, the majority of these facilities are to be found in Erongo and Khomas regions which are predominantly urban areas.

The public health facilities have a comprehensive health information system which provides data to the national level on cases treated of various conditions. However, for the private sector such a reporting system is not in place. The Health Act does not make provision for private institutions to provide data on cases treated or prevention of disease. The private sector is of the opinion that reporting to a central level is not a necessity as this arises from the patient – doctor relationship of confidentiality. In order to reverse this trend greater government leadership in advocating for information sharing through mechanisms such as the medical associations be encouraged and or the revision of the Act to include the necessary contribution made towards their social responsibility of private practices and submit information on diseases. In general, the business and private sectors provide significant technical support especially during emergency outbreaks or national health events. These are such as Namdeb, Old Mutual, Rotary International, and Standard Bank. The private sectors are also guided by the Ministry of Health and Social services policies and guidelines.

The Blood Transfusion Service of Namibia (NAMBTS) a licensed association (registered under section 21 Company, Association not for gain), is collecting and processing blood as stipulated by the National Blood Policy (2007) of the Ministry of Health and Social Services.

There is a strong collaboration between NAMBTS and the Ministry to ensure quality blood services. The policy made provision for terms of management of blood and blood products to be defined in memorandum of understanding between the Ministry, NAMBTS, Namibia Institute of Pathology and other hospitals blood banks.

In the fight against preventable childhood illnesses, the Ministry has put in place mechanisms such as the National Polio Eradication Committee (NPEC) chaired by the private medical officer to coordinate the efforts on polio eradication in the country. On the other hand, the Integrated Management of Childhood illnesses cooperate with training institutions such as the University of Namibia to build the capacity of health workers.

### **2.4.3 NGOs and Faith-based institutions**

According to the Government of The Republic of Namibia Partnership policy of 2005, all Ministries including the Ministry of Health and Social Services will designate a contact officer to handle relations with Civic Organizations (COs) operating in their specific field of their work.

Over the years, churches and many non-governmental organizations (NGOs) continue to play a significant role in the health and social welfare of the Namibian people. They have contributed to the reduction of mortality and morbidity. Many of them are involved in the delivery of community-based health care. With the exception of those NGOs that are participating in the planning processes of HIV/AIDS, programme only a few are actually involved in the Ministry's planning and decision-making process.

In support of the Ministry's efforts, the Namibia Red Cross Society has been requested to coordinate the activities of the community counsellors who were trained by Child Line/Life line to counsel clients on HIV. Today these community counsellors are found in all the health facilities providing ART/PMTCT services.

The Namibia Planned Parenthood Association (NAPPA) was established by the Ministry and financially supported by UNFPA, to complement the sexual and reproductive health services. Today this association is independent, strong and self sustain. The association has its own clinic focusing on adolescent health and through its social mobilization programme; they are providing services to the communities that the Ministry is unable to reach.

The Faith based organizations such as Catholic AIDS Action (CAA), Council of Churches in Namibia (CCN), Evangelical Lutheran Church in Namibia (ELCIN) and Anglican AIDS Action to name but a few, are also supporting the efforts of the Ministry of Health and Social Services to fight diseases.

### **2.4.4 Community based providers**

The PHC guideline place emphasis on community involvement and over the years communities plays an important role in the implementation of health services. During National Immunization Days (NIDs) families and communities provide volunteers and work hand in hand with the Ministry' staff during immunization campaigns. The community leaders such as headmen, councillors and church leaders mobilize communities for action during national health events, emergencies, and disease outbreaks.

Some trained Traditional Birth Attendants (TBAs) are supporting the reproductive health services at their level by ensuring clean delivery and advise women on the importance of

immunization, ante and post natal care, family planning and HIV testing. They are provided by the Ministry with HIS forms to collect information and submit it to the nearest health facility. However, there is a need to strengthen the linkage between the communities and the facilities. An assessment on community volunteers was conducted in 2005 and as a result, a community based health care policy was developed and approved. Depending on the focus and the aims of the organization, the community volunteers have many functions such as providing home based care for the chronically ill clients.

## CHAPTER 3. GOVERNANCE: STRUCTURES, POLICIES, AND FUNCTIONS

*“Health education is only geared towards HIV/AIDS there are a lot of problems in the communities that we need to be educated about.”*

### 3.1 Structure and Functions

The Ministry of Health and Social Services organisation and management structure is organised in three levels: Central, regional and district levels, in line with the national health policy framework of 1998. The regional structures from the early 1990's up to 2002 consisted of four regional directorates which were changed to thirteen regional directorates in 2003 to be in line with the 13 political administrative regions.

At national level, seven directorates have been created with the Primary Health Care Directorate providing the impetus for the transformation of the health sector in the post-apartheid era. The directorate of Planning and Human Resource Development was established in 1993 to coordinate planning in the sector, while the Directorate of Special Programmes was created in 2003 to facilitate the coordination of HIV, malaria and TB interventions. A public health system has now been established a network of health facilities consisting of approximately 1,150 outreach points, 260 clinics, 40 health centres, 30 district hospitals, 3 intermediate hospitals and one national referral hospital.

#### 3.1.1 Levels of the public health system

Overall, the ministry has continued to refocus its attention to the improvement of services and has made significant changes in its structures since independence in order to enhance the delivery of good quality services. The functions of the three levels of the public health system are outlined below:

##### Central Level:

The permanent secretary is the overall accounting officer of the Ministry of Health and Social Services, assisted by a deputy permanent secretary, three departments, and seven directorates. The functions of the central level are as follows:

1. Policy formulation and review
2. Policy planning and monitoring
3. Strategic planning
4. Coordination of services
5. Resource mobilization and allocation
6. Technical support to lower levels of services planning, care and implementation
7. Setting standards for health services delivery
8. Performance management
9. Legislative responsibilities, regulation of services, and the overall stewardship of the health sector

**Regional Level:**

The regional level is headed by 13 directors who are heading the Regional Management Teams. Their functions are as follows:

1. Provision of leadership and management support to the entire region.
2. Translation of central level policies and strategies into operational plans for implementation at the regional and district levels. Regional directorates also participate in policy formulation process at the central level through an ongoing process of consultation.
3. Coordination of implementation of services, programmes and activities to ensure equity and access to services among districts.
4. Provision of technical support to district level managers and staff as well as provision of technical input to key programmes such as FP, EPI, IMCI, food and nutrition, school and adolescent health, mental health, control of communicable diseases including HIV/AIDS, TB and vector borne diseases, environmental health and hospital care.
5. Supervision support to district level.
6. Information management; monitoring and evaluation of programmes implementation, including reporting and feedback to the districts and central level.
7. Preparation of budgets and assisting districts in preparing budgets, allocation of resources to districts, monitor expenditure and ensuring that equity of access to services is achieved and sustained.
8. Management of human resources, including recruitment, deployment, recommendations for promotion and implementation of disciplinary procedures as per Public Service Rules and Procedures.
9. Management and coordination of stores and logistics. This includes oversight on ordering and distribution of supplies and pharmaceuticals in a timely manner.
10. Ensuring inter-sectoral consultation and coordination at regional level, including participation in regional development committees and other local level or community initiatives, as they deem necessary.

**District level:**

The District Coordinating Committee is the management team at district level. This management team is headed by a principal medical officer who has the following functions:

1. Facilitating the coordination of activities at district level in order to ensure efficient and effective implementation of regional directed and managed projects and programmes.
2. Implementation of the district health package in collaboration with communities and other partners in health.
3. Managing district resources: e.g. financial, human, supplies including pharmaceuticals
4. Support Community based activities.
5. Liaison with community leaders and other partners in health development.

**3.1.2 Duplication of Structures and Functions**

Following interviews with key stakeholders and key informants at national and regional levels it was found that there was fragmentation and duplication of functions in a number of divisions within various directorates including:

- Human Resource Management in Directorate of Human Resources and General Services whereas Human Resource Development is in Directorate of Policy Planning and Human Resource Development.

- Disability Prevention in Primary Health Care Directorate and Rehabilitation is in Developmental Social Welfare Directorate.
- Licensing of health facilities is in the Human Resources Management and General Services whereas another licensing and inspection function is in the PHC directorate.
- Facility Planning is in Policy Planning and Human Resource Development Directorate whereas Facility Management is in Human Resources and General Services Directorate.
- General Services is Human Resources Management and General Services whereas Logistics is in Finance Directorate.
- The Directorate Policy Planning & HRD is responsible for the preparation of MTEF documents while the Sub-division on budgeting and budget control under Finance and logistics also have a budgeting responsibility.

This duplication has resulted in little sharing of information and poor coordination. It was also found that divisions within one directorate often fail to realize the interrelationship of their functions and hardly cooperate with each other or coordinate their plans and activities. In some cases, certain functions are allocated to a certain Directorate but the functions are carried out in another Directorate. A good example of this is the budget preparation which is currently being done by the Policy Planning and Human Resource Development Directorate, while this function falls under the Subdivision on budgeting and budget control which is under Finance and Logistics Directorate.

### **Information Systems**

The MOHSS has many stand-alone information systems managed by different divisions in different directorates and running on different software. These systems include: Health Information System (HIS) which is in Primary Health Care Directorate; Social Welfare Information System (SWIS) in Developmental Social Welfare Directorate; Management Information and Research in Policy Planning and Human Resource Development Directorate; and Monitoring and Evaluation Special in Programmes Directorate. This fragmented structure has created overlaps and duplication between the various systems.

### **Vertical Programmes**

Overall, there is inadequate coordination between the various vertical programmes. This is particularly evident in the parallel management of HIV/AIDS and other Primary Health Care programmes. Many respondents noted that HIV/AIDS tended to attract all the attention and resources away from traditional programmes and yet there was an opportunity for HIV/AIDS prevention and control efforts to strengthen the health system. A specific example was given regarding the lack of coordination or collaboration between reproductive health and HIV/AIDS: The scaling up of Prevention of Mother to Child Transmission (PMTCT) could be accelerated if there was better coordination between the two directorates.

### **Social Welfare Services**

The responsibility for social welfare is spread among different government ministries, notably Health and Social Services, Gender Equality and Child Welfare and Labour and Social Welfare. This has added confusion on the roles and responsibilities in the social welfare sector with duplication of services and lack of coordination in service delivery.

Namibia does not have a national social welfare policy. Consequently, there is no framework to guide different ministries in their interventions. When the Directorate of Social Welfare Services (previously Social Services) was first established, the objective was to promote and

improve the social welfare and functioning of individuals, groups and communities through professional social work services and social assistance.

### **Health extension work in communities**

The formal structure of the health system ends at the clinic level and outreach points. Although the ministry has put emphasis on the implementation of community based health care and has trained about 5,000 community health workers, there are no clear structures to support community based health care services. There is some progress in the development of guidelines and standards for the implementation of community based health care. However, CBHC strategy does not sufficiently encourage involvement of regional and local councils and inter-sectoral support in its implementation. The volunteer community health workers have no incentives and have inadequate support from communities and health workers.

### **Health Promotion**

The ministry has not developed a clear national strategy for health promotion and for behaviour change communication. There is inadequate capacity to support health promotion needs at national, regional, district and community levels. No structure for health promotion and regional and district level. There is a lack of standardized training and IEC materials on various health issues and inadequate coordination of health promotion activities by various programmes.

### **Decentralization**

The review found that there was a delay in decentralization of services to the regional councils. However, there has been some deconcentration of the planning process, management and implementation of services and programmes from the central level to the regional and district levels. The issuance of Funds Distribution Certificates (FDCs) and payments are done at national level.

### **Regulatory Bodies**

It was observed that regulatory authorities do not have adequate resources to enforce regulations. Further, there are a number of areas which require establishment of regulatory bodies such as radiation protection.

## **3.2 Governance**

The Ministry of Health and Social Services plays a stewardship role in the health sector through the key functions of central level management as described above. The Ministry sets the health policy agenda, formulates legislation and regulations governing the health sector, and prepares the health sector medium and long-term plans. The Ministry also established statutory professional bodies that coordinate the professional conduct of health workers. These are in the form of the umbrella body, the Health Professions Councils of Namibia and the professional councils governing the scope of practice and conduct of the different categories of health workers. There are five professional councils. The Councils are semi autonomous and are subsidized by the Ministry. It is found that the Health Professional Councils are experiencing resource scarcity to enable them to implement their programmes effectively.

Another regulatory body, the Medicine Control Council is not autonomous and is coordinated from within the division of pharmaceutical services which serves as its secretariat. The current arrangement of placing the Medical Control Council in the division pharmaceutical services is a strain on the limited human resources in that division and further undermines the

council's autonomous role of ensuring safety of medicine including those used by the Ministry.

The Ministry also implements the Hospital and Health Facility Act (act no: 36 of 1994) This act regulates the establishment and certification of private health facilities and is implemented and coordinated within the subdivision health facilities regulation in the directorate Human Resource Management and General Services. The act is having some loopholes and regulations for implementation of the act are not in place. This allows for the uncoordinated mushrooming of private practices. In addition, the Public Health Act of 1919 is outdated and is hardly relevant to the post-independence changes and reforms.

Research activities in the Ministry are currently not well coordinated despite the existence of well-defined mechanisms in the research management policy and the guidelines on clinical trials. The proposed Research Management Committee (RMC), the Biomedical Research Ethical Committee (BREC) and the Research Advisory Group (RAG) are not functioning despite the fact that some of these committees have been officially constituted.

Although the Act on Atomic Energy and Radiation Protection (act no: 5 of 2005) has been adopted by Parliament already, its implementation is on hold as there seems to be a lack of clarity as to which Ministry should implement the act. This Act proposes regulatory mechanism for atomic energy and radiation safety. Despite the existence of this act, poor coordination of radiation safety as be highlighted as an issue of concern during the review.

Supervision between the different levels was found to be unsatisfactory. This problem is particularly evident at district level, where rural health facilities are hardly visited and supported by district teams. This has been mainly attributed to the lack of transport and human resources.

The Organisational Performance survey and interviews revealed problems in the area of system leadership, clinical leadership and capacity and mindset of individuals.

With regard to system leadership, the following were found to the weaknesses:

- Clarity of direction fades at lower levels in the organization
- Perception gap in the effectiveness of the provided direction, e.g. directors have a more positive view than the rest of staff.
- The executive leadership team's contribution to the organization is not visible
- Current managers do not role model desired behaviours.
- No clear performance indicators or metric tracking system to give feedback on how well goals are met.

Clinical leadership was found to be lacking due to the following:

- Formal systems hamper development of clinic leadership e.g. limited incentive to chose a leadership position, and lack of mentoring.
- Leadership capability among clinicians is not systematically nurtured.
- Beliefs that clinical leadership is of low value, e.g. limited data to show impact, not perceived as core to the clinicians professional identity.

With regard to capabilities and mindset, the interviews revealed that there is lack of confidence due to sufficient management and leadership training hamper the effectiveness of individuals in pivotal roles.

Other prevalent mindsets that were found to inhibit performance were distrust, lack of accountability and demotivation.

### Recommendations

1. Review the core functions of the health sector and clarify roles and responsibilities of various levels of the health system.
2. Restructure the ministry's organization structure to be responsive to new challenges.
3. All social services should be coordinated under one sector.
4. There is a need to immediately address overlaps in the following divisions and harmonize their functions: a) HRM and HRD; b) Disability Prevention and Rehabilitation in separate directorates; c) Facility Planning and Facility management; d) logistics and general services; e) health facility licensing and inspections; and f) Management in separate directorates.
5. Improve the coordination between HIV/AIDS and other Primary Health Care programmes.
6. Decentralise some components of PHC to Regional Councils (e.g. spraying programmes, sanitation, distribution of water purification tabs, CBHC, etc).
7. Establish community based health care providers as the lowest level of health services delivery, in collaboration with Regional Councils.
8. Build regional leadership capabilities and cross regional collaboration.
9. Ensure leadership renewal through ongoing development and succession planning.
10. Put a clear metric tracking system in place to clarify responsibilities and give feedback on how well people are meeting goals.
11. Elevate importance of clinical leadership, and enable talent (both MOHSS and other stakeholders) to thrive by putting a support structure in place, e.g. clear career paths incentives, training opportunities, etc.
12. Develop replicable model for hospital-based clinical leadership (e.g. Oshakati)
13. Extend clinical leadership programme across the PHC network and remaining referrals hospitals.
14. Revise incentive systems to shift limiting mindsets, e.g. distrust towards the system lack of accountability and demotivation.
15. Assess and improve specific capabilities across pivotal roles through training.
16. Develop an integrated M&E system for all programs under one roof to coordinate health, social services and management information.
17. Develop a national strategic plan for the health and social services sector that promotes coordination and synergy among the various programmes and pays a special attention to reaching the difficult to reach areas.

### 3.3 Policies

The importance of policies to provide overall guidance and direction for health services delivery cannot be overemphasized. In the course of the desk review, all existing policies and guidelines produced by the ministry were collected and reviewed. This was followed during the review with specific investigations on the processes of development, participation of different levels, availability of the policies and guidelines at the facility level and their utilization.

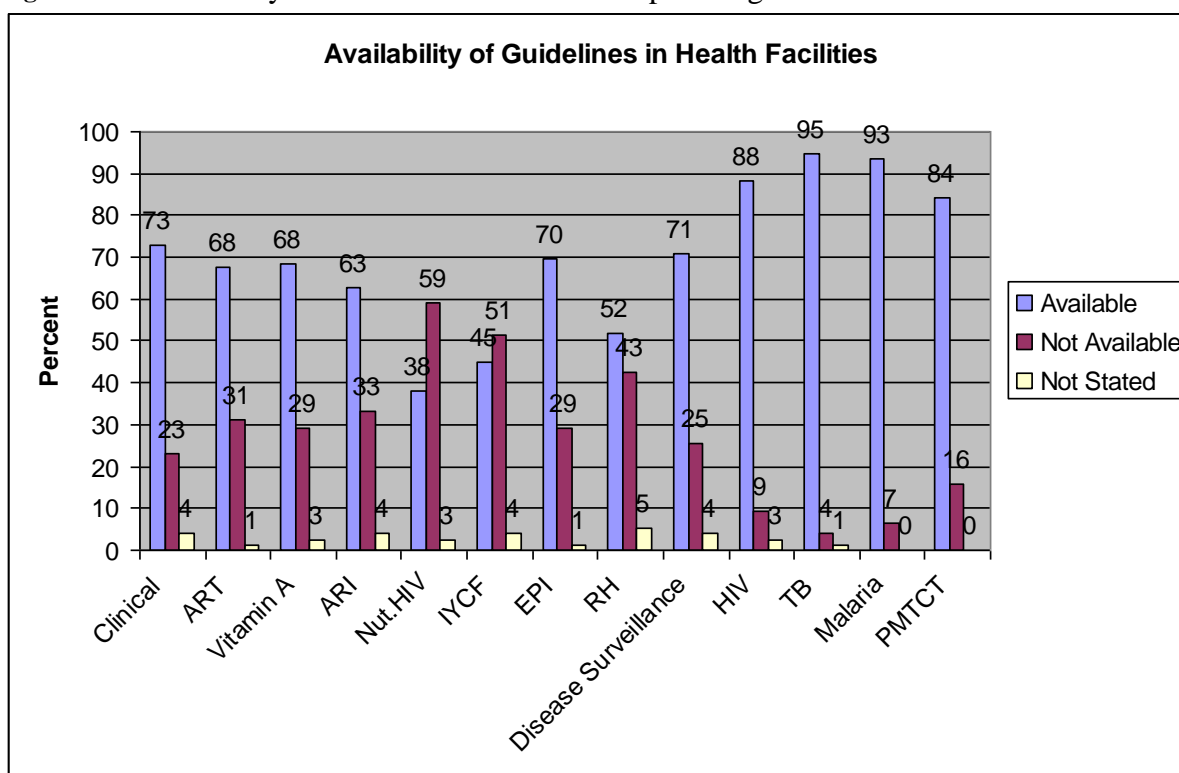
#### Availability of Policy Guidelines

The review found that there are quite a number of policies and guidelines in existence in the ministry, covering different aspects of service delivery. The large number of policies can be

attributed to the fact that as the ministry embraced new programmes and initiatives, it was necessary to provide clear policy guidelines to guide their introduction and implementation. Each new programme therefore developed its own policy and or guidelines. The review revealed that most health facilities had copies of the most important guidelines, including clinical, ART, cholera, pharmaceutical, IYCF, school health, Vitamin A, CHBC, ARI, EPI, RH, TB, malaria, HIV, PMTCT, FP, and mental health guidelines.

Over 80 percent of the 76 health facilities visited during the review had guidelines PMTCT, HIV, Malaria, and TB. On the other hand, less than 60 percent of the facilities had guidelines nutrition and HIV/AIDS, infant and young child feeding and reproductive health. Health workers showed that they were familiar with these guidelines and utilized them in the delivery of services.

Figure 17: Availability of Guidelines in Seven Sampled Regions



The key informant interviews revealed that a significant number of top management of the ministry at national, regional, and district levels are not aware of the existence of some policies and guidelines critical for the delivery of health and social services. The key informant interviews showed that as much as 50% of managers at both national and regional level were not aware of the existence of some national policies. It was also found that only a few of the regional and district managers were involved in the development of the policies.

**Policies in draft forms**

A number of policies, guidelines, and protocols developed by different Directorates remain in a draft form and need to be finalized and endorsed by ministry for implementation. These include minimum packages at all levels; accommodation policy; social welfare policy; waste (including medical waste) management policy and protocols, health promotion policy. The review revealed that is also an urgent need to finalise the guidelines on referral of patients, strategy for sanitation and hygiene, guidelines for employers on recruiting people with

disability (PWD) and the Public Health Act (as the country is currently using that of 1919) to provide guidance for sanitation and hygiene amongst others.

**Policies to be updated**

There are a number of policies which are more than five years old and need updating to make them relevant for the current and future needs for effective service delivery. They include the 1998 National Health Policy Framework, various policy directives contained in the famous Otjiwarongo Document, guidelines for the establishment of health facilities, standard and norms document for construction of Health Facilities, and the National Transport Policy. Others include the user fees policy, to specifically exempt orphans and vulnerable groups; EPI policy to accommodate new vaccines, e.g. hepatitis B, Haemophilus influenza B Vaccines, Pneumococcal vaccine, rota virus vaccines, etc.; national disability policy; NEMLIST (to allow the following medicines to be administered at clinics: Anti-retroviral medicines, new anti-hypertensive therapies, HIV testing).

Those policies needing amending include the policy and guidelines on working hours of clinics (in order to provide 24 hour operation after hours and public holidays – taking into account the Labour Act provisions); minimum health service packages; the supportive supervisory check list; Acts regulating the community service for new health related graduates to provide for longer period of public services by newly trained doctors; and the development cooperation policy.

**Policies to be developed**

The review also established that there are some areas in health and social services that currently do not have relevant policies, guidelines and protocols and scope of practice to guide implementation. In this regard, new policies and/or guidelines will need to be developed to address human resources for health, including HRH management guidelines; budget and resource allocation to ensure equity; health specific emergency preparedness and response protocols (anticipating emerging and re-emerging situations); guidelines on community-based rehabilitation; policy and guidelines on the incorporation of community health and social workers/volunteers into the health system; ambulance policy, including its inclusion in the structure of the ministry. Lastly, the Ministry needs to develop induction/orientation manuals for newly recruited staff at all levels; policy and guidelines for granting financial assistance to welfare organizations; and policy/guidelines on the provision of condoms for inmates in prisons.

**Constraints**

The major constraint in the policy area is the limited capacity for health policy analysis and development in the ministry to support the elaboration, monitoring of policy implementation, assessment of continued relevance of policies, identification of issues and areas that require new policies, and the drafting of amendments to policies.

This capacity constraint manifests in the absence of clear policies and guidelines in some areas that hampers the correct and speedy implementation of programmes in the Ministry. It has also led to the existence of quite a number of policies that have been in draft form for a number of years.

The health system review identified the lack of knowledge of the existence of key sector policies and guidelines by the managers a significant constraint. This is compounded by the finding that there is not enough wide-ranging consultation in policy formulation. These

factors could be contributing factors for the non-implementation of existing policies, as well as the lack of awareness and ownership of the produced policies.

Another constraint in the policy arena is the lack of guidelines in some areas to support implementation of policies that have been developed.

The survey identified that absence of a structured orientation and or induction process for newly recruited health workers into the health systems by exposing them to national health and social services policies as another constraint.

A final constraint identified in the review is the absence of structures such as the National Health Council, National Disability Council, and other relevant bodies, to regulate, facilitate, and monitor the policy development and implementation.

### **Recommendations**

1. Update the 1998 Health Policy Framework.
2. Engage in an on-going policy analysis and review process to ensure that all policies and guidelines remain relevant to emerging challenges.
3. Revise the policy/directives on after-working hours, working during weekends and holidays in clinics and remote areas to make service available to the population at these times.
4. Ensure active participation of all stakeholders at all levels, including citizens' groups, in the formulation of health sector policies.
5. Strengthen the capacity of the Ministry for policy formulation, analysis and implementation.
6. The Private Health Facility Act and collaboration with private sector should be revised in order to provide for issues of social responsibility.

### **3.4 Partner Coordination**

The review found that there was a lack of over-arching coordination of the various partners involved in the health sector. The current approach of donor coordination, for example, is built on a number of structures that bring stakeholders with common interest together. These include the quarterly review meetings of the MOHSS and UN Agencies, MOHSS – USG Agencies (PEPFAR) Review meetings, Inter-Agency Coordination Committee that bring stakeholders together on immunization, and NACCATUM, the Country Coordinating Mechanism for Global Fund.

Under the current approach the working system of the various development partners are fragmented with an inevitable duplication of programmes and in some cases to certain regions only. It is however recognized that development partners have different cycles of planning. There is therefore a need for development partners to have a common platform with the MoHSS so that all plans to be undertaken are understood and communicated to all for partners to incorporate the implementation of the activities within their planning cycle.

Improved donor coordination would ensure that development resources are optimally mobilized through sustainable means, effectively coordinated, equally distributed and efficiently utilized in accordance with the overall Government's Development Cooperation Policy Framework, guidelines, goal and objectives as well as the Ministry's Policy Framework. Currently, donor coordination in MOHSS is facilitated by a Subdivision: Development Cooperation (SDC) within the Division Policy and Planning, in the Directorate:

Policy, Planning & HRD (P, P & HRD) as well as Subdivision: Resource Mobilization and Development Coordination” in the Directorate Special Programmes.

To date, sixteen development partners have pledged their support to the MoHSS, and 36 Agreements / Memoranda of Understanding have been entered into inclusive of local partners. Among the Development Partners supporting MOHSS are the following:

- a) **Multilateral Agencies:** WHO, UNICEF, UNFPA, EU/EC, Global Fund.
- b) **Bilateral Agencies:** USAID, CDC, PEPFAR (USA), Health Unlimited (Britain), GTZ (Germany), Medicos del Mundo (MdM, Spain), CESTAS (Italy), People in Need (Czech Republic), Chinese Medical Programme, German Development Services (GDS / DED).
- c) **International and Local NGO's:** KFW / GITEC (Nasoma), Bristol Myers Squibb, Volunteer Services Overseas (VSO), etc.

The major areas of donor support to the Ministry include:

- a) HIV/AIDS prevention, treatment, care and support: GTZ, KFW/GITEC (Nasoma), EU/EC, Global Fund, Nedico, People in Need, MdM, USAID, CESTAS, PEPFAR.
- b) Capacity Building in areas of Sexual and Reproductive Health, Maternal & Child Health, Adolescent Friendly Health Services: UNFPA, UNICEF, GTZ, Health Unlimited.
- c) Human Resources Development / Provision of Volunteers: Health Care Professionals and Development Workers: German Development Services (GDS / DED), Volunteer Services Overseas (VSO), Chinese Medical Programme, Cuba, Egypt and Russia.

Further, coordination among the NGOs in Namibia has on the other hand improved over the years with the formation of Namibia Non-Governmental Organisation (NANGOF) which coordinated all NGO activities and Namibia National Aids Support Organisation (NANASO) which coordinates NGOs involved in HIV/AIDS control. There is, however, a need strengthen the collaboration between the umbrella NGO bodies and the Ministry of Health and Social Services.

## **Recommendations**

1. Establish a coordination mechanism for partners in the health sector
2. Hold an Annual Health Assembly to bring together all partners from all sector to review progress made by the sector and constraints faced
3. Strengthen donor coordination mechanisms

## CHAPTER 4. HUMAN RESOURCES

*“This nurse though alone at the clinic, she is trying her best, from treatment to wound dressing. Her attitude never change, she is a very good nurse.”*

### 4.1 Background

Human Resource for Health (HRH) is a vital component within the Ministry of Health and Social Services (MOHSS) and is spear-headed by two Directorates; namely the Directorate of Human Resource Management and General Services, and the Directorate of Policy, Planning and Human Resource Development. The HRH division is responsible for the overall planning, co-ordination, monitoring and evaluation of human resources development aspect in the health sector. Whereas the division HRM is dealing with human resource management aspects.

After independence in 1990, one of the major challenges faced by the Namibia’s health system was the lack of skilled human resources crucial for the successful provision of health care. In order to address these constraints, the Government launched various initiatives towards the development of Human Resources for Health, including short-term, medium-term and long-term strategies. Hiring expatriates from neighbouring countries had been the immediate short-term strategy to fill in the gap.

In the absence of a local medical training institutions; the Ministry of Health and Social Services initiated a 2 years pre-service training programmes for sub-professionals; including the Enrolled Nurses, Pharmacy Assistants, Medical Rehabilitation Assistants, Medical Laboratory Assistants, Environmental Health Assistants, Orthopaedic Technicians and Radiographic Assistants. These are offered through the Training Network comprising of the National Health Training Centre (NHTC) and four Regional Health Training Centres (RHTCS).

However, it was found that NHTC is having inadequate human capacity to cope with its demand especially in the area of pre-services training and continuous education. While the NHTC and the RHTC offer pre-service training, there in-service training is predominantly in HIV rather than the other program areas. Furthermore, due to the high intake of students there available training space is far from adequate. This is especially noticeable in the regions at the Training Networks. It was also noted that there is a miss-match between the NHTC staff responsibilities and their levels of grading.

The University of Namibia (UNAM) has also been training part of the health professionals, including the Registered Nurses, Social workers, and Radiographers. Doctors, Pharmacists, Dentists, and other health related professionals are still being trained outside the country. However, in 2002, a pre-medical and pre-pharmacy training programme was established at UNAM.

The training programmes have resulted in the production of a significant workforce for Namibia. The programmes have trained 3,798 health related workers since 1990 and expect to train 3,933 during the NDP3 period (2008-2012).

To further, bolster the workforce, the MOHSS awards fellowships to enable health and social welfare workers to be trained, developed and re-oriented both in quantity and quality of care. Priority is given to rural/remote and gender. The majority of the postgraduate education for various health professionals' categories takes place outside the country except education for nursing, social work, and postgraduate management training. Recipients of the fellowship sign a bonding agreement with the MOHSS for a continued period of at least equivalent to the number of study years paid for by the Government.

In order to avoid any drop out for students trained in health related fields, the MOHSS provides additional financial assistance to students sponsored by the Government Students Financial Assistance Fund (GSFAF) which has proven to be not enough to cover all expenses incurred by students. For the financial year 2004/5, a total number of 107 students received additional financial assistance from the MOHSS for which N\$ 1,126,480, 20 was spent.

### Human Resource Strategic Framework

The MOHSS has drafted a Long-Term Human Resource (HR) strategic framework forecasting the future needs and supply of required staff in the country for a period of thirty years (1997-2027). Subsequently, a Medium-Term Human Resources Plan (1997-2007) and Five-year Human Resource Development Plans (2000-2005; 2008-2012) were produced to serve as guidelines for HR planning. In addition, through the NDP2 & 3, the Ministry has initiated programs of further education, upgrading, in service training, and orientation of existing personnel, to increase the managerial and technical competence of personnel at all levels.

The HRMIS (Human Resource Management Information System) that is currently being changed from paper-based to the electronic system is a valuable tool for accomplishing an efficient management of the workforce within the public sector.

## 4.2 Current Situation

The doctor to population ratio in Namibia is favourable when compared to other African countries. On average, Namibia has three doctors per 1,000 population. Different ratios of key health care professionals to the population are presented in the table below.

**Table 5:** The Ratio of HealthCare Professional to the Population<sup>28</sup>

Category	Ratio per National Population
Doctors	1:2,952
Registered Nurses	1:704
Pharmacists	1:10,039
Dentists	1:20,078
Social workers	1:13,519
Health Inspectors	1:28,562

Although Namibia's health worker capacity is above the WHO benchmark of 2.5 health workers per 1000 population (with 3.0 health workers per 1000 population), there is a marked disparity in health workers capacity between the public and private sectors. While the private sector has 8.8 health workers per 1000 population, the public sector barely has 2.0 health workers per 1000 population (below the WHO benchmark). Within the public sector, the

situation is compounded by chronic staff shortages amongst frontline workers (doctors and nurses) which - if addressed - could result in Namibia reaching the WHO benchmark of 2.5 health workers per 1000 population.

Overall, the total number of key human resource workforce registered with different interim health professional Councils of Namibia in 2006/2007 was estimated at 7,697 health workers nationwide. The table below presents details of the registered workforce as well as their distribution in the public and private sectors.

**Table 6:** Distribution of Health Professionals in the public and private sectors<sup>29</sup>

Professional Category	Health Workers registered during 2006/07	No in Public Health Sector		No in Private Sector	
		No	Percentage	No	Percentage
Doctors	774	216	28	558	72
Registered Nurses *	2989	1626	54	1363	46
Enrolled Nurses *	2761	1884	68	877	32
Dentists	90	11	12	79	88
Pharmacists	239	27	11	212	89
Pharmacist Assistants	137	65	47	72	53
Occupational Therapists	48	15	31	33	69
Environmental Health Officers*	140	37	26	103	74
Environmental Health Assistants	58	37	64	21	36
Social Workers *	250	76	30	174	70
Orthotists	14	4	29	10	71
Orth. Technician	26	26	100	0	0
Radiographers	109	27	25	82	75
Radiographic Assistants	62	32	52	30	48
<b>Total</b>	<b>7697</b>	<b>4063</b>	<b>53%</b>	<b>3634</b>	<b>47%</b>

\*No in private and other Gov-sectors than health sector

While the public sector continues to be the leading employer of health professionals with fifty three percent (53%) of the total workforce, the table above clearly shows a very prominent private health sector that accounts for 47% of the overall workforce in the country.

Registered Nurses and Enrolled Nurses are the predominant health workers categories and constitute 74% of the overall total workforce. While the proportion of registered nurses serving in the private and public sector is almost equal, the ratio of enrolled nurses in the public sector is greater than twice those in the private sector.

More challenging is the distribution of health workers in favour of the private sector for some key professionals categories; such as Doctors where 72% are practicing in the private sector; Dentists 88%; and Pharmacists 89%. The same applies also for occupational therapists, social workers, orthotists, orthotists technicians, and radiographers who are overburdened by high workloads.

Overall, the public health sector is characterized by a heavy reliance on foreign health professionals, high vacancy and attrition rates.

#### 4.2.1 Urban/Rural Distribution of Health Workers

The distribution of health workers is characterized by urban-rural disparities as shown in the table below.

**Table 7:** Urban/Rural Distribution of Health Workers<sup>30</sup>

Professional Category	Total no. registered 2004/2005	Urban		Rural	
		No	Percentage	No	Percentage
Doctors	598	457	76.4	141	24
Nurses (Registered and Enrolled)	6214	3,767	61	2,378	39
Dentists ( Dental Assistants included)	113	101	89	12	11
Pharmacists ( Pharmacist assistants included)	288	198	68	92	32
Physiotherapists	68	67	98.5	1	1.5
Occupational Therapists	30	28	93	2	7
Environmental Health Officers (Env. H Assistants included)	240	107	45	133	55
Social Workers	270	230	85	40	15
Psychologists	68	67	98.5	1	1.5

#### 4.2.2 Vacancy Rates in the Public Health Sector

Even though Namibia has good ratios of health personnel to the total population compared to other Southern African Countries, data show that the health system requires additional health personnel to effectively deliver needed health services. There is an imbalance between the number of establishment posts and the actual filled posts.

The table below gives the total number of posts filled in the public health sector compared with the approved posts. Out of the total 5,509 established posts 1,482 (26.9%) remain vacant. Most categories are characterized with very high vacancy rates ranging from 20% to 63%, most significantly doctors at 36% and nurses at 24%

**Table 8:** Number of posts filled in the MoHSS<sup>31</sup>

Professional Category 2006/2007	No of Approved Posts	No of Posts filled	Percentage	No of vacancies	Percentage
Doctors	285	183	64	102	36
Pharmacists	46	27	59	19	41
Dentists	21	11	42	10	48
Radiographers	41	27	66	14	34
Social Workers	155	76	49	79	51
Registered Nurses	2,083	1,626	78	457	21
Med. Specialists	47	33	70	14	30
Health Inspectors	66	37	56	29	44
Env. H. Assistants	84	37	44	47	56

Professional Category 2006/2007	No of Approved Posts	No of Posts filled	Percentage	No of vacancies	Percentage
Pharmacists Assistants	76	65	85	12	15
Radiographic Assistants	40	32	80	8	20
Enrolled Nurses	2,482	1,884	76	638	24
Physio/Occupational Therapists	40	15	37	25	63
Orthotists	7	4	57	3	43
Orth. Technologists	10	6	60	4	40
Orth. Technician	26	25	96	1	4
<b>Total</b>	<b>5,509</b>	<b>4,088</b>	<b>74.1</b>	<b>1,482</b>	<b>26.9</b>

### Reasons for High Vacancy rates

The vacancy rate in the overall public sector stands at 27% and the MOHSS institutional records reveal that the shortage of all categories of staff is a recurring problem in most of the facilities.

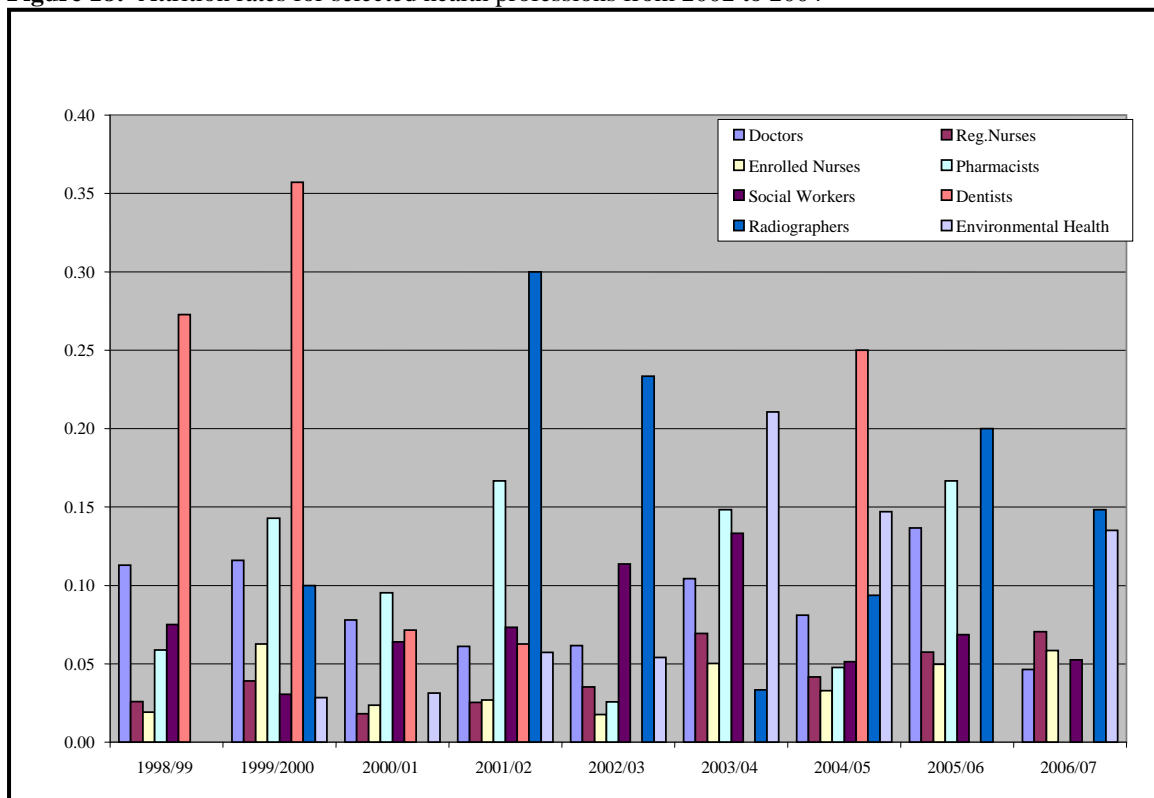
This situation is due to the following:

1. The current staff establishment is outdated and is non responsive to accommodate new developments and new programs (e.g. increased demand in HIV/AIDS, outreach staff, school health staff, CBHC staff, Pharmacist Assistants, Medical Rehabilitation Workers, radiographic assistants, mental health, etc.). The staffing number and deployment no longer meet the service needs at national, district and clinic levels.
2. There is a long recruitment process for government positions. Recruitment through the Public Service Commission (PSC) is a lengthy process, requiring several steps. Graduates in key health professional categories like doctors, pharmacists, and dentists are willing to enter public service, but the long waiting time for government positions discourages many of them; and as a result, they turn to the private sector for employment.
3. The long process for issuing work permits to foreign nationals does not easily facilitate the hiring of much needed expatriates.
4. Students financial assistance quotas received from the Ministry of Education are insufficient. Therefore, some health related students at the local and foreign academic institutions are not beneficiaries of the Namibia Students Financial Assistance Fund (NSFAF), and continue to study in very difficult conditions.
5. Students supported through the Namibia Students Financial Assistance Fund (NSFAF) are not obliged to work for the Government after completion of their training. They can take up employment with any sector provided that they pay back to the Fund. This contributes to the shortage and a high turnover of health professionals in the public sector.
6. Salary scales/grades are not correlated to educational levels or years of training. This is evidenced by the high vacancy rates among Physio/Occupational Therapists

### 4.2.3 Attrition Rates in the Public Sector

The public health sector has suffered from high levels of attrition in the past ten years. A cumulative loss of three thousand three hundred and nine (3,309) health professionals has been registered. The figure below shows the attrition rates for selected key health professions

Figure 18: Attrition rates for selected health professions from 2002 to 2004



The annual average attrition rate for the above key health professionals is 5%. Radiographers have the highest attrition rate at 16%; followed by Dentists 11%; Pharmacists 10%; Environmental Health Officers 9%; Doctors 8%; Social Workers 8%; and Registered Nurses and Enrolled Nurses 4%.

These very high rates are threatening the sustainability and efficacy of the health system, due to the prevalent shortage of health professionals. Prompt recruitment of additional staff and retention schemes establishments could help to curve these very challenging attrition trends.

**Reasons for Staff Losses**

The main reasons for Human Resource losses from the public health service during the year 2005/2006 were resignations with 51%, followed by retirements 20%, as outlined in the table below.

Table 9: Reasons for Staff losses during the period 2005/06

Reason	Number of staff	Percentage
Resignation	226	51
Retirement	88	20
Death	77	17
Transfer to other GRN sectors	22	5
Medical discharge	20	5
Dismissal	8	2
Contract expires	0	0
<b>Total</b>	<b>441</b>	<b>100%</b>

The resignation from the public sector is primarily due to better pay, career growths and advancement. There are also few cases of nurses who have resigned to migrate abroad. Staff losses could also be explained by the lack of *deprivation packages* in rural areas which were abolished in 1995; yet health workers are practicing in an unpleasant working environment in rural areas.

A lack of in-service training is another cause for loss of staff. While the NHTC and the RHTC offer pre-service training, their in-service training is predominantly in HIV rather than the other program areas.

Furthermore, the staff also suffers from low motivation due to the high workload resulting from high vacancy rates, the increasing morbidity caused by HIV/AIDS and other diseases, and the lack of recognition from their supervisors.

### **Lack of HR Retention Strategy**

There is limited career movement in the public health sector leading to a high staff turnover. The Public Service Management Circular No 32 of 2002 stipulates that staff members in public service may only apply for promotional posts one grade higher than their own. However, applicants who are not in the public service are allowed to apply for posts at any level. There is a lack of a career ladder in some type of health professionals/sub professionals who are condemned to remain in an entry position until retirement or to have not more than one promotion in their whole life.

There is also a lack of Performance Management System (PMS). The PMS is not yet functional; the staff appraisal is still being done in a traditional manner, where performance is not necessarily rewarded.

Generally, there is no in-service training plan for regions and districts. Therefore, there is a limited continuing education for improved service delivery for those already in the service.

Overtime allowances are only applicable to staff members working in hospitals and not those working in Primary Health Care health centres and clinics.

### **Staff Burn Out**

Generally, there is high workload in the ministry as a result the Ministry staff is experiencing burn out. This is more evident in health facilities due to high disease burden especially HIV/AIDS. Although this is the situation, the Ministry has not yet implemented Employee Assistance Programme, which is aimed at enhancing. The EAP therefore is aimed at enhancing the health, well-being and performance of the workforce. EAP is dedicated to supporting and strengthening the workplace environment by providing professional help for employees whenever they need it, placing emphasis on prevention, treatment, support, care and confidentiality.

## **4.3 Recommendations**

Despite the tremendous progress made in Human Resources for Health issues since Independence, there are still many challenges that need to be addressed.

1. Review the staff establishment to accommodate posts for emerging needs.
  - a. The staffing of health facilities should be based on population, distance and workload.

- b. Filling of vacant posts should be accelerated.
  - c. The MoHSS should seek from the Ministry of Home Affairs and Immigration a special treatment for health workers and if possible to become part of the Immigration Board to speed up the process.
2. A compulsory community service by all new health related graduates should be enforced before registered as independent practitioners. These regulations should be enforced by various health professional councils.
3. Private health professionals should be encouraged to offer part time services in public health facilities.
4. The MoHSS should lobby with the Ministry of Education (MOE) to implement the conversion of the study loans received by health related students from the Namibia Students Financial Assistance Fund (NSFAF) into grants.
5. Capacity of local training and academic institutions should be strengthened to increase the intake of students in the various professions.
6. Expedite the establishment of a medical school.
7. The community health workers should be made extension workers of the Ministry of health in order to strengthen the primary care approach and incentives provided to them.
8. Better career marketing & promotion of the health related professions through intensive career guidance should be conducted by the MoHSS in collaboration with the MOE in high schools.
9. Strengthening and improvement of Human Resource Management Systems.
10. The Performance Management System (PMS) should be implemented
11. Establish Performance indicators for service personnel and a comprehensive monitoring and verification system.
12. Consider career path development of all job categories which is not attached to competitive promotional positions at least once or twice in each job category e.g. senior and principal level.
13. Review and adjust of salary grades to harmonize remuneration packages of staff members in same occupational categories and carrying out the same functions
14. Review and re-introduce the deprivation packages for staff working in remote areas, in order to improve their conditions of service
  - a. Health workers should be exempted from the renting fee in rural area.
15. Consider the creation of new specialist cadres of nurses to address the current constraints. For example, specialist nurses in the functional areas of anaesthesia, radiography, oncology, community health nursing, and mental health care could be introduced to mitigate the current shortage of specialised cadres in these areas. This process should be carried out in close consultation with the Nursing Council to ensure recognition of the additional training and skills gained plus appropriate incentives. The ministry would also need to recognize these specialist positions in the official staff establishment.
16. Implementation of EAP should be expedited by establishing the unit and staffing to support staff members.

## CHAPTER 5. SERVICE PROVISION

*“Clinics should be opened during weekends and public holidays; we don’t choose when to get ill.”*

### 5.1 Primary Health Care

#### 5.1.1 Introduction

A good health service is one that delivers effective, safe, quality personal and non-personal health interventions to those requiring them, when and where needed, with minimum waste of resources. Services – be they prevention, treatment or rehabilitation - may be delivered in the home, community, the workplace or in health facilities. The Namibia health system review was mandated to identify the strengths and weaknesses of the system, examine the factors responsible for non-optimal functioning of the Health system with regard to service delivery, and make appropriate recommendations. From both the literary review and the surveys involving health managers at the three levels of the Namibian health system (central, regional and district levels), as well as from clients of health services, some important findings emerged.

This chapter outlines service coverage, major progress made over the past five to ten years, key challenges and possible impact of the various primary health care and social welfare services provided by the Ministry of Health and Social Services. It also provides consumer perspective the quality of services provided. Apart from the general findings on section 5.1.2, this chapter describes the various Primary Health Care programmes and their potential impact over the past decade.

#### 5.1.2 General Findings

Following the introduction of Primary Health Care Approach, there was a remarkable progress in key indicators in Namibia as evidenced by the 1992 and 2000 Demographic and Health Surveys. However, the 2006 DHS has shown a reversal of these indicators has highlighted in the epidemiological profile. In this section, it is also evident that although coverage indicators remain high, there has been a decline in some critical areas.

The results from the health facility checklist and exit interviews as well as the focus group discussions have highlighted a number of general findings as highlighted below.

##### Access to services

The vastness of country causes geographical accessibility challenges, high opportunity cost and lack of transport. Out of the 295 clients interviewed upon exit from the 76 health facilities, 41.5% had travelled for less than 5 kilometres, 27% travelled for 5-10 kilometres, 8% 11-20 kilometres and 13% travelled for greater than 21 kilometres.

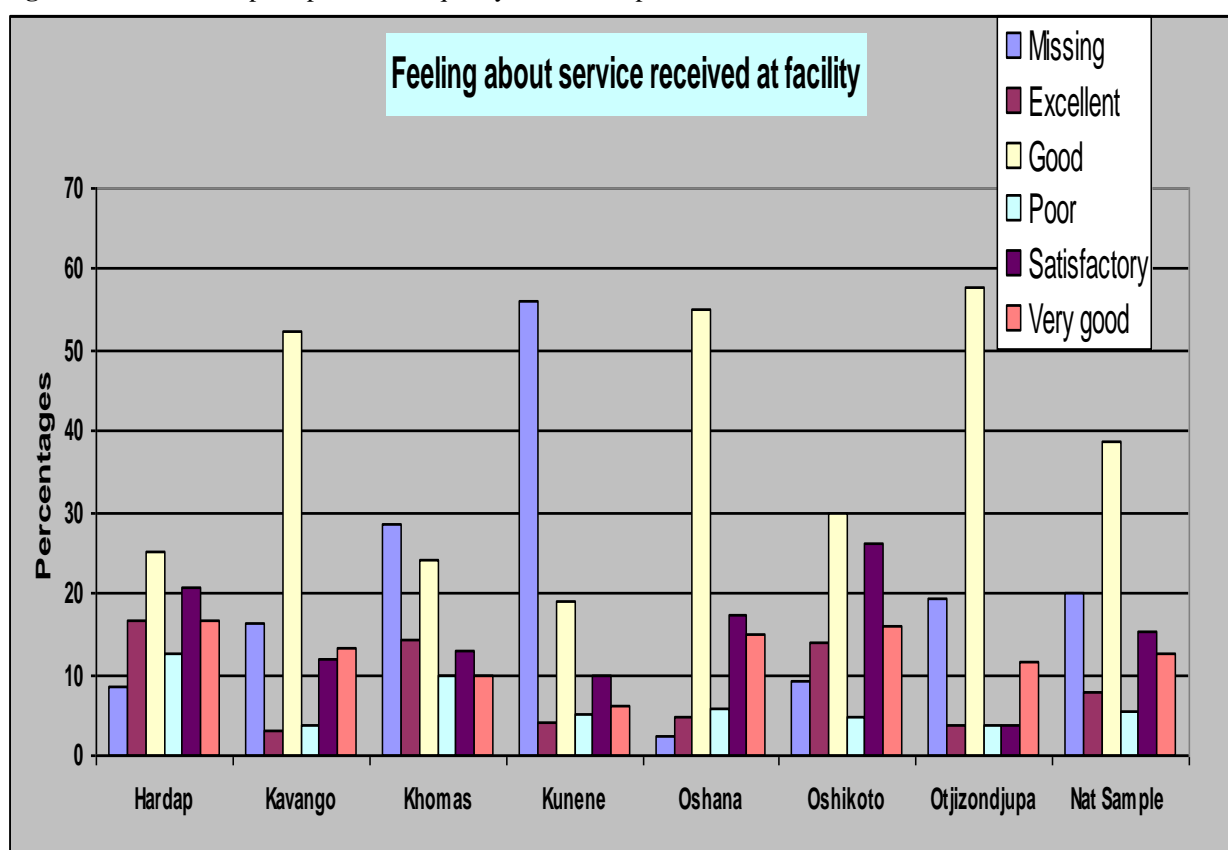
Distances between health facilities in Namibia remain a big challenge to provision of services especially in sparsely populated areas. Referral services are most affected given the general lack of transport in most regions. The review found that there was a lack of ambulances in the

health facilities; 46 % of health facilities in Otjozondjupa region reported availability of ambulances, whereas only 9% of health facilities in Oshana had ambulances. All the facilities are, however, able to call for ambulance services although they experience delays in getting these services. This compromises referral services.

Satisfaction with services

Consumer perception about quality of services received was very favourable with less than 10 percent rating the services as poor in all regions except in Hardap where 12.5% rated services as poor. As highlighted in the figure below, about 60 percent of respondents in exit interviews rated the services they received as good and above. Hence, there was a general satisfaction among communities with the services provided. However, many respondents were unhappy with the closure of health facilities during weekends and holidays.

**Figure 19:** Consumer perception about quality of services provided



Participation of community members

Overall, 72% of health facilities visited during the review had health committees which included community members: Oshana region had the highest percentage (100%) followed by Oshikoto with 92% whereas in Khomas only 17% of health facilities visited had committees with community members. This relatively high participation of community members may have contributed to the relative satisfaction with the services provided.

Supervisory visits

Support supervision from the regional levels to the 76 health facilities sampled in the review was generally weak. Overall, 30% of the health facilities were visited once in the 3 months before the review visit. 67% of facilities in Khomas, 66% in Kunene, 20% in Kavango, 27%

in Oshana, 25% in Oshikoto, 23% in Otjizondjupa were visited once in the previous three months. It is evident that support supervision is poor in most of the regions.

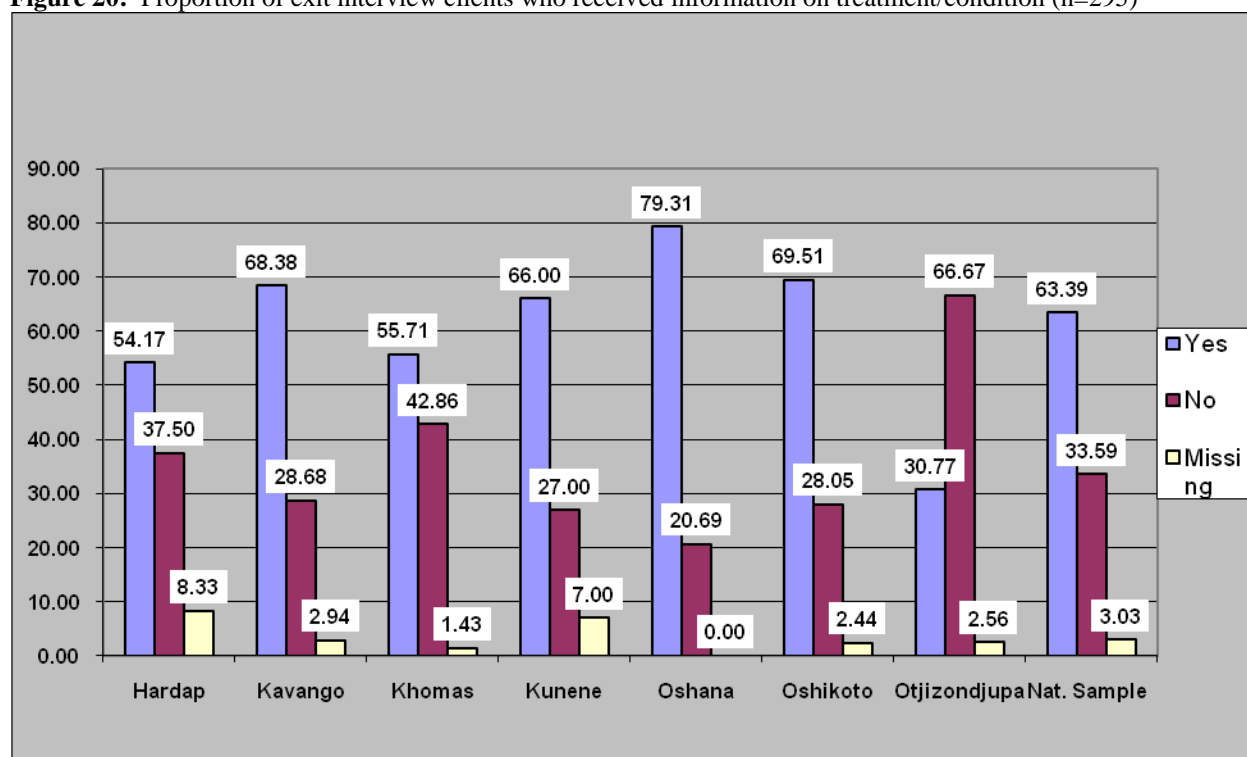
Outreach/mobile health services

The review found that outreach/mobile services are not functioning optimally as most of the regions reported having no transport for outreach services. This impact negatively on a number of health indicators such as EPI coverage and Infant mortality rate – it is therefore not surprising that IMR has increased over the years.

Health Promotion

Overall, health promotion is inadequate at all levels. In the focus group discussions as well as in the exit interviews, respondents indicated that apart from HIV/AIDS, they receive little or no information on health issues. Sources of information include the media (radio), health workers and from community health workers. About 63 percent of the 295 exit interview respondents stated that they had received information from the health workers on their treatment/condition with Oshana scoring the highest at 79% and Otjizondjupa scoring the lowest at 30 percent. This is an indication that some health education takes place in health facilities. Overall, it was found that the capacity at the national and regional levels for adequate support to health promotion and for effective behaviour change communication was weak.

**Figure 20:** Proportion of exit interview clients who received information on treatment/condition (n=295)



The survey, however, found that there were issues with friendliness of staff, as some health workers tended to display a non-friendly attitude. Complaints of nurses being rude and not paying attention to the clients were reported. It was also found that there were language barriers (and lack of communication for the blind and the deaf) and lack of physical structures to facilitate access by people with physical disabilities

**Major constraints:**

1. Essential health package to be applied in various levels of care is yet to be finalised.
2. Lack of health extension work is a hindrance to universal coverage of primary health care services especially given the sparse population and the vast distances between health facilities in Namibia.
3. Policy and strategy on health promotion is yet to be developed.
4. Outreach services are weak due to lack of transport and poor motivation of staff serving in hard to reach areas.
5. The referral system is poor, so no continuity of care is provided.
6. With regard to Quality of care, there is inadequate staff, and inappropriate skills mix in the health system to ensure quality of care. Equipments (x-rays, theatre equipment, laboratory) are not always in a functional state, nor is there a preventive maintenance service for medical equipment.
7. Lack of supervisory checklist and supportive supervisory visits from all levels of the system.

**Quotes from focus group discussions and exit interviews.**

“Health education is only geared towards HIV/AIDS there are a lot of problems in the communities that we need to be educated about.”

“Privacy is lacking you sit here telling the nurse your problems, others can hear tomorrow you are the talk of the town”

“Talking of Outreach services, we only see them during NIDs”

“We have access to information related to health through the radio, especially about Cholera from the Director.”

“The services was good today because I was not shouted at as usual”

“We wait long periods for treatment because nurses are too slow and they open the clinic past 10h00 sometimes.”

“Goodness the ambulance is here today, it normally doesn't happen they came maybe because they know you are here”

“Services to be brought to the community? That is a joke if you do not take your feet and go to the clinic then you are just wasting your time.”

“What are these people working with pensions doing? We have a lot of disabled people in homes they should visit this houses, disabled people are neglected”

**Recommendations**

1. Extend the health services into communities, through the recruitment of paid community health workers.
2. Reach consensus on a minimum package of an essential health service provision and cost it to inform resource allocation and HR deployment.
3. Ensure availability of a separate vote for outreach services in order for programme coverage to reach the desired levels.
4. Supportive supervision is essential and must be done regularly, with an accepted supervisory checklist, aimed at improvement of service delivery.
5. Continue update knowledge and skills of health workers including on interpersonal communication.
6. Develop a communication strategy to support health promotion activities.

### 5.1.3 Child Health

#### Expanded Programme on Immunisation

The Expanded Programme on Immunization (EPI) within the Ministry of Health and Social Services (MOHSS) was formally established in June 1990, 3 months after independence. The programme aims to achieve and maintain vaccine coverage above 90% for all antigens in every district with a dropout rate of less than 5% by the year 2010 and beyond, sustain the elimination of neonatal tetanus, poliomyelitis measles by the year 2010 and beyond.

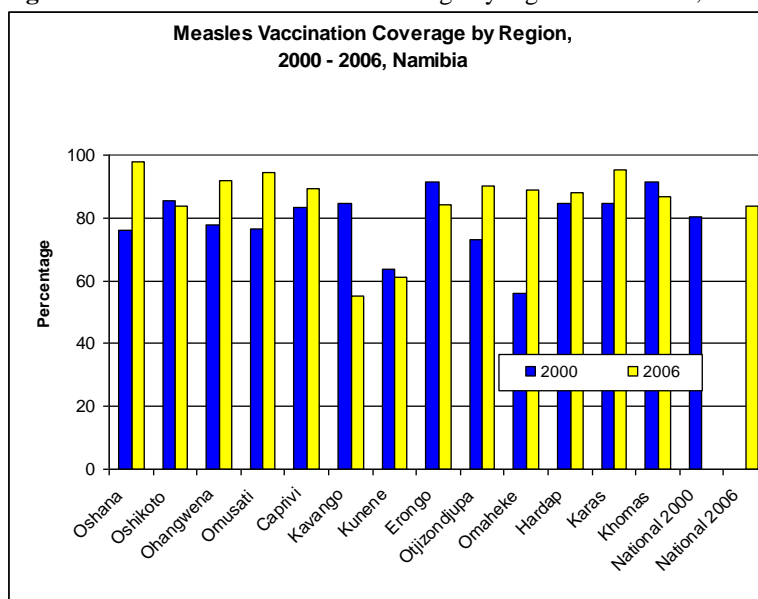
The major focus of EPI programme has been to strengthen routine immunisation. At the same time, EPI acceleration weeks were conducted 4 times a year between 1990 and 1995 in all districts to raise vaccination coverage. Because of this, a significant increase was observed in coverage of all antigens including OPV3 from 40% -80% during this period. However, from 1996 onwards National Immunization Days (NIDs) were introduced to further reduce variations between regions and districts. Due to frequent crossing of populations between Angola and Namibia, the two countries have synchronized their NIDs activities since 2007.

Recently, the ministry has introduced the “Reach Every District Approach” (RED) in order to reach every child in all the corners of the country. This strategy is helping to give children the opportunity not to miss immunization. Vigilant active and case based surveillance activities have been implemented.

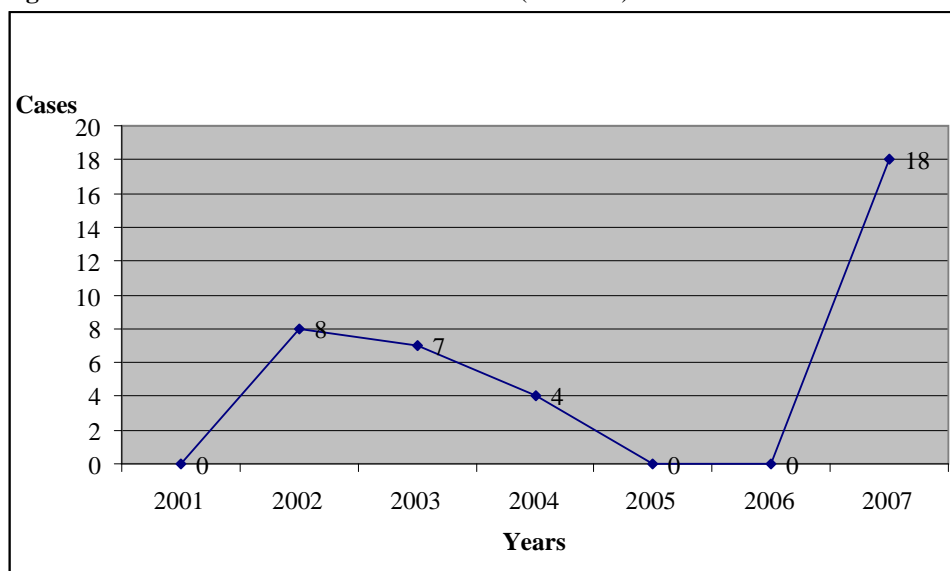
#### Service Coverage

The proportion of children vaccinated against measles by age 12 months slightly increased from 76% in 1992 to 84% in 2006, slightly surpassing the national district target of 80%. There were, however, regional variations in coverage with Kavango, Erongo and Kunene regions recording a drop in the measles vaccination while other regions showed an increase in the vaccination coverage between 1992 and 2006 (*see figure below*).

**Figure 21:** Measles Vaccination Coverage by region 2000-2006, Namibia (DHS 2000, 2006)



Immunisation programme had a major impact in Namibia resulting in virtual elimination of neonatal tetanus by 2005, and significant reduction of measles cases between 2003 and 2007. However, recent surveillance data indicates a re-emergence of neonatal tetanus cases as shown below.

**Figure 22:** Neonatal Tetanus Cases 2001-2007 (HIS data)

In addition, Namibia was on the verge of eliminating polio until the recent outbreak in 2006 following importation of wild polio virus from Angola. Following the successful outbreak response, no cases of polio have been reported since 2007.

### **Integrated Management of Childhood Illness (IMCI)**

The implementation of IMCI started in 1999 with the support of WHO and UNICEF, professional groups and other stakeholders in the country. Between 2000 and 2006, IMCI was implemented in the districts of Engela, Gobabis, Katima Mulilo, Mariental, Okakarara, Omaruru, Onandjokwe, Opuwo, Oshakati, Rundu, Walvis Bay, and Windhoek. The strategy has now been expanded to Keetmanshoop, Okahao, Okahandja, and Usakos districts. As a result, IMCI has now been implemented in 47% of the 34 districts and in 157 out of 331 health facilities.

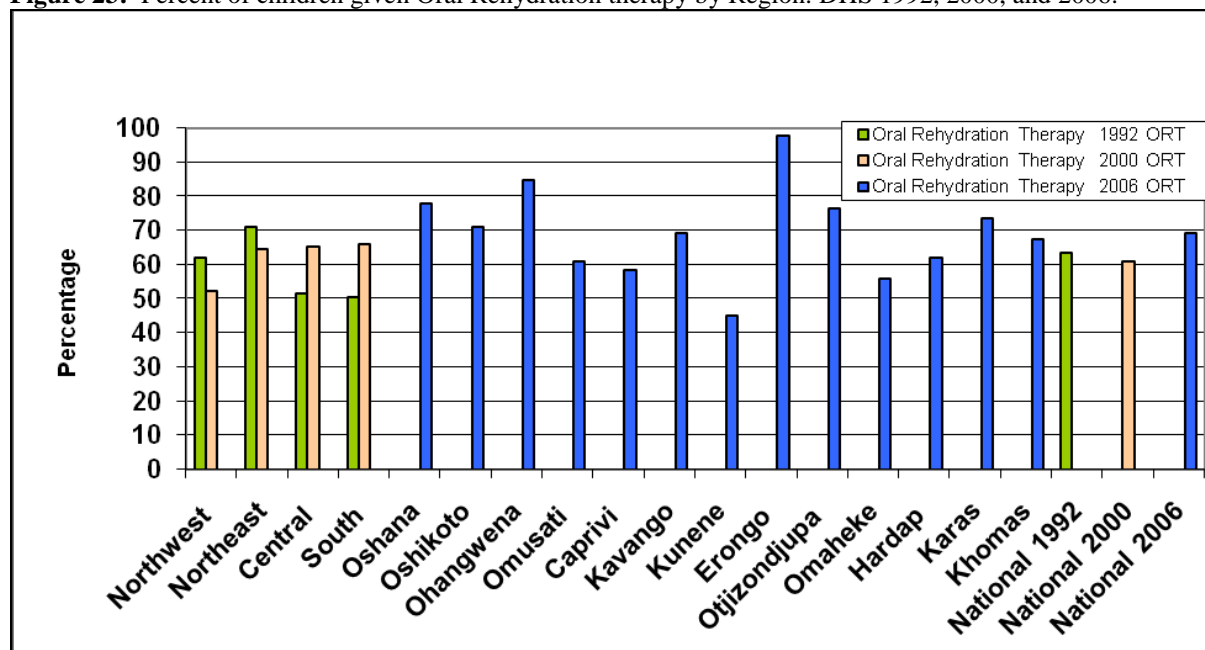
A total of 577 (70%) out of eligible 828 health workers have been trained in IMCI case management. 35 health workers have been trained in follow-up skills while a total of 68 health workers have been trained in facilitation skills. In addition, pre-service IMCI training was introduced into University of Namibia (UNAM) nursing curriculum since 2002. A total of 545 final year nursing students have now been trained in IMCI case management in Windhoek and Oshakati campus. The health workers have been deployed in various regions and districts including those where IMCI was not formally introduced.

Overall, the review has found that the implementation of IMCI has been slow and follow-up as well as support supervision inadequate. All the same, the IMCI strategy has contributed to good prescribing patterns with the reduction in the use of paracetamol and unnecessary prescription of antibiotics. It has also been reported (REF) that 90% of caregivers were satisfied with quality of care provided to their children (time spent with the patient, information sharing with the care giver on the child's condition and drugs given and on the was health workers examined a child. Further, IMCI has brought renewed interest among health care workers on assessment, classification, treatment, and provision of health education on childhood conditions. The treatment of children is now given priority attention in the implementing health facilities.

The management of acute respiratory infections as well as of diarrhoea are part of the IMCI strategy. However, in the districts where IMCI has not been implemented efforts needed to be made to continue implementation of ARI and ORT activities. The ORT rate has increased slightly between 2000 and 2006 according to DHS findings. There is regional variation with Erongo and Ohangwena regions having over 80% ORT rate whereas Kunene, Caprivi and Omaheke less than 60% ORT rate.

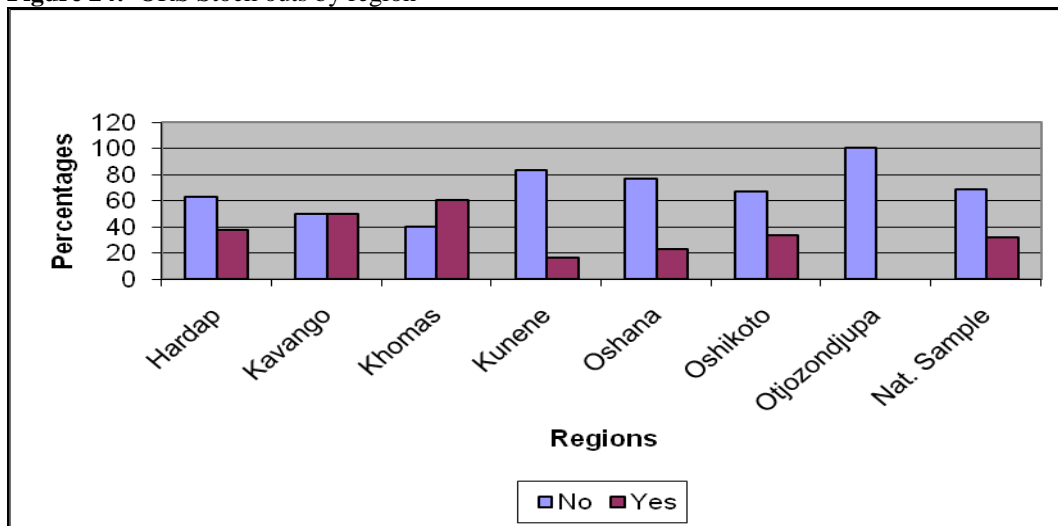
Although acute respiratory infections are among the leading causes of morbidity and mortality in children under-five, not enough has been done to improve the management of acute respiratory infections. The MOHSS essential indicators report of 2006/07 show that diarrhoea (29%), pneumonia (29%) and HIV/AIDS (8%) are the major causes of infant mortality. The same three conditions are the leading cause of child mortality (age 1 to under5 years) with diarrhoea causing 35% of reported deaths and pneumonia and HIV/AIDS causing 24% and 8% of reported deaths respectively. The high prevalence of diarrhoea is largely due to poor sanitation and hygiene practices especially in some regions such as Caprivi, Kavango and Ohangwena. Community based treatment for pneumonia has not yet been introduced in Namibia.

Figure 23: Percent of children given Oral Rehydration therapy by Region: DHS 1992, 2000, and 2006.



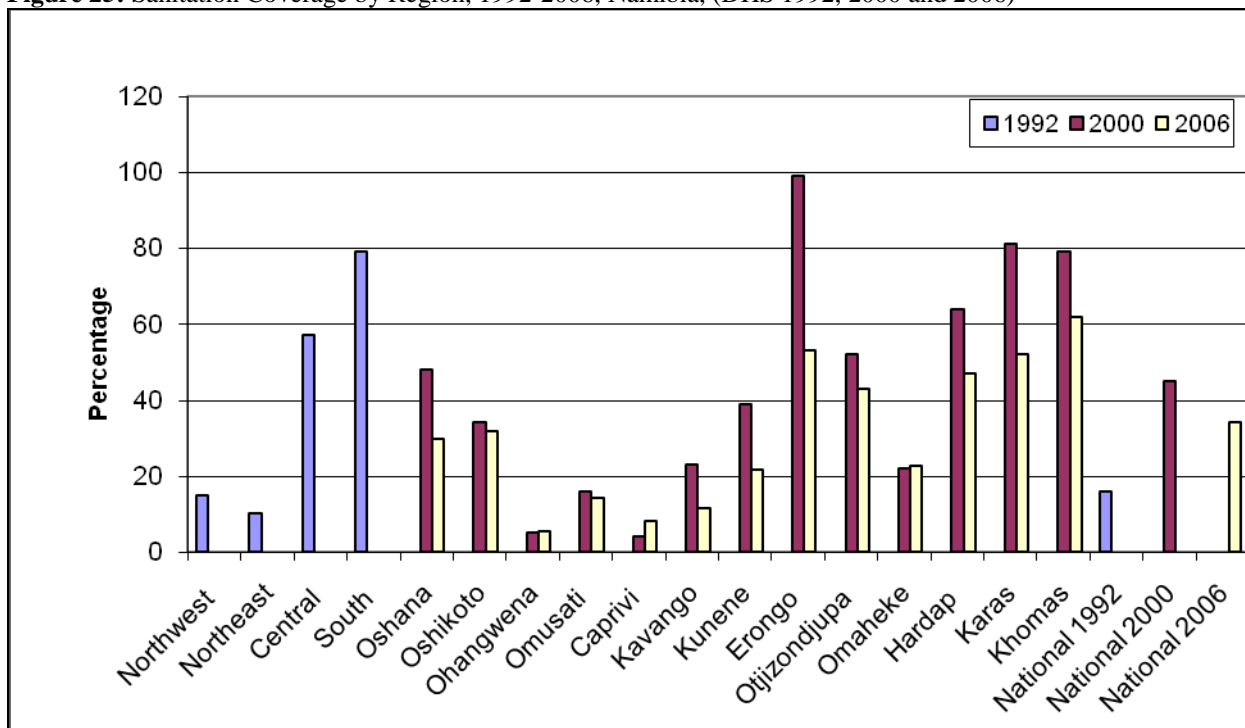
The health facility checklist administered to the 76 health facilities in seven regions as part of the health systems review found that there were stock outs of ORS and Cotrimoxazole in a number of regions. Although Kavango had an ORT rate of 70% according to the 2006 DHS, the review found that 50% of health facilities in the region had stock-outs of ORS in the three months prior to the review as highlighted in the figure below.

Figure 24: ORS Stock outs by region



As is evident in the figure below, sanitation coverage in Namibia is poor with a national coverage in 2006 of less than 40%. Ohangwena, Omusati, Caprivi and Kavango all had less than 20% sanitation coverage in 2006.

Figure 25: Sanitation Coverage by Region, 1992-2006, Namibia, (DHS 1992, 2000 and 2006)



**Recommendations**

1. Roll out and support the “Reach Every District” (RED) Approach, and use it to strengthen routine immunization coverage.
2. Provide assistance/advice and monitor identified low performing district (training/micro-planning etc).
3. Support EPI programme management at all levels in order to increase immunization coverage. (Immunization coverage levels of 90% and above in all districts).
4. Support the introduction of new Vaccines.

5. Mobilise financial and human resources to support the scaling up of IMCI implementation.
6. Training of health workers in IMCI correct case management, facilitation skills, supervisory /follow-up skills and participatory rural appraisal.
7. Improve the household and family practices on disease prevention and management
8. Develop Information Education and Communication (IEC) materials and messages on caring practices with focus on high impact interventions such as ORT, hand washing and exclusive breastfeeding.
9. Introduce Child Days to accelerate routine immunisation coverage especially in the sparsely populated areas.

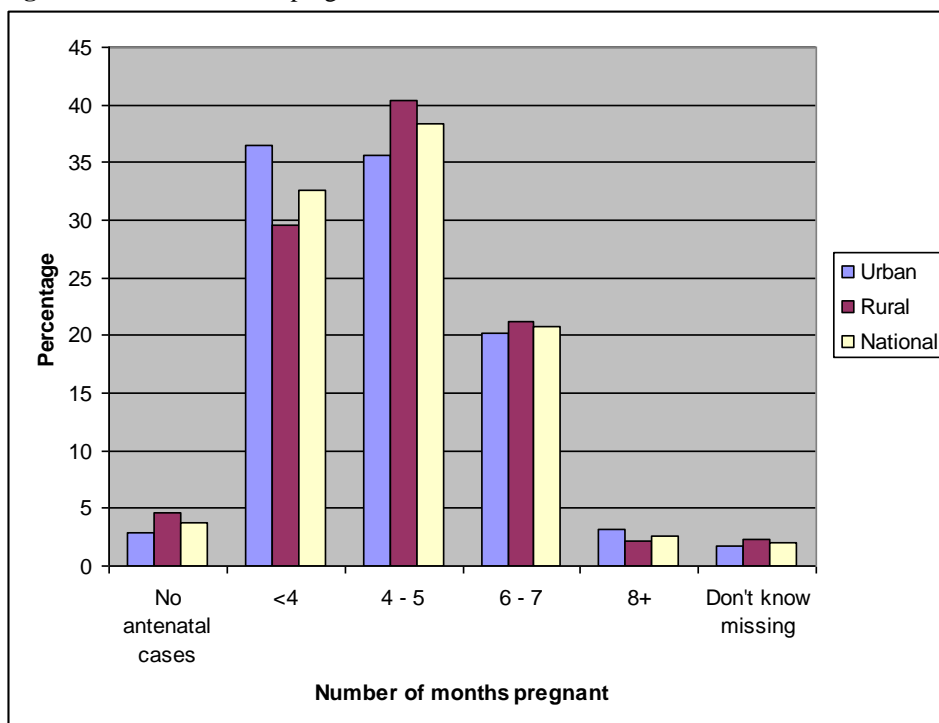
### 5.1.3 Maternal Health

Although maternal mortality ratio remains high in Namibia, there is good access to antenatal and delivery services in all regions of the country.

#### Antenatal Care

Antenatal care attendance in Namibia is overall high at 94.6 percent in 2006 received antenatal care showing a slight increase of 1.6 percent compare to 2000 DHS. Although most women tend to delay first visit to ANC, rural women are more compare to urban women. A significant percentage (23.4 %) of women only visit ANC after six months of pregnancy, which may lead to late detection of pregnancy complication.

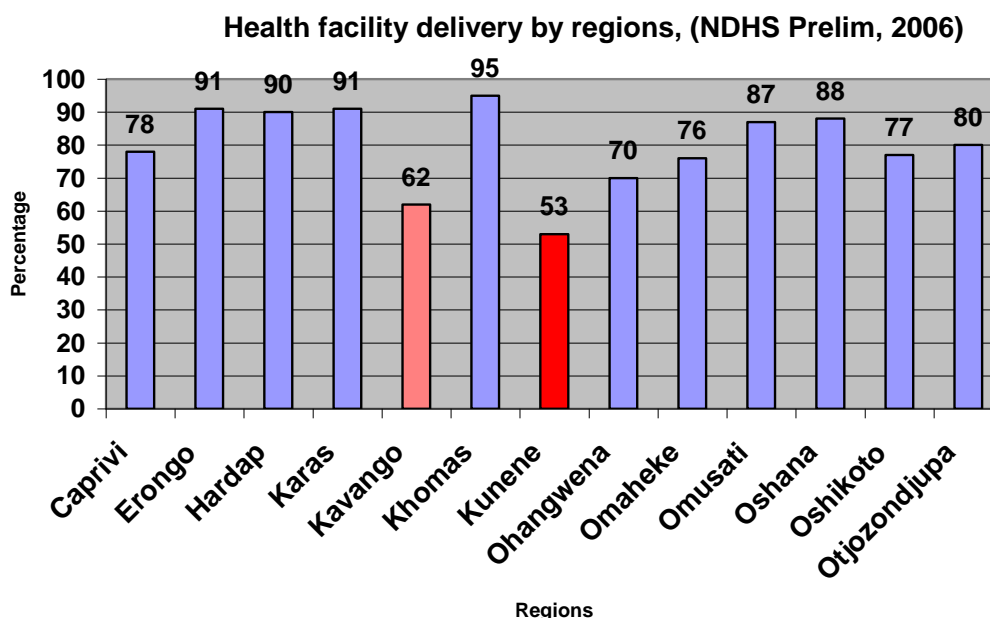
**Figure 26:** No. of months pregnant at the time of first ANC visit



From the figure above, 62% of pregnant women seek care within four months of pregnancy whereas 70.4% attended ANC four times or more. According to 2006 DHS, women have listed the following reasons: distance to the health facility, have to take transport, getting money for treatment and concern that the provider will not be available, as key factors hampering access to health facilities.

The 2006 DHS found that a high proportion of deliveries (81%) take place in health facilities as illustrated in the figure below. There are slight regional disparities with Khomas having 95% of women delivering in health facilities followed by Karas and Erongo at 91% then Hardap at 90%, and Oshana and Omusati at 88% and 87% respectively. Kavango and Kunene have the lowest proportion of women delivering in health facilities at 62% and 53% respectively.

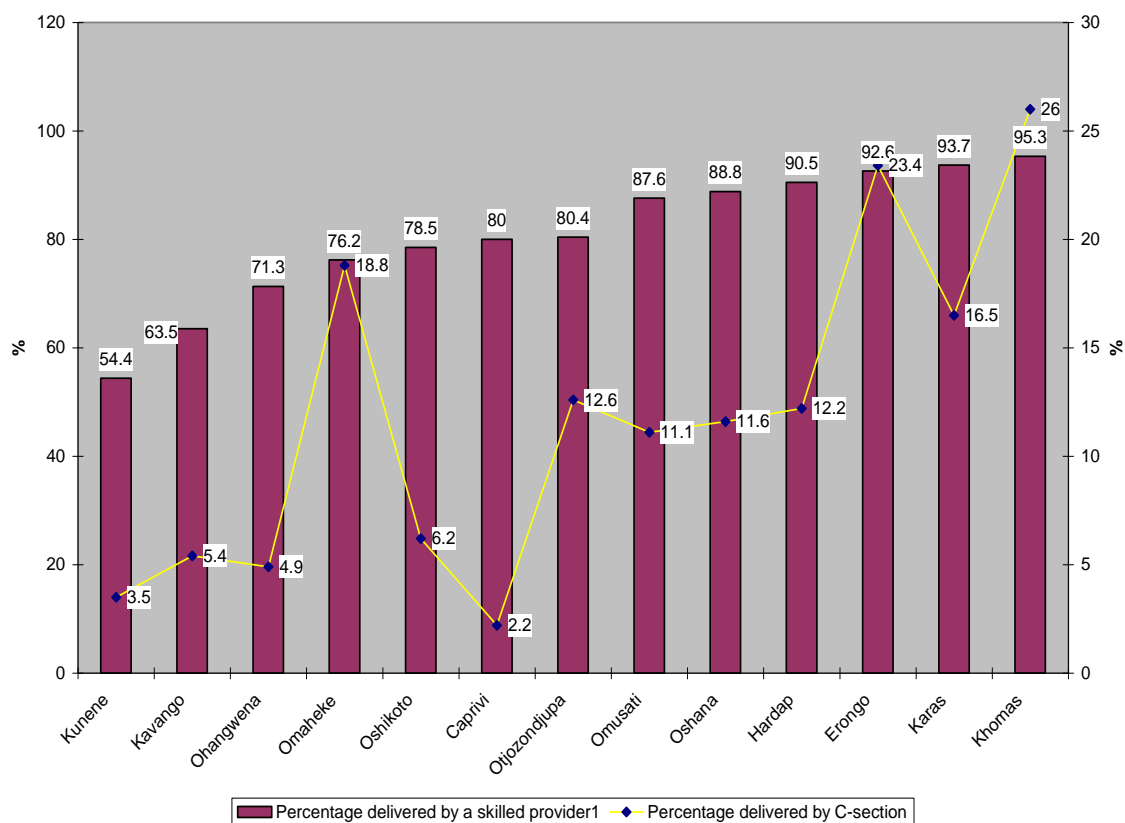
Figure 27: Delivery Health Facilities by Region



**Skilled Attendance during delivery:** Overall, there was a notable increase in the proportion of deliveries attended by skilled personnel (medical professionals - doctors, nurses/midwives) between 1992 (68.2%) and 2006 (81.4%), while a relative number of women (11.2 %) gave birth with the assistance of a relative or someone they know. It is worth noting that women in those regions who recorded the highest neonatal, infant and under-five mortality rates (Ohangwena, Caprivi, Kavango, Omusati) were less likely to deliver with assistance of a health professional particularly a doctor.

There are low caesarean section rates in most regions especially in Kunene (3.5%), Kavango (5.4%), Ohangwena (4.9%), Oshikoto (6.2%), and Caprivi which has the lowest rate at 2.2%. This situation is partly due to inability of various hospitals to conduct caesarean sections due to a number of factors including lack of anaesthetists.

**Figure 28:** Percentage of women who delivered with the assistance of a skilled health provider, per Region, (2006 DHS, MoHSS)



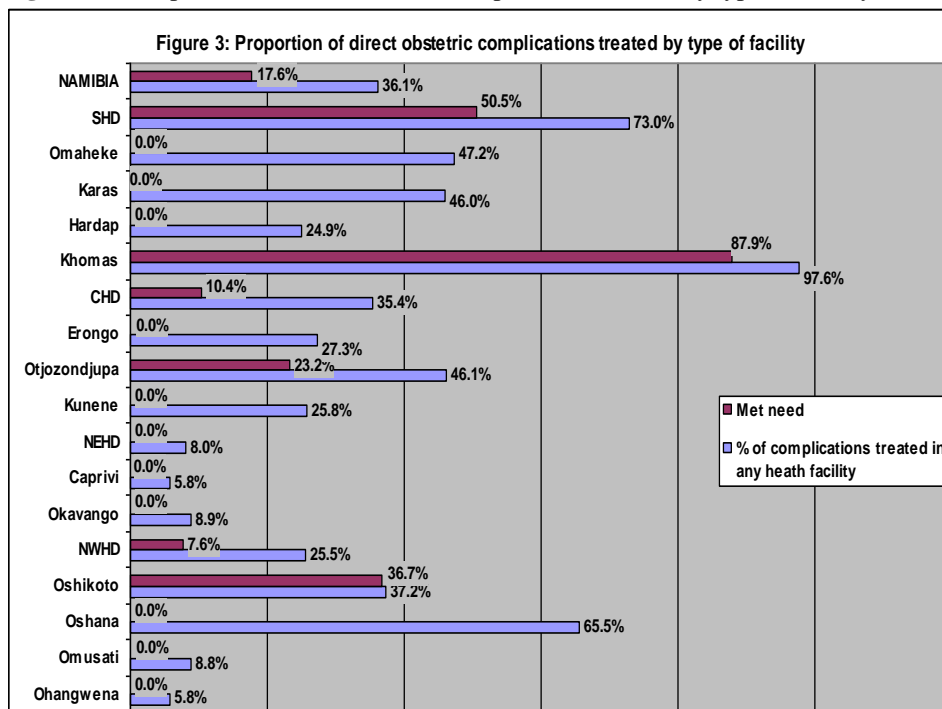
**Emergency Obstetric care:** A survey of all hospitals, health centres conducted in all 13 regions in 2005/06<sup>32</sup> found that only 4 (11.8%) out of 34 hospitals provided comprehensive emergency obstetric care, i.e., provision of the following services: a) administration of parenteral antibiotics; b) administration of parenteral oxytocics; c) administration of parenteral anticonvulsants; d) manual removal of placenta; e) removal of retained products e) assisted delivery; f) blood transfusion and g) caesarean section. These are the live saving functions which must be provided by all hospitals to ensure that the 15% of pregnant women expected to have complications are adequately cared for. Among the reasons, why health workers did not carry out these procedures were lack of awareness of their indication and lack of training.

On the other hand, no health centres provided the basic emergency obstetric care, i.e. the provision of all the above services except for blood transfusion and caesarean section.

Overall, only 17.6% of women expected to have obstetric complications are treated in EmOC facilities. This means that there is a big unmet need for EmOC of over 80%. The situation is worse in northern regions as illustrated in figure below

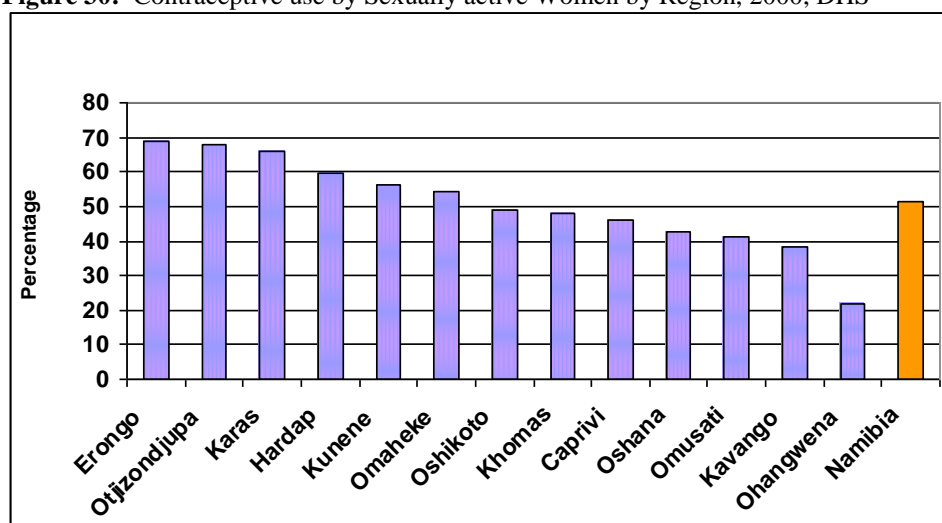
Given that 81% of women deliver in health facilities (DHS 2006) there is a great potential to reduce deaths due to pregnancy complications if the observed gaps in the provision of EmOC services are adequately addressed and efforts made to improve technical support supervision to hospitals and health centres

Figure 29: Proportion of direct obstetric complications treated by type of facility<sup>33</sup>



**Contraceptive Prevalence Rate:** Overall, 38 percent of all women in Namibia are currently using a contraceptive method, with 37% using modern contraceptive methods. Marked differences are found among regions. Contraceptive prevalence among sexually active women is highest in Erongo, followed by Otjozondjupa and Karas Regions, where around two-thirds of women are currently using modern contraceptives. At the other end of the spectrum, one in five sexually active women in Ohangwena Region is currently using family planning methods.

Figure 30: Contraceptive use by Sexually active Women by Region, 2000, DHS



**Recommendations**

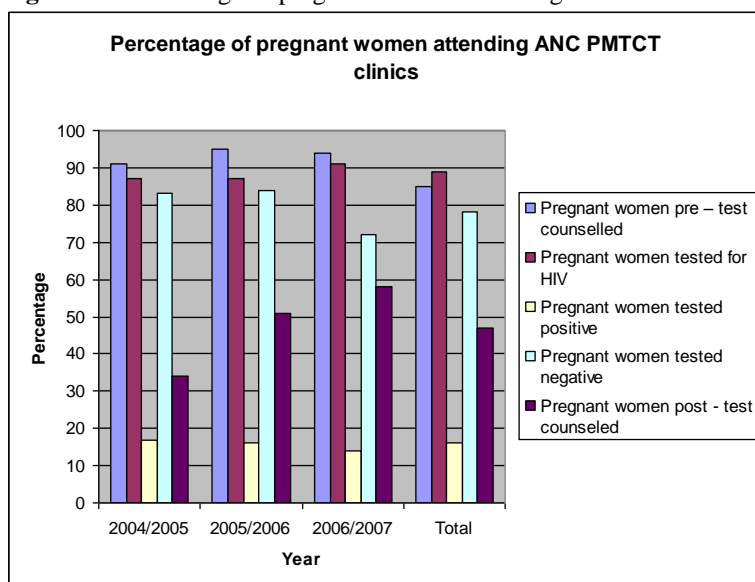
1. Roll out the Road Map on reducing maternal mortality and improving newborn health.
2. Accelerate the recruitment process and provide adequate staff at facilities.

3. Scale up Basic EmOC in health centres and large clinics and ensure all hospitals provide comprehensive EmOC: Equip health centres and large clinics with basic EmOC equipment to do routine deliveries.
4. Provide health facilities with transport/ambulances to enable them to refer complicated cases without delay.
5. Increase coordination between HIV/ AIDS & RH programmes.
6. Review training curriculum and scope of practice on midwifery to include life – saving functions.
7. Establish health facilities in the far remote areas despite the minimum number of population to qualify for a health facility.
8. Reinstate outreach comprehensive health services backed with required resources (transport, human).
9. Review and shorten the PNC follow-up period before 6 weeks.
10. Increase advocacy for male involvement and expedite the mass male circumcision programme.
11. Strengthen advocacy for empowerment of women.
12. Increase awareness on statutory rape in communities to prevent adolescent pregnancy.
13. Roll out AFHS approach to all 34 districts.
14. Revive family planning as part and parcel of HIV/AIDS prevention

### 5.1.4 Prevention of Mother to Child Transmission

Prevention of Mother to Child Transmission (PMTCT) of HIV/AIDS services was first introduced in the Katutura and Oshakati State hospitals on a pilot basis In March 2002. By March 2007, PMTCT services had been rolled out to 189 (57%) out of 331 health facilities (all 35 hospitals and 153 health centres and clinics).

Figure 31: Percentage of pregnant women attending ANC PMTCT clinics<sup>34</sup>



In 2004, there was an acceleration of PMTCT services following the introduction of an ‘opt-out’ policy. PMTCT was therefore made part of Ante Natal Care (ANC) services making it possible for pregnant women attending ANC clinics to access PMTCT services. As a result of this strategy, there has been a significant scaling up of pregnant women accepting HIV

testing as highlighted in the table below that shows cumulative data for PMTC roll-out as from March 2002 to 30/03/2007.

**Table 10:** Prevention of Mother to Child Transmission of HIV/AIDS 2002–2007<sup>35</sup>

	2002/2003	2003/2004	2004/2005	2005/2006	2006/2007	Total
Pregnant women who start ANC at PMTCT sites	5220	19 845	18752	39 016	51 767	134 600
Pregnant women pre-test counselled	<b>10%</b> (511)	<b>55%</b> (10254)	<b>91%</b> (17986)	<b>95%</b> (37019)	<b>94%</b> (48679)	<b>85%</b> (114 49)
Pregnant women tested for HIV	<b>87%</b> (444)	<b>90%</b> (9230)	<b>87%</b> (15 597)	<b>87%</b> (32090)	<b>91%</b> (44690)	<b>89%</b> (102051)
Pregnant women tested positive	<b>58%</b> (298)	<b>20%</b> (1881)	<b>17%</b> (2702)	<b>16%</b> (4982)	<b>14%</b> (6273)	16% (16136)
Pregnant women tested negative	<b>42%</b> (146)	<b>80%</b> (7349)	<b>83%</b> (12 895)	<b>84%</b> (27 108)	<b>72%</b> (32223)	<b>78%</b> (79721)
Pregnant women post test counselled	N/A	<b>5%</b> (465)	<b>34%</b> (465)	<b>51%</b> (16292)	<b>58%</b> (26087)	<b>47%</b> (48156)
Partners who took HIV test	<b>14%</b> (41)	<b>6%</b> (110)	<b>9%</b> (254)	<b>16%</b> (805)		
Partners who tested negative	<b>49%</b> (20)	<b>58%</b> (64)	<b>52%</b> (131)	<b>63%</b> (504)		
Partners who tested positive	<b>51%</b> (21)	<b>42%</b> (46)	<b>32%</b> (82)	<b>24%</b> (190)		
HIV + pregnant women who had CD4 test done		<b>4%</b> (68)	<b>27%</b> (727)	<b>72%</b> (3579)	<b>70%</b> (4366)	<b>54%</b> (8740)
HIV + pregnant women with CD4<250		<b>1%</b> (21)	<b>30%</b> (219)	<b>29%</b> (1026)		<b>15%</b> (1266)
Total women who delivered	7618	21750	22335	37700	43648	133051
Women with unknown HIV status		<b>95%</b> (20704)	<b>73%</b> (14 941)	<b>35%</b> (13183)	<b>21%</b> (8969)	<b>43%</b> (57707)
Women with known HIV status		<b>5%</b> (1046)	<b>27%</b> (5461)	<b>65%</b> (24517)	<b>79%</b> (34679)	<b>49%</b> (65703)
HIV + women who delivered	<b>3%</b> (194)	<b>5%</b> (1046)	<b>29%</b> (1743)	<b>13%</b> (4771)	<b>16%</b> (6968)	<b>11%</b> (14722)
HIV + women who took Nevirapine before delivery	<b>93%</b> (180)	<b>67%</b> (704)	<b>94%</b> (1 645)	<b>89%</b> (4244)	<b>76%</b> (5292)	<b>82%</b> (12065)
Babies exposed to HIV who received Nevirapine after delivery	<b>102%</b> (198)	<b>94%</b> (979)	<b>94%</b> (1647)	<b>96%</b> (4557)	<b>97%</b> (6787)	<b>96%</b> (14168)
<b>Cumulative total health facilities providing PMTCT services</b>	<b>2</b>	<b>21</b>	<b>41</b>	<b>165</b>	<b>189</b>	

The review considers this experience of implementing ANC and PMTCT in an integrated manner within an 'opt-out' strategy as a best practice.

During the reporting period of March 2006 to March 2007, 94% of women starting ANC services were pre-test counselled and 91% accepted to be tested for HIV. Seventy percent (70%) of all HIV positive women had a CD4 count done in 2006/2007

The number of women who receive post-test counselling has increased from 5% in 2003/04 to 58% in 2006/07. A major constraint is delay in getting results, as women have to wait for HIV test results submitted to the laboratory for HIV ELISA antibody testing. If rapid testing were available in all PMTCT sites, this situation would change significantly, as all women would be offered post-test counselling and the opportunity to prevent paediatric infection through PMTCT. This situation is expected to change with the current plans to roll out rapid testing.

On average, 82% of HIV positive pregnant women received Nevirapine before delivery. On the other hand, 96% of babies born to HIV positive mothers received Nevirapine after delivery.

Further, the proportion of HIV positive women who choose to breastfeed has increased significantly from 48% in 2002/03 to 90% in 2006/07.

### **Training of staff in PMTCT**

Training is going on well, with quite a number of the student nurses having received pre-service training. This is very important for the rollout of PMTCT and for reasons of ensuring sustainability. To date a total number of 1968 health workers are trained in PMTCT. It is always difficult to rely only on in-service training of health workers, as this takes them away from their workstations and leads to a disruption of services. Therefore, the programme has also embarked upon training student nurses during pre – service training. A total of 440 student nurses were trained during pre – service training in the last 6 months.

Clinical support visits to give ongoing support to nurses in ANC and Labour Ward: Clinical support visits have been conducted by the tutors from the National Health Training Network. These tutors are recruited through I-TECH with PEPFAR support while the remaining tutors are supported through the Ministry of Health and Social Services (MOHSS) and the Global Fund.

Namibia introduced HIV DNA PCR in 2006 for Early Infant Diagnosis in exposed infants from as early as 6 weeks of age. At the end of FY 2006/07, 52 health facilities were collecting the samples through DBS for the DNA PCR test. A total number of 4,202 infant PCR tests were completed, 3,461 (82%) being the first test for an HIV exposed infant, 432 (10%) for symptomatic infants, and 309 (7%) repeat PCR. HIV prevalence varied by reason for test i.e. 13.0% for asymptomatic first PCR tests, 8.3% for repeat PCR tests, and 25.7% for symptomatic tests. Training in the Dried Blood Spot collection technique has been introduced since January of 2006. This technique makes specimen collection from babies easier and simplifies transportation for sites that are distant from the Referral Laboratory in Windhoek. Since January 2006 to date, 276 health workers have been trained in DBS collection technique, 130 of whom were trained in the last 6 months. Training has been scaled up since the recruitment of a DBS trainer through I-TECH.

### Challenges and constraints

The PMTCT regimen that are frequently changing resulting in frequent revising of programme document, such as guidelines and training curriculum.

Data collection has been a challenging activity at the health facilities, and ongoing training needs to be intensified to improve data capturing and accuracy when abstracting information from the registers onto the summary forms.

Absence of a strategy to ensure comprehensive follow-up of the mother-baby pair, including testing of the baby and ongoing care and support for the family needs.

Inadequate male participation in PMTCT activities

### Recommendations

1. Training in Dried Blood Spot collection technique needs to be scaled-up in order to cover health workers from all facilities that offer PMTCT services to increase early infant diagnosis.
2. Comprehensive follow-up needs to take account of the mother's partner and her family too (PMTCT plus). This aspect needs strengthening, as male involvement in PMTCT remains a challenge.
3. A strategy should be developed to bring more men into PMTCT services: Social mobilization activities should be accelerated to bring in men to PMTCT.
4. There is a need to further strengthen the monitoring of PMTCT and ANC services: Print adequate ANC, Labour and Delivery and HIV DNA PCR registers, as well as the respective summary forms.

#### 5.1.5 Nutrition

The Food and Nutrition Subdivision is responsible for the food and nutrition issues supporting preventive interventions of nutrition related diseases. It is supported by three programmes namely the micronutrient deficiency and food standards responsible for the prevention and control of Vitamin A, Iodine and iron deficiencies, the nutritional surveillance and maternal and child nutrition which focuses on early warning and promotion maternal and child nutrition and non-communicable diet-related diseases focusing on delaying mortality from non-communicable diseases and to promote healthy ageing of people. In response to the HIV/AIDS pandemic in the country, it has become necessary to extend the focus by including nutrition care of people living with HIV/AIDS in the activities of the Subdivision.

The National Food Security and Nutrition policy of 1995<sup>36</sup> addresses issues of food and nutrition security, promotion of maternal and child nutrition through improvement in household food security including nutrition safety nets. The policy also outlines an institutional framework for the implementation of nutrition interventions. The policies goal is to improve the nutritional status of the Namibian population with special emphasis on vulnerable groups, women, children and People Living with HIV/AIDS (PLWHA), resulting in the reduction of morbidity and mortality due to or associated with malnutrition.

The caring and feeding practices also contribute to the high malnutrition rates in Namibia. Exclusive breastfeeding at 5 months has declined from 26% in 2000 to 24% in 2006 with most of the hospitals with delivery facilities declared baby friendly.

A 1992 survey identified high levels of iodine deficiency amongst children aged 8-12 years. This was followed by nationwide supplementation and legislation of salt iodization in 1994.

A follow up survey in 1999 showed complete elimination of goiter but with 14.9% of sampled children with severe iodine deficiency (urinary iodine < 2mg/dl). The same survey reported that 90.3% of households' use adequately iodized salt. The most recent survey (2000 NDHS) showed that only 58.9% of households used adequately iodized salt. Vitamin A deficiency is considered as one of the major causes of blindness in Namibia. A 1992 survey of 17 showed that 20% of preschool children sampled had moderately/severe vitamin A deficiency. Vitamin A supplementation as part of the annual national immunization days targeting children aged 9 months – 5 years reaches an average of 75% every year. However, vitamin A supplementation over the last 6 months in the same age group is 38%. There is no recent data on iron deficiency anaemia. Further, no progress has been made in implementing zinc supplementation. Legislation for micronutrient fortification as recommended in the 1995 National Food Security and Nutrition policy is under consideration.

Namibia is a net importer of food to cover the country's food needs and has no serious problem of food availability at the national level. However, affordability at the household level is a major problem. According to available information, most rural households earn between N\$250s and N\$320 per month which is insufficient to purchase food for households comprising 7 to 10 persons. The recent price increases of food and basic commodities have further exacerbated the situation. A nutritional surveillance system to monitor the vulnerability of communities is in its initial phase of development and growth monitoring and promotion currently covers 30% of children attending babies attending childcare clinics.

The MoHSS has developed a number of policies and guidelines to address nutrition issues, these include: The Food and Nutrition Guidelines for Namibia: *Food Choices For A healthy Life (2000)*, The National Policy on Infant and Young Child Feeding (2003), National Guidelines and Training Manual on Nutritional Management for People Living with HIV/AIDS (2006). Implementation of these policies and guidelines however is constrained by inadequate human resources and nutrition structures at the regional and district levels, lack of community based interventions and limited knowledge on the importance of nutrition.

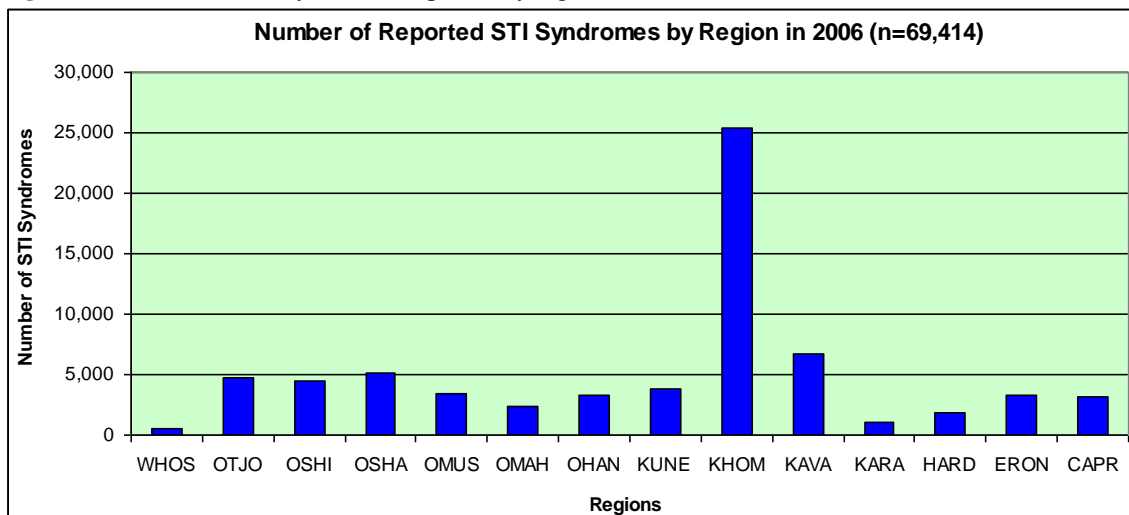
## Recommendations

1. Revise nutrition staff establishment at regional and district levels to make provision for the nutrition focal persons, dieticians and nutritionists and strengthen community awareness on nutrition, including growth monitoring and promotion and infant and young child feeding practices.
2. There is a need to institutionalize the nutrition surveillance system to support the implementation of nutrition at the national, regional district, community and household levels.
3. Revive the baby Friendly Hospital Initiative and accelerate the promotion of exclusive breastfeeding in communities.
4. Implement Child Days to facilitate bi-annual supplementation of Vitamin A.
5. Advocate for the introduction of Zinc supplementation.
6. Promote caring practices through effective communication for behaviour change.

### 5.1.6 HIV/AIDS and other Sexually Transmitted Infections

There is a high prevalence of Sexually Transmitted Infections (STIs) in Namibia. Data from show that in 2006, a total of 67,414 STI cases were reported (*see figure below*). The highest number of STIs was reported from Khomas in 2006 followed by Kavango with the two regions contributing to 37% and 10% of reported cases respectively.

Figure 32: No. of all STI syndromes reported by region in 2006<sup>37</sup>



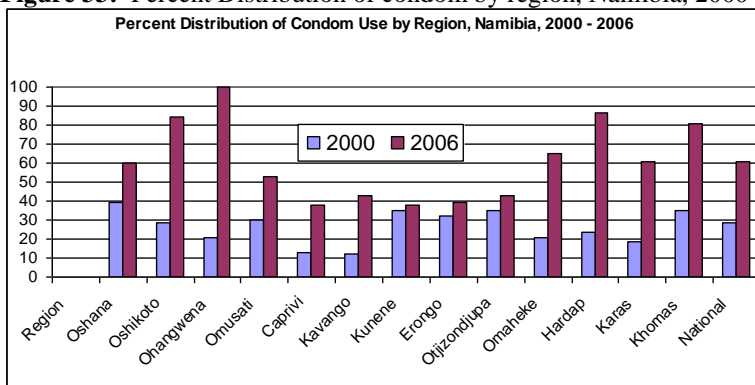
The ministry provides STI treatment in public health facilities based on syndromic management. During 2006, TOT’s STI training was conducted in seven regions with support from SADC/DFID STI Project after the TOT for all the regions were conducted in 2005. A total of 210 health workers were trained in Karas, Oshana, Khomas, Oshikoto, Omusati, Otjizondjupa and Kunene regions. Supervision of all health workers rendering STI services and STI syndromes recording and reporting system have been strengthened.

**HIV Prevention**

Namibia has adopted the COMBI strategy to promote the ABC prevention package to all regions. Although abstinence and being faithful to partners are promoted, priority has been given to condom promotion.

**Condom Usage:** There is a remarkable increase in condom use between 2000 and 2006. During the 2000 DHS, more than one-quarter of women said they used a condom the last time they had sex. In 2006, this practice has improved drastically with about two-thirds of the women reporting use of condoms. However, condom usage among women in nine out of the 13 regions was below 60%.

Figure 33: Percent Distribution of condom by region, Namibia, 2000-2006 (DHS)



During the period, 2006 to 2007, male and female condoms were distributed by regions as seen in the table below.

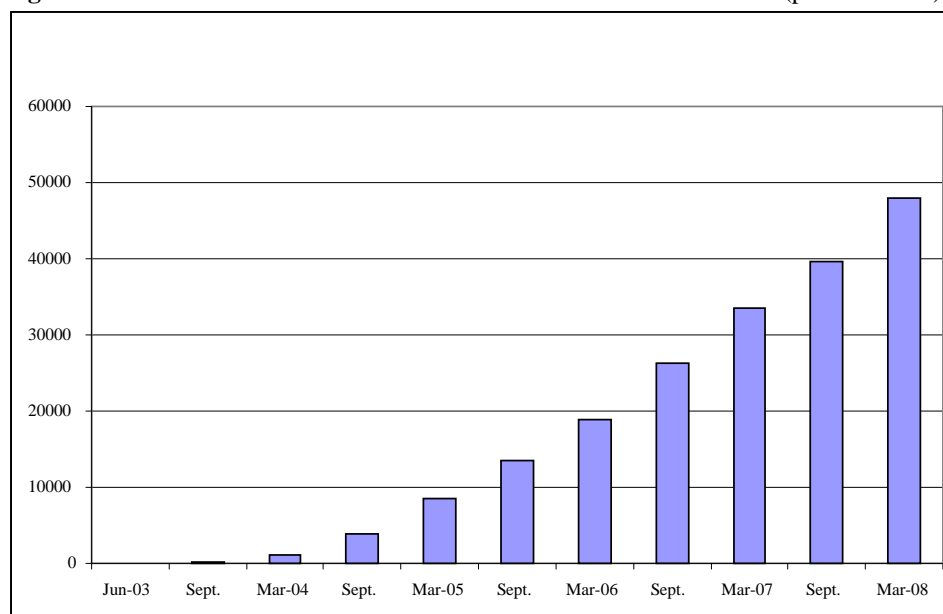
**Table 11:** Regional Condom Distribution Figures, 2006-2007 (MOHSS, DSP)

Region	2006		2007	
	Male	Female	Male	Female
Caprivi	187,200		1,180,800	7,000
Erongo	941,760	2,100	1,163,520	22,000
Hardap	521,280	1,200	100,800	4,000
Karas	704,160	0	662,400	44,000
Khomas	3,807,391	27,870	1,327,680	52,000
Kunene	1,037,200	5,000	662,400	7,000
Kavango	2,188,800	4,000	1,895,040	13,000
Omaheke	794,880	1,000	345,600	5,000
Otjozondjupa	2,003,440	33,500	843,840	27,000
Oshana	5,212,512	44,000	8,899,200	20,000
Oshikoto	164,160	100	1,607,040	59,000
Omusati	686,160	10,000	432,000	10,000
Ohangwena	100,800	0	172,800	0
National level Distribution	4,686,656	325,000	2,039,040	70,000
<b>Total</b>	<b>23,018,400</b>	<b>453,770</b>	<b>21,332,160</b>	<b>340,000</b>

**HAART**

Namibia has performed well in the provision of anti-retroviral treatment. A total number of clients on anti-retroviral therapy as at March 2008 stand at 47,963.

**Figure 34:** No. of Patients on HAART between June 2003-March 2008 (public Sector)



**Recommendations**

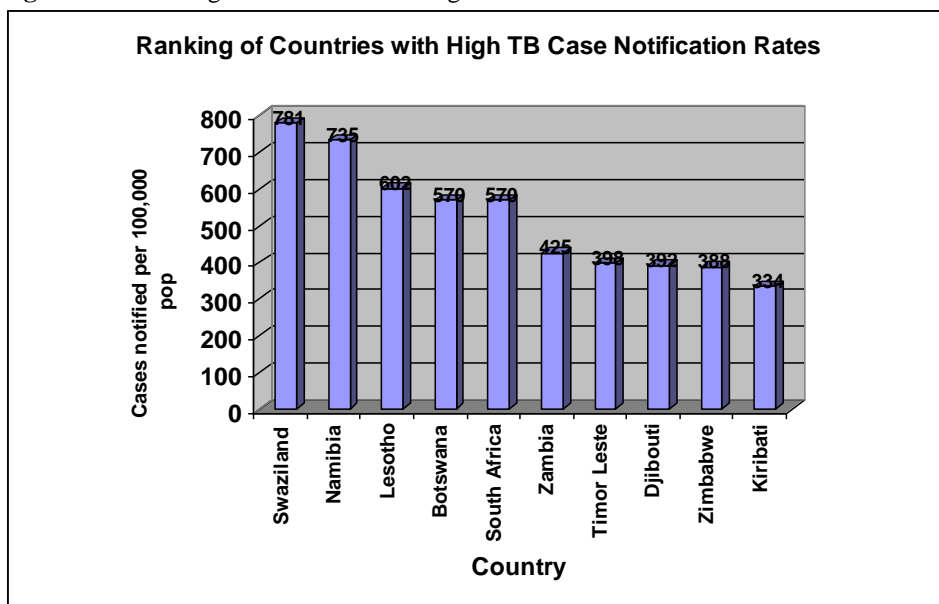
1. There is a need to integration of the training programme for STI in the NHTC for consistent training and supervision of health workers
2. Research is needed in the community on the acceptability of STI services and preferential place for treatment.
3. Scale up COMBI prevention strategy in all regions in Namibia.
4. Build the capacity of health workers in order to further scale up ART in all regions.

### 5.1.7. Tuberculosis

Tuberculosis is a major public health problem in Namibia, a situation that is compounded by the HIV epidemic. In 2006, 15,771 tuberculosis cases were reported in the country, with a case notification (CNR) of 765 cases per 100,000 population.

Although there has been a downward trend in the number of notified cases, from 790 in 2005 to 722 in 2007, the CNR is one of the highest in the world as seen in the figure below.

Figure 35: Ranking of Countries with High TB Case Notification Rates<sup>38</sup>



In terms of the regional distribution of TB cases, Hardap, Erongo and Karas regions reported the most cases of TB in the country, with CNRs of over 1000 per 100,000 population, with Omusati and Kunene regions having the least CNRs as seen in the figure below.



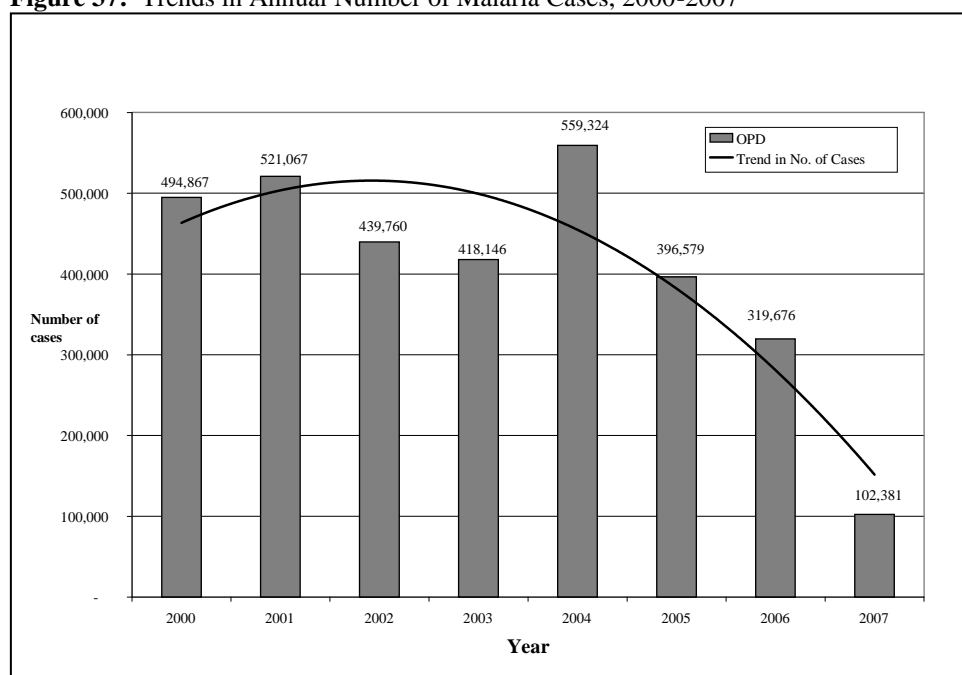
**Recommendations**

1. Conduct public education to increase case detection and retention
2. Strengthen community-based DOT programme in all regions
3. Improve the monitoring of multi-drug resistant TB in all regions

**5.1.8 Malaria**

Malaria is one of the leading causes of illness among under-five children and adults in Namibia. Nine of the 13 regions and 22 of the 34 districts, mainly in the northern and central parts of the country are affected, with approximately 67% of the population living in the malaria endemic areas. The disease also ranks among the list of top ten causes of hospital deaths. Annually, an average of 400,000 malaria cases and 1000 malaria deaths are recorded in the country with an annual incidence of 205 cases per 1000 population.

**Figure 37:** Trends in Annual Number of Malaria Cases, 2000-2007



The annual number of malaria cases has declined consistently since 2000, except in 2004. In 2006 and 2007, the outpatient malaria cases dropped by 35% and 79% respectively when compared with the 2000 level. Similarly, malaria deaths declined by 41% and 82% in 2006 and 2007 as seen in the figure above.

Pregnant women and children under the age of five years are at higher risk of malaria and its adverse consequences. However, due to the unstable and seasonal nature of malaria transmission, almost all age groups are equally affected.

In 2005, government changed the first line anti malarial medicine to atesunate combination therapy (ACT) using Arthemeter Lumefantrine, with the policy being implemented in all regions. Diagnosis using Rapid Diagnostic Tests was introduced in all peripheral health facilities as part of the introduction of ACT.

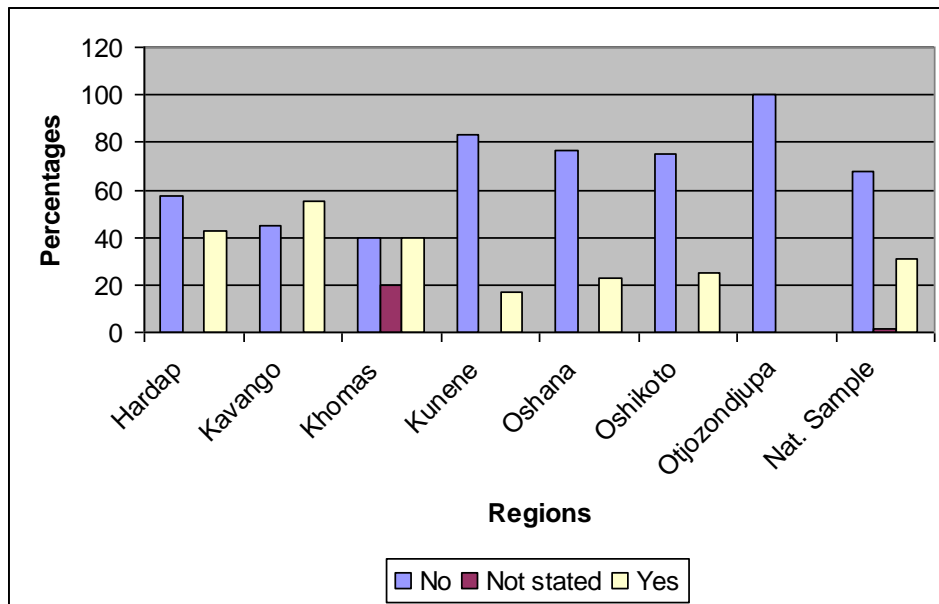
The survey carried out during the review showed that stock outs of the antimalarial medicines existed in the sampled health facilities in six of the seven regions. From the total sample, only

about 65% of the facilities did not experience stock outs, while 35% reported stock outs of Coartem (see figure below).

**Recommendations**

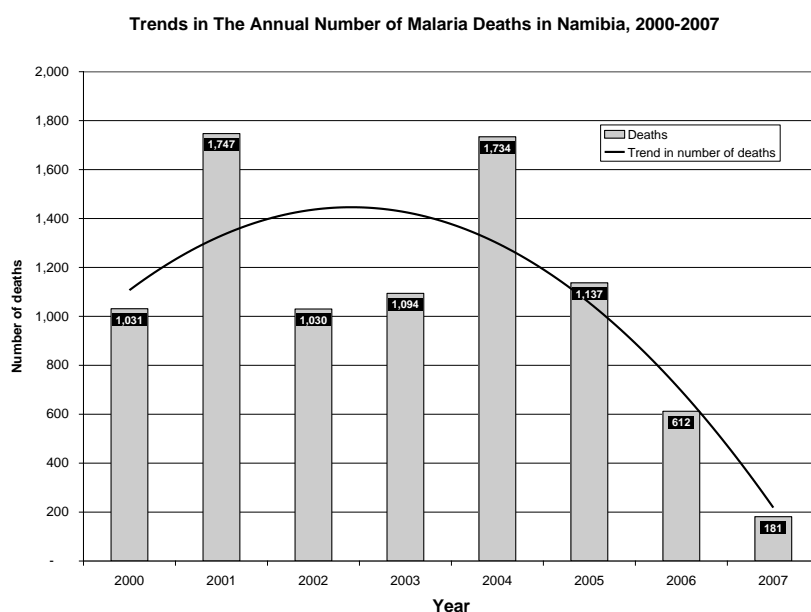
1. Reduce antimalaria drug stock outs in health facilities.
2. Scale up insecticide treated nets especially in northern Namibia and promote use.
3. Monitor the use of Rapid Diagnostic Tests which been introduced in all peripheral health facilities as part of the introduction of ACT.

**Figure 38:** Stock out of First-line Antimalarial Medicine



Through its selective vector control strategy, government distributed 390,726 mosquito nets to pregnant women and children under the age of five years in the nine endemic regions. There has been an improvement in the Indoor Residual Spraying (IRS) coverage, with at least 658,635 structures sprayed during the 2007/8 spraying cycle. The national spraying coverage for this year was 89% with 85% of the at risk population protected.

The major challenge in malaria control is the expansion of coverage of interventions to newer areas in order to move towards the goal of elimination of malaria in the country.

**Figure 39:** Trends in the Annual no. of Malaria Deaths 2000-2007

### 5.1.9 Non-communicable Diseases

Although population-based data are lacking, there is concern that Non-Communicable Diseases (NCDs) are emerging as important causes of morbidity and mortality in the country. Health facility based data indicate hypertension and diabetes as the first and second causes of disability among adults respectively. From HIS reports, heart failure, hypertension, and stroke collectively were responsible for 5% of all health facility deaths in 2005. The proportion of these NCDs deaths grew to 6% in 2006 and 8% in 2007. Mental, neurological, substance abuse and psychosocial related disorders are considered a problem, although reliable data are not available. Cancers are also on the increase, constituting 0.6% of hospital deaths between 2005 and 2007.

Namibia participated in the 2003 World Health Survey, conducted STEP 2 Survey in 2005, and Namibia Global School-Based Student Health Survey in 2004. The findings from these studies indicate that 41% of study population were physically inactive, 31% lead sedentary life, 41% of school students did not do any physical exercise. Among schoolchildren aged 16-18 years, the prevalence of alcohol consumption ranged between 31% and 41%. The NDHS 2006 shows that tobacco use among men in the 15-19 years age group was 9.1%, with 25% of the group smoking more than 6 cigarettes a day. About 21% of men in the age group 15 – 45 years smoke, with about 45% classified as heavy smokers, taking more than six cigarettes a day. Comparatively, only 2.5% of women in the 15-19 years age group smoke, and 5% of all women use tobacco.

The increasing burden of these NCDs compound the burden on the health system that is already overstretched with the high prevalence of communicable diseases in the country.

### Recommendations

1. Establish a division within Primary Health Care Directorate to oversee implementation of programmes to control non-communicable diseases.
2. Mount public education on the prevention and treatment of non-communicable diseases.

3. Use Health Information System to generate data for monitoring non-communicable diseases in all regions.

### **5.1.10 Community Based Health Care**

Community based health care aims to empower communities to increase awareness and knowledge and improve attitudes and practices related to the prevention, treatment, care (including both curative and palliative), and rehabilitation of most common diseases. Policies, guidelines, and standards on Community Based Health Care Policy have been developed to guide its implementation. Overall, there has been an increasing number of community based organisations and larger NGOs and FBOs that have become involved in delivering CBHC at the household level. In 2007, 290 organizations and around 20,000 volunteers have been involved in delivering CBHC.

About 5000 community based health care providers have been trained in provision community health services (such as hygiene, home based care, prevention of diarrhoea, etc). 11,000 HBC kits purchased and distributed to all regions for HBC and palliative care. An assessment has been carried out on community volunteers and community based health care programmes.

A register for monitoring the community level activities has been developed and used by community health care workers to collect information (mostly on mother and child, community meetings, distribution of condoms) that is entered in HIS.

Collaboration with NGOs such as Advanced Community Based Health Care Services Namibia (COHENA) operating in Omaheke and Hardap, Chestas, Red Cross, AIDS Care Trust, and Namibia Planned Parenthood Association.

#### **Constraints, challenges, & bottlenecks**

- CBHC strategy does not sufficiently encourage involvement of regional and local councils and inter-sectoral support in its implementation
- No clear strategy for health promotion and for behaviour change communication
- Lack of standardized training and IEC materials on various health issues
- Inadequate resources (financial and human) to support health extension work in communities, especially those difficult to reach
- Lack of coordination among vertical programmes involved in supporting community based interventions
- Poor coordination of the many organizations, especially NGOs, involved in CBHC
- Lack of incentives and support for community based health care providers.

#### **Recommendations**

Health promotion and CBHC should have strong linkages and coordination under one directorate.

- Update CBHC strategy to address the involvement of regional and local councils and inter-sectoral support in its implementation and lack of incentives for community based workers
- Finalise health promotion policy and behaviour change communication strategy
- Develop standardized training and IEC materials
- Distribute, train facilitators and volunteers and support application of materials

- Undertake monitoring and evaluation of health promotion and CBHC activities

### 5.1.11 Mental Health

Mental illness is a major cause of morbidity as well as some mortality amongst the population of Namibia. Measures of disability and mortality combined show the significant level of disability created by mental disorders and the enormous economic, social, and psychological burden imposed on families of people with mental disorders. It is widely accepted that there is an increased risk of mental disorders among people who are HIV positive. This includes both organic mental disorders such as AIDS dementia, and the psychological sequelae of living with HIV, such as depression, anxiety, and suicide.

Data showed that 42,124 people who were treated at outpatient clinics carried a mental health diagnosis and 40,940 people who revisited the outpatient clinics were admitted under the diagnostic category of mental health disorders. Similarly, 4,182 people treated at the inpatient level were discharged with a mental health diagnosis, ranking this condition as number twelve of all twenty-five discharges. Table 1 shows the distribution of outpatient cases by diagnosis, sex, and age.

**Table 12:** Distribution of out patients cases by diagnosis, sex, and age: April 2007 to March 2008

Diagnosis	Age in years										TOTAL
	Under 10		10 -20		21 -40		41-60		Over 60		
	F	M	F	M	F	M	F	M	F	M	
Schizophrenia	0	0	31	40	357	850	228	306	56	46	1914
Major depression	0	0	53	35	281	239	121	57	21	20	827
Psychoactive substance-related disorders	0	0	5	31	34	266	24	59	8	10	437
Bipolar I Disorders	0	0	8	0	94	40	20	20	6	0	188
Epilepsy	2	5	17	10	25	41	13	20	0	0	123
Para suicide	0	0	28	9	51	32	12	10	1	1	144
Organic mental disorder	5	1	11	13	68	102	30	31	12	11	284
Anxiety disorders	1		8	12	25	24	6	3	7	0	86
Mental retardation	7	5	22	44	14	53	5	11	2	0	163
Others	17	32	118	80	221	298	105	74	47	27	1019
<b>TOTAL</b>	<b>32</b>	<b>43</b>	<b>301</b>	<b>264</b>	<b>1170</b>	<b>1945</b>	<b>564</b>	<b>591</b>	<b>160</b>	<b>115</b>	<b>5185</b>

Major constraints include lack of adequate skilled Human resource and mental health facilities and equipment, and inaccessibility of services by majority of the population particularly those in rural areas. Similarly, because there is no proper structure for mental health care providers, mental health issues are frequently not covered by health plans as other illnesses at regional, district and community levels.

### Recommendations

1. To establish a comprehensive mental health service structure for appropriate mental health services at national, regional and district and community level.
2. Train/recruit adequate mental health professionals (psychiatrists, clinical psychologists, occupational therapists, mental health nurses and security orderlies).
3. Trained Advanced Psychiatric Nurses must be fully recognized and given the authority to assess, make a medical diagnosis, initiate and review patients' treatment as well as refer, discharge and follow -up patients through home visits and outreach services.

4. Investigate the best possible ways to position the Mental Health Care Centre in the Ministry.
5. Strengthen of rehabilitation programs e.g. gardening, sewing, etc. at the Mental Health Centre (occupational therapy department) by sufficient budget allocation.
6. Establish psychiatric units/wards at all districts hospitals.
7. Review the NAMLIST to avail psychotropic medicine at clinic and health centre level.

### **5.1.12 School Health**

The School Health Program addresses the health situation of the school going population. The program is crucial in strengthening the services to learners, empowering them with knowledge and skills to make informed decisions about their health and well-being and to improve their quality of life.

The Program implements the Health Promoting School Initiative (HPSI) project that compliments the School Health Program, encouraging schools to constantly strengthen their capacity as healthy settings for living, learning, and working. The project promotes the provision of safe drinking water and basic sanitation facilities, as well as skills-based and health education programs in schools.

School health services are provided in all 13 regions of the country, although there is no uniformity in the services provision in the different regions. The National Policy on School Health Services has been approved and a draft operational guideline for the implementation of the Health Promoting Schools Initiative developed. These will help guide implementation in the future. Furthermore, although awareness creation on the Health Promoting School Initiative was done in the 13 regions, currently only 5 regions (41%), namely Erongo, Khomas, Hardap, Omaheke, and Otjozondjupa are implementing HPSI. Out of the approximately 1,600 schools in the country, only 141 (9%) schools have successfully implemented the HPSI.

A school-based student health survey was conducted in 2004 to determine the prevalence of health risk behaviours and protective factors among the 13 – 15 years old students. The results of this study are still to be launched.

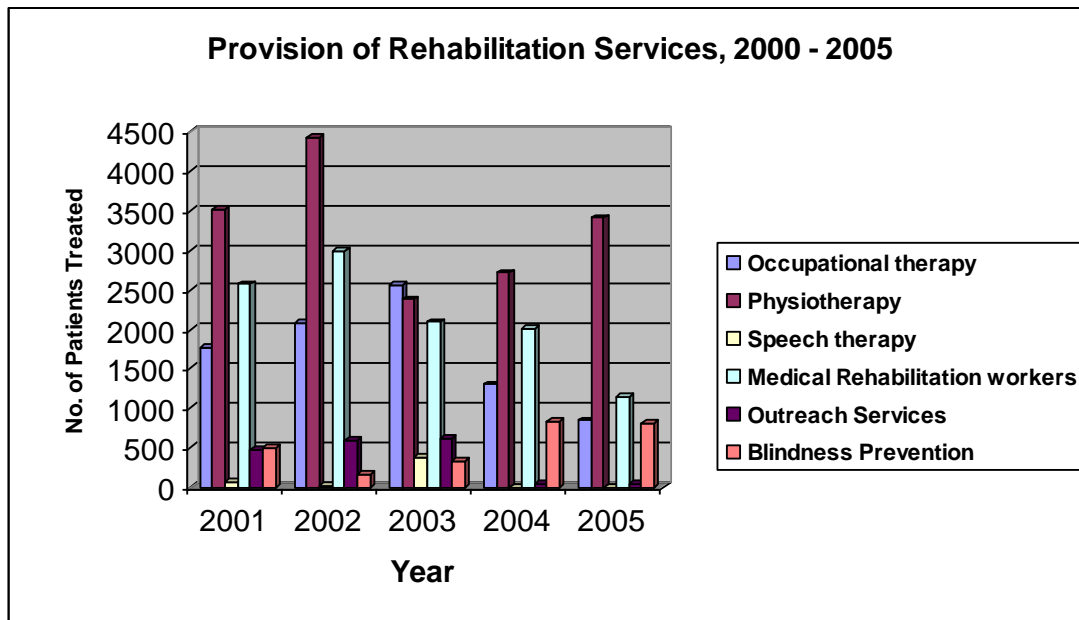
### **Recommendations**

1. Finalize the School-based Student Health Survey report and disseminate findings.
2. Design appropriate school health education interventions based on the findings of the School-based Student Health Survey.
3. Print and distribute the policy on school health.
4. Finalize the guidelines for the implementation of the Health Promoting Schools Initiative (HPSI).
5. Link School Health programme to the district outreach services.

### **5.1.13 Disability and Rehabilitation**

Rehabilitation services (Physiotherapy, Occupational therapy, Speech therapy, Blindness prevention and Medical rehabilitation) cover all 13 regions. From the Population and Housing Census of 2001, Namibia has 85,567 persons living with disabilities. Between 2001 and 2005, the programme provided services to 50,716 patients, representing about 60% of the total number of persons with disabilities (see figure below).

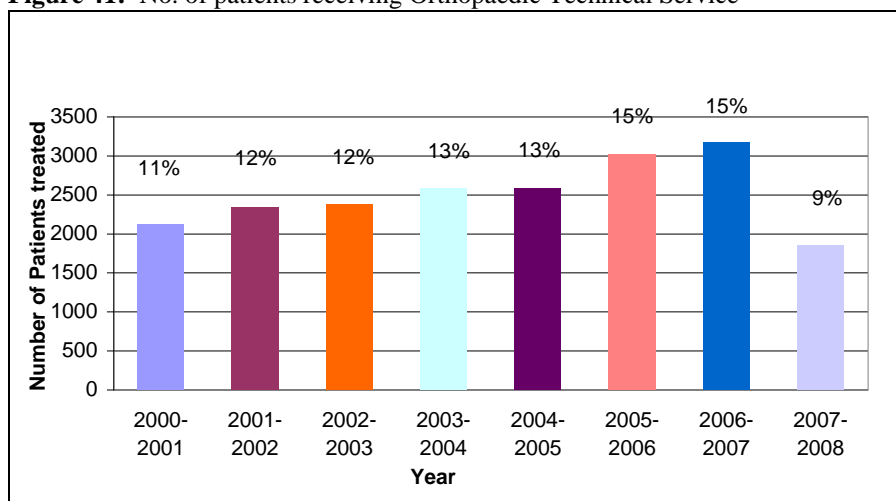
Figure 40: No. of Patients Receiving Rehabilitation Services in Namibia



The Orthopaedic Technical Services (OTS) provided appliances and treatment to people with disabilities and those with medical conditions that require orthopaedic treatment. A total number of 10 out of 13 regions provide Orthopaedic services either in form of outreach or permanent facility services. Over the five-year period from 2000 to 2005, the number of patients provided services and treatment grew steadily to 17,930 out of the 32,192 PWDs in need of these services. Patients in need of assistive devices were also served (*see figure below*).

The capacity of health professionals to provide these services have been strengthened over the period, with qualifying training provided for various Orthopaedic technical categories. In addition, 67% of Orthopaedic facilities at Rundu, Oshakati, and Windhoek were renovated.

Figure 41: No. of patients receiving Orthopaedic Technical Service



**Key Constraint/Challenges**

Disability Prevention and Rehabilitation (DPR) services face several challenges in the service provision. The main challenge has been the lack/insufficient service facilities in the regions (*e.g.* orthopaedic laboratories, eye care units, rehabilitation departments.) The health facilities

do not accommodate the required human resources at all levels of services. There is also the problem of duplication of roles by the two divisions of Rehabilitation in the Ministry of Health and Social Services causing confusion to staff and beneficiaries. Furthermore, insufficient human resource for- multi-disciplinary team results in poor treatment; insufficient number of vehicles for DPR and outreach services; high staff turnover; insufficient financial allocation for DPR services and the increasing cost of materials, component and operational equipment/tools.

### **National Blindness Prevention**

The National Program for the Prevention of Blindness is primarily designed and aimed at the prevention and control of identified preventable blindness and visual impairments at primary level of the health care system.

The blindness prevention provides eye care services. This includes cataract surgical intervention; organized as eye campaigns in different regions. The services are provided in all 13 regions. The surgical rate improved from 600 per 1,000,000 persons in 2000 to 1,800 per 1,000,000 persons in 2004.

The programme has for the past five years, scored remarkable achievements in the areas of prevention of blindness and visual impairments in the country, the training of eye care providers as well as the establishment of an eye care clinical network across the 13 regions.

1. A total 9 additional new district eye care units have been established at Tsumeb, Onandjokwe, Engela, Eenhana, Outapi, Opuwo, Swakopmund, Okahao and Gobabis Districts of the 13 Regions as additional to the previously existed 5 ones at Windhoek Central, Katima Mulilo, Rundu, Keetmanshoop and Otjiwarongo state Hospitals.
2. A total 3739 cataract blind people from across the 13 Regions had their sights restored through the cataract surgical control projects conducted in the regions over the past 5 years.
3. The cataract surgical rate (CSR) has increased from 700 in 2001 to 1880 cataract operations/million population/per year.
4. A total number of 9 additional new ophthalmic personnel (ophthalmic clinical officers) have been trained in outside the country and seven existing staffs have successfully upgraded their skills on clinical refraction technique in South Africa.

### **Recommendations**

The following main recommendations are proposed:

1. Construct the Oshakati Orthopaedic Technical Laboratory and other rehabilitation facilities;
2. Develop guiding documents e.g. policy guidelines, and protocols; improve working conditions of DPR staff (recommend new salary structure and other benefits);
3. Restructure and recommend the new staff establishment for the nationwide DPR including provision for physiotherapists and occupational therapists at appropriate levels.
4. Disability prevention and rehabilitation functions to harmonised under one directorate.

### **5.2 Clinical Services**

The Clinical Support Services Division consists of four sub-divisions:

- a) Ambulance Service Management, whose objectives, among others, are to provide operational standards and guidance for ambulance service delivery to all health care providers at all levels, and ensures access to a 24-hour ambulance services at all levels;

- b) Medical Equipment Management that aims at enforcing recommended standards and practices, and ensure that government policies and procedures on medical equipment are followed;
- c) Radiographic Services charged with responsibility of ensuring an affordable, sustainable and quality radiographic service nationwide; and
- d) Medical Laboratory Services that functions to ensure efficient and effective pathology testing services, ensure optimal laboratory services, and optimize the National Blood Programme.

In the last three years, the Clinical Support Services Division has established a national ambulance services system with a draft policy and strategic plan awaiting finalization. The strategic plan was developed to strengthen the capacity of staff to optimize service delivery; provide medical guidelines to hospitals; provide advise to health facilities on issues relating to medical equipment; acquired a quality assurance kit through the IAEA, for evaluations/assessment and monitoring of radiography outputs; supported the training of radiographic assistants; formulated and launched guidelines for the appropriate clinical use of blood and blood products in Namibia; and formulated and launched the National Blood policy.

All clinical engineering workshops in the country have been equipped with minimum needed standard tools and test equipment, while health facilities have been supplied with guidebook on safety of medical equipment. The Ministry of Finance approved a special allocation of the N\$17million for replacement of medical equipment in the Cancer Care Centre in 2008/2009. A total of 1647 repairs were carried out on pieces of equipment from Windhoek Central Hospital and remote health facilities, with 153 pieces of equipment repaired by external companies. In addition, during financial year 2008/2009, outreach visits to different health facilities to service and repair X-Ray equipment resulted in cost savings of over N\$2 million. Planned preventative maintenance is carried out routinely in health facilities across the country.

Significant strides have been recorded with blood safety in the country over the past years. Working in collaboration with the Namibia Blood Transfusion Service and the Namibia Institute of Pathology, the Ministry has been able to achieve 100% voluntary unpaid blood donation. As seen in table below, although the target for blood units to be collected is 22,000 units, the actual collection has been above 18,000 in the last few years, meeting actual needs. The improvement in management of stocks as well as reduction in unnecessary transfusion makes collected units sufficient for needs. All blood units transfused in health facilities are screened before transfusion and the table shows that less than 2% of the units are discarded because of transfusion transmissible infections. The proportion of donors that have HIV, Hepatitis-B virus, Hepatitis-C virus and syphilis at less than 1% for all these TTI's is negligible.

Major constraints include lack of structure for ambulance service delivery; shortage of ambulances and equipment; problems with converted ambulances; lack of budget for ambulance services which makes it difficult for ambulances to be maintained and to be repaired; difficulties in providing remote support as some departments sometime fail to communicate or delay the reporting of faulty equipment; shortage of skilled Human resource in all the subdivisions.

**Table 13:** Blood Safety Indicators, 2004-2007

	2004	2005	2006	2007
Number of blood units collected per year <b>(January–December)</b>	19,154	19,133	18,422	18,309
<b>Types of blood donors</b>	<b>Percent (%)</b>	<b>Percent (%)</b>	<b>Percent (%)</b>	<b>Percent (%)</b>
Voluntary, non-remunerated	100%	100%	100%	100%
Replacement/family	0%	0%	0%	0%
Paid	0%	0%	0%	0%
Regular VNRBD	-	-	-	76.2%
First time VNRBD	-	-	-	11.8%
Lapsed VNRBD	-	-	-	11.9%
<b>Units screened for</b>				
HIV	100%	100%	100%	100%
HBV	100%	100%	100%	100%
HCV	100%	100%	100%	100%
Syphilis	100%	100%	100%	100%
Percent of units discarded due to TTIs	1.80%	1.86%	1.61%	
Prevalence of HIV in donors*	0.51%	0.53%	0.45%	0.59%
Prevalence of HBV in donors*	0.80%	0.78%	0.92%	1.47%
Prevalence of HCV in donors*	0.07%	0.09%	0.12%	0.17%
Prevalence of syphilis in donors*	0.40%	0.44%	0.21%	0.30%

\* Prevalence based on results of confirmatory testing

## Recommendations

1. Due to shortage of nursing staff there is a need to develop new cadre especially paramedics to complement the effort of nursing staff during emergencies.
2. Nurses should be trained in trauma and emergency handling especially those working in health facilities where there are no doctors and those working at casualties, intensive care, maternity and high care units.
3. A standardized ambulance system should be established. Ambulance services should be clearly defined as emergency services and should run independently from the general transport services.
4. Positions at regional and district levels should be filled by trained ambulance officers. This will ensure the services to run for twenty-four hours effectively.
5. All ambulances should be fully equipped with all necessary life support medical equipment.

## 5.3 Hospital Services

Hospitals play a critical role in the delivery of health services in Namibia. Their availability, spatial distribution, accessibility to the population, range of services delivered, management, and attitudes of health workers providing services in them go a long way in determining the perception of the quality of services by the utilizing population. The survey of the sampled hospitals revealed a number of pertinent strengths, challenges, and opportunities that are summarized below.

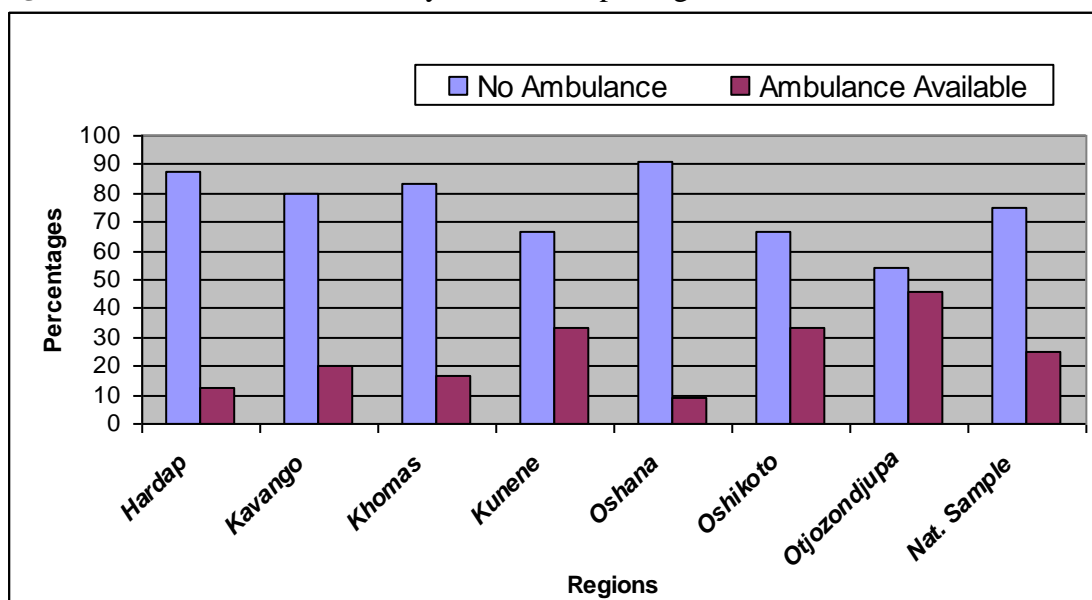
The survey found that hospitals in the country provide a full range of medical services including diagnostic, treatment, pharmaceutical, care, counselling, rehabilitation, and emergencies. They also serve as referral centres for the lower level facilities (health centres and clinics) and are available for 24 hours of the day.

With respect to diagnostic services, the survey found that all hospitals provide laboratory and radiographic services. All blood products are screened before transfusion. The services provided by the NIP to the hospitals are complemented by private licensed laboratories. Some hospitals reported shortages of some blood groups. Some hospital laboratories are not connected to the standby generator. Hospitals provide 24 hours radiographic services but are affected by inadequate number of staff as well as frequent breakdown of equipment.

The infrastructure and resources to provide emergency services to Namibians was found to be inadequate. Although medical officers are available 24 hours of the day in hospitals, essential equipment are available and some ambulance drivers have training in first aid, some hospitals have no or limited space or are housed in dilapidated structures for emergency services provision. There is a high variability in the availability of ambulances across hospitals in the country. From Figure 23 below, only 25% of facilities in the national sample had ambulances, with Oshana region having the least number of facilities with ambulances.

It is significant that the clients exit interviews indicated that long distances to hospitals act as a major barrier to service utilization, and the inadequacy of ambulance services in many hospitals has a negative impact on service delivery. Many hospitals do not have the required human resources for emergency services. There were concerns over the partitioning of some hospitals that do not meet minimum standards for infection control. For example, the absence of isolation wards for TB and psychiatric patients pose risks to other patients.

Figure 42: Ambulance Availability in facilities per region



It was observed that some hospitals are over-crowded as a result of referrals from lower level facilities. This over utilization can be attributed to inadequacy of service provision at the lower referring levels. Patients are bypassing the lower level facilities and access the hospitals directly, where they believe they will receive quality services. The implication for staff workload and morale in such facilities impacts on the quality of services delivered in these hospitals. In contrast, some other hospitals have very limited workloads and there is a need to explore ways of fully utilizing the existing network of hospitals more efficiently. The physical partitioning of some hospitals was found to be inadequate, leading to inadequate

classification of patients. Finally, the health workers' survey revealed that there was insufficient feedback provided by the referral hospitals to the referring lower level facilities.

The survey found effectively functioning pharmaceutical services in most hospitals. The hospitals are implementing an efficient ordering system, with no major problems of stock-outs. The major issue with hospital pharmacies across the country is the shortage of pharmacists and insufficient transport facilities. The survey revealed that most hospitals provide social-psycho services to patients/clients, refer clients to stakeholders where appropriate, approve grants for people living with disabilities, and have a few trained social workers.

The survey revealed that in spite of the availability of maternity services in hospitals, a lot of home deliveries take place across the regions of the country due to cultural beliefs and vast distances to health facilities. There are many instances of delayed referrals, absence of surgeons to do caesarean sections and shortage of trained personnel/midwives in some hospitals, all contributing to avoidable maternal deaths.

With respect to hospital management, the survey found that most hospitals are currently being managed by medical personnel who may not necessarily be skilled or trained in hospital management. The management/organizational structures in the national and intermediate hospitals are not well defined. Most hospital management teams do not hold regular management meetings. There is a lack of supervision of subordinates by managers in most hospitals. Some doctors do not adhere to working hours. Crucially, there is a practice among some doctors of leaving the hospitals to do other remunerative activities such as locums and part time private practice during working hours, with the attendant adverse effect on service delivery. There is no or limited capacity in the hospitals for the collation and analysis of all HIS, MIS data and research.

With respect to the non-medical services, the survey a general level of dissatisfaction with the laundry, kitchen, security, and cleaning services in most hospitals in the country. The attitude of the workers in these sections was found to be unacceptable. The equipment were few, old and broke down frequently. Supervision of the workers is poor leading to poor services, even for those services such as security that have been out-sourced.

### **Major Constraints**

The major constraint identified by the survey in hospitals is the inadequacy, in numbers and skills mix, of key health personnel (doctors, nurses, midwives, social workers, pharmacists, radiographers, among others). Although hospitals have more human resources than the lower level facilities, the huge workload in some of the hospitals put the available health professionals under a lot of strain leading to burnouts and high attrition rates.

The next most critical constraint is the insufficient level of infrastructure for service delivery in hospitals. There is a general paucity of transport logistics for service delivery – to facilitate movement of drugs and supplies, and staff for out reach services and supervisory visits. The survey found the ambulance services to be inadequate to meet the needs of the hospitals. With vast distances between hospitals and some communities, the need for well-equipped ambulance, with trained staff cannot be over-emphasized. The absence of a clear policy on ambulance services is therefore a major constraint.

The insufficiency of resources for maintenance of the hospitals' infrastructure is another constraint. The frequent breakdown of some critical equipment and machines, coupled with the absence of equipment replacement plans were identified as a constraint to the delivery of quality services. The inadequate service provided by the Department of Works responsible for maintenance of all government infrastructure was found to be a major constraint. In terms of management, the major constraint identified is the lack of managerial skills. The insufficiency of supportive supervision as well as the lack of mechanism for staff performance appraisal was also highlighted. Finally, the survey noted the poor performance of the non-medical services in the hospitals is a critical constraint.

### **Recommendations**

1. Strengthen the capacity to deliver PHC services at health centres and clinics level to reduce overcrowding at hospitals and instances of patients accessing the health system directly at the hospital level. This will make the hospitals concentrate on specialized and referral services and lead to more efficient utilization of scarce resources.
2. Address the human resource crisis as recommended in the HR section of this report
3. Explore the possibility of outsourcing the non-medical services and strengthen the current contractual arrangements that are in place.
4. Strengthen the hospitals' managerial capacity through relevant training for current manager in Hospital Management. Recruit non-medical CEOs for hospitals.
5. Clearly define the management/organizational structures of the National and Intermediate Hospitals. A consideration should be given to the creation of Hospital Management Boards for the hospitals to be run as body corporate(s).
6. There is need to re-establish a Directorate Health Service Management at national level to specifically support the hospitals the following divisions: -
  - a. Quality Improvement
  - b. Nursing services
  - c. Hospital services
7. There is need to urgently develop a clear ambulance policy.

### **5.4 Oral Health and Dental Services**

Oral and dental services are being rendered in fifteen (44%) out of the 34 health districts hospitals across the country. The other areas are served by outreach programme on rotational basis by dental teams in the regions. Schools visits form part of Smiling School Project which was piloted in Windhoek, Khomas Region, from 1996 to 1998 then rolled out to other regions.

Despite the fact that, tooth extraction is discouraged it is still preferred method of treatment by patients. Another contributing factor is the unavailability of restorative materials in state dental clinics, coupled with lack of appropriate dental instruments.

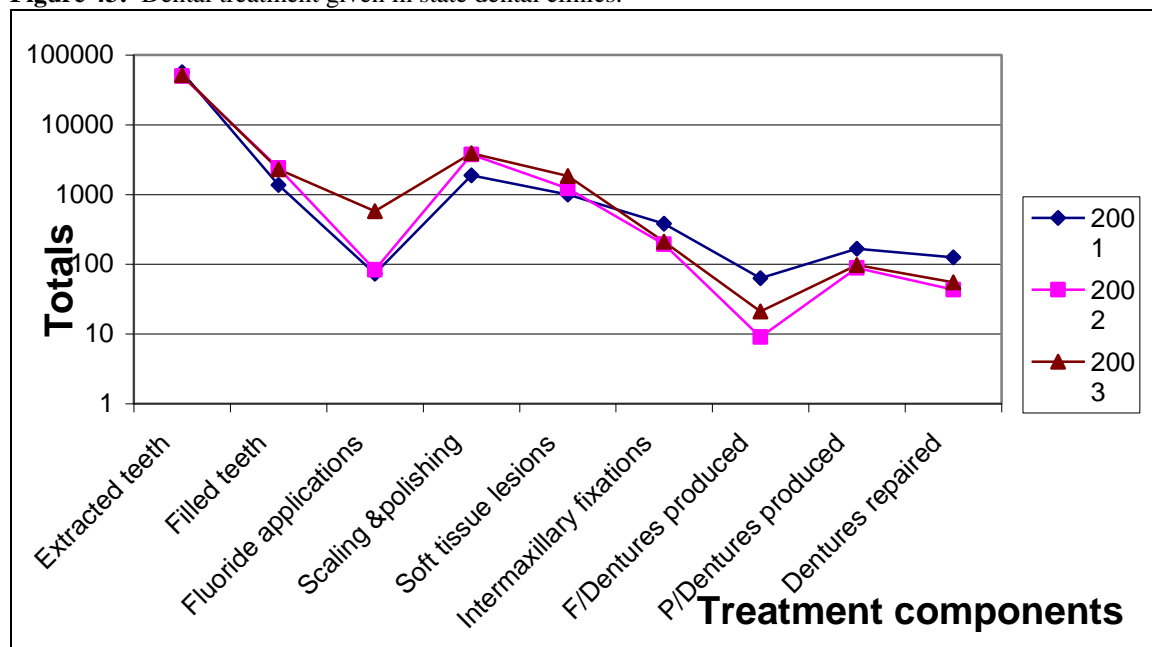
The "Smiling School Project" funded by the Federation Dentaire International (FDI) started in 2002. This project assisted Namibian children of school going age to achieve and maintain optimal oral health through the provision of activities and services based on prevention of diseases, promotion of health and reduction of barriers to oral health care.

Under this project, oral health education was provided in schools by dentists and dental therapists, coordinated and/or supervised tooth brushing sessions in schools, cleaning – scaling, stain removal and dental cleaning.

Countrywide, this project was being implemented in 107 schools only with the majority of schools in Khomas (20) and Erongo (12) regions.

Oral Health modules were included in training of nurses and teachers because they have contact with young children and have greatest influence on primary school children (target group). IEC material was developed for Oral Health. Oral Health was included in the guideline of Health Promoting School Initiative.

Figure 43: Dental treatment given in state dental clinics.



**Constraints**

A major constrain facing dental health services is the lack of adequate dental instruments and material which lead to tooth extraction as mode of treatment. In addition, lack of transport, especially mobile dental unit, for dental outreach programme has resulted in poor access to dental services by the rural population. The schools visits are also affected by unavailability of transport. The lack of inclusion of dental staff in HIV/AIDS workshops despite the fact that oral manifestations are the first signs and the shortage of human resources (qualified dental personnel) are among the key constraints. There is only one Dentist per region except Khomas, Oshana and Otjozondjupa regions.

**Recommendations**

1. Procurement of instruments and dental material to ensure improved and diversify dental services at all state facilities.
2. Procure and equip mobile dental units at least one per region.
3. Sensitise other health worker, workshops planners at national level about the importance of Oral Health so that dental staff is included in workshops, especially related to HIV/AIDS.

## 5.5 Pharmaceuticals

The Pharmaceutical Services Division comprises of three sub-divisions, namely Pharmaceutical Control and Inspection (PC&I), National Medicines Policy Co-ordination (NMPC) and Central medical Stores (CMS).

In 2007, there were 103 pharmacy staff working in the public health sector, and 63-development partner funded staff compared to 68 MoHSS and 18 Development partner funded staff in April 2005.

**Table 14:** Pharmaceutical Staffing (2007)

Description	No. of posts	Filled posts	Vacant posts	lower cadre in post	MoHSS Extra to Staff estab.	Non MoHSS extra Staff
Pharmacist's Assistant	54	50	4	0	4	30
Sr. Pharmacist's Asst.	27	22	4	1	0	0
Pharmacist Intern	2	4	0	0	2	
Pharmacist	12	6	6	0		33
Sr. Pharmacist	6	3	3	1		
Principal Pharmacist	22	13	9	0		
Chief Pharmacist	6	5	1	0		
Deputy Director	1	0	1	0		
<b>TOTAL</b>	<b>129</b>	<b>103</b>	<b>27</b>	<b>2</b>	<b>6</b>	<b>63</b>

Sixty-three additional pharmacy staff have been recruited to complement the MoHSS staff. These posts are funded through development partners, namely CDC, MSH, SCMS, Global Fund and Intra Health. These staff are mainly involved in providing HIV related services, but all efforts have been made to provide integrated HIV and other services rather than having two separate systems one for HIV related issues and another for non-HIV related issues. Without these additional staff, it would not be possible to run pharmaceutical services in the MoHSS.

The CMS serves as the Ministry's central agency for procurement, storage and distribution of essential medicines and related clinical supplies for the public health sector. Medicines procured, stored and distributed are those approved by the Ministry and are specified in the Namibian Essential Medicines List (Nemlist). The CMS manages about 1,600 items sourced from some 75 suppliers. These items were distributed to all the public health facilities as well as the two regional medical stores and 15 school hostels. Distribution of medicines is done by a pull system. Health facilities have order books and place regular orders to the facility that supplies them, either a medical store or a district hospital.

In certain districts – mainly due to space constraints in the hospital pharmacy and or large number of PHC facilities to be supplied – the PHC facilities receive their supplies directly from a medical store. This is the situation in Rundu, Oshakati, Windhoek and a couple of other districts. The disadvantage of this is that it is difficult for a Medical Stores to have information about the size and workload of a particular clinic and hence one way in assuring rational medicine use is lost when medical supplies are delivered directly to the PHC facilities from a medical store.

### Procurement

The MoHSS operates a centralised procurement system that is run by Central Medical Stores. The annual value of medicines received by Central Medical Stores in 2007/08 financial year was almost N\$192 million. Of this amount, N\$ 63.6 million was accounted for by ARV medicines alone.

### Service Level from Medical Stores

The service level provided by the CMS is calculated each year, was 92% for the financial year 2006/07, and increased to 95% in 2007/08. Information from the Pharmacy Management Information System (PMIS) Report showed that the national availability of key items on 1<sup>st</sup> October 2007 was 93.6%. The CMS report that ARV service level at 97% in 2006/07 and 98% in 2007/08. Only 2 districts reported any ARVs being out of stock during the reporting quarter.

### ARV Related Services

All districts have patients on Antiretroviral Therapy, and by end of March 2008 all pharmacies had a computerised ARV Dispensing Tool (ADT) that assists with patient and stock management as well as printing labels for dispensed ARVs. The table below shows a three-fold increase in the number of patients on ARVs between 2005/06 and 2007/08.

**Table 15:** Cumulative number of Patients receiving ART in Public Health Facilities

Financial Year	Cumulative # of patients on ART			Data as at this date
	Adult	Paeds	Total	
2005/06	12480	1916	14396	Dec-05
2006/07	25944	3923	29867	Dec-06
2007/08	42316	5992	48308	Mar-08

### Funding for ARV purchases

At the initiation of the ART programme all ARVs were purchased by the MoHSS using GRN funds. However as the programme rolled out to more districts and the number of patients receiving ARVs increased rapidly the cost implications became enormous.

Currently the MoHSS receives support for purchasing ARVs from GRN funds, Global Fund, US Government (through CDC and SCMS). In the last financial year the cost of ARVs was covered as described in the table below;

**Table 16:** Funds for ARV procurement 2007/08

Source of funds	Amount budgeted N\$	Amount used N\$
Global Fund	43,231,474.00	18,878,817.77
CDC/PEPFAR	27,733,091.75	21,145,221.39
GRN	-	23,555,169.98
<b>TOTAL</b>		<b>63,579,209.14</b>

### Major Achievements in Last 3 Years

The establishment of a national Therapeutic Information and Pharmacovigilance Centre (TIPC). The centre is currently staffed by one medicine information pharmacist and one adviser.

In order to improve monitoring and evaluation of pharmacy service provision across the country, a Pharmacy Management Information System (PMIS) has been developed, launched and implemented.

The roll out of ART services in the MoHSS has been a major challenge and has led to the development, launch and implementation of a computerised ARV dispensing tool for use in hospitals providing ART services. In addition, a system for monitoring ARV stocks and usage across the country has been developed together with the operational level pharmacy staff. A monthly report is submitted each month to the Division giving details of ART patients in all districts, plus stock levels on hand.

### **Major Constraints**

Despite the additional staff recruited by development partners there is still a shortage of skilled pharmacy personnel in the Ministry – both at the head office and at operational level – has hampered development of pharmaceutical services in the country. The roll out of ART services to all districts in Namibia has put increased pressure on the Central Medical Stores, especially due to rapid changes in treatment guidelines and products available on the market. There has been no commensurate increase in staff. Additionally there is a shortage of appropriate storage space in the CMS has become a constraint – especially following the major increase in demand for ARVs.

### **Recommendations**

1. There is an urgent need to revise the current MoHSS staff establishment for pharmaceutical services so that it can cater for the additional services that are now being provided – both at operational level and national level. An investigation should also be done into the feasibility of starting a pharmacy diploma course in Namibia.
2. The revision of the National Medicine Policy has started but needs to be completed as a matter of urgency and a second National Pharmaceutical Master Plan developed to guide pharmacy services in future years.
3. Focus must also be given to strengthening the Pharmacy role in promoting rational medicine use through strengthening Therapeutics Committees, utilisation of data from the PMIS and ART monthly reports, and providing supportive supervision. In addition, a continuing professional development (CPD) programme for pharmacy staff is required and this will contribute to improving rational medicine use in Namibia.
4. There is need to expand space for Central Medical Stores.

## **5.6 Social Services**

### **Prevention and treatment of substance abuse**

The social welfare sector provides treatment and rehabilitation to abusers of drugs and alcohol. The treatment is provided at treatment centres and is followed by after care services which are essential in minimising relapses. The Ministry runs outreach programmes to sensitise communities and promote responsible lifestyle and behaviours.

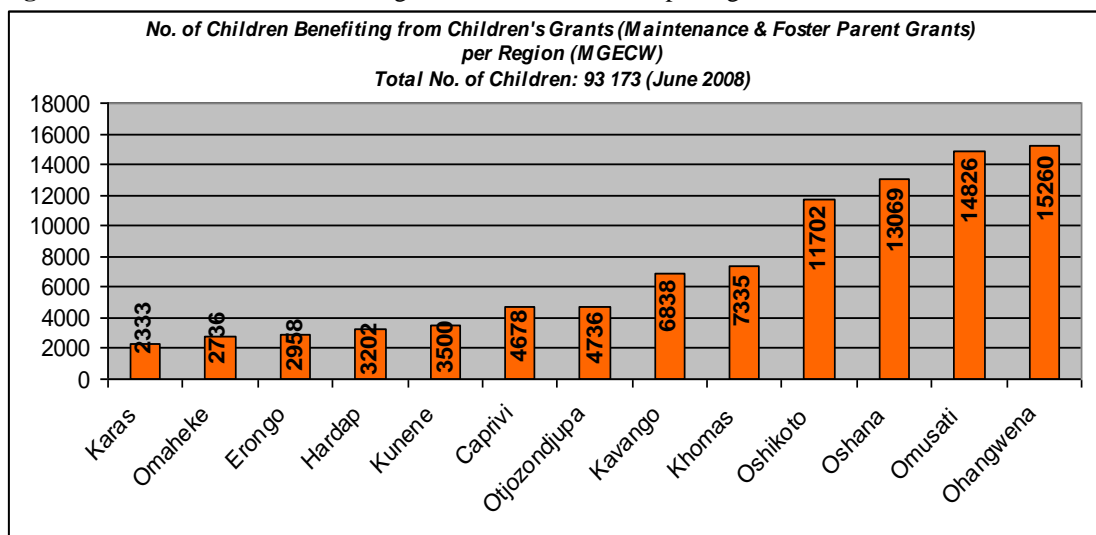
The Coalition on Responsible Drinking (CORD) is an alcohol and drugs campaign that disseminates information against the use and abuse of alcohol and other drugs, promotes sober lifestyle and responsible drinking. Regional and constituency CORD Committees were established in the following six regions: Erongo, Oshikoto, Omusati, Kavango, Karas and Otjozondjupa.

**Family Welfare**

This function has been severely compromised following the transfer of key functions, such as child welfare and social assistance to other Ministries. Despite this, the Ministry intervenes in order to ensure that the family functions as an integrated unit. It provides marriage counselling, bereavement counselling, suicide, family violence, unwanted pregnancies, prostitution, property grabbing and links families to appropriate resource systems. Much emphasis is placed on promoting the well-being of older people.

The number of children who are classified as orphans and vulnerable children (OVC’s) is on the increase. The government (MGECW) in accordance with the Children’s Act, 1960 (Act No. 33 of 1960) effect payment of maintenance grants and foster parent allowances to children in need. The graph below indicates the number of children from the different regions, who received the mentioned grants for the period June 2008. It must be emphasised that although the mandate for child welfare functions was transferred to the MGECW, Social Workers of the MOHSS continued to do the statutory placements of children to qualify for foster parent allowance. Ohangwena and Omusati, which show the highest number of children, have the lowest number of Social Worker posts filled in the MOHSS, as well as the MGECW.

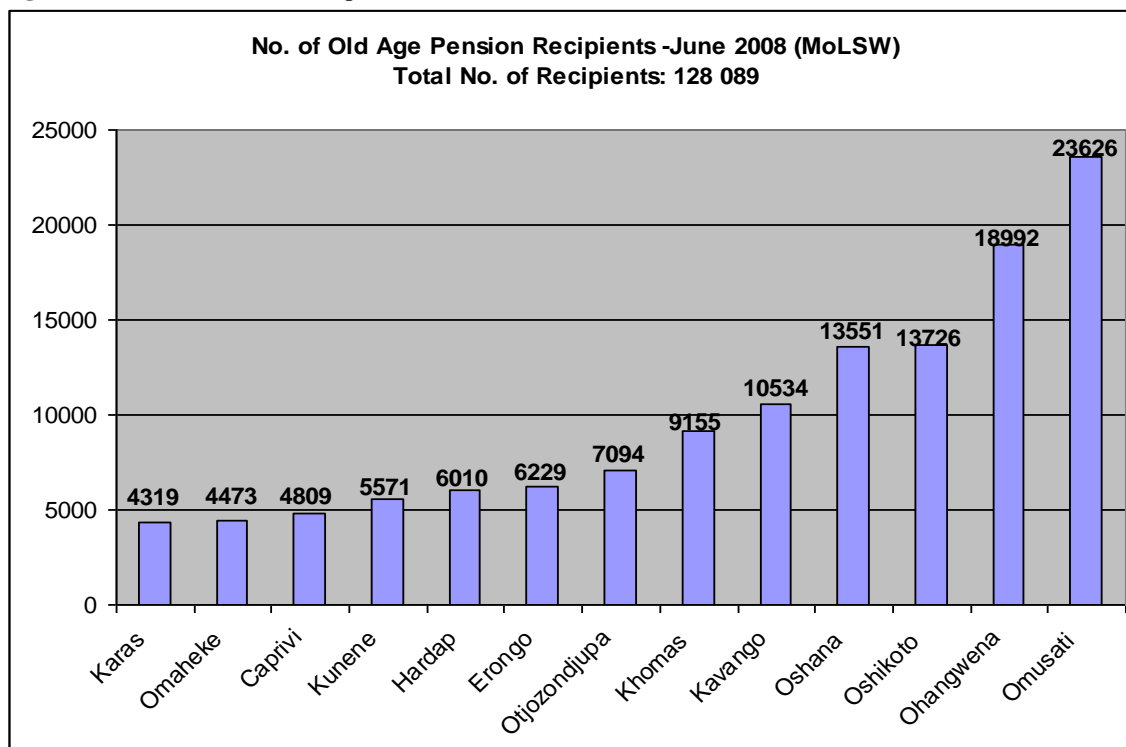
**Figure 44:** No. of children benefiting from Children’s Grants per region



**Old people**

The Directorate Social Welfare Services has a statutory responsibility to register homes for older people and develops the requirements and minimum standards for registration, including guidelines, and provides quality assurance through inspection and investigations of complaints. The homes for older people are registered at the MOHSS are: Hardap (1), Omaheke (1), Karas (2), Khomas (3), Otjozondjupa (4) and Erongo (5). Most of the homes for older people were registered before independence. The MOHSS does not encourage the establishments of homes of older people as it is very expensive type of care, not affordable to most senior citizens and not sustainable.

Part of the formal safety nets provided by Government, is the provision of basic state grant to older people by the MoLSW. The recipients for the month of June 2008 were as follows for the respective Regions:

**Figure 45:** No. of Pension Recipients-June 2008

### Welfare Organisations

The Ministry is responsible for the registration of welfare organisations which complement the efforts of Government in the provision of social welfare services. In recognition of the contributions of welfare organisations, the Government the Directorate Social Welfare Services to provide subsidies and financial assistance to welfare organisations. The Directorate also provides supervision and technical support to welfare organisations. In this regard, inspection visits are undertaken yearly. There are a total of 286 registered welfare organisations in Namibia. 68% of these organisations are operating in Khomas. The northern region has very few registered welfare organisations. The first welfare organisation in the Caprivi Region, was registered only in 2003, Kavango Region in 2004, Omusati Region in 2005 and Ohangwena Region in 2007. More of these organisations are needed to complement and extent the services of social welfare staff, especially at grassroots level.

### Social welfare information system

Through the social welfare information system, the Directorate seeks to create a computerised database on social welfare services in Namibia. This will enable the Directorate to analyse trends in social welfare service delivery and uses it as the basis for determining appropriate interventions, advocacy, planning and budgeting. The shortage of computer equipment for the social welfare staff needs to be addressed as a matter of urgency.

### Human security and prevention of social problems

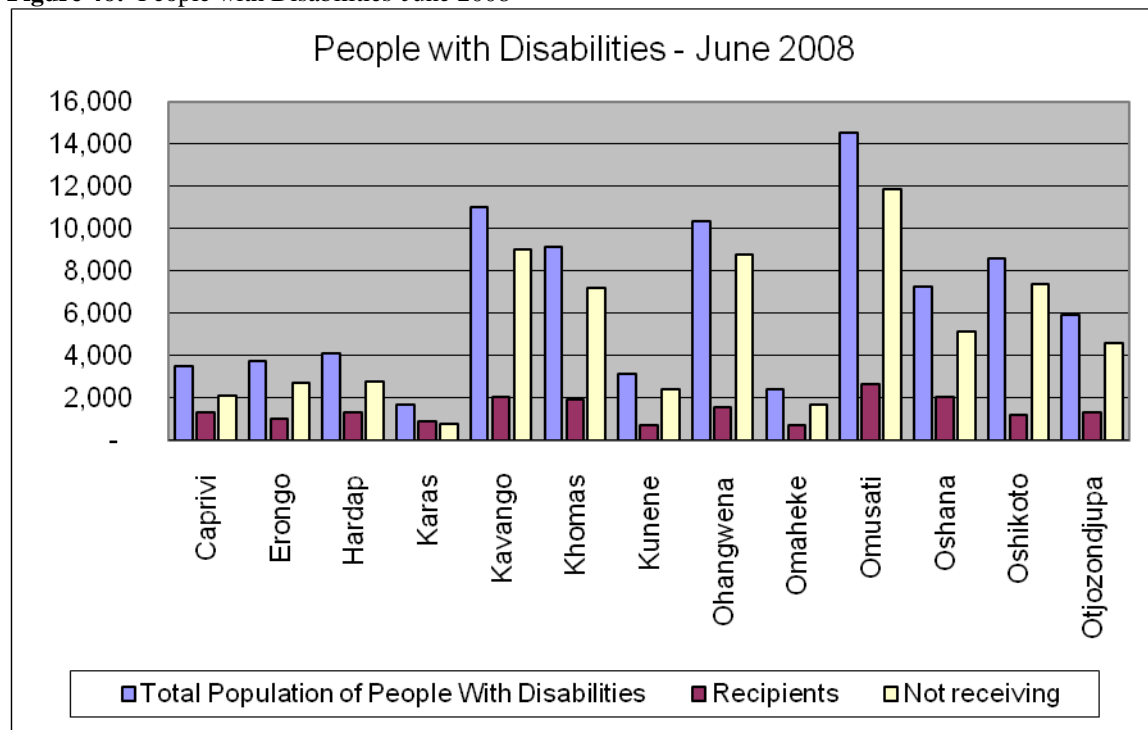
In line with its thrust towards developmental social welfare, the Directorate has a new function which seeks to contribute to national efforts on poverty reduction. The Directorate seeks to ensure that national efforts such as Poverty Reduction Action Plan and Poverty Reduction Strategy find expression in the social welfare sector. In addition, the Directorate is promoting the establishment of community welfare committees.

**Rehabilitation**

The 2001 Population and Housing Census, shows that the number of people with disabilities in Namibia is around 85,567 or 4.7 % of the total population. The population is almost equally distributed between females and males, but higher in rural areas than urban areas.

Although social pensions are available to people with disabilities, most of them are not receiving the grant (as shown in the graph below) due to the following factors: lack of national documents, lack of information ,inaccessibility of health and social welfare facilities ,fragmentation of social welfare services to mention but a few.

**Figure 46:** People with Disabilities-June 2008



**Constraints**

Several challenges were encountered in the area of social welfare service delivery throughout the past five years:

The delivery of social welfare services is administered by different Ministries, resulting in fragmentation, duplication, confusion on the roles and responsibilities in the social welfare sector, inefficiency and ineffectiveness in meeting the needs of our clients.

The fragmentation of the social welfare sector in Namibia also contributed to the fact that the draft Social Welfare Policy is no longer applicable and was shelved. Several planned activities had to be transferred from MOHSS to other Ministries, but was delayed due to a lack of capacity in the some of the Ministries.

Shortage of social welfare staff, especially social workers, high staff turnover, long distances to social welfare offices, lack of transport for clients and social workers, language barrier between social welfare staff and clients, lack of national documents necessary for accessing social welfare services and a lack of awareness of social welfare services, seriously hamper social welfare service delivery.

The delayed establishment of the National Disability Council, outdated Disability Policy, limited access for people with disabilities to public buildings, public transport, information, education, employment, health care, counselling services, and any other services due to environmental barriers (these include lack of brailled materials, lack of sign language interpreters and inaccessibility of physical environment) and negative attitude of the community towards people with disabilities.

### **Recommendations**

1. The finalization of a national developmental social welfare policy, to guide social welfare delivery should be expedited.
2. Consolidation of social welfare services in Namibia under one Ministry to ensure better service delivery and to avoid duplication of efforts.
3. Transfer of pension clerks from MoHSS to the MoLSW .
4. Social welfare structure should be revised to meet the social welfare services roles and responsibilities at all levels.
5. Revise and implement social welfare information system.
6. More welfare organisations need to be established in all regions especially in remote areas.
7. Division of Rehabilitation and Disability prevention should be merged under one directorate.
8. Establishment of the National Disability council.
9. Training of social welfare staff in sign language.
10. IEC material should be made accessible to people with disabilities.

## **5.7 Support Services**

### **Transport**

The Ministry is having its own fleet of approximately 700 vehicles inclusive of ambulances. There seems to be lack of a proper vehicle fleet management system in the Ministry. Transportation is a complex field involving several players and decisions to be taken at various levels with uncertainty and considerable capital expenditure. Furthermore, there is no proper vehicle fleet management system to provide the information on daily basis for the effective and efficient manner to provide transport services. There are several different fleet management information systems that have been developed that are aimed at assisting the transport managers to monitor, control and administer the transport operations. However, functions such as the following are almost non-existence in transport system of the Ministry.

The Master Vehicle Fleet List is outdated and can therefore not provide management information such as the profile and status of the fleet.

The current Transport Policy document provides a legal framework and requirements to utilize the fleet of the Ministry. However, some transport managers do not adhere to these requirements and stipulations, such as vehicle accident reports, completion of log sheets. Furthermore, although some managers adhered to provisions of the Transport Policy there is a need to use the information provided for effectively and efficiently gives services in the health sector. The Transport Policy is outdated as it does not make provision for current situation on the ground. This policy was developed in 1999.

There is currently no replacement plan although vehicles has to replaced when the running cost per kilometre exceed N\$ according to the Transport policy. A lack of funds has hampered continues replacement of vehicles especially ambulances and outreach services vehicles. There is also no system in place that assured the availability of funds such as what happening in Ministries of Agriculture and Works and Transport which use a Trade Account for the replacement of Vehicles. Clients hire vehicles on a predetermined tariff which is used to replace the vehicle.

Due to the no replacement plan of vehicles, transport officers tend to keep vehicles for a period way past their life span and as a result, the running cost become very expensive. There is however, an attempt to auction the old vehicles but it is on the discretion of the individual directorates or transport officers. There is no policy in place to indicate that if a vehicle reaches a certain kilometres or after depreciation over a certain number of years the vehicle has to be written off.

### **Catering Services**

As a result of poor contract management on catering, daily scales are not being followed and sometimes there is shortage of food. In order to effectively control the performance of the catering contractor, one should be equipped with sufficient technical knowledge on preparation of the special diets and meals and ingredients in general. There are not many dieticians in the ministry to provide the technical advice.

### **Cleaning Services**

The Ministry is responsible for the cleaning of all hospitals and other facilities with the exception of Head offices outside premises, which is cleaned by personnel of the Department of Works.

It was noted that in many facilities there is poor supervision of cleaners because the cleaning staff do not fall directly under the nurse in-charge, as it was the case before. It was further noted that cleaners have bad attitudes/lack of commitment and tend to disappear from work before their knock off time.

There is lack of recognition of the importance of cleaning services this demonstrated in the lack of training given to this cadre.

### **Waste Management**

The Ministry experiences serious problems with regard to waste management. This is attributed to lack of the waste management policy. Many of incinerators at district hospitals are also not always in functional states due to old age and irregular maintenance. New Incinerators provided at newly constructed clinics and Health centres are of poor quality.

### **Laundry Services**

The ministry is faced with ageing laundry equipment which is in most cases dysfunctional or semi-functional marred by regular breakdowns. As a result, a substantial number of hospitals are transporting the lined to other hospitals or making use of private laundry suppliers. This in turn means that the staff at the Ministry who are employed for this function are not utilized. There is also serious shortage of linen.

**Security Services**

Poor supervision of security guards by the contractors and poor interpersonal relationship with service user due to lack of training. The securities are not always on duties and there are not security guards at some facilities.

**Capital Asset Management**

The Ministry is responsible for the maintenance, repair, replacement and purchase of equipment. There majority of equipment are old and not functioning and yet there is no equipment replacement policy. There is no preventative maintenance system in place for equipment.

**Contract management**

The Ministry spends large sums of money on the provision of catering, cleaning, laundry services, security and equipment maintenance. However, there is evidence that the Ministry is losing substantial amounts due to the weak management of contracts with private sector suppliers. There is a general lack of knowledge of the contract contents amongst Ministry administrative staff.

**Information Technology**

The Subdivision is very much under staffed. The staff establishment does not make provision for adequate posts and does not cater for some IT job categories. The Subdivision has only 3 systems Administrators and one PC technician to handle all the IT issues in the entire Ministry. The few staff members became jacks-of-all-trades and masters of none. They are overworked which resulted in a demoralised workforce hence poor performance. Human resource constraint is the biggest problem in the Subdivision.

The Subdivision does not have an IT budget, the less allocations received are always shared among the activities in the entire Directorate. Since the initial IT investments are always high most activities could not be done for example the setup of network infrastructure, Systems Development and many others.

Additional to information technology functions under the Directorate Human Resource Management and Resource Management, there is also a Video Conferencing System under the Sub-division Information Services at the National Health Training Centre. The Video Conferencing System has been established in 2003 at NHTC and has been rolled out to the following active Direct Video Conference Sites:

- Oshakati Regional Health Training Centre
- Engela Training Centre
- Rundu Regional Health Training Centre
- Otjiwarongo Regional Health Training Centre
- Keetmanshoop Regional Health Training Centre
- The Directorate: Special Programmes

Current activities being carried out through DVC are training related such as those for pre-service training programmes: sessions, debates, demonstrations, role playing and meetings that are presented at one of the centres and can be attended at all other DVC sites at the same time.

In addition, many HIV/AIDS related in-service trainings are also presented through DVC as well as job interviews with candidates from far places especially outside Namibia.

The DVC system is very useful mechanism, which can enhance effective and efficiency in the Ministry as it save time and resources such transport for staff members or students not to travel to one place or centre to attend training sessions or meetings.

The system is however faced with a challenge in the sense that all staff members who manage this system currently are under the development partners' employment, namely Centre for Disease Control (CDC) Programme and International Training & Education Centre on HIV (ITECH). The sustainability of this system is therefore not guaranteed.

### **Legal Services**

Although the Ministry has subdivision Legal Support, the capacity of this subdivision is very much limited to manage legal services in the Ministry. The Ministry therefore relies on the legal advice from the Attorney Generals office for all legal matters.

### **Recommendations**

1. Revise Transport Policy
2. Develop a vehicle fleet management system
3. Develop a vehicle replacement plan
4. Introduce Trade Account for vehicles replacement
5. Separation of ambulance services from general transport service at referral hospital
6. Strengthen contract management on catering, including improved tender procedures and selection
7. Gradual replacement of all laundry machines in facilities
8. Outsourcing of laundry services
9. Outsource cleaning services
10. IT structure should be revised to become responsive to the needs of the Ministry.
11. The Ministry should come up with an IT Budget which will cater exclusively for IT issues as per E-governance Policy.
12. All IT activities should be placed under one sector in order to enhance proper coordination. Let all the IT development partners place under different Directorate plan together with the Ministry's IT unit.
13. DVC system should be linked to the overall Ministry's Information Technology System and the current IT staff under the Ministry should be involved in the management of the DVC. In order for them to do so, they have to be trained in the operation of the DVC equipment and the whole system. By doing so, the Ministry will be in a position to coordinate the maintenance and the replacement of the system and equipment when necessary.
14. In future, the Ministry should create positions for DVC staff on its establishment.

## CHAPTER 6. INFRASTRUCTURE

*“The Ministry make promises which they do not meet, they make us dig holes for Pit latrines years ago, we dug but they never came back and never heard from them again”*

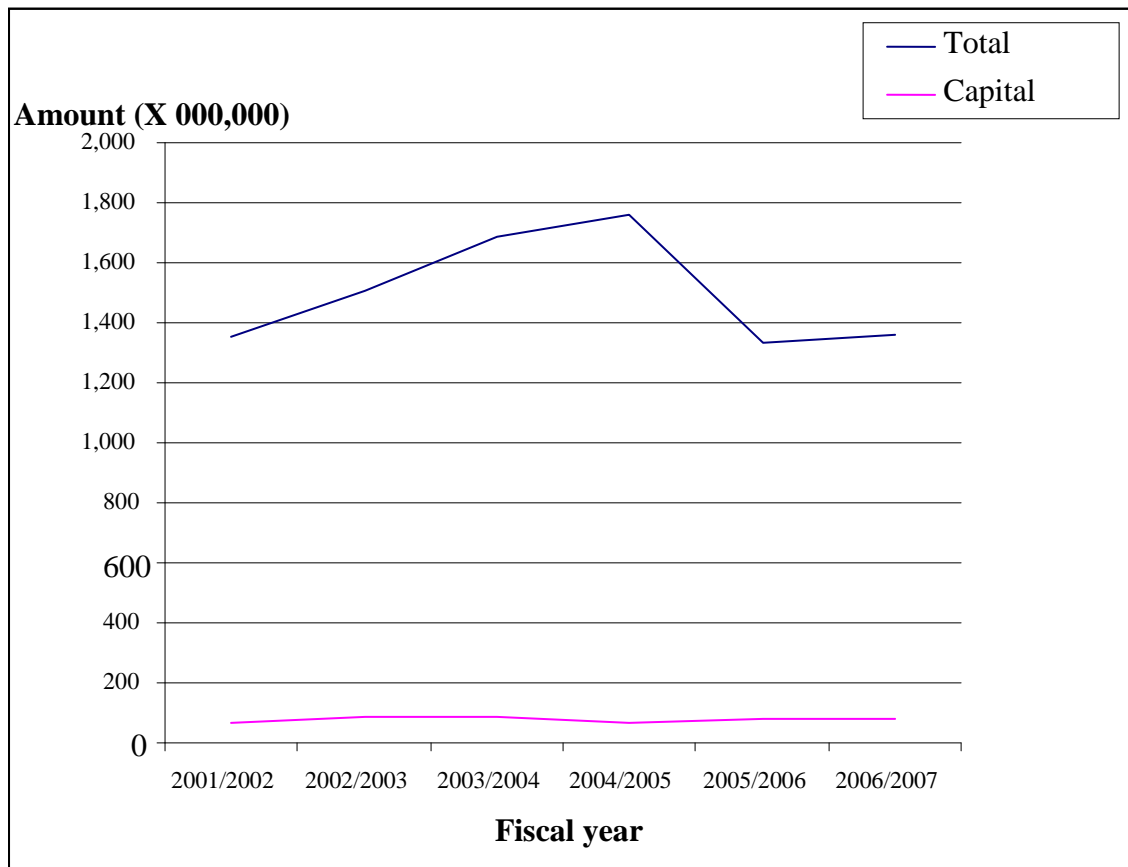
### 6.1 Current Situation

Infrastructure and facilities maintenance lag far behind in the delivery of health services. The MOHSS has taken measures to improve health delivery through medical and staffing interventions. The MOHSS has also implemented a Health Information System to provide data on hospital, health centre and clinical services. However, the HIS does not include information on property (building area, materials and plant inventory). In addition, the MOHSS does not have a property asset register. It is imperative that the MOHSS develop an Asset Management System which can provide a framework for Facilities Management and Maintenance (FMM).

Health facilities owned and operated by the MOHSS often are poorly maintained. This can be attributed to several causes including inadequate funding, failure of material and finishes and poor supervision, and unclear lines of responsibilities between the MOHSS and the MOWTC.

The chart below illustrates that capital budgetary allocation remains fixed irrespective of the total budget. The capital budgetary allocation is lower than international norms, and is further burdened by maintenance backlogs, ongoing maintenance, and new construction.

Figure 47: Capital expenditure



The creation of a facility management and maintenance unit within the MOHSS will significantly improve the provision of health services, increase the life of the facility, decrease the likelihood of exposure, ensure higher staff morale and promote a healthy environment

Furthermore, the advisory services of experienced professionals in the building trade within the MOHSS can ensure proper planning in the development of health facilities that have unique sets of requirements and material use. The same staff can also take the responsibility of capital planning and prioritizing while maintaining the existing stock.

The table below include figures on MOHSS facilities (hospitals, health centres and clinics) and respective number of beds. The table below draws a correlation between the population, beds and health facilities.

**Table 17:** Facilities Summary 2006/2007<sup>39</sup>

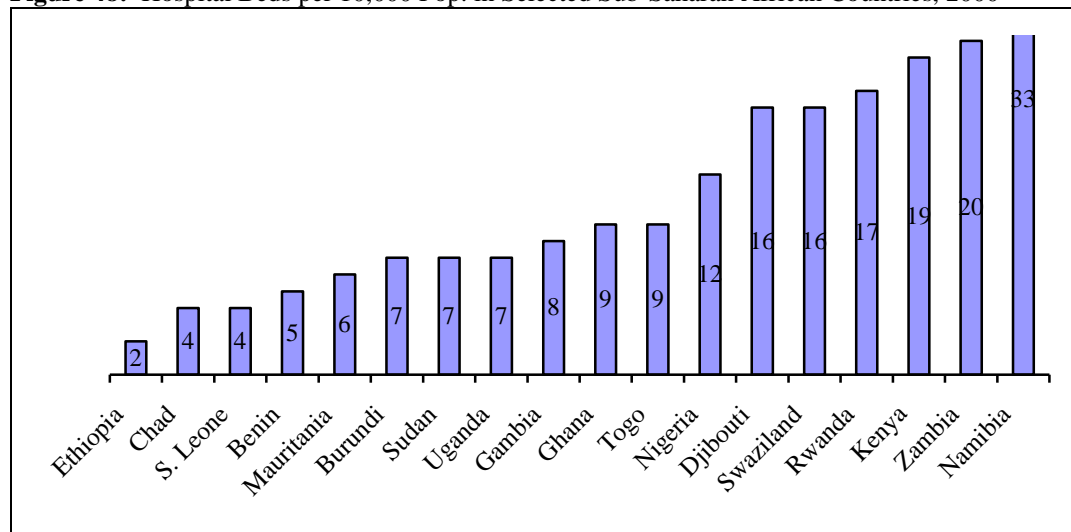
Region	Health Districts	No. of Hospitals	No. of Beds	No. of Health Centres	No. of Beds	No. of Clinics	No. of Beds	Total Beds
Ohangwena	3	3	412	2	42	36	0	454
Omusati	4	4	516	6	61	36	0	577
Oshikoto	2	2	526	3	41	16	0	567
Oshana	1	1	750	4	20	11	0	770
Caprivi	1	1	220	3	9	25	9	238
Kavango	4	4	552	7	109	45	0	661
Erongo	4	4	413	3	0	15	0	413
Kunene	3	3	250	3	0	21	0	250
Otjozondjupa	4	4	411	3	0	15	0	411
Hardap	2	2	272	4	65	12	12	349
Karas	3	3	353	3	0	14	2	355
Khomas	2	2	1531	2	0	7	0	1531
Omaheke	1	1	172	1	7	12	16	195
National	<b>35</b>	<b>34</b>	<b>6378</b>	<b>44</b>	<b>354</b>	<b>265</b>	<b>39</b>	<b>6771</b>

**Table 18:** Population and bed correlation to health facilities<sup>40</sup>

Region	Pop. (2007)	Total Beds	Beds per 10,000 pop	Pop. Per Hospital	Pop. Per Health Centre	Pop. Per Clinic
Ohangwena	251,111	454	<b>18.08</b>	83,704	<b>125,556</b>	6,975
Omusati	242,885	577	<b>23.76</b>	60,721	40,481	6,747
Oshikoto	175,650	567	32.28	87,825	58,550	<b>10,978</b>
Oshana	173,893	770	44.28	<b>173,893</b>	43,473	<b>15,808</b>
Caprivi	87,274	238	27.27	43,637	29,091	3,491
Kavango	268,701	661	<b>24.60</b>	67,175	38,386	5,971
Erongo	114,845	413	35.96	28,711	38,282	7,656
Kunene	75,518	250	33.10	25,173	25,173	3,596
Otjozondjupa	155,430	411	26.44	38,858	51,810	<b>10,362</b>
Hardap	69,072	349	50.53	34,536	17,268	5,756
Karas	73,954	355	48.00	24,651	24,651	5,282
Khomas	274,957	1531	55.68	<b>137,479</b>	<b>137,479</b>	<b>39,280</b>
Omaheke	75,102	195	25.96	75,102	75,102	6,259
National	<b>2,038,392</b>	<b>6771</b>	<b>33.22</b>	<b>58,240</b>	<b>46,327</b>	<b>7,692</b>

The table above shows that while the national average of beds is 33.22 per 10,000 population. The districts of **Ohangwena, Kavango** and **Omusati** are significantly below the median. On the other hand, while the national average number of populations per hospitals is 58,240, the districts of **Oshana** and **Khomas** have hospitals that serve greater than double the national average. As compared to other countries the region, Namibia has the highest number of beds per 10,000 population.

Figure 48: Hospital Beds per 10,000 Pop. in Selected Sub-Saharan African Countries, 2000<sup>41</sup>



In terms of Health centres, while the national average is 46, 327 populations per health centre, **Ohangwena and Khomas** are serving greater than double the national average and greater than 5 fold the standards will have to. The Ministry of Health and Social Services standards as established in the Policy on Establishing New Health and Social Welfare Facilities or Services requires a clinic for every 20,000 people in the northern region and a clinic for every 15,000 in the southern and central region.

It is also worthwhile to note that the total number of Health Centres (44) is close to the number of Hospitals (35).

The national average of population per clinic is 7,692. **Oshikoto, Oshana, Otjozondjupa and Khomas** are underserved by clinics. In this instance **Khomas'** clinics service nearly five (5) times the national average. The Ministry of Health and Social Services standards as established in the Policy on Establishing New Health and Social Welfare Facilities or Services requires a clinic for every 8,000 people in the northern region and a clinic for every 5,000 in the southern and central region.

**Population and Density Correlation**

It is estimated that about 80% of the population lives within 10 km distance from public health facilities. However, if a cut-off distance of 5 km were used, then the population living within this distance from a health facility would only be 40%.

However, with a population density of only 2 persons per square kilometre, diseconomies of scale and size are likely to be widespread, thus inflating the costs of running a health facility. In turn, this scale of inefficiency is likely to constrain the amount of resources available for making the facilities accessible or well maintained. This problem has necessitated the establishment of outreach services/mobile clinics.<sup>42</sup>

The Hospital Efficiency Report has identified inequities in hospital recurrent expenditures, the hospital with the highest allocation (Onandjokwe) receiving ten times more than that of Karasburg hospital, which receives the least.

Moreover, while the ratio of beds to hospitals cannot be disaggregated from the table above, however, the Hospital efficiency report has shown that the mean number of beds is 130 (SD =

78), with small fluctuations from one year to the other. The range is between 40 and 450 beds for Okahandja and Onandjokwe hospitals respectively.

We can observe from the data that there are great inequities in resource allocation as well as distribution of health facilities. Scale inefficiency is found to be widespread. The predominant form of scale inefficiency is *increasing returns to scale*. To improve efficiency in the presence of increasing returns to scale, it is important to consider merger of hospitals that are in close proximity to one another. Having fewer and bigger hospitals in centrally located areas and scaling down some of the hospitals to lower-level facilities (e.g. health centre) is an option that needs to be explored. This can be associated with the establishment of an efficient referral system.

On the other hand, inefficiency related to large size (decreasing returns to scale) is observed in a few hospitals (namely Onandjokwe and Oshikuku). In such a situation, there is a need to break down such hospitals into a manageable size. For example, Onandjokwe hospital with 450 authorized beds is considerably above the expected size of district hospitals.

### Capital Investment Expenditure.

The total estimated expenditure for the three years under review was N\$ 111 million, N\$ 98 million and N\$ 131 million. This gives an average of N\$ 113 million a year. In the NDP 2 section on Health and Sanitation, the Public Sector Investment Programme (PSIP) expenditure for the period 2001/2-205/6 is estimated at about N\$ 697 million. This implies a yearly requirement of about N\$ 139 million. Thus, there is a substantial resource gap between what is needed and the present capital expenditure. It should be noted that the PSIP in NDP 2 refers only to capital expenditure needs of the MoHSS. Hence, it can be visualized that if the health system as a whole (including the public and private sector) is considered, the resource requirement becomes even greater. Thus, there was a need for allocating higher amounts to capital formation if the targets of NDP 2 were to be realized.

Between 1990 and 2007, a total of 115 new health facilities have been constructed whereas 75 facilities have been renovated or upgraded. The NDP2 goals for construction of new clinics have been achieved. However, according to the NDP 3, the capital expenditures specifically in the renovations of clinics and health centres are below the target established in NDP2.

**Table 19:** Health facilities constructed, renovated and upgraded 1990-2007

Type of Health Facility	No. of new health facility constructed	No. of health facilities renovated/upgraded	Total
Hospitals	3	27	30
Health centres	5	18	23
Clinics	107	30	137
<b>Total</b>	<b>115</b>	<b>75</b>	<b>190</b>

The NDP3 report has identified some critical needs shortages including:

1. Adolescent Mental health unit in Oshakati Hospital.
2. Mental health unit in Rundu Hospital.
3. Orthopaedic laboratory at Oshakati Hospital.
4. The national referral forensic Psychiatric unit at Windhoek Central Hospital has limited capacity to cater for the entire nation.

5. Insufficient capacity of the national referral eye care unit at Windhoek Central Hospital.

Similarly, there are no appropriate structures or furniture for:

1. Public eye care units at all secondary hospitals.
2. CBR at clinic and health centre/community level
3. Rehabilitation units at the Physiotherapy, occupational therapy and Medical Rehabilitation workers at all district hospitals.
4. ENT services at tertiary hospitals.
5. Shortage of official accommodation facilities at hospital level e.g. family houses, nurses homes and doctors quarters.
6. Insufficient lecture rooms, furniture and required training audiovisual equipment at the national and regional health training centres.<sup>43</sup>

The ministry plans to build a total of 79 new health facilities between 2008 and 2012 as part of NDP3 capital projects targets. At the same time, the ministry will renovate or upgrade 3 health-training centres, 3 mortuaries and 3 regional management offices.

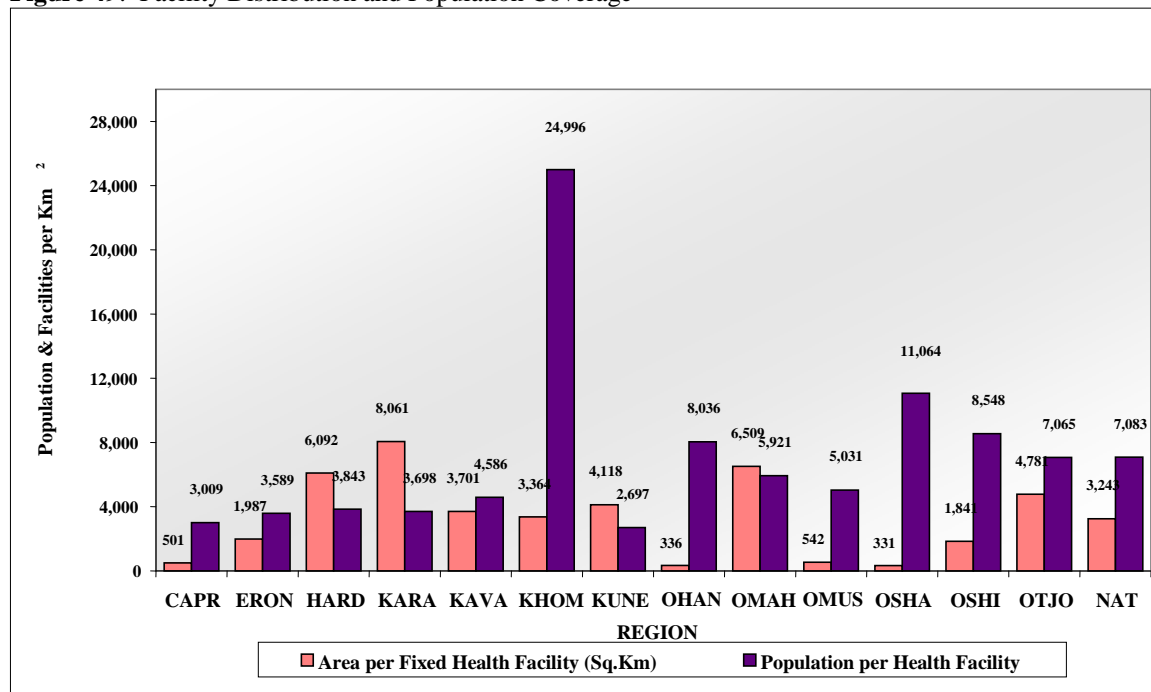
**Table 20:** NDP3 targets for capital projects 2008-2012

Type of Health Facility	No. of new health facility to be constructed	No. of health facilities to be renovated/upgraded	Total
Hospitals	1	18	19
Health centres	1	8	9
Clinics	18	33	51
<b>Total</b>	<b>20</b>	<b>59</b>	<b>79</b>

The survey noted some significant successes in respect of increasing the stock of health infrastructure in the country in the past years. Specifically, the MOHSS completed the construction of 107 clinics, 5 health centres and 3 hospitals between 1990-2007, while 27 hospitals, 18 health centres and 30 clinics were renovated during the same period. The MOHSS has also recently purchased 24 new ambulances to strengthen the outreach services.

Government has made appreciable progress in the establishment of health facilities over the country resulting in a decrease in the population per health facility as seen in the figure below.

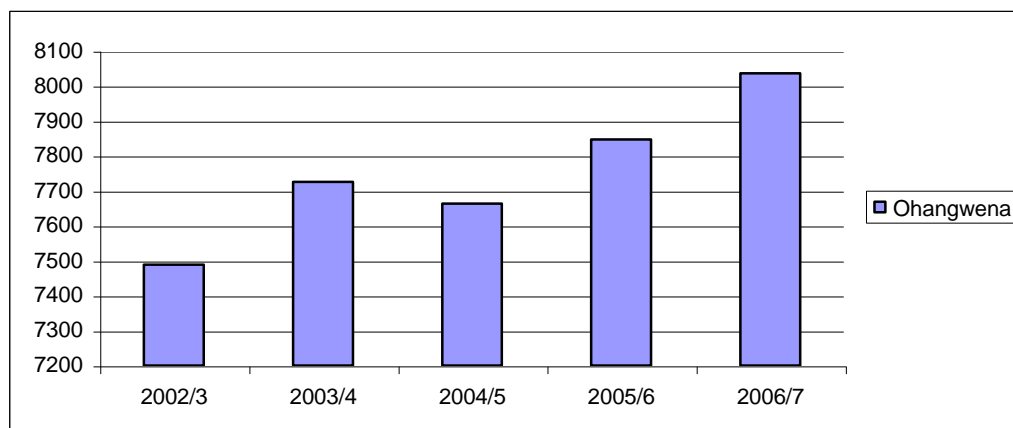
Figure 49: Facility Distribution and Population Coverage



Nationally, there are about 7,000 persons to each health facility in the country, with the highest ratio in Khomas region with 24,000 persons to one facility and the lowest in Kunene with 2,700 persons to one health facility.

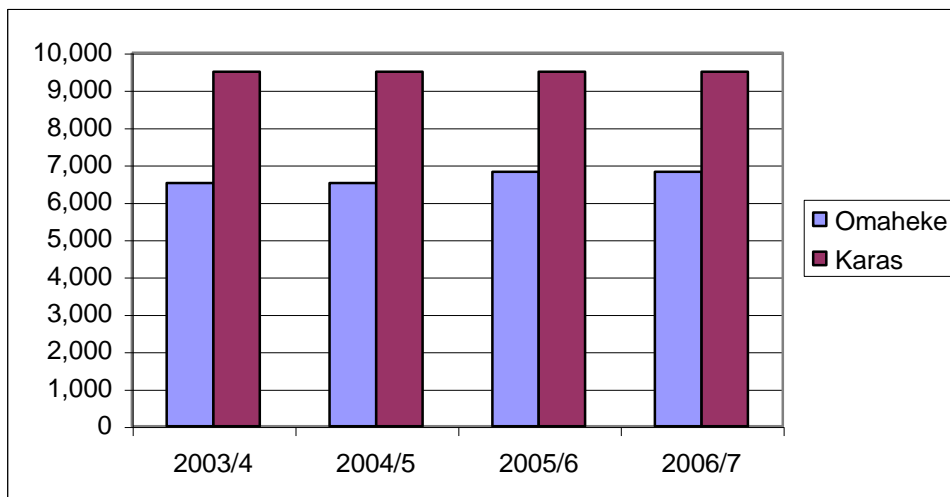
The survey noted that with the high level of awareness of health among the population, there is a strong demand for more health facilities to be located near the population. The exit interviews and focus group discussions clearly showed that many potential users of health facilities are not happy over the long distances they have to cover. The figure above shows that there is one facility within 3,250 sq km in the country.

Figure 50: Trends of population per health facility for Ohangwena Region



The survey noted some significant successes in respect of increasing the stock of health infrastructure in the country in the past years, resulting in a decrease in the population per health facility. However, regions population per fixed health facilities has remained high in Khomas and Ohangwena due to in-migration and high population growth rate respectively.

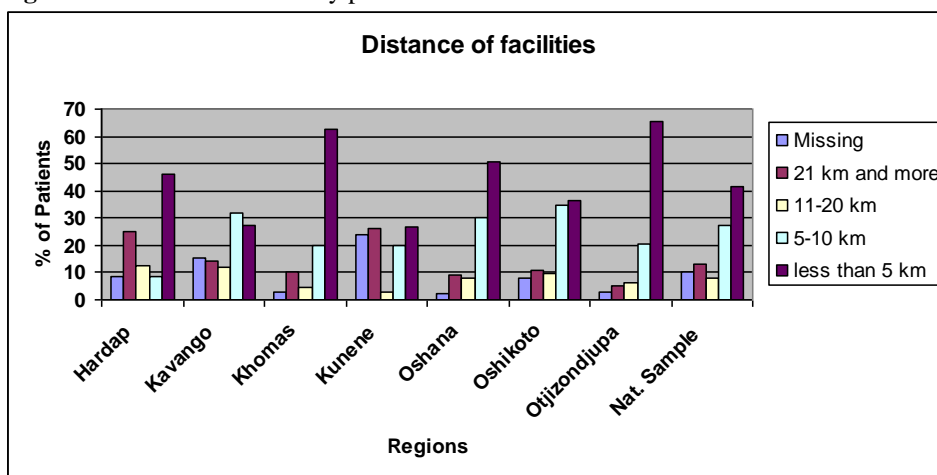
Figure 51: Trends of Area per fixed health facility for Omaheke and Karas Regions



Area per fixed facilities has changed tremendously in some regions but has changed little in the regions in such as Omaheke and Karas. In some regions, people are travelling for more than 300km to get to the closest hospital. The review noted that the current criteria for establishment of new facilities put more emphasis on population and less on distance.

The implication is that visits to health facilities are delayed until the conditions become more severe, with attendant difficulties in their management. Significant differences exist for accessibility of the population to health facilities in the country, with the proportion of the population living more than 5 km from facilities larger in the northern regions than in the south.

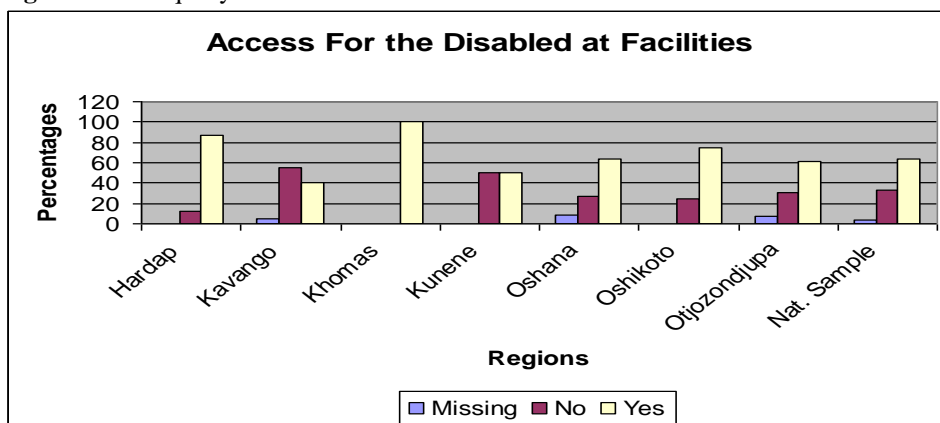
Figure 52: Distance covered by patients to reach health facilities



From the figure above, it can be seen that among the sampled regions, only Khomas, Oshana and Otjizondjupa regions have 50% or more of their population living less than 5 km from the facilities. The sampled average is 40%. Corroborating the demand side arguments, the key informants interviewed stated that the criteria for the establishment of health facilities do not meet the current needs and demand for rendering comprehensive quality health care services.

Only about 60% of the sampled facilities had adequate access for the disabled clients, with Kunene region with the highest proportion of facilities with this deficiency. Many facilities were found to be not user friendly in terms of adequate spaces and working areas for all programmes. The demand for service delivery for HIV/AIDS patients for example has stretched the capacity of existing facilities. It was also found that in some facilities, the partitioning of the physical space for infection control was not adequate. In some other facilities, the problem was one of inappropriate utilization of available spaces, e.g. seclusion rooms for psychiatric patients used as storerooms.

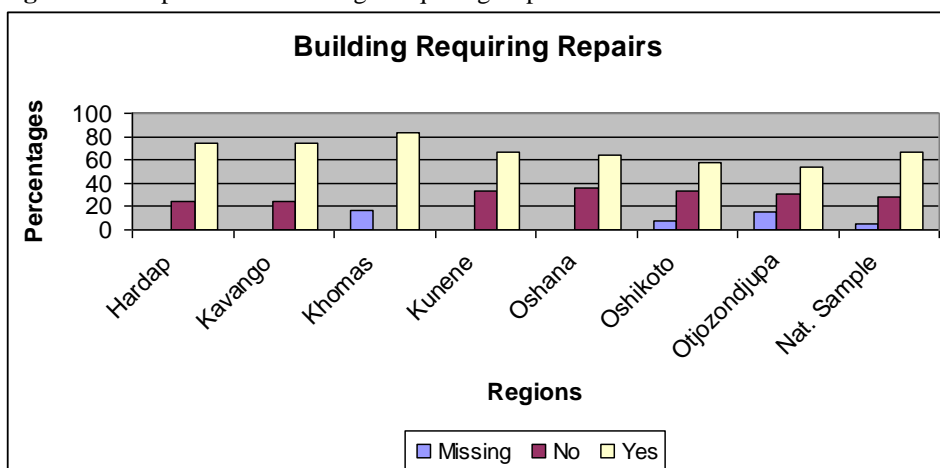
Figure 53: Adequacy of Access for Disabled Clients at Facilities



Several health facilities were found to lack some essential facilities, e.g. incinerators, mortuaries, ablution facilities, isolation/seclusion rooms/wards for TB and Psychiatric patients, kitchens, laundries, standby-generators, ART clinics, resting-rooms for staff members, proper facilities for people with disabilities, etc.

The survey revealed that most health facilities owned and operated by the MOHSS often are poorly maintained. The figure below shows that about 60% of the buildings in the sampled facilities require repairs. The key informants interviewed attributed this to a number of factors, including inadequate funding, failure of material and finishes and poor supervision, unclear lines of responsibilities between the MOHSS and the MOWTC, the highly centralized intra ministerial process to obtain authorization and lack of adequate competences to perform equipment maintenance

Figure 54: Proportion of Buildings Requiring Repairs in Health Facilities



The survey noted that there were extreme delays in the implementation of major/minor capital projects due to lack of supervision and monitoring, related to inadequate level of capital financing for the MOHSS as well as lack of specialized staff.

Finally, it was noted that several health facilities lacked proper complementary infrastructure in terms of roads, telecommunication, internet facilities, clean water and electricity.

## **6.2 Major Constraints**

The most significant constraint within the infrastructure component is the lack of professional staff and maintenance staff within the facilities and maintenance areas. There are no architects, clerk of works, quantity surveys or even accountants. The facilities planning department is run by a very small staff and a clerk who manages an annual budget of over N\$ 200 million. Because of the lack of technical staff, the projects are managed wholly by the Department of Works and at their schedule and often duplicating activities within the construction process. The MOHSS does not have the staff to vet architectural/construction drawings, nor does it have the staff to monitor ongoing work, or the completed facility. The lack of an empowered institution that can properly plan, manage and maintain facilities is the primary weakness in the infrastructure sector. This deficiency affects all other sectors of health delivery. For instance, the lack of ventilation affects the morale of staff. The lack of properly planned facility forces many facilities to use the outside as the waiting room.

Another constraint identified by the survey in infrastructure is the inadequacy of the existing criteria for the establishment of health facilities. While some facilities are over-subscribed, some others only see a handful of patients daily. Most key informants also identified the lack of involvement of users in planning process, designing, and construction project as impacting negatively on service delivery in the country.

The survey noted that the heavy bureaucracy and multiple centres of decision-making unnecessarily constrain the quick completion of construction projects as well as delays in carrying out routine maintenance.

Shortage and frequent breakdown of equipment/machines as well as the absence of suitably qualified professional staff in the MOHSS and health facilities was identified as a major constraint.

The low priority given to capital projects as reflected in the budget allocation, compounded by the centralization of the budget for construction/maintenance of health facilities were also noted as major constraints.

Finally, the poor construction materials, poor workmanship, unavailability of local materials used for construction and maintenance all combine to put additional strain on the health infrastructure in the country.

## **6.3 Recommendations**

The availability of, design and physical layout of health facilities as well as the presence of essential facilities within them goes a long way in assuring quality service delivery in Namibia. In a country with a vast geographical area with sparsely distributed population like Namibia, the challenge of optimally citing health facilities to meet the needs of the population is daunting. Managing the maintenance of these dispersed health facilities also

poses a critical challenge to the MOHSS, more so that facility maintenance was the responsibility of another line ministry – Ministry of Works, Transport and Communication.

1. Strengthen the Facilities Management Unit (with combined competencies of maintenance and capital planning).
  - a. Create new positions within the Facilities Management Unit with technical staff including architect, engineer, quantity surveyor and accountant.
  - b. In line with Cabinet decision, a building maintenance unit should be established at the National level and a strategy to decentralize this function to the regional and district levels.
2. Review the criteria for establishment of health facilities and subsequently revise the relevant standards and norms policy document for establishment of health facilities
3. Increase the budgetary allocation to capital projects and decentralize the major and minor capital projects with its budget to the regions.
4. Actively involve all stakeholders in planning process, designing, and construction of projects at regional, district and clinic levels.
5. Construction of all new facilities should cater for all essential services and programmes, while attempts should be made to refurbish existing facilities to provide space for the essential services.
6. The criteria for tender procedures must be revisited to prevent poor workmanship and cheap labour.
7. Posts for technical experts, e.g. architects, at the national level to facilitate coordination, should be created.
8. In collaboration with other stakeholders, communication infrastructures (roads, telecommunication, electricity, etc.) should be provided and/or improved upon.

## CHAPTER 7. HEALTH CARE FINANCING AND FINANCIAL PLANNING

### 7.1 Health Care Financing

#### 7.1.1 Sources

As in many countries, the Namibian health care system is comprised of a mix of public and private financing. The public system provides universal coverage and is predominantly funded through general taxation, while the private health care system which provides either comprehensive or partial health care coverage is funded largely through employee and employer contributions.

Namibia's total health expenditure (THE) as a percentage of GDP for 2005 was 6.7%. Over the ten-year period (1996-2005) the expenditure as percentage of GDP has averaged 6.7% with the lowest 6.1% (2002), and the highest 7% (1999 & 2000). In terms of per capita expenditure for the period 1996–2005, the range is N\$ 580 - N\$ 1264. The total health expenditure as a percentage of GDP compares favourably with countries in Southern and Eastern Africa as indicated in table below; however, the per capita total expenditure of Namibia is nearly than half of Botswana or South Africa.

**Table 21:** Selected countries health expenditure indicators for 2004<sup>44</sup>

Country	THE as % of GDP	Per capita total expenditure in USD
Botswana	6.4	329
Kenya	4.1	20
Mozambique	4	12
Namibia	6.8	190
South Africa	8.6	390
Zambia	6.3	30
Zimbabwe	7.5	27

For the period 2000–2005, the health sector was financed by government, private and external resources. The table below shows that over the five-year period, the government was the greatest source of financing. However, the proportion of health financing from both the government and private has been on the decline. Contrastingly, there has been an increase in development partners' contribution from a low of 3.7% in 2000 to the 19.7% in 2005.

**Table 22:** Percentage share of various source of financing<sup>45</sup>

	2000	2001	2002	2003	2004	2005
Government	66.4	64.5	61.3	61.2	59.1	54.7
Private	29.9	30.4	30.4	27.6	26.5	25.6
Development partners	3.7	5.1	8.4	11.2	14.4	19.7

It is to be noted that the proportion of private expenditures consists private households' out of pocket payment and pre-paid risk pooling plans.

The overall increase in absolute terms of the contributions from the various financing sources is depicted in the table below.

**Table 23:** Financing agent magnitude increase<sup>46</sup>

Financing Agent	2001/02	2006/07	Increase
Government	1,055,730,913	1,641,597,829	1.55
Public Insurance	321,127,930	614,222,886	1.91
Private Insurance	373,967,669	842,723,230	2.25
Out-of-Pocket	57,491,032	126,080,880	2.19
Companies	16,693,706	29,545,265	1.77
Donors	28,943,658	635,670,045	21.96
<b>Total</b>	<b>1,853,954,908</b>	<b>3,889,840,136</b>	<b>2.10</b>

The magnitude of increase for the financing agents by the financial year 2006/07 increased twofold from base of financial year 2001/02. Within individual financing agent a significant increase is observed with the development partners who have increased 22 fold.

It is to be indicated that the MoHSS provides public health care for 85% of the Namibian population who are the poor and low-income earners, while the private health care provides for the remaining 15% who are the middle and high-income earners. From the above table resources used by the private sector is almost half of that of government. This illustrates inequities in resources in terms of populations served.

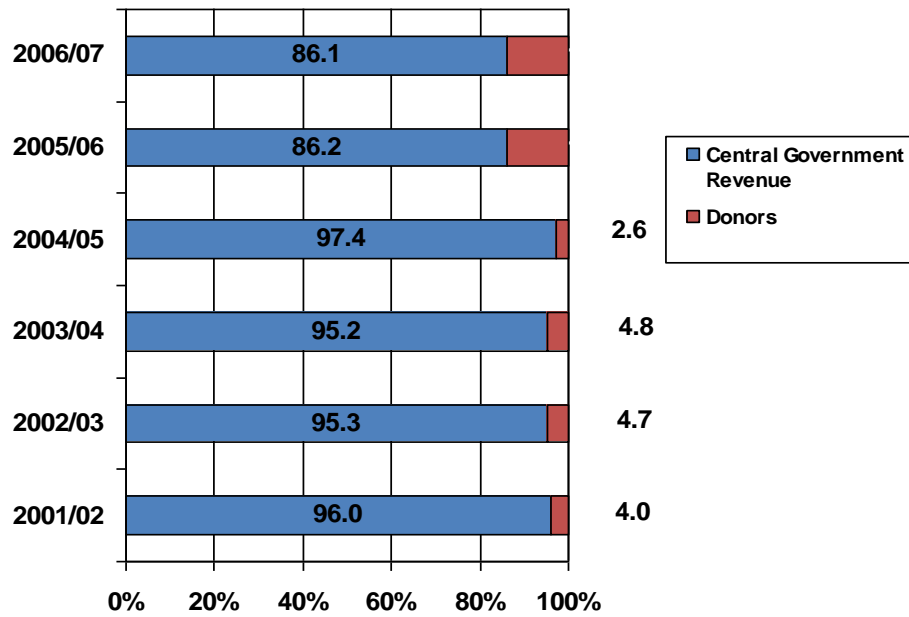
Government's expenditure on health has over the period exceeded the 10% of the annual government expenditures; however, it falls short of the 15% target as set by the Abuja Declaration. In comparison to other countries in the regions, Namibia surpasses all.

**Table 24:** Selected countries government expenditure on health as percentage general government expenditures<sup>47</sup>

Country	2000	2001	2002	2003	2004
Botswana	7.7	10.2	6.4	7.5	10.5
Kenya	11.4	8.1	9.2	7.3	8.2
Mozambique	12.9	10.7	11.5	10.9	9.1
Namibia	12.3	11.1	11.1	12.6	13.5
South Africa	10.9	11.2	11.6	10.7	10.8
Zambia	9.4	9.6	12.5	11.9	12.8
Zimbabwe	7.4	9.2	9.8	8.9	8.9

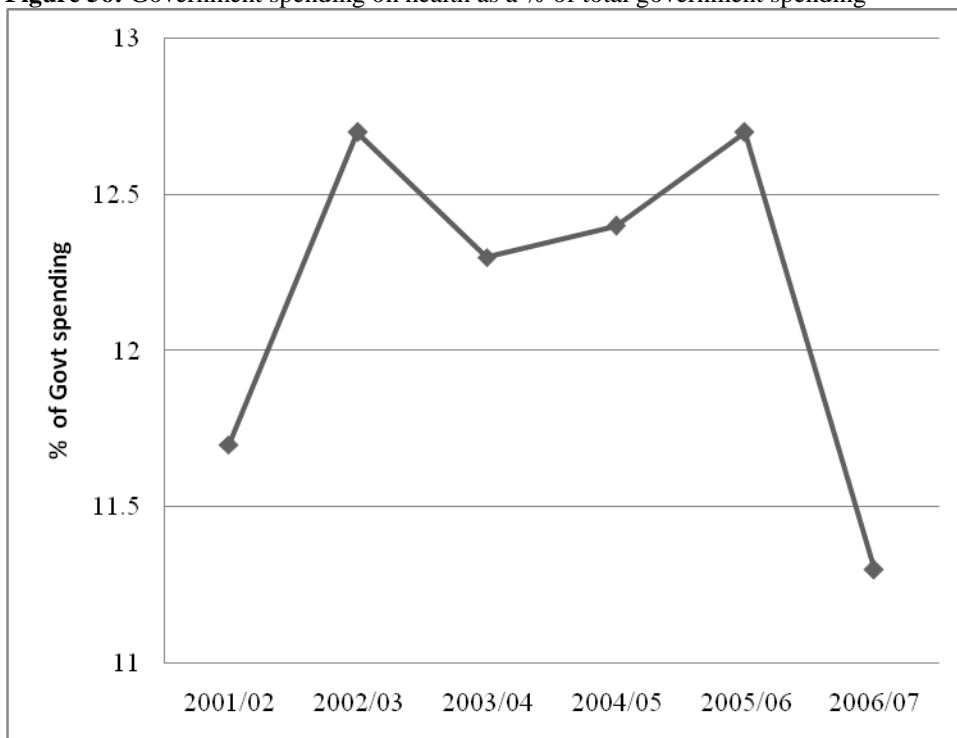
The budget for the MoHSS as the provider of public health services is established within the annual government budget. The ministerial budget is set within the realms of the Medium-Term Expenditure Framework. The budget allocation from treasury does not include development partners' contributions as these are channelled outside the state revenue fund. The figure below indicates that the MoHSS receives its funding from central government revenues and donors. The contribution from donors was 4% in financial year 2001/02 however; there has been a significant increase of funding in financial year 2005/06 and 2006/07.

Figure 55: Trends in MoHSS financing<sup>48</sup>



From the figure below, it is evident that the government spending on health as a percentage of general government spending has fluctuated over a seven-year period.

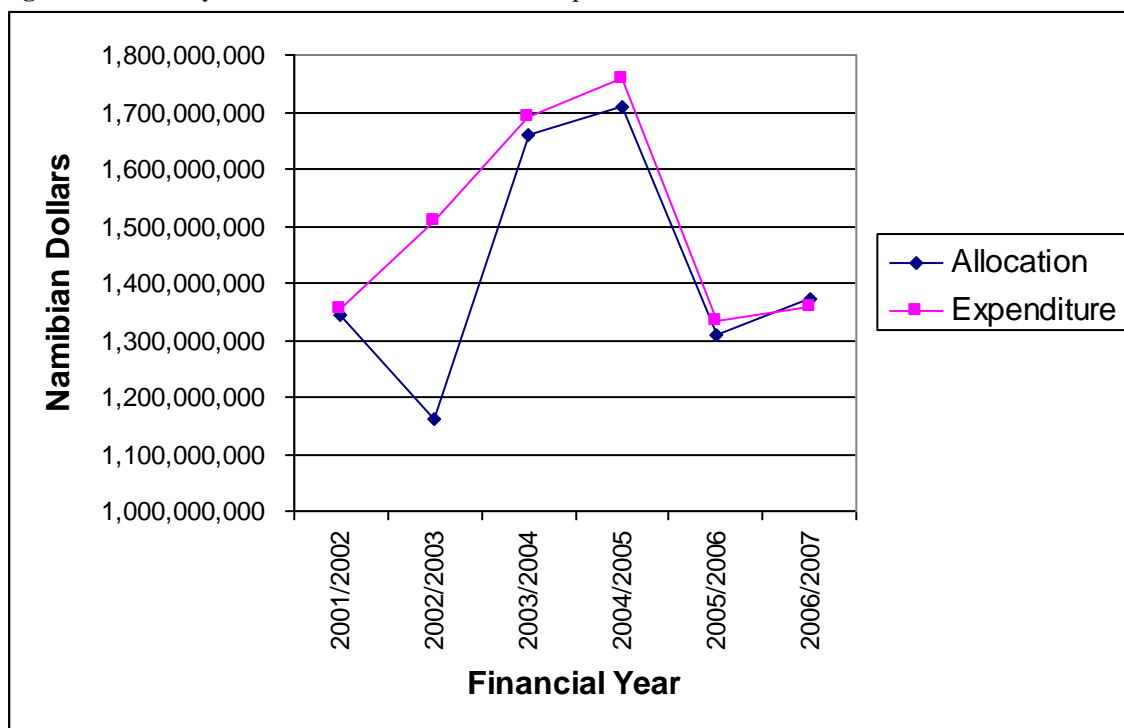
Figure 56: Government spending on health as a % of total government spending<sup>49</sup>



The spending, as illustrated in the figure above, has averaged at 12.2% over the six-year period. This is a shortfall of the Abuja Declaration, which states that Governments in Africa should spend 15% of their funds on health by the year 2015.

The actual expenditure has been greater than the allocation as depicted in the figure below. The Parliamentary Public Accounts Committee has over the years summoned the accounting officer to explain the anomalies and to provide strategies in order to improve expenditure management. This discrepancy between allocations vs. actual expenditure might be indicative of either insufficient budget allocation to the health sector or inefficiency in the utilization of the allocated amounts. It is therefore imperative that the health managers do more with the available resources by improving efficiency within programmes and services, including innovation.

Figure 57: Ministry of Health allocation vs. actual expenditure 2001/02–2006/07



### 7.2 Intra-Sectoral Allocation

The table below indicates that the Ministry’s actual expenditure for a period of 6 years has been increasing in absolute terms. However, the average percentage change in expenditure for the period 2001/2002–2006/07 is 0.01. This therefore indicates that there has not been a significant increase in MoHSS expenditures year-on-year in the provision of services, despite the introduction of new health services.

**Table 25:** MoHSS expenditure (N\$) and by categories (%)<sup>50</sup>

Category	Financial Years					
	2001/2002	2002/2003	2003/2004	2004/2005	2005/2006	2006/2007
MoHSS expenditure	1,354,131,443	1,508,439,638	1,689,704,327	1,759,018,716	1,334,858,637	1,358,296,632
Personnel	38.7	40.5	39.4	39.9	56.2	56.9
Goods and others services	24.7	23.9	22.5	21.3	26.2	24.6
Subsidies	30.7	29.2	31.7	33.6	10.8	11.2
Assets	0.9	0.8	1.4	1.3	0.7	1.3
Capital formation	5.0	5.6	5.0	3.9	6.1	6.0

As illustrated in table above, personnel emoluments take up the greatest share of the Ministerial expenditures, rising from 39% in 2001/2002 up to 57% in 2006/2007. Goods and other services consume about a quarter, subsidies in the form of grants about a tenth, while assets and capital formation amounts to about 6% of the total expenditures of the ministry. The high personnel share is not unexpected as health care delivery is largely human resource driven. It is to be noted that percentage expenditure on personnel emoluments for the financial years 2005/06 and 2006/07 is more than half of actual expenditure and has increased by more than 10% in comparison to the previous years.

In terms of the intra-sectoral allocation among the service areas, the table below indicates that during the period 2001/2002–2006/07, community health services (district hospitals, health centres, clinics and outreach points) took more than 40% of actual expenditure, while specialized health services (referral and national referral hospitals) took approximately a third of all expenditures. The percentage on primary health care category seems to be low. This is due to the fact that the bulk of the PHC activities are performed within the community health services category and the available financial systems limits further analysis.

**Table 26:** Expenditure by category

Category	Financial Years					
	2001/2002	2002/2003	2003/2004	2004/2005	2005/2006	2006/2007
Specialized health services	27.6	27.8	27.5	27.0	36.3	34.4
Community health services	40.1	42.2	40.4	39.4	54.1	54.8
Primary Health Care	1.1	1.1	1.2	1.3	1.8	1.9
Social Welfare	26.7	24.0	25.9	27.3	1.1	0.8

## 7.2.1 Financial Planning

### Planning and budgeting

The budgeting process in the ministry involves all levels at national, regional and district, to ensure that the budget allocations match priorities at the specific levels. The overall budgeting for the Ministry is a dual responsibility of the Directorates Policy, Planning and Human Resource Development (PP&HRD) and Finance and Logistics, whereby PP&HRD prepares Medium Term Plans whereas Finance and Logistics prepares the line item budget.

On an annual basis, the Ministry convenes planning meetings where all FDC holders present their activities of the year as well as for the upcoming financial year. However, costing of the activities planned is not included as the financial management meeting is convened after the planning meeting. Although annual Financial Management Meeting was introduced, it seems they do not provide the necessary results that were anticipated. The Ministerial annual

planning meeting is preceded by planning meeting of all FDC holders. For example, a regional directorate will have its planning meeting with the districts it has administrative authority over to determine the course of action for the year. FDC holders provide their budgets for the upcoming year to the Directorate of Finance and logistics which aligns the budget according to the Medium Term Expenditure Framework (MTEF) allocation.

The Ministry of Finance started with a budget reform process whereby a program budget approach was introduced. The MTEF was then introduced during the 2004/2005 financial year. The purpose of this reform was to do away with the line item budget and starts with a program budget whereby Ministry's objectives and targets (goals) with estimate outcomes are determined beforehand.

In the MTEF, the ministerial programmes are as follows:

- a. **Tertiary health Care:** Budgets of the four referral hospitals plus a certain percentages of the budgets of the Office of the Minister, HRM and GS, Primary Health Care, Tertiary Health Care Services, Planning and HRD, and Finance and Logistics.
- b. **Regional and District Health Services:** Budgets of the 13 regional directorates plus a certain percentages of the budgets of the Office of the Minister, HRM and GS, Primary Health Care, Tertiary Health Care Services, Planning and HRD, and Finance and Logistics.
- c. **Disease Control & Special Programs:** Budget of the Directorate Special Program and plus a certain percentages of the budgets of the Office of the Minister, HRM and GS, Primary Health Care, Tertiary Health Care Services, Planning and HRD, and Finance and Logistics.
- d. **Social Protection:** Budget of the Directorate Social Welfare Services and plus a certain percentages of the budgets of the Office of the Minister, HRM and GS, Primary Health Care, Tertiary Health Care Services, Planning and HRD, and Finance and Logistics.

The programmes in the MTEF are therefore a clustering of Main divisions of the old line item budget with a percentage included of National Directorates budgets calculated based on staffing. This type of budgeting does not constitute a correct form of the programme budgeting.

### **Budget control**

The ministerial allocations are managed by Funds Distribution Certificate holders (FDC) depicted in table below. Overall, 23 FDC holders manage and control the finances of directorates, referral and national hospitals and in some cases handle revenue collection. The bulk of the resources are allocated to Windhoek Central Hospital, Katutura Hospital and Oshakati Hospitals which serve as referral hospitals as well as the provision of specialist services and teaching hospital. With regard to regional FDC holders, Omusati has received substantial funding, while Khomas has received the lowest. The allocation to the various FDC holders in the table below are operational expenditure and hence do not take into account the capital projects.

**Table 27:** Expenditure by Funds Distribution Certificate holders in N\$

Region	2001/2002	2002/2003	2003/2004	2004/2005	2005/2006	2006/2007
Caprivi	32,153,841	30,500,485	34,982,690	34,293,537	33,432,047	35,362,172
Erongo	41,381,477	47,406,483	57,756,395	58,937,730	53,053,162	59,186,761
Hardap	38,483,031	39,114,312	44,614,454	43,357,679	41,709,279	43,702,096
Karas	42,680,166	49,467,281	52,049,816	53,578,606	55,683,575	50,581,498
Kavango	45,279,903	68,364,453	70,265,810	68,554,678	68,260,499	68,081,635
Khomas	26,089,904	29,262,447	28,520,174	31,079,757	30,808,306	28,536,609
Kunene	25,740,045	32,695,486	33,964,613	34,673,869	28,399,326	39,186,187
Ohangwena	43,605,330	54,595,479	55,730,161	57,689,884	67,246,672	67,819,762
Omaheke	17,631,565	21,458,466	22,296,310	22,732,567	23,245,458	23,190,643
Omusati	62,676,919	64,104,624	67,721,088	74,054,233	86,580,815	90,409,550
Oshana	14,281,031	14,987,758	18,620,013	19,718,129	23,243,283	24,497,508
Oshikoto	62,827,881	78,016,806	84,984,919	88,099,713	97,646,093	86,602,604
Otjozondjupa	46,857,331	53,348,930	61,629,888	63,750,271	63,258,624	69,335,380
Rundu Hospital	29,569,463	33,422,332	37,987,952	40,105,227	45,096,274	41,233,033
Katutura Hospital	104,991,198	121,456,620	139,123,874	137,118,925	146,999,248	145,126,567
Oshakati Hospital	90,697,657	104,067,371	99,313,713	116,716,421	117,342,906	117,536,867
Windhoek Hospital	133,128,643	138,821,146	163,706,105	166,945,824	152,936,413	148,714,013
Office of the Minister	2,644,934	2,623,881	2,673,050	2,200,278	2,670,900	2,453,796
HRM & GS	39,524,175	44,481,378	49,266,143	35,917,621	43,054,159	48,369,379
PHC	15,559,357	17,324,464	20,539,807	18,743,670	19,326,746	20,191,075
Social Welfare Services	358,961,001	361,436,865	436,891,407	480,624,462	10,177,559	10,918,822
THCCSS	3,411,947	4,665,884	6,136,100	10,177,446	14,977,226	22,015,360
Planning & HRD	5,938,164	8,401,912	11,690,360	11,192,543	12,072,488	13,654,313
Finance & Logistics	2,668,627	4,036,165	4,848,175	16,142,203	12,525,483	15,290,574
Special Program	-	-	-	3,690,348	3,918,000	4,647,987
<b>Total</b>	<b>1,286,783,588</b>	<b>1,424,061,026</b>	<b>1,605,313,015</b>	<b>1,690,095,621</b>	<b>1,253,664,540</b>	<b>1,276,644,188</b>

The directorates, referral and national hospitals are responsible for the payment of goods and services to suppliers. The regional directorates as a link between national and district level administrate the budgets for the respective districts in their region. Hence, although a district is allocated a budget, the control is with the regional directorate.

In order to control funds the Ministry of Finance developed an Integrated Financial Management System that is Windhoek based and at the Head quarters of the Ministry. In budget control, funds are released on a monthly basis with Treasury Authorization Warrants by the MOF. FDC holders request funds through the budget forward plans. However, these plans sometimes do not correlate with the activities or statutory payments of the FDC holders and creates a delay in the payment process of suppliers and services are ultimately cut/stopped. This can be because of lack of understanding the business process or a lack of commitment from all stakeholders. It has been found that funds are not released on time also. The Accounting Officer has delegated some of the responsibilities to cost centre

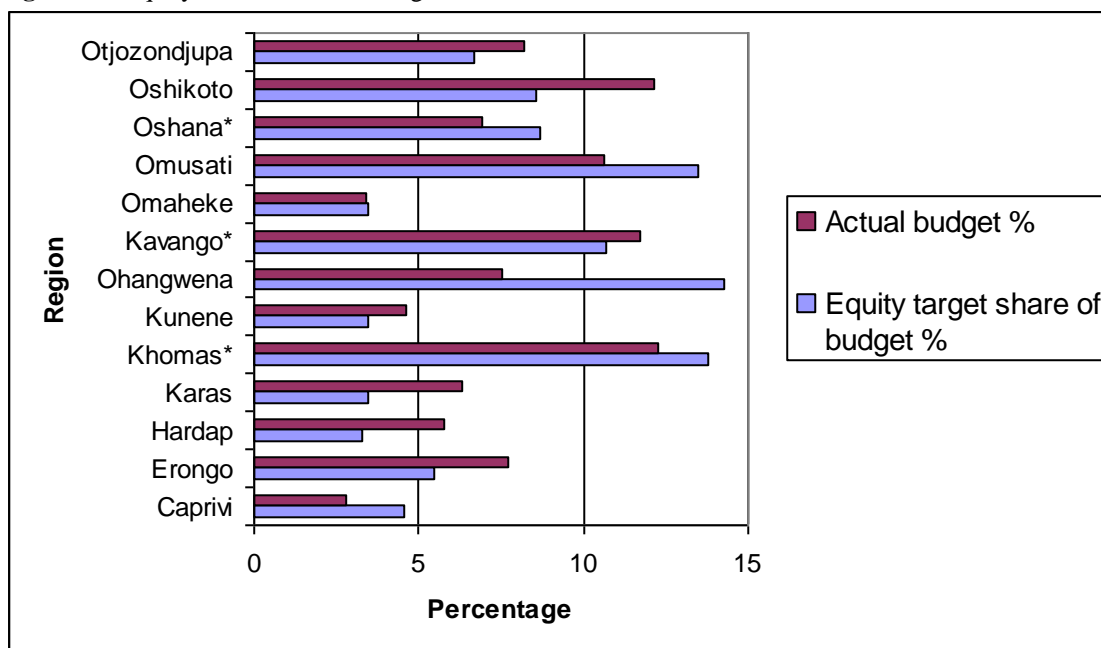
holders but it happens that sometimes these FDC holders are not meeting on regular basis and commitment registers are not up to date.

The payments of suppliers of goods and services are done through the Integrated Financial Management System (IFMS). The introduction of the IFMS at national level had created problems which were not anticipated. The method of payment is cumbersome in particular to the regional directorates as there is a need to travel to Windhoek on a monthly basis for payment of supplier. This has impacted negatively on the prompt payment of supplier. Furthermore, there is inadequate staff in the procurement section to handle all requisitions of the Ministry and the lack of access to computers leads to some directorates opting for handwritten orders which in cases lead to non-availability of funds when the invoices are due for payment. Expenses such as Government Garage and Governments Stores are not directly committed on the IFMS.

**Budget allocations**

In terms of financial allocation to the various levels, the Directorate of Finance and Logistics allocates a budget to each regional management team and referral hospitals for the provision of health care to a geographically defined population as well as to the national level directorates. The criteria for allocation have over the past years been on a historical basis and does not take into account in particular the needs of regions so as to ensure equitable allocation. Such an allocation exacerbates inequities as evidence indicates that regions with the highest Human Development Index (HDI) receive a relatively greater allocation from the MoHSS, regions with a higher per capita income have higher allocation, and regions with higher levels of stunting receive lower allocation and regions with the lowest deprivation indices receiving less. For example, the figure below illustrates those regions that are more deprived such as Ohangwena the actual expenditure is less than the equitable allocation. Furthermore, there are no clear criteria for intra – regional allocation.

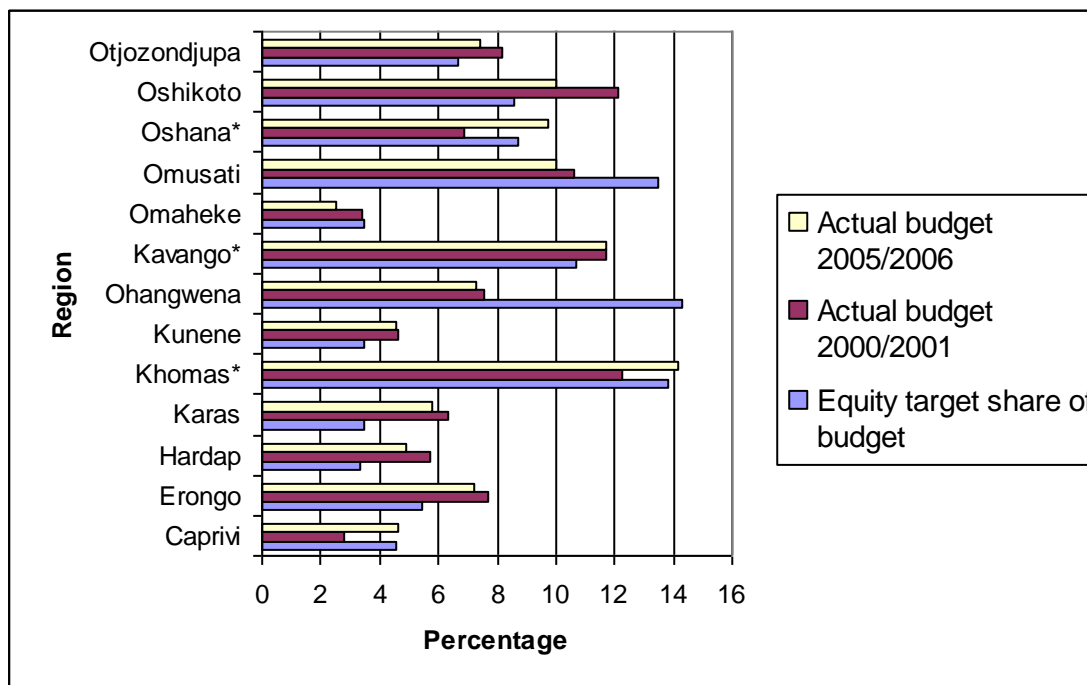
**Figure 58:** Equity share vs. actual budget for 2000/2001<sup>51</sup>



Since 2001, the MoHSS has been considering the implementation of needs – based resource allocation formula and to this effect research has been conducted as to shed light on the

mechanism of health resource allocation in the public sector with a view to developing an equitable funding system. There has been commitment in implementing the formula such as the establishment of a task team to manage the implementation process, this team has not yet been established and the formula has not been implemented to date due to unfilled senior management posts in sections of the Ministry critical to the resource allocation process and the necessary technical skills. Although this is the case, recent research indicates that some progress have been made towards equitable resource allocation. The figure below illustrates that Caprivi is receiving its equity share of the budget, while for Erongo, Hardap and Karas there has been a decline towards the equity share of the budget.

Figure 59: Resource allocation trends <sup>52</sup>



Although there has been a reversal in trends much more needs to be done in developing indices for use in resource allocation.

Development partner have made significant financial contribution in the Namibian health sector. As indicated earlier their share of contribution has increased from 3% (2001) to 23% (2006). These funds are directed toward activities of programmes in the Ministry, non – governmental organization (NGO) and civic organizations. Preliminary analysis from the National Health Accounts 2007 however, reveals that 73% of all donor funds are managed by donors and NGOs.

### 7.3 Revenue

The Ministry is required to contribute to state revenue albeit at a relatively low level given the fact that its services fall within the realm of the wider social sector. The introduction of user fees is to enhance efficiency by providing a signal to patients/clients to enter the health services at lower level facilities and hence contribute to the decongestion of more expensive higher-level services. Furthermore, the user fees were designed to improve the patient understanding that he/she needs to value the services received and thereby contribute to better compliance, cooperation and quality assurance.

There are various classifications of fees which are paid at health facilities and the trends of income realized from them are illustrated in table below.

**Table 28:** Classification of revenue and trends of income

	2001/2002	2002/2003	2003/2004	2004/2005	2005/2006	2006/2007
Health services	12,598,388	19,263,839	27,349,864	23,225,426	28,206,744	28,289,581
Board & Lodging	2,290,475	2,959,336	4,165,246	4,814,080	4,440,674	3,542,077
Fees for meals	4,873,970	49,911	2,365	-	-	-
Contribution orders	1,110	810	-	10,763	-	-
Inspection fees	69,832	172,340	194,121	208,736	234,833	301,522
Mortuary fees	122,609	259,221	288,274	304,907	310,238	268,819
Sale of electricity	2,286	20,209	28,290	31,272	58,262	40,887
Ambulance fees	17,006	34,848	81,129	39,752	32,649	34,305
Private telephone calls		28,368	25,355	32,431	49,369	16,617
Unclaimed cheques	293,209	2,134,084	620,312	469,858	233,413	1,057,256
Miscellaneous	1,781,878	2,039,458	5,384,931	2,137,047	1,093,628	3,622,295
Vehicle sales	71,735	-	-	-	204,518	-
<b>Total</b>	<b>22,122,498</b>	<b>26,962,424</b>	<b>38,139,887</b>	<b>31,274,272</b>	<b>34,864,328</b>	<b>37,173,359</b>

The component of health services contributes the largest share of income about 76% and it includes the payments made by clients for services at all levels. The revenue collected from category of ambulance services although minimal (0.1%) of total revenue impacts on service delivery as those who are unable to pay may not receive the necessary attention required. The fees charged to patients are collected by the health facilities on behalf of the Ministry of Finance and are banked on a daily, weekly and monthly basis to the receiver of revenue account.

The fees vary between clinics, health centres and hospitals and differ between state and private patients. The fee range from N\$ 4 (clinic level) to N\$ 30 (national referral) for state outpatient patients and is inclusive of all services received, while for follow-ups it ranges from N\$ 2 to N\$ 15. The patient classification of state and private patient of Namibians and permanent residence holders is done by the admitting officer. Foreigners are classified as private patients and this has become problematic especially in regions bordering other countries, as people visiting the nearby facilities from neighbouring countries do not have the means of payment for private services.

Exemption for the payment of user fees is provided for certain services i.e. notifiable diseases, preventive and promotive services and for vulnerable groups such as children under five and pregnant women. Furthermore, its government policy not to turn away patients that are unable to pay and waiver mechanisms is in place. However, the implementation is problematic as the mechanisms for waiver are cumbersome and may deter patients in need of care.

It is government policy to set aside some beds in hospitals to cater for private patients. These beds are being used for patients who have the means as well those having medical aid of the Public Service Employee Medical Aid Scheme or private scheme. As user fees should enhance equity private patients are charged fees at cost of service, however, this is problematic due to the non – existence of billing system at hospitals.

**Major Constraints and Challenges**

1. Lack of Accountability of FDC Holders
2. Lack of Commitment registers and Economizing Committees
3. Proper budget system
4. Lack of Technical staff for costing
5. Lack of resource allocation criteria
6. Proper management accounting system
7. Proper system of procurement and payment of suppliers

**7.4 Recommendations**

1. Since the allocations do not meet expenditure, there is a need to allocate more resources taking into account the additional health services (transport & outreach) as well as the achievement of the Abuja target.
2. In order to enhance the decentralization process there is a need to provide greater autonomy in financial expenditure to district level and furthermore to provide cost centres for health centres and clinics to have a greater view of what is being spent on primary health care.
3. The decentralization of the IFMS to regional directorates will ensure efficiency of payments of goods and services as well as reduce cost of subsistence and travelling.
4. Development of a system of procurement and payment of suppliers
5. The annual planning and budgeting meetings of FDC holders are held separately and there is a need to realign the meeting to one, where annual plans are accompanied by budgets. The assessment reveals that there is a considerable amount of donor resources in the health sector. It is therefore imperative to have joint planning meeting with all stakeholders to avoid duplications. As the current budget of FDC holder is by line item, there is a need to move towards a programme budget which is being implemented in the allocation of resources to the health sector.
6. Review of budget preparation responsibility, the Ministry's budget and planning process should be seen as one exercise therefore it would in the best interest of the Ministry that this process should be handled by the Directorate Policy, Planning and HRD.
7. Conduct a costing exercise of programmes.
8. As there has been a commitment towards a resource allocation formula, there is a need to revitalize the resource allocation committee to ensure equitable resource allocation among regions and referral hospitals.
9. User fees are seen as a barrier to access services. There is therefore a need to institutionalise the policy on exemption for those unable to pay and to reduce the bureaucracy in the waiver system. As user fees should enhance equity, private patients at public hospitals should be charged fees at cost of service and there is hence a need to improve the billing system at hospitals. The MOHSS needs to also evaluate other sources of income such as port health and agricultural services.
10. Consider universal coverage (free health services through universal insurance scheme).

## CHAPTER 8. CONCLUSION

The Health and Social Services System Review has been an extensive task successfully undertaken over a three-month period, largely as an internal review. This is the first of a two-phase process aimed at transforming the ministry of Health and Social Services into an effective and progressive public institution.

As has been stated, the objectives of the whole exercise were to: a) Conduct a comprehensive review and analysis of the health and social services system, including the Policy Framework of 1998 and all management systems and structures; b) make a comprehensive review of the Primary Health Care Approach, its implementation, relevance, and impact on improving access to services; c) assess the provision of social services by the Ministry of Health and Social Services; and d) utilise the findings and recommendations of the review to redefine existing management and organizational structures, propose national policy changes and develop a national strategic plan for health and social services.

It is evident from this report that the objectives of phase one of the report have been met. In this report, major findings and recommendations have been made in each section of the report and summarised in the Executive Summary. From these findings, it can be concluded that the sector has made major progress since independence to address the health needs of Namibians, although major challenges remain. According to the results of the Demographic and Health Surveys, there was remarkable progress in key indicators between 1992 and 2000 following the introduction of Primary Health Care Approach soon after independence. However, the 2006 DHS has found a reversal in a number of these key indicators as already highlighted in the report.

In phase two of this exercise, the MOHSS will develop a *Five-Year Strategic Plan* which will address these and other challenges. In addition, the policy framework (including Mission and Vision Statement) will be updated to enable the ministry to respond to the challenges faced. Further, strategies for primary health care and for social development will be updated with active involvement of key stakeholders.

In conclusion, it is evident that the review has re-energised the health sector and that the leadership in the sector is fully committed to reforming the sector.

## ANNEX A – Personnel Involved in the Review

### STEERING COMMITTEE MEMBERS

Mr. K.S.M. Kahuure (Chairperson)	Permanent Secretary (MoHSS)
Dr. N. Forster	Dep. Permanent Secretary (MoHSS)
Mr. P. Ndaitwa	Under-Secretary: MoHSS)
Ms. C. Usiku	Director: PP & HRD (MoHSS)
Mr. T. Mbeeli	Acting DD: PP & HRD (MoHSS)
Ms. B. Katjuongua	Director: DSWS (MoHSS)
Mr. L. Le Roux	Director: (Synergos)
Ms. M. Nghatanga	Director: PHC-Services
Ms. K. Mhoney	Program Manager (Synergos)
Dr. T. Okorosobo	Health Economist (WHO)
Mr. E. Tofoatsi	HIV/AIDS Prog Specialist (UNFPA)
Dr. A. Munyiri	Chief MSCD (UNICEF)
Mr. H.C.R. Beukes	Director: THC & CSS (MoHSS)
Ms. D. Tjipura	Director: THC & CSS (MoHSS)
Dr. P. Gichangi	Senior Advisor: HIV/AIDS (USAID)
Ms. M. Zauana	CHPA: PP & HRD (MoHSS)
Ms. K. Mutirua	HR Advisor: HRD (I-Tech)
Ms. S. Owoses	CHP: DSP (MoHSS)
Ms. S. Hinalulu	SHRM: HRM (MoHSS)
Ms. H. Kaukungua	DD: HRM & GS (MoHSS)
Mr. E. Amundaba	DD: RCS (MoHSS)
Ms. G. Muballe	CCRN: QNCU (MoHSS)
Mr. F.J. Mouton	DD: (OPM)
Mr. K.S. Mbangu	Chief Efficiency Analyst (OPM)

### SECRETARIAT:

Mr. C. Limbo	CHPA: PP & HRD (MoHSS)
Mr. B. Tjivambi	CHPA: PP & HRD (MoHSS)
Mr. L.C. Usurua	HPA: PP & HRD (MoHSS)
Ms. L.K. Kaiyamo	CHPA: PP & HRD (MoHSS)
Ms. T.N. Naukushu	SHPA: PP & HRD (MoHSS)
Ms. J.A. Gawanas	CHPA: PP & HRD (MoHSS)

### TASKFORCE COMMITTEE MEMBERS MEMBERS:

Ms. C. Usiku (Chair)	Director: PP & HRD (MoHSS)
Ms. M. Nghatanga	Director: PHC-Services
Mr. T. Mbeeli	Acting DD: PP & HRD (MoHSS)
Ms. D. Tjipura	Director: THC & CSS (MoHSS)
Ms. K. Mutirua	HR Advisor: HRD (I-Tech)
Ms. B. Katjuongua	Director: DSWS (MoHSS)
Ms. M. Zauana	CHPA: PP & HRD (MoHSS)
Mr. L. Le Roux	Director: (Synergos)
Ms. K. Mhoney	Program Manager (Synergos)
Dr. T. Okorosobo	Health Economist (WHO)

Dr. A. Munyiri  
Dr. E. Njelesani

Chief MSCD (UNICEF)

**SECRETARIAT:**

Mr. C. Limbo  
Mr. B. Tjivambi  
Mr. L.C. Usurua

CHPA: PP & HRD (MoHSS)  
CHPA: PP & HRD (MoHSS)  
HPA: PP & HRD (MoHSS)

**ANNEX B – Data Analysis Workshop Agenda****Health and Social Services System Review - Data Analysis  
Workshop 18<sup>th</sup> - 24<sup>th</sup> May 2008**

MORNING		AFTERNOON	
DATA ANALYSIS	8:00–10:00 AM	DATA ANALYSIS	2:00-3:30 PM
TEA BREAK	10:30-11:00 AM	TEA BREAK	3:30-4:00 PM
DATA ANALYSIS	11:00 AM–1:00 PM	DATA ANALYSIS	4:00-5:00 PM
DATE/TIME	TOPIC	PRESENTERS/CHAIR RPERSONS	COMMENTS
<b>Day 1 Monday, 19 May 2008</b>			
8:00 - 8:30	Registration	Support Staff	
8:30 - 8:45	Welcoming remarks	Ms. C. Usiku	
8:45 - 9:00	Overview and Objectives of Health and Social System Review	Ms. C. Usiku	
9:00 - 10:00	Health and Social System Review- Methodology and Framework	Ms. M. Zauana Dr. Vincent Orinda	
10:00 - 10:30	Tea Break		
10:30 - 11:00	Introduction to the data analysis process	Ms. M. Zauana & Mr. P. Katjujanjo	
11:00 - 13:00	<p><b>Data Analysis: Group Work</b></p> <p>Key informant interviews:</p> <ul style="list-style-type: none"> <li>-national</li> <li><b>Group 1</b></li> <li>-regional and districts</li> <li><b>Group 2</b></li> <li>Health facility check list</li> <li><b>Group 3</b></li> <li>Social Services check list</li> <li><b>Group 4</b></li> <li>Exit interviews</li> <li><b>Group 5</b></li> <li>Focus group discussions</li> <li><b>Group 6</b></li> <li>Hospitals (Health facility check list addendum)</li> <li><b>Group 7</b></li> </ul>		<p>Review field reports from the Review Teams</p> <p>Summarise Key findings in the following areas:</p> <ul style="list-style-type: none"> <li>- Governance, structures, functions</li> <li>- Human resources</li> <li>- Service provision</li> <li>- Infrastructure</li> <li>- Finance/resource allocation</li> </ul> <p>Highlight: regional disparities; health system strengths and weaknesses; constraints and</p>

			bottlenecks Summarise conclusions and recommendations
13:00 - 14:00	Lunch Break		
14:00 - 17:00	Data Analysis Group Work continue		
<b>Day 2 Tuesday, 20 May 2008</b>			
8:00 - 10:00	Data Analysis and Report Writing continues		
10:30 - 11:00	Tea Break		
11:00 - 13:00	Report back –Major findings	Group Leaders	
13:00 - 14:00	Lunch Break		
14:00 - 17:00	Report back –Major findings continues		
<b>Day 3 Wednesday, 21 May 2008</b>			
08:00 -	<p>Review of programs: (goals, targets, progress, weaknesses, constraints etc)</p> <p><b>Group 1</b> PHC/CBHC</p> <p><b>Group 2</b> Reproductive Health</p> <p><b>Group 3</b> Child Health</p> <p><b>Group 4</b> Nutrition</p> <p><b>Group 5</b> HIV/AIDS/TB/Malaria</p> <p><b>Group 6</b> Mental Health</p> <p><b>Group 7</b> Social Services – (Rehabilitation/ disability)</p>		<p><i>Key questions:</i></p> <ul style="list-style-type: none"> <li>- What are the goals, objectives, and targets for each programme area?</li> <li>- What has been achieved/strengths in past five years?</li> <li>- What are the weaknesses?</li> <li>- List challenges, constraints and bottlenecks</li> </ul> <p><i>Additional questions:</i></p> <p><b>Group 1:</b> What are the new strategies, policies or other changes needed to strengthen CBHC?</p> <p><b>Group 2:</b> What are the underlying reasons why infant and under five mortality remain high?</p> <p><b>Group 3:</b> Maternal mortality has increased in recent years. Why is this so? What is the way forward?</p> <p><b>Group 4:</b> Namibia continues to</p>

			<p>have a high malnutrition rates. Why? What are the major constrains/bottlenecks to be addressed and by whom?</p> <p><b>Group 5:</b> HIV/AIDS prevalence has continued to rise over the years. Are the strategies working? What else needs to be done? Comment on coordination with other programmes/sectors/stakeholders.</p> <p>Malaria should also be considered by groups 2 and 3</p> <p>All groups should comment on health promotion activities and community involvement</p>
10:00 - 10:30	Tea Break		
11:00 - 13:00	Review of programs continue:		
13:00 - 14:00	Lunch Break		
14:00 - 17:00	Report Back		
<b>Day 4 Thursday 22 May 08:00 - 13:00</b>			
Tea Break (10:00 – 10:30)	<p>Group Work and Report Writing</p> <p><b>Group 1</b> Governance/ structures and functions</p> <p><b>Group 2</b> Policies -PHC and CBHC -Policy Framework -Decentralization</p> <p><b>Group 3</b> Human resources</p> <p><b>Group 4</b> Service provision</p> <p><b>Group 5</b> Service provision</p> <p><b>Group 6</b> Hospital</p>		<p>Highlight key issues and findings</p> <ul style="list-style-type: none"> <li>- Strengths</li> <li>- Weaknesses</li> <li>- Opportunities</li> <li>- Constraints/bottlenecks</li> </ul> <p>Summarise conclusions</p> <p>Draft recommendations</p>

	management <b>Group 7</b> Infrastructure <b>Group 8</b> Information systems and research <b>Group 9</b> Finance		
<b>13:00 - 14:00</b>	Lunch Break		
<b>14:00 - 17:00</b>	Report Writing Continues		
<b><u>Day 5 Friday, 23 May 2008</u></b>			
<b>08:00 - 10:00</b>	Group presentations on conclusions and recommendations		
<b>10:00 - 10:30</b>	Tea Brea		
<b>10:30 - 13:00</b>	Group presentations on conclusions and recommendations		
<b>13:00 - 14:00</b>	Lunch Break		
<b>14:00 - 17:00</b>	Discussions on Conclusions and recommendations		
<b>17:00</b>	Closing remarks	Ms. C. Usiku	
<b><u>Day 6 24 May 2008 Departure All Participants</u></b>			

## ENDNOTES

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