



NAMIBIA

A paper produced by DFID's Health Systems Resource Centre for the UK Department for International Development

Namibia became an independent country in March 1990 and has since been undergoing a process of restructuring and reorganising its health sector in line with the principles of a new democratic and multi-racial dispensation. UN supervised elections led the country to democratic rule and ushered in the SWAPO Government led by President Sam Nujoma. This government has initiated a number of development plans that are aimed at redressing some of the inequities inherited from previous political and economic systems.



Introduction

Namibia is a relatively large arid country and covers an area of 825,000Km². It is framed between two major deserts, the "Namib" on its western coast and the "Kalahari" occupying its eastern borders. Availability of water is a constant problem.

The last census in 1991 put the population of Namibia at 1,409,920¹ (current est. 1,700,000), with a growth rate of 3.11 per cent. Average population density is 1.7 per square kilometre. Sixty eight per cent of the population were deemed to live in rural areas though the urban growth rate was estimated at 5.5 per cent compared to 2.0 per cent for rural areas².

As a result of its colonial history, Namibia has a very uneven distribution of wealth between the rich and the poor, almost entirely distributed along racial lines.

The economy of Namibia remains intimately linked to that of its powerful neighbour South Africa and depends on mining of diamonds, uranium and other minerals and a commercial agricultural sector, including the Fisheries and Livestock industry. Tourism is an important economic activity.

¹ Excluding Walvis Bay - still South African territory in 1991

² 1991 Population and Housing Census, CSO 1991

Key health indicators

The health indicators for Namibia are relatively good compared to sub-Saharan Africa averages in spite of the fragmented approach to health development before independence. However the skewed availability of services means a sizeable section of the population have much worse indicators than the averages shown.

HIV-AIDS: This has become a major problem in Namibia as with other Southern African countries. In 1994 alone 3328 HIV infections were reported (NDP1) with a survey showing prevalence among ante-natal attendants of 8.4 per-cent. 1996 estimates show a 15.4 per cent rate of infection among the sexually active population. The North Eastern section of the country is the most heavily affected area with estimates as high as 25 per cent. Blood donor sero-prevalence rose from 0.3% in 1991 to 0.9% in 1994. By the beginning of 2000AD a total of some 70,000 persons were diagnosed with HIV of which 14866 had AIDS³. The epidemic is being tackled with a multi-pronged approach involving an inter-sectoral committee. Aggressive TV messages and promotion of condom use are being actively pursued. Several donor assisted projects (EU, GTZ, USAID, French, Swedish, Finnish and UK Governments) are tackling various aspects in different locations.

³ 2nd National Devp. Plan 2: 2001-2006. HIV/AIDS. Oct. 2000.

Figure 1: Key Health Indicators

Indicator:	Value:	
	Data from the World Health Report 1999, WHO (except otherwise stated)	Data from the World Development Report 1999/2000, World Bank
Life expectancy	Male:52, female 53	54, 55
Infant mortality (per 1000 live births)	65	67
Under-five mortality (per 1000 live births)	Male: 125, female: 119	112
Maternal mortality (per100, 000 live births)	370/100000	230
Total fertility rate	4.9	4.8
Contraceptive Prevalence rate	26%(from 1992 DHS)	29
Immunization against measles(%)	86%(from 1999 MOH-HIS)	Not available

More recent surveys show a marked increase in the prevalence of HIV AIDS.

Health problems and diseases of importance in Namibia are mainly due to the usual preventable environment and social factors. The top cause of mortality has now become HIV/AIDS (26%) followed by Pneumonia(11%), tuberculosis(10%) and malaria(6%)⁴.

Health sector financing

The levels of social sector budget spending are relatively high compared to other Sub-Saharan African states though it is recognised in the health sector that resources need to shift from curative based services to more population based primary care services.

Since independence, the proportion of MOHSS expenditure as percentage of GDP rose from 3.9% (1995/6) to 4.5% (2000/01). Proportion of government expenditure on health however decreased from 15.6%(1995/96) to 14.6% (2000/01).

The costs associated with medical care and worker attrition due to HIV/AIDS could affect the progress made in other areas of health such as immunisation coverage by taking up resources from primary health care.

Private insurance schemes exist for those who can afford it and those in employment. The rest of the population have to rely on the public health services funded from general government revenue. Service is free or at nominal set fees at point of service in the public system and structured according to the level of service⁵. Revenue accumulated is not retained by the MOHSS but paid into a

government account.

Private sector health services are substantial in Namibia especially in the capital and major towns.

Non-Governmental service providers also exist, mainly in the form of various religious mission. These are subsidised by the government and include hospitals, health centres and clinics mainly in rural areas of the north.

Key health policies

Following independence, the health sector undertook many changes to meet with new policy directions and challenges. In 1992 a Primary Health Care Policy⁶ was adopted and national guidelines were launched by the President mandating the MOHSS to make changes for PHC and community based health care⁷. These guidelines were seen as a basis for the decentralization process which empowered regions to identify health needs and plan and execute the services. The PHC Policy emphasises: immunisation against major infectious diseases (Polio, diphtheria, TB, measles, tetanus, and whooping cough), maternal and child health care and family planning promotion of proper nutrition, safe water supply, and basic sanitation and a secure and conducive environment for education and training.

Health sector structure and provision

The National level

Ministry of Health & Social Services.

The Ministry of Health is organised into four main levels: 1) the National Level, 2) four "Regional Directorates" with responsibility for geographical zones, 3) 13 Regions (Regional

⁴ Data from MOHSS HIS(Health Info System).

⁵ This means free health care at the lowest levels and a system of exemptions, where applicable, at higher levels.

⁶ Towards Achieving Health for all Namibians": Ministry of Health and Social Services, 1992

⁷ The Official National PHC/Community Based health Care Guidelines, MOHSS. Feb. 1992.

Health & Social Welfare Management Teams) covering areas coterminous with new administrative Regions run by local governments called Regional Councils, 4) "Districts" (but not recognised political or administrative units) which are managed by District Co-ordinating Committees.

The National Level was recently restructured into 2 Departments (Health Care Services & Social Services, Policy Development & Resource Management) with 5 Directorates of [i] Policy, Planning & Human Resources Development (PPHRD), [ii] Tertiary Care and Clinical Support Services (TCSS), [iii] Primary Health Care (PHC), [iv] The Developmental Social Welfare Services [v] Finance & Resource Management (FRM). These directorates are responsible to two Under-Secretaries (heading a "Department" with 2 and 3 Directorates each), a Deputy Permanent Secretary and a Permanent Secretary who is the Administrative Head of the MOHSS. A division for "Regional Management & Co-ordination" is to be placed in the Office of the Deputy Permanent Secretary.

Regional level: The Regional level may be considered as two levels due to the transition to a more decentralised system. The first level is the "Regional Directorate" (four in all) with responsibility for a number of "Regions" (ranging from 2 to 4 Region per Directorate). The operational levels are the 13 Regions with "Regional Management Teams" which have responsibility for Districts (range 1 - 4 per Region). The Regional Directorates are to be phased out under the decentralization policy with their responsibilities shifting to the new Regional Teams and to a co-ordinating Division at the National Headquarters. The Regional Management Teams reflect the political administrative regional councils set up as part of the decentralization process by the Government and are expected to plan for and implement health services in their areas. The delivery of "Primary Health Care" services are to be vested in the Regional Councils as part of the decentralization Policy. This process is still ongoing and being implemented in phases.

Hospitals Administration: The newly restructured MOHSS proposes a network of four 'State Referral Hospitals' (3 Intermediate and 1 Central) around the country that provide national referral services. The apex of this system is the Windhoek Central Hospitals in Windhoek, which is the main referral hospital in the country. These referral hospitals operate under the national directorate of Tertiary Care and Clinical Support Services.

Health Policy: Health Policy in Namibia has Primary Health Care as its cornerstone and embraces decentralization and a restructuring and rationalisation of health services. This policy was elaborated in a document published in 1995⁸. In 1998 a policy framework⁹ was also published, which redefined the overall goals of the health sector, the roles of the various levels and emphasised issues of equity, accessibility, affordability, community involvement and inter-sectoral collaboration. Various other policy documents have since been developed for specific areas.

A move has been made from the ethnically based health administrations of the previous governance into a unitary national system with increased emphasis on preventive services and equity in resource distribution.

Health Planning: A first National Development Plan (NDP1) was published by the National Planning Commission in October 1995 which also included strategic plans for the health sector. The health sector and indeed 6 regions have produced their own five year "strategic Plans" based on the guidance of the National Development Plan. Regular annual planning takes place as a bottom-up process consisting of plans compiled by units and from Districts, through regional teams to the National level and co-ordinated through National Planning Meetings. The 2nd National Development Plan 2001-2006 is almost completed.

Health Service Management: Health sector reforms in Namibia have focused on righting the wrongs imposed prior to independence, and shifting more responsibility to decentralised levels under a unitary national health system. The MOHSS has been restructuring itself from some 9 Directorates to 5 with the role of developing, implementing and monitoring policy and strategic direction. Decentralization is ongoing and the previous "regional Directorates" overseeing the actual Regions are to be eventually phased out. Significantly, however major functions and decisions remain quite centralised including staff management as well as finances and logistics. Planning and monitoring is well decentralised now. Hospital autonomy is proposed but has not been implemented with the managers requiring to seek approval for relatively small expenditure from the national head quarters.

⁸ Integrated Health Care delivery: The Challenge of Implementation. A Situation Analysis and Practical Implementation Guide. MOHSS GRN. January 1995

⁹ Towards Achieving Health and Social well-being for all Namibians: A Policy Framework

A 5 Year Plan document produced by the PHC Directorate indicates that Namibia is also faced with a number of health related social problems such as Alcoholism, Drugs abuse, Abuse of women and children, and a high level of teenage pregnancies.

DFID involvement in Namibia:

Under the current Memorandum of Understanding, DFID is involved in four main areas of the Namibian health sector.

- Support for malaria control programmes in the endemic regions of the North West and North East involving public education, bed-net and treatment schemes.
- Management strengthening for Ohangwena region with support for locating a VSO Management Advisor in that region to work with the Regional Health Management Team.
- Funding for the Health Management Training Project, which will train 200 hundred health and social service managers in management skills using open learning techniques, and will also strengthen local institutions to continue with the courses and their certification.
- Support for HIV/AIDS projects and community education programmes in the north-west regions including sponsoring an advisor.

Role of other development agencies:

Donor agencies are coordinated through the Policy, Planning and HRD Directorate of the MOHSS in its Sub-Division for Donor Coordination. Currently, there is no move towards a Sector Wide (SWAP) system of donor and government programme coordination.

Current donor involvement is as follows:

Finnish Government has provided substantial financial, material and technical support to various aspects of health services under its Health and Social Sector Support Programme (No.2) started in January 2000. The project has five components covering – i). Strengthening Regional Management Teams, ii). Strengthening the Training System and Network, iii). Strengthening Social Services policies and programmes, iv). Support for Equipment and Logistics system, v). Support for Infrastructure development and maintenance systems.

The **EU** has supported management and planning strengthening and supported pharmaceuticals management and planning systems as well as strengthening health economics and financing systems.

UNICEF supports its traditional areas of child health, safe motherhood, nutrition, and support to children in need, and the HIV/AIDS programmes. UNICEF also focuses its support on 7 pilot districts spread throughout the country.

GTZ supports reproductive health programmes especially with regards to HIV/AIDS targeting the key areas of the North West and East with education and control programmes and strengthening management of the programmes.

USAID supports reproductive health programmes and strengthening of their management.

WHO in Namibia is supporting management development and capacity building through its fellowship programmes, and supports several technical programmes including Malaria, HIV/AIDS, Immunisation and Human Resources policies and planning development.

UNFPA - Supporting population activities and strengthening demographic capacity building and systems in the country

Key documents

- First National Development Plan (NDP1) Vol.1 Govt. of Republic of Namibia. National Planning Commission.
- Namibia: Human Development Report 1997 & 1998. UNDP (with UNAIDS Co-Sponsors)
- MOHSS Towards Achieving Health & Social Well Being for All Namibians. A Policy Framework, July 1998.
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- Memo: Progress report on Restructuring. From Dr. N. Shivute to Permanent Secretary MOHSS. Aug. 1996
- Draft National Development Plan II - 2001/06. Chapter 23: "Health & Sanitation". Oct. 2000.
- Draft National Development Plan II - 2001/06: "HIV/AIDS". Oct. 2000.

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