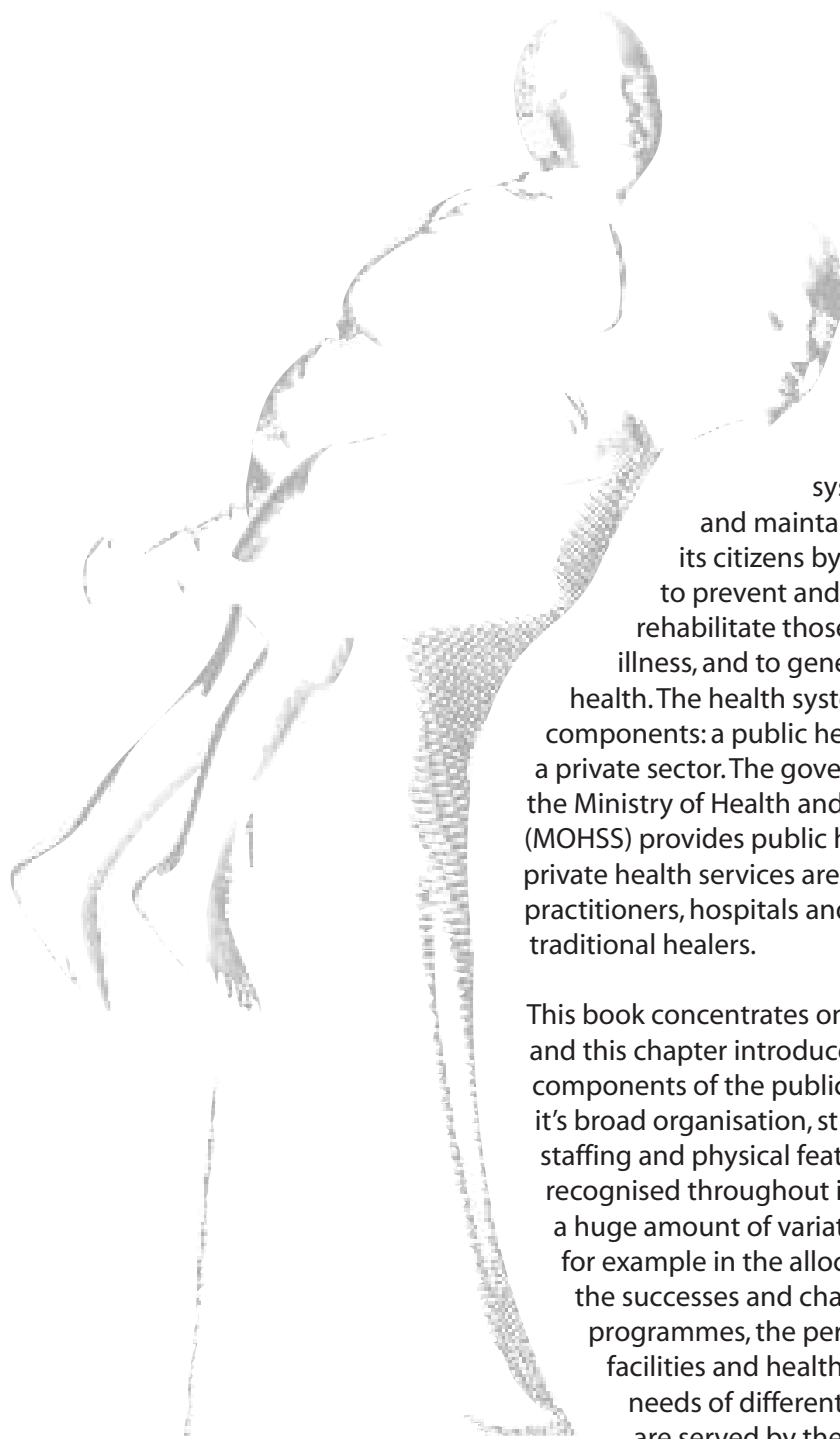


Chapter One



Namibia's health system aims to improve and maintain the well-being of its citizens by providing services to prevent and cure diseases, to rehabilitate those that have suffered illness, and to generally promote good health. The health system has two main components: a public health service and a private sector. The government through the Ministry of Health and Social Services (MOHSS) provides public health services, while private health services are offered by private practitioners, hospitals and clinics and by traditional healers.

This book concentrates on the public services, and this chapter introduces some of the components of the public health system, its broad organisation, structure, funding, staffing and physical features. What must be recognised throughout is that there is also a huge amount of variation in the system, for example in the allocation of resources, the successes and challenges of different programmes, the performance of different facilities and health workers, and in the needs of different communities who are served by the health system.

A brief history

The first formal health services in Namibia were established in the 1890s, and consisted of a field hospital for German soldiers in Windhoek and a hospital in Swakopmund. Several clinics in northern Namibia followed between 1902 and 1908. These were set up by the Finnish Missionary Society. From those early beginnings, four clear features or trends characterized the development of health services over the next 100 years until independence in 1990. First was the obvious increase in the number of facilities and other services. For example, the number of doctors in Namibia rose from 9 in 1907, to 43 in 1948, 130 in 1966, 324 in 1991, and to about 600 in 2001. Much of the development occurred in central and southern Namibia because the white population were the primary recipients of medical services. A number of facilities were also established in what were known as “native reserves” and “homelands” to serve the black population. Most of these services were first set up by missions, while the South West African administration provided additional facilities in later years.

The second trend was the increasing support given to mission facilities by the South West African administration. This also meant that the administration could increasingly control these facilities. The first free medicines were supplied to mission hospitals in 1935. By 1966, all running costs of the mission health services were subsidized by the government.

A third feature was, of course, the huge disparities between health services provided for whites and for blacks. Compared with the number of people, many more and better-quality services were available to whites than blacks. The disparities had many consequences, one example being that many more black than white children died at an early age. Thus, infant mortality rates were five to six times higher among blacks than whites between 1960 and 1981.³

Finally, health services concentrated heavily on curative services, largely provided in well-equipped hospitals in urban areas. Very little attention was given to disease prevention, the promotion of good nutrition or educational programmes. The great majority of Namibians, therefore, spent most of the past 100 years lacking the kinds of services that most people take for granted today.

The structure of health services

The overall orientation of the public health service is towards the provision of primary health care, where the predominant focus is on community health, preventative measures and on treatments that can be provided relatively easily, cheaply and quickly. Most primary health care is delivered through outreach points, clinics, health centres and district hospitals. More serious health conditions are generally referred to and treated at higher (secondary and tertiary) levels. Health centres and district hospitals offer secondary level care, while the most specialized and tertiary level care is offered at the main referral hospitals in Rundu, Oshakati, and Windhoek. This hierarchy allows for different facilities to be staffed and equipped appropriately to provide different kinds of health services. Greater cost-effectiveness is also achieved by channelling problems to levels where they are best treated. Much more emphasis has been placed on primary health care since independence in 1990.

While most MOHSS activities take place in its health facilities around the country, several programmes target special issues. These are part of the larger primary health care focus and include programmes on HIV/AIDS and sexually transmitted diseases; tuberculosis; immunization; family

planning and mother and child health; school health; blindness, diarrhoeal diseases; vector-borne diseases such as malaria and bilharzia; Acute Respiratory Infections; and rehabilitation.

There are two principal levels of management of public health: the national MOHSS head office in Windhoek, and regional management. The head office consists of the ministerial offices, the offices of the Permanent Secretary and Deputy Permanent Secretary, and two departments. One of these is responsible for Social Services, Policy Development and Resource Management. The other department is in charge of Health Care Services, which is further divided into two directorates: one for Primary Health Care and one for Tertiary Health Care (*Figure 1.1*).

In general, the head office is responsible for policy formulation, strategic planning, legislation and regulation, monitoring and overall coordination. The Deputy Permanent Secretary is responsible for a Regional Co-ordination Unit, which provides direction for the regional level of management. The regional level is responsible for policy implementation and the provision of services. Until recently, four directorates administered public health services in the country, and the directorates were divided into 34 health districts. The areas covered by these former directorates are shown in *Figure 1.2*. The system of regional management is soon to be further decentralized to the 13 political regions, where MOHSS Regional Management Teams will manage health and social services within each region in close collaboration with its Regional Council.

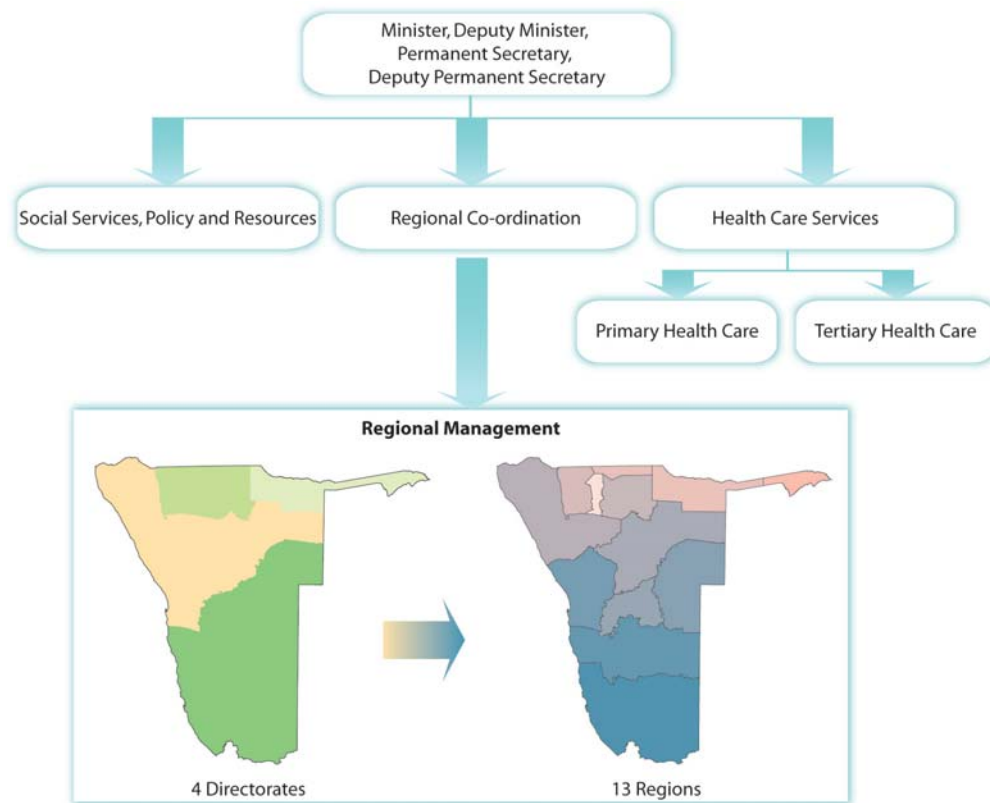


Figure 1.1. The broad organisation and lines of responsibility in the Ministry of Health and Social Services, and changes in regional management from 4 health directorates to the 13 political regions

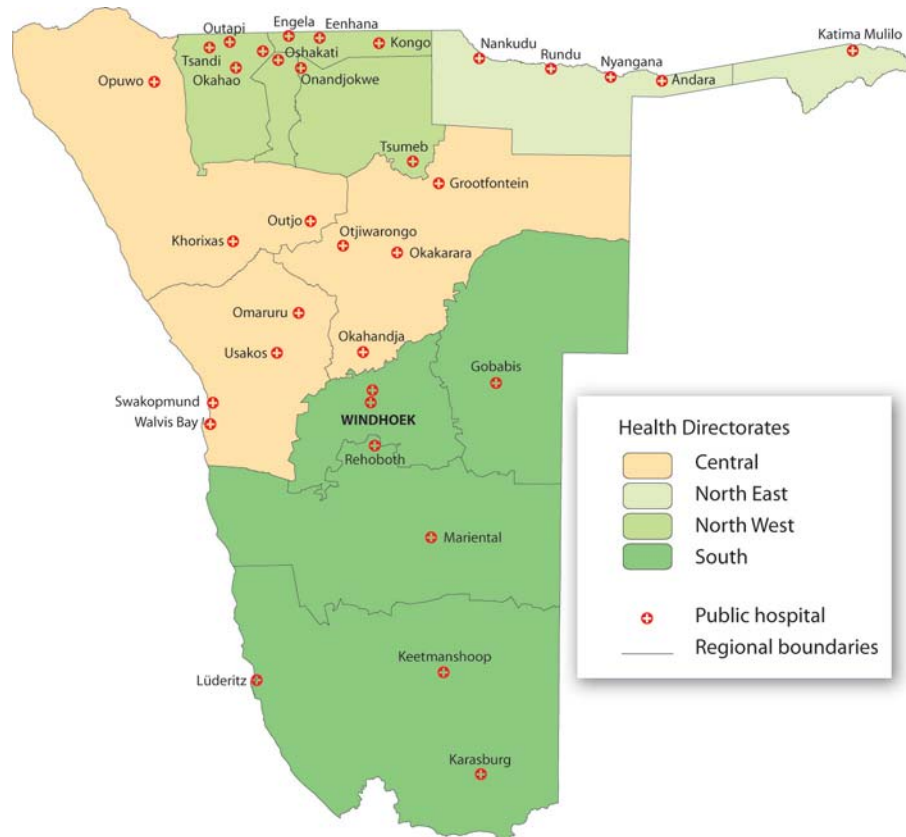


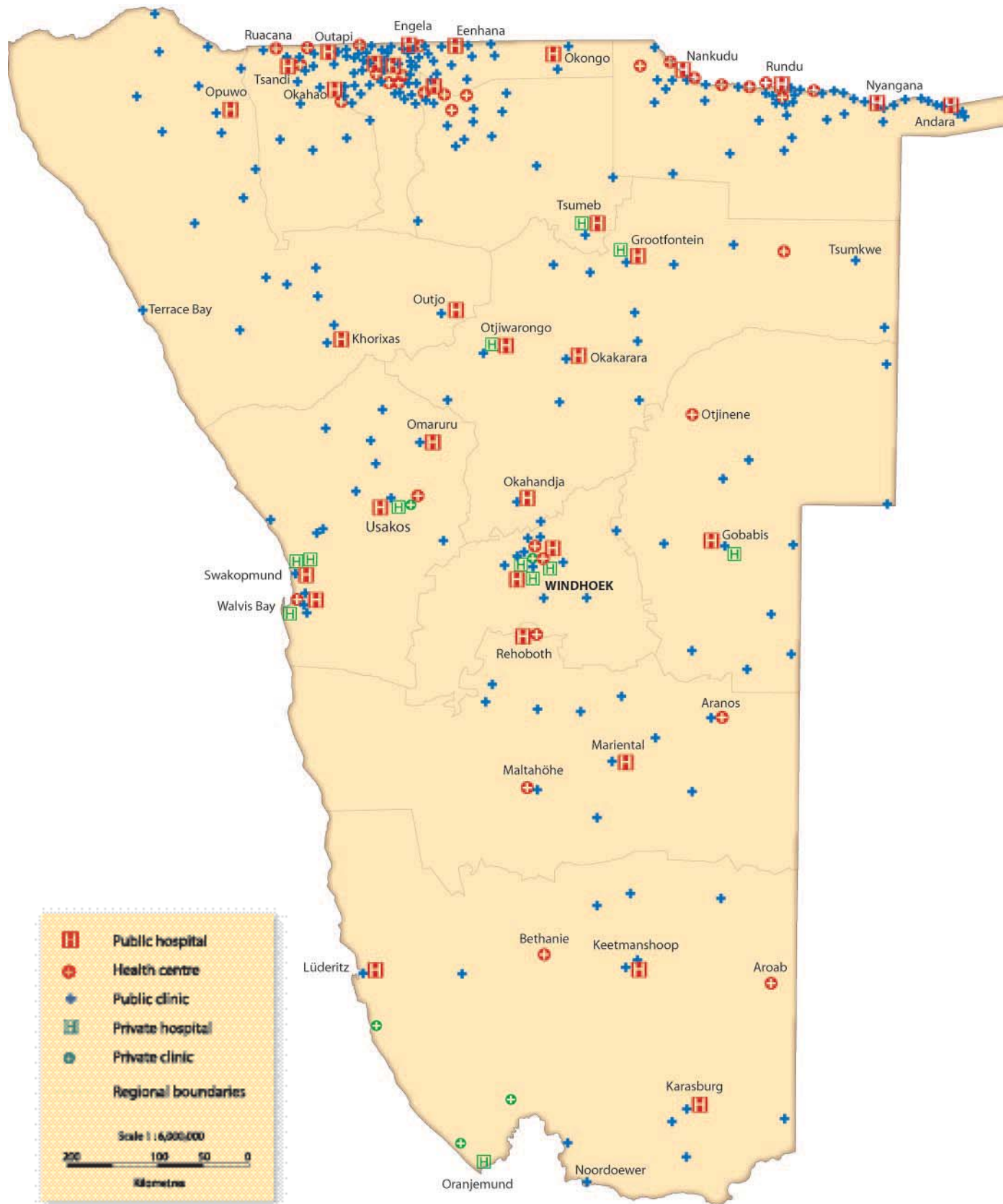
Figure 1.2. The Ministry of Health and Social Services' four health directorates and public hospitals

Health facilities

The majority of facilities are in northern Namibia and in the larger towns (*Figure 1.3*). This distribution largely reflects the presence of larger numbers of people in those areas, and business centres to which people from surrounding areas are attracted. The degree to which people have access to health facilities is considered on page 21. Many clinics and health centres also have one or more outreach points in more remote places. Health workers periodically visit these points to provide preventative and promotive services, and to attend to illnesses and other conditions amongst people living there (see page 22).

Numbers of health facilities in 2001

Type of facility	Clinics	Health centres	Hospitals
Public (MOHSS and church missions)	244	37	34
Private	5	0	12
Total	249	37	46



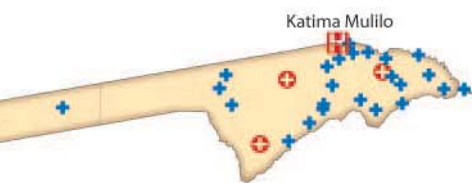


Figure 1.3. The distribution of public and private health facilities in Namibia in 2001

Staffing the health system

Health services are provided directly or indirectly by about 10,000 people employed by the MOHSS. Some 3,000 of the staff are trained health workers practising as medical doctors and nurses, and in a range of other capacities and positions, while the remaining employees render administrative and other kinds of support to the Ministry. There were about 250 doctors, 2,000 registered nurses and 1,800 sub-professional (enrolled and auxiliary) nurses employed by the MOHSS in the year 2000. In addition, there are those employed at facilities run by church missions and private practitioners. About 350 doctors are in private practice in Namibia. The distribution of health workers is discussed on page 23.

Most nurses received their training in Namibia. Registered nurses qualify after a four-year training diploma offered by the University of Namibia. About 40 students enrol each year to be trained as registered nurses, and much of their coursework is orientated towards the provision of primary health care. The University also trains radiographers and social workers. Enrolled nurses, orthopaedic technicians, assistant radiographers, environmental health workers and pharmacist assistants are trained at the MOHSS National Health Training Centre in Windhoek and in Regional Health Training Centres at Oshakati, Rundu, Otjiwarongo and Keetmanshoop.

All doctors and specialists, on the other hand, have been trained in foreign countries: 67% were trained in South Africa, 18% in Europe, 8% in other African countries, and 7% in countries elsewhere.⁴ Most professional staff are also immigrants, and 55% of doctors in 1998 were expatriates. This reflects the overall shortage of skilled personnel in the public health system, especially doctors, senior managers and other specialists. It is also in sharp contrast to the very large numbers of less skilled people employed by the MOHSS.

Funding the health system

Namibia's health system costs a good deal. Government funds are the main source of revenue, with the MOHSS budget comprising about 14-16% of total government expenditure since 1990. These are very high proportions by international standards. The total operational budget of the MOHSS in the 2000/2001 financial year was about N\$1,2 billion.

Expenditure on primary health care increased during the early 1990s in line with the policy to provide better preventative programmes and more immediate curative care at a local level through health centres, clinics and outreach services. Thus, allocations to primary health care increased from 27% of the total operational budget in 1990 to between 35 and 42% over the past seven years (*Figure 1.4*). Other substantial areas of spending include hospital services (26-28% of the budget in recent years) and funds for social pensions (25-28%). About 5-8% of the total budget has generally been allocated to medicines and pharmaceutical supplies each year. However, the ability of the MOHSS to buy adequate supplies has decreased due to inflation, the declining value of the Namibia Dollar and real increases in the costs of drugs internationally.

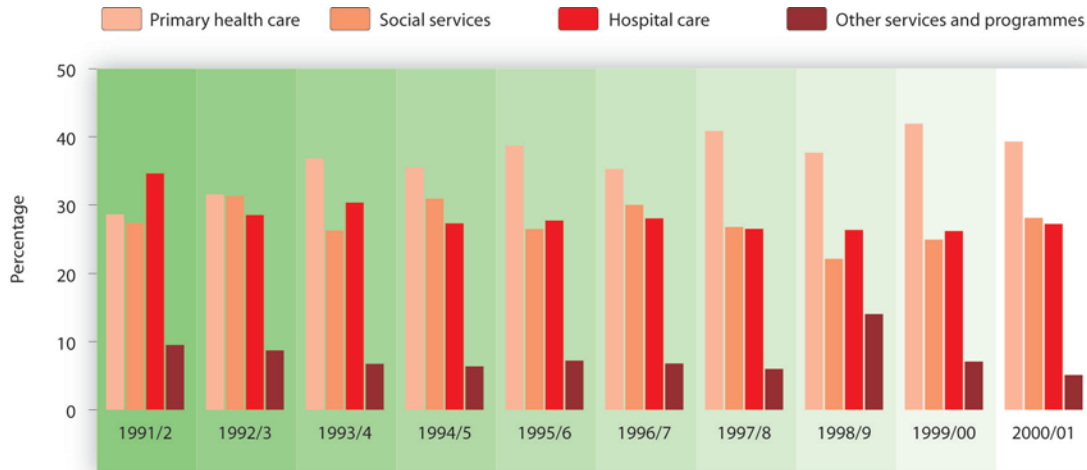


Figure 1.4. Percentages of the MOHSS budget allocated for primary health care, hospital care and social services each financial year. These, and smaller categories pooled as "Other services and programmes," make up the total operational budget of the MOHSS ⁵

Substantial proportions of the budgets allocated to each sector, for example primary health care or hospital services, are used to pay the people working in those programmes. In fact, more than half of the total spending on health now goes to paying salaries and other staff benefits and, again, this is a high percentage by international standards.

Capital development funds have also been allocated to the building and maintenance of health facilities and the establishment and further development of public health programmes. These are reflected in the MOHSS development budget. The sums provided have risen from about N\$48 million in 1995/1996, to N\$88 million in 2000/2001.

In addition to government funding of the public health system, international aid agencies have contributed significant amounts of money to a variety of projects and programmes aimed at improving the health sector. Between N\$50 and N\$67 million has been granted by these agencies annually over the past five years. Most development aid has been devoted to primary health care issues, such as HIV/AIDS and reproductive health. Finally, some N\$16 million is obtained as income each year from fees paid by patients receiving treatment at hospitals and other health facilities. The amounts paid vary according to the type of service provided, the type of facility used and the patient's ability to pay. At the Windhoek Central Hospital, for example, considerable income is generated from private patients who have their own medical aid or insurance. However, all such income goes to the government's revenue fund and is not directly available to help cover the MOHSS's annual costs.

Medicines

The MOHSS compiled a list of about 400 essential drugs in 1996, and it is these and their generic equivalents (where possible) that are supplied to facilities throughout the country. All medicines are purchased through the government's tender board, and then stored at a central medical store in Windhoek. From there, stocks are distributed to regional stores at Rundu and Oshakati, at regional distribution facilities, or direct to health facilities elsewhere in the country.