

2017/2018

BUDGET

CHILDREN AND THE
NAMIBIAN BUDGET:
HEALTH AND SANITATION



This Budget Brief is one in a series of four briefing papers that examine the extent to which the Namibian Government budgets have addressed the needs of children in Namibia.

It focuses on Health and Sanitation. The other UNICEF Budget Briefs focus on social assistance and welfare; basic education and the national budget.



10.4%

Allocation to MoHSS as share of total budget, 2017/18



KEY MESSAGES AND RECOMMENDATIONS

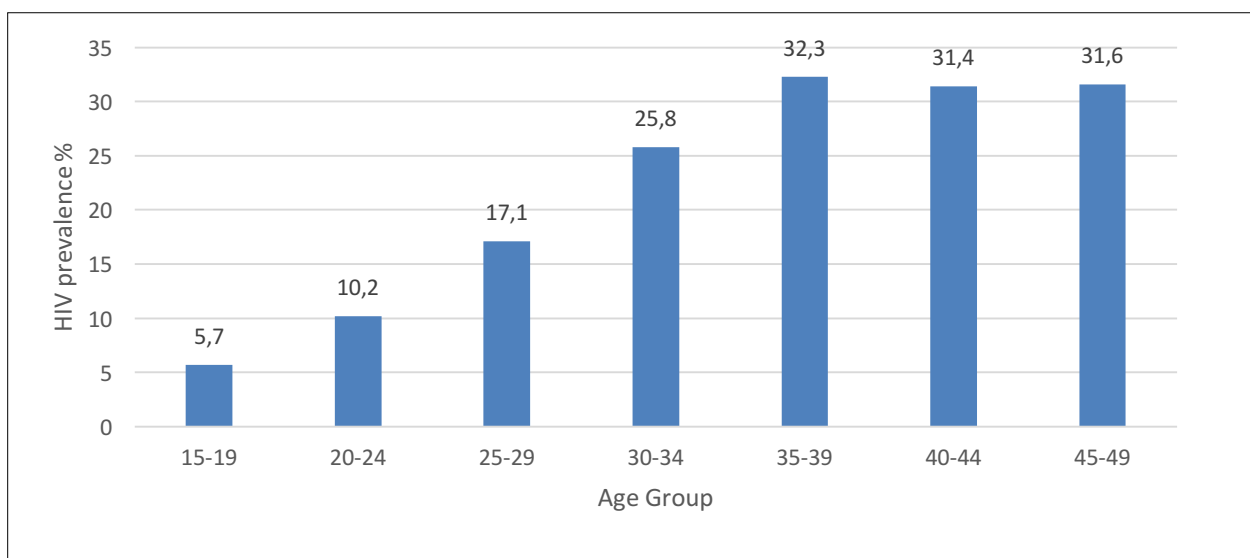
- The government's overall commitment to investing in health is strong but still remains far below minimum international spending benchmarks.
- There is very limited investment in preventative services. It's very ineffective spending!
- The Ministry of Health and Social Services (MoHSS) is using a top-down approach for budget allocation to regions. There is a need to ensure that the budget allocation be based on budgeted work plans from regions and health districts.
- Donor funding has decreased significantly over recent years, private sector spending is relatively low at 30%. The Government should consider to increase the contribution of private providers by contracting with them in the provision of health care to relieve some of the pressure on the public health system and to increase efficiencies and achieve the Abuja target.
- HIV is the underlying cause of more than 35% of under-five mortality rate. Government needs to re-invigorate its efforts on combination prevention especially among adolescent and young people, eMTCT agenda, and use HIV as the entry point to strengthen the health system and deliver other high impact and community based interventions like immunization
- Considering data from Demographic Health Surveys 2007 and 2013, under five mortality decreased from 69 to 54 deaths per 1,000 live births while neonatal mortality remains flat at 20 deaths per 1,000 live births for the same period. The Every Newborn Action Plan (ENAP) initiative provides evidence of reduction of newborn deaths by 50% and should be up-scaled
- Stunting rates in Namibia is very high at 24% of under five children. Scaling up Nutrition is pertinent in addressing high stunting rates.

Key indicators

Neonatal mortality rate per 1,000 live births, 2013	20
Infant mortality rate per 1,000, 2013	39
Under-five mortality rate per 1,000, 2013	54
Maternal mortality rate per 100,000, 2013	385
Proportion of urban and rural households with access to improved sanitation facilities, 2016	53.3%
Proportion of urban and rural households with access to safe water, 2016	92.9%
Allocation to MoHSS as share of total budget, 2017/18	10.4%
Allocation to personnel as share of total MoHSS budget, 2017/18	50.5%
Allocation to MoHSS as share of Gross Domestic Product, 2016	4.3%
Total Health Expenditure as share of Gross Domestic Product, 2014/15	9%
Share of health professionals over total MoHSS staff, 2017/18	69.0%

Source: Economic Association of Namibia compilation based on information from the Demographic and Health Survey, Ministry of Finance, Estimates of Revenue and Expenditure; Namibia Statistics Agency (NSA), National Accounts; NSA, Namibia Inter-censal Demographic Survey 2016 Report; and MoHSS, Namibia 2014/15 Health Account Report.

Figure 1. HIV prevalence per age group 2016



Source: HIV sentinel survey 2016, MoHSS

Introduction

The MoHSS is responsible for the provision of public health services in Namibia. The MoHSS runs four programmes, namely 'Public Health', 'Clinical Health Services', 'Health System Planning and Management', 'Development Social Welfare'. The public health programme includes activities such as Maternal and Child Health, Disease Prevention and Control, Environmental Health, Mental health and Community Based Health Care. Staffing of health facilities particularly in rural areas remains a challenge. However, the establishment of the School of Medicine will increase the number of Namibian health professionals over time and reduce its reliance on foreign professionals

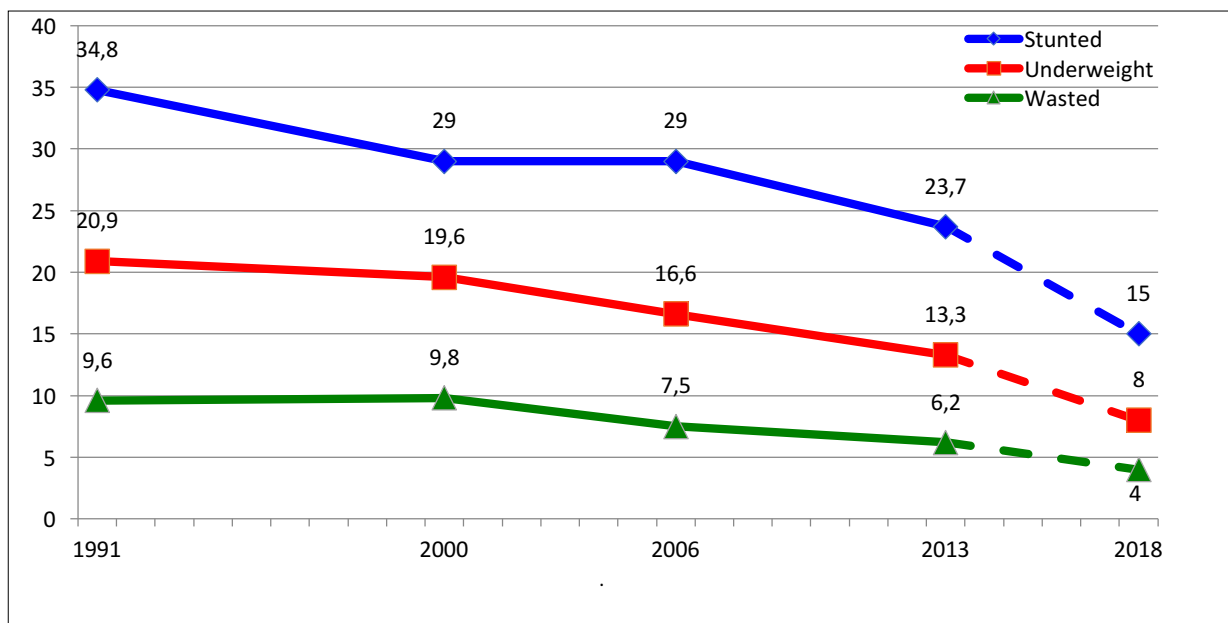
Teenage pregnancy is rising. The share of girls who are mothers at the age of 15 years tripled between 2000 and 2013 from 0.8% to 2.5%. The share of girls at the age of 16 and 17 years increased as well but at a much slower pace, although from a high level of 4.8% and 10.7% respectively. Although no country-wide data is available, reports in the media suggest that teenage pregnancy continues to increase. This could result in an increase in the HIV prevalence rate for teenage girls. However, teenage pregnancy does not only affect the health sector, but also the education sector. Pregnant learners drop out of school, at least temporarily, which can have a negative impact on their educational performance even if they return to school after a while.

The HIV prevalence rate among girls of 15 to 19 years of age has dropped from double digit figures before 2008 to 5.7% in 2016. The national prevalence rate among

women between 15 and 49 years of age increased slightly from 16.9% (2014) to 17.2% in 2016. Likewise, the prevalence rate for the age cohort of 20 to 24-year-old young women increased to 10.2% in 2016 from 9.8% in 2014. This is a reminder that efforts of educating in particular young girls on sexual and reproductive health have to be strengthened. Additional research is needed to establish, whether social grants for young girls can reduce their vulnerability, prevent teenage pregnancy and therefore reduce the risk of exposure to Sexually Transmitted Diseases.



Figure 2. Stunting, underweight and wasting amongst Namibian children aged under 5 years (%)



Source: Source: Global DHS online database, via <https://www.statcompiler.com/en/>; MoHSS, 2014, p. 73

The nutritional status of children remains a concern.

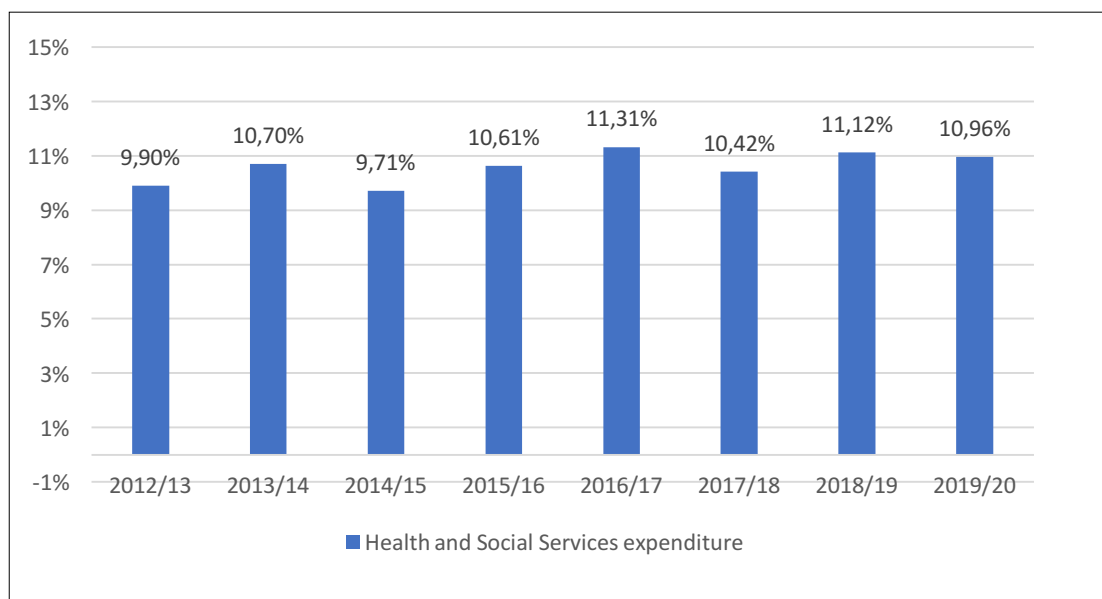
In 2013, 23.7% of under-five children were stunted (too short for its age) and 6.2% were classified as wasted (too thin for their age). Furthermore, lack of nutritious meals has among others a negative impact on the learning ability and the effectiveness of medication such as anti-retroviral treatment. While the school feeding programme ensures that school children receive at least one meal per day, it comes too late to prevent stunting and wasting. Various interventions could help improving household food security, including support to mothers during pregnancies with the right diet, support for urban and peri-urban agriculture as well as a shift to climate smart and conservation agriculture, and the provision of fortified foods to households. The 2018 nutrition targets represent a halving of the 2006 rates (Figure 2).

Key observations

- ➔ The number of teenage mothers has increased and is posing not only challenges to the health sector, but also to the education sector.
- ➔ The high number of stunted and wasted children requires interventions at the very early stage of pregnancy in order to prevent future health challenges and lower returns on investment in education.



Figure 3. Allocation to the MoHSS as share of the total budget in %, 2012/13 – 2019/20



Source: EAN based on Ministry of Finance (MoF), various years.

Health spending trends

The Ministry of Health and Social Services (MoHSS) has received the second largest share of the national budget since the Financial Year (FY) 2016/17. The allocation to the MoHSS has increased in absolute and in real terms. The MoHSS's budget grew by 206% over the past ten and by 24% over the past five years, exceeding the cumulative effect of inflation of 72% and 23% respectively. The allocation represented 9% of the Gross Domestic Product (GDP) in 2016, the highest rate in Eastern and Southern Africa. However, the share of the total budget declined slightly from 11.3% (2016/17) to 10.4% in 2017/18, but is expected to return to about 11.0% until 2019/20.

The amount of government health expenditure has increased steadily from year to year, representing the government's commitment to health. However, the total government expenditure is increasing at a faster pace than the government expenditure on health, which means that health may be of decreasing importance in terms of the government's priorities.

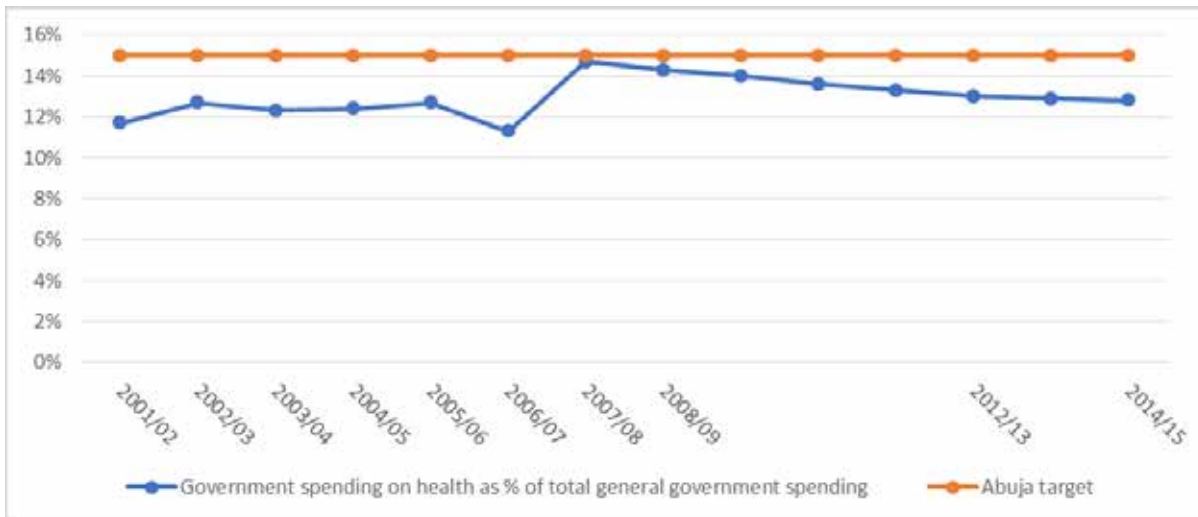
The substantial government contribution to health spending comprises 13% of the government's total spending, a higher level than in other countries in the region. Between 2001 and 2013, government health expenditure as a percentage of total government expenditure varied between 11.7% and 14.7%, the latter percentage occurring in 2007/08. As of 2012/13, government health expenditure as a percentage of total government expenditure was 13% and remained unchanged in 2014/15 (see figure 4). This means that the government came very close to allocating the targeted 15% of its budget to the health sector in

accordance with the Abuja Declaration in 2007/08, but has slightly moved away from this target again in more-recent years. Nonetheless, the government has demonstrated a strong continued commitment to the achievement of the target. As the government continues its efforts to achieve universal health coverage, this commitment needs to persist.

The 2014/15 Health Accounts estimations show a significant increase in government spending on health compared to in 2012/13, when the government contribution amounted to 54 percent. The percentage contributions of THE by employers, households, and donors all decreased in relation to the figures in the 2012/13 Health Accounts, when the contributions by these entities were 22 percent, 16 percent and 8 percent respectively. The government needed to offset the anticipated decrease in donor funding (from 22 percent in 2008/09) as donors responded to Namibia's transition to an upper-middle-income country. The government also seems to be compensating for a proportionate decrease in spending by employers (from 22 percent to 20 percent) and households (from 16 percent to 10 percent).

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Figure 4 : Trends in government spending on health as a percentage of total general government spending in comparison to the Abuja target, 2001/02–2014/15



Source: Economic Association of Namibia analysis based on Ministry of Education, Arts and Culture information.

Namibia’s transition to an upper-middle-income country. The government also seems to be compensating for a proportionate decrease in spending by employers (from 22 percent to 20 percent) and households (from 16 percent to 10 percent).

Composition of Health Spending

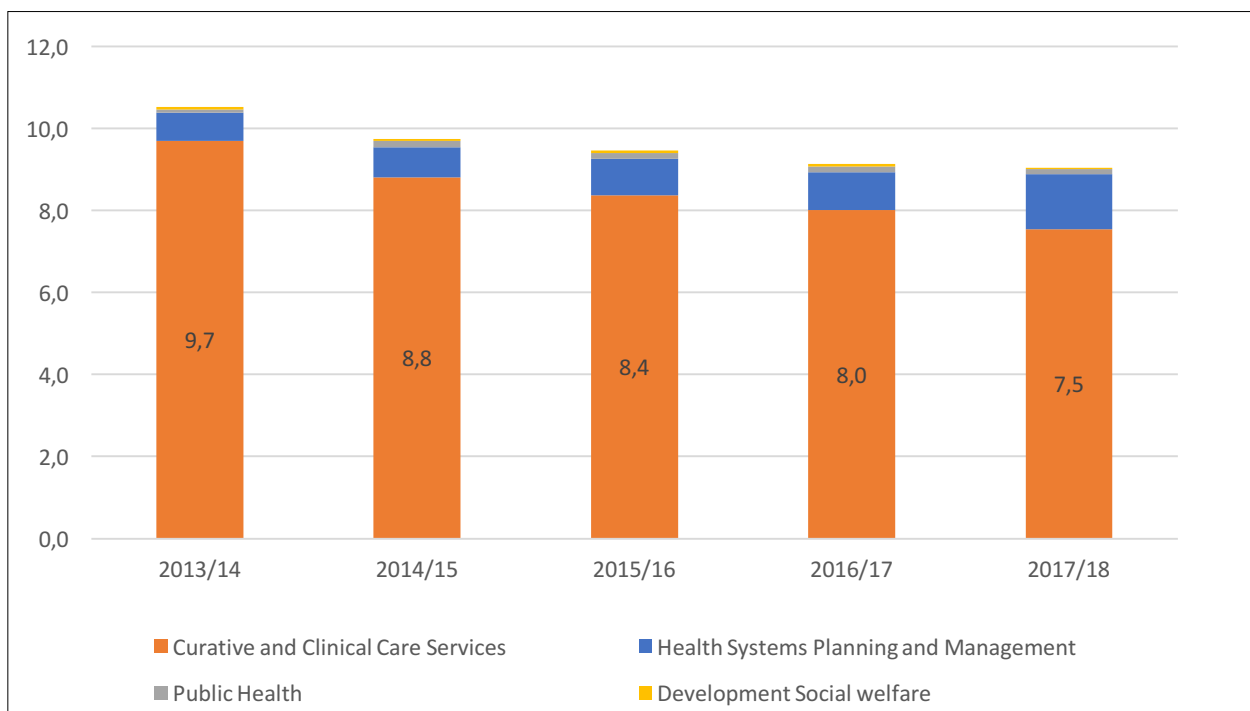
The overall health budget is primary geared toward supporting curative services with almost nothing going to support prevention of key health issues. Indeed, 75% to 80% of the national budget are allocated to the curative and clinical care services. Other key programmes like Public Health Programme, Development and Social Welfare Programme, and Health System Planning and Management programme have in total less than 20%-25%¹ (Figure 5). Based on the 2014/15 Health Account

report, Namibia has spent a large proportion of health expenditure on curative care (59%) and only 17% on primary health care services. It is important to note that the analyses do not capture external funds that are not channelled through the State Revenue Fund, such as for HIV.

- Curative and Clinical services programme – To provide curative and specialized services to patients referred and to develop and strengthen the skills and knowledge of health workers through clinical training
- Health systems planning and management programme - To advise and assist Ministry in the development of relevant policies in accordance with legislative requirements and national objectives, and to facilitate the implementation of the operations of the Ministry
- Public health programme - To improve the quality of life by rendering services through programs in the field of Family Health, Epidemiology, Public and environmental health, disability prevention and rehabilitation as well as information, education and communication.
- Development and Social Welfare programmes - To provide support and social relief services to families and individuals with special welfare needs, particularly the old and those living with disabilities.

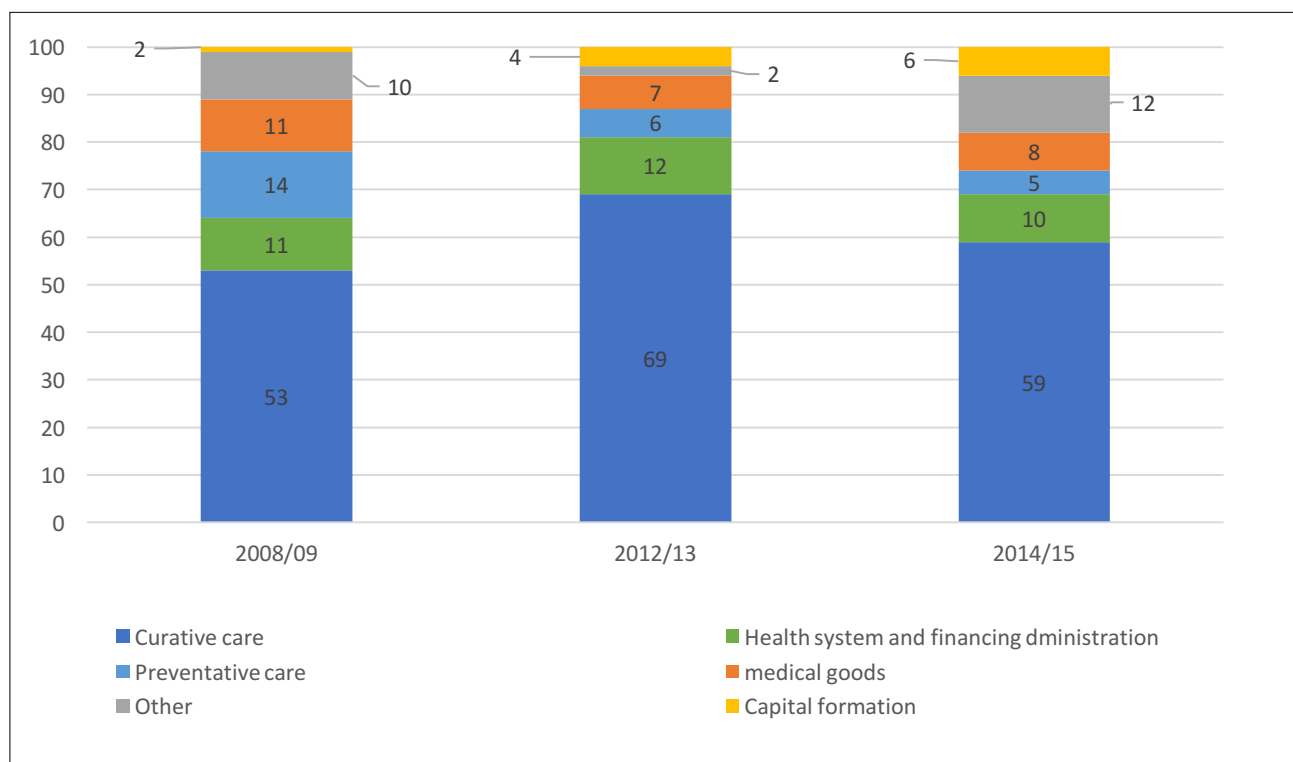


Figure 5: Budget allocation to Health Programmes in percentage of National budget



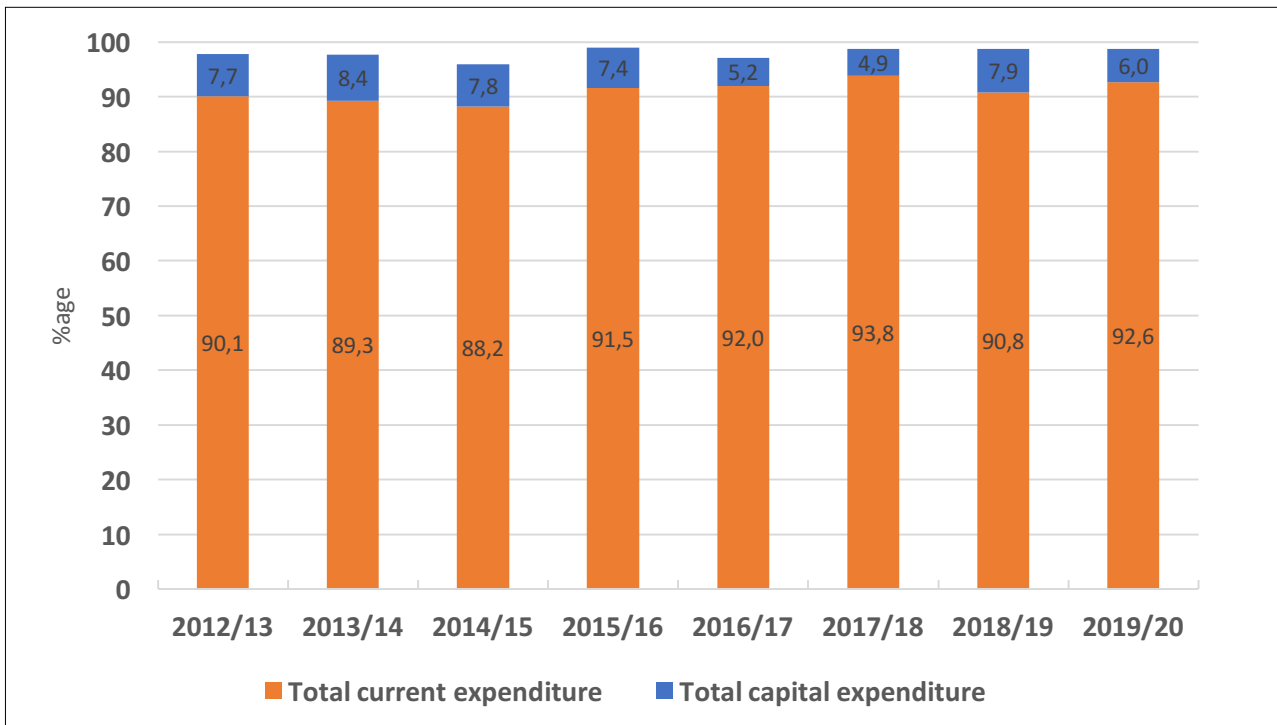
Source: UNICEF analysis based on Ministry of Finance, Estimates of Revenue and Expenditure, various years

Figure 6: Proportion of Health budget on different services



Source: National health accounts 2014 – 2015, MoHSS

Figure 7: Allocation to current and capital expenditure as share of the MoHSS total budget, in %, 2012/13 – 2019/20



Source: EAN based on Ministry of Finance, Estimates of Revenue and Expenditure, various years

In terms of capital and recurrent spending in the health sector, the budget refers mainly to the purchase of vehicles and operational equipment, was utilised to an even lesser extent varying between 42% and 76%. On average, only 53% of the allocation was actually spent. This is alarming, since vehicles (ambulances) and hospital equipment are vital for the provision of life-saving and quality health care services. Contrary, personnel expenditure exceeded the budget limits by 2% to 10% during this period and on average by 7%. The directorate ‘Development Social Welfare Services’ did not use its budget fully. Between 75% (2012/13) and 88% (2013/14) were utilised over the four-year period averaging 80%.

Current expenditure absorbs more than 90% of the ministry’s budget, while less than 8% is allocated to capital expenditure (figure 7). The low allocation to capital expenditure is compounded by a low execution rate, implying that the funds are not even fully spent (see below ‘Budget Execution’). Personnel expenditure accounts for the largest chunk of the budget.

The MoHSS employs 10,962 staff, making it the fourth largest ministry in terms of employment. It accounts for 11.7% of government’s wage bill. 50.5% of its budget is spent on employee’s remuneration in 2017/18. Personnel expenditure increased from 44.5% the year before due to budget cuts on mainly capital projects and materials and supplies while capital expenditure dropped from on average 7.8% between FY 2012/13 and FY 2015/16 to 4.9%





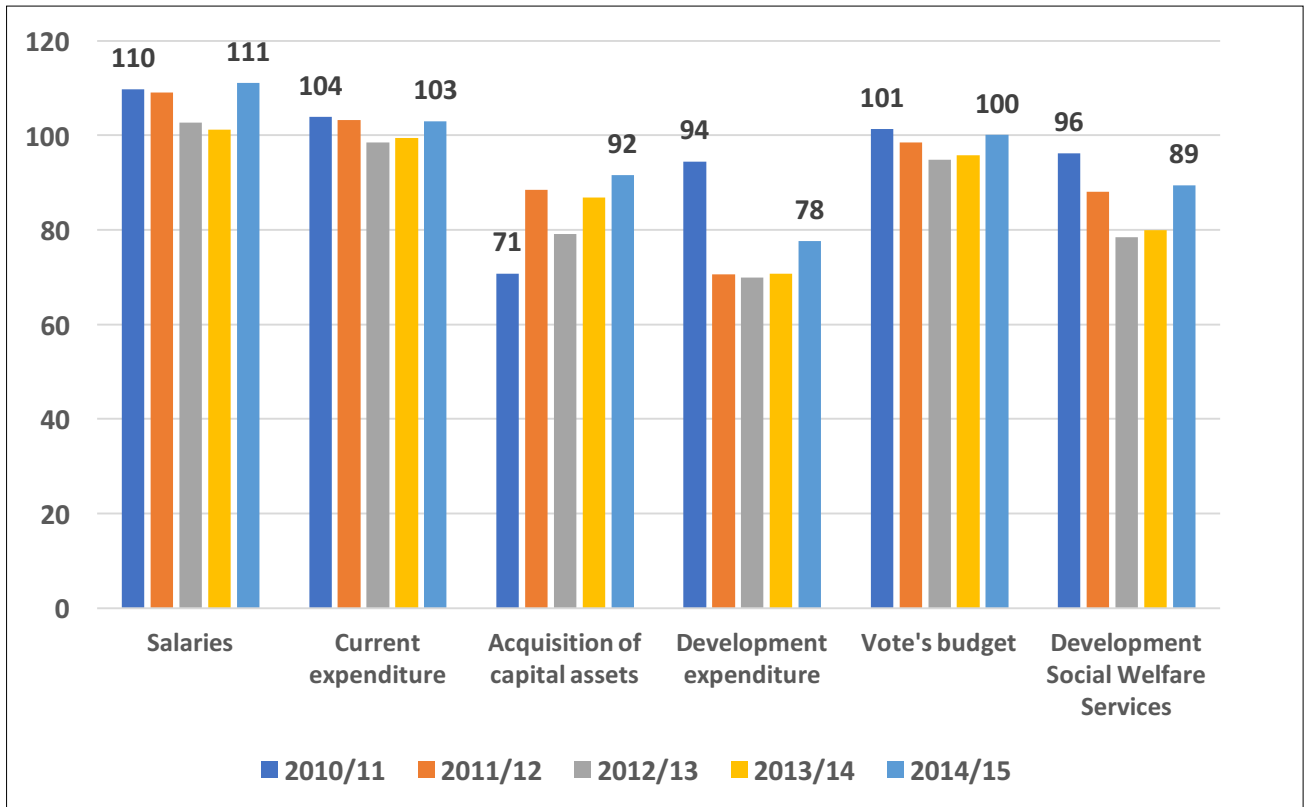
in 2017/18. The MoHSS is expected to spend around 50% of its budget over the next two FYs on wages and salaries. 9.6% of a total of 12,123 established positions, however, remain vacant. Due to the large staff complement and hence wage bill it is imperative that proper controls are in place to reduce the risk of 'ghost workers' – workers that are on the payroll, but actually do not exist. The UNICEF Budget Brief on education refers to findings that suggests the existence of ghost workers in the education sector (see UNICEF Budget Brief – Basic Education), which warrants stronger controls in other labour-intensive ministries as well.

About 69% of staff are health professionals including dental and medical interns from Namibia's School of Medicine and universities abroad, nurses, pharmacists and physiotherapists. It is expected that the training at Namibia's School of Medicine helps alleviating the severe shortage of in particular medical doctors and pharmacists in the country. Besides the shortage of certain professionals, staff is also unequally deployed at clinics, health centres and hospitals resulting in often overburdened staff at clinics in rural areas. These shortages have implications for the quality of health care provisions. The shortage of staff affects especially specialist services such as psychologists, psychiatrists, eye specialists and audiologists to mention a few and is compounded by the concentration of specialists in the Khomas region that is home to the capital Windhoek. While graduates from Namibia's School of Medicine and other universities will help alleviate the situation over time, the transition from mainly foreign professionals to Namibian professionals has to be planned carefully in order to maintain expertise and experience in the health sector.

Key observations

- ➔ Very limited investment in prevention!
- ➔ The largest proportion of the budget allocation to health is allocated to wages and salaries leaving little room for improving the health infrastructure through capital projects. Despite the high share of the budget absorbed by personnel expenditure, in particular rural health facilities face a shortage of health staff.
- ➔ Funding for the health sector has increased in real terms and comes close to the Abuja Declaration of 15% of the total national budget. However, it is mainly channelled to curative rather than preventive health care services.
- ➔ International Cooperation Partners have in some years supported the public health sector with substantial funding. However, it is channelled outside the State Revenue Fund and therefore not reflected in the budget documents and the Appropriation Act.
- ➔ Donor funding in the health sector is decreasing and government needs sustainable funding model fill the funding gap.

Figure 8: Actual expenditure versus authorised expenditure for the health sector, 2011/12-2014/15



Source: Economic Association of Namibia analysis based on Office of the Auditor General, Report of the Auditor General on the accounts of the Ministry of Health and Social Services, various years.

Budget Credibility and Execution

Budget execution in the health sector has been very strong in recent years. Over the period 2012/13 to 2015/16 the MoHSS budget was almost fully executed (97%). The FY 2016/17 is excluded from the analysis, because of the budget cuts for all ministries announced in October 2016. Therefore, the revised budget cannot be compared to the initial budget. The execution rate for development (capital) projects was in particular low although increasing steadily over time from 59% (2012/13) to 69% (2015/16).

The analysis of the Auditor General’s reports points in the same direction, but the magnitude of deviations differs. The Auditor General’s reports include virements (authorised reallocation of funds between divisions) and hence estimated allocations as per Appropriation Act differ from authorised expenditure. However, actual expenditure of the directorate Development Social Welfare Services were on average 13.6% lower than

authorised expenditure during the period 2010/11 to 2015/16.

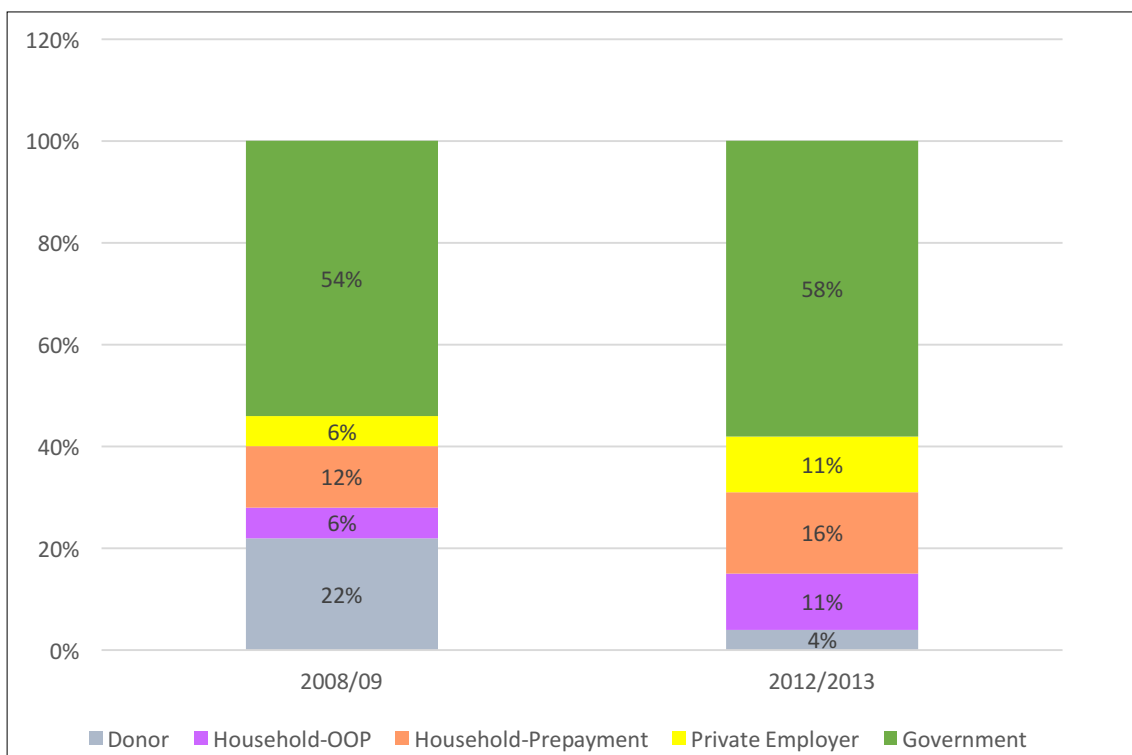
Expenditure on the acquisition of capital assets was 16.6% lower, while personnel expenditure exceeded the authorised amount by 6.7% during the same period. The use of virements authorised by the Ministry of Finance has helped smoothing the deviations from the original budget allocations.

Key observations

- ➔ Execution in the sector has been strong overall.
- ➔ While personnel expenditure exceeded the budgeted and authorized amounts in every year, investment into vital equipment, such as vehicles, and health facilities remained below the funds available.

Actual expenditure of the directorate Development Social Welfare Services were on average 13.6% lower than authorised expenditure during the period 2010/11 to 2015/16.

Figure 9: Shares of Total Health Expenditure (THE), 2009-2013, Namibia



Source: MOHSS and Health System 20/20 Project, 2008; MOHSS, 2015; WHO, 2015.

Financing the Health Sector

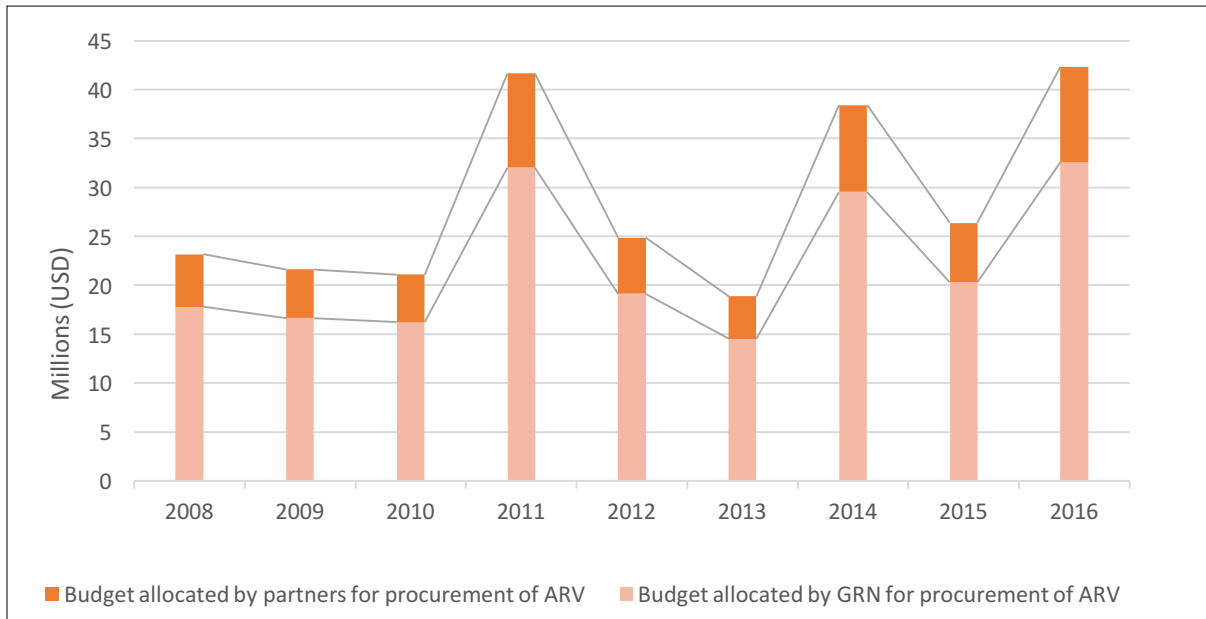
The government is the largest funder of healthcare. It is committed to progressing toward universal health coverage (UHC) as outlined in the National Health Policy Framework 2010–2020 and has been making efforts to ensure and grow the government budget line item for health. Namibia funds more than 75% of its total health expenditure (THE) through domestic resources. The three major domestic health financing sources are general government revenue, private employers' contributions, and household contributions (both prepayment and other out-of-pocket (OOP) payments). Employers contribute 11% of THE, primarily by making contributions to private

medical aid schemes on behalf of their employees. Both employer and household prepayment contributions have increased, with households now paying 16% of THE through prepayment schemes. Although financial risk protection has improved, OOP expenditure, excluding prepayment schemes, has also increased from 6% to 11% in 2014.

Employers and households have increased their contributions to healthcare, primarily through prepayment schemes. Donor funding declined from its peak in the mid-2000s, when HIV funding spiked and donor transition ensued as the country became an upper middle-income country (Figure 9).



Figure 10: Funding of ARVs, 2008-2016, (in USD)



Source: Central Medical Store (CMS), consolidated reports 2008-2016

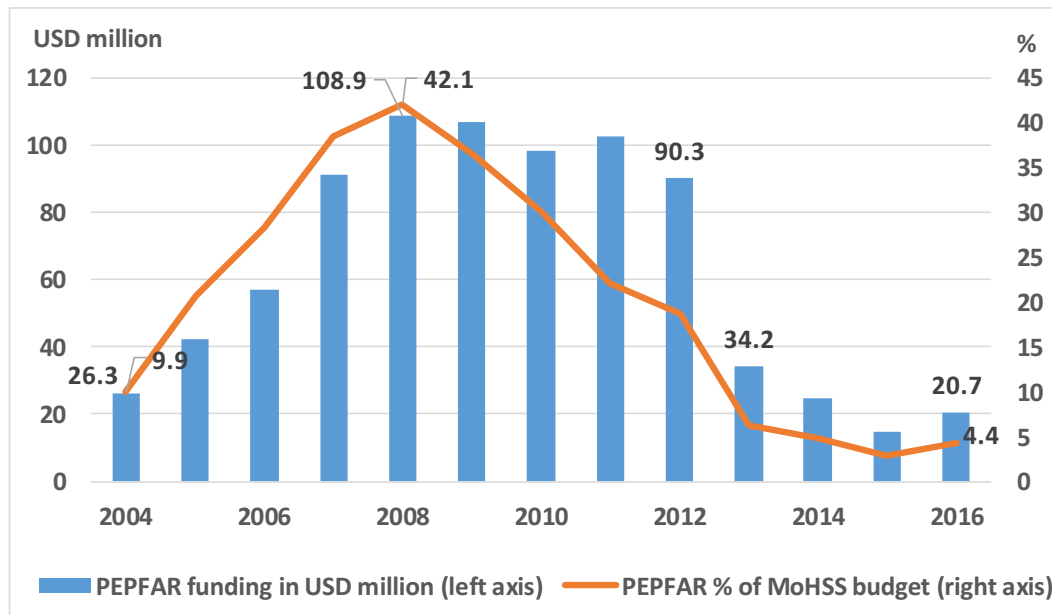
Namibia has made a commitment to achieve universal health coverage (UHC), which requires the provision of quality health services to the population at an affordable cost. Health financing is a key element to consider in the move towards UHC. Namibia needs to strategize on the sustainability of its health financing. Aggravating matters, Namibia is experiencing a substantial decrease in its economic growth. This, combined with factors such as more than half of the population living below the poverty line, and the current health financing system being predominantly tax-based, has created increasing pressures on the fiscal space for health. At the same time, demand and costs for health services are increasing due to an aging population, increasing incidence of non-communicable diseases (NCDs), and the continuous threat of communicable diseases. To increase affordable access to quality health care while funding shrinks and costs rise, equitable allocation of available resources and efficient use of those resources should be prioritised. That will help prevent the loss of the health gains to date.

HIV Financing

HIV accounts for the largest proportion of lives lost (28.6%) in the country, but total AIDS expenditure accounts for an estimated 13% of THE. The financing landscape is significantly different for HIV services compared to overall health—51% of health sector HIV funding is supported by donors (primarily PEPFAR and the Global Fund to Fight AIDS, Tuberculosis and Malaria), whereas the government pays for 37%. However, according to the National AIDS Spending Assessment in FY 2013/14, which includes non-health sector contributions to HIV, the government paid 62% of the overall HIV response



Figure 11: PEPFAR funding in USD million and as share of MoHSS budget, 2012/13 – 2019/20



Source: Economic Association of Namibia (EAN) analysis based on Ministry of Finance, Estimates of Revenue and Expenditure, various years, and on PEPFAR (<http://www.pepfar.gov/countries/namibia/>).

Note: USD converted into NAD by EAN using the average annual exchange rate.

(USAID, 2015). In 2010, the public sector medical aid scheme covered antiretroviral therapy for 6% of its members by accessing care through the private sector, paying a significantly higher price for antiretrovirals than through the Ministry of Health’s bulk procurement prices (Pereko et al., 2013). Private medical aid schemes cover HIV services, but employers’ contributions are low, showing that people are likely accessing more HIV services through alternative means (e.g., for free through the public sector). Households pay for only 2% of HIV spending, indicating that people living with HIV are relatively well protected from financial risk. More than USD 258 million to the purchase ARVs from 2008 to 2016 (70% from the state budget and 30% from partners)

Substantial financial and human resources to the fight against the spread of HIV/AIDS, TB and malaria are given through development partners. These diseases continue to have a significant impact on Namibia’s health status, albeit decreasing donor funding. The adoption in 2017 of the new National HIV/AIDS Strategic Framework for the five-year period to 2022 aims to strengthen the national multi-sectoral and decentralised HIV/AIDS response, with attention to the provisions of NDP5 as well as Goal 3 of the SDGs (‘good health’). Interventions such as the prevention of mother-to-child transmission programme have achieved a major reduction in the transmission rate of HIV from mother to child from 12% in 2007 to 4% in 2015.

The analysis of HIV funding excludes external funding not channelled through the State Revenue Fund and hence not reflected in the national budget documents. The ministry received in some years substantial financial resources from the United States President’s Emergency Plan for AIDS Relief (PEPFAR). PEPFAR funding peaked in 2008 at USD108.9 million, but declined in subsequent years with some fluctuations to USD20.7 million in 2016. The funding added an additional 42.1% to the ministry’s budget in 2008 and 4.4% in 2016. The funding, as well as funds received from the Global Fund are not listed in the ministry’s Medium-Term Plan (MTP) that is part of the Medium-Term Expenditure Framework as additional resources. For the sake of transparency and accountability, external funding should be mentioned in the MTP and ideally be channelled through the State Revenue Fund in order to allow parliamentary scrutiny.

Key observations

- ➔ As an UMIC, Namibia is transitioning off the remaining donor support to full country ownership and financial responsibility for supply chain operations and commodity procurement.
- ➔ As this transition continues to progress, donor support, both technical and financial, will decline requiring smart investment of resources to improve supply chain capability and performance.



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