This is one in a series of four briefing papers, initiated by UNICEF, that examine the extent to which the Namibian Government budgets have addressed the needs of children in the country.

Other briefs focus on education; social assistance and welfare; and the macro picture – a general overview of the socio-economic situation in Namibia and the budgeting process.
KEY MESSAGES

- Some major donor funding within the health sector is not included in the national budget since it is not channelled through the State Revenue Fund.
- Access to sanitation and water in rural areas and informal settlements needs to be improved, in particular at schools, in order to improve the health status of children and adults.
- A budget line for sanitation needs to be included in the budget of the Ministry of Urban and Rural Development in order to prioritise sanitation.
- Full implementation and funding to implement the World Health Organization’s Every Newborn action plan needs to be ensured, in order to reduce child mortality.
- Immunisation coverage increased mainly due to immunisation campaigns, but routine immunisation remains a major issue. Full implementation of the recommendations of the 2016 programme review will revitalise routine immunisation.
- The nutritional status of children under the age of 5 remains a concern, although the share of stunted children dropped. The share of severely stunted and wasted children declined only slightly. There is a need to have a dedicated budget line for nutrition activities to ensure implementation of activities under the Scaling Up Nutrition country implementation plan.
- Comprehensive sexuality education, reproductive health care and HIV prevention in primary and secondary schools should be promoted, with a dedicated budget line in the state budget.
- There is a need to accelerate the elimination of mother-to-child transmission agenda and identify potential sources of funding.
Provision of health services has been the government’s second key priority after education. The budgetary allocation to the Ministry of Health and Social Services (MoHSS) averaged 9.9% of total expenditure over the past 10 years (see macro brief for more details). This share is expected to rise to 11.1% in 2018/19 (see Figure 1). The budget of the MoHSS was equivalent to 5.8% of the gross domestic product in 2015. The ministry’s share of the total budget is below the target of 15% of public spending that African governments committed themselves to at the 2001 Abuja Health Summit. However, the quality of spending as measured by outcome targets is more important than the quantity of inputs.

As explained in the macro budget brief, not all external donors, for health as well as other social sectors,
channel their funds through the State Revenue Fund. The United States President’s Emergency Plan for AIDS Relief (PEPFAR), for instance, contributed between N$168 million (2004) and N$903 million (2009) to combat tuberculosis, malaria and HIV and AIDS. The contribution dropped to N$271 million in 2014 and N$230 million in 2015, accounting for 4.7% and 3.7% of the MoHSS budget respectively (see Figure 2). In addition, other international cooperation partners, such as The Global Fund, have provided substantial funding over the years. It is recommended that budget documents mention these donor contributions, which is currently not the case, and that donors channel their funds through the State Revenue Fund in order to increase accountability and transparency.

The MoHSS ranks fourth in terms of public sector employment, accounting for 10.3% (10,380 employees) of all filled posts in 2016/17. However, more than every fifth approved post remains vacant. Professional staff (nurses, dentists, physiotherapists, etc.) account for about 48% of all established positions in the MoHSS in 2016/17 but for only 42% of all filled positions, indicating a shortage of professional health staff. This is supported by a separate analysis of professional health staff and administrative staff. While 32% of established positions for professionals were vacant at the beginning of 2016/17, vacancies for other staff were 20 percentage points lower, at 12%. Wages and salaries within the ministry are slightly above the average government salaries since the ministry’s budgetary allocation for

**Figure 2. PEPFAR funding in US$ and N$ (in millions), 2004 to 2015**

remuneration accounts for 12.3% of total government remuneration. The wage bill absorbs 45.6% of the ministry’s total budget. Capital expenditure (mainly for renovation and construction) accounts for 8.3% and acquisition of capital assets (mainly for vehicles/ambulances and operational equipment) for 2.6% on average for the period 2012/13 to 2018/19.

The ministry overspent on personnel costs by between 2% and 10% during 2012/13 and 2014/15, but underspent in 2015/16 by 5%. In contrast, funds allocated to development expenditure were not fully used. The execution rate of development expenditure, however, increased from 59% in 2012/13 to an expected 95% in 2015/16.

Based on the latest health accounts for 2012/13, the MoHSS spent 71% of its budget on secondary and tertiary health care services compared to 11% on primary health care services. The allocation indicates that more emphasis is placed on curative health services (75%) than on prevention (0.03%). Another 14% is allocated to administration. (See Figure 3.) All 31 state hospitals have dedicated children’s wards. In total, 238 medical staff members are assigned to the children’s wards, including two social workers (0.8%). Namibia’s child population was 860,003 in 2011.

Despite the high commitment of the government to achieving the health agenda, access to health facilities for the population living within one kilometre of a health facility remained almost unchanged between 2003/04 and 2009/10, at 30.3% and 29.9% respectively.

In contrast, a number of health indicators improved over the past two decades. Full immunisation coverage rose from 58% (1991) to 87% (2015), mainly due to mass campaigns conducted twice a year (see Figure 4). Under-five and infant mortality rates declined from...
83 and 57 per 1,000 live births in 1992 to 54 and 39 in 2013, respectively. For the same period, the maternal mortality rate increased from 271 in 1992 to 385 per 100,000 live births in 2013 (see Figure 5). The reduction of infant and maternal mortality rates is a priority in the Harambee Prosperity Plan, which outlines the government’s priorities for the period 2016 to 2020.

A contributing factor to the worsening health indicators during this period could have been the HIV and AIDS pandemic that reached its peak at an average prevalence rate among pregnant women aged 15 to 49 years (20.3%) during the period 2000 to 2006. The prevalence rate has declined since then to 16.9% (2014). HIV and AIDS remains, however, the major underlying cause of high maternal and under-five mortality rates, despite the roll-out of antiretroviral treatment and the prevention of mother-to-child transmission (PMTCT) programme. Namibia has reduced new HIV infections among children by 79% since 2009. Namibia provides antiretroviral medicines to 95% of pregnant women living with HIV, meeting The Global Plan goal of 90%. The budget does not articulate separate budget lines on state expenditure on HIV and AIDS.

The PMTCT intervention reduced the transmission rate of HIV from mother to child from 12% in 2007 to 4% in 2015. About 68% of the 214,956 people who are known

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**Figure 5. Mortality rates**

- Under-five mortality per 1,000
- Infant mortality per 1,000
- Neonatal

Source: Demographic and Health Survey, various years.
to live with HIV receive antiretroviral treatment, while 95% of pregnant women have access to PMTCT. It is estimated that some 17,000 youth between the ages of 10 and 19 years are living with HIV. The prevalence rate amongst girls from 15 to 19 years of age dropped from double-digit figures, reflected in an average of 10.8% between 2000 and 2006, to 5.8% in 2014 (see Figure 6). In 2015, over 95% of children living with HIV received antiretroviral therapy.

Various public awareness campaigns and targeted in-school prevention campaigns have most likely contributed to the general reduction. However, strong fluctuations in the prevalence rate since 2006 and a slight uptick between 2012 and 2014, from 5.4% to 5.8%, clearly indicate that additional efforts are needed to reduce new HIV infections.

In this context, it is of concern to note that teenage pregnancy is on the rise. More young girls aged 15 to 18 years had given birth, were pregnant or had begun childbearing in 2013 than in 2000. The share of girls who are mothers at the age of 15 years has tripled between 2000 and 2013 from 0.8% to 2.5%. The share increased for girls aged 16 and 17 years as well, but dropped for 18-year-old girls (see Figure 7). It is estimated that teenage pregnancy stood at 19% in 2013. The MoHSS’s policy on family planning states that all sexually active
individuals shall have access to contraceptives on request, but expenditures on family planning are not included in the budget as separate line items. However, the use of contraceptives is low among all women aged 15 to 19 years (24.5%), while it is between 46.1% (45 to 49 years) and 62.7% (25 to 29 years) for women older than 19 years of age.

Furthermore, young women between 15 and 19 years of age have the highest usage of traditional methods of contraceptives (5%), while this ranges between 0.4% and 1.7% in the older age categories. Poverty is an underlying issue in the major health issues disproportionately affecting the poorest regions. Therefore, health investments should be equity-based, focusing on the poorest regions and most vulnerable populations.

According to the Demographic and Health Survey 2013, education plays an important role in the use of contraceptives, since their use is lowest among women with no formal education and highest among women with more than secondary education. Therefore, a stronger focus should be placed in schools on sexual and reproductive health and comprehensive sexuality education.

The ministry’s Medium-Term Plan, contained in the Medium-Term Expenditure Framework, provides a description of the components of its public health and other programmes, such as maternal health and child health. However, the budgetary information at the end of the Medium-Term Plan is categorised according to other criteria such as communicable and non-communicable diseases, and therefore is not comparable with the components mentioned.

The nutritional status of children remains a concern since it has not significantly improved over the years. In 2000, 24% of children were classified as stunted (too short for their age). This share increased even further to 29.0% in 2006 before it dropped to 23.7% in 2013. The share of severely stunted children also increased slightly over this period, from 8.0% to 8.2% (see Figure 8). While the share of wasted children (too thin for their age) declined from 7.5% to 6.2% between 2006 and 2013, the percentage of severely wasted children remained virtually unchanged (1.9% and 2.0% respectively).

There is no dedicated programme in the budget that addresses the nutritional status of children. There is a need to place more emphasis on household food security. A number of interventions are available to address malnutrition, including consumption of fortified foods, supplementation and interventions in the agricultural sector ranging from peri-urban and urban horticulture to different crop and rangeland farming methods such as conservation agriculture.

Furthermore, a new regulation will require grain millers to fortify processed grain with micronutrients in order to obtain a license to sell to the public. This regulation is expected to come into effect in April 2017. In addition, the adoption of good practices in hygiene will further contribute to healthier children.

The central government is responsible for the rural water supply through the Ministry of Agriculture, Water and Forestry. Rural water supply accounts for 23.3% of the ministry’s budget and 0.8% of total government expenditure in 2016/17. The share has fluctuated strongly over the past few years because of capital projects, and reached a high of 2.3% of total government expenditure in 2013/14 or 45.6% of the ministry’s budget.

Namibia’s scorecard for access to safe drinking water is...
very good, with an increase from 60% in 1991 to 87% in 2013. According to the Namibia Population and Housing Census 2011, access to safe water and sanitation remains a challenge in rural areas, where almost one in three do not have access to safe water.

The Ministry of Urban and Rural Development is involved in rural sanitation. Over the past three years 2,000 rural toilets were constructed. However, the objective to end the bucket toilet system in 11 villages was not achieved because of insufficient resources. The ministry is also responsible for the implementation of the sanitation objectives contained in the Harambee Prosperity Plan, which was adopted in 2016, but there is no dedicated budget line for rural sanitation in the ministry’s budget.

Namibia has one of the lowest levels of sanitation coverage in eastern and southern Africa, and despite the effort made, the percentage of the population that had no access to toilet facilities dropped from 65.0% in 1991 to 48.6% in 2011. There is a marked discrepancy between urban (51%) and rural areas (83%). In urban areas, this is explained by rural-urban migration and the consequent expansion of informal settlements. According to the Population and Housing Census of 2011, a total of 59% of children do not have access to toilet facilities, with the highest percentage being 83% in Ohangwena. Therefore, the open defecation rate is high (72% in rural areas and 19% in urban areas).

In 2014, UNICEF funded formative research on hygiene. It shows that Namibian communities demonstrated high levels of hygiene knowledge (87%). However, there is a huge gap between knowledge and practice. Only 53.9% are washing hands with water and soap (68% in urban and 37% in rural areas).

Water, sanitation and hygiene at schools remain a huge challenge. According to the Educational Management Information System (EMIS) 2015, 16.5% of schools did not have sanitation facilities and 16.3% of schools did not have water for handwashing. Kavango East and Kavango West remain poorly serviced in sanitation and water supply. In these regions, only 59.5% and 58% of schools, respectively, have toilets while 65.2% and 65.3% of schools, respectively, have water supply mechanisms.