# MINISTRY OF HEALTH AND SOCIAL SERVICES

# ANNUAL REPORT 2012/2013

**REPUBLIC OF NAMIBIA**
**Ministry of Health and Social Services**

Annual Report
2012/2013

Private Bag 13198
Ministerial Building
Harvey Street
Windhoek, Namibia

Tel: +264 (0)61 203 9111
Fax: +264 (0)61 227 607
E–mail: doccentre@mhss.gov.na
Website: http://www.healthnet.gov.na

# CONTENTS

# TABLE OF TABLES & FIGURES

# ABBREVIATIONS

| | |
|---|---|
| AFHS | Adolescent Friendly Health Services |
| ANC | Ante-natal Care |
| ART | Anti-Retroviral Therapy |
| AU | African Union |
| CDC | Centre for Disease Control |
| CHBC | Community Home Based Care |
| CHCP | Community-based Health Care Providers |
| C-IYCF | Community Infant and Young Child Feeding |
| CNR | Case Notification Rate |
| DOT | Direct Observed Treatment |
| DPR | Disability Prevention and Rehabilitation |
| DNA PCR | Deoxyribonucleic Acid –Polymerase Chain Reaction |
| EmOC | Emergency Obstetric Care |
| EmONC/LSS | Emergency Obstetrics and Neonatal Care/Life Saving Skills |
| e-MTCT | eliminate Mother-to-Child Transmission |
| FBF | Fortified Blended Flour |
| GDP | Gross Domestic Products |
| HAART | Highly Active Antiretroviral Therapy |
| HCT | HIV Counselling and Testing |
| HCWs | Health Care Workers |
| HDI | Human Development Index |
| HIS | Health Information System |
| HIV | Human Immunodeficiency Virus |
| HIVQUAL | HIV Quality Improvement Programme |
| IEC | Information, Education and Communication |
| IFMS | Integrated Financial Management System |
| IMAI | Integrated management of adolescent and adult Illnesses |
| IPT | Ionized Preventative Therapy |
| IT | Information Technology |
| LAN | Local Area Network |
| LPP | Limited Private Practice |
| MDGs | Millennium Development Goals |
| MDR | Multi-Drug Resistant |
| MoF | Ministry of Finance |
| MoHSS | Ministry of Health and Social Services |
| MWT | Ministry of Works and Transport |
| NACS | Nutrition Assessment Counselling and Support |
| NAFIN | Namibia Alliance for Improved Nutrition |
| NCD | Non Communicable Disease |
| NDHS | National Demographic Health Survey |
| NGO | Non-governmental Organisation |
| NIP | Namibia Institute of Pathology |
| NMPNDR | National Maternal Peri/Neonatal Death Review |
| NSF | Namibia Strategic Framework |
| OTS | Orthopaedic Technical Services |
| PHC | Primary Health Care |
| PLHIV | People Living With HIV |
| PMTCT | Prevention of Mother-to-Child Transmission |
| PPP | Public Private Partnerships |
| RUTF | Ready-to-use Therapeutic Food |
| SADC | Southern African Development Community |
| SH | School Health |
| TB | Tuberculosis |
| THP | Traditional Health Practitioners |
| TIPEEG | Targeted Intervention Programme for Employment and Economic Growth |
| UNAM | University of Namibia |
| UNICEF | United Nations Children Fund |
| VCT | Voluntary Counselling and Testing |
| VSO | Voluntary Service Overseas |
| WHO | World Health Organisation |
| WAN | Wide Area Network |
| XDR | Extensively Drug Resistant |

# MINISTER'S FOREWORD

The mandate of the Ministry of Health and Social Services (MoHSS) is derived from Article 95 of the Namibian Constitution which emphasises the adoption of policies and the enactment of legislations to ensure the "health and strength" of Namibians.

Drawing from the supreme law of the country, the Ministry's mandate is to promote and protect the health of the Namibian people and provide quality social services to all, especially the weak and vulnerable members of society. This means that the Ministry has an overall function to develop essential health care programmes based on a primary health care approach which is scientifically sound and socially acceptable.

This Report thus presents the achievements and challenges of the Ministry for the fiscal year 2012/2013 within the afore-stated context. The reporting period saw the implementation of interventions to maximise preventative measures, build capacities and allow the provision of high quality health services, accessible both geographically and financially to the entire population.

The period was characterised by a continued focus by health workers and support staff to provide quality healthcare to Namibians. As noted in the Report, we made significant headway in reducing the incidences of communicable diseases. More communities today have access to clinics than ever before, and infant and maternal mortality rates are declining.

However, the spread of HIV infection remains a very pressing and serious concern. The Ministry will not relent in its pursuit to strengthen the capacity of the public health workers to deliver more efficiently and effectively. We will also not give up in fighting Malaria and Tuberculosis.


**Dr Richard Nchabi Kamwi, MP**
**Minister of Health and Social Services**

# PREFACE

During the period under review, the main challenges facing the Ministry of Health and Social Services included out-dated legislations and the cumbersome process of legal drafting. The Ministry is in consultations with the Ministry of Justice and the Office of the Attorney General to table some of the urgent legislations such as the Public Health Bill, Medical and Dental Bill, Nursing Bill, Allied Health Professions Bill, Social Work and Psychology Bill and the Food Safety Bill.

Lack of adequate funding to maintain the current health facilities, build new ones and procure hi-tech lifesaving equipment was of great worry to the Ministry in its efforts to meet the citizens' growing demands for quality health care. Population growth and urban migration brought its own maladies. For instance, the emergence of new diseases and unprecedented congestions at health facilities because of old infrastructure designed to cater for a limited number of people. Thus, the Ministry is in consultation with the Ministry of Finance and the National Planning Commission (NPC) to address the emergence of new diseases through the construction of adequate health infrastructure.

With regards to maintenance, the Ministry is currently establishing maintenance units at all health facilities to respond rapidly to problems. In the past, this function existed under the Ministry of Transport and Works and was quite cumbersome to effect, hence the unacceptable condition of the infrastructure. The National and Ministerial Public Private Partnership (PPP) policies were approved by Cabinet. The Ministry in consultation with the Ministry of Finance and the Office of the Attorney General will explore the best method of involving the private sector in the development of health infrastructure.

It is our intention to effectively address the challenges highlighted in the Report during the next financial year thus reflecting our priorities of quality service and the improvement of the human resource for health.

Ministry of Health and Social Services
Office of the Minister

**Andrew Ndishishi**
**Permanent Secretary**

# CHAPTER 1: INTRODUCTION

The reporting period saw the implementation of interventions to maximise preventative measures, build capacities and allow the provision of high quality health services, accessible both geographically and financially to the entire population. More specifically, the main challenges that faced the Ministry during the year 2012/2013 included:

- Outdated legislations and cumbersome processes of legal drafting;
- Aging health infrastructure;
- Inadequate financial resources to undertake sufficient maintenance and renovations;
- Bureaucratic procurement procedures of essential consumables and hi-tech lifesaving equipment and;
- The none-maintenance of infrastructure without regard to health emergencies resulting in delays in delivering quality health services to the needy.

The Ministry is in consultation with the Ministry of Finance and the National Planning Commission to address some of the pressing issues especially the insufficient health infrastructure, and the timely provision of consumables and hi-tech lifesaving equipment.

With regards to the maintenance of health infrastructure, the Ministry hopes to establish maintenance units soon at all health facilities. This highly centralised function was previously performed by the Ministry of Works and Transport.

During the reporting period, Cabinet approved the National and Ministerial PPP policies. The Ministry in consultation with the MoF and the Office of the Attorney General will explore the best method of involving the private sector in the development of health infrastructure.

The Ministry introduced a distance Leadership and Management Training Programme for all management cadres at both national and regional levels to enhance health planning, efficient supervision of workers, monitoring and evaluation of programmes and improve the management of hospitals and health facilities.
With regard to quality and standards, the Ministry is committed to ensure a quality health service provision that conforms to national laws and international standards prescribed by the WHO, International Standard Organisation, Codex Allimentarius, AU and SADC. To this end, all health professional staff will undergo in-service training on the best health practices. More importantly, the Ministry has stepped up its efforts to ensure that patients have access to safe medical care and pharmaceutical products.

The Ministry is aware of the national outcry concerning the attitude and conduct of some of the health professionals and support staff at health facilities. All supervisors, especially national and regional directors and hospital managers are under strict instructions to enforce operational manuals, ethics and discipline. Where applicable, they are directed to use the provision of the Public Service Act to instil discipline.

Other directives include the provision of regular supportive supervision and a consistent follow-up on identified problems. The Ministry's management is directed to recognise and reward staff that are doing their best to execute their duties.
To address overcrowding at the Katutura Intermediate Hospital, the Ministry decided to upgrade Katutura and Khomasdal Health Centres to provide 24-hour services, seven days a week, to reduce pressure on the Katutura Intermediate Hospital and to make services more available to the increasing population of the Khomas Region.

In addition, feasibility studies for the establishment of district hospitals in Khomas and Oshana Regions will be undertaken during the 2013/14 financial year and construction is envisaged to start in the 2014/15 financial year. The Ministry is also investigating the possibility of other health centres in the country operating on a 24-hour basis.

The Ministry will continue to place great emphasis on the primary health care approach which remains the benchmark for health and social service delivery as the approach is responsive to rational evidence-based health needs and social expectations of the people.

# CHAPTER 2: DEMOGRAPHY & SOCIO-ECONOMIC DEVELOPMENT

## 2.1 DEMOGRAPHY

Namibia is divided into 13 regions where health services are delivered. The regions vary in size in terms of square kilometres and populations served. Regional demographic profiles serve as important indicators for planning, monitoring and evaluation of service programmes.

Regions with the highest population of more than 200 000 people include Khomas, Ohangwena, Omusati, and Kavango while regions with less than 70 000 people are Hardap, Karas, Omaheke and Kunene. The regions with the highest urban populations are Khomas, Erongo and Karas, while Ohangwena, Omusati and Oshikoto have the lowest urban populations.

## 2.2 SOCIO-ECONOMIC DEVELOPMENT

Namibia is classified as an upper middle-income country with an estimated annual GDP per capita of US$5 293. However, this relatively high-income status marks extreme inequalities in income distribution, standard of living, and quality of life. In terms of the 2012 HDI, Namibia is ranked 128 out of 186 countries with an HDI of 0.608.

The incidence of poverty is estimated at 28.7% of the population, with a poverty gap of 8.8% of the poverty line, while about 15% of the population is estimated to be living in severe poverty. Namibia is rated as one of the most unequal countries in the world with a Gini-Coefficient of 0.597. Although onaggregate,the level of inequality might appear to be declining, it has increased slightly in seven of the 13regions, namely Khomas, Kunene, Ohangwena, Omusati, Caprivi, Karas and Otjozondjupa.

With relatively high poverty levels estimated at 29% of the population, a high unemployment rate of 27.4%; HIV/AIDS prevalence rate at 18.2%; a large proportion of the Namibian population is particularly vulnerable to unfavourable developments in the global economy.

## 2.3 HEALTH STATUS

Namibia's average spending on the health sector is above that of sub-Saharan Africa and that of the upper-middle income countries. Namibia spends more than 6% of her GDP on health. However, in comparison with other countries, Namibia's health expenditure has remained static while that of countries like Botswana has increased over the same period.

Quality health is important for people to live a productive life. Since independence, Namibia focused more on preventative care and expansion of services to all Namibians. But,despite a relatively high rate of spending on health, Namibia is struggling to meet its health-related Millennium Development Goals (MDGs) with respect to infant, under five and maternal mortality rates.

# CHAPTER 3: POLICY, PLANNING & LEGISLATION

## 3.1 POLICY, PLANNING AND LEGISLATION

Effective planning, and appropriate management support towards policy formulation and development cooperation is critical.

### 3.1.1 Policy Management and Development

The Ministerial Policy Management, Development and Review Committee (PMDRC) approved regulations from the Health Professions Council of Namibia and some policy documents. The policies that were approved include:

- National Health Laboratory Policy;
- National Policy on Sexual;
- Reproductive and Child Health;
- National Medicine Policy, and;
- National Referral Policy

In addition, staffing norms for clinics and health centres were reviewed and approved by PMDRC.

The draft National Food Safety Bill and Policy are at second draft stage, whilst the Public and National Environment Health Bills were submitted to Cabinet Committee on Legislation for discussions.

In collaboration with the Health Professions Council of Namibia (HPCNA), task shifting for registered nurses to perform Male Circumcision (MC) procedures were approved. Furthermore, proposed amendments to the various Acts from the HPCNA were approved by the MoHSS.

Furthermore, PMDRC approved the following applications for the establishment of new health facilities. These include:

- Conversion of the old maternity ward to nurses accommodation facilities in Erongo Region;
- Application for a new clinic at Malengalenga and renovation of the Katima Mulilo Laboratory in Caprivi Region;
- Application for a new clinic at Othithiyaand Onaanda health post in Omusati Region;
- Prefabricated units for Khomas Region and Large Rural Health Centre at Tsumkwe in Otjozondjupa Region.

### 3.1.2 Legal Services in the Ministry

Legal support services provided during the period covered civil claims against the State on medical, transport and administrative issues. The biggestachievement in this regard was the filling of the Deputy Director position for Legal Services. The Directorate carried out its legal functions in consultation with the Attorney General's office. The Ministry spent N$515 461 on legal cases while N$468 960 was spent on legal drafters. Table 1 shows the legal cases finalised.

Table 1: Legal cases handled in 2012/13

| Type of case | Number |
|---|---|
| Claims in respect of Government vehicle accidents | 4 |
| Claims related to medical negligence | 2 |
| Claims from suppliers | 1 |
| Labour related claims | 1 |
| **Total** | **8** |

### 3.1.3 Registration and licensing of health facilities

Registration and licensing of health facilities in the Khomas Region was decentralised. Six hundred (600) licences for operating private health facilities were renewed while 119 new licences were issued. One hundred and thirty six (136) health professionals were authorised to use State health facilities.

## 3.2 DEVELOPMENT COOPERATION

- The Ministry participated in cross border meetings between Namibia and Botswana as well as between Namibia and Angola. The Ministry also participated in the Joint Permanent Commissions between

Namibia and other countries, including Botswana; Cuba; Indonesia; Nigeria; Zambia; and Zimbabwe.

- A Memorandum of Understanding (MoU) between MoHSS and the Ministry of Education was reviewed. The MoU provides for a mutually cooperative partnership as opposed to an obligatory one to improve the well-being, health and academic achievements of school learners.
- The MoHSS collaborated with the Roman Catholic Hospital, De Beers Marine and Novo Nordisk to screen communities for high blood pressure, blood sugar and cholesterol levels, which included measuring the waist circumferences of the 2 750 guests at the commemoration of Healthy Lifestyle Day in February 2013.
- Essential dental equipment/instruments/materials worth about N$322 731 were donated to Grootfontein Hospital by the Dentists Without Limit Foundation. This has increased accessibility of dental services in the district.

Table 2: Development projects and agreements signed in 2012-2013

| Development Partner | Title/Area of support | Agreement date | Duration | Region |
|---|---|---|---|---|
| 1. Nampharm Foundation Trust | Agreement: Operation of Children born with facial imperfections | 3 August 2012 | 5 years | All regions |
| 2. Cuba | Agreement: Specific Agreement for Cuban Medical Services | 9 December 2012 | 2 years | All regions |
| 3. Namibia Planned Parenthood Association (NAPPA) | Agreement: Supply and distribution of family health commodities from the MoHSS to NAPPA were concluded | 15 December 2012 | – | All regions |
| 4. Skorpion Zinc Pty Ltd | Agreement: Construction of a TB ward at Katutura Hospital | 20 October 2012 | Until full completion of the project under the Agreement | Khomas |
| 5. Synergos Institute | MoU: Provision of Technical Professional staff to the MoHSS | 14 February 2013 | 2 years | Khomas |
| 6. Cuba | Agreement: Specific Agreement for Academic purposes | 28 February 2013 | 7 years | Khomas |
| 7. OK Prosthetics | Agreement: Assisting in the Provision of Specific Prosthetics Solutions, Material Components and Training Delivery in Namibia | 26 March 2013 | 3 Years | All regions |
| 8. Church of Jesus Christ (Latter Day Saint) | Agreement: Provision of Wheel Chairs and Assertive Devices | 29 March 2013 | 3 years | All regions |
| 9. Finland Ministry of Foreign Affairs | Strengthening of a comprehensive school health programme | October 2012 | | |

## 3.3 MANAGEMENT INFORMATION SYSTEMS

The Management Information System is designed to provide information for decision making, specifically to support strategic planning, assess health status needs, and track performance and to allocate resources efficiently and equitably.

### 3.4 RESEARCH

The health system's research and development are important cornerstones as they help with the development of a deeper understanding of challenges confronting the Ministry and consequently provide innovative ways of dealing with these challenges. They are also important in creating new opportunities by using and applying the benefits of science and technology as well as providing the edge for competitive sourcing of medical equipment, supplies and infrastructure development among others. During the reporting period, the Ministry undertook the following studies and research.

### 3.4.1 National Demographic Health Survey (NDHS)

The Ministry in collaboration with the NSA and NIP will conduct a Demographic and Health Survey during 2013. This is a population based survey which will be done in all regions of the country. The findings of the survey will provide policymakers with evidence-based information for planning issues such as key demographic rates, fertility, infant mortality, under-five mortality, and adult mortality rates. Furthermore, the survey will give the prevalence rate of HIV, Anaemia and High Blood Pressure at national and regional levels.

### 3.4.2 Resource Allocation Criteria

The Ministry intends to develop and implement a resource allocation formula as a way of promoting more equitable access to health services in line with its strategic plan. In developing the formula, various research studies were undertaken such as the costing of outreach services. Further research is to be done on populations, including foreign clients, served by referral centres.

### 3.4.3 Operational Research

As regard operational research, 22 health-related research proposals were submitted to the Research Ethics Committee for review. Of the 22 proposals, 20 were approved while two were pending approval.

### 3.4.4 Other Research and Surveys

The Ministry conducted the following researches and surveys:

- Food Consumption and Micronutrient Survey
- NCD Step Survey
- Exploratory Study on ICD
- Study on Teenage Pregnancy
- Baseline Survey on Health Extension Workers
- Home-based Care Assessment Survey
- Basic Research on Hygiene Promotion,
- Flood Impact on the Affected Communities,and
- Integrated Biological and Behavioural Surveillance Survey.

# CHAPTER 4: RESOURCE MANAGEMENT & GENERAL SERVICES

## 4.1 HUMAN RESOURCE MANAGEMENT

The mobilisation of human resources for health is an attempt to provide the health personnel the country needs in sufficient numbers, with the right competence so that the population can have quality health.

### 4.1.1 Distribution of Health Professionals

The Ministry had 11 270 posts on its establishment of which 9 899 were filled representing 88% post filled rate. To augment the Ministry's staff establishment, 46 volunteer health professionals were sent to various regions and hospitals.

The Ministry recruited 812 new employees as reflected in the Table 3. Of this number, 331 were non-Namibian health professionals who were issued work permits. There were 405 doctors in the public health sector of whom 347 were medical officers and 58 medical specialists. Additionally, 120 staff-were promoted into higher positions.

Overall, close to 17% of staff were recruited at Katutura Intermediate Hospital, followed by Oshakati Intermediate Hospital with 11.2% as shown in Table 3. Oshikoto Region had the highest recruitment rate among the regions with 11.0 %. Only 3.2% of staff were recruited at the National level directorates. As to job categories, the highest numbers of health professionals recruited were registered nurses at 206, followed by enrolled nurses at 160 and doctors at 60.

Medical doctors are one of the key health professionals required in any health sector. The Ministry had 348 medical doctors and 66 medical specialists in its employment during the reporting period. Numbers of doctors and specialists per directorate/hospital are presented in tables 4 and 5. In addition, the number of medical officers and specialists includes volunteers who were not appointed in the medical officer or specialist positions.

Table 3:
Summary of staff recruitment per region or hospital

| Region/Hospital/ Directorate | # of Staff recruited | % |
|---|---|---|
| Caprivi | 25 | 3.1% |
| Erongo | 41 | 5.0% |
| Hardap | 25 | 3.1% |
| Karas | 34 | 4.2% |
| Kavango | 41 | 5.0% |
| Khomas | 22 | 2.7% |
| Kunene | 13 | 1.6% |
| Ohangwena | 44 | 5.4% |
| Omaheke | 15 | 1.8% |
| Omusati | 28 | 3.4% |
| Oshana | 24 | 3.0% |
| Oshikoto | 89 | 11.0% |
| Otjozondjupa | 45 | 5.5% |
| Katutura Hospital | 137 | 16.9% |
| Oshakati Hospital | 91 | 11.2% |
| Rundu Hospital | 36 | 4.4% |
| Windhoek Central Hospital | 76 | 9.4% |
| National Level Directorates | 26 | 3.2% |
| **Total** | **812** | **100%** |

Table 4: Medical officers and specialists in MoHSS from April 2012 to March 2013

| Region/Hospital/ Directorate | # of doctors in posts | # of doctors additional to Staff establishment | # of Volunteers | # of Specialists | Total |
|---|---|---|---|---|---|
| Caprivi | 6 | 3 | 4 | 0 | 13 |
| Erongo | 15 | 4 | 1 | 0 | 20 |
| Hardap | 7 | 0 | 0 | 0 | 7 |
| Karas | 9 | 0 | 0 | 0 | 9 |
| Kavango | 7 | 0 | 3 | 0 | 10 |
| Khomas | 10 | 5 | 12 | 0 | 27 |
| Kunene | 7 | 0 | 0 | 0 | 7 |
| National Level | 4 | 1 | 1 | 0 | 6 |
| Ohangwena | 10 | 4 | 2 | 0 | 16 |
| Omaheke | 6 | 0 | 0 | 0 | 6 |
| Omusati | 18 | 0 | 1 | 0 | 19 |
| Oshana | 6 | 0 | 3 | 0 | 9 |
| Oshikoto | 8 | 1 | 1 | 0 | 10 |
| Otjozondjupa | 18 | 0 | 2 | 0 | 20 |
| Windhoek Central Hospital | 49 | 0 | 0 | 32 | 81 |
| Katutura Hospital | 37 | 59 | 8 | 10 | 114 |
| Oshakati Hospital (Oshana Region) | 36 | 3 | 0 | 14 | 53 |
| Rundu Hospital (Kavango Region) | 15 | 0 | 0 | 10 | 25 |
| **Total** | **268** | **80** | **38** | **66** | **452** |

Table 5: Health specialists per hospital 2012/13

| Field of Specialisation | Windhoek Central Hospital | Katutura Intermediate Hospital | Oshakati Intermediate Hospital | Rundu Intermediate Hospital | Total |
|---|---|---|---|---|---|
| Surgery | 3 | 4 | 2 | 1 | 10 |
| Plastic Surgery | | | 1 | | 1 |
| Urology | 2 | 1 | 1 | | 4 |
| Anaesthesiology | 3 | 1 | 1 | | 5 |
| Gynaecology | 2 | 1 | 2 | | 5 |
| Orthopaedic | | | 2 | | 2 |
| Physician | 4 | 2 | 2 | 1 | 9 |
| Psychiatrist | 2 | | 1 | | 3 |
| Radiologist (Diagnostic) | 1 | | 1 | | 2 |
| Radiologist (Radio therapy) | 1 | | 0 | | 1 |
| Ear, nose & throat | 1 | | 0 | | 1 |
| Intensivist | 1 | | 0 | | 1 |
| Nuclear Medicine | 1 | | 0 | | 1 |
| Ophthalmology | 2 | | 0 | | 2 |
| Oncologist | 2 | | 0 | | 2 |

| Table 5 Continued: Health specialists per hospital 2012/13 | | | | | |
|---|---|---|---|---|---|
| Field of Specialisation | Windhoek Central Hospital | Katutura Intermediate Hospital | Oshakati Intermediate Hospital | Rundu Intermediate Hospital | Total |
| Pathologist | | | 0 | | |
| Neonatology | 1 | | 0 | | 1 |
| Gastro-Entrology | 1 | | 0 | | 1 |
| Neurology | 1 | | 1 | | 2 |
| Cardiac Paediatric | | | 0 | | |
| Cardiologist | 1 | | 0 | | 1 |
| Cardiothoracic Surgeon | 1 | | 0 | | 1 |
| Paediatric | 1 | 1 | 0 | | 2 |
| Arthoplast | 1 | | | | 1 |
| **Total** | **32** | **10** | **14** | **2** | **58** |

From the 58 medical specialists, 56 were registered with the Health Professions Council of Namibia (HPCNA), while two were authorised to practice by the Ministry. Furthermore, of the 56 registered specialists, 40 were authorised to do Limited Private Practice (LPP).

The Ministry absorbed 37 donor-funded doctors by appointing them in vacant positions as additional staff. One hundred and twenty (120) staff were promoted into higher positions. Table 8 represents those promoted per Directorate.

| Table 6: Staff promoted in 2012/13 | |
|---|---|
| Directorate/Hospital | Number of Staff Promoted |
| Caprivi | 7 |
| Erongo | 10 |
| Hardap | 4 |
| //Karas | 4 |
| Kavango | 5 |
| Khomas | 5 |
| Kunene | 3 |
| Ohangwena | 0 |
| Omaheke | 2 |
| Omusati | 8 |
| Oshana | 4 |
| Oshikoto | 2 |
| Otjozondjupa | 9 |
| Katutura Hospital | 19 |
| Oshakati Hospital | 9 |
| Rundu Hospital | 9 |
| Windhoek Central Hospital | 12 |
| National Level Directorates | 8 |
| **Total** | **120** |

Despite its staff recruitment drive, the Ministry lost 660 staff during the reporting period. Tables 7 presents summaries of the numbers of staff losses per directorate/hospital and numbers of staff recruited versus staff losses in selected job categories.

With regard to job categories, enrolled nurses represented the highest number of staff losses at 234 (35.5%), followed by other administrative and technical staff at 186 (28.1%), registered nurses 173 (26.2%), doctors 45 (6.8%), pharmacists 5 (0.8%), pharmacist assistants 7 (1%), social workers 6 (0.9%), and radiographers 4 (0.6%).

Resignations were responsible for the highest staff losses. Three hundred and forty nine (349) staff resigned during the period representing 52.8%. Closely behind were those who retired at 143 (21.6%). Through contracts ending, the Ministry lost 52 staff (7.9%) while 51 (7.7%) died. Twenty seven, representing 4.1% left because of ill health, 21 (3.1%) were dismissed while 17 (2.6%) absconded. A high number of staff losses in certain job categories reversed the progress made through recruitment. Staff recruited in comparison to losses is reflected in Table 7.

| Table 7: Staff recruited versus staff losses in selected job-categories | | |
|---|---|---|
| Job category | # of staff recruited | # of staff losses |
| Doctor | 60 | 45 |
| Registered Nurse | 206 | 173 |
| Enrolled Nurse | 160 | 234 |
| Pharmacist | 46 | 5 |
| Pharmacist Assistant | 18 | 7 |

| | | |
|---|---|---|
| Environmental Health Officer | 2 | 0 |
| Radiographer | 11 | 4 |
| Social Worker | 35 | 6 |
| Total | 120 | |

A high number of disciplinary cases depicted symptoms of dissatisfaction, poor motivation and low morale among staff. Table 8 presents numbers of disciplinary cases per region.

Table 8: Disciplinary cases per region in 2012/13

| Region/Referral Hospital | # of cases |
|---|---|
| Caprivi | 1 |
| Erongo | 2 |
| Hardap | 1 |
| //Karas | 5 |
| Kavango | 0 |
| Khomas | 2 |
| Kunene | 3 |
| Ohangwena | 1 |
| Omaheke | 0 |
| Omusati | 2 |
| Oshana | 1 |
| Oshikoto | 4 |
| Otjozondjupa | 7 |
| Katutura Hospital | 3 |
| Oshakati Hospital | 15 |
| Rundu Hospital | 3 |
| Windhoek Central Hospital | 3 |
| National Level Directorates | 12 |
| **Total** | **65** |

Katutura Intermediate Hospital had the highest number of disciplinary cases while Kavango and Omaheke regions recorded no single disciplinary case.

### 4.1.2 Staffing in the Public Health Sector

Referral and regional hospitals are the MoHSS' implementation units of service delivery. According to the staff establishment, the number of posts filled at these units is 87%. The number does not inform the skewed distribution of human resources, their competencies and placements.

Table 9: Staffing in the public health sector

| Offices | # of Posts Approved | # of Posts Filled | # of Posts Vacant | Additional Posts Filled |
|---|---|---|---|---|
| Intermediate Hospital Oshakati | 1 079 | 986 | 93 | 26 |
| Oshana region | 280 | 254 | 26 | 0 |
| Hardap Region | 355 | 305 | 50 | 13 |
| Ohangwena Region | 714 | 625 | 80 | 55 |
| Oshikoto Region | 467 | 404 | 63 | 6 |
| Erongo Region | 710 | 753 | 57 | 12 |
| Kunene Region | 508 | 425 | 83 | 3 |
| Kavango Region | 443 | 357 | 86 | 9 |
| Omaheke Region | 267 | 232 | 35 | 6 |
| //Karas Region | 564 | 481 | 83 | 3 |
| Khomas Region | 311 | 271 | 40 | 20 |
| Windhoek Central Hospital | 1 484 | 1 264 | 220 | 36 |
| Khomas Region | 1 063 | 1 014 | 49 | 91 |
| Omusati Region | 741 | 656 | 85 | 52 |
| Caprivi Region | 379 | 329 | 50 | 4 |
| Otjozondjupa Region | 670 | 604 | 66 | 14 |
| National Level | 791 | 555 | 236 | 21 |
| RMT-Kavango | 511 | 420 | 91 | 4 |
| **Total** | **11 337** | **9 935** | **1 493** | **375** |

## 4.2 HUMAN RESOURCE DEVELOPMENT

### 4.2.1 Pre-service Training

- Twenty six (26) Namibian Medical and 10 Pharmacy interns started with their internship training programmes at Windhoek Central Hospital and Katutura Intermediate Hospital respectively.
- Three hundred and seventy five (375) students completed training on the Ministry's Training Network.
- Two thousand and seven students (2 007) are pursuing health related training programmes at UNAM and the Polytechnic of Namibia respectively. This number includes 129 students in Environmental Health Sciences and 97 in Bio-Medical Sciences.
- Two hundred students (200) completed Nursing, Social Work and Radiography at UNAM while 18 were pursuing their academic studies in Environmental

Health and 21 in Bio-Medical Sciences in the 2011 academic year.
- Twenty five pharmacist assistants (25) and 230 enrolled nurses completed their two year certificate course in the MoHSS Training Network.

### 4.2.2 In-service and Continuous Education

- One hundred and forty (147) staff are pursuing a three-year Diploma in Comprehensive Nursing and Midwifery and various other nursing specialisations
- One hundred and eighty four (184) are pursuing B-Degree in Nursing at UNAM.

### 4.2.3 Post Graduate Training

- Five medical doctors completed specialisation in Pathology, General Surgery, Obstetrics and Gynaecology, Anaesthesiology and Ophthalmology respectively.
- Twenty two (22) doctors are pursuing specialisation training programmes. Of these, three are expected to complete Nuclear Medicine, Obstetrics and Gynaecology and Cardio-thoracic Surgery in 2013/14.
- Twelve (12) doctors are expected to complete studies in various specialisation fields in 2014/15.
- Four doctors are scheduled to start with specialisation programmes in 2013. Two in Dermatology and the other two in General Surgery.

## 4.3 EMPLOYEE ASSISTANCE PROGRAMME

The core mandate of the Employee Assistance Programme (EAP) is to provide technical support to the HIV/AIDS Workplace Programmes and to staff in the Ministry. During the reporting period, 30 Wellness Programme focal persons from 10 regions were trained to ensure staff wellbeing.

## 4.4 GENERAL SUPPORT SERVICES

### 4.4.1 Contract Management

Service level agreements for rendering laundry services were signed, while tenders for the following services were advertised: Security, laundry detergents and protective wear. Requests for price increase for medical gasses, catering and cleaning chemicals were approved. Payment of the following contract related services made and a total amount of N$35 407 903 94.00 was spent

Table 10: Contracted Services

| Contracted Agency | Amount Paid |
|---|---|
| Telecom | 4,053,077.80 |
| MTC | 278,265.65 |
| NamPost | 75,932.68 |
| Telepassport | 919,861.73 |
| Lithography | 132,888.99 |
| Security | 1,216,962.80 |
| Internet | 744,571.41 |
| City of Windhoek | 27,986,342.88 |
| **Total** | **35,407,903.94** |

### 4.4.2 Information Technology

IT situation analysis visits on LAN and WAN were conducted in all regions while a new IFMS version was installed at all regional offices. E-Health was rolled out to the Oshana Region, while D-base software on specific human resource information was installed. Wireless installations were done at Keetmanshoop, Windhoek Central, Oshakati and Rundu hospitals.

The Ministry also completed the implementation of the Integrated Health Care Information Management System (E-health) at the Windhoek Central Hospital. The system is now employed at Oshakati Intermediate Hospital. The tender for strengthening the network infrastructure at Windhoek Central, Oshakati, Rundu and Keetmanshoop hospitals was awarded and the work has already started at Oshakati and Rundu hospitals.

Three hundredand forty (340) computers and other IT equipment were bought to fast track the operation of the system in the said hospitals. A database on private hospitals and health facilities was developed.

Several systems were developed that capture HIV, TB and health data. However, these systems are not harmonised or linked. To address this issue, the Ministry has started a transformational process to develop an integrated and sustainable health information system. The development is based on three core areas; strategic planning, human resources, and the alignment of information systems to the integrated vision for HIS.

### 4.4.3 Stakeholders Relations and Coordination

The Ministry maintained a good relationship with relevant stakeholders and enforced compliance to legislations with regard to the Health Facility Act during the reporting period. In its quest to implement the Health Facility Act, the Ministry issued 600 licences to private health facilities. In addition, the Ministry issued authorisations to 136 private health professionals to use State health facilities as part of promoting PPP.

Annexure 1 attached presents the number of health facilities per region. A database on private hospitals and health facilities was developed.

Twenty (20) ministerial management meetings were held, while consultative meetings were held with relevant stakeholders including(OPM, Telecom, Department of Works, City of WHK, and security companies).

# CHAPTER 5: FINANCE & LOGISTICS

## 5.1 FINANCIAL MANAGEMENT

### 5.1.1 MoHSS Budget Allocation

The initial budget allocation to the Ministry during the 2012/2013 was N$3 975 968 000 (Operational Budget N$3 480 042 000 and Development Budget N$495 926 000). During the financial year the Ministry was granted approval by Treasury to virement funds for the defrayal of anticipated shortfalls, within the operational budget, development budget and from the development budget to the operational budget. After the implementation of virements the operational budget stood at N$3 537 445 878 and the development budget N$438 522 122. The highest budget allocation of the main sub divisions was for the procurement of vehicles, which had an allocation of N$32 700 000.

### 5.1.2 Revenue Collection

The total Non-Tax Revenue collected for the financial year ending March 2013 was N$100 992 848. The total revenue collected against the estimate is summarised in Table 11.

Table 11: Revenue collected per Revenue Head (N$'000)

| Source of Revenue | Expected Revenue | Revenue Collected | Percentage |
|---|---|---|---|
| Private Telephone Calls | 10 | 12 | 121% |
| Miscellaneous | 15 783 | 42 437 | 269% |
| Health Services | 35 700 | 44 439 | 124% |
| Board and Lodging | 5 300 | 7 105 | 134% |
| Inspection Fees | 318 | 442 | 139% |
| Mortuary Fees | 267 | 192 | 72% |
| Sale of Electricity | 95 | 267 | 281% |
| Ambulance Fees | 102 | 139 | 137% |
| Vehicle sales | 900 | 0 | 0% |
| Incineration | 1 090 | 1 353 | 124% |
| Medical Reports | 500 | 378 | 76% |
| Registration of Medicine | 655 | 684 | 99% |
| Retention Fees | 3 562 | 3 544 | 104% |
| **Total** | **64 282** | **100 993** | **157%** |

75% of the total revenue collected was from user fees paid by patients when visiting State facilities. The largest part of Ministerial revenue was generated through Retention Fees paid yearly by companies on pharmaceutical products registered in terms of the Medicines and Related Substances Control Act, (Act 13 of 2003).

### 5.1.3 Operational Budget Execution

The overall budget execution rate for the financial year was 95%, the operational budget execution rate being 98% and development budget 70%. The virements especially from the development budget to the operational budget were to cater for the shortfall as a result of the 8% salary increases. An amount of N$51 012 903 was viremented from the development budget to the operational budget for this purpose.

### 5.1.4 Development/Capital Budget

The development of capital projects, especially health facilities is crucial if health and social services are to be accessible to all citizens. During the reporting period, the Ministry implemented a number of capital projects which included the concept and design of feasibility studies, renovations, maintenance, construction and upgrading of health facilities.

The Ministry in collaboration with MWT developed infrastructure through TIPEEG. Under the TIPEEG programme, the Ministry advertised tenders, evaluate and recommend successful bidders to the Tender Board Committee for approval. This process has ensured that the Ministry implements its capital development projects efficiently.

#### 5.1.4.1 Construction of hospitals

The following hospitals were under construction during the reporting period

Table 12: Hospital under construction

| Project | Components | Procurement method | Status |
|---|---|---|---|
| Katutura Hospital | Replacement of all hot and cold water piping, sewerage and drainage systems, upgrading electrical reticulation, replacement of condensate air conditioning, piping and the renovation of pharmacy and dentistry units | MWT | Construction on-going |
| Windhoek Central Hospital | Replacement of the entire hospital sewerage pipes. Replacement of lifts and construction of additional doctors' quarters | MWT | Construction on-going |
| Windhoek Central Hospital Maternity Unit | Upgrading of ante and post natal wards, premature unit, kitchen, new ART Clinic &electrical/mechanical works | MWT | Construction on-going |
| Oshakati Hospital | Nuclear Medicine, Ward 54 & 55 and maternity ward | MWT | Construction on-going |
| Rundu Hospital | Feasibility and documentation for maternity ward. | MWT | |
| Onandjokwe Hospital | Feasibility and documentation for maternity ward | MWT | |
| Usakos Hospital | Administrative offices | TIPEEG | Construction on-going |
| Omuthiya Hospital | Feasibility and documentation for alterations to newly constructed hospital | TIPEEG | Tender awarded and contract to be signed |
| Outjo Hospital | Upgrading of male and female wards, nurses home, and mortuary | MWT | Construction on-going |
| Tsandi Hospital | New administration block, renovations to existing wards and construction of elevated water tower tender evaluation underway | TIPEEG | Construction on-going |
| Okahao Hospital | New administration block, renovations and alterations to existing Casualty/OPD, Renovations and alterations to existing mortuary and all related mechanical and electrical services, new PHC clinic & ART clinic, new guard house and entrance gate construction | MWT | Contractors have completed renovations and alterations to existing mortuary and all related mechanical and electrical services and guard house. PHC and ART clinic and rest of the work. Tender to be advertised |
| Katima Mulilo Hospital | Upgrading of OPD/Casualty, maternity ward, ablutions, drying yard &x-ray unit. Up-grading of laundry, low care ward & remainder of general wards TB ward, generator room | MWT | Construction on-going |
| Gobabis Hospital | Replacements of roofs | TIPEEG | Roof replacement completed |
| Keetmanshoop Hospital | Construction of the TB ward | TIPEEG | Construction on-going |
| St. Mary's Hospital | Construction of five-bedroom houses, renovation of private ward and water tank | TIPEEG | Construction on-going |
| Okakarara Hospital | Dormitories 2 &3, matron's house and garage, demolition of buildings and site works | MWT | Evaluation to be submitted to Tender Board |

### 5.1.4.2 Construction of health centres

The Ministry undertook the construction of the following health centres, of which only Mangeti Dunes in Otjozondjupa Region was completed.

Table 13: Health centres under construction

| Project | Components | Procurement method | Status |
|---|---|---|---|
| Okalongo | Omusati | MWT | Annual contractor for electrical works completed |
| Sesfotein | Kunene | TIPEEG | Construction on-going |
| Okankolo | Oshikoto | TIPEEG | Construction on-going |
| Bethanie | Karas | TIPEEG | Construction on-going |
| Mangetti Dunes | Otjozondjupa | MWT | Completed |
| Okondjatu | Otjozondjupa | TIPEEG | Construction on-going |

### 5.1.4.3 Construction of clinics

The Ministry also carried out the construction of the following clinics countrywide as reflected in the Table 14.

Table 14: Clinics under construction

| Project | Region | Procurement method | Status |
|---|---|---|---|
| Kanono (upgrading) | Caprivi | MWT | Construction on-going |
| Masokotwane (upgrading) | Caprivi | MWT | Construction on-going |
| Hakhaseb (upgrading) | Erongo | TIPEEG | Construction on-going |
| Mondesa (new clinic & staff accommodation) | Erongo | TIPEEG | Construction on-going |
| Otuani (new clinic &staff accommodation) | Kunene | MWT | Construction on-going |
| Ombombo (new clinic & staff accommodation) | Kunene | MWT | Construction on-going |
| Otjondeka (upgrading) | Kunene | TIPEEG | Construction on-going |
| Block E Rehoboth (upgrading) | Hardap | TIPEEG | Construction on-going |
| Buitepos | Omaheke | TIPEEG | Construction on-going |
| DaanViljoen | Karas | TIPEEG | Construction on-going |
| Rosh Pinah | Karas | MWT/Skorpion Zinc | Completed |
| Gcaruha | Kavango | TIPEEG | Construction on-going |
| Ncaute | Kavango | TIPEEG | Construction on-going |
| Shamaturu | Kavango | TIPEEG | Construction on-going |
| Oshivelo | Oshikoto | TIPEEG | Construction on-going |

| | | | |
|---|---|---|---|
| Omuhongo | Ohangwena | TIPEEG | Construction on-going |
| Onamutayi | Oshana | TIPEEG | Construction on-going |
| Ehafo | Oshana | TIPEEG | Contract signed and contractor has taken possession of site |
| Impalila | Caprivi | TIPEEG | Construction on-going |
| Swakopmund ART | Erongo | TIPEEG | Construction on-going |
| Arandis | Erongo | TIPEEG | Construction on-going |
| Rundu ART | Kavango | TIPEEG | Construction on-going |
| Epukiro Mortuary | Omaheke | TIPEEG | Completed |

#### 5.1.4.4 Renovations of health facilities

Sixty nine (69) health facilities and other infrastructure were renovated and repaired through a capital works budget of N$20 000 000.

Table 15: Health facilities renovated during 2012/13

| Type of Facility | Region | Name of Facility |
|---|---|---|
| Referral Hospitals | Khomas | Windhoek Central Hospital |
| | Kavango | Rundu Hospitals |
| Intermediate Hospitals | Khomas | Katutura Intermediate Hospital |
| | Oshana | Oshakati Intermediate Hospital |
| District Hospitals | //Karas | Lüderitz Hospital |
| | Ohangwena | Okongo & Engela Hospitals |
| | Erongo | Swakopmund, Walvisbay & Omaruru |
| | Hardap | Mariental Hospital |
| | Otjozondjupa | Grootfontein Hospital |
| PHC Clinics | Khomas | Groot Aub and Robert Mugabe clinics |
| | Hardap | Klein – Aub Clinic |
| | Omaheke | Tallesmanus, Leonardville, Omitara and Otjinene clinics |
| | Caprivi | Ibbu, Mbalasinte, Itomba, Choi, Chintimane, Mafuta and Batubaja Clinics |
| | Kavango | Kandjara, Nkarapamwe Clinics |
| | Oshikoto | Ontunda, Tsinsabis Clinics |
| | Ohangwena | Odobe, Eudafano, Endola Clinics |
| | Omusati | Uutsathima Clinic |
| | Erongo | Kuiseb -, Tamariskia, Okombahe Clinics |
| Health Centres | Oshikoto | Onyaanya Health Centre |
| Other Facilities | Khomas | Khomas Regional Office, Ministerial Assigned Houses |

| | | |
|---|---|---|
| Staff Accommodation | Otjozondjupa | Okahandja, Otjiwarongo |
| | Erongo | Swakopmund, Omaruru, Walvis Bay |
| | Hardap | Rehoboth |
| | Karas | Keetmanshoop |
| ARV Clinics | Khomas | Katutura ARV Clinic |
| | Karas | Lüderitz ARV Clinic |
| Offices / RMT | Khomas | Khomas Regional Offices, Head Office, Central Medical Store |
| | Kavango | Kavango RMT |
| | Erongo | Erongo RMT |
| Other Facilities | Khomas | Windhoek Central Mental Hospital, Okuryangava Disability Centre, National Health Training Centre, Eastern Court Old Age Home |
| | //Karas | Daan Viljoen Old Age Keetmanshoop |
| | Kunene | Outjo Old Age Home |
| | Omaheke | Elium Old Age Flats |
| | Oshana | Ondangwa Pension Office |
| Roads | Karas | Head Office |
| Parking Bays | Kunene | Khorixas |
| | Karas | Keetmanshoop |
| | Erongo | Swakopmund |

## 5.2 LOGISTICS

### 5.2.1 Transport

The Ministry acquired 59 new vehicles. During the financial year the Ministry took over 100 vehicles from Global Fund. However most of these vehicles were not in a good running condition and were older than five years. The fleet register reflected (1 861) vehicles at the end of the financial year. There were also 52 accidents reported to the Ministerial Transport Committee with an estimated repair cost of N$1 061 587.72. Six (6) off these vehicles were damaged beyond repair.

Table 16: Donation, acquisition and written off vehicles

| Types | Donation | Acquisition | Written off |
|---|---|---|---|
| Boat | | | |
| Bus 14 Seats | 1 | | 3 |
| Bus 65 Seats | | 5 | |
| Pick-ups D-cabs | 64 | | 5 |
| Pick-ups Scabs | | 14 | |
| Pick-ups Scabs LC for Ambulances | | 25 | |

| | | | |
|---|---|---|---|
| Sedans | 5 | 7 | |
| Station Wagons | 4 | 2 | |
| Tractors | 14 | | |
| Trailers | 12 | | |
| Trucks | | 4 | |
| Water Tanks | | 2 | |
| **Total** | **100** | **59** | **8** |

### 5.2.2 Tender Administration

Tenders for catering, security, laundry, supply and delivery of protective clothing, supply and delivery of laundry detergents and computer equipment, were advertised. Service agreements for laundry were signed while requests for price increases for medical gasses, catering, security services and cleaning chemicals were approved. Tender specifications for physical facilities retainer were drawn-up and tender proposals submitted to the Tender Board for advertisement.

### 5.2.3 Stock Taking

The Ministry recognised the need to undertake a Comprehensive Medical Equipment Inventory and Audit to improve the management of medical equipment. The exercise provided baseline equipment data that would help with planning and budgeting and related activities such as repairs, service and maintenance. The last inventory and audit was done in 2002/2003. The tender for the

Comprehensive Medical Equipment Inventory and Audit was advertised. In addition to the inventory and audit, the Ministry is also exploring possibilities for a Computerised Maintenance Management System.

## 5.3 AUDITING

### 5.3.1 Internal Audit

An audit conducted revealed that staff shortages in clinics and hospitals were a matter of concern, but could only be addressed through the restructuring process. Some over and under payments on salaries were discovered and it was recommended that offices rectify the errors. Supervisory checks were advised to strengthen the processes.

Audits also revealed that the transport policy was not being complied with. Vehicles were filled more than their tank capacities while logbooks and trip authorities were not completed as per requirements. Fleet management reports were not used as a control tool to prevent misuse of Stannic cards.

An audit was conducted on the Disability Council that showed that the council failed to implement previous recommendations which included huge interest payments on a bank overdraft.

# CHAPTER 6: PUBLIC HEALTH SERVICES

Public health services include family health, disease surveillance and epidemic control. They also include such services as public and environmental health, disability prevention and rehabilitation, health promotion and education. The Ministry in partnership with other stakeholders is continually providing public health care services aimed at promoting, protecting and improving the health and wellbeing of all Namibians.

## 6.1 FAMILY HEALTH

### 6.1.1 Community Based Health Care and School Health

#### 6.1.1.1 Community Based Health Care

The Ministry identified the need for Health Extension Workers (HEWs) as critical in ensuring access to services for all Namibians, especially those living in the sparsely populated and hard to reach areas of the country.

In April 2012, the HEWs programme was introduced as a pilot project. Forty HEWs were recruited and trained of whom 36 graduated. The graduates have since been providing health services to their respective communities.

This programme will help build local community capacities for greater involvement and participation in PHC interventions, reduce morbidity and mortality among women and children. The programme has been located in the subdivision with a strong component on child health, nutrition, as well as maternal and neonatal health.

The standardised training of Community-based Health Care Providers (CHCP) is on-going and has so far covered Khomas, Erongo and Hardap regions. The training will empower CHCPs with the knowledge and skills on health promotion, disease prevention and care and support of those sick at home. So far, 300 CHCPs from the three regions were trained and are providing services in their communities.

The programme has 7 406 active health providers, 29%,(2 190) of whom are in the Kavango Region, making it the number one region with the highest figure of providers. Closely behind Kavango is Oshana with 28% providers (2 123). Of the 2 190 providers in the Kavango Region, 103 are new to the programme while in Omaheke Region, 99, were new during the period under review.

Table 17: Community Health Workers in the regions

| Region | Community health worker | Community health worker/CORP new | Community Health worker CORP meetings | Community meetings | Pregnant women attended by CHW |
|---|---|---|---|---|---|
| Caprivi | 923 | 7 | 72 | 19 | 142 |
| Erongo | 149 | 39 | 13 | 1 | 114 |
| Hardap | 167 | 3 | 37 | 25 | 295 |
| //Karas | 14 | 0 | 1 | 14 | 66 |
| Kavango | 2 190 | 103 | 137 | 104 | 1 425 |
| Khomas | 0 | 0 | 0 | 1554 | 511 |
| Kunene | 0 | 0 | 2 | 0 | 0 |
| Ohangwena | 227 | 0 | 14 | 26 | 1 683 |
| Omaheke | 404 | 99 | 36 | 117 | 164 |
| Omusati | 1 046 | 6 | 52 | 25 | 294 |
| Oshana | 2 123 | 6 | 5 | 40 | 13 751 |
| Oshikoto | 6 | 0 | 4 | 4 | 82 |
| Otjozondjupa | 157 | 0 | 0 | **5** | **38** |
| **Total** | **7 406** | **263** | **373** | **1 934** | **18 565** |

- Additional Activities conducted:Three thousand (3 000) copies of the National CBHC Policy were reprinted and distributed to ensure that all stakeholders had copies of the policy. The CBHC documents provide guidelines, direction and relevant information on issues of community health care provision.

- Two thousand and fifty (2 050) CHBC trainers' and participants' manuals were printed to standardise the training of CHBC providers throughout the country.
- Six Health Extension Programme Steering Committee meetings were organised and convened to provide strategic guidance and technical inputs. This will ensure coordination, effective implementation and accelerate scaling up of community-based health systems.

### 6.1.1.2 Outreach Services

A total of 5 078 outreach visits were made. Walvis Bay Hospital, Usakos, Tumbisis and Tamariskia clinics, Rehoboth Health Centre, Oshakati, Oshikuku, Nyangana, Khorixas, and Eenhana hospitals were among the health facilities that carried out more than 10 outreach visits each in 2012.

### 6.1.1.3 School Health

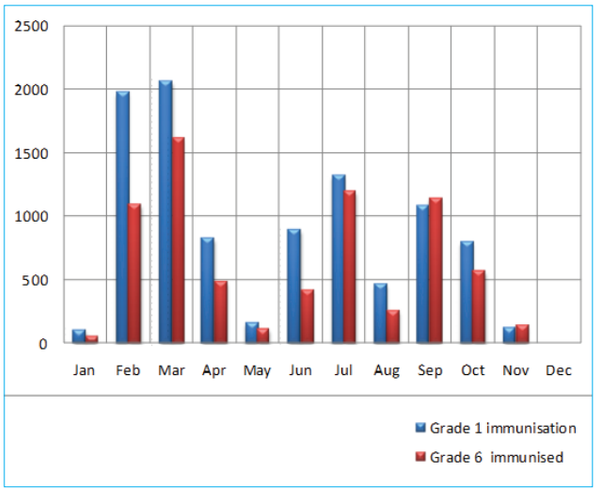
The number of school visits decreased significantly compared to the previous year. Of the planned 22 visits only 12, representing 54%, were conducted. There is a need to strengthen the integration of the "Smiling School" campaign into the Health Promoting School Initiative.

Table 18 shows that more Grade 1 learners were immunised compared to Grade 6s countrywide. More referrals from schools were made in the month of March accounting for about 1 144 referrals.

Table 18: School health activities

| Month | Grade 1 immunised | Grade 6 Immunised | Children with Disabilities | Referrals – School Health |
|---|---|---|---|---|
| January | 99 | 51 | 10 | 29 |
| February | 1 975 | 1 088 | 12 | 878 |
| March | 2 062 | 1 613 | 168 | 1 144 |
| April | 821 | 487 | 1 | 332 |
| May | 157 | 114 | 7 | 11 |
| June | 891 | 412 | 118 | 209 |
| July | 1 319 | 1 197 | 10 | 420 |
| August | 468 | 253 | 8 | 97 |
| September | 1 078 | 1 140 | 5 | 315 |
| October | 798 | 571 | 4 | 173 |
| November | 124 | 143 | 0 | 122 |
| December | 0 | 0 | 0 | 0 |
| **Total** | **9 792** | **7 069** | **343** | **3 730** |

Figure 1: School health immunisations




### 6.1.2 Oral Health and Dental Services

A project with the Dentists Without Limited Foundation (DWLF) was established in order to strengthen the capacity of the Ministry to improve community oral health. A total of (2 583) patients were treated for different dental problems. Eight portable dental autoclaves were bought to support infection control in dental outreach services.

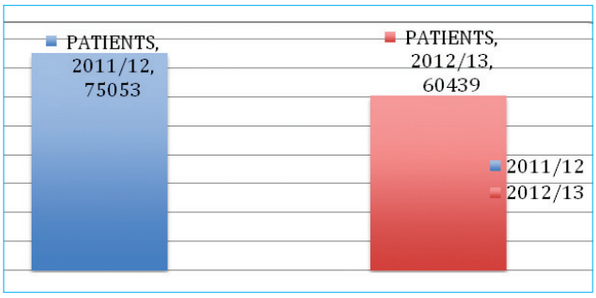
In striving to improve the quality of oral health services, the programme has produced guidelines including National Guidelines on Oral Health Services and the Standard Guideline on Cross Infection Prevention Control in a dental surgery. The National Oral Baseline Survey Findings Report was completed, printed and disseminated. These findings will serve as a scientific guide in designing tailor-made interventions to respond to specific oral health problems.

Information Education and Communication (IEC) materials on oral health were developed and distributed to different regions during Oral health awareness week. The materials were aimed at raising awareness on the determinants of oral health in the community.
Oral Health Awareness Day was commemorated in Windhoek and well attended by learners who are the main target group. During the commemoration, oral health teams in all the 13 regions conducted community oral health activities including health talks, screening and treatment. The scope of practice of dental therapists and the minimum requirements of study for registration as dental therapists was completed and submitted to the Health Professions Council.

Surgical instruments for maxillofacial surgery were bought and handed over to Katutura Intermediate Hospital. These instruments will be used by the part-time contracted maxillofacial surgeons for operating on State patients.

A refresher course for 17 dentists and 14 dental therapists on management of emergencies in dentistry was done. The training was aimed at equipping participants with the up-to-date knowledge in emergency dentistry. This will cut down the number of unnecessary referrals from the district hospitals.

Figure 2: Total number of patients who attended dental treatment.




As per Figure 2, the number of patients who attended dental treatment during the year in review slightly decreased compared to the previous years, 2011/12. One of the contributing factors could be the shortages of staff as three dental therapists resigned during the year under review. In addition, two regions, namely, Omusati and Caprivi had no regional dentist for a significant period.

Table 19: Dental conditions and diseases

| | 2011/12 | | 2012/13 | |
|---|---|---|---|---|
| Condition | Absolute Figure | % | Absolute Figure | % |
| Dental cavity | 48965 | 74.82 | 39799 | 73.18 |
| Periodontal diseases | 7260 | 11.09 | 7057 | 12.98 |
| Dental-dry socket | 679 | 1.04 | 582 | 1.07 |
| Attrition (Dental-fluoride application) | 386 | 0.59 | 409 | 0.75 |
| Dental – Impactions | 1579 | 2.41 | 1297 | 2.38 |
| jaw fractures | 320 | 0.49 | 428 | 0.79 |
| Oral cancer | 112 | 0.17 | 172 | 0.32 |
| Soft tissue lesions | 1904 | 2.91 | 1553 | 2.86 |
| Dental abscess | 4242 | 6.48 | 3091 | 5.68 |
| **Total** | **65447** | **100** | **54388** | **100** |

Table 19 shows that dental cavity was the highest dental disease, at 73.18%, to be dealt with during both the 2011/12 and 2012/13 financial years followed by periodontal diseases at 12.98%. Generally, there has been an increasing trend in the condition of dental diseases in 2012/13 compared to the previous year, 2011/12.

Table 20: Types of dental treatments

| Treatment | 2011/12 | 2012/13 |
|---|---|---|
| Teeth extraction | 54 620 | 49 122 |
| Filling | 3 945 | 2 449 |
| scaling and polishing | 426 | 2 730 |
| Fluoride application | 386 | 409 |
| Intermaxillary Fixation(IMF) | 182 | 138 |
| Denture | 415 | 310 |
| Dissipation | 1 579 | 1 297 |

Generally, the number of treatments given during the year decreased slightly compared to the previous year, 2011/12, as shown in Table 20. Teeth extraction was the main treatment at 88% followed by fillings at 4%. Scaling and polishing was only at 1%. The later could be attributed to lack of community awareness, shortage of staff and malfunctioning dental equipment in some hospitals. Most patients visited the dental clinic when they had unbearable pain with most advanced carious lesions hence the only choice of treatment was extraction. More awareness campaigns need to be conducted in communities.

### 6.1.3 Food and Nutrition

A Nutrition Assessment, Counselling and Support (NACS) programme and inpatient management of severe acute malnutrition was rolled out to all 34 health districts. The components of NACS include nutrition assessment and counselling, provision of specialised food products and referrals to livelihood strengthening services, where available. Therapeutic and supplementary foods are prescribed for a limited duration after a careful clinical assessment.

The indicators for the NACS programme were developed and integrated into the ART patient care booklets for adults and children. The revised child health passport was tested in four regions. A meeting was conducted for the regions to share their experiences and challenges and make suggestions. A team is now reviewing the findings and consolidating

it for presentation to the Ministerial Management Committee.

The nutrition guidelines for preventing and managing non-communicable diet related diseases was completed and printed. The Nutrition Landscape Assessment Report was also completed and launched in November 2012.

An international Infant and Young Child Programming meeting was held in April 2012 with UNICEF's technical and financial support. A plan was drafted to improve the nutritional status of infants and young children with a special focus on improving the rates of exclusive breastfeeding.

In October 2012, a UNICEF-funded Community Infant and Young Child Feeding (C-IYCF) training for trainers programme was piloted. Sixteen people, 13 MoHSS staff and three from NGOs, were instructed under this programme. A week later, the trainers taught 72 other people. In total 110 health workers and 65 community counsellors were trained since then in Oshikoto, Oshana, and Erongo regions. This training will improve knowledge and skills in counselling and will assist in increasing exclusive breastfeeding rates in the country.

The Ministry conducted training of health workers in Infant and Young Child Feeding programmes in five regions. Twenty five (25) workers in each region were trained in Omusati, Oshikoto and //Karas and 24 in the Khomas Region.

Supportive Supervisory visits were conducted at Opuwo, Outjo, Khorixas, Aranos, Mariental, Rehoboth, Okakarara, Otjiwarongo, Okongo, Eenhana, Okahao, Tsandi, Katima Mulilo and Gobabis districts to support health workers on NACS programmes after training.
Three meetings of the Namibia Alliance for Improved Nutrition (NAFIN) took place under the chairmanship of the Right Honourable Prime Minister.
Links with the Ministry of Education and The World Food Programme were established. The Maternal and Infant and Young Child Nutrition Technical Working Group met twice.

In-patient management of severe acute malnutrition is done in 31 district hospitals and four referral hospitals. For the past three years, there were no significant changes in the prevalence of malnutrition in all 13 regions among the under-fives. However, Oshana, Hardap, Oshikoto, Omaheke and Karas showed a slight decrease compared to 2011.

Table 21: Diagnosis of malnutrition as per HIS 2011 and 2012

| Malnutrition | 2011 | 2012 |
|---|---|---|
| Under 5 cases | 4 374 | 3 852 |
| 5 to 17 years | 1 182 | 838 |
| 18 years and older | 3 076 | 2 725 |

Table 21 shows that there was a significant decrease in the number of people diagnosed with malnutrition in 2012 compared to 2011. This could be attributed to the NACS programme.

### 6.1.4 Reproductive and Child Health

#### 6.1.4.1 Safe Motherhood and New-born Care

A National Family Planning guideline was completed, printed and distributed to all the regions. This will guide health workers in the provision of family planning to all eligible clients.

A booklet on postnatal care was developed, printed and distributed to all regions. The booklet provides information to all health officials in-charge of health facilities and to all health care providers regarding the package of post-natal care services. The new schedule is aimed at detecting possible complications at an early stage in the puerperium period with subsequent timely lifesaving actions.
The National Maternal Peri/Neonatal Death Review (NMPNDR) Committee is functional and had three meetings to analyse the cases forwarded from the regions from April 2010 to March 2012 in order to compile the first country report.

There was a tremendous increase in institutional maternal deaths during this financial year in comparison with three previous years. This could be attributed to many factors including inaccurate reporting. A thorough investigation needs to be carried out. However, the institutional Maternal Mortality Rate of 116/100 000 live births is lower than the 2005/6 NDHS which were449/100 000per live births.

Table 22: Maternal and neonatal deaths in 2012/2013

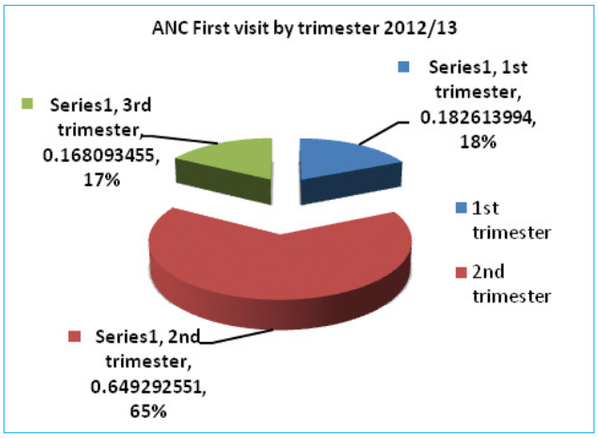
| | 2010/ 2011 | 2011/ 2012 | 2012/ 2013 |
|---|---|---|---|
| Total Deliveries | 54 643 | 59 769 | 63 783 |
| Live Births | 51 829 | 52 731 | 62 923 |
| Neonatal Deaths | 627 | 740 | 860 |
| Fresh Still Births | 0 | 0 | 424 |
| Macerated Still Births | 0 | 0 | 613 |
| Maternal Deaths | 49 | 47 | 73 |

| | | | |
|---|---|---|---|
| Neonatal Mortality Rate per 1 000 live births | 11 | 12 | 14 |
| Maternal Mortality Rate per 100 000 live births | 89 | 79 | 116 |

Ideally, pregnant women should start antenatal care as soon as they notice they are pregnant or during their first trimester, because this will ensure that they receive preventive interventions, such as early diagnosis, treatment, and emergency care when needed.

However, Figure 3 shows that the majority of women, 65% only start their first ANC visit during the second trimester. More community education needs to be done to ensure that pregnant women attend ANC as early as possible preferably in the first trimester. Early ANC attendance contributes to the reduction of maternal and newborn morbidity and mortality.

Figure 3: ANC visits by trimester




The majority of women, 88%, delivered their babies normally while births through C-section were only 12%, which falls within the WHO recommended levels of 5% to 15%, see Figure 6. However, it is of great concern that proportionally no vaginal births were assisted either by vacuum or forceps,one of the nine emergency obstetric care (EmOC) signal functions that can save the life of a woman and her baby during a complicated delivery.

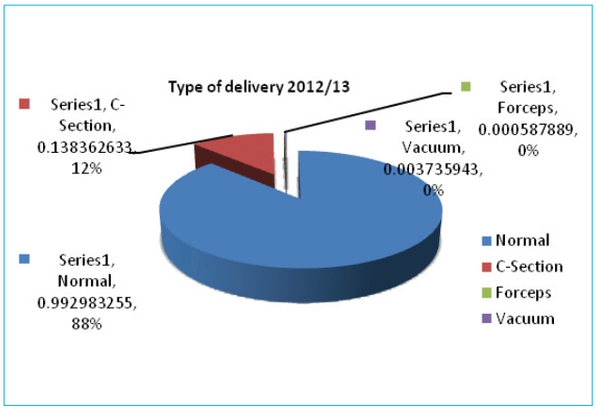



Figure 4: Types of deliveries

Seventeen health workers were trained and certified in Emergency Obstetrics and Neonatal Care/Life Saving Skills (EmONC/LSS) by trainers from the American College of Nurse Midwives. In addition, five hospitals were certified as EmONC/LSS training sites and training has been scaled up to other regions. Twenty six traditional birth attendants from the Khomas Region were trained to recognise danger signals in pregnant mothers and new-borns and timely refer them to the nearest health facility.

Mother baby follow-up care was strengthened through the development of health facility-based registers and monthly summary forms for HIV exposed infants in four pilot regions, Oshana, Oshikoto, Caprivi and Khomas regions. Incorporating of the summary data into the national health information system will help the flow of data from a health facility level to the national level. It will also ease the monitoring of the PMTCT programme. The Nationwide expansion of the mother baby follow-up care system to the remaining regions is expected to start in 2013/14.

### 6.1.4.2 Prevention of Mother to Child Transmission (PMTCT) of HIV Infection

As part of the Ministry's efforts to eliminate mother-to-child transmission of HIV and keep mothers and children alive, a decision was taken to switch from PMTCT prophylaxis Option 'A' to Option 'B+' which entails initiating a life-long triple ARV treatment for all HIV positive pregnant and lactating women irrespective of their CD4 count or clinical staging, and NVP from birth to six weeks of age for their infants. Preparations for implementation of Option 'B+' started with the review of PMTCT guidelines to include option 'B+' and the development of operational plans. A phased-roll out of option 'B+' is expected to start in the 2013/14 calendar year.

Namibia's strategy is to eliminate mother-to-child transmission (e-MTCT). The strategy was completed and launched during the period under review. The goal of the e-MTCT plan is to eliminate new paediatric HIV infections and improve the survival of children and their mothers within the context of HIV infection.

Male participation in PMTCT programmes remains a major challenge. Rates of male partners of pregnant women attending ANC, who knew their HIV status, remained low at around 4% between the period 2009/10 to 2011/12. This shows that Namibia is not on track in meeting the 2012/13 National Strategic Framework (NSF) targets of 21%.

First Lady, Madam Penehupifo Pohamba is the Patron of the Maternal and Child Health Agenda. The First Lady launched a campaign on male involvement under the slogan "An HIV Free Tomorrow Needs Caring Men Today", as part of the Maternal and Child Health Agenda. The campaign on male involvement focuses on four key areas, namely, maternal mortality reduction, exclusive breastfeeding, PMTCT and increased male involvement in pregnancy and child birth. The second phase of the campaign on male involvement was extended to the Caprivi Region and launched under the same theme in 2012.

#### 6.1.4.3 Deoxyribonucleic Acid (DNA) –Polymerase Chain Reaction (PCR) Testing

Namibia launched an early infant diagnosis programme using DBS samples for DNA-PCR testing in the latter part of 2005. Expansion of the services is on-going currently available in more than 60% of health facilities. In 2011/12, PMTCT was the main reason for DNA-PCR testing among HIV exposed infants accounting for 83% of all DBS samples tested at the NIP compared to 75% in 2010/11. This was an indication that more HIV exposed infants access early infant diagnosis services.

#### 6.1.4.4 Integrated Management of New-born and Childhood Illness (IMNCI)

The Integrated Management of New-born and Childhood Illnesses strategy is aimed at significantly reducing morbidity and mortality associated with major causes of disease in children under five years. It is also expected to contribute to their health, growth and development. Twenty four out of 34 district hospitals, 71%, are implementing the strategy at different phases.

Data collection tools, especially child health passports were revised and a protocol for mother-baby follow-up was developed. The revised tools for mother-baby follow-up will be tested in four pilot regions before rolling out the improved programme nationwide.

#### 6.1.4.5 Non-Communicable Diseases

A total of 3 750 people were reached through diabetes screening and dissemination of diabetes IEC materials. From the 3 750 people tested, 27, representing less than 1%, were found with high levels of blood glucose and referred to the nearest health facility.

#### 6.1.4.6 Expanded Programme on Immunisation (EPI)

Two rounds of the National Immunisation Days campaign were carried out successfully in June and July 2012 to counter the low child immunisation coverage. During these campaigns, most children who missed routine immunisations were covered, thus minimising the potential outbreaks of vaccine preventable diseases. The national immunisation coverage rate during the campaign was as follows:

- Polio 97%
- Measles 104% for under-fives and 85% for those 5 years to 15and,
- Vitamin A 102%

Post–measles routine immunisation coverage was carried out after the National Immunisation Days Campaign in August 2012.The coverage for routine immunisation for 2012 for Penta 3 (DPT3) was recorded at 84% and measles at 76%.

## 6.2 DISEASE CONTROL

### 6.2.1 HIV/AIDS

After the first HIV case in Namibia was diagnosed in 1986, the country witnessed a rapidly expanding HIV epidemic, as was obtaining in other southern African countries. Namibia now faces a mature generalised HIV epidemic with an estimated adult prevalence of approximately 13.2 (2012) which is primarily heterosexually transmitted. Key drivers of the epidemic are related to underlying social, economic and cultural factors. These include multiple and concurrent partnerships, low and inconsistent condom use, low risk perception of HIV infection, low levels of medical male circumcision, widespread alcohol use and abuse, intergenerational sex, transactional sex, oscillatory mobility and migration and decreasing numbers of people in marital and cohabiting relationships.

#### 6.2.1.1 HIV Prevention

Namibia has made tremendous progress in its HIV response. This response has seen the country implementing a combination of interventions targeting behavioural, biomedical and structural drivers of the epidemic in accordance with the National Strategic Framework.

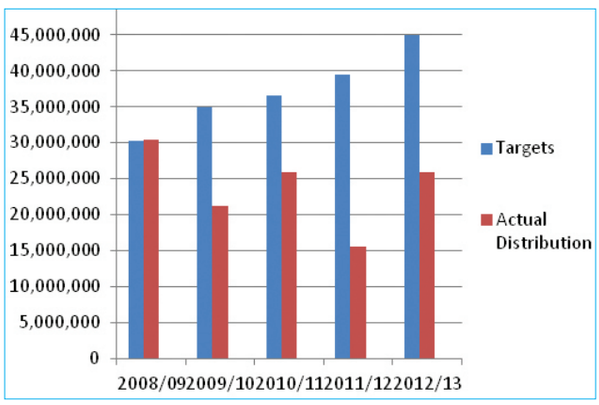
##### 6.2.1.1.1 Condom promotion and distribution

The STI and Condom programme distributed 25 865 112 condoms, which is about 57% below the NSF targeted distribution for the period 2012/13 as

indicated in Figure 5. The total distribution included 3 545 280 49mm size (Slim Fit) condoms, 183 000 female condoms and 22 136 832 standard-sized condoms.

The programme procured condoms based on available resources and since the NSF was not adequately financed, the targets for condom distribution were unlikely to be met. There was a review of the national target through the Quantification of Commodity Requirements for Key Public Health Programmes in Namibia, 2013-2016 documents that will bring the target closer to realistic performances of programmes. The increase in the availability and distribution of condoms is related to Government's commitment to fully support the procurement and distribution of condoms.

Figure 5: Condoms distributed versus target from the NSF




The programme successfully conducted training for the CLO on HIV/STD risk behaviours, condom logistics and promotions including gender roles in condom use.

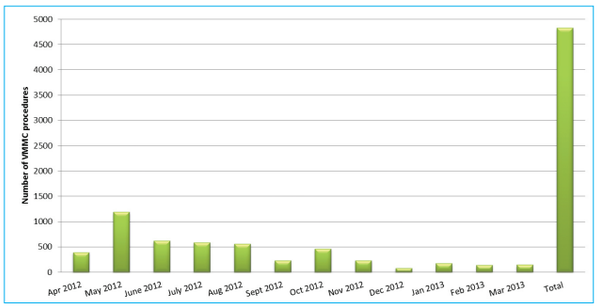
### 6.2.1.1.2 Voluntary medical male circumcision

According to NSF, 450 000 adolescents and adult males would be circumcised as part of the minimum package of HIV prevention by 2015/16 as well as 167 900 male new-born babies in the first week of life. However, neonate circumcision has not yet started. The Ministry hopes to introduce this programme in the near future. A draft Male Circumcision Strategy and Operational Plan was developed and was to be completed in the first quarter of 2012/2013. This will inform communications for behavioural change, the procurement of resources and implementation modalities.

The Ministry has also immensely contributed to male circumcision programmes through the provision of human resources, consumables, availing infrastructures and transport that moved staff to and from training venues. NSF set targets for at least 21 000 medical male circumcision procedures to be performed per quarter, 84 000 per year. However, only 4 829 (5.74%), male circumcision procedures were performed during the reporting period compared to 6 082(7.24%) the previous year. These low numbers can directly be attributed to the critical shortage of skilled staff and low demand for male circumcision services. At least 4 272 (88.5%) were tested for HIV before the procedure of which 4 184 (98%) tested negative. Four thousand six hundred and ten (4 610) circumcised clients, representing a 95%rate returned for post-operative care after 48 hours and follow up visits.

A major legislative programme achievement was the approval by the Nursing Council in 2012 for registered nurses to perform male circumcision. Trained registered nurses are today performing male circumcision procedures in public health facilities. The supervision of the medical officers is still required just to ensure quality male circumcision service provision and manage adverse effects promptly if any. There are only four dedicated male circumcision nurses to date at Oshakati, Onandjokwe, Rundu and Otjiwarongo State hospitals.

Figure 6: Male circumcisions per month April 2012 to March 2013




80% of male circumcision procedures done were on males of 15 years and above. The programme has reached the more sexually active target group that would help prevent new HIV infections, thereby reverse HIV trends in the country.

Quality assurance assessment was implemented, although no support supervisory visits were conducted. About 21, (0.4%) moderate and 12 (0.2%) severe adverse events were recorded and were instantly well managed.

The male circumcision programme is also linked to other sexual and reproductive health services and HIV prevention and treatment programmes which include HCT, STIs, family planning, ART and ANC. The programme has been incorporated, to a less extent, into maternal and child health services. The male circumcision programme was introduced in ANC to educate pregnant mothers about the benefits of the procedure when considering neonate circumcision which is yet to start.

The programme managed to procure 290 000 IEC materials in different languages and distribute them to all districts in the regions. Six radio sessions were conducted. All clients were educated and counselled through group education and individual counselling on the male circumcision prevention comprehensive package. The minimum package includes HIV prevention, counselling and testing, risk reduction, screen for and treatment of STIs syndrome, promotion of consistent and continuous condom usage, importance of follow-ups and post-operative care, healing period, risk inhibitions, family planning and other male reproductive health related issues.

### 6.2.1.2 Sexually Transmitted Infections Control

The strategic objectives of the STI Programme are to:

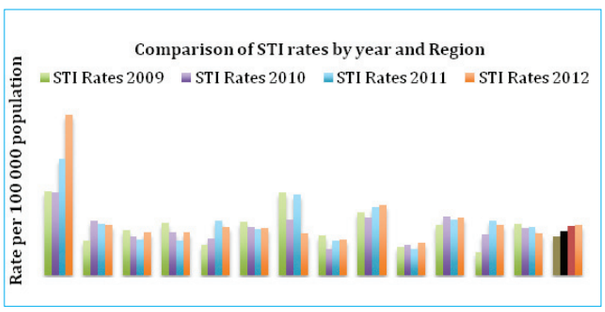
- Reduce STI cases through strengthening management at all levels of health care delivery by availing updated guidelines on syndromic management of STIs.
- Increase the knowledge of health care workers through training and quality assurance.
- Strengthen the surveillance, monitoring and evaluation of STIs through regular HIS data analysis and supportive supervision.

The reported number of STIs increased from 56 844 in 2009/10 to 66 532 in 2010/11 and jumped to 73 593 in 2011/12. In the reporting period of 2012/13, the total number of cases increased to 74 784. The 2012/13 figures represent an increase of 1.6%. In terms of absolute numbers, the Khomas Region reported the highest figures of cases (11 314), followed by the Caprivi Region, (10 256), then Kavango Region, (7 522), and the fourth highest was Oshana Region, (7 221). The lowest figures were in //Karas Region (2 357 ), Hardap Region,(2 397)and Kunene regions (2 559) cases.

The reported national STI rate per 100 000 population for 2012/13 was 3 539. On comparing the STI rates by region, the Caprivi Region reported the highest rate of STIs per 100 000 population at 11 321. This was more than double the rate of the second highest region, the Omaheke at 4 942 per 100 000. Third highest was Oshana at 4 087, followed by Oshikoto at 3 562 per 100 000. The lowest number of STI rates were reported in Omusati Region at 2 259, similar to the previous year. Although the Khomas Region contributed 15% to the total number of STI cases reported nationally, it was ranked seventh highest at 3 307 cases per 100 000.

There has been a stead increase in the reported STI rates since 2009. In 2012, the STI rate was 3 539 per 100 000 population. The rate for 2011 was 3 496 cases per 100 000 as compared to the rate of 3 104 cases per 100 000 in 2010 and 2 702cases per 100 000 in 2009. The increases in the rates for 2012 were noted in seven regions namely; Caprivi, Hardap, Karas, Khomas, Ohangwena, Omaheke and Oshana Regions.

Figure 7: Comparison of STI rates by year and region




The Health Information System (HIS) monitors five main syndromes. For 2012, there was an increase in the number of reported cases for three of the five syndromes, namely urethral discharge syndrome, genital ulcer disease and "other" STIs compared to the 2010 statistics. However, reported cases of pelvic inflammatory disease and vaginal discharge syndrome decreased.

Like in the previous years, the vaginal discharge syndrome continues to account for the majority, (32.7%) of the STI cases. A total of 24 464 cases were reported showing a decrease from the previous year figure of 25 657. A worrying concern is that 22% of the reported STI cases were classified under "OPD other STI disease diagnosis". There is need to further strengthen training as well as figure out the different conditions which end up being lumped into this group. According to WHO, urethral discharge and genital ulcer disease are more useful in monitoring trends in STI incidence while STI syndromic cases have limitations. These first two syndromes usually represent recently acquired sexually transmitted infections. But, the HIS tends to lump these together.

### 6.2.1.3 HIV Counselling and Testing

The HCT programme goal is to reach out to more people particularly those with undiagnosed HIV infections and successfully link them to treatment care and support services. Namibia has maintained and continues to promote a mixed HCT delivery model

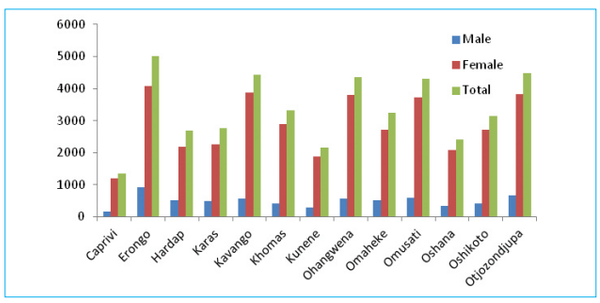
including integrated, standalone and outreach/mobile sites in the public and NGO sector. The year under review witnessed some strategic shift to mobile/outreach HTC, including preparation for home based testing models. These are aimed at reaching out to populations with low access and use of HCT, especially males, couples and first time testers. The number of individuals who received HCT and got their results during the period under review, was 323 410 against a country target of 253 750.

#### 6.2.1.3.1 National Testing Day

The National Testing Day and World AIDS Day were jointly commemorated under the theme "Zero New Infections" which focuses on prevention of HIV from mother-to-child. The main event was commemorated in Arandis, Erongo Region from 5-7 December 2012. During the three-day event, 44 134 clients were tested, exceeded the target of 40 000. All the registered clients received information and were either counselled in a group or as a couple or individually before HIV testing.

The highest percentage of those who signed up was in Erongo Region (11.5%) followed by Otjozondjupa (10.3%) and Kavango (10.1%) while the lowest percentage was in Caprivi (3.1%) and Kunene (4.9%). Of the total registered clients, 44 126 indicated their gender with 14.5% saying they were male while the majority, 85.2%, said they were females.The majority of clients, across all the regions, who were tested, counselled and received their results were women.

Figure 8: Number of clients who received their HIV results by gender and region




#### 6.2.1.3.2 Home Based HIV Counselling and Testing

The Ministry, in collaboration with Development AID from People to People (DAPP), piloted the Home Based HIV Counselling and Testing in Kavango and Oshana regions from August to November 2012. Home based HCT entails providing HIV counselling and testing within the home environment. The project target was to offer HBCT to 3 000 households, test 5 000 individuals and 250 couples over four months.

The project reached 4 169 households, counselled and tested 10 963 individuals against the set target of 5 000. Of this number534 people tested HIV positive of whom513 were successfully referred to care, support and treatment services with a remarkable 96% linkage rate. Overall, the project achieved twice the set target number of clients with a very low refusal rate which indicates willingness and acceptability by the community for these services.

#### 6.2.1.3.3 Mobile Outreach HIV Counselling and Testing

During the period under review the Ministry through CDC PEPFAR support procured four mobile vans. Caprivi, Ohangwena, Kunene, and //Karas regions were the first four recipients of the vans. The regions were orientated during a three-day meeting on the mobile concept which was developed to provide institutional guidance to public servants in implementing mobile outreach services. The mobile vans were used during the 2012 National Testing Day. An additional three vans were procured for Kavango, Omusati and Khomas regions through USAID. The MoHSS recruited a mobile/outreach coordinator with support from Global Fund.

### 6.2.1.4 HIV Prevention Coordination

Effective HIV prevention relies on a strategic simultaneous implementation of multiple evidence based strategies. Namibia's national plan on HIV and AIDS, the National Strategic Framework 2010/11-2015/6, prioritises a prevention combination as the key strategy to address HIV and AIDS in the country.

Thus, in an effort to coordinate different prevention efforts, the Ministry established an HIV prevention coordinator's office to synergise and harmonise prevention programming.The HIV prevention office coordinates linkages with all thematic areas of prevention; HIV Counselling and Testing, VMMC, STI and condoms, PMTCT, blood safety, BCC, ART, and TB, both in the MoHSS, and other offices ministries and agencies.

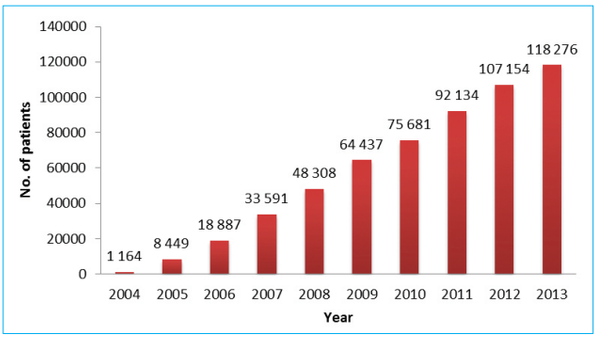
### 6.2.1.5 Treatment, Care and Support

#### 6.2.1.5.1 Patients on ART in public health facilities

In the current reporting period the total number of patients on ART as at end of March 2013 stood at 118

276, an increase of 11 122 from 2011. This translates into a coverage of HAART of 86% using a CD4 count of 350 spectrum estimates of 138 613 in need. The ART uptake is credited to increased access to HIV care through outreach services, rolling out of services to new art sites, implementation of the IMAI strategy and the roll out of Rapid HIV Testing at more sites. In addition, the revised guidelines which entail early initiation of ART have impacted on the programme. More importantly, 86% of the patients were on the first line ARV regimens which indicate probable low levels of resistance and high compliance with treatment guidelines. This augurs well for our patients and gives room for future treatment options should patients fail on the current first line regimens.

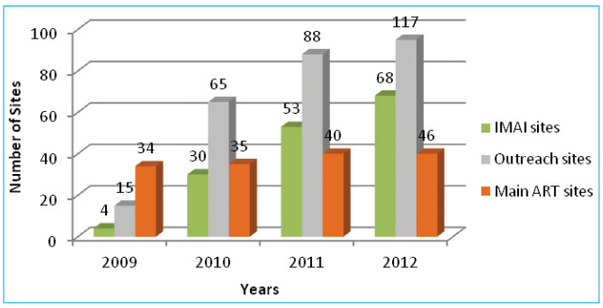
Figure 9: Patients on HAART March 2004 to March 2013




### 6.2.1.5.2 Facilities providing ART

Timely and expanded access to antiretroviral therapy (ART) in Namibia is showing benefits for those who are HIV-positive. Roll-out of IMAI and increased outreach points, especially in the hard-to-reach areas has significantly increased access to ART services. ART is provided through a mix of fixed facilities which can be further classified as full ART, outreach or IMAI sites. By end of this reporting period ART was available in 221 decentralised sites that included 46 full ART sites, 117 outreach and 68 IMAI sites. The programme has integrated the IMAI and task-shifting training curricula.

Figure 10: Health facilities providing ART in Namibia during 2012/13




### 6.2.1.5.3 ART retention and lost to follow up

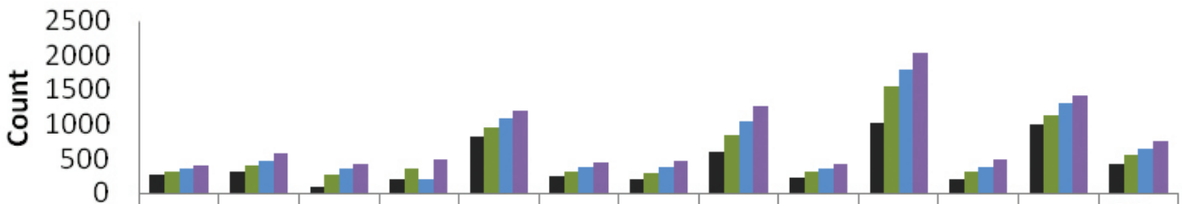
In the absence of a formal ART outcomes evaluation, cumulative ART data by the end of March 2013 was used to give a preliminary assessment. The measurement showed that more than half, 67%, of the patients were still alive on ART. Furthermore, the data showed that 20% of the patients could not be followed-up, 7% could not be traced while 6% had died. The upcoming ART Outcomes Study will better inform the programme on some factors associated with lost follow-ups and give a true reflection of retention rates at 36 months. This information will be used to programme and improve retention and mitigate measures against loss to follow up.

### 6.2.1.5.4 Mortality related to HIV

The number of AIDS related deaths is estimated to be decreasing rapidly mainly due to the rapid scale up of Highly Active Antiretroviral Therapy (HAART) for those in need. The estimated number of annual AIDS related deaths has decreased from over 12 000 in 2005/06 to less than 4 500 in 2010/11 and is projected to go down further to 3 160 in 2015/16.

Although death rates due to HIV related diseases have stabilised, over the past three years, some regions such as Omusati, Oshikoto, Kavango and Ohangwena still show worrisome trends. Further analysis will need to be done to address programme issues that could be responsible for the current trends seen in these regions as shown in Figure 11 overleaf.

Figure 11: Number of AIDS related deaths by region




| | Caprivi | Erongo | Hardap | Karas | Kavango | Khomas | Kunene | Ohangwena | Omaheke | Omusati | Oshana | Oshikoto | Otjozondjupa |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mar '10 | 270 | 323 | 82 | 195 | 823 | 249 | 209 | 601 | 228 | 1,028 | 206 | 1,004 | 425 |
| Mar '11 | 318 | 394 | 267 | 362 | 963 | 308 | 286 | 836 | 305 | 1,548 | 317 | 1,132 | 565 |
| Mar '12 | 366 | 463 | 347 | 210 | 1,089 | 373 | 372 | 1,045 | 358 | 1,793 | 374 | 1,300 | 638 |
| Mar '13 | 406 | 574 | 427 | 487 | 1,195 | 452 | 459 | 1,261 | 417 | 2,031 | 501 | 1,414 | 756 |

### 6.2.1.5.5 ARV Stock Management

Procurement of ARV are done through the CMS, no stock-out was reported during the financial year. The programme considers security of supply and consistent availability of medicines as of paramount importance and will collaborate closely with the pharmaceutical services division to strengthen inventory control systems for ARVs in the next financial year to reduce occurrence of stock-outs in the future.

### 6.2.1.5.6 TB and HIV co-infection and other opportunistic infections

TB and HIV remain a high priority for the country. The co-infection rate stands at 47%. The two programmes, TB and HIV, have adopted interventions intended to reduce the co-infection rate. In addition, TB and HIV activities are incorporated into TB and HIV policies, technical guidelines and strategic plans.

The percentage of TB patients tested for HIV stands at 89%, up from 76% in 2010 while that of TB patients initiated on ART is now at 71%, up from 43% in 2010. The programme HIVQUAL reported Isoniazid Preventative Therapy (IPT) coverage at 26% and the TB screening in HIV patients at 95%. In addition an IPT/ICF assessment is planned for the next financial year.

Increased access to ART and opportunistic infections prophylaxis has had a remarkable impact on the reduction of hospital admissions and deaths among PLHIV. The provision of Cotrimoxazole (CTX) Prophylaxis remained at 100% during the reporting period. Cotrimoxazole and INH prophylaxis is readily accessible in all public health facilities country-wide.

Latent TB therapy, IPT is given to all eligible HIV-positive persons who are not yet infected with TB.

The IPT coverage remained low during the reporting period due to recording challenges. The revised ART booklet will be able to capture IPT information to ensure that the challenge is addressed in the next financial year.

### 6.2.1.5.7 HIV quality of care

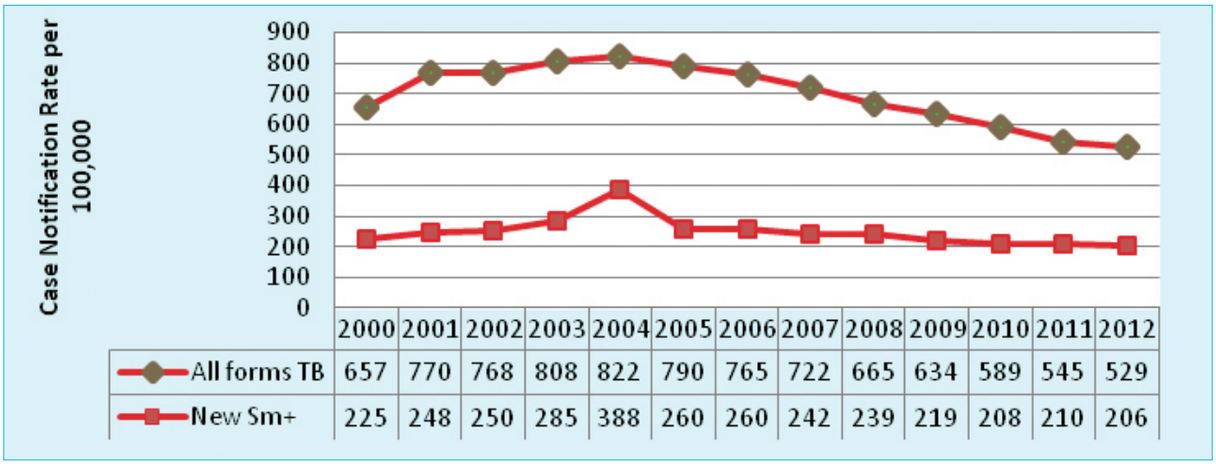
The Ministry introduced the HIVQUAL programme to ensure that the quality of services is monitored, improved and maintained. A core set of indicators selected from the ART guidelines reflect the different elements of HIV care. During the period under review, the HIV qualities of care indicators were revised through a consultative stakeholder meeting.

The key outcome was the selection of new indicators and modifications of the existing ones across the adult HIV cascade as well as identification of paediatric indicators care continuum. These were aligned to the updated WHO guidance and the revised Namibia 2010 ART guidelines, while taking cognisance of the imminent further ART guidelines review in 2013.

Currently, the HIVQUAL programme is implemented across all 34 health districts and three health centres. A roll-out plan was developed and will be expanded to cover additional selected ART sites through a phased approach, health centres first before cascading down to clinics, during the current financial year. Out of 37 implementing sites, 26 sites which translate into 70% submitted their performance data for the reporting period of April to September 2012.

Similar to the previous reporting periods, this review witnessed improvements in the proportion of patients screened for TB and those initiated on ART. However, the results show a worrying gradual decline in the performance of TB-IPT coverage as reflected in combined aggregate performances. The latter is most

Figure 12: Trends in TB Case Notification Rates in Namibia from 2000 to 2012




| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| All forms TB | 657 | 770 | 768 | 808 | 822 | 790 | 765 | 722 | 665 | 634 | 589 | 545 | 529 |
| New Sm+ | 225 | 248 | 250 | 285 | 388 | 260 | 260 | 242 | 239 | 219 | 208 | 210 | 206 |

likely due to the data capturing system limitations. To address this challenge, the programme has put in place a strategy to strengthen the monitoring and evaluation system to ensure data accuracy and correctness in future.

All participating health facilities are measuring their quality indicators as per programme directives and most sites are conducting quality improvement initiatives targeting the areas identified as requiring improvement. A quality organisational assessment tool was revised to help implementing facilities develop a sustainable high performing quality programme.

### 6.2.2 National TB Control Programme

Tuberculosis (TB) remains a major health problem, and the second leading cause of death because of the infectiousness of the disease. Poverty and HIV infection continue to be the major drivers of this disease, with 1.1 million new TB cases co-infected with HIV reported in 2010 worldwide.

#### 6.2.2.1 TB Case Notification Rate (CNR)

Namibia is among countries worst affected by TB as shown by a very high TB Case Notification Rate (CNR) for all forms of TB at 529/100 000 population in 2012. Forty seven percent of TB patients tested for HIV in 2012 were positive. The country continues in the efforts to control TB and eliminate it as a public health threat within the framework of the Second Medium-Term Strategic Plan for Tuberculosis and Leprosy (TBL MTP-II).

There has been a drive to pay greater attention to advocacy, communication and social mobilisation to improve community awareness and enhance demand-driven service provisions. These efforts have led to a significant decrease in the number of notified cases from a peak of 16 156 in 2004 to 11 145 cases reported in 2012. Fifty eight percent of the notified cases of New Smear Positive TB, the main source of transmission of TB in the community, were male, while 42% were female. As indicated in Figure 12, the Case Notification Rate, i.e., the number of cases per 100 000 population, has shown a gradual decline since 2004 as shown in the chart.

#### 6.2.2.2 Treatment Results

The treatment success rate for new smear positive cases was 83%. There is continued expansion of coverage of community-based DOT which is being implemented with the support of various partners. This will ensure the country surpasses the target for treatment success. It is encouraging to note that in this regard the defaulter rate, one success measure of a country's TB programme, has decreased dramatically from 17% in 2000 to 5% in 2012.

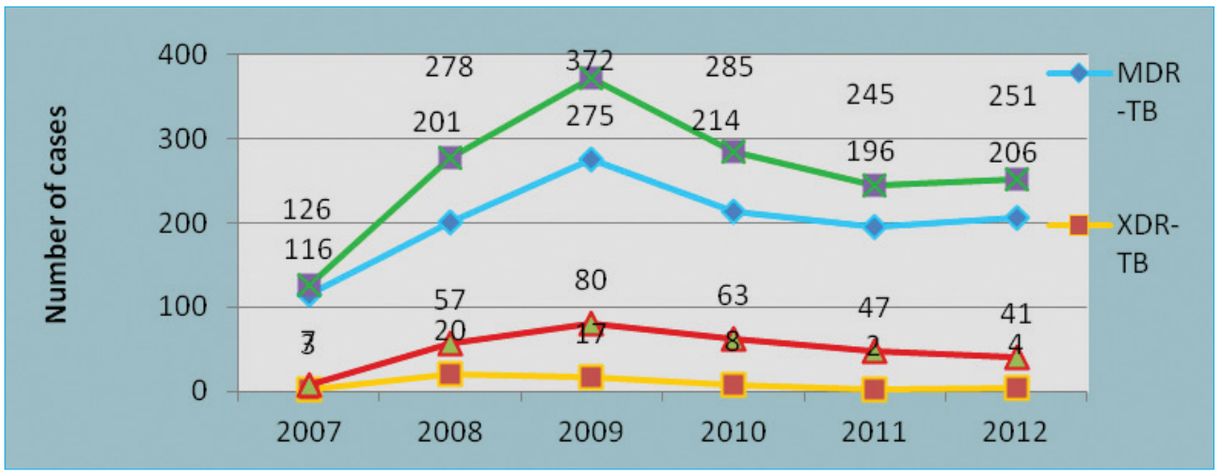
#### 6.2.2.3 Drug Resistant Tuberculosis

The burden of TB in Namibia is compounded by the increasing significance of drug-resistant TB (DR-TB), with high numbers of cases of Multi-drug Resistant MDR and Extensively drug Resistant XDR-TB continuing to be reported. Since the establishment of programmatic management of drug-resistant tuberculosis in 2008, the challenges with the management of DR-TB has increasingly become prominent. The Government continues to ensure uninterrupted supplies of high quality first and second line anti-TB medicines, and capacity building initiatives for health care providers in both the public and private sectors.

There appeared to be a stabilisation of annually reported cases of drug-resistant TB in 2012, with 329 registered cases recorded in all the regions. Of these, 206 were confirmed multi-drug resistant or poly-drug resistant cases, as shown in Figure 14. Seventy more cases were put on second line anti-TB treatment as suspected MDR TB, often with no bacteriological confirmation of resistance.

The NIP remained the main provider of diagnostic services for DR TB. Rapid molecular diagnostics for DR TB were introduced in August 2012 with the acquisition of four sets of equipment for the Gene

Figure 13: Trends in the number of reported cases of drug resistant TB




pert platform for the Xpert MTB/RIF® and subsequent implementation in the Windhoek Central Hospital laboratory. Additional equipment was donated by Peralin Paints Namibia, and earmarked for use in Grootfontein in the Otjozondjupa Region, to benefit the Tsumkwe community.

### 6.2.3.4 TB/HIV Co-management

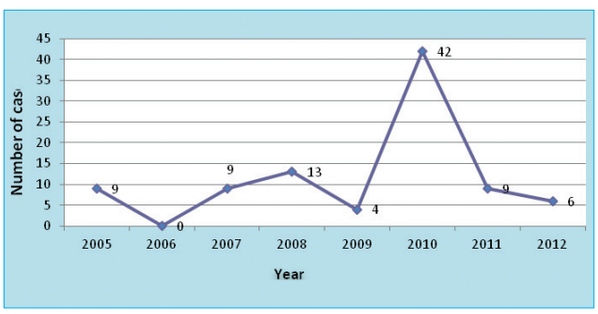
Management of TB/HIV co-infection is a high priority for Namibia since there is a high co-infection rate. Efforts were made to ensure that all TB patients had a known HIV status. Thus the proportion of patients with a known HIV status has increased from 16% in 2005 to 89% in 2012. Forty seven percent (47%) of those tested were HIV positive. Co-management of these cases is being expanded as evidenced by the fact that 99% of them were on Cotrimoxazole preventive therapy while 71% were on antiretroviral therapy. Namibia's target is to achieve HIV testing rates of more than 95% among TB patients. Gradual progress was made in this regard since 2005.

### 6.2.3. Leprosy

The National TB and Leprosy Programme (NTLP) has developed national guidelines for the management of leprosy in Namibia. The first leprosy leaflets with basic information were distributed to all 13 regions to sensitise the communities. In 2012, Government funding for leprosy activities was made available. Commemoration of the first ever Leprosy Day was held on the 04 February 2013, with involvement of health care workers from various regions and the NTLP staff. The Minister of Health and Social Services officiated at the event, which is characterised as a first step towards realising the goal of eventually eradicating leprosy in Namibia.

In 2012, six new cases were reported. Three of these cases were multi bacillary while the other three were Grade 2 Disability (GRD). Figure 14 shows the trends in the reported leprosy cases in 2005 to 2012. The graph mirrors a continued decline in the number of reported leprosy cases.

Figure 14: Trends in reported leprosy cases from 2005 to 2012




Multidrug Therapy (MDT) is provided for free through WHO Geneva by the Novartis Foundation. The introduction of MDT to countries affected by leprosy has shown success in the global elimination of leprosy. Globally, since1985 and the beginning of 2008, nearly 15 million people were diagnosed with leprosy and cured with multidrug therapy. In Namibia, four regions were given MDT blister packs.

### 6.2.4 National Malaria and Vector Borne Disease Control Programme

Namibia continues to witness a major transition in the malaria epidemiology over the last years. Significant reduction in malaria morbidity and mortality were observed annually since 2005. As the country moves towards malaria elimination, there is a need to strengthen the component of monitoring and evaluation, and surveillance. We also need to update and implement suitable malaria prevention and control strategies at all levels of health care, including community.

#### 6.2.4.1 Morbidity and Mortality

The reduction in malaria mortality and morbidity in the country can be attributed to the scaling up of major interventions and strategies applied at all levels. The morbidity and mortality were significantly reduced between 2011 and 2012. A total 14 409 malaria cases were reported in 2011. This number was reduced drastically to only 3 512 in 2012. The number of malaria related deaths was reduced from 45 in 2011 to only four in 2012. These results show a 76% and 91% reduction in morbidity and mortality respectively, see Figures 15-17 overleaf.

#### 6.2.4.2 Malaria diagnosis and case management

With the introduction of Artesunate Combination Therapy (ACTs) in 2005, the programme started scaling up malaria diagnosis by introducing Rapid Diagnostic Tests in all peripheral health facilities to improve diagnosis and prevent drug resistance. RDTs, currently using Care Stat combo tests, have since been rolled out and are in use in all peripheral health facilities. The programme further reviewed the National Strategic Plan (2010-2016), where all suspected malaria cases are to receive parasitological confirmation and should be treated correctly with appropriate anti-malaria medicines, currently Artemether Lumefantrine as first line.

The programme continues to implement trainers of trainers (TOTs) model to ensure correct implementation of the national policy and guidelines. Thirty six health (36) workers from the malaria affected regions were trained on malaria case management and they in turn trained 141 health workers in their respective regions. The programme recently introduced a clinical mentor's model to conduct onside mentorship of health workers to further improve the implementation of national policies and guidelines. The national team continues to conduct annual supervisory support visits to the regions and health facilities.

#### 6.2.4.3 Vector control

Indoor residual spraying was successfully completed in the eight malaria regions and 669 578 structures out of 719 412 targeted were sprayed by the end of January 2013, representing 93% coverage nationwide. The programme conducted bioassays and susceptibility studies in the regions to evaluate the quality of spraying and the efficacy of insecticides. The results have shown that most of the regions produce up to standard and quality spraying and that malaria vectors are 100% susceptible to insecticides (DDT and Deltamethrine) used in Namibia.

#### 6.2.4.4 Long lasting insecticide-treated nets

For the year under review, 87 900 insecticide treated nets were procured with the support of the Global Fund. Seven thousands of the nets were distributed to beneficiaries in Kavango while the rest will be distributed using mass campaigns in the next financial year.

#### 6.2.4.5 The Schistosomiasis and soil transmitted Helminthes

A study to determine the prevalence of Schistosomiasis in the country was carried out in two regions, Caprivi (Zambezi) and Kavango in November 2012. Ninety nine (99) schools were involved, 23 of these were from Caprivi (Zambezi) while 76 were from Kavango. The study population included children between the ages of 3-17 from both regions totalling to 5 915. The outcome of the survey has shown that the prevalence of the disease in the two regions stands between 10%-49%. All children who participated in the study received treatment using praziquantel and albendazole. This survey was supported by MoHSS, END FUND, UNAM, Polytechnic of Namibia and the Liverpool School of Tropical Medicine.

#### 6.2.4.6 Operational research, surveillance, monitoring and evaluation, epidemic preparedness and response

As part of monitoring and evaluation, the programme conducted supervisory support visits to all eight malaria regions. Seventy three (73) public health facilities, 21 private pharmacies and 13 private practitioners were visited. All health facilities were 100% stocked with ACTS while only 97% were stocked with RDTs.

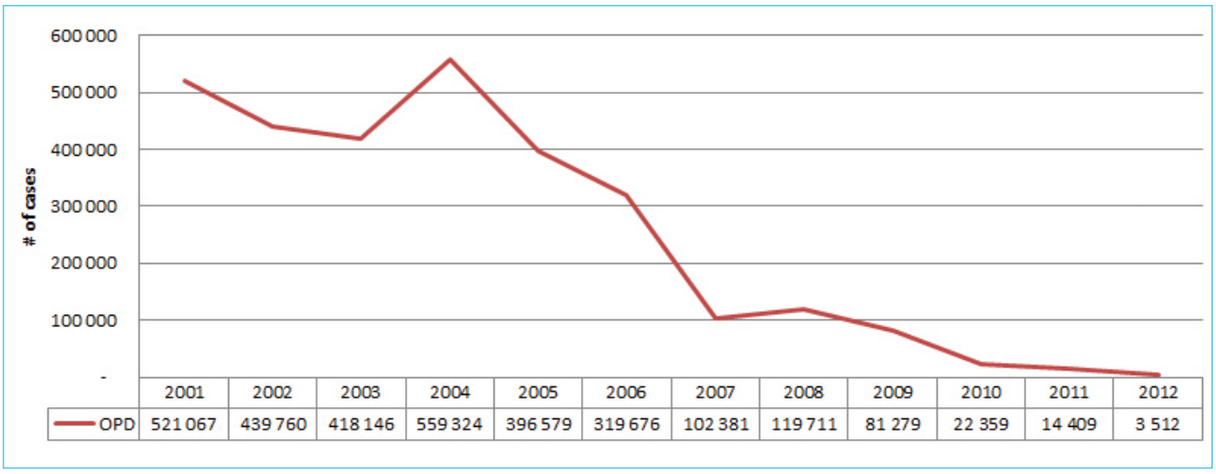
On the operational research, the programme continues to monitor the spraying quality and susceptibility of malaria vectors to insecticides used in the country. Up to standard spraying quality is maintained while susceptibility of malaria vectors stands at 100%. The monitoring of Artemether Lumefantrine was not conducted due to lack of an adequate sample size. The programme is currently conducting a survey on Epidemiology of Border Malaria in Engela District to guide the programme on appropriate surveillance systems in border districts.

Other studies being conducted include the malaria elimination case study to guide the programme on malaria elimination as envisage in the 2010-2016 strategic plan.

The programme participated in the following publications:

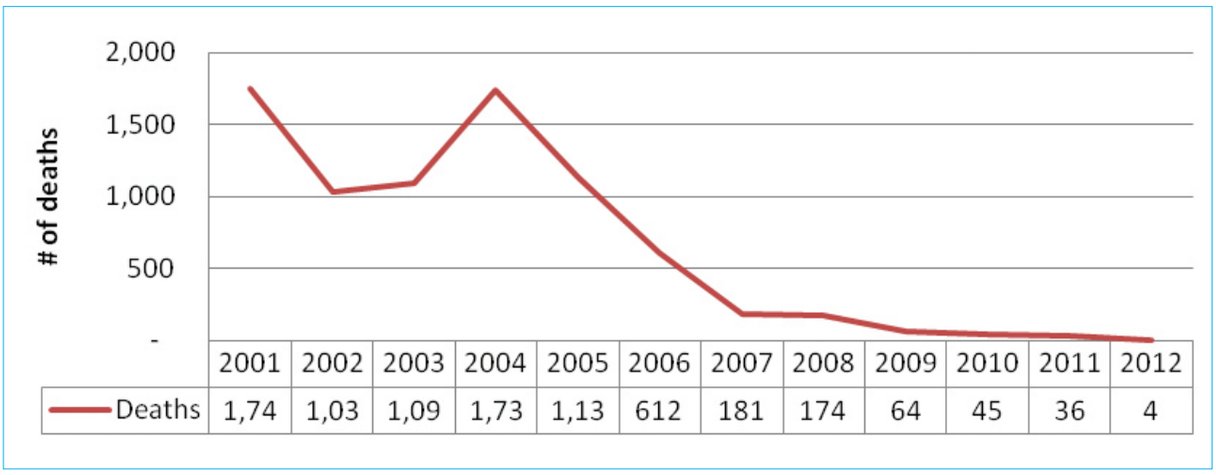
- The Receptive Versus Current Risks of Plasmodium Falciparum Transmission in Northern Namibia: Implications for Elimination
- Malaria Control and the Intensity of Plasmodium Falciparum Transmission in Namibia 1969-1992

Figure 15: Outpatient malaria cases in Namibia from 2001-2012



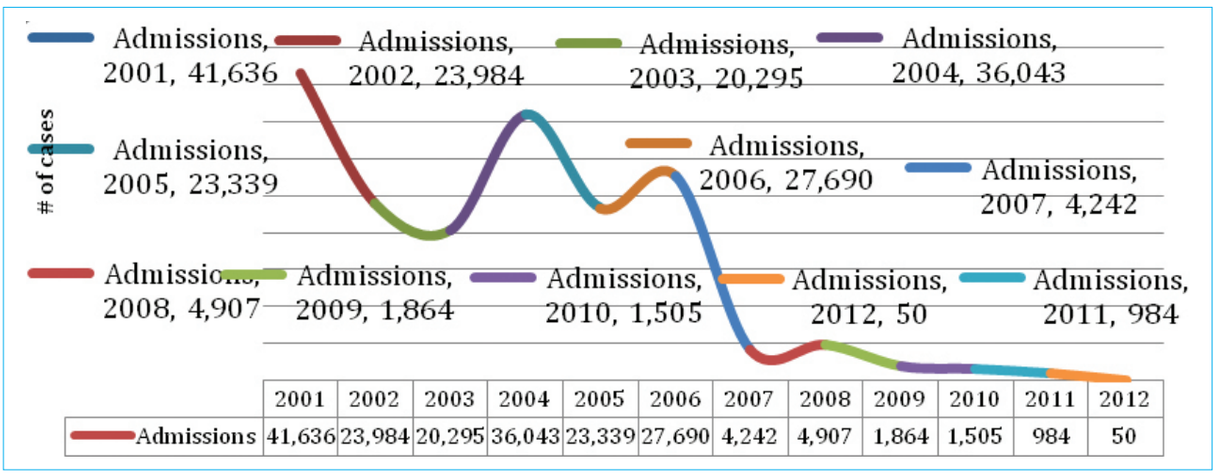

| | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| OPD | 521 067 | 439 760 | 418 146 | 559 324 | 396 579 | 319 676 | 102 381 | 119 711 | 81 279 | 22 359 | 14 409 | 3 512 |

Figure 16: Malaria related deaths in Namibia from 2001-2012




| | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Deaths | 1,74 | 1,03 | 1,09 | 1,73 | 1,13 | 612 | 181 | 174 | 64 | 45 | 36 | 4 |

Figure 17: Malaria admissions in Namibia from 2001-2012




| | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Admissions | 41,636 | 23,984 | 20,295 | 36,043 | 23,339 | 27,690 | 4,242 | 4,907 | 1,864 | 1,505 | 984 | 50 |

## 6.3 DISEASE SURVEILLANCE

### 6.3.1 Epidemiology

Disease Surveillance, Emergency Preparedness and Response and Health Information System activities undertaken during the reporting period included the completion of key guidelines and drafting of reports. Completed were the:

- 1. National Technical Guidelines for Integrated Disease Surveillance and Response, Second Edition July 2011
- 2. Adaptation of Training Modules for the National Technical Guidelines for Integrated Disease Surveillance and Response, Second Edition July 2011

The 2008-2010 HIS Report and the Revision of the National Health Emergency Preparedness and Response, Second Edition will be completed in the 2013-2014 financial year.

### 6.3.2 Field Epidemiology and Laboratory Training Programme

The Field Epidemiology and Laboratory Training Programme (FELTP) is aimed at strengthening Namibia's capacity to effectively respond to public health emergencies by developing technical capacities in field epidemiology and laboratories and strengthening the linkage between veterinary epidemiology and public health.

The training is in two parts, short and long courses using the FELTP model. The Centre for Disease Control (CDC) is currently assisting the MoHSS to build strong, effective and sustainable programmes to improve public health capacity and systems at local, regional, and national levels.

Training needs in management and leadership were identified and staff were trained in various courses and attended different workshops dealing with leadership, management, disease surveillance, emergency preparedness and response and health information systems.

Two Short Courses were conducted in August 2012 and February 2013. A Scientific Conference took place in February 2013 where trainees presented their field work projects.

## 6.4 ENVIRONMENTAL HEALTH SERVICES

The quality of a people's environment is known to directly or indirectly determine a population's health status and well-being. Poor quality of life, overcrowded dwellings, unsafe drinking water, inadequate sanitation, poor waste management practices, exposure to hazardous substances in living and workplaces, unsafe foodstuffs and poor town planning are just some of the many different environmental health problems facing Namibia.

The environmental threats faced by communities are numerous and can be divided into "traditional hazards" associated with under-development, and "modern hazards" associated with unsustainable development. Many of the environmental hazards faced today are the legacies of pre-independence neglect of primary health care and basic environmental health needs such as rural sanitation, proper waste management, safe water supply and hygiene promotion.

Preventive intervention services, of which Environmental Health Services is one of the key components for achieving this objective of the Ministry's policy framework. The policy also sets out seven guiding principles for health and social services that are: Equity, Availability, Accessibility, Affordability, Community Involvement, Sustainability, Inter-sectoral Collaboration and Quality of Care. Furthermore, the Ministry has carried out a number of activities in the following main areas, Water Sanitation, Public Hygiene; Food Safety and Occupational Hygiene and Port Health.

### 6.4.1 Water and Sanitation

Sanitation refers to the safe disposal of human excreta. The Global Hand Washing Day was commemorated in Oshana to raise awareness among communities about the importance of washing hands. Furthermore, the programme has trained all district and regional EHP on WASH strategy in order to strengthen the regional and district level capacities. Five hundred containers were bought and distributed to all regions including town councils for the promotion of hand washing. Additional containers were acquired from UNICEF as one of the stakeholders. Furthermore, the Ministry conducted training and orientation of EHP on the use of water test kits.

### 6.4.2 Public Hygiene Services

Supervisory and support visits were conducted to strengthen environmental health services in the country and various stakeholder meetings were held. Also, a national annual environment awareness campaign was conducted. With the enactment of the Tobacco Product Control Act, a national awareness campaign was conducted in all theregions. The World No Tobacco Day was commemorated. Furthermore, the Ministry conducted inspection of hospitals throughout the country. The inspection focused on general hygiene in municipal proclaimed areas.

### 6.4.3 Food Safety and Occupational Hygiene

The Ministry in collaboration with the Directorate of Veterinary Services of the Ministry of Agriculture, Water and Forestry conducted a refresher training

course of regional staff on inspections and meat hygiene at abattoirs. Two staff were trained in occupational health techniques. Following support supervisory visits to the regions, the Ministry closed the Tsumeb Abattoir, as it was found unfit to continue its operations.

Three stakeholders meetings were held to find common solutions regarding strengthening of food safety systems in the country. The meetings adopted the following key directives:

- responsibilities or roles of line ministries as per National Food Safety Policy;
- proposed an inter-ministerial coordination mechanism of various competent authorities on aspects relating to food safety;
- proposed aspects to be detailed in the Legislation to be gazetted by various line ministries, including MoHSS, after enactment of the food safety legislation.

The SADC Committee on Food Safety nominated Namibia, through the Ministry together with the Malawi health ministry to identify laboratories in the region that would become reference laboratories in the SADC Region.

### 6.4.4 Port Health Services

The Ministry in collaboration with the WHO country's representative office continue to implement the International Health Regulation (IHR, 2005). The National Port Health Strategy and Standard Operating procedures were developed and a functional IHR coordinating committee at national level was established. However, more needs to be done on the implementation of IHR core capacity. As a consequence, the Ministry is in the process to obtain two years further extension of the core capacity implementation.
Furthermore, the Ministry has visited different designated points of entry throughout the country and it was observed that a lack of infrastructure and human resources remain a critical challenge. In an effort to mitigate these challenges, the Ministry appointed and deployed an EHP at point of entry in some regions to take care of Port Health Activities.

## 6.5 OCCUPATIONAL HEALTH SERVICES

The Occupational Therapy Services aim to prevent dysfunction in people, to promote, develop, restore and maintain abilities needed to cope with daily activities, to live a satisfying independent healthy life-style and to increase functioning and productivity (rehabilitation).

In addition, the Occupational Therapy Department conducts outings (to the annual agricultural shows), organises or co-organises events for patients (end-of-year parties, mental health sports day, kids-fun-fair) as part of the rehabilitation programme, as well as commemorates/celebrates international days (e.g. international Mental Health Day, International Occupational Therapy Day) and campaigns for the rights of the patients (Disability Prevention And Rehabilitation Campaign And 16 Days of Activism).

The number of patients that received Occupational Therapy Services for various conditions dramatically increased during the financial year 2012/2013 in comparison with the previous financial year 2011/2012. The improvement can be ascribed to the increased vacancy rate at the department with skilled therapists.

## 6.6 ATOMIC ENERGY AND RADIATION

### 6.6.1 Regulatory Mechanism

The Atomic Energy and Radiation Protection Act of 2005, embodies the scope and purposes of the policy, including the establishment of the Atomic Energy Board and National Radiation Protection Authority. An important part of the Namibia Radiation Protection Authority's work is to ensure that the Act and its regulations are introduced, understood, implemented and enforced. To this end, 40% of the 169 known facilities were evaluated and found to comply with the administrative requirements. Seventy three inspections were conducted; 79 facilities were registered and issued with authorisation letters and/or licences while 26 compliance orders were handed out.

Other matters include security of radiation sources and nuclear material; decommissioning and rehabilitation of facilities; control of sources of non-ionising radiation; and extraction and processing of source materials.

### 6.6.2 Inspections and Licensing

Licensing, inspection and enforcement are conducted in conformity with the Atomic Energy and Radiation Protection Act and the Radiation Protection and Waste Disposal Regulations of 2012.

These regulatory instruments were introduced to facilities and practices, including the operational regime of ensuring compliance. To this end, during this reporting period, 121 applications/notifications were considered; 73 safety assessments conducted; 37 radiation management plans reviewed; 79 authorisations/registrations and licences granted while 26 compliance orders were issued. A further breakdown of the inventory of regulatory activities is presented in Figure 18.

The regulatory activities serve as an important measure to give assurance that the facilities that use or generate radioactive substances are controlled and the risk is managed such that people and the environment receive the highest level of protection. They also ensure that safety is maintained.

Furthermore, the total number of facilities and practices that have been subjected to the full cycle of the regulatory regime stand at 73 of the 169 in the current inventory. Seventy percent (70%), or 51 of the 73 facilities were non-compliant mainly due to not having fulfilled the administrative requirements while 22 of the 73 were non-compliant due to non-optimal performance of equipment. Subsequently 68 of 73 facilities were authorised after responding to the non-compliance issues.

### 6.6.3 Nuclear Support Technology

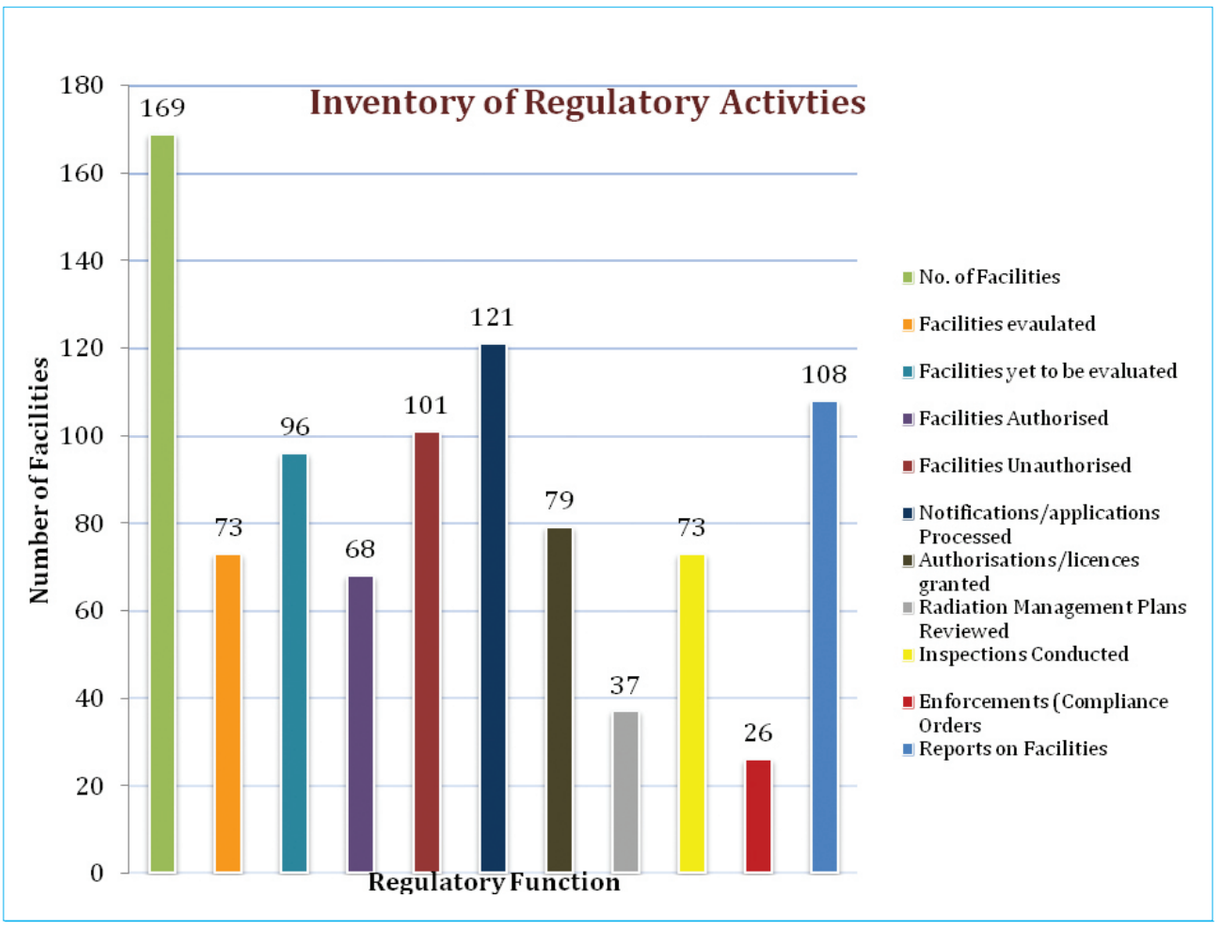
The Fourth National Development Plan (NDP IV) recognises economic growth, increasing employment and income inequality as overarching goals to be addressed by strengthening the basic enablers (education and skills; health; reduction of extreme poverty; and public infrastructure) to stimulate and sustain economic growth (logistics and distribution; tourism; manufacturing capability; and agriculture). Nuclear Science and Technology is a competitive, unique and complimentary tool that could strengthen some of these areas such as the institutional environment for research and development; health; education and skills development which in turn will contribute to growth of the economic priorities such as agriculture and manufacturing capabilities. For this reason progress is underway to develop a nuclear science and technology policy and strategies to enlarge the contribution of nuclear technology to national development in alignment with the priority areas identified in NDP IV.

### 6.6.4 Occupational Exposure

With the exception of one case, the occupational radiation exposure of workers remained below the legal limit of 20mSv with an average value of 0.6 mSv per annum. Although this value is below the legal limit, it is necessary that it is optimised to be as low as reasonable achievable. Monitoring of public and capturing of data also needs to be improved by strengthening the regulatory activities.

During the reporting period, two incidents were reported to the Authority. In one case, a sealed source dislodged from its case, but was successfully brought under control with the highest potential radiation dose

Figure 18: Regulatory Activities



estimated to be less than 0.01mSv. A second case of suspected leakage was reported and the source was removed from operation and stored in a safe place. In both cases arrangements were made to return the devices to the suppliers. An elevated level of radon concentration was reported, which potentially could have caused a dose of 4.5 mSv/a. There has also been a report of 28 mSv exposure, exceeding the dose limit, for which unfortunately the exact cause of the radiation dose has not been established with certainty.

While the Authority is proactively seeking to ensure that facilities have up to date emergency response plans, it is also developing its own response capacity for cases which may be beyond the scope and capacity of response of the facilities. This plan is to be expanded in the next year and thereafter integrated with the national emergency response plans.

## 6.7 HEALTH PROMOTION AND EDUCATION

The Ministry commemorated the following national events as part of its promotion strategy to create awareness and educate communities on preventative diseases:

- Traditional Medicine Day
- Diabetes & Health Lifestyle Day
- World Breastfeeding Week
- Child Health Day

The Ministry established the the following technical working groups to strengthenn its stewardship role:

- Production of indigenous foods to treat acute malnutrition
- Research on childhood obesity
- De-worming
- National CBHC TRG
- School health task force
- PMTCT TWG

## 6.8 DISABILITY PREVENTION AND REHABILITATION

Disability prevention and rehabilitation services were provided to the public and private sectors. DPR plays a vital role in the prevention of deafness and blindness and issues assistive devices such as orthopaedic appliances. Other health services include physiotherapy, occupational and speech therapy.

The ultimate goal of DPR, which is based on the tenants of PHC, is to help those with disabilities to lead a socially and economically productive life.

The following draft guidelines were developed:

1. CBR Training Manuals, 700 copies were printed
2. Development of OTS in independent Namibia Report
3. Disability Prevention and Rehabilitation Strategy
4. Burns Management and Care Guidelines
5. CBR Guidelines
6. Standard of Practice Guidelines for Occupational Therapists and Physiotherapist
7. Protocols for Rehabilitation of the Visually Impaired
8. Management Care and Rehabilitation of Spinal Cord Patients Guidelines
9. Occupational Therapy Services (OTS) Mobile Clinic Guidelines
10. Mental Health Bill finalised and submitted to CCL

Collaborative efforts with DOH in South Africa resulted in astudy tour on forensic psychiatric services. A multidisciplinary team from the Windhoek Central Hospital accompanied by the MoHSS Deputy PS and stakeholders from the ministries of Justice and Safety and Security visited South Africa.
The MoHSS in collaboration with Operation Smile South Africa surgically helped 46 children with cleft and palate conditions. With regard to health promotion, the Ministry successfully organised the National Disability Awareness week. The main event took place in the Kavango Region. Its focus was to raise awareness among doctors and regional councillors on rehabilitation services in Namibia.

OTS Outreach Clinics were carried out in Otjozondjupa, Hardap and //Karas regions. Four hundred and fifty nine (459) clients were attended to and received their devices while the Windhoek Central Hospital helped 987 clients. Furthermore, pre-screening of children with cleft lips/palates was conducted in the regions and 46 children were operated on in April 2013.

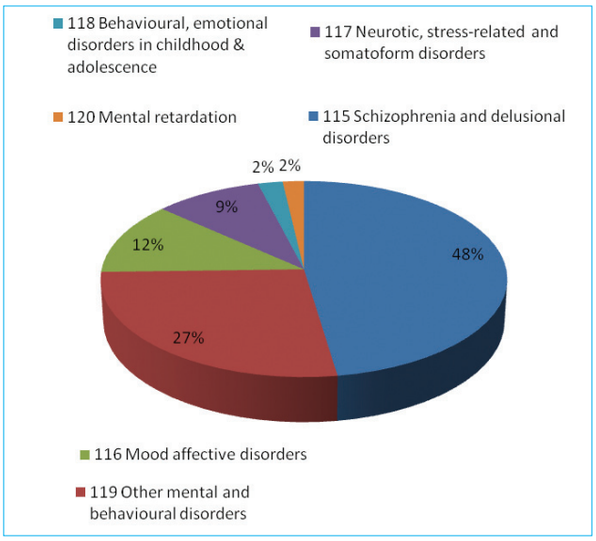
### 6.8.1 Blindness Prevention

The Ministry successfully conducted the Cataract Induced Visual Impairments Programme by performing 1 306 sight restoring cataract operations through its five cataract surgical projects in Kavango, Karas, Oshikoto and Caprivi, Oshana and Omusati and Ohangwena regions. Twelve people with visual impairments were issued white cane in Kunene Region during the Disability Prevention and Rehabilitation (DBR) National Awareness Week.

### 6.8.2 Mental Health

A mental health promotional programme was successfully organised in collaboration with the mental health centre to commemorate World Mental Health.

Figure 19: Admissions with a psychiatric diagnosis 2011-2012




Total admissions and discharges were 3 836 while deaths with a psychiatric diagnosis were 47.

Mental health services are currently available at the following institutions:

### (i) Oshakati Intermediate Hospital

The Psychiatric Unit has an 80-bed capacity but admits up to 90 patients. The outpatient clinic provides services to a minimum of 100 patients per day. This Unit has one psychiatrist and does not have clinical psychologists.

### (ii) Windhoek Central Hospital

The Mental Health Care Centre, which is the country's referral centre, has a 112 bed capacity. The Forensic Service Unit is located within the premises of the Windhoek Mental Health Care Centre and has 99 beds. Emergency mental health services are also provided at district hospitals and patients are admitted in the general wards. There are no specialist mental health staff at these facilities.

## 6.9 SOCIAL WELFARE

### 6.9.1 Family Welfare

- Promotional messages were developed for both print (leaflets) and electronic media (Radio and TV)
- Guidelines were finalised and printed and are being disseminated to all regions and stakeholders
- Training manuals were piloted with NHTC and RHTC tutors
- National Standards on AFHS are in place, and were sent to all the regions and stakeholders to guide the implementation of AFHS in health facilities
- Training of Health Care Workers (HCWs) on AFHS was integrated into the UNAM pre-service curricular

### 6.9.2 Substance Abuse Prevention, Drug Control and Rehabilitation

In order to increase awareness on social ills and its effects on society, various international and national days were commemorated. The International Day Against Drug Abuse and Illicit Trafficking was commemorated with the launching of the 7-Days of Activism Against Alcohol and Drug Abuse, as well as the Etegameno Resource Centre. The 7-Days of Activism Against Alcohol and Drug Abuse was commemorated nationwide. Furthermore, the Ministry commemorated the World Elder Abuse Awareness Day in Rundu, Kavango Region.

### 6.9.3 Specialised Social Welfare Services

Seven (7) registered welfare organisations in receipt of financial assistance, submitted their six-monthly progress reports in line with the contractual agreement. This arrangement also served as a mechanism to detect non-compliance at an early stage and to provide the required guidance and support. Three new welfare organisations were registered.

Nine (9) residential care facilities for older people were subsidised during the period under review, adding onto residential care facilities and the improvement of living conditions of poor and vulnerable people.

## 6.10 DISABILITY PREVENTION AND REHABILITATION

Disability prevention and rehabilitation services were provided to the public and private sectors. DPR plays a vital role in the prevention of deafness and blindness and issues assistive devices such as orthopaedic appliances. Other health services include physiotherapy, occupational and speech therapy.

The ultimate goal of DPR, which is based on the tenants of PHC, is to help those with disabilities to lead a socially and economically productive life.

The following draft guidelines were developed:

- CBR Training Manuals, 700 copies were printed
- Development of OTS in independent Namibia report
- Disability Prevention and Rehabilitation Strategy
- Burns Management and Care Guidelines
- CBR Guidelines
- Standard of Practice Guidelines for Occupational Therapists and Physiotherapist
- Protocols for Rehabilitation of the Visually Impaired
- Management Care and Rehabilitation of Spinal Cord Patients Guidelines
- Occupational Therapy Services (OTS) Mobile Clinic Guidelines
- Mental Health Bill finalised and submitted to CCL

Collaborative efforts with DOH in South Africa resulted in a study tour on forensic psychiatric services. A multidisciplinary team from the Windhoek Central Hospital accompanied by the MoHSS Deputy PS and stakeholders from the ministries of Justice and Safety and Security visited South Africa.

The MoHSS in collaboration with Operation Smile South Africa surgically helped 46 children with cleft and palate conditions. With regards to health promotion, the Ministry successfully organised the National Disability Awareness week. The main event took place in Kavango Region. Its focus was to raise awareness among doctors and regional councillors on rehabilitation services in Namibia.

OTS Outreach Clinics were carried out in Otjozondjupa, Hardap and Karas regions. Four hundred and fifty nine (459) clients were attended to and received their devices while the Windhoek Central Hospital helped 987 clients. Furthermore, Pre-screening of children with cleft lips/palates was conducted in the regions and 46 children were operated on in April 2013.

### 6.10.1 Blindness Prevention

The Ministry successfully conducted the Cataract Induced Visual Impairments Programme by performing 1 306 sight restoring cataract operations through its five cataract surgical projects in Kavango, Karas, Oshikoto and Caprivi, Oshana and Omusati and Ohangwena regions. Twelve people with visual impairments were issued white cane in Kunene Region during the Disability Prevention and Rehabilitation (DBR) National Awareness Week.

### 6.10.2 Mental Health Services

A mental health promotional programme was successfully organised in collaboration with the mental health centre to commemorate World Mental Health. Total admissions and discharges were 3 836 while deaths with a psychiatric diagnosis were 47.

Mental health services are currently available at the following institutions in Namibia:

(i) Oshakati Intermediate Hospital
The Psychiatric Unit has an 80-bed capacity but admits up to 90 patients. The outpatient clinic provides services to a minimum of 100 patients per day. This Unit has one psychiatrist and does not have clinical psychologists.

(ii) Windhoek Central Hospital
The Mental Health Care Centre, which is the country's referral centre, has a 112 bed capacity. The Forensic Service Unit is located within the premises of the Windhoek Mental Health Care Centre and has 99 beds. Emergency mental health services are also provided at district hospitals and patients are admitted in the general wards. There are no specialist mental health staff at these facilities.

The tables overleaf reflect both 1st and re-visits treated and seen at OPD in Public and Mission Facitities during the period under review.

Table 23: Total number of Psychiatric First visits treated in OPD in public and mission facilities in Namibia, 2012-2013

| Regions | 2012 | 2013 | Total |
|---|---|---|---|
| Caprivi | 209 | 387 | 1374 |
| Erongo | 708 | 914 | 4133 |
| Hardap | 323 | 296 | 1476 |
| Karas | 222 | 200 | 1350 |
| Kavango | 1012 | 921 | 5168 |
| Khomas | 1426 | 1492 | 8385 |
| Kunene | 173 | 188 | 1054 |
| Ohangwena | 1147 | 1320 | 6435 |
| Omaheke | 223 | 145 | 1134 |
| Omusati | 1092 | 1563 | 5748 |
| Oshana | 1414 | 2217 | 8188 |
| Oshikoto | 595 | 808 | 4859 |
| Otjozondjupa | 243 | 184 | 1226 |
| **Namibia** | **8787** | **10635** | **50530** |

Table 24: Total number of Psychiatric Re-visits seen in OPD in public and mission facilities in Namibia, 2012-2013

| Regions | 2012 | | 2013 | |
|---|---|---|---|---|
| Caprivi | 1155 | 2.00% | 1819 | 2.40% |
| Erongo | 3572 | 3.40% | 3475 | 2.70% |
| Hardap | 2448 | 4.10% | 2807 | 4.30% |
| Karas | 1356 | 2.90% | 1581 | 3.80% |
| Kavango | 5817 | 6.50% | 6391 | 6.80% |
| Khomas | 10770 | 2.80% | 9526 | 2.30% |
| Kunene | 1486 | 5.60% | 1582 | 5.70% |
| Ohangwena | 11950 | 7.10% | 13741 | 7.50% |
| Omaheke | 2174 | 4.80% | 1798 | 4.80% |
| Omusati | 9831 | 7.20% | 10550 | 6.90% |
| Oshana | 18289 | 13.40% | 19834 | 13.70% |
| Oshikoto | 5036 | 5.00% | 4911 | 4.90% |
| Otjozondjupa | 4368 | 6.80% | 3940 | 5.60% |
| **Namibia** | **78252** | **5.20%** | **81955** | **5.10%** |

% = Number of Psychiatric Re-visits/ Total Revisit/ Follow-Up Visits (General)

# CHAPTER 7: HOSPITAL SERVICES

## 7.1 EMERGENCY SERVICES

### 7.1.1 Ambulance Services

- Basic life support training was conducted and 16 ambulance officers were awarded Basic Life Support certificates.
- Four 4x4 ambulances were distributed to Usakos, Omuthiya, Opuwo and Mariental.
- An Emergency Medical Rescue Services Policy and Strategic Plan was launched.
- A Memorandum of Understanding and Service Level Agreement with the MVA Fund were revised.

### 7.1.2 Casualty Services

Casualty Department renders emergency services for private practitioners during the day. All other casualty patients are referred to Katutura Intermediate Hospital. During the period under review, 521 patients were circumcised at the Windhoek Central Hospital Causality Department. This brings the total to 1 846 male circumcision operations performed since its inception in 2009

## 7.2 MEDICAL SERVICES

### 7.2.1 General Outpatient Services

According to the data from HIS, the leading causes of deaths in public health facilities are HIV/AIDS, TB and diarrhoea. As a result, addressing these conditions remains a priority.

| Table 25: Top 10 causes of deaths in outpatients April-December 2012 | |
|---|---|
| OPD other respiratory disease diagnoses | 476 267 |
| Musculo-skeletal system disorder | 318 287 |
| Common cold | 200 658 |
| OPD other skin disease diagnoses | 190 299 |
| Trauma | 188 770 |
| Diarrhoea without blood | 188 710 |
| Nose or throat disease/disorder | 179 943 |
| OPD Other Syndrome/Diagnosis | 150 037 |
| OPD other gastro-intestinal disease diagnoses | 143 099 |
| Neurological disease/disorder | 111 133 |

### 7.2.2 General in-patient services

| Table 26: Top 10 causes of deaths in inpatients from April-December 2012 | |
|---|---|
| HIV disease (AIDS) | 45 |
| Pulmonary (respiratory) tuberculosis | 30730 |
| Diarrhoea, gastroenteritis, presumed infectious | 28 |
| Pneumonia | 19 |
| Malnutrition | 13 |
| Chronic renal failure | 9 |
| Heart failure including CCF | 8 |
| Gastric, duodenal ulcer | 6 |
| Fracture of skull or facial bones (mandible, maxilla, nose, etc.) | 6 |
| Anaemia | 6 |
| Diabetes mellitus (including hyperglycaemia, ketoacidosis) | 6 |

### 7.2.3 Operating Theatre

The Operating Theatre is the only department which caters for both private and state patients and it is equipped with highly sophisticated medical equipment. During the period under review, Two (2) Anaesthetic machines were received and an intercom system was installed. The Ministry with the support of

an Inter-plastic Surgeon from Germany successfully conducted plastic operations.

The Ministry further undertook staff development as eight staff members attended training in South Africa on Cardiac Nursing for a period of three to six months. Furthermore, three Registered Nurses underwent an advanced diploma in operating room training, while one Registered Nurse and four Enrolled Nurses posts were filled. The E-Health training is progressing well.

Table 27: Operations conducted in the Main Theatre

| Types Of Cases | Private Operations | Private Emergency Operations | State Operations | State Emergency Operations |
|---|---|---|---|---|
| Major Cases | 2949 | 490 | 2727 | 576 |
| Minor Cases | 1530 | 214 | 1528 | 337 |

## 7.3 SPECIALISED MEDICAL SERVICES

### 7.3.1 Specialised Services

One hundred and fifty (150) patients were referred to the private haemodialysis treatment centre because there are currently no such specialised services at public hospitals.

### 7.3.2 Special Fund

Fourteen patients (14) were referred to Cape Town, South Africa for cardiac surgery with financial assistance from the Special Fund.

### 7.3.3 Cardiac Unit

The number of outpatients seen at the Cardiac Outpatient Unit was 3 950. The patients underwent various procedures such as thoracic, adult cardiology, rheumatic heart disease, paediatric, congenital and echocardiogram. The inpatient statistics for the unit are reflected in Table 26.

Table 28: Patients admitted to the Cardiac Unit

| Cardiac Procedures | Total |
|---|---|
| Open Heart Surgery | 65 |
| Thoracic Surgery | 71 |
| Patent Ductus Arteriousus | 5 |
| Permanent Pacemaker | 19 |
| Lobectomy | 6 |
| Cardio Angiogram | 80 |
| Cardio Angioplastie | 10 |
| Total number of patients admitted Cardiac Unit | 110 |

# CHAPTER 8: TERTIARY HEALTH CARE & CLINICAL SUPPORT SERVICES

## 8.1 PHARMACEUTICAL SERVICES

The Ministry continued to implement the Medicines and Related Substances Act, Act 13 of 2003, as amended. During the reporting period, revenue of N$320 573.00 was collected through various regulatory activities. The Ministry is working on strengthening the Medicines Registration Section, Inspectorate, Therapeutic Information and Pharmacovigilance Centre and the Quality Surveillance Laboratory.

The Medicines Registration body reviewed 111 records, processed 101 Compassionate Clearance Certificates and 113 Narcotics Permits. The Inspectorate inspected 17 local premises, ranging from private clinics to public health facilities.

The Central Medical Store is critically under staffed. The resignation of staff, especially pharmacist assistants, is threatening to cripple the services. The Ministry was forced to authorise staff to work overtime to cover the accumulated delivery backlog. Delivery of essential medicines such as ARVs, anti-TBs and anti-Malaria drugs was prioritised.

## 8.2 CLINICAL SUPPORT SERVICES

Clinical Support Services provides clinical support and technical assistance to the MoHSS. Under, Clinical Support Services are five important functions, namely Medical Equipment Management, Medical Laboratory Services, Radiographic Services, Ambulance Management Services and Administrative Support Services.

### 8.2.1 Medical Equipment Management

This function is aimed at providing medical equipment management and related services of the highest quality to customers in Namibia. This function is fulfilled through an effective national management system for the acquisition and utilisation of medical equipment in hospitals, health centres and clinics. In addition, this function involves monitoring the implementation of policies and guidelines on medical equipment procurement, replacement, maintenance and repairs, donations and planned preventive maintenance.
During the reporting period, the following key activities were undertaken:

- Contracts for the repair and maintenance of x-ray, nuclear medicine and radiation therapy & associated equipment we rerenewed, pre-evaluated and awarded.
- Contracts for the repair and maintenance of medical and dental equipment were renewed, pre-evaluated and awarded.
- Tender specifications for contracts for the Supply and Delivery of low tech medical equipment were updated extensively and are due for pre-evaluation.

Furthermore, tender specifications were compiled for different regions/health facilities. These included, Autoclave for Okahandja, Mariental & Aranos; Washer Disinfector, Arthroscopy System with Camera, and Choledocho Fiberscope for the Oshakati Intermediate Hospital; Multislot CR with Printer, PACS/RIS for Katutura and Oshakati Intermediate Hospitals; Multislot CR with Printerfor the Katima Mulilo, Keetmanshoop, Walvis Bay District Hospitals.

Also, approval was obtained from the Tender Board to procure backup digitiser for CR Systems at the WCH and IHK X-Ray Departments. Outapi District Hospital was assisted with the backup Aneasthesia Unit from Windhoek Central Engineering Workshop (WCEW).

### 8.2.2 Medical Laboratory Services

The Ministry through the Medical Laboratory Services (MLS) is responsible for all operational, administration and financial matters relating to the Namibia Institute of Pathology (NIP) and the Blood Transfusion Services of Namibia (NAMBTS) both of which are autonomous

entities. A 7% tariff increase from NIP and 9% from NAMBTS for the year 2012/2013 was effected for state health facilities.MLS has ensured payment of NAMBTS and NIP for services rendered to MoHSS through verification of correctness of accounts in liaison with regional management teams and referral hospitals. This involved both PEPFAR funded Bio clinical monitoring HAART invoices as well as routine pathology testing invoices from NIP.

The Rapid Strengthening of the Blood Programme in Namibia under the PEPFAR project and some NIP projects were reduced by a further 14% in April 2012 and are projected to continue decreasing. This led to an increased budgetary constraint on the MoHSS in the 2012/2013 financial year. Furthermore, the Ministry has provided relevant guidelines for the submission of specimens suspect of viral hemorrhagic fevers like Marburg from NIP to CDC special pathogens branch in addition to international laboratory bio-safety standards during transportation of infectious specimens.

The post of Chief Medical Laboratory Technologist has been filled. This created a vacant post for the Medical Laboratory Technologist. The establishment of the National Public Health Laboratory Systems (NPHLS) in order to co-ordinate the fragmented laboratory services in the country was authorised by Cabinet. Four members of the IPHLC were trained in strategic management of public health laboratory systems during a two weeks seminar that was held in Dar es Salam, Tanzania, on 21 October to 02 November 2012 by the George Washington University in collaboration with the Association of Public Health Laboratories. This was funded by the CDC development partners.

### 8.2.3 Ambulance Management Services

The MoHSS is experiencing an ever-increasing demand for emergency medical care and pre-hospital services caused by increased incidents of trauma from motor vehicle crashes, violence and other related emergency medical conditions. In an effort to curtail this rapid growing challenge, the Ministry develop human capital to render specialised pre-hospital care services to the communities and general population of Namibia. In addition, the Ministry further strengthened collaboration with relevant stakeholders. Specifically, the following activities were undertaken:

- Sixteen (16)medical staff,eight doctors and eightnurses were trained in Advanced Cardiac Life Support and Trauma Management in collaboration with the MVA Fund. Furthermore, 32 ambulance drivers were trained to provide basic emergency medical care.
- Ambulance Life Support equipment were distributed to Omusati, Kavango, Oshana and Oshikoto Regions.
- National EMRS implementation framework review meetings were held with relevant stakeholders (Emergency Assist 991 Namibia, National Road Safety Council, MVA Fund and ATA International Namibia).
- The Ministry participated in the national conference on Road Safety 2013 and the Decade of Action for Road Safety Forum.

## 8.3 RADIOGRAPHIC SERVICES

The need for two backup digitisers for Windhoek Central Hospital and Katutura Intermediate Hospital was identified and equipment procured in efforts to ensure contingency of the medical imaging services.

Oshakati and Rundu Intermediate hospitals and 13 district hospitals have been earmarked for digitisation of the X-Ray film processing. The process will not only improve efficiency and workflow at X-Ray departments but also help achieve a reduction in radiographic waste and avail more storage space. Supervisory support visits to X-Ray facilities in Otjozondjupa and Kunene regions were conducted.

The Ministry and Scrap Salvage have revised the existing Service Level Agreement to improve the collection of Radiographic Waste in all regions. Unfors Quality Control kits were sent to SA for annual calibrations. The Ministry has forwarded invitations to relevant stakeholders to nominate candidates to establish a technical working group for the compilation of QA manuals in Radiography.

The X -Ray patient register was registered with the OPM, printed and made available for ordering through the Central Government Stores.

# CHAPTER 9: CONCLUSION AND THE WAY FORWARD

The period under review was characterised by the continued focus by health workers and support staff in providing quality healthcare to Namibians. As noted in the Report, the Ministry made significant headway in reducing the incidence of communicable diseases. More communities today have access to clinics than ever before, and infant and maternal mortality rates have declined.

However, Namibia is faced with an acute shortage of medical doctors and specialists, Registered Nurses, and other allied health professionals. The new UNAM School of Medicine is yet to produce the required medical doctors and pharmacists. Even at the current pace of intake, there will still be significant shortages. Similarly, there are other challenges that need to be addressed such as the availability of lecturers and professors.

Apart from the recruitment of foreign health experts, the Ministry undertook several measures to address staff shortages. One such measure was the introduction of Registered Nurse training at Windhoek, Keetmanshoop and Rundu Health Training Centres. Two hundred and seventy (270) students will be enrolled to undergo training before June 2013. This new approach will compliment the on-going enrolled nurse training at five other health training centres countrywide.

In addition, the Ministry is consulting with the Public Service Commission with regard to fast tracking the recruitment of health professionals, improve the condition of service for those working in remote and rural areas.The Ministry hopes to improve its staffing norms and structure to be responsive to the country's health growing needs.

The Ministry introduced a distance Leadership and Management Training Programme for all management cadre, at both national and regional level, in order to enhance health planning, efficient supervision, monitoring and evaluation of health programmes and improve the management of hospitals and health facilities. With regard to quality and standards, the Ministry is committed to ensuring that health service provision in the country conforms to national laws, standards and prescribed international standards. To this end, all health professional staff are undergoing in-service training on the best health practices. More importantly, the Ministry has stepped up its efforts to ensure that patients have access to safe medical care and pharmaceutical products.

The Ministry will upgrade the Katutura and Oshakati Intermediate hospitals to operate 24 hours, seven days a week, in efforts to stem overcrowding at these health facilities caused by the increasing populations. The Ministry is also investigating the status of all health centres in the country to operate on a 24 hour basis.

In addition, feasibility studies for the establishment of district hospitals in Khomas and Oshana regions will be undertaken during the 2013/14 financial year. The construction is envisaged to start in the 2014/15 financial year.

Finally, the spread of HIV infections remains a very pressing and serious concern. The Ministry will not relent in its pursuit to strengthen the capacity of the public health workers to deliver more efficiently and effectively.