

**Report of the Presidential Commission of Inquiry:
Ministry of Health and Social Services
to His Excellency, President Hifikepunye Pohamba
January 31, 2013**



Executive summary

Introduction

Health and Social well-being are fundamental human rights. Consequently, the ultimate goal of the Government of Namibia and the Ministry of Health and Social Services is the attainment of a level of health and social well-being by all Namibians, which will enable them to lead economically and socially productive lives. This will be achieved through using a cost-effective developmental social welfare and Primary Health Care approach, which includes promotive, preventive, curative and rehabilitative services in collaboration with other sectors, communities, individuals and partners. Furthermore, the Ministry's Mission is to provide a determined leadership to make health and social welfare services effective, and efficient to create conditions for organised communities, households and individuals to take control of their health. These actions must be driven by a shared commitment to health of the nation (*MoHSS Policy Framework: 2010*).

The goals and Mission are premised on a number of principles namely:

- a) All Namibians have the right to enjoy good health through access to primary care and referral level services according to need.
- b) Health and social welfare services will be affordable and the principle of equity and fairness will underpin the commitment expressed in the Ministry's policy framework; special attention will be given to the needs of vulnerable groups.
- c) The responsibility for health and social welfare is not the prerogative of one single government sector.
- d) Intersectoral collaboration in terms of active engagement of other sectors in targeted health action, is a dimension which adds strength to interventions; Quality of care is and will be pivotal dimension of all health services.
- e) All Namibians will be encouraged and empowered to actively participate in activities, which promote good health and prevent ill health at individual, family and community level hence complementing the health social and welfare care.

- f) Namibia has a pluralistic health system and this will continue (*MoHSS Policy Framework 2010*).

Our inquiry revealed a host of problems and challenges facing the question of provision of quality health services to the people of Namibia.

The Commission gathered enough convincing evidence through various consultations, and from documentary as well as oral evidence in the course of its visit to the various regions of the country. The problems/shortcomings of the health delivery system are briefly as follows:

1. Shortage of health professionals

There is an acute and critical shortage of health professionals such as doctors, nurses, pharmacists and allied health professionals arising from the following factors:

- a) High demand for health professionals in a very competitive labour market, especially between the public and private health sector.
- b) Inadequate number of health professionals trained in the country.
- c) Lack of adequate and suitable accommodation particularly in the remote rural areas.
- d) Lack of other incentives such as promotion and recognition of the services rendered by those dedicated to serve as required by their professions.
- e) Outdated staff establishment which is no more responsive to the current demands and expanding programmes.

The result is that many nurses and doctors opt to leave the public health sector at alarming rates and go to the private sector where remuneration packages and other conditions of services are far much better. Many if not all rural clinics and health centres that the Commission visited are inadequately staffed, and in the case of nurses where, registered nurses are required, the facilities are staffed by enrolled nurses. Many hospitals and health centres are headed by foreign professionals from countries like Cuba, Kenya, Democratic Republic of the Congo (DRC), and Zimbabwe, to name only a few.

2. The quality of patient care in public health facilities in Namibia leaves a lot to be desired.

This was attributed to the following factors:

- a) According to submissions from regional directors, medical doctors, the Health Professions Council of Namibia (HPCNA), senior staff of the MoHSS including the current and former permanent secretaries and information gathered during public hearings, the attitude and conduct of some doctors and many nurses negatively impact on the provision of health services.
- b) The overcrowding of patients needing attention leads to nurses experiencing what is called burnout; in other words the nurses are so overworked and this result in their negative careless attitude to patients. The written submissions made to the Commission are almost unanimous in describing this problem.
- c) Lack of adequate space at most health facilities compromises patient care in that in some cases there is no privacy and confidentiality during consultations.
- d) Mental health care is poor in all regions. This state of affairs has led to suicide at Oshakati Intermediate Hospital.

3. The quality of training of doctors and nurses, training infrastructure, curricula, training materials and internship.

The problem in this area was discussed by the Commission with, in particular, University of Namibia School of Medicine, School of nursing and Public Health and the Ministry's Training network. The Dean of the School of Medicine and various heads of departments related the following to the Commission:

- a) The absence of legally binding arrangement between the two teaching hospitals of Katutura and Windhoek Central Hospital and lack of opportunities of UNAM lecturers to do clinical supervision of students in training at teaching hospitals. This has a negative impact on the training of medical students who are left at the mercy of the nurses who are usually overworked.
- b) At various health facilities lack of staff accommodation is a big problem. Where provided, in some health facilities accommodation is in deplorable conditions, at best totally inadequate, at worst unfit for human habitation.

- c) The curricula for both medical and nursing students at UNAM (School of Medicine and School of Nursing and Public Health) are adequate and were developed with inputs from MoHSS, the HPCNA and other stakeholders.
- d) Inadequate library and research facilities at the two teaching hospitals.
- e) A number of the public and professional people pointed out that nurses trained at the MoHSS training centres performed better than those trained at UNAM. The Commission is of the opinion that the different system of clinical exposure (exposure to practical instruction in the wards and lack of supervision therein) is the reason for the difference in performance of the two groups.
- f) Lack of hands-on theoretically oriented UNAM lecturers.

4. The quality of public health facilities.

It was a painful experience for the Commission to see the state of dilapidation and decay in which many hospitals, clinics and health centres are. On inspection of these facilities the Commission took photographs that depict this state of affairs. These pictures are attached as annexures to this report.

- a) To begin with, the Commission makes special mention of Onandjokwe hospital in Oshikoto region. This hospital performs as a referral hospital for the region, but most of the buildings are old, some in a terrible state of dilapidation or decay, except the private and the two medical wards. One needs to see the hospital in its present state to appreciate the need for urgent intervention.
- b) The Commission saw a considerable number of hospitals in the regions that have ceilings leaking and falling apart, ablution facilities broken down and out of use for many months if not years, walls cracked, no proper ventilation and worst of all very dirty. Keetmanshoop hospital is one of the few exceptions, neat and tidy and well maintained.

5. The status of available medical equipment and infrastructure

Complaints raised in respect can be summarised as follows:

- a) Unavailability of essential equipment at some facilities is one of the factors contributing to unnecessary referrals. Some hospitals, for example, either do not have anaesthetic machines at all; or are equipped with obsolete, non-functioning machines. Some health facilities do not have essential equipment such as electrocardiogram (ECG) monitors, defibrillators, cardiotocograph (CTG) and ultrasound machines.
- b) The major complaint as regards to the acquisition of equipment is that many a time very expensive equipment is ordered without any consultation with the end users. An unacceptable degree of resource wastage was noted whereby equipment were procured but found not to be useful by the users themselves. In some instances, users would not know how to operate the equipment or the equipment was delivered incomplete and without accessories. A good example of such situation was observed in Windhoek Central Hospital where the following was noted.
- An industrial sports machine, estimated at a cost of one million Namibian dollars, was procured in 2007, delivered at outpatient department (OPD) and a wall had to be broken down in order to install the machine, but it has never been used.
 - Two (2) ultrasound machines, estimated at a total cost of N\$ 300,000, were delivered and kept in boxes for two years before it was discovered that they were incomplete (without accessories), at which time the warranty had already expired.
 - An anaesthetic machine (at a cost of N\$ 600,000) was only used once when it stopped halfway during an operation. This machine is not being used for the past two years as there is no maintenance contract in place, and the local supplier does not have technical capacity to do repair.
 - A screening x-ray machine procured in 2008 at an estimated cost of between N\$ 700,000 – 800,000, has been faulty since installation. Apparently the MoHSS was informed by the supplier that the broken part is not repairable. Replacement value of the entire machine will cost the Ministry in excess of N\$ 2.4 million.

These incidents raised serious questions as to the effectiveness of the tender process for the supply of expensive equipment. The sad fact is that these machines are lying unused for years, become obsolete and spare parts might not be available in the market. It is suspected that kickbacks might have been involved in the acquisition of such machines. In its consultation with the Hon. Minister of Health, the Commission brought this issue to his attention.

- c) In our tour of the health facilities, we were shown some gadgets which the nurses and doctors described as of such poor quality that they broke down and could not be repaired after a few uses. Such cheap equipment included blood pressure (BP) machines.
- d) Infrastructural design of some buildings and health facilities, for example, the new maternity ward at Windhoek Central Hospital (WCH), are very impressive to see. However, upon inquiry, we were informed of many defects as poignantly pointed out in some affidavits put before us (*Annexure B1.2*).
- e) A number of hospitals and clinics inspected by the Commission have inadequate facilities to isolate patients suffering from infectious diseases - raising the risk of cross infection. Many clinics do not have enough waiting space for patients, resorting to keeping a patient on intravenous infusion or for observation under a tree whilst waiting for the ambulance.

6. Availability of medicines in public health facilities

Availability of medicines is found to be good with usual stock levels of above 90%. Stock-outs were seldom experienced, in those rare cases attributable to the failure of suppliers to honour their contract with Central Medical Stores (CMS).

7. The status of maternal, newborn, child and adolescent health

The Commission found that policies and guidelines on maternal, newborn, child and adolescent health are in place, but there is general lack of implementation and non-uniformity in adhering to protocols and guidelines for management of obstetric care in MoHSS.

The following factors were found to affect maternal, newborn, child and adolescent health:

- Staff shortages and limited skills
- Inadequate essential equipment
- Poor accessibility to health facilities due to long distances and poor road infrastructure
- High teenage pregnancy rate
- HIV and AIDS

8. Transport for referral of patients

- a) The Commission appreciates that Namibia is a big country which is sparsely populated. Referral cases are mainly to Windhoek Central Hospital, Katutura, Oshakati and Rundu Intermediate Hospitals. An efficient transport system is therefore essential.
- b) In its visits to the Regions, the Commission found that Regions generally had vehicles but experience a shortage of drivers. This was because the number of driver posts on the staff establishment was not sufficient.
- c) On the other hand, emergency cases are transported by ambulances, both within towns/settlements, or long distances from clinics to hospitals or from district hospitals to referral hospitals. The usual complaints are that:
 - i) ambulances take long to come;
 - ii) there is a shortage of ambulances and drivers;
 - iii) distances are too long; and
 - iv) poor road infrastructure and some inaccessible during rainy season.

In this regard health workers and community leaders strongly proposed for air lifting deserving emergency cases, especially for regions far from the referral points and those prone to floods. This will call for collaboration with relevant stakeholders like Ministry of Defence, Regional Councils, Municipalities, etc.

9. Shelters for expectant mothers near hospitals

- a) The need for shelter for expectant mothers was expressed by all regions, except Khomas, Hardap and Karas.

- b) Several alternatives for construction and operation of these facilities were proposed, including partnership between the MoHSS and Regional Councils, Public-Private Partnerships, and the MoHSS taking overall responsibility. It was further suggested that some State-owned Enterprises, specifically GIPF and the SSC lend funds to the Government for this purpose.

10. Proposed restructuring of the MoHSS

The Commission observed that the MoHSS is currently using operational structure that is not responsive to the current demands. The low staffing norms and inadequate skill mix in health facilities are regarded as a result of this old structure. As a result, a new structure has been proposed for all the three levels in the Ministry's organisational hierarchy (national, regional, and district levels). This new structure is yet to be finalised and forwarded to the Office of the Prime Minister for approval. While the new proposed structure has not yet reached its final form, what is currently in the proposal seems to have addressed the above deficiencies as it was a product of extensive consultations.

11. Bureaucracy and delays to implement programmes and projects

It is our observation that the many challenges facing the MoHSS are attributable to bureaucratic methods of attending to issues and to the lack of a culture of quick and effective implementation of ideas or projects that have been worked out. For example, the process of buying-out of items when stock-out is experienced at CMS was reported to be cumbersome and lengthy.

It is incumbent upon the Commission to mention in particular that many good ideas and or projects have been made after a lot of conferencing and workshops, especially some recommendations from the Health and Social Services System Review of 2008 which have not yet been implemented. Another example is the slow pace of the restructuring process. Many consulted and key informants pin a lot of hope on this exercise as they see it as an answer to a lot of problems facing the MOHSS.

The Commission makes various recommendations based on each term of reference which we discussed in the main body of our report.

12. Recommendations

The Commission proposes the following recommendations as the most critical:

- 1) Fast-track the restructuring process of the Ministry of Health and Social Services to address staff shortage and fragmented functions and services.
- 2) Devise strategies to attract, motivate and retain staff to work in the public health sector and in rural area in particular.
- 3) Train more health professionals locally in order to saturate the job market and satisfy both the public and private subsectors.
- 4) Establish focal points for medical and nursing services at national level to ensure that harmonised clinical standards and protocols are implemented at all health facilities and to promote professional ethics and professionalism of the two professions.
- 5) An effective disciplinary system for unethical conduct should be introduced by the Health Professions Councils with serious consequences in case of offenders, including suspension and deregistration.
- 6) An effective supervision and disciplinary system should be established to ensure that cleaning services is rendered effectively and efficiently in all health facilities including option of outsourcing these services. In addition, a tailor-made training programme for MoHSS cleaners should be developed and implemented.
- 7) Provide adequate staff accommodation, especially in remote areas and make this part of a comprehensive incentive package for retaining staff in such areas.
- 8) Revise and redesign placement of nursing students in the clinical setting to increase exposure to clinical practice; the block system proposed by UNAM is a good initiative.
- 9) Recruit clinical instructors to mentor students (medical and nursing) in the clinical setting.

- 10) Increase the number of teaching health facilities to accommodate a large number of students and formalize the conversion of WCH and Katutura State Hospital into a Teaching Hospital Complex.
- 11) Increase funding to the Ministry of Health and Social Services to meet both the development and operational budgets, and work towards achieving the Abuja Declaration target of 15% of Government budget for health.
- 12) Government should take the upgrading of health facilities as a major programme, the financing of which calls for extreme measures such as: special appeal to donor agencies and special levy on all health services provided by private hospitals, pharmacies and companies (same as petrol levy for MVA Fund);
- 13) Implement the Cabinet Directive No. 22nd/11.12.07/006 on decentralization of maintenance of Government buildings and infrastructure to Offices/Ministries/Agencies.
- 14) Mental health services should be addressed as a matter of urgency by constructing a suitable room in each hospital and upgrade existing or construct adequate mental health facilities at Oshakati and Windhoek Central hospital including training of mental health professionals.
- 15) Capacitate all district hospitals to offer Comprehensive Essential Obstetric Care (CEmOC).
- 16) Provide a vehicle to all clinics that are more than 50km from district hospitals/referral point and are accessible only over bad and difficult roads; and
- 17) Increase the number of driver posts on the staff establishment of hospitals.

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Figure 15: Group of expectant mothers taking shelter under a tree at Outapi, Omusati region.

Acronyms and Abbreviations

AIDS	.....	Acquired Immune Deficiency Syndrome
ARV	.....	Antiretroviral
BEmOC	.....	Basic Emergency Obstetric Care
CARMMA	.....	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CEmOC	.....	Comprehensive Emergency Obstetric Care
CMS	.....	Central Medical Stores
CPAP	.....	Continuous Positive Airway Pressure
CSSD	.....	Central Sterile Supply Department
CTG	.....	Cardiotocograph
DMPDRC	.....	District Maternal and Peri/Neonatal Death Review Committee
DOT	.....	Directly Observed Treatment
DoW	.....	Department of Works
DRC	.....	Democratic Republic of Congo
DSTV	.....	Digital Satellite Television
ECG	.....	Electrocardiogram
EmOC	.....	Emergency Obstetric Care
EMRS	.....	Emergency Medical Rescue Services
EN	.....	Enrolled Nurse
EPI	.....	Expanded Program on Immunization
GIPF	.....	Government Institutions Pension Fund
GRN	.....	Government of the Republic of Namibia
HIV	.....	Human Immunodeficiency Syndrome
HMIS	.....	Health Management Information System
HMPDRC	.....	Hospital Maternal and Peri/Neonatal Death Review Committee
HPCNA	.....	Health Professions Council of Namibia
HRD	.....	Human Resource Development
IEC	.....	International Electrotechnical Commission
IMAI	.....	Integrated Management of Adult Illness
IMAM	.....	Integrated Management of Acute Malnutrition

IMCI.....Integrated Management of Childhood Illness
 IMNCI.....Integrated Management of Neonatal and Childhood Illness
 ISOInternational Organization for Standardization
 MAWFMinistry of Agriculture, Water and Forestry
 MDGMillennium Development Goals
 MDR –TBMulti Drug Resistant Tuberculosis
 MMC.....Ministerial Management Committee
 MoHSS.....Ministry of Health and Social Services
 MoUMemorandum of Understanding
 MRTCMinisterial Restructuring Technical Committee
 MTEF.....Medium Term Expenditure Framework
 MVA.....Motor Vehicle Accident
 MWT.....Ministry of Works and Transport
 NDPNational Development Plan
 NemListNamibia Essential Medicine List
 NGO..... Non-Governmental Organization
 NHTC National Health Training Centre
 NIPNamibia Institute of Pathology
 NQANamibia Qualifications Authority
 NSFAPNamibia Students Financial Assistance Fund
 OPDOut Patient Department
 OPM..... Office of the Prime Minister
 PEPFAR..... The U.S. **President's Emergency Plan for AIDS Relief**
 PHCPrimary Health Care
 PMDRC..... Policy Management and Development Review Committee
 PMTCT..... Prevention of Mother-to-Child Transmission
 PPPPublic – Private Partnership
 PSC Public Service Commission
 RMPDRC..... Regional Maternal and Peri/Neonatal Death Review Committee
 SADCSouthern African Development Community
 SSCSocial Security Commission
 TBTuberculosis
 ToRTerms of Reference
 TVTelevision

UNAM University of Namibia
UNFPA United Nations Fund for Population Activities
UNICEF United Nations International Children’s Emergency Fund
VCT..... Voluntary Counselling and Testing
WCH Windhoek Central Hospital
WHO World Health Organization
XDR-TB..... Extensively Drug Resistant TB

Section A: Introduction

I. Establishment of the Commission of Inquiry

1. On August 13, 2012, The President of the Republic of Namibia, His Excellency Dr Hifikepunye Pohamba, appointed a Commission of Inquiry to look into the activities, affairs, management, and operations of the Ministry of Health and Social Services, with the overall aim of improving the health system in the country.
2. The Commission comprised three commissioners, namely Honourable Justice Simpson Mtambanengwe as chairperson, and Dr Edward T. Maganu and Dr John Keiseb as members. Ms. Celine Usiku was appointed as Secretary to the Commission, to be assisted by four additional administrative staff members (Ms. L. K. Kaiyamo, Ms. L. Karunga-Beukes, Ms. R. Karises, and Mr. J. Nghipundjwa). Ms Muvangua was appointed as legal officer to assist the Commission during public hearings. Each member of the secretariat and the legal officer took an oath of confidentiality before embarking on their assignment with the Commission. Clear terms of reference were given to guide the Commission.

II. Terms of Reference

2. The Terms of Reference (ToR) of the Commission are to inquire into:
 - a) The quality of patient care in public health facilities of Namibia;
 - b) The status of maternal, newborn, child, and adolescent health;
 - c) The quality of training of doctors and nurses, including training infrastructure, curriculum, training materials, tutors, duration, quality, adequacy and relevance of residence and internship;
 - d) The quality of public health facilities infrastructure;
 - e) The status of available medical equipment and eventual needs for upgrading;
 - f) The availability of medicines in public hospitals, health centres and clinics;

- g) The human resources adequacy (both in quality and quantity), attraction, motivation and retention factors (such as availability of accommodation, career promotion and allowances for remoteness);
- h) The conduct, ethical and professionalism of health professionals, and their attitude *vis-a-vis* patients;
- i) The adequacy of transport for referral of patients;
- j) The need for waiting shelters for expectant mothers near hospitals and health centres, especially in rural areas; and
- k) The adequacy of the proposed restructuring of the Ministry of Health and Social Services. (*Annexure A*)

III. Methodology

3. In terms of the Regulations governing the Commission, the chairperson of the Commission determined the procedures to be followed when collecting data. The chairperson, in consultation with the other commissioners, decided to adopt the following method of work: Desk review, written submissions by key informants, group consultations with various cadres of health workers and key informants, interviews with individual key informants, visits to selected key health facilities, and public hearings.
4. The desk review entailed reviewing existing documents within the MoHSS, such as relevant Acts, policies and guidelines, reports of research studies, and annual reports.
5. To sensitise and engage the public, advertisements were placed in four local daily newspapers, running for four consecutive days. One newspaper published the advertisement for an additional four days at no cost. Through the advertisement members of the public were invited to make written submissions to the Commission, in the form of an affidavit, endorsed by a Commissioner of Oaths. Specific key informants were invited to make written submissions on their perceptions of the health service provision in the country. The key informants included, amongst others, the Minister and Deputy Minister of MoHSS, current and former Permanent Secretaries, Special Advisor to the Minister of MoHSS, the

Deputy Permanent Secretary, Undersecretaries, all National and Regional Directors, Deans of health-related schools at the University of Namibia (UNAM), Polytechnic of Namibia, Ministry of Works and Transport Permanent Secretary, Registrar of the Health Professions Council of Namibia (HPCNA), and Medical Superintendents of Hospitals. A list of all those who made written submissions is attached as Annexure B. The response to the advertisements was good.

6. The Commission subpoenaed or invited some individuals who, in the opinion of the Commission, needed to give oral evidence. In accordance with the method adopted by the Commission, such individuals gave evidence under oath or affirmation. The majority comprised people who had received poor services from public health facilities.
7. Individual key informant interviews, group consultation sessions and public hearings were audio-recorded to complement notes taken by the Secretariat during these sessions. The Commission arranged for interpretation services during public hearings to ensure that members of the public gave oral evidence in their own language. Audio-records were transcribed verbatim and the Commissioners perused these transcripts and noted key points raised during interviews and group consultations.
8. In terms of the Regulations, structured data collection tools were developed to collect data required.
9. Four health facilities, namely a district hospital/intermediate hospital, a health centre, one urban clinic, and one rural clinic, were visited in each region, except Khomas Region (where seven health facilities were visited), Otjozondjupa (five) and Kavango (six). These included, amongst others, both Windhoek Central and Katutura Intermediate Hospitals. Regional health directorates, except Khomas, identified the visited health facilities. Since the Commission started its work in the Khomas Region, the region was used as a pre-test to establish what was practical so that any adjustments could be made to the schedule before visiting other regions. The Commission exercised flexibility by not only visiting health facilities identified by the regional health management, but also visited some health facilities on the recommendation of regional councillors.

10. In addition to public hearings, consultative meetings with key informants, notably governors and regional councillors and health workers were held in all the 13 regions. The Commission made its own observations during visits to health facilities. Issues that constantly emerged from the written submissions, group consultations, individual interviews and public hearings were given specific attention and duly noted. These topics, fortified by personal observations made during visits to health facilities, form the basis of this report.

IV. Scope of the Inquiry

11. In terms of the Regulations, the Commission was given four months to complete its task and report back to His Excellency the President.
12. Due to the nature of activities and the inquiry process applied by the Commission, it was however not possible to finalise the task within the initially prescribed time. A one-month extension was therefore requested and granted. The Commission thus executed its task over a period of five months. The report was completed in January 2013.

Section B: Background to health services in Namibia

13. The provision of Health Care in Namibia is guided by the Namibian Constitution as well as various Acts (*Annexure C*). Article 95 of the Constitution provides that: “The State shall actively promote and maintain the welfare of the people by adopting, [...] e) ensurance that every citizen has a right to fair and reasonable access to public facilities and services in accordance with the law”. It is also inspired by Vision 2030 which states in its Broad Strategy No. IV: “Providing excellent, affordable health care for all”.
14. Namibia inherited a fragmented and curative-based health system which provided health services along ethnic and racial lines during the pre-independence era (MoHSS Policy Framework 1998). To remedy the situation immediately after Namibia’s independence in 1990, the Government of the Republic of Namibia

embraced the Primary Health Care (PHC) approach (MoHSS Policy Framework 1998).

15. The organisation and management structure of the MoHSS is defined in three levels namely; national, regional, and district (Ministry of Health and Social Services, 2008). In 1990, Namibia had only four regional health directorates until 2002, after which 13 regional health directorates were established in 2003 (MoHSS Systems Review 2008).
16. The MoHSS currently has an operational structure that is seen to be non-responsive as it can no longer cope with developments in the health sector.
17. At national level there are eight directorates operating under the Minister and his Deputy, the Permanent Secretary and his Deputy, and three Under Secretaries responsible for Health and Social Welfare Policy, Policy Development and Resource Management, and Regional Health and Social Welfare Services (MoHSS Systems Review 2008).
18. There are 13 Regional Health Directorates, overseeing 34 Health Districts. Four regions, namely Caprivi, Khomas, Omaheke and Oshana, each have only one health district and the region therefore coincides with the District (MoHSS Systems Review 2008).
19. The health system in Namibia is based on Primary Health Care principles, thus placing great emphasis on universal access. Health facilities in the public sector consist of:

Referral hospitals:	4 (1 x National and 3 x Intermediate)
District hospitals:	30
Health Centres:	40
Clinics:	260
Outreach points:	1,150

(MoHSS Systems Review 2008)

20. Since independence, the health and social services sector in Namibia has been guided by the 1990 Policy Statement which was followed by the 1998 Policy Framework (MoHSS Policy Framework 2010). Noticeable progress was made

towards achieving health for all people in Namibia during the period 1990-2010 (MoHSS Policy Framework 2010).

21. The following are, inter alia, projects and reforms embarked upon by the MoHSS:
- Adoption of a decentralisation policy through the creation of 13 regional health directorates in 2003, in line with the 13 political administrative regions (MoHSS Systems Review 2008);
 - Establishment of new directorates in an effort to keep pace with service demands. These include the Directorate of Special Programmes (2003) and the Directorate of Atomic Energy and Radiation Protection Regulator (2009);
 - Review of the health and social services systems in 2008, including the Health Policy Framework of 1998. The review provided numerous recommendations, some of which have already been implemented inter alia development of the Ministry's five-year Strategic Plan covering the period 2009 -2013. The Plan addresses five broad areas that the MoHSS aims to improve, namely:
 - a. Service provision
 - b. Human resources management
 - c. Infrastructure development and management
 - d. Governance
 - e. Financial management

At the time it was estimated that the MoHSS would require about N\$8-billion to execute a total of 83 initiatives set out in the Strategic Plan. The top four were listed as:

- Revision of the Policy Framework of 1998 and development of the National Health Policy Framework 2010 – 2020; (accomplished)
- Development of a Five-Year Human Resource Development Strategy in line with NDP 3, covering the period of 2008-2012; (accomplished)
- Conducting of a study on incentives to attract and retain health professionals and scarce skills to remote/rural and hardship areas (study done but the proposed incentives have not yet been implemented);
- Restructuring of the MoHSS (not completed).

22. In the current financial year (2012/2013), MoHSS received the second highest portion of the national budget after the Ministry of Education (Ministry of Finance 2012). This amount represents 10.5% of the national budget, 4.5% short of the Abuja Declaration benchmark of 15%. The World Health Organisation's assessment of progress by African countries towards the Abuja target indicates that Namibia is one of those countries that had made progress in this regard (WHO Report on Abuja Declaration 2011).

Section C: Findings

23. The Commission's findings are presented below in line with the Terms of Reference (ToR).

ToR (a) The quality of patient care in the public health facilities of Namibia

24. Quality of patient care in public health facilities was generally described by the public and health professionals to be below acceptable standards. Overcrowding at outpatient departments, long queues and long waiting times were particularly cited as indications of poor quality patient care. Numerous other factors were said to compromise patient care. These were enumerated as:
- 24.1 Inadequate numbers of various cadres of health professionals such as doctors, nurses, and various types of needed allied health professionals. In addition, there are shortages of different types of medical specialists such as surgeons, obstetrician/gynaecologists, anaesthetists, physicians and paediatricians. This was cited and found to be the main contributing factor to poor quality patient care. In most health facilities, the ratio of health professionals to patients per day is so low that provision of good quality patient care is almost impossible.
- 24.2 It was apparent during public hearings that outpatients do not always get prompt and requisite attention due to overcrowding, poor attitude of health workers and in some instances, shortage of and poor quality equipment that worked for a short time and then broke down. The pharmacy at Oshakati Intermediate Hospital, for

example, does not always attend to all patients who were seen on a given day, but some patients instead have to return the next day to collect their medicines.

24.3 Outpatient departments (OPD) in almost all hospitals were described as overcrowded with long queues; patients only being attended to by doctors shortly before or after lunch. This was ascribed to the shortage of medical officers, exacerbated by the non-availability of medical doctor posts on the staff establishment of the hospitals. Another complaint raised in relation to poor quality patient care was that some doctors do not carry out physical examination before prescribing medication.

24.4 Members of the public in all 13 regions were not happy about limited operating time and days of clinics (08:00 – 17:00 and Monday to Friday) and expressed a need for these health facilities to open longer during the working days as well as weekends and public holidays.

24.5 Basic nursing care, such as washing/bathing, administering medication, feeding and turning bed-ridden patients, are reportedly provided by relatives of patients and not by nurses. There was evidence under oath that some patients developed bed sores because they were not attended to when they wet themselves. In regional public hearings people complained that relatives of patients who are unable to feed themselves often find uneaten food on patients' bedside tables at visiting times. These problems have made the public to believe that they need to be in hospital wards to care for their relatives outside visiting hours. In some regions (e.g. Oshana, Ohangwena, Otjozondjupa and Omaheke), members of the public demand for shelters outside of hospital to be close to their relatives. The Commission witnessed some relatives sleeping on pavements and under trees outside of district hospitals for this purpose.

24.6 The same complaint also related to medicines. Some relatives testified that in-patients who are not able to assist themselves are not safe if their relatives are not around. For example:

- Two affidavits submitted to the Commission mentioned the case of two San patients with severe burn wounds and in critical condition having been admitted to Grootfontein State Hospital during September 2012. Their sheets were stained and dirty and they had no pillows or blankets. Their

wounds were not regularly or appropriately dressed. They were not on drips and no attempt was made to help them eat or drink, but food and water were left at their bed side while a nurse was sitting at the nurses' station doing her nails. (*Specific attention is drawn to Annexure B 1.1*)

- Another affidavit mentioned an incident of the 27th September 2012 where all nursing personnel in Intensive Care Unit in Windhoek Central Hospital were sitting in the tea room behind closed doors and had left the unit with critical, helpless patients alone. (*Specific attention is drawn to Annexure B 1.2.*)

24.7 While the public ascribed poor patient care to the unacceptable conduct of nurses, health workers on the other hand believe staff shortages paralyse them from providing the expected level of patient care. Severe staff shortages are also seen to be the cause of burn-out and stress in the ranks of health workers.

24.8 Inadequate equipment and supplies affect patient care. Some district hospitals do not have functional essential equipment, such as anaesthetic machines in theatres, ECG monitors, defibrillators in casualty departments and cardiocograph machines in maternity wards. An example of this state of affairs was Outapi Hospital. Engela Hospital had no ultrasound and cardiocograph machine despite having a very busy maternity unit.

24.9 Language barriers were identified as one of the factors contributing to poor patient care, as patients are often not able to fully articulate their complaints to doctors. This reportedly results in poor and sometimes “wrong” treatment being given to patients. This issue was particularly emphasised in the Khomas, Kunene, Omaheke, Hardap, and Karas regions. Concern was also expressed in most regions about the manner in which young graduate nurses communicate with patients, especially the elderly. These young nurses are said to choose to speak English to patients, irrespective of whether the patient is conversant with the language or not.

25. Inadequate space was mentioned by staff in most health facilities visited as a major problem. They indicated that many new programmes have been implemented without corresponding expansion in space and facilities. While this was expressed mainly in clinics, many health centres and hospitals faced the same

problem. The challenge of limited space is also compounded by a shortage of partitioning screens in consulting rooms to ensure privacy. Subsequently health workers in many health facilities share one consulting room when attending to patients. This compromises efficiency as well as privacy and confidentiality of patients/clients. For example, Kandjara Clinic in Kavango region (*Annexure 1: Figure 1*) has only one small multi-purpose room in which all the services, including administrative functions are being performed.

26. Hakhasseb Clinic in Usakos District is temporarily using a municipality hall partitioned with boards to serve as consulting rooms, resulting in patients listening to each other's conditions. This is because their clinic had to be closed since it was structurally unsound.
27. Another major challenge affecting quality patient care is the long distances from clinics or health centres to the next referral centre, worsened by poor road infrastructure. Some clinics are situated more than 100km from the nearest health centre or hospital with specialised services. This makes referral of emergency cases quite risky.
28. It was further noted that specialists in the Referral Hospitals do not do outreach and regular visits to district hospitals, which result in more patient referrals from district hospitals even in situations where cases can be handled at that level with the assistance of a specialist.
29. Clients of health services pay nominal user fees, N\$4-00 at clinics and N\$8-00 at hospitals. There are exemptions for senior citizens, orphans and vulnerable children, war veterans, patients with HIV/AIDS and those with communicable diseases such as TB. Whilst it is Government policy that nobody should be turned away because they cannot afford the nominal user fee, there is evidence, however, that patients do get turned away. But no study has ever been done to determine just how much these user fees, nominal as they may be, act as a barrier to access health care by the very poor.
30. Mental health care in state hospitals is poor due to lack of proper mental health facilities in all regions except at Oshakati and Windhoek Central Hospital. It is also noted that six mental patients committed suicide in the psychiatric ward at Oshakati hospital over the past three years (*Annexure B 1.3*).

31. Leadership-related deficiencies were identified as factors contributing to poor quality patient care. This includes:

- Lack of the appropriate governance structure that will have skills to plan, implement policies and use resources (finance and human) prudently.
- Ineffective management of hospitals, due to lack of appropriate leadership/management and administrative skills. In Namibia, by law hospitals have to be headed by Medical Superintendents who are Medical Doctors. It is not a requirement that they be trained as Managers.
- Inefficient implementation of rules and regulations including lack of accountability.
- “Lack of communication amongst nursing supervisors, matrons/principal medical officers, chief medical officers, directors’ offices, and the office of the Permanent Secretary.
- Lack of culture of business unusual: accountability, ethics and professionalism are values that need to be instilled in the public health sector to ensure that each citizen receives the highest possible level of healthcare available, is treated with respect and dignity, and healthcare workers are made accountable for their actions”. (*Specific attention to Annexure B 1.4 – Hon. Minister’s Affidavit.*)
- Lack of supervision and awareness of duties and responsibilities.
- Lack of a focal point at National level for medical and nursing services to enhance the implementation of harmonized clinical standards and protocols and a culture of professionalism.

Recommendations

Based on the above findings, our recommendations focus on two separate but related questions, namely how quality of patient care as well as the system of patient care can be improved.

1. Create focal points for nursing and medical services at National level.
2. Review the staff establishment of health facilities in accordance with current and emerging needs.

3. Increase medical officers' posts on hospital staff establishments so that OPD and casualty departments can be well-covered.
4. Introduce a system of orientating non-Namibian health professionals in basic indigenous languages.
5. The MoHSS should consider recruiting interpreters to remedy the language barrier between patients and health professionals.
6. Expand health facilities, especially OPD and casualty departments, to ensure privacy and confidentiality. This would also avoid sharing of consulting rooms by health workers when consulting clients/patients.
7. Establish health facilities in remote areas even when the population of the area does not fit the population threshold stated in the criteria for health facilities.
8. Revise the policy/directives on working after-hours, working during weekends and holidays in clinics and remote areas where necessary to make service available to the population, including relevant incentives for health workers.
9. Specialists in the Referral Hospitals should do outreach and regularly visit district hospitals. This would facilitate the transfer of skills to doctors and improve quality of patient care in these hospitals.
10. Amend the Hospitals and Health Facilities Act, No. 36 of 1994, to provide that:
 - i) any person other than a medical practitioner, preferably with training in hospital or health administration, may be appointed as Chief Executive Officer of a hospital.
 - ii) all hospital managers should undergo training in hospital management and administration.
 - iii) each health facility should have a functioning advisory body (Committee or Board), with a representation of community members.
 - iv) all hospitals should have a functional customer care unit to deal with patients' complaints and concerns. This unit should strengthen the relationship between the hospital, patients/clients and the community at large.

SOME OF THESE RECOMMENDATIONS WERE MADE IN THE 2008 HEALTH AND SOCIAL SERVICES SYSTEM REVIEW BUT HAD NOT YET BEEN IMPLEMENTED BY THE MINISTRY.

ToR (b) The status of maternal, newborn, child, and adolescent health

31. Maternal and peri/neonatal deaths are a major concern to the government of the Republic of Namibia and it is for this reason that Namibia adopted the Millennium Development Goals 4 (reduction of maternal mortality by 75% of the level in 1990 by the year 2015) and 5 (reduction of infant and child mortalities by ⅔ of 1990 level by 2015 (MoHSS Road Map for accelerating reduction of maternal and neonatal morbidity and mortality 2010)).
- 31.1 Maternal mortality ratio increased from 225/100,000 live births in 1992 to 271/100,000 in 2000, and increased further to 449/100,000 in 2006/07 (MoHSS Road Map for accelerating reduction of maternal and neonatal morbidity and mortality 2010). This sharp increase from 2000 to 2006 was attributed to contribution of HIV to maternal mortality, as HIV infected mothers are 6 times more likely to die compared to HIV negative mothers. However, there seemed to have been a decline again in 2010, according to WHO data to 200/100, 000 live births (World Health Statistics 2012). According to Millenium Development Goal (MDG) 4 the aim is to reduce maternal mortality rate by 2015 to 68/100,000 live births.
- 31.2 Furthermore, infant mortality was 60 per 1000 live births in 1992, 46 per 1000 live births by 2006 and the aim is to reduce it to 20/1000 live births by 2015. Under 5 mortality was reported at 86 per 1000 live births in 1992, 69/1000 live births in 2006, and is expected to be reduced to 29/1000 live births by 2015.
- 31.3 In addition, teenage pregnancy rate is to be reduced by 13.3% from 15% in 1990 to 13% by 2015.
32. To realise these goals the MoHSS has adopted the safe motherhood initiative in 1991 as well as the following programmes and study reports.
- Roadmaps for accelerating the reduction of maternal and neonatal morbidity and mortality 2006-2007.

- First national emergency obstetric care assessment report 2005/06.
- Report on the launching of the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA), 2009..
- Guidelines in essential and emergency obstetric care launched 2009 to standardise the management of pregnancy related complications in the country.
- Establishment of Maternal and Peri-/Neonatal Death Review Committees in hospitals, districts, regions and national levels in 2011 to improve maternal death reporting and related services.
- Report of survey on the factors contributing to maternal mortality and the prevalence of neonatal and maternal deaths in Namibia in 8 Northern regions in 2010.
- Health and Social Services Review 2008.
- Report on regional consultations in maternal and child health 2009.
- Guidelines for completing the maternal and peri-/neonatal death review form established 2010.
- Report of the maternal and peri-/neonatal death review support visits to all regions 20 June – 09 July 2011.
- Maternal health initiative pilot projects with Synergos groups and MoHSS.
- Dr N. T. Hamata, Special Advisor to the Minister of Health familiarisation visits to all 13 regions during the period 18 August 2011 – 21 December 2011 (*Annexure B 1.5*)
- National Policy on Reproductive Health and adoption of adolescent friendly initiatives in health facilities.
- Nutritional surveys were conducted in Northern regions affected by floods to assess nutritional status of children and pregnant women.

All the above programmes and studies were conducted by MoHSS in conjunction with partners such as WHO, UNICEF, UNFPA and other NGOs and provided critical information and recommendations regarding challenges in maternal,

newborn, child and adolescent health. Despite all these studies, reports and recommendations the Commission noted delays in implementation thereof.

UNFPA report regarding trends in maternal mortality 1990-2010 clearly states that progress is being made in saving mothers lives, even if progress is slower than called for MDGs in most countries. Countries with rapid progress have however aggressively tackled problems of:

- i) Developing trained midwives.
 - ii) Ensuring adequate availability of emergency obstetric equipment and supplies.
 - iii) Making family planning accessible.
 - iv) Focussing on availability of facilities, accessibility and use of facilities and providing timely obstetric care to prevent complications.
- Namibia, through MoHSS, needs to become more aggressive with implementation of above challenges to be the leading nation in Africa in maternal and child health.
33. However, we observed several factors impeding maternal, newborn, child and adolescent health. These factors are grouped into the following broad categories: human resources; equipment and infrastructure; operational arrangements; and miscellaneous.

34.1 Human resource factors

34.1.1 Availability of skilled personnel and access to Comprehensive Emergency Obstetric Care are essential during childbirth in order to minimise maternal and newborn deaths. Staff shortages were found in almost all health facilities (antenatal clinics and maternity wards) visited. For example, a labour ward could have only two midwives, with three mothers in labour at the same time.

Moreover, there are also limited skills in obstetric care as some intermediate hospitals, Oshakati and Rundu, are struggling to recruit specialists for emergency obstetric care, such as obstetricians and gynaecologists; paediatricians, and anaesthetists. Since the number of local specialists is limited, the country mainly depends on expatriates who are recruited through a lengthy and cumbersome

process. The clinics do emergency deliveries, but if something goes wrong with a pregnancy or labour, a fatal outcome is a highly probable result.

Some clinics are staffed by only one Enrolled Nurse (EN), not trained in comprehensive nursing and midwifery.

- 34.1.2 Another concern raised is the apparent inadequate clinical exposure of nurse graduates from the University of Namibia (UNAM), resulting in incompetent midwives. Staff in the MoHSS, individually or as a group, suggested that midwifery be taught for a longer period, such as at an advanced post-basic level, and that there be more hands-on clinical experience during training. UNAM indicated that it is changing its clinical attachment for the General Nursing and Midwifery programme to a block system. This will entail working full time during periods of attachment, including night duty.
- 34.1.3 The Commission also learnt that the Nursing Council, with the support of the MoHSS and UNAM, is in the process of introducing a 12-month internship programme for registered nurse graduates. Six months of this programme will be spent in the maternity department – an initiative that would ensure adequate clinical exposure in midwifery science. In addition, the Commission also learnt that UNAM plans to introduce an advanced postgraduate programme in midwifery as from 2013.
- 34.1.4 The Commission further found that some medical officers, for example doctors at Khorixas District Hospital, lacked skills on how to use some basic medical equipment such as ultrasound, including detection and interpretation of the image.
- 34.1.5 There was a lack of uniformity in adhering to protocols and guidelines for management of obstetric care in MoHSS.
- 34.1.6 In addition the Commission learnt that doctors are reluctant to come out at night when phoned by nurses in cases of complicated labour, which lead to nurses and midwives being blamed for any incidence that may occur.
- 34.1.7 Furthermore making nurses perform tasks which are primarily not nursing tasks takes nurses and midwives away from what they were primarily trained to do, thereby compromising real nursing and midwifery care.

34.2 Equipment and infrastructure factors

- 34.2.1 Some district hospitals are not in a position to provide Comprehensive Emergency Obstetric Care (CEmOC) due to the unavailability of essential equipment. A health facility is said to provide CEmOC if it can offer the following eight signal functions: Caesarean section; parenteral (injectable) anti-convulsants, oxytocics and antibiotics; manual removal of placenta; removal of retained products of conception; blood transfusion; assisted vaginal delivery; and neonatal resuscitation (WHO EmOC Monitoring Handbook 2009). According to the CEmOC assessment of 2005/2006 only four hospitals (Otjiwarongo, Katutura, Onandjokwe and Windhoek Central Hospital) were providing all eight signal functions (critical life-saving services) (MoHSS EmOC assessment Report 2006).
- 34.2.2 Some health facilities were found not to have the necessary equipment, such as cardiotocography and anaesthetic machines. Out of 17 hospitals visited, three hospitals were found not to have cardiotocography machines, namely Engela, Outapi, and Swakopmund. Those that had such equipment reported that the machines were neither adequate nor functioning properly. Although fetoscopes were available at all health facilities, the use of cardiotocography in maternity wards is essential.
- 34.2.3 It was reported by key informants that Windhoek Central Hospital's neonatal intensive care unit had old non-functioning ventilators with no alarm systems, too few saturation monitors that are moved from one baby to the next with the risk of cross infection, and shortage of Continuous Positive Airway Pressure (CPAP) machines. In addition, there was no mobile x-ray machine in the neonatal unit; this necessitated transporting critically-ill babies to the main x-ray department far away.
- 34.2.4 There was only one old ultrasound machine in Oshakati Intermediate Hospital's maternity ward, which handles up to 18 deliveries per day.
- 34.2.5 The Commission found that Outapi District Hospital did not have a functional anaesthetic machine for more than three years; hence the hospital has been referring expectant mothers requiring Caesarean section to Oshakati Intermediate Hospital. This does not only put the life of the mother and the baby at risk due to delays in getting the needed care, but also puts strain on the receiving health

facility. As an alternative, doctors at Outapi District Hospital sometimes performed Caesarean section under spinal anaesthesia. Once the spinal anaesthesia fails, they are not able to convert to general anaesthesia – exposing the mother and baby to risk of morbidity and mortality.

34.3 Operational arrangements

34.3.1 Doctors generally complained that their hands are sometimes tied by policies in situations that call for urgent intervention. For example, they sometimes refer pregnant women to other hospitals for Caesarean section because it is against policy to perform a Caesarean section without at least three medical officers (an operating medical officer, an assistant and another administering anaesthesia), in attendance. This is despite the fact that the available doctor(s) is skilled and has all the necessary equipment available. This has led to missed opportunities as timely intervention is an important factor in managing obstetric emergencies.

34.3.2 In addition, it was found that expatriate doctors, except Cuban volunteers, are not clinically assessed before deployment and do not receive a comprehensive induction on standards and treatment manuals, including management of obstetric cases in Namibia.

34.3.3 Health centres are not allowed to perform Caesarean section (MoHSS 1994) even if skills and equipment are available. Cases of obstetric emergencies requiring operation would therefore be referred to hospitals which are allowed to offer such a service. For example, Aranos Hospital was reported to have been downgraded to a health centre although it has posts of medical officers and a well-equipped operation theatre. Under the current policy, Aranos Health Centre has to refer all women in need of Caesarean section to Mariental Hospital, which is about 140km away.

34.4 Miscellaneous

34.4.1 Non- and/ or delayed attendance of antenatal care by some expectant mothers due to long distances to the nearest health facilities was found to be the most common factor affecting maternal and new born care.

- 34.4.2 Maternal and newborn care; child and adolescent health are also affected by an increasing trend of teenage pregnancies, which were reported to be significantly high in regions such as Kavango, Ohangwena, Hardap, Oshikoto, and Otjozondjupa. There is unequivocal evidence that teenage pregnancy is associated with poor obstetric outcomes, such as premature delivery, low birth weight, high neonatal mortality (Gilbert et al. 2004; Fraser et al. 1995; Magandi 2006), and high risk of maternal mortality (Gupta et al. 2010).
- 34.4.3 Adolescent friendly and family planning services are not provided at health facilities falling under Catholic health services, which in our view may contribute to an increase in teenage pregnancy.
- 34.4.4 A string of incidents of maternal and newborn deaths at state hospitals (theatre and maternity wards) was reported to be scaring pregnant women away from delivering in public health facilities. This issue was particularly underlined during public hearings in Kavango and Omusati regions.
- 34.4.5 The Commission also learnt from the public that nurses tell expectant mothers in early stages of labour to walk around the hospital in order to accelerate labour or being sent back home to go and wait without proper assessment of labour stage. This sometimes leads to expectant mothers delivering in public unassisted. Walking during labour has been shown to reduce discomfort to the mother and accelerate labour without harm to mother and baby (*Cochrane Library 2009 2; 1-86*). This may, however, lead to undesirable consequences if mothers are left unattended.
- 34.4.6 On a more positive note, despite the challenges health workers face particularly in rural and remote areas, the Commission found the following in place at most health facilities with regard to maternal, newborn and adolescent health services:
- Emergency Obstetric Care (EmOC) guidelines being implemented;
 - Focused antenatal care services taking place in all clinics and health centres;
 - Integrated services at primary health care facilities including voluntary counselling and testing (VCT), anti-retrovirals (ARVs), prevention of mother-to-child transmission (PMTCT), reproductive health and family

planning, Integrated Management of Neonatal and Childhood Illness (IMNCI), Integrated Management of Adult Illness (IMAI), Integrated Management of Acute Malnutrition (IMAM) programmes in place in all primary health care facilities.

- An algorithm for flow of information to report a maternal death was found to be followed in all health facilities.

Recommendations

1. Create more nurses posts on the staff establishment of hospitals to enable hospital management to allocate appropriate number of midwives to maternity wards based on responsive staffing norms.
2. Scale up Basic Emergency Obstetric Care (BEmOC) in health centres and large clinics and ensure all hospitals provide comprehensive EmOC.
3. Equip health centres and large clinics with basic EmOC equipment to do routine deliveries.
4. Review training curriculum and scope of practice on midwifery.
5. Provide health care facilities with transport/ambulances to enable them to refer complicated cases without delay.
6. Develop a comprehensive induction programme on standards and treatment protocols for expatriate doctors before deployment to their respective duty stations.
7. In situations where emergency Caesarean section is required, the Commission suggests that authorization be granted to allow an able medical officer to perform both anaesthesia and Caesarean section to avoid fatal risks which may arise from delays due to transfer to the next referral facility.
8. Strengthen maternal death review process by:
 - Reviewing all “Near Misses” in district and referral hospitals to improve maternity care;
 - Strengthening National Maternal and Neonatal Death Review Committee by elevating the Reproductive and Child Health sub-divisions to divisions;

- Ensuring regular coordination of planning, implementation, monitoring and evaluation of maternal and neonatal health activities with all stakeholders;
 - Providing support to Regional Maternal and Peri-/Neonatal Death Review Committee (RMPDRC), District Maternal and Peri-/Neonatal Death Review Committee (DMPDRC) and Hospital Maternal and Peri-/Neonatal Death Review Committee (HMPDRC).
 - Involving private sector in recording and reviewing of all maternal and neonatal deaths nationwide.
9. Involve women, families and communities in activities and programmes aiming at improving maternal and neonatal health and reproductive health in general.
 10. Support UNAM to re-introduce the advanced post-basic programme in midwifery.
 11. Provide necessary annual refresher training courses on EmOC and newborn health for all health care workers in maternity.
 12. Increase capacity building of skills at clinics, health centre and district hospitals by specialist obstetricians and paediatricians visits.

ToR (c) The quality of training of doctors and nurses, including infrastructure, curriculum, training materials, tutors, duration, adequacy and relevance of resident- and internship

35. Training of health personnel is a topical issue in Namibia as the country is progressing towards having adequate local health workforce to provide health services to the Namibian population. The training of health professionals currently takes place at three institutions namely, UNAM School of Medicine, and School of Nursing & Public Health, the Polytechnic of Namibia, and the Training Network under the Ministry of Health and Social Services.

35.1 Training of medical doctors

This training is still in an infantile stage as the Medical School has not yet produced any graduates. The first medical student intake was in 2010 and it is now in the fourth year. There are issues relating to training infrastructure,

specifically with regard to the facilities for clinical teaching. These issues include the inadequacy of the Windhoek Central and Katutura hospitals for clinical teaching. According to the written and oral submission by the School of Medicine, these issues include the following:

35.1.1 Physical infrastructure

- Old structures that cannot provide the very basic hygiene for patients and staff; this means lack of a safe environment for infection control.
- Improper hospital design which does not allow the provision of privacy and maintenance of the dignity of patients during medical history taking and physical examination.
- Lack of teaching facilities at hospitals such as lecture halls, well-functioning libraries as well as space and equipment for students to collect specimens and perform simple diagnostic tests.
- Undeveloped telemedicine facilities.
- Lack of offices for heads of departments and senior medical staff performing administrative duties, and a well-functioning cafeteria for public, students and staff.
- Slow pace in renovating and upgrading of both Katutura and Windhoek Central Hospitals.

During the consultation with the Ministry, the Commission was however informed that the MoHSS plans to equip the two teaching hospitals with relevant infrastructure and sufficient human resources to provide clinical training.

35.1.2 Governance

The Commission found that there is no legal or administrative instrument that mandates or defines Windhoek Central and Katutura Hospitals as a teaching complex, in other words there is no Act of Parliament regulating it. In addition, there is no implementation document that translates the signed Memorandum of Understanding (MoU) between the MoHSS and UNAM into a living document outlining the *modus operandi* of the teaching and clinical work.

During the consultation with the UNAM School of Medicine, the Commission was informed that there is a serious communication breakdown between the School of Medicine and the MoHSS as there is no proper communication mechanism in place, such as a coordinating committee for clinical teaching, consisting of staff members from the two institutions. Currently only the Founding Dean of School of Medicine meets with the two hospitals' medical superintendents to arrange for clinical placement.

The Commission was also informed that medical specialists in the Ministry are reluctant to provide clinical teaching to students as it is not in their work contract and they therefore demand extra remuneration.

Furthermore, the School of Medicine pointed out that the Board of the National School of Medicine could not perform its functions effectively; there is a feeling that it suffers from conflict of interest to a large extent.

The School of Medicine in addition pointed out that there is lack of coordination between institutions of training and registration, which includes UNAM School of Medicine, Health Professions Council of Namibia (HPCNA) and the MoHSS. This is due to the fact that some non-Namibian specialists employed by UNAM School of Medicine to teach both theory and clinical practice in the teaching hospitals are not registered by HPCNA. Thus, they are not allowed to work and teach in these teaching hospitals. This may lead to clinical practice teaching of the School of Medicine students to be inadequate, thereby affecting the quality of doctors to be produced.

35.1.3 Doctors trained at foreign academic institutions

The Commission took note that Namibia has been using foreign academic institutions to train health professionals and still has many medical students studying outside the country of which the majority are in South African universities while some are in Cuba, Algeria, Kenya, Russia, Ukraine, China, to mention but a few. During the financial year 2011/12, a total 132 Namibian medical students were studying medicine at foreign academic institutions (MoHSS Annual Report 2011/12).

A concern was raised that since many Namibian doctors are trained in different countries on different health systems, there is a need to harmonise standards and the clinical management system in the Ministry. There should be a solid clinical leadership in place and an overall focal point to coordinate medical services so as to ensure that all medical practitioners practise in the same way in all health facilities.

35.1.4 Curriculum and training materials

The Commission took note that the following are in place with regard to the training of medical students:

- A curriculum in the form of a prospectus
- Study guide
- Basic domain models
- Student log books

Duration of training for medical students is five (5) years, followed by a two-year internship programme, which is in line with many of the medical school systems in the Southern African Development Community (SADC) Region.

35.1.5 Internship programme

Katutura and Windhoek Central Hospitals are accredited teaching hospitals for medical interns and have been doing it for many years. Non-Namibian medical interns also pursue this internship programme in these institutions.

Teaching hospitals indicated that they have a critical shortage of both medical officers and specialists to adequately supervise junior doctors and medical interns. There is a growing concern that specialists working in state hospitals and doing limited private practice are spending too much time in their private practices and therefore not investing enough time to teach students or supervise junior doctors.

35.2 Training of nurses

The UNAM School of Nursing and Public Health trains nurses through a four-year bachelor degree in General Nursing and Midwifery, as well as a three-year Diploma in General Nursing and Midwifery. Both cadres from this programme

are referred to as Registered Nurses and Midwives. A second category of nurses is the Enrolled Nurse Midwife, trained at the training network under the Ministry of Health and Social Services through a two-year programme.

The Commission learnt that the curricula for both registered and enrolled nurses are compiled in collaboration with relevant stakeholders (MoHSS, Health Professions Council of Namibia, Namibia Qualifications Authority and Private health institutions). Concerns raised by both UNAM, individual key informants and in group consultations are that:

- The Enrolled Nurse Midwife curriculum only covers normal midwifery and not a comprehensive midwifery programme, although these nurses will eventually work in all settings where cases of abnormal labour may also present themselves. Enrolled Nurses are deployed in health facilities where comprehensive skills in midwifery are needed; hence lack of these skills may contribute to maternal mortality.
- Some of the Enrolled Nurses, especially those trained many years ago were not even trained in midwifery at all. For example, an Enrolled Nurse working alone at Ohandungu Clinic in the Kunene region confirmed and shared his fear of managing maternity/labour cases because he was never trained in midwifery.

Regarding Registered Nurses, there seems to be consensus amongst key informants that the current graduates of both degree and diploma programmes at UNAM are lacking in both skills and attitude. The common problem is that they do not spend enough time in clinical practice during training and there is no role playing. This is due to the following:

- The current system places students for two and half days in class and two days in a clinical setting which is not enough.
- Student nurses do not work night shifts which would expose them to clinical cases and procedures.
- Accredited teaching health facilities are too few.
- The student population is too large compared to the number of cases or procedures they need to observe or carry out.

- There is a lack of clinical instructors as well as coordination of the clinical teaching process in health facilities.
- Tutors do not go to clinical sites sufficiently as much as they should and are therefore too theoretically oriented.

Midwifery is again the best example. Namibia, as with many other countries, reformed its training of nurses to suit the PHC approach as adopted in Alma Ata in 1978. This led to the inclusion of midwifery as a main subject of general nursing. The change removed the double qualification of registered nurse/registered midwife and made it registered nurse who is also a qualified midwife. This was done to ensure that all registered nurses are trained in basic midwifery though not as specialised midwives, the latter being a training programme which is referred to as advanced midwifery course that can be pursued as a post basic training programme. Those who wanted to specialize as midwives had to pursue this programme at South African academic institutions as UNAM stopped offering it in the mid-nineties. Having recognised the need for these advanced midwives, UNAM plans to reintroduce this programme as from 2013.

35.3 Adequacy of medical and nursing students

35.3.1 The Commission noted that the training of medical doctors is promising after the establishment of School of Medicine in the country. The Ministry's five-year Human Resource Development Strategy 2008-2012 (NDP3) projected a total number of 225 medical students to be enrolled at foreign academic institutions during this period. It is, however, impressive to note that during the financial year 2011/12 there was a total number of 334 medical students under training of which 202 were at the UNAM School of Medicine and 132 at foreign academic institutions (*MoHSS HRD Report 2011/12*).

35.3.2 The number of annual student output, however, remained low for the same period between 16 and 20, and only picked up in 2011 when the number increased to 26. This reflects the small intakes of students before 2005. The number of output is expected to increase as from 2014 when the first medical students from the local school of medicine will graduate.

35.3.3 With the training of nurses, a total number of 2,375 student nurses was projected to enrol for training during the five-year period 2008-2012. By 2011 a total of 2,495 students (982 for the registered nursing programme and 1,513 enrolled nurses) registered for training.

35.3.4 Concerning the numbers of nurses, it is obvious that the current system where registered nurses are only trained at UNAM, both at diploma and degree level, is not producing enough registered nurses, and the skills are also inadequate. There is need for an increased output of registered nurses, especially at diploma level. However, the Commission learnt that the Ministry plans to introduce a diploma course at some of its existing Health Training Centres in order to increase the output of registered nurses in the country.

35.4 Factors influencing the training of medical doctors and nurses

The Commission observed that the following factors hamper the training of adequate numbers of Namibian doctors and nurses:

- Inadequate training facilities; Otjiwarongo Regional Health Training Centre, for example, has only one classroom for two groups of students (1st and 2nd year enrolled student nurses).
- Lack of proper student accommodation on teaching hospital premises as nurses' homes do not have space for students because qualified nurses and other workers such as administrative staff occupy the rooms. Many students live in environments not conducive to study, for example informal settlement and shacks.
- Students' accommodation facilities visited by the Commission in Oshakati, Otjiwarongo and Onandjokwe hospitals are very old, overcrowded and in dilapidated conditions. Ablution facilities are in very bad conditions, showers and toilets are not functioning, ceilings are collapsing, taps are leaking, some of the laundry rooms are converted into kitchens and very dirty (*Annexure 1, Figure 2*).
- Students and lecturers complained about Government student financial assistance under the Ministry of Education which is in the form of study

loans as many students do not qualify to receive these loans. Those who manage to receive them wait for almost one whole academic year before the Ministry disburses the funds. The amount allocated is also not sufficient to cover all the students' costs.

- Financial assistance provided to the Ministry's Training Network's students is inadequate to cater for their needs. The students receive N\$10,000 each per year. The MoHSS tries to assist students who do not receive any funding from the Ministry of Education by giving them a grant of N\$6,000 per year per student. This is not enough to pay for accommodation, food, daily transport to and from training centres, and buy books, stationeries, and materials.
- The MoHSS has been struggling to acquire land to build training centres in Otjiwarongo, Oshakati and Rundu for the past three years.

35.5 Tutors

35.5.1 The MoHSS's training network indicated that it experiences shortages of staff due to inadequate staff establishment. Proposed new positions are part of the Ministry's restructuring process which has been going on since 2009. With the current structure the training network will find it difficult to produce skilled and competent nurses. The same concerns were pointed out by the UNAM nursing tutors who are overwhelmed by workload.

35.5.2 A similar situation prevails at UNAM School of Medicine which is supposed to have around 50 academic staff but to date has only 35 since its inception in 2010. Prevailing complaints are that the pay packages are low and do not attract clinicians and specialists in the Namibian private health sector or internationally.

35.5.3 One of the concerns pointed out during discussions with the UNAM School of Medicine is that the school advertises vacancies including those not for head of departments with a specific requirement that candidates should be professors. Although a number of interested Namibian medical specialists are keen to apply, they feel disadvantaged as they believe they will never get the opportunity to join

the School of Medicine and help reduce Namibia's reliance on expatriate professors.

35.5.4 Another concern is the delay in obtaining work permits from the Ministry of Home Affairs. Candidates who apply for vacancies at the UNAM School of Medicine wait between six months to a year before they can get a work permit. Often these take up employment elsewhere during the waiting period.

35.5.5 Moreover, the HPCNA is reported to be reluctant to register some non-Namibian academics that are recruited by the School of Medicine.

35.6 Training of Namibian medical specialists

The Commission learnt that during NDP3 (2008-2012), the Ministry planned to enrol a total number of 33 Namibian doctors in various specialisation training programmes at foreign academic institutions. Medical specialisation programmes take between 4-5 years to be completed. By 2012 a total number of 21 medical doctors were granted special study leave with full pay to pursue specialisation programmes in various disciplines. Four of them completed training during the financial year 2011/12, while the rest are expected to complete between 2012 and 2016 (MoHSS HRD Annual Report 2011/12).

Recommendations

1. Enact legislation to officially establish a teaching hospital complex.
2. Establish a health professionals skills/training committee consisting, inter alia, of MoHSS, UNAM School of Nursing and Public Health, School of Medicine, National Health Training Centre, HPCNA, and Namibia Qualifications Authority to foster coordination and dialogue with regard to training of health professionals in Namibia.
3. Establish a committee consisting of the MoHSS and the School of Medicine to coordinate clinical placement of medical students at teaching hospitals.
4. Encourage and open up more opportunities for Namibian medical specialists to teach at the School of Medicine.

5. UNAM and Ministry of Home Affairs should enter into an official agreement to speed up issuing of work permits for teaching staff in health-related fields.
6. Create sufficient clinical instructor posts at both UNAM and health facilities.
7. Introduce internship programmes for all nursing graduates.
8. Support UNAM to re-introduce a postgraduate advanced midwifery training programme.
9. Accelerate the upgrading and renovation of Katutura and Windhoek Central hospitals to improve teaching environment.
10. Increase the number of teaching health facilities and academic staff to accommodate a big number of students.
11. Strengthen local academic institutions by upgrading infrastructure including student accommodation.
12. Review contracts of all medical specialists and job descriptions of medical officers in the MoHSS to incorporate student training and teaching.
13. Introduce a joint appointment system between UNAM School of Medicine and MoHSS. This means some specialists will be employed by School of Medicine and others by MoHSS, but they will all be involved in lecturing at School of medicine and service provision, clinical teaching of students as well as supervision of interns in the Ministry's teaching hospital complexes. It will be desirable for such joint appointment post to have one clinical and academic head of department irrespective of the appointment site. Attraction, motivation and retention of such specialists will benefit both institutions.

ToR (d) The quality of public health facilities infrastructure

36. The Commission observed that public health infrastructure, especially at hospitals, is generally in poor physical condition. This was also noted by the 2008 Health and Social Systems Review. The poor physical condition is attributed to several reasons which are inadequate funding, failure of material and finishes, poor supervision and maintenance, and confusion regarding maintenance responsibility between the MoHSS and the Ministry of Works and Transport (MWT).

37. It was further observed that many hospital buildings are old, some even older than 50 years without major renovations to date. For example, Aranos Hospital was built 60 years ago and was never renovated. Some facilities are going through renovations, albeit at a very slow pace.
38. Criteria for the establishment of health care facilities were found to be a major constraint in infrastructure development. In addition, health workers complained that end users are not adequately involved in the planning of construction of health facilities.
39. The Commission found that most hospitals and other buildings belonging to MoHSS were in a bad state of disrepair, including staff and student accommodation. Walls were cracked with paint peeling while floors were badly damaged and ceilings falling apart (*Annexure 1, Figure 3*). Toilets/bathrooms are not working, taps are leaking, and sewage running freely on the premises. Management in all 13 regions indicated that the Department of Works had always been informed on numerous requests for repairs, but either repairs were not done satisfactorily or nobody turned up at all. In some cases it was reported that there were no funds to do the repairs.
40. The Commission was informed that the same problem is experienced in relation to repair of non-medical equipment such as laundry machines, kitchen stoves, boilers, power generators, and autoclaves. The contracts for maintenance and repairs are administered by the Department of Works, but the contractors generally fail to keep these machines functioning.
41. The cleanliness of the health facilities, including accommodation, was also a point of concern. Most hospitals were dirty and unkempt. At Windhoek Central Hospital, for example, the dirty condition of the floor of the main theatre and adjacent areas was shocking. By comparison, the cleanliness and hygiene at both Dr AB May Cancer Care Centre and the intensive care unit at Windhoek Central Hospital were found to be comparable with private health facilities. Clinics and health centres in general were found to be cleaner than hospitals. It is surprising that supervision of cleaners is poor— a function that does not involve any extra cost.

42. The Commission noted that the MoHSS has an ambitious programme of upgrading health facilities through renovations and expansion in all regions. Virtually every hospital and health centre visited had a programme or at least a promise to upgrade/renovate. The approach does not seem to be consistent but rather haphazard being done in a piece meal way, with small components of the upgrading being undertaken in various facilities at a time. It might be worth considering structuring the upgrading in such a way that a facility is completed before moving to the next one, even if several facilities are done at the same time.

43. Infrastructure maintenance

43.1 The Commission observed that there is a dire need to clarify roles and responsibilities of line ministries and the Department of Works (DoW) regarding maintenance of government infrastructure. This is because the Commission was informed that in some instances the MWT had handed over maintenance to individual ministries but every facility still blamed the bad state of infrastructure on the Ministry of Works and Transport. Many health workers in the regions were not aware of the purported new development where the Department of Works is tasked to decentralize maintenance of infrastructure to individual ministries. According to the Ministerial Management, the establishment of a maintenance unit to take over the maintenance as well as budgeting for such a function is part of the restructuring exercise which is yet to be finalized.

43.2 Despite the explicit terms of Cabinet Directive referred to hereunder, the Ministry of Works and Transport still maintains that:

- It is responsible for providing, managing and maintaining Government facilities and infrastructure by virtue of its mandate deriving from the Constitution.
- through the Development Budget of the Government, it implements and oversees the construction of various facilities on behalf of user ministries, including facilities for the Ministry of Health and Social Services;
- after completion, it is responsible for regular maintenance of the facility, while the user of the facility has to budget for any upgrading, alterations or general renovations due to wear and tear over a period of time.

- 43.3 The Ministry of Works furthermore maintains that after 10 to 15 years of maintenance, facilities generally need renovation as day-to-day maintenance is no longer effective and sufficient. Failures and breakdowns tend to occur more often because components need to be replaced in their entirety. Health facilities constructed in Windhoek and Oshakati in the 70s and 80s have reached this stage. The infrastructure with regard to reticulation of services (water, electricity, sewage) has reached its lifespan and needs to be replaced in its entirety.
- 43.4 Cabinet Action Letters of 25 January, 2008 and 05 February, authorise basic maintenance of Government buildings to be decentralised to the regional councils and offices/ministries/agencies after their staff have received basic training. Offices/ministries/agencies were also to ensure that old equipment in their respective buildings, which had outlived their life span, were replaced through regular budgeting.
- 43.5 There is nothing to indicate that these directives had been implemented. Certainly in relation to MoHSS, basic maintenance has not really been decentralised. Staff members in health facilities still call on the Department of Works for everything although the budgeting part for replacement of equipment seems to have been decentralised to some extent. Even in his written submission at request of the Commission, the Permanent Secretary of the Ministry of Works and Transport made no mention of the Cabinet decision on decentralisation of maintenance (*Annexure B1.6*).
- 43.6 In a nutshell, maintenance of health facilities is poor and worrisome. It was noted that for minor defects or even small items like replacing fused bulbs, repair of an electric adaptor, a door handle, broken windows or a leaking tap, some health facilities wait for the Department of Works instead of doing the repairs themselves or paying for a private contractor via quotations, to carry out these minor repairs. For example, Windhoek Central Hospital theatre and mortuary had defects of most of the aforementioned items that waited for Department of Works for years. In contrast some facilities attend to these minor defects, especially facilities in the southern regions.

44. Psychiatric facilities

44.1 In general, psychiatric services in the entire country are rendered from old-fashioned and poorly designed facilities. All district hospitals visited by the Commission do not have standard rooms to keep acute psychiatric patients before they are transferred to referral psychiatric units. Hygienic conditions and maintenance at the two psychiatric units in Oshakati and Windhoek are not well managed. The Commission took note of research initiated by the Prosecutor General which revealed that, over the past three years, six mentally-ill patients committed suicide at Oshakati Psychiatric ward by hanging themselves, taking advantage of the roof not constructed according to psychiatric unit specifications (*Annexure B1.3*).

There is a dire need for MoHSS to address the psychiatric health services in the country. A cadre of specialised nurses is needed in psychiatric facilities and in selected health facilities across the country. The idea would be to avoid institutionalisation of many patients but to instead promote community based mental care.

44.2 The Commission was made aware of a series of meetings of stakeholders that have been going on for several months regarding psychiatric health services, including the conditions of those held at the State President's pleasure. These meetings followed intervention by the Prosecutor General in regard to the condition of the psychiatric unit following press exposure. That these meetings have taken place was revealed after the Commission specifically directed a query to the MoHSS as to the follow up on that intervention. The Commission noted that agreement was reached on most matters, particularly the management of State Presidential Detainees, and the fact that the country needs a referral Psychiatric Hospital. A benchmarking trip was planned to South Africa to look at the psychiatric referral facilities there.

45. Tuberculosis facilities

45.1 Namibia has a huge burden of Tuberculosis. The current system of admitting or looking after Tuberculosis cases causes problems because there are no special TB wards in many district hospitals. Admission facilities are needed for TB cases that are seriously ill and need nursing care, or for cases with Drug Resistant TB. The

Commission found that in many hospitals, TB cases or suspect TB cases were mixed with patients in general wards, thus putting other patients, or even staff, at risk.

45.2 Advanced TB facilities were found to be in place in Oshakati and Rundu, which are able to care for very ill TB patients and for MDR/XDR-TB cases. Such facilities, especially for drug resistant TB, need to be designed with infection control in mind, for example, allowing good air circulation with advanced air circulation facilities and ultra-violet light.

With the TB epidemic that has been exacerbated by the HIV/AIDS pandemic, and with the emergence of Multi-drug Resistant (MDR) and Extensively-Drug Resistant (XDR) tuberculosis, at least three TB hospitals are needed which would cater largely for drug resistant TB. These facilities would have space for some seriously ill TB patients, although district hospitals could look after TB patients needing hospitalization. Generally speaking, the majority of TB patients should be on Directly Observed Treatment (DOT) and do not need to be hospitalized. Ambulatory treatment should be adequate for them so that they continue with their lives.

46. Proposals from the public and health workers on infrastructure

46.1 The demands from the public and health workers are many and include the following among others:

- A teaching hospital complex in Windhoek some suggested a completely new site while others leaned towards the upgrading of the current Windhoek Central and Katutura Intermediate Hospitals to a teaching hospital complex;
- Re-examining the issue of referrals - some community members questioned whether it was worth referring a patient with a stab wound in the chest or a woman in obstructed labour to a referral facilities 400 km away risking such patients' lives due to delays caused by long distances and sometimes bad roads. The community thus recommended that each region should have a regional referral hospital;

- Government should build district hospitals for Khomas and Oshana Regions to alleviate overcrowding at the two intermediate hospitals, namely Katutura and Oshakati;
- Upgrading health centres and clinics. In many cases the demands were that health posts be upgraded to clinics and clinics to health centres; and
- A revision of criteria used for construction of health facilities should be responsive to the vastness of the regions taking into account the issue of population vis-à-vis the distance.

46.2 The Commission learnt that the MoHSS is revising its referral system in relation to the current classification of hospitals into district, intermediate and national. The proposal aims at having four levels of hospitals:

- a) National tertiary/academic complex (Windhoek Central and Katutura Hospitals);
- b) B1 referral hospitals in Oshakati and Rundu;
- c) B2 hospitals that will have some basic specialties (surgery, obstetrics/gynaecology, anaesthesia, internal medicine and paediatrics) in Katima Mulilo, Keetmanshoop, Onandjokwe, Otjiwarongo and others to be decided on later; and
- d) At least one district hospital in each region with the expertise mentioned in B2 hospitals.

47. General findings on infrastructure

47.1 During its visits to facilities, the Commission observed that staff **accommodation** is a challenge in virtually all regions. It is either inadequate, dilapidated, or in unhygienic condition. Some clinics and health centres for example the Ohandungu clinic in Kunene Region, and Odimbwa Clinic in Omusati Region, have not been able to fill the vacant posts for nurses due to lack of accommodation. Some accommodation facilities at Opuwo, Outapi, Otjiwarongo and Nankudu hospitals, among others, are in a bad state as they have not been well maintained or managed.

- 47.2 Most **toilets, showers and bath tubs at staff accommodation** are dirty and broken. Generally taps are leaking and there is a constant pool of water covering bath areas. Kitchens and laundries are used as store rooms for unwanted items; cooking takes place on hotplates in the bedrooms (*Annexure 1, Figure 4a - c*).
- 47.3 **Patients' toilets and bathrooms** at many health facilities visited are unhygienic and out of order. Toilets are blocked because patients use anything at their disposal like stones, newspapers or sticks after relieving themselves and this has caused blockages and damaged the sewerage system. Out of 56 health facilities visited by the Commission, only five (8.9%) had toilet papers in the toilets because patients reportedly take whole rolls home. It was reported that health facilities receive limited supplies per month. In some facilities, patients are given toilet paper on each visit to the toilet. In some cultures such as the Ovahimba community in Opuwo, the Commission learnt that people prefer using stones and sticks. The management at Opuwo has gone as far as closing down the patients' toilets at Opuwo Clinic for almost 10 years because of frequent toilet blockages (*Annexure 1, Figure 5a-c*).
- 47.4 Health workers in almost all facilities visited complained of **inadequate space** for services. Casualty departments at district hospitals are small with three to four examination beds. This is a challenge especially with hospitals that are near the B1 road where most car accidents occur like the Otjiwarongo and Okahandja hospitals. Okahandja Hospital, for example, has only a corner serving as casualty department with one oxygen point and one mobile oxygen machine; this compromises service delivery in case of emergencies.
- 47.5 Outpatient departments lack **adequate consulting rooms** in most facilities. In Rundu Hospital, two doctors share one consulting room which compromises privacy and confidentiality. In Gobabis Hospital, doctors consult patients at reception due to limited space.
- 47.6 **Maternity wards** are very small in some facilities, for example in Oshakati Hospital, some patients sleep on mattresses placed in the corridors while the Oshakati Maternity Ward is being reconstructed. There is also congestion at Gobabis and Engela hospital maternity wards.

- 47.7 Many clinics, especially in the northern regions, are **small with limited space**. Clinics in Uukwiyuushona in Oshana, Onambutu in Ohangwena, Odimbwa in Omusati and Kandjara in Kavango often face challenging situations with some like Uukwiyuushona and Odimbwa resorting to keeping a patient on intravenous infusion under a tree or for observation while waiting for an ambulance (*Annexure 1 Figure 6*). It was further reported to the Commission that donor-funded constructions of health facilities, for example Omuthiya hospital, are not constructed according to the MoHSS standards and make provision of healthcare services impossible.
- 47.8 Population growth in towns such as Windhoek, Otjiwarongo, Mariental, Oshakati, Opuwo, Rundu and Swakopmund has skyrocketed because of fast growing informal settlements. This has pushed up the need for more clinics to reduce **long queues** at existing health facilities. The Commission saw the need in these areas.

48 Specific reference to cases of defective infrastructures

The Commission observed the following cases of defective infrastructures:

- 48.1 Onandjokwe Hospital in Oshikoto Region is old and dilapidated; all the buildings are in bad condition, with the exception of two medical wards and the private ward. Urgent intervention is needed.
- 48.2 Odimbwa Clinic in Omusati Region faces different challenges as it was built by the community. The structure does not meet approved health facility standards and norms.
- 48.3 The Mariental Urban Clinic is old and poses a danger to staff and patients because some walls have big cracks through which one can see, while ceilings are falling apart (*Annexure 1, Figure 7*).
- 48.4 During the Commission's visit to Erongo Region, we learnt that all mortuaries in Omaruru District were out of order and corpses had to be transported to mortuaries in nearby districts.

- 48.5 We found the outpatient departments at Windhoek Central, Katutura, Engela, Otjiwarongo, Swakopmund, Nankudu and Onyaanya that they lacked proper ventilation. The Commission learnt that at Engela OPD some nurses contracted TB, which could be due to lack of ventilation (*Figure 8*).
- 48.6 At Windhoek Central Hospital the main theatre was found in an appalling condition because of a general lack of maintenance. It had broken doors and cupboards, leaking taps, a blocked sluice, non-functioning wall suction, electrical plugs, ventilators and blocked toilets in staff changing rooms.
- 48.7 It was further found that all health facilities built with prefabricated materials, such as Nankudu Hospital in Kavango Region; Onyaanya Health Centre in Oshikoto Region; paediatric ward, pharmacy and administration block in Otjiwarongo Hospital; and Aranos Health Centre staff accommodation, were not suitable for provision of health services and for human habitation. The Commission saw that these facilities lacked ventilation and were very hot during summer and extremely cold in winter. Nankudu and Onyaanya are former South African Army bases. With regards to Nankudu, plans are underway for a new hospital at Nkurenkuru but as for Onyaanya and Aranos nothing concrete was stated.
- 48.8 The Commission also learnt that feasibility studies done before construction have sometimes been inaccurate. At Usakos, the Hakhaseb Clinic temporarily operates from a rented kindergarten since the newly constructed facility collapsed because it was built on a soil foundation that was not suitable. The Commission was informed that another clinic was being built at a better site.
- 48.9 **Water and electricity at health facilities** - The Otavi Health Centre, Eenhana and Omaruru hospitals did not have working backup power generators. Staff members at Eenhana Hospital are hesitant to conduct Caesarean sections because of lack of backup power and frequent power failures were reported. Sangwali Health Centre and Chetto Clinic in Caprivi are some of the health facilities that use solar power which was described as inadequate and staff members there resort to making use of candles if they have an emergency during the night.

- 48.10 Okangwati Health Centre in the Kunene uses water from a borehole that does not run properly due to inadequate water pressure despite several repairs by the Department of Works. Toilets at both the health centre and nurses flats do not flush well, forcing nurses to use buckets to collect water and pouring in the cistern in order to flush the toilets. This has been going on since 2005, the Commission learnt.
- 48.11 At Oshakati Hospital sewerage pipes near the Maternity Ward have been blocked for almost five years and sewerage is constantly running between the surrounding buildings. Very often there is no hot water in some health facilities like Katutura Hospital, Windhoek Central Hospital and the Swakopmund TB ward.
- 48.12 **Boilers** – The main boiler at Windhoek Central Hospital, which is supposed to supply hot water to different departments, has not been working for the past 10 years because of malfunctioning pumps. As a result the eight washers in the Central Sterile Supply Department (CSSD) have not worked for the past seven years forcing nurses to resort to washing all the instruments and other medical items by hand. Other departments like the kitchen, and general wards are also affected, especially with the supply of hot water. All companies called in so far seem not to know how to repair the boilers.
- 48.13 **TB wards** - Only Oshakati and Rundu have separate blocks for MDR/XDR-TB patients while other facilities like Onandjokwe Katutura Hospital and other small hospitals keep these patients in an area within the normal TB ward, which is a big risk for cross-infection.
- 48.14 **Laundries** – Only eight out of 17 hospital laundries we visited (47%) wereworking. Those that were not working include: Outapi, Swakopmund, Nankudu, Okahandja, Eenhana, two Windhoek hospitals and Aranos Health Centre were found not working. In the case of Okahandja Hospital a second-hand laundry machine was brought from Grootfontein Hospital in 1996 to be used by Okahandja. However, it required to break the wall for the machine to be installed in the laundry room. That was not done and as a result the machine was dumped outside where it still stands, rusted and obsolete. (*Annexure 1: Figures 9a-c.*)

48.15 **Oxygen** - Health workers at Swakopmund Hospital expressed concern about the oxygen supply which they said was not reliable. They said the supplier, Intaka, does not have technical people or an office in the region to look after the supply and this has led to the cancellation or transfer of theatre cases to Walvis Bay Hospital.

49. Despite the above challenges, the Commission is happy to report that the following health facilities were constructed to acceptable standards:

Koes Clinic, Katima Mulilo Hospital OPD, Keetmanshoop Hospital, Okatana Health Centre, Hedimbi Clinic, Eluwa Clinic, Onesi Health Centre, and Eenhana Clinic.

Recommendations

1. MoHSS and MWT should urgently implement the Cabinet Decision No. 22nd/11.12.07/006.
 2. It is recommended that MoHSS and MWT enter into agreement regarding maintenance of infrastructure and plants such as boilers, generators, laundry equipment, autoclaves and incinerators while the maintenance unit is being established in the MoHSS.
 3. Allocate sufficient minor capital works and maintenance budget to the maintenance unit.
- i) Government should view the construction and upgrading of health facilities as a major programme and allocate adequate funding for completion of such projects. Special measures should be taken through legislation to provide such funding. The following options may be worth considering:
- collecting levy on all health services provided by private hospitals, pharmacies, medical aid schemes, and health-related companies (same as petrol levy for MVA Fund);
 - Sourcing funds from the Social Security Commission and Government Institutions Pension Fund (GIPF);

- Allocating a certain percentage from revenue collected by MoHSS additional to capital project budget of the MoHSS.
- ii) The capital development budget and management thereof should be decentralised to Regional Councils.
 4. Consider phasing the upgrading of health facilities in such a way that a facility is completed before moving to the next one, even if several facilities are done at the same time.
 5. Construct modern stand-alone psychiatric and TB referral hospitals as the current facilities in the country are completely inadequate.
 - i) For psychiatry, the B1 and B2 hospitals should have mental annexes with a capacity to handle “quiet” patients, and to also handle acute or serious patients who need just short hospitalization before referral to the national psychiatric hospital. Training of more nurses in mental health should be considered to provide mental health services at district hospital, health centre, clinic and community level.
 - ii) Three TB hospitals or major wards with the capacity to handle DR-TB through modern isolation facilities with appropriate infection control features, including air flow mechanisms should be made available in the country. Each hospital in the country should have a ward for looking after ordinary TB patients who might need admission for any reason.
 6. Support the Ministry’s initiatives to revise and implement the proposed referral system as mentioned under paragraph 43.2 above.
 7. Facilities built with prefabricated materials should be replaced with modern ones, so should old buildings built with clay/sand bricks.
 8. Government should consider constructing health facilities to the same standard as the examples mentioned under paragraph 46 above.
 9. MoHSS should outsource non-core functions like laundry, catering and cleaning services as per recommendation in the 2008 Health and Social Services System Review.

10. The MoHSS should accelerate the process to revise standards and norms for health facilities and revise the criteria for establishing health care facilities.
11. Government should build district hospitals for Khomas and Oshana Regions to alleviate overcrowding at the two intermediate hospitals, namely Katutura and Oshakati.
12. Install fixed, lockable toilet paper dispensers in the patients/clients' toilets at all health facilities.
13. Install ventilation facilities, mostly at OPD and casualty departments and ensure that air conditioning systems in hospitals are functioning and maintained.
14. Emergency measures should be taken by Government and Lutheran Medical Services to rescue Onandjokwe hospital and infrastructure.
15. Strengthen joint planning, implementation and continuous monitoring of National Development Projects with relevant stakeholders. For example, joint planning between MoHSS, Ministry of Mines and Energy, MWT, Regional Councils, Ministry of Agriculture, Water and Forestry (MAWF), and Ministry of Information and Communication Technology should precede construction of health facilities in order to ensure that all basic services would be available at a health facility.

ToR (e) The status of available medical equipment and eventual needs for upgrading

50. There is generally an inadequate supply or total absence of essential life support equipment like ECG monitors, blood-gas machines, glucometres, defibrillators, incubators, cardiotocograph (CTG), suction machines, blood pressure machines and incubators in health facilities that should have them. This has caused frustration and compromised service provisions. In some cases it was found that only one suction machine was available for the whole facility, for example at the Okahandja Hospital where it is alternatively used by the delivery room and theatre.

51. Unavailability of essential equipment contributes to unnecessary referrals. Outapi Hospital for example has no anaesthetic machine as the existing one has been out of order for more than three years. The hospital refers its patients to Oshakati. Outapi hospital does not also have ECG monitors, defibrillators and CTG machines in casualty department. Engela Hospital handles about 18 deliveries per day yet it does not have ultrasound or cardiotocograph equipment.
52. The Commission observed or was informed that while some facilities are well equipped, others in the same region or even neighbouring region have none or only redundant equipment. Keetmanshoop State Hospital for example is well equipped with incubators while Koes Clinic, which is situated about 120km from Keetmanshoop and does about four emergency deliveries per month, has none. Katutura Intermediate Hospital is well equipped with ultrasound machines in maternity to the extent that some are underutilised. The same can be said about Khorixas Hospital which had two underutilised ultrasound machines while Oshakati Intermediate Hospital struggles with its one old machine. Evidently, there is no system of equitable resource allocation.
53. It came to light that there are problems with the tendering and procurement system for medical equipment, as equipment is sometimes purchased without proper consultation with end-users. This sometimes results in the procurement of equipment that is redundant, or that users cannot operate, or is of poor quality.
54. It is evident that the GRN (MoHSS) invested in medical equipment, such as through the GRN and the Government of Finland Project concluded in 2008 which resulted in a good catch-up when medical equipment worth more than N\$133-million was purchased. In addition, medical equipment worth N\$80-million was procured under the development budget of the MoHSS, benefiting about 22 hospitals. The system for maintenance and replacement of obsolete equipment however seems to be unable to keep up with demand.
55. The Commission found some equipment that was obviously beyond serviceable repair and needed to be replaced. The system for boarding and getting rid of such obsolete equipment is inefficient. For example, an X-ray machine at Aranos Health Centre had been dismantled more two years ago, but has not been discarded or auctioned. Managers at that health centre were not familiar with the

GRN procedures of writing off of such obsolete equipment. Some equipment still in operation, like anaesthetic machines, are technically obsolete (*Annexure 1: Figure 10*), while some medical equipment is either outdated and no longer fit for current daily operations or are inefficient to respond to the demand for daily work. This includes manually operated machines instead of electronic or digital-operated equipment like blood pressure machines.

There are obviously problems of maintaining available equipment; hence the need for a proper medical equipment replacement and maintenance plan for all medical equipment.

56. The following are the contributing factors to this problem:
- Lack of capacity in the field of Biomedical Engineering in the country;
 - Lack of local training institutions for medical engineering programmes; and
 - Lack of Clinical Engineers/technicians posts in all district hospitals, except Regional Clinical Engineering workshops at Oshakati, Rundu, Keetmanshoop, Otjiwarongo and one in Windhoek, but even these clinical workshops are understaffed. For example, out of the total number of 24 clinical engineers' posts, only 9 (37.5%) are filled (*Annexure K 5*).
57. Although servicing and repair of some equipment have been outsourced to private companies, the companies concerned sometimes refuse to fulfil the contract because of delayed payments for their services, mostly due to limited funds allocated to the equipment maintenance vote of the Ministry. The budget vote for operational equipment is not only for medical equipment but include non-medical equipment. As a result all funds are in a pool and used at a first comes first served basis. This came out clearly in the written submission by Directorate Tertiary Health Care and Clinical Support Services.
58. The Commission observed a remarkable degree of resource wastage whereby equipment was procured but found not to be useful by the users. In some instances, users would not know how to operate the equipment because they were not trained on how to use it or the equipment was delivered incomplete and could not function without buying additional parts. A good example of such a situation is what we saw in Windhoek Central Hospital, namely the following:

- An industrial sports machine, estimated at a cost of N\$1-million, was procured in 2007, delivered at WCH and a wall had to be broken down in order to install the machine, which has never been used (*Annexure 1: Figure 11*).
- Two (2) ultrasound machines, estimated at a total cost of N\$300,000, that were delivered and kept in boxes for two years before it was discovered that they were incomplete (without accessories), but their warranty had already expired.
- An anaesthetic machine (at a cost of N\$600,000) was procured without the users' input. It was only used once, when it stopped halfway during an operation and has now been standing idle for more than two years. The Commission was informed that there was no contract for repair in place in this case.
- A screening x-ray machine procured in 2008 at an estimated cost of between N\$ 700,000 – 800,000, has been faulty since installation.
- A new computer tomography scanner (CT) has been standing in a corridor for nine months waiting for the x-ray department to be renovated before it is installed. There is a high likelihood of malfunctioning after installation due to possible rusting of the tube.

All this came to light in consultation during the Commission's visit to the hospital on 7th September 2012.

The sad fact is that these machines are lying there unused for years and will have become obsolete and spare parts could not be sourced when and if someone came to know how and needed to use the same. It is widely suspected that kickbacks might have been involved in the acquisition of such machine. In its consultation with the Hon. Minister of Health the Commission drew his attention to this discovery.

59. Another challenge is that Namibia does not have any law on the standardisation, control and quality of medical equipment and related devices entering the

country. Any company may import and sell any equipment even if it is substandard. There is no mechanism of inspecting equipment before entering the country. This has had an impact on the health facilities capabilities to deliver quality care. The Commission learnt that according to the World Health Assembly Resolution 60.29 (WHO Forum on Medical Devices 2010), WHO is mandated to encourage member states to develop legislation that guides member states to:

- establish surveillance systems and other measures to ensure the quality, safety and efficacy of medical devices.
- good manufacturing and regulatory practices

In view of the above, it is therefore important that Namibia has legislation in place that will control the import and selling medical equipment and devices by ensuring making these companies comply with certain **regulations and be registered**. All equipment should meet **international, regional or national safety and performance standards**. Since Namibia does not have any regional or national standards for medical equipment, the Commission encourages the use of suitable internationally-recognised standards such as International Electrotechnical Commission (IEC) and International Organization for Standardization (ISO), as part of tendering specifications.

In the opinion of the Commission, such wanton wastage of resources is completely unacceptable.

Recommendations

1. A full-scale medical equipment audit should be conducted in order to determine the real status of machinery in all health facilities, and to come up with an essential list. This will ensure an accurate assessment, procurement as well as distribution of equipment.
2. The MoHSS should introduce a medical equipment inventory system as a matter of urgency.
3. In cases where it was found that the procurement procedures were not followed and end-users not consulted resulting in wrong and incomplete equipment being

purchased, an investigation should be instituted in order to bring those responsible to book.

4. Each hospital should have a functional Medical Equipment Advisory Committee to facilitate procurement, quality control and maintenance. The committee should be composed of clinical engineer/technician and hospital management team.
5. End-users must participate in decisions to acquire equipment, consumables and should be trained regularly.
6. The MoHSS should create clinical engineering posts at each hospital.
7. A submission should be made to the Public Service Commission to re-grade the job category of clinical engineers to be at par with general engineering professionals to attract and retain them in the public health sector.
8. The MoHSS should approach institutions of higher learning in Namibia to introduce a training programme in clinical engineering.
9. The clinical engineering/medical equipment services should be strengthened by building capacities and seeking collaboration with other countries, secondment of engineering staff while building local capacities through training.
10. The MoHSS should temporarily outsource or enter into consultancy services with regards to medical equipment maintenance, repair and servicing. Servicing and maintenance of all medical equipment must be adhered to especially annual preventive maintenance which should be carried out and specifically financed.
11. Dedicated votes for medical equipment should be created.
12. Enact legislation to regulate medical devices/health care technology in terms of import and sale. Since Namibia does not have any regional or national standards for medical equipment, in the meantime, suitable internationally recognised standards, such as International Electrotechnical Commission (IEC) and International Organization for Standardization (ISO), should be used as part of tendering specifications.

ToR (f) *The availability of medicines in public hospitals, health centres and clinics*

60. To achieve its aims, a health system should ensure equitable access to essential medical products, vaccines and technology of assured quality, safety, efficacy and cost-effectiveness and their sound and cost-effective use.
61. The Commission observed that distribution of medicines and vaccines are generally adequate in the public health facilities. While some stock-outs are occasionally reported, generally stocking levels of essential medicine and vaccines according to the Namibian Essential Medicines List are good (in most facilities above 90%).
62. General observations through group discussions, key informants interviews and visits to health facilities by the Commission, were that:
- Occasional stock-outs at regional level were reported mainly due to stock-outs at Central Medical Stores (CMS) in Windhoek, which is caused by tenderers (the external suppliers) breaching tender conditions. The external suppliers either fail to supply or just delay in supplying. During the time of the Commission's visit to the regions, Chlorpromazine was one medicine that was reported to be out of stock, even at CMS, due to supplier failure.
 - In addition, it was found that there are very few pharmacists employed in the MoHSS while some district hospitals have no pharmacist posts at all. Only pharmacist assistants are available at district hospitals. It should however be noted that professionals at the level of pharmacists need to be employed as the pharmacist assistants are artisans and have limited skills.
 - All clinics and some health centres do not have pharmacist assistants' posts, thus leading to nursing staff in these facilities managing all pharmacy issues, including inventory control and dispensing, which may lead to irrational use of medicines.
63. The process of buy-out medicines when stock-out is experienced at CMS was reported to be cumbersome and lengthy. In the case where medicines have to be sourced through buy-outs from local private pharmacies or from South Africa, such health facility is expected to complete a form at facility level and send it

through the bureaucratic channels to national level in Windhoek for approval. This means that the Therapeutic Committee has to scrutinize and approve the request before an Economising Committee approves the funding and only then can the procurement be done. By then the patient's condition might have deteriorated.

64. Inadequate storage space was one of the factors contributing to stock-out at some health facilities (*Annexure 1: Figure 12a - b*). Because of this, such facilities are not able to order medicines in bulk but do so only on a weekly basis, even where such facilities are expected to supply other rural facilities within the district (e.g. Onandjokwe and Engela hospital pharmacies).
65. Sometimes some facilities receive medicines in bulk that are close to their expiry dates, which might result in wastage unless such facilities could send such medicines to those that are short of them.
66. It was noted that according to the Namibia Essential Medicines List (NemList), only certain medications are allowed at clinics, health centres and district hospital levels including authorization to prescribe. If medication needed is not on the authorized list for a specific facility at these levels, a separate motivation is submitted to the Therapeutic Committee in Windhoek for evaluation and justification before granting permission. These processes delay treatment of patients at that specific health facility.
67. The Commission observed that misoprostol (cytotec[®]), used worldwide and in private sector in Namibia to prevent and treat post-partum haemorrhage, is not on the NemList.
68. Health facilities, for example Engela and Rundu hospitals that share borders with neighbouring countries reported high pharmaceutical bills as they have no control on the influx of patients from across borders. These health facilities are also faced with frequent disease outbreaks that they are not able to control because of budget constraints. The budget allocation usually does not take into consideration population size or the surrounding circumstances.

Recommendations

The Commission recommends the following:

1. Review NemList to ensure availability of all essential medicines at all levels, recognizing that drugs have to be stocked according to level of health facility.
2. Build capacity of Central Medical Stores in order to ensure efficient contract management to prevent stock-out due to non-compliance of suppliers.
3. Strengthen pharmaceutical services at all levels through training of adequate number of Namibian pharmacists.
4. Create posts and employ professional pharmacists at all district hospitals and health centres, as well as pharmacists' assistant posts at clinics.
5. Revise the process of buy-out of pharmaceuticals to make it faster and more efficient.
6. Include misoprostol (cytotec[®]) on the NemList as a controlled medicine and make it available in all health facilities conducting deliveries.
7. Budget allocation criteria for pharmaceuticals to regions should take into account population size, likelihood of disease outbreaks, and cross-border population influx.

ToR (g) The human resources adequacy (both in quality and quantity), attraction, motivation and retention factors (such as availability of accommodation, career promotion and allowances for remoteness)

69. For a health workforce to perform well, it has to work in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances, that is, there are sufficient numbers and mix of staff, fairly distributed, competent, responsive and productive.

69.1 Human resource inadequacies

- 69.1.1 The Commission acknowledges that Namibia has challenges in the human resource field. A larger proportion of health workers in Namibia are in the

private sector. Less than 50% of the registered medical practitioners (277/909) were working in the public health sector in 2011/12, while about 60% (2101/3355) of registered nurses and just over 50% of enrolled nurses (2360/3469) were also in the employ of the public sector. Table 1 below depicts numbers of some key health professionals registered in Namibia during 2011/12 and where they were working:

Table 1: Number of health professionals registered in Namibia and employed by MoHSS during 2011/12

Professional category	Number registered	Number in MoHSS
Doctors	909	277
Pharmacists	314	35
Dentists	139	17
Registered nurses	3,355	1,680
Enrolled nurses	3,469	2,360

Source: MoHSS HRD Annual Report 2011/2012

- 69.1.2 This indicates that there are relatively big numbers of health professionals in the country but there are obviously insufficient numbers of staff in the public health sector. There is also a growing concern that the few specialists and medical officers working in state hospitals and doing limited private practice are spending too much time in their private practices and therefore not investing enough time to perform duties in the public health facilities.
- 69.1.3 However, the Commission learnt that although there is a large number of health professionals in the private sector who might wish to assist in the public health sector voluntarily, there is no policy in the Public Service guiding such private practitioners wishing to offer their services in public health facilities as part of their social responsibility.
- 69.1.4 Staffing ratios are far from ideal in all health facilities. Health workers repeatedly stated that in hospitals, it is common to find one nurse looking after a ward of 20 to 30 patients alone, especially at night. The Commission witnessed the overcrowding at outpatient departments and wards manned by relatively few health workers. Health facilities visited in all the regions, except those in the Karas, Hardap and Omaheke regions, were overcrowded.

- 69.1.5 The Commission observed that the MoHSS relies heavily on foreign health workers, especially medical doctors, pharmacists, radiographers and other cadres.
- 69.1.6 Statistics from the Ministry indicate that during 2012, there were 199 foreign Medical Officers, 34 Medical Specialists, 24 Pharmacists, 165 Registered Nurses and other foreign health professionals employed by the MoHSS.
- 69.1.7 Furthermore, the staffing norms for rural clinics as observed from the Ministry's staff establishment of 2003, is one registered- and one enrolled nurse, which is grossly inadequate. This means if one nurse is on leave or ill then one nurse would run the clinic alone. Overall, the situation is that a large number of clinics only have one enrolled nurse running the facility because of the shortage of registered nurses. This is due to lack of accommodation and interest to work in rural areas, and resignations. As a result enrolled nurses end up performing duties above their scope of practice.
- 69.1.8 In addition, nurses, especially in clinics and health centres, carry out work regarded as non-nursing duties such as ordering, medicine stock control and dispensing, and revenue collection. This adds to the already heavy workload at health facilities and they end up not having time to properly attend to patients. This increase in workload may lead to burn-out and job dissatisfaction in most cases. As one commissioner remarked, in countries in the extreme south of southern Africa (Botswana, Lesotho, Namibia, Swaziland, South Africa) there is no middle level health worker with clinical skills, such as a clinical officer or medical assistant, the nurse has been found to be the most versatile health worker suitable for multi-tasking and task-shifting. In some countries, nurses are beginning to object to doing the so called non-nursing duties.
- 69.1.9 According to the latest WHO figures (*WHO World Health Statistics Report 2012*), Namibia had 27.8 nurses and midwives per 10,000 people in the period 2005-2010 which is among the best figures in the SADC region. The top position is held by Botswana at 28.4 per 10,000 people. Comparable figures of other countries like South Africa, Lesotho and Swaziland were not quoted in the report.
- 69.1.10 Though the MoHSS tries its best to recruit health professionals, it still faces high numbers of vacancies in some job categories. Out of the 17 hospitals visited,

only three district hospitals had their entire doctor posts filled, namely Gobabis, Swakopmund and Nankudu. Rundu and Katutura Hospitals had the highest vacancies for doctors at 20 and 17 respectively while others had between one and three vacancies.

With regard to registered nurses, Rundu Hospital had the highest vacancies of 46 followed by Katutura with 44, Windhoek Central 12, Keetmanshoop eight, Gobabis and Mariental Hospitals six each and the rest had between two and five vacancies.

69.1.11 The Commission learnt that two factors emerged as having caused staff shortages, namely an outdated staff establishment and the inability to fill vacant posts. Many health facilities appear to be experiencing difficulties in filling posts once staff members resign while some vacancies take too long to fill because of the bureaucracy encountered between MoHSS, Public Service Commission, Ministry of Home Affairs, and HPCNA when recruiting foreign health professionals. For example, Oshakati Intermediate Hospital reported that it had remained without a paediatrician for the past 10 years preceding this inquiry. Although this is a specialised skill, there were also many instances cited where health facilities were unable to fill the entry-level posts of registered nurses. In Kunene Region for example, only one clinic was reported to have a post of registered nurse filled out of the 21.

69.1.12 As mentioned above, bureaucracy was identified as one of the main factors responsible for the delays in the recruitment of expatriate professionals. The following were reported to be the contributing factors:

- Delay in getting approval of appointment by the Public Service Commission;
- Issuing of work permits by Ministry of Home Affairs;
- Difficulties in registration of expatriate health professionals by HPCNA;

The Ministry of Home Affairs, however, explained that although there is an arrangement made with the MoHSS to fast-track issuing of work permits, delays are caused by the fact that applications are sometimes received at short notice and at other times without all required documentation.

During consultations with the Commission, the Health Professions Council of Namibia (HPCNA) revealed that the delay in registering expatriate health professionals is mainly due to incomplete documentations by the applicants. In such cases, the HPCNA would not register a health professional as this would be tantamount to a violation of the Health Professions Acts of 2004.

69.1.13 In addition, the Commission learnt that insufficient budget also contributes to high vacancy rates in the MoHSS. Reports submitted to the Commission by the MoHSS show that during the financial year 2011/12, the Ministry had a total of 1,234 vacancies, of which 937 were for health professionals, and 293 for administrative and other job categories. During the same financial year, the MoHSS requested a total N\$90 million to fill these vacancies but Treasury allocated only N\$30 million. This resulted in only crucial professional posts being filled while the majority of administrative posts remained vacant.

69.1.14 The Commission further observed that even health facilities with all doctors and nurses posts filled, still experience staff shortages due to the fact that the staffing components are too small and no longer responsive to the current workload and new services that have been introduced over the years.

69.1.15 All 11 district hospitals visited by the commission did not have pharmacists' posts on their staff establishments, but only those for pharmacist assistants. The same hospitals do not have dentists' posts, but only dental assistants' and dental therapists' posts. There is only one dentist post for each region.

Okahandja, Nankudu, Mariental, Eenhana and Outapi district hospitals do not have radiographer posts, but only radiographic assistants' posts.

69.1.16 All 12 rural clinics visited had only one registered nurse and one enrolled nurse post each. Out of the 12 rural clinics only two had a clerical post for revenue collection and issuing of patients' health passports, while none had a pharmacist's assistant post. This means nurses are the ones serving as revenue collectors and medicine dispensers, which may cause long queues and exhaustion of nurses especially at clinics with 50-100 case loads per day.

69.1.17 Furthermore, four out of these rural clinics, Ohandungu in Kunene, Odimbwa in Omusati, Rietoog in Hardap and Kandjara in Kavango regions had vacant

registered nurse posts which means they are only run by enrolled nurses. The Commission learnt that three out of these clinics had failed to attract registered nurses due to lack of accommodation while one was due to lack of interest by registered nurses (Ohandungu).

69.1.18 Eleven of these 12 rural clinics have one post for a cleaner each except Koes Clinic in Karas Region which has two posts. The same clinic also has one driver post while all others do not have these posts, although all of them are more than 100km from the nearest health centre or hospital. Interestingly, although Koes Clinic has a driver post, it does not have a vehicle. In contrast, Chetto Clinic in the Caprivi Region has a vehicle without a driver post. This means that the registered nurse concerned has to transport referred patients to Katima Mulilo Hospital and is obliged to close the clinic during those trips if the enrolled nurse is absent, as was the case during the Commission's visit.

69.1.19 The nurses running these clinics are on call 24 hours, and patients seeking help often wake them up, sometimes four times a night, and the same nurses have to be on duty at 08h00 the next morning.

70 Attraction of human resources, motivation and retention factors

70.1 Although the MoHSS is trying its best to attract and retain its employees, it still faces challenges because of the high demand for health professionals in a competitive labour market especially between the public and private health sector. This challenge can only be addressed if the market is totally saturated with health workers.

70.2 The MoHSS annual report of 2011/2012 indicates that a total number of 704 employees were recruited during that financial year, but it also lost 394 staff members. Two hundred and twenty nine (229) of the 394 employees resigned. The highest number of staff loss was nurses (112 registered and 121 enrolled nurses).

70.3 The Commission learnt that a significant exodus of nurses, through resignations, from the MoHSS was registered across the country during 2012. Although no further study was done to establish reasons for the resignations, studying medicine and joining the private sector were some of the reasons cited. In the

two Windhoek hospitals, nurses were reported to have resigned to acquire their pension benefits and then returned after a few months. Most of the health workers consulted indicated that remuneration packages in the public sector are relatively lower than those offered by the private sector. To crown it all, the working environment in the public health facilities is also reported not to be conducive due to unbearable workloads, inadequate equipment, and a slow procurement process.

70.4 Health professionals stated that their workload is so heavy that it leads to staff burn-outs and frustrations, and resign from the public service because of the prevailing difficult conditions under which they work, compounded by low salaries.

The Commission learnt that health workers working in mental health institutions are not adequate; the few available lack special skills, and feel that they are not adequately protected when dealing with aggressive patients due to a shortage of security orderlies.

70.5 A study has been done by the MoHSS to look at possible incentives and retention systems that can be put in place to attract and retain health professionals and scarce skills especially in remote/rural areas in the public sector (MoHSS Draft Report on Incentive Study 2011). The draft report and recommendations of the study are still being discussed by the Ministry's management before submission to the Office of the Prime Minister for consideration. The staff, especially nurses in rural areas, kept quoting the fact that teachers have a remote area allowance, euphemistically referred to as a bush allowance, whereas the nurses do not receive such an allowance.

70.6 The findings of the Commission confirm most of the findings in the Draft Report. The following were repeatedly mentioned as reasons for health professionals not to be attracted and retained:

- High workloads in public health facilities and poor salary for all health workers. Young graduates said they would opt to go into private sector for better pay so that they can pay back the study loans they received from Government. The Government salary is too low for them to pay a monthly

portion to the Ministry of Education. Their appeal to Government for their study loans to be converted into grants and for them to pay in kind by working in the public health sector fell on deaf ears.

- Poor working environment in public health facilities.
- Lack of equipment.
- Lack of professional leadership, resulting nurses' and doctors' professional concerns not being attended to. For example, the supply of uniform to nurses by the Ministry is not constantly done. This results in nurses buying their own uniforms.
- Inadequate Home Owner's Scheme for Staff Members, resulting in many staff members not to be in a position to buy houses.
- Lack of recognition and appreciation for good performance.
- Lack of career paths in most of the job categories and no automatic promotion to a next level because of good performance, with so many feeling that they remain in entry posts until retirement because the promotion posts are very limited.
- Lack of adequate and suitable accommodation where such is provided. The Commission observed that this is a major problem in many of the facilities that we visited. Many remote or isolated clinics have only one or, at the most, two housing units, usually with one bedroom. Nearby villages also lacked modern housing which could be rented by civil servants. The following are specific examples of accommodation problems which we observed:
 - Two of the 12 rural clinics visited, namely Odimbwa and Olukonda, do not have accommodation at all. Nurses walk to and from work, over distances of eight and 20km respectively.
 - Two clinics, Kandjara and Rietoog, have a one-bedroom flat each and both have vacant posts for registered nurses that cannot be filled because of this lack of accommodation.
 - Chetto Clinic in Katima Mulilo has one two-bedroom flat which might not accommodate two nurses of different gender.

- Odimbwa, Onambutu, Hedimbi and Rietoog clinics do not have telephones and nurses use their own cell phones at their own expense to call for ambulances.
- All the 12 rural clinics are far from basic facilities such as banks, NamPost and there is no public transport to and from town. For example, staff members at Koes Clinic in Karas region informed the Commission that, to go to town they have to call a taxi from Keetmanshoop at a return fare of N\$1000. Similarly, staff members at Rietoog clinic in Hardap region pay a return fare of around N\$300 to the nearest town (Rehoboth) for shopping.
- Chetto clinic and Sangwali health centre in Caprivi are provided with solar panels for power generation, but they are not functioning properly. Therefore nurses get ice cubes from nearby police stations to keep vaccines for Expanded Programme on Immunization (EPI) within the required temperature range. In addition, there is also no TV or radio reception in these areas.

The Commission learnt that in some cases, administrative staff members occupy official accommodation on or close to hospital premises while health workers who carry out essential services need to be accommodated in these dwelling places.

71. Human resources adequacy in terms of quality

71.1 The issue of adequacy in quality of human resources in the Ministry is complicated by the two systems of admission to practise as a health professional in Namibia, namely authorisation by the Minister and registration by the HPCNA. In terms of Section 62 of the Medical and Dental Act, No. 10 of 2004, the Minister of MoHSS is empowered to grant on application written authorization to certain persons from abroad to practise in any field in the public health system under certain conditions. One of the conditions is that the person concerned "(c)(i) is entitled in terms of the laws of any other country or State prescribed by the Minister for such purpose, to practise the profession concerned in such a country or State; or (ii) if he or she is not entitled to practise the profession concerned as contemplated in sub-paragraph (i), that person has obtained at an

educational institution situated outside Namibia a qualification or has received education, tuition or training in or relating to such profession which in the opinion of the Minister indicates a satisfactory standard of professional education which will enable that person to practise such profession.”

The Act provides that the Minister may exercise this discretionary power after consultation with the HPCNA.

71.2 The application for authorisation must be accompanied by

“(3) (a) written proof –

(i) of the qualification or qualifications upon which the applicant relies to be granted the written authorization concerned; and

(ii) that the applicant is entitled in terms of the laws of any other country or State prescribed by the Minister in terms of subsection (2) (c) for such purpose, to practise the profession concerned, alternatively complies with subsection (2) (c) (ii);

(b) documentary proof of his or her identity; and

(c) a letter of good standing, if the applicant is a person referred to in subsection (2) (c) (i), issued by the registering authority relating to the profession concerned in respect of each country in which the applicant has practised the profession concerned during the period of five years immediately preceding the date such application,

to the satisfaction of the Minister.”

71.3 The Health Professions Council of Namibia is legally the body responsible for registering all health professionals in Namibia. During a number of consultations and in written submissions as well as during public hearings, the complaint was raised that the system of authorization is open to abuse in that unqualified persons might be authorized to practise when in fact they should not. The affidavits submitted to the Commission reveal a number of cases of persons from Kenya, Nigeria and the Democratic Republic of the Congo (DRC) who were authorized to practise as doctors apparently without consultation with HPCNA who were later found to be completely unsuitable to practise as such either because they

obtained the Minister's authorization fraudulently or did not provide the required documentation or they did not comply with other requirements of the Act (*Annexure B 1.7*).

A number of such "doctors" were subsequently discharged from the public employment by the Public Service Commission. Regrettably, such remedial action amounted to shutting the stable doors after the horse had bolted.

The Commission also learnt that some expatriate health professionals employed by the MoHSS only work for a short period of time before leaving the Public Service for private practise in Namibia.

71.4 However, it transpired through consultations with key informants in the MoHSS that due to critical shortage of health professionals, the urgency to fill vacant positions, and a lengthy process of registration by the HPCNA, the Ministry opts to authorise to ensure that health services are provided. The Commission was also informed that authorisation also helps keep expatriate health professionals longer in the public health sector, unlike when they registered with the HPCNA. For those registered with the HPCNA, chances are high that they would only work in the public sector for a shorter period before they leave for private practice.

71.5 To address the challenges of authorisation and registration, the Commission learnt that the MoHSS, together with the HPCNA, drafted a bill providing for a unified registration process consisting of professions categories to ensure that all healthcare professionals practising in Namibia are registered. (*Annexure B 1.9*)

Recommendations

1. The policy on limited private practice should be revised and elaborated, especially the conditions under which specialists or doctors in the public sector can do private practice.
2. A clear policy to guide private specialists or doctors who wish to assist in the public sector voluntarily or for a fee should be developed and implemented.
3. Review the staff establishment to accommodate posts for emerging needs.

4. Accelerate the filling of vacant posts.
5. Review staffing norms to ensure that health facilities are staffed based on case load, population, and remoteness from the nearest referral centre.
6. The existing arrangement between the MOHSS and the Ministry of Home Affairs regarding fast-tracking of issuing work permits of expatriate health professionals should be honoured.
7. The Ministry of Education must implement the conversion of the study loans received by health-related students from the Namibia Students Financial Assistance Fund (NSFAF) into grants in as per Cabinet Decision No. 17th/02.10.07/001 as replaced by Cabinet Decision No. 17th/23.11.10.002.
8. All health practitioners should do a compulsory community service as one of the conditions for registration as independent health practitioners.
9. Fast-track the finalization of the proposed unified health professionals' registration process to ensure that all health professionals practising in Namibia are registered.
10. In the interim, the Ministry should adhere to all health professions Acts of 2004 when authorising health professionals to practise to avoid non-qualified health professionals to slip into the system and practice illegally.
11. The current agreement between the Public Service Commission and foreign health professionals should be reviewed to provide that such professionals are bound to work in the public service for a specified period, subject to renewal. The above condition should be stipulated in the work permits granted by the Ministry of Home Affairs to such professionals.
12. The MoHSS and Public Service Commission should consider introducing a career path development for all health job categories that are not attached to competitive promotional positions, but based on performance, for example senior and principal levels.
13. Post graduate clinical qualifications for all health care professionals should be recognised and regarded as promotional requirements in that specific discipline

and new specialist cadres of nurses should be created to address the current constraints related to career movement and a shortage of such skills.

14. Introduce incentives to attract and retain scarce skills in the public health sector.
15. The MoHSS should introduce retention packages for staff working in remote areas, in order to improve the conditions of service in line with the recommendations of the Incentive Study. The Commission finds it necessary to include remote area allowance, free accommodation, Digital Satellite Television (DSTV) and internet.
16. Provide adequate staff accommodation, preferably separate dwellings, considering the number of posts on staff establishment, especially for remote/rural clinics and health centres.
17. Review and adjust salary grades to harmonise remuneration packages of staff in the same occupational categories carrying out the same functions across the public service.
18. The MoHSS should train, or recruit where applicable, adequate mental health professionals, psychiatrists, clinical psychologists, occupational therapists, mental health nurses and security orderlies.
19. Introduce fixed overtime for those staff members on call 24 hours, especially those in rural/remote areas.
20. Introduce a national annual recognition day for well-performing employees in the MoHSS, selected in consultation with the public, to award prizes. To this end, all health workers should carry a clear name tag while on duty.
21. Create posts for Pharmacists and Allied Health Professionals on all district hospital establishments.

ToR (h) The conduct, ethics and professionalism of health professionals, and their attitude vis-a-vis patients

72. The conduct, ethics, and attitude of some health workers towards patients were described as having become unacceptable. This is an area that attracted most comments in public hearings, but was also raised very frequently in group consultations with health workers and other groups, such as Regional Councillors. The complaints were that health workers, especially doctors and nurses who are in constant contact with patients, are rude, impatient and sometimes incompetent or negligent in their behaviour. For obvious reasons, nurses attract the most negative comments.
73. This is found to be a multi-factorial problem, and that is why different reasons for negative behaviour are advanced by different categories of those who commented. These comments include the following:
- 73.1 The health workers themselves, mainly nurses, advance shortage of staff resulting in burn-out as the main cause for such behaviour. They referred to the fact that one nurse sometimes looks after a ward of 20 or more patients alone, especially at night, while in clinics, one nurse may screen more than 50 patients per day, and do revenue collection and dispensing medicines in addition. They also attribute their behaviour to the fact that patients themselves are sometimes rude to them. The same arguments are advanced to some extent by other health workers, especially doctors.
- 73.2 Older health workers put the blame on the training of nurses which they said lacked emphasis on ethics. It was said often to the Commission that the selection of students for nursing no longer takes character into account. Others state that nursing is no longer a calling, but just another job, and students choose nursing because they are sure of a job at the end of training, but lack the spirit to serve.
- 73.3 The public and political leaders singled out the newly-appointed young staff, especially nurses, as the ones prone to this type of behaviour, and for lack of respect to clients, patients, or even to their seniors. They also attribute their behaviour to unmet expectations, such as better salaries, good working conditions, availability of accommodation and uniforms. For nurses, the feeling

of professionalism and pride was always portrayed by their dressing code. Nowadays, due to erratic supply of nurses' uniforms, nurses buy their own uniforms and end up with different designs.

73.4 The more philosophical ones argue that nurses are a product of the society they come from. The Namibian society has changed and is more impersonal; traditional mores have been abandoned, there is more crime etc. So, the behaviour of those who join nursing reflects their family and societal background. Some even stated that those from the upper classes are ruder. Some members of the public in Opuwo and Otjiwarongo even went to an extent of providing the Commission with the names of rude nurses.

73.5 Specific instances were cited that, whilst on duty, some nurses sit around at nurses stations playing games on their cell phones and laptops, talking on phones for a long time, filing their nails, selling items to colleagues and even to patients, while helpless patients are not fed, bathed or assisted to take their medications. Cleaners were also criticised for indulging in the practice of selling items while on duty.

73.6 The public as well as some nurses complained that some doctors do not care much about state patients. They do not spend enough time consulting state patients but rather rush in order to go to their private consultations. When on call, if called for an emergency, a doctor may say "*I am in church*" or the wife may answer the phone: "*My husband is sleeping*". Some doctors just give telephonic orders to nurses or junior doctors on duty despite the need for them to come and see the patient at that moment.

73.7 It was also alleged that some nurses go to work under the influence of alcohol and such situation poses danger to the patients and clients. It was also related to the Commission that these nurses go without being disciplined. This issue leads to another scenario; that of lack of effective disciplinary measures being taken by those who should be responsible for enforcing such measures as per Public Service Staff Rules. Those responsible blame their attitude to the following:

- Disciplinary action and measures in the public service is a long and cumbersome process;
- Fear of threats by trade unions and lawyers; and

- Political interference by relatives of health workers.

73.8 Other complaints given in evidence under oath as well as from public hearings were that nurses shout at patients and utter foul languages to them like, *“Is it this one again, why not just keep her/him at home until the day comes” (Oshakati hospital), or to a woman in labour “You were alone when you were making the baby, so see how to manage” (Opuwo hospital).*

It was reported that it is a common practice for professional midwives to physically slap clients in the labour ward during delivery when the midwives consider the client not being cooperative.

UNAM School of Nursing and Public Health informed the Commission that nurses are taught ethics, professionalism and right attitude towards patients. In spite of that, the conduct and attitude of many nurses remain uncaring.

73.9 It is also worth noting that some key informants argued that, although there are some health professionals whose behaviour tarnishes the image of the health professions and the MoHSS at large, the number of health professionals who are doing their best, sometimes under very difficult conditions, is far higher than the number of those who spoil the name of the esteemed professions.

73.10 Whatever the cause, it was generally agreed that ethical standards in the health professions have deteriorated over the years. Those who teach health workers, especially nurses, state that they do emphasise ethics and professionalism, but they are often overwhelmed by behavioural traits the students have absorbed from society.

Recommendations

1. The various Health Professions Councils should be called upon to play a more active role in disciplinary matters, and acts of unethical behaviour should be reported to the HPCNA.
2. Public Service Staff Rules should be enforced for any staff member who is proven to have misbehaved whilst on duty. All staff members must be made

aware of the Public Service and Patient Charters and remedial action must be taken against those who do not conform.

3. All applicants wishing to join any of the health professions should be properly scrutinized with the inclusion of the psychometric test.
4. The public must be encouraged to report to the HPCNA bad conduct by health professionals for appropriate disciplinary action to be taken.
5. It should be made mandatory for all health workers to wear clear identifications with their names and rank. Failure to do so should be regarded as misconduct.
6. The Ministry should seriously take the issue of supplying uniforms to all health workers as a matter of urgency.

ToR (i) The adequacy of transport for referral of patients

74. Namibia is a very large country in geographical terms, with a relatively small population. In view of the fact that referral facilities are mainly in Windhoek, Windhoek Central Hospital and Katutura Intermediate Hospital, and to some extent in the North, Oshakati and Rundu Intermediate Hospitals, an efficient transport system is very crucial for the management of referral cases across the country. In each region there is also a great need for transport, especially ambulance type of transport for urgent cases from clinics and health centres to hospitals, and indeed from homes to health facilities in all districts. A case in point is that of obstetric cases, where pregnant mothers are transported on bad roads, in situations of life or death for both mother and baby.
75. According to the MoHSS Draft National Referral Policy of April 2012, the Ministry experiences referral system challenges due to the old fleet of vehicles it has. There are frequent breakdowns and the Ministry lacks skilled personnel for transport management. The fleet was regarded then as still insufficient despite some vehicles having been bought.
76. In its visit to the Regions, the Commission found that Regions generally had vehicles but a shortage of drivers. This is due to limited number of drivers' posts on the staff establishment.

77. The Commission learnt that patients are transferred from the regions to Windhoek Central and Katutura State hospitals largely by scheduled buses or sometimes smaller vehicles. This serves quite well for cold cases (non-emergencies). However, some regions like Otjozondjupa and Karas indicated that the current patient busses do not have sufficient seats to accommodate all referrals at any given time.
78. On the other hand, emergency cases are transported by ambulances, both within towns/settlements, or long distances from clinics to hospitals or from district hospitals to referral hospitals. The main complaints in this regard are that:
- ambulances take long to come;
 - there is a shortage of ambulances and drivers;
 - distances are too long; and
 - some roads are bad and are at times washed away during the rainy season.
79. The Commission had firsthand experience of the very bad roads leading to some clinics and health centres in remote areas (e.g. Hedimbi clinic in Oshikoto, and Kandjara clinic in Kavango region). (*Annexure 1: Figure 13a-b*).
80. In this regard, health workers and community leaders strongly proposed air lifting for deserving emergency cases, especially for regions far from the referral points and those prone to floods during the rainy season such as Caprivi, Kunene, Ohangwena, Oshana and Omusati regions. This would call for collaboration with relevant stakeholders like Ministry of Defence, Regional Councils, Municipalities, etcetera.
81. Both the public and health workers complained about unsuitable vehicles allocated to various difficult terrains where the normal 4x4 pickups/ambulances will not reach due to sandy, rocky or slippery roads. This situation was reported to be typical to rural health centres and clinics in *Oshikoto, Ohangwena, Kavango and Kunene regions*. Cars like *4x4 Land Cruisers* were suggested or even *airlifting* for emergencies. Still on the type of vehicles, complaints were that sometimes double cabs given to health facilities were neither fit nor acceptable for transporting patients. For example, a mattress with a patient can not fit in a double cab.

82. It was found that most clinics did not have a vehicle to be used in running errands. According to the recent October 2012 MoHSS Report (*MoHSS Supportive supervisory visits 2012*):

“Some health centres and clinics very far from the referral health facilities have no ambulances or a doctor. Sesfontein and Okangwati Health Centres have ordinary pick-ups that are used in the event of an emergency. In the absence of ambulances, patients are brought in by their families in private cars or donkey carts. Some of these transportation methods are not good for a very sick patient or for a woman in labour.”

Moreover, the report also indicates that some ambulances, especially those donated, were not fully equipped with all necessary ambulance life support equipment.

83. According to the MoHSS report (*EMRS Situational analysis Report 2008*), Namibia had no national ambulance system. In all the 13 regions the ambulance services fall under the transport section. The transport section is headed by a senior clerk and after hours the service is coordinated by a driver or a nurse in-charge of the health facility. Only Windhoek Central Hospital had an ambulance service structure. It was also noted that the public appears to have limited information on who is responsible to pay for an ambulance and circumstances under which an ambulance should be called to collect a patient from the community.

84. The Commission learnt that the MoHSS has developed a policy, on Emergency Medical Rescue Services (EMRS) in 2011. The purpose of the policy is to ensure adequate provision of an integrated, affordable, accessible, quality pre-hospital care and timely transportation services that are responsive to the needs of the Namibian population. There is no documentation to indicate if the policy has been implemented, but the Commission noted that a Strategic Plan for EMRS has been developed and adopted by the Ministry. Observations during the Commission’s sittings indicate that the policy and strategy are not yet implemented as ambulances were still controlled from the transport sections of the hospitals.

85. Specific observations on transport by the Commission

- A broken patient bus stands parked at the premises of Swakopmund Hospital for almost seven years. The vehicle is rusted and totally obsolete but according to management it is still on the master list and its registration is still being paid every year (*Annexure 1: Figure 14*).
- Two ambulances at Outapi Hospital were found not working during the Commission's visit. The hospital often borrows an ambulance from a health centre when the need arises.
- Hedimbi Clinic in Oshikoto Region is very remote, with a very bad road (*Annexure 1: Figure 13b*), and like with other clinics it did not have a vehicle. According to staff members, their newly bought vehicle was stationed at Omuthiya Hospital under which the clinic will fall once the hospital becomes fully operational. For emergencies an ambulance has to come from Tsumeb which is about 150km away.

Recommendations

1. The MoHSS should develop a comprehensive fleet master plan which indicates each vehicle's life span and replacement period.
2. All health centres should be provided with ambulances to share with the surrounding clinics.
3. Provide all rural clinics with multi-purpose vehicles that would transport patients when needed but perform other functions as well.
4. Increase number of driver posts on staff establishment.
5. Provide health facilities with transport/ambulances to enable them to refer complicated cases without delay; start by providing vehicles or ambulances to clinics and health centres that are further than 50km from their base hospital/referral point and accessible only over bad and difficult roads.
6. Government ministries should do joint planning and implementation of national projects, e.g. MWT and MoHSS should work together to ensure that road infrastructure is in place when a health facility is established especially in rural areas.

7. Implement without delay the Policy and Strategic Plan on Emergency Medical Rescue Services.
8. Government should consider air transport for deserving emergency cases and the use of Werewolf/Casspirs in areas subject to flooding during the rainy season. This will call for collaboration with relevant stakeholders like Ministry of Defence, Regional Councils, Municipalities, etc.

ToR (j) The need for waiting shelters for expectant mothers near hospitals and health centres, especially in rural areas

86. Despite concerted efforts to improve prenatal and perinatal health care in developing countries, child birth remains hazardous to both mother and child, mainly due to poor access to maternity services. Sufficient evidence from developing countries in Africa such as Ethiopia, Kenya, Malawi, Nigeria, and Tanzania suggests that maternal mortality is particularly high in areas where access to hospitals is difficult (Poovan et al. 1990). Several measures have been initiated in developing countries to try and reduce maternal and perinatal morbidity and mortality. One such measure is the establishment of maternity waiting shelters at or near hospitals where mothers can wait so that when labour starts or they develop antenatal complications, they are close to the hospital for management and safe delivery.

In the 1950s such shelters helped to reduce maternal mortality rate in a hospital in Ituki, Mboug, Eastern Nigeria, from ten to less than one per 1000 deliveries and stillbirth rate from 116 to 20 per 1000 births. Cuba built its first maternity waiting shelter in 1962 and by 1984 there were 85 such shelters in the country, with 99% deliveries occurring in hospitals, and a reduction in maternal mortality from 118 to 31 per 100 000 live births (Poovan et al. 1990). A study by Tumwine et al. evaluated the relationship between maternity waiting shelters and pregnancy outcome in the period May 1987 to April 1989 in the Chimanimani district in Zimbabwe recorded reduction in perinatal mortality as well as fewer low birth weight babies (Tumwine et al. 1996).

87. During the Inquiry, the need for shelter for expectant mothers was not expressed in all the regions, but the majority (77%) of the regions felt such a need. Three regions, Khomas, Hardap and Karas, did not express the need to have these shelters. The Commission noted a general lack of agreement in the regions with regard to who will be responsible for construction, maintenance, and running cost of these structures. Whereas some Regional Councils felt that this initiative should be a partnership between the MoHSS and Regional Councils, others were of the opinion that the MoHSS should solely be responsible for these shelters.
88. The Commission further observed that in some health districts, initiatives to construct these shelters were already taken. These structures were mainly built by community organisations and pregnant women contribute a nominal fee for lodging. For example, the shelter near Engela Hospital charges N\$10.00 per client per month. The shelter is staffed by a female caretaker who is paid from these contributions. Similar structures were found at Eenhana and Onandjokwe Hospitals. In addition, we found that women bring their own food and bedding, and there was no policy or system in place whereby midwives visit these women daily for assessment.
89. In Omusati Region, the Regional Council mobilised N\$100,000.00 from business persons towards the establishment of such a shelter near Outapi Hospital where a greater need was felt.
90. We found approximately 100 pregnant women under a tree near Outapi Hospital in small tents. The situation is extremely worrisome because there are no ablution facilities available and these women are exposed to harsh conditions (*Annexure 1 Figure 15*).
91. The Commission learnt of and appreciates the involvement of the First Lady of Namibia, Madam Penhupifo Pohamba, a Registered Nurse and Midwife by profession, in resource mobilization for the construction of waiting shelters.
92. During consultations with Regional Councils, it was proposed that Public-Private Partnership should be encouraged should Government decide to construct these facilities. Some Regional Councils suggested that State-Owned Enterprises, specifically GIPF and the SSC, lend funds to the Government for this purpose.

93. The Commission feels it is necessary for these shelters to be provided near hospitals for the following reasons:
- Lack of local health facilities in rural areas with skilled birth attendants (midwives and doctors);
 - Shortage or lack of transport to nearest referral hospitals;
 - Unforeseen natural disasters such as floods that are making access to health facilities impossible;
 - Inadequate road infrastructure for fast and safe referral of pregnant mothers during an emergency from rural health facilities to referral hospitals;
 - Long distances between rural health facilities and referral hospitals; and
 - Frequent occurrence of obstetric complications in rural health facilities.

Recommendations

1. The Commission recommends that, the Government develop standards and norms for these shelters and make them available.
2. Resources for construction, maintenance and running cost of these shelters may be obtained through Public-Private-Partnership (PPP) and loans from SSC and GIPF. Government should come up with a scheme to guide the suggested Public-Private-Partnership.

ToR (k) The adequacy of the proposed restructuring of the Ministry of Health and Social Services

94. The Commission observed that the MoHSS is currently using an operational structure that is not responsive to current demands. The Ministry is structured in a three-tier hierarchy consisting of the national, regional and district levels.

The national level has eight directorates operating under the Minister and his Deputy, the Permanent Secretary and his Deputy, and three Under Secretaries responsible for Health and Social Welfare Policy, Policy Development and Resource Management, and lastly Regional Health and Social Welfare Services respectively (*Annexure K 1*). There are 13 regional directorates and they oversee

34 health districts. Four regions, namely Caprivi, Khomas, Omaheke and Oshana have only one district each, and the region therefore coincides with the district.

95. One of the complaints that were articulated during the inquiry was that the organization of the Regions and Districts was more of an inverted pyramid, with district staff supervised by regional staff who are more in numbers. There have also been questions regarding having an intermediate level in the form of a Region in a country with just over two million people, whether it is just adding another layer of bureaucracy or it was necessary. It was however found to be necessary as the Regions are the areas of Government designated for decentralization and the health sector has to follow Government administrative regions.
96. With regard to resource allocation and utilisation Districts complained that the Regional Directorates sometimes divert funds meant for particular districts to other purposes.
97. Furthermore, the Commission learnt that a new draft Organizational Structure has been proposed through an elaborate process in April 2012. This draft has been under consideration by the Ministry management since then and by May 2012 it was agreed upon in principle at the workshop held in Otjiwarongo. This proposed structure is still to be costed and discussed with the Office of the Prime Minister (OPM). (*Annexure K 2*)
98. Revised Staffing norms for clinics and health centres were also agreed upon during this workshop and a team was constituted by the Permanent secretary to revise the staffing norms for hospitals. The revised staffing norms for all health facilities (clinics, health centres and hospitals) were then to be presented to the Policy and Management Development Review Committee (PMDRC) at end of May 2012.

The revised staffing norms for clinics and H/Centres were approved by the PMDRC in June 2012. The hospitals' staffing norms are still to be revised. When that process is completed, the whole set, including the revised structure, will be presented to OPM for approval.

The Commission learnt, however, that although the proposed structure of April 2012 was in an advanced stage of finalization, a new process was initiated when

the newly appointed Permanent Secretary felt that there was a need for the Ministry's functions to be reviewed. The functions were accordingly reviewed resulting in another proposed structure. The latter was discussed by the Ministry's management in early August 2012. We further learnt that this has been costed and was to be referred to the Ministry of Finance for inclusion in Medium Term Expenditure Framework (MTEF) before submission to OPM for approval (*Annexure K 4*). Those involved in this exercise, expressed satisfaction that the new structure adequately addresses the shortcomings of the old structure.

99. While the new proposed structure has not yet reached its final form, the Commission feels that what is currently in the proposal seems to have addressed the above deficiencies as it was a product of extensive consultations. The Commission is happy with improvements made with regard to the proposed staffing norms for clinics and health centres. It is however recommended that norms for driver posts be reviewed (see paragraph 99.1). These improvements are as follows:

100. **Staffing of clinics and Health Centres**

The proposed staffing norms for clinics and health centres are based on case load both in urban and rural areas (*Annexure K_3*) as opposed to the current staffing which is the same fixed number of job categories in all health facilities:

100.1 Clinics are proposed to be staffed by:

- Registered nurses
- Enrolled nurses
- Clerical staff
- Cleaners
- Driver for clinics 100km away from the next referral facility (The Commission proposes 50km for clinics accessible over bad roads).
- Doctors and Pharmacist Assistants for clinics with case loads of more than 17, 000 per year and for which provision was not made on the current staff establishment.

100.2 Health centres without in-patient services

- Registered nurses

- Enrolled nurses
- Doctor (from 11 000 case load per year)
- Pharmacist Assistant (from 5000 case-load per year) and for which provision was not made on the current staff establishment.
- Radiographic assistant
- Data clerk
- Clerk
- Clerical Assistant
- Drivers
- Cleaners
- Institution workers

100.3 Health centres with in-patient services

- Registered nurses
- Enrolled nurses
- Doctor (from 11 000 case load per year)
- Pharmacist Assistant (from 5000 case-load per year) for which provisions were not made on the Health centres' establishments of 2003.
- Radiographic assistant
- Data clerk
- Clerk
- Clerical Assistant
- Drivers
- Cleaners
- Cook
- Mortuary attendant
- Institution workers

101. Staffing norms for volunteers and Community counsellors currently employed by development partners (PEPFAR and Global Fund) were not developed as it was not clear whether they would be taken over by the Ministry. It was, however, reported during the inquiry that the Ministry is now in the process of taking over these volunteers as extension health workers after they have gone through

training. The process of developing norms for this cadre has therefore started. These proposed staffing norms and those for hospitals will be discussed during the Ministry's Management Development Forum in February 2013 before submission to Public Service Commission (PSC).

102. The Commission however observed that while all the above-described processes are taking place, the Regions and Districts cannot wait any longer and are anxiously looking forward to the implementation of the new structure, primarily because they believe it will increase their staffing criteria (establishment) and also create more posts for promotion as they believe career structures are currently too compressed, with the result that there are no opportunities for promotion.

In order for any structure to function appropriately, there is a need for harmony, cooperation, and commitment between the various individuals concerned.

Recommendations

The Commission strongly recommends that the restructuring process should be speeded up especially to improve management systems of the MoHSS, with specific emphasis on the following:

1. Review the core functions of the health sector and clarify roles and responsibilities of various levels of the health system.
2. Address the issue of duplication and fragmentation of functions.
3. Strengthen clinical leadership to ensure rendering of quality health care.
4. Clearly define the management/organizational structures of the National and Intermediate Hospitals.
5. For efficient management of national and intermediate hospitals, establish Hospital Management Boards.
6. Consolidate social welfare services under one Ministry to enhance service delivery and avoid duplication entailed in the present system whereby responsibilities are shared by various ministries.
7. Initiate development of management/administration occupation-specific training programmes to build capacity of mid- and lower level employees within the Ministry.

Section D: Healthcare Financing

102. Although financing did not feature as such among our Terms of Reference, the commission found it important to mention this issue because in our view it is crucial and the successful implementation of any of the measures we recommend will depend on the availability of funds. As Your Excellency specifically stated “value for money” in the health system is one of the things the Commission was to examine. There is no question that the public and the health workers in Namibia have a very high expectation of the outcome. The demands are however such that Government is unlikely to have the financial resources needed to meet all of them. There is high expectation on both capital and recurrent budgets, with exceptionally high expectations on upgrading and building of new health facilities, upgrading of equipment and increases in human resources. This will also call for more expenditure on transport, consumables and medicines.

After careful consideration, the Commission therefore further recommends:

1. The MoHSS should come up with a master plan for upgrading health facilities that need upgrading.
2. The plan should be costed to cover both capital and recurrent expenditure over a medium to long term period of about 10 years.
3. Budgetary allocations, especially operational budgets, should in the meantime be adequate to fully meet the needs of the regions and avoid the running out of funds three to four months before the end of each financial year as is currently the case in some regions.
4. Greater autonomy in financial expenditure should be accorded to districts so that they will have a greater appreciation to manage their own budget according to their work plans.
5. Since in many countries user fees are generally seen as a barrier to access services, the Government policy of not turning away anybody for failure to pay user fees should be applied both in spirit and practice. All health workers, including administrative staff, should be made aware of this policy.

Section E: Overall recommendations

It is the Commission's opinion that Government consider special schemes of financing the public health system in Namibia. Examples of such an initiative already exist in the country, such as:

- Petrol levy for MVA Fund;
- Provision for the Social Security Fund;
- Provision of National Training Fund for vocational education and training.

The Government should study the feasibility of either a Social Health Insurance or National Health Insurance.

Desk review of various documents from the MoHSS reveals that most of the recommendations in this report have been made at the Ministry level previously. The overriding problem is lack of implementation. It is the Commission's hope that recommendations contained in this report are implemented and will not remain *a mere academic exercise*.

John Kehoe wrote in his seminal Book: *Mind Power into the 21st Century* (page 97):

“There is no particular virtue in doing things the way they have always been done. Sometimes breaking rules, initiating a revolution in our lives and overthrowing the tried habits that are keeping us stagnant is the most sensible way to go”.

He goes on to state (page 98) ... “Don't be afraid to stir things up. When the dust settles you are often better for it.

“5 Use your imagination. Our imagination is not bound by real-world constraints. Our imagination knows no limitation. Whatever your imagination can conceive of and believe, you can achieve. Our creative imagination helps us to explore different options and envision numerous scenarios and outcomes. By harnessing this faculty we can change and improve our life”.

We appreciate that it is the prerogative of your Excellency to decide whether to make this report public or not, but we would humbly recommend that the Report be made public.

Section F: Limitations of the Inquiry

103. It is worth stating that the Commission was not without challenges during the period of discharging its task. Firstly, the Commission worked under a very tight schedule as it needed a minimum of three days per region to conduct all the three data collection methods, group consultations with the regional councils, MoHSS regional and district management teams, health facility visits, and public hearings. In most regions, health facilities were visited in one day due to time constraints. This was particularly challenging due to the fact that most of the regions are vast and have difficult terrains.
104. Secondly, the Commission had to enlist the services of interpreters during public hearings. In regions with diverse ethnic groups, for example Otjozondjupa Region, an interpreter had to interpret up to three local languages, which further prolonged the time for consultations. At times, members of the Secretariat had to do the interpretation as some regions could not mobilise interpreters.
105. Despite these challenges, the Commission was able to collect adequate amounts of information that enabled it to recommend remedial actions. The consistency of information generated from different regions demonstrates that all health facilities and communities, including those that were not visited, share similar sentiments and experiences.

Section G: Records of the Commission

106. The Commission produced and collected various documents. These include correspondences and minutes of the Commission's meetings; notes taken during consultations; audio-records; transcripts of audio-records; structured data collection tools; photographs taken during health facility visits and public hearings; submissions from key informants and the Commission's report.
107. All records that the Commission collected and produced during the time of its operations will be handed over to the Office of His Excellency the President of the Republic of Namibia.

Section H References

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ANNEXURE 1: List of Figures



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Annexure 1 -Figure 2: A broken down sink at Otjiwarongo Regional Health Training Centre, Student accommodation



Annexure 1 - Figure 3: Dilapidated Onandjokwe hospital TB ward



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Annexure 1 - Figure 4: (b) Broken and blocked shower in Opuwo hospital



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Annexure1 - Figure 5 (a): Opuwo urban clinic patients toilets locked for the past 10 years



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Figure 5 (c): Constantly running tap at Katima Mulilo urban clinic



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Annexure 1 -Figure 10: Obsolete Anaesthetic machine in Okahandja hospital



Annexure1 - Figure 11: Unused industrial sport machine at Windhoek central hospital.



Annexure1 - Figure 12 (a): Lack of space in Onandjokwe hospital pharmacy



Annexure1 - Figure 12 (b): Lack of space in Okahandja hospital pharmacy



Annexure1 - Figure 13 (a): Sandy road to Kandjara rural clinic in the Kavango region



Annexure1 - Figure 13 (b): Sandy road to Hedimbi rural clinic in the Oshikoto region



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Annexure1 - Figure 15: Group of expectant mothers taking shelter under a tree in Outapi, Omusati region

ANNEXURE B

LIST OF AFFIDAVITS SUBMITTED AS PER REGULATIONS

LIST OF SUBMISSIONS RECEIVED: MOHSS NATIONAL LEVEL

LIST OF SUBMISSIONS RECEIVED: MOHSS

Name	Designation	Institution
Hon. Richard Nchabi Kamwi	Minister	MOHSS
Hon. Petrina Haingura	Deputy Minister	MOHSS
Mr A. N. Ndishishi	Permanent Secretary	MOHSS
Dr N. Forster	Deputy PS	MOHSS
Dr. N. T. Hamata	Special Adviser	MOHSS
Mr P. K. Ndaitwa	Undersecretary:	Policy Dev. & Res. Mngt.
Ms B. Katjivena	Director:	Policy, Planning & HRD
Ms P. K. Nghipandulwa	Director	THC & CSS
Mr A. Tibinyane	Director	Atomic Energy
Ms O. Kutenda	Deputy Director	NHTC
Ms M. Nghatanga	Director	PHC
Ms L. Nashixwa	Acting Director	HRM & GS
Dr Ali EL Sherif	CMO	MOHSS National Level
Mr I. Poppas	Senior Control R/N	Quality Assurance - MOHSS
Windhoek Central and Katutura hospital		
Dr G. A. Judmann	Medical Superintendent	Katutura Intermediate Hospital

Dr S. K. Shalongo	Medical Superintendent	WCH
Nurses	Nursing Services	Katutura Intermediate Hospital
Dr Clarissa Pieper	Specialist Paediatrician	Paediatrics Departments – Kat. & WC Hospitals

LIST OF SUBMISSIONS RECEIVED: OTHER INSTITUTIONS

Name	Designation	Institution
Ms. Dianne Hubbard	Coordinator, Gender Research & Advocacy project	Legal Assistance Centre
Mr Ivin Lombardt	CEO	NANGOF Trust
Dr Shitaleni C. Herman	Chairperson	Namibia Medical Society
Dr Johannes Andries Coetzee	Medical Practitioner & CEO	NPPF
Ms E. Barlow & Ms G. N. N. Muballe	Registrar	HPCNA
Dr Tangeni C. Iiyambo	Secretary General	SWANU Parliament Office
Amb. Patrick Nandago	Permanent Secretary	Ministry of Home Affairs & Immigration
Mr P.Mwatile	Permanent Secretary	Ministry of Works and Transport

LIST OF SUBMISSIONS RECEIVED: INDIVIDUAL

Name	Designation	Institution
Dr Kalumbi Shangula	Former PS	MOHSS
Mr Kahijoro Kahuure	Former PS	MOHSS
Dr Helen Nkandi-Shiimi	Former Medical Sup.	WCH
Olyvia Martha Imalwa	Prosecutor General	High Court
Mr Frans Tjongarero	Driver	Directorate: DSP
Mr Andreas E. Peltzer	Treasurer	Namibian Catholic Bishops'
Mr Willem Petrus Andrew	Chief Security	MOHSS – Mental Health Centre, Forensic Unit
Ms Rosy Rosina Cloete	Chief Registered Nurse	WCH Theatre
Rev. Hendrik Johannes van Zyl	Reverend	Dutch Reformed Church Tsumkwe
Ms Janet Bean	Public member/tourist	Oxfam Australia
Dr. Y. Vasin	Chief Forensic Medical Officer	WCH Mortuary

LIST OF SUBMISSIONS RECEIVED: ACADEMIC INSTITUTIONS

Name	Designation	Institution
Prof. P. M. Nyarango	Founding Dean	School of Medicine/ Dean Faculty of Health Sciences
Prof. S. R. Moyo	Dean	Polytechnic of Namibia: School of Applied Sciences
Prof. Kingo Mchombu	Dean	UNAM: Humanities and Social Sciences
Dr Scholastika N. Ipinge	Dean	UNAM: School of Nursing and Public Health

LIST OF SUBMISSIONS RECEIVED: MOHSS REGIONS

Name	Designation	Institution
Mr T. Shapumba –	Regional Director	Kunene
Mr W. S. Kapenambili –	Regional Director	Omusati
Mr S. Taapopi	Regional Director	Oshana
Eliud Amunyela	Control Registered Nurse	Intermediate Hospital Oshakati
Mr J. N. Hango –	Acting Regional Director	Ohangwena
Dr N. Siame	CMO	Oshikoto
Mr A. M. Maswahu –	Regional Director	Caprivi
Mrs M. F. Kavezembi	Regional Director	Otjozondjupa
Dr J. R. Ndile	CMO/Act. Regional Director	Karas
Ms. C. Thataone –	Regional Director	Hardap
Ms M. Valombola	Acting Regional Director	Erongo

ANNEXURE C

Legal instruments guiding MoHSS in its operations

- Public Health Act 1919.
- Hospitals and Health Facilities Act, 1994 (Act No. 36 of 1994).
- Medical and Dental Professions Act, 1993 (Act No. 21 of 1993).
- Nursing Act, 2004 (Act No. 8 of 2004).
- Allied Health Professions Act, 2004 (Act No. 7 of 2004).
- Mental Health Act, 1973 (Act No. 18 of 1973).
- Abortion and Sterilization Act, 1975 (Act No. 2 of 1975).
- Atomic Energy & Radiation Protection Act, (Act No. 5 of 2005).
- Medicines and Related Substances Control Act, Act (2003) with amendments (2008).
- Namibia Institute of Pathology Act, 1999 (Act No. 15 of 1999).
- Pharmacy Act 2004 (Act 9 of 2004).
- The Abuse of Dependence-Producing substances and Rehabilitation Centres Act, 1971 (Act 33 of 1971).
- National Welfare Act, 1965 (Act 79 of 1965).
- Aged Persons Act, 1967 (Act 81 of 1967).
- National Welfare Amendments Act, 1993 (Act 9 of 1993).
- National Policy on Disability (1997).
- National Disability Council Act, 2004 (Act 26 of 2004).

Other legal instruments pertaining to the operations of the MoHSS:

- Public Service Act, 1995 (Act No. 13 of 1995).
- State Finance Act, 31 (Act No. 31 of 1991).
- Labour Act, 2007 (Act No. 11 of 2007).
- Tender Board of Namibia Act, 1996 (Act No. 16 of 1996).
- Social Security Act, 1994 (Act No. 34 of 1994).
- Children Status Act, 2006 (Act no. 6 of 2006).
- Combating of Rape Act, 2000 (Act 8 of 2000).
- Combating of Domestic Violence Act, 2003 (Act 4 of 2003).

- Criminal Procedure Act, 1977 (Act No. 51 of 1977), Criminal Procedure Amendment Act, 2003 (Act 24 of 2003).
- Maintenance Act, 2003 (Act No. 9 of 2003) Adults.
- Combating of Immoral Practices Act, 1980 (Act 21 of 1980) and the Combating Immoral Practices Amendment Act, 2000 (Act 7 of 2000).

ANNEXURE D

Annexure D 1: Key concerns by Hon. Minister of Health and Social Services

The Honourable Minister of Health and Social Welfare, Honourable Dr R. N. Kamwi pointed out the following key concerns in his written submission, as well as during consultation with the Commission:

- a) Lack of a public health oriented management to translate vision, mission, mandate, strategic orientation and aspirations from Cabinet and the Minister into concrete actions that would improve the health status of the population.
- b) Inadequate middle level management capacity which results in delay and ineffective manner of execution of directives as well as lack of communication, information sharing and feedback between senior management and leadership.
- c) Ineffective coordination among various levels of Government specifically when it comes to tendering and procurement processes.
- d) Shortage of human resources attributed to factors such as delay in recruitment, lack of motivation and high turnover rates.
- e) Wide spread social determinants of ill health such as poverty, unemployment, poor housing and sanitation that are negatively influencing the population's health and compromising the impact of actions in the health sector.
- f) Balancing access and quality: As the expansion of health services is not always accompanied by adequate levels of services, mainly due to the shortage of human resources.
- g) Inadequate funding; despite the fact that health has been one of the top priority areas for Government funding, the allocation of funds has not been adequate to address the health challenges faced by the country.
- h) Lack of a culture of business unusual whereby accountability, ethics and professionalism and values are not instilled in the public health sector to ensure that each citizen receives the highest possible level of health care available and to be treated with respect and dignity.
- i) Nurses' poor attitudes partly because they are overworked/burn out due to heavy workload and lack of incentives.

[... Ends]

Annexure D 2: Concerns by the Permanent Secretary, Mr A. Ndishishi

- a) Current organizational structure of the Ministry is not structured in such a way that it addresses the revised functions and objectives in order to be able to contribute to the public health service delivery.
- b) Lack of standards of uniformity in many areas in MoHSS 'operation
- c) Lack of professional Managers /CEOs to head hospitals
- d) Institutional policy and legal environment: Outdated laws and slow pace of law reform and amendment , or replacement thereof
- e) Government conflicting laws e.g. the Labour Law wants the rights of workers to be honoured in terms of eight hours a day's work and not more than 8 hours per day, meanwhile emergencies and health services are not based on these 8 hours. This results in the Ministry paying overtime to health workers who exceeds these hours and this causes the Ministry to overspend its remuneration budget.
- f) Occupational titles of staff members that are wide open e.g. Control Officer: anybody qualifies to be a Control Officer in health administration; which means this person should be in charge of a hospital even without any clue about health issues.
- g) Lack of career path in most of health professions occupational categories as the seniority of a staff member depends on the number of people under his/her command (e.g. chief registered nurse, control registered nurse etc.).
- h) A "one size fits all " in the Public Service whereby when a surgeon is needed to be employed urgently one should go through the PSC process, the same procedure followed when non essential services staff members are recruited. The time the application reaches Home Affairs for work permit the interested surgeon has already found a job in another country.
- i) Two health professionals' registration systems whereby some are registered with HPCNA while others are authorized by the Ministry to practice. Sometimes it is too difficult for foreign health professionals to register with HPCNA whilst authorization is quicker. However, some health professionals might be authorized to practice without meeting minimum requirements.
- j) Infrastructure development and maintenance: many hospitals are very old and some function as referral and district hospitals at the same time. They can therefore not cope with these demands as the population they serve also grows. This results in lack of space especially at OPD where two doctors may share one consulting room, compromising the patients' privacy and confidentiality. Lack of isolation facilities for patients with infectious diseases is also a challenge.
- k) Lack of essential equipment and some that are obsolete and outdated.
- l) Donated health facilities that do not meet required health facilities standards.

- m) Lack of adequate training facilities for health personnel in the country and need of highly specialized teaching hospital with capacity to accommodate the school of medicine students.
- n) Insufficient and unbalanced resource allocation eg.: 80% (4 billion) of the Ministry's budget is operational and it is mostly to cover salaries and overtime while N\$ 400 million for pharmaceuticals and medical supplies. The remaining 5% is for capital development.
- o) Lack of clear policy on PPP, an approach which can contribute to the benefit of health services especially the relationship between private health practitioners and public health facilities. If PPP initiative is in place, skills and expertise of private practitioners can be used in the public health facilities. In addition, PPP will also be useful in the area of infrastructure development.

[... Ends]

Annexure D 3: Key concerns of the Undersecretary: Regional Health and Social Services, Dr T. Ithindi-Shipanga

- a) The process of recruiting medical doctors: Due to the shortage of medical doctors, doctors (especially Non-Namibians) are only recruited through assessing their qualifications from the CV's and accompanying documents without conducting interviews and proper induction to determine their skills. This results in unbalanced skill mix in health facilities. In some situations, emergency obstetric cases cannot be managed in some district hospitals due to lack of skills in Gynae & Obstetrics and Anesthetics, forcing the hospitals to refer these cases to intermediate hospitals.
- b) The challenge of two systems to register health professionals and authorization by the Ministry: Due to the shortage of doctors, the Ministry started to authorize doctors to practice without consulting the HPCNA. This resulted in authorizing some doctors who did not meet minimum requirements.
- c) Lack of unified clinical standards to harmonize the multicultural medical doctors from different systems while clinical manuals are also not available to everybody.
- d) Lack of clinical and general leadership as well as management skills resulting in managers relying on common sense in management.
- e) Shortage of staff on the ground impacts negatively on quality of patient care and health professionals do not have time for clinical sessions or to conduct research as they have to attend to long queues.
- f) Difficulties in filling of vacant posts in some regions like Caprivi and Kavango especially those for registered nurses. Another challenge is that even if the bodies become available there is no accommodation for these nurses at most health facilities. The latter challenge also affects the recruitment of Cuban volunteers who do not have to be appointed in posts.
- g) Staff shortage furthermore results in abandoning of specialists outreach services to district hospitals whereby services could be brought closer to the people in the regions. Currently all patients who require specialized medical services should be referred to Windhoek. These referrals also contribute to overcrowding in these hospitals.
- h) Lack of essential equipment and most of those available are obsolete especially the equipment to manage emergencies in neonatal care. Analysis was done and the report is in place about what equipment is needed but there is no budget to purchase them.
- i) A Challenge of managing the arrangement of limited private practice by medical specialists and locums by medical officers, which results in neglect of state patients as everybody is running a private practice to get more money that does not come for free thereby neglecting the government service where the monthly salary is guaranteed.

- j) Lack of Technical capacity in the country to manage capital projects either to construct new or upgrade existing health facilities where the whole country relies on DoW. This results in delay of construction of health facilities.
- k) Lack of accountability by staff members in the Ministry that patients can be admitted in wards but will not be seen by doctors for some days and nobody is accountable.
- l) Lack of technical staff in the Ministry especially when it comes to medical equipment which results in equipment being delivered but will not be used because end-users are not being trained on how to use it.

[... Ends]

Annexure D 4: Key concerns by Regional Councils and members of the public

- a) The Ministry's Policy and criteria for establishing health facilities hamper accessibility of health services by the citizens because they are rigid and focus on population and distance without taking into consideration other factors such as regions that are isolated, remote and prone to natural disasters.
- b) Long queues at health facilities.
- c) Inadequate transport for referrals and lack of appropriate transport during emergencies from health facilities to referral centres, flood prone, remote and difficult to reach areas where ambulances and vehicles can hardly reach.
- d) Inability to access health services during weekends and public holidays as clinics are closed.
- e) Lack of communication between doctors and patients due to language barrier.
- f) Poor attitudes of health workers especially nurses.
- g) Some doctors do not physically examine patients before prescribing medicines.
- h) Helpless patients in the hospitals are neglected as they are not being bathed and fed. Some develop bedsores and not treated with dignity at all. Some feel this is due to staff shortage whilst some say nurses are sitting around nurses stations doing nothing.
- i) Too many deaths of mothers and babies occurring in hospitals.
- j) Most prescriptions at health facilities are only Panado

Annexure D 5: Key concerns by Health workers

- a) Shortage off staff in most job categories, especially for health professionals like psychologists, physiotherapists, occupational therapists, speech therapists, nutritionists, orthotists, clinical technologists clinical engineers/technicians). There are no posts for these occupational categories on district hospitals' staff establishment and all patients who require related services are transferred to intermediate or national hospitals. In addition, the salary scales of these occupational categories are very low compare to their qualifications and technical functions they carry out.
- b) Lack of essential equipment and non-conductive working environment.
- c) Low salaries and inability to afford houses.
- d) No provision of adequate protective clothing (uniforms).
- e) Lack of career path in public service (many remain in entry positions till retirement).
- f) Lack of recognition for good performance; only negatives things are said about health workers, especially media exposure by top leadership of the Ministry.
- g) Lack of disciplining non-performers.
- h) Lack of accountability.
- i) Lack of accommodation.
- j) Lack of professional leadership (doctors and nurses).
- k) Lack of incentives especially those in remote/ rural areas.
- l) Non respect from the public.
- m) Insufficient budget
- n) Unsafe and nonconductive working environment (dirty health facilities, no ventilation, overcrowding, no adequate number of security staff at mental health institutions).
- o) Inadequate essential equipment and those available are obsolete or cheap prone to break down easily.
- p) Inadequate supplies
- r) Non-Namibian health professionals who are not allowed to attend training workshops (e.g. TB, HIV related workshops) therefore unable to implement new clinical guidelines and protocols.

Others issues of concerns:

Inadequate communication between health workers in clinical setting e.g. nurses to doctors, doctors to other doctors and also between institutions which affect the quality of patient care as health workers do not consult each other.

Inadequate record keeping in health facilities, especially when it comes to patients' records that are usually incomplete.

Most programmes being introduced do not have focal personnel at operational level and this results in one health worker running up to five or more programmes at a district level, especially PHC programmes.

When it comes to maternal health, there is lack of clinical skills especially for the young registered nurses, which is due to inadequate exposure to clinical setting during their training. The system does not also have nurses' specialists in midwifery. This is also the case with other disciplines such as surgery, orthopaedics, neonatology, Internal medicine to mention just a few.

There is a need for nurses to be trained in these areas at a post basic level to improve nursing care in these areas. The few who are in the Ministry are trained in South Africa. To create a critical mass of these nurses, UNAM should introduce training in these areas. It is also important for the specialized nurses to have a career ladder and not to fall under the same range of all other nurses without these qualifications.

Inadequate skills development of administrative staff in the Ministry as most of the time training is only focusing on health professionals although the effective and efficient functioning of the Ministry depends on all staff members' contributions.

ANNEXURE E: LIST OF DESK REVIEW DOCUMENTS

1. TREATMENT GUIDELINES

- 1.1 Namibia Essential medicine list Fourth Edition December 2008
- 1.2 National Guidelines for Medicine safety Surveillance November 2011
- 1.3 Government Gazette of the Republic of Namibia 28 December 2007
- 1.4 Government Gazette of the Republic of Namibia 29 July 2004
- 1.5 Government Gazette of the Republic of Namibia 25 July 2008
- 1.6 National Pharmacy Management Information System (PMIS) Feedback Report covering data submitted for October – December 2011.
- 1.7 National Medicine Policy Second Edition – January 2012
- 1.8 Treatment Manual for Clinics
- 1.9 Namibia standard Treatment Guidelines, 1st Edition
- 1.10 The Patient Charter of Namibia, July 1998
- 1.11 Terms of Reference: Uniform Technical Appraisal of Medical Facilities in Namibia
- 1.12 National Health care Technology Policy March 2003
- 1.13 National Blood Policy September 2007
- 1.14 Policy on emergency Medical Rescue services (EMRS) September 2011
- 1.15 Strategic Plan for Policy Implementation: April 2012
- 1.16 Policy on Orthopaedic Technical Services: April 2001
- 1.17 Draft National Referral Policy, April 2012
- 1.18 Policy on Official Accommodation, 02 June 009
- 1.19 Report on Familiarisation Visits and Situation Analysis of Ambulance services in Namibia, June 2007-March 2008

2. FAMILY PLANNING

- 2.1 Report on Needs Assessment; Screening for reproductive system Cancers August 2011
- 2.2 National Standards for Adolescent friendly Health Services August 2011
- 2.3 Guidelines for the Management of Sexually Transmitted Infections using the Syndromic Approach, 2nd Edition 2009
- 2.4 Family Planning Service Protocols for Operational Level Health Workers, October 1996
- 2.5 Family planning Policy August 1995
- 2.6 Breastfeeding Advocacy Kit 2008
- 2.7 Circular no. Management of Emergency Contraception (EC) 26 March 2010
- 2.8 Guidelines on PAP Smear Screening and Cervical cancer Management 21 July 2010
- 2.9 Managing contraceptives and HIV/AIDS, 26 March 2010

- 2.10 Focused Antenatal Care (FANC) and Treatment of Anaemia amongst Pregnant Women 2012
- 2.11 Child Health: Caring for the mother and child; Adverting maternal and child deaths in Namibia 10-12 March 2009
- 2.12 Family Planning and Safer Pregnancy: A Counselling Tool for Health Care providers 2011
- 2.13 Road map for accelerating the reduction of maternal and neonatal morbidity and mortality February 2010

3. HEALTH SYSTEMS STRENGTHENING

- 3.1 Health and Social Services system Review 2008
- 3.2 Strategic Plan 2009-2013
- 3.3 National Health Policy 2010-2020
- 3.4 Ministry of Health and social Services 20 Years of Progress 1990-2010
- 3.5 Situational Analysis: Implementation of Programme Budgeting May 2010
- 3.6 Equity in Health Care in Namibia Towards needs-based allocation formula April 2005
- 3.7 Namibia Health and HIV/AIDS Resource Tracking: 2007/08 & 2008/09
- 3.8 Ministry of Health & Social Services: Annual Report 2005/2006
- 3.9 Ministry of Health & Social Services: Annual Report 2007/08
- 3.10 Ministry of Health & Social Services: Annual Report 2008/09
- 3.11 MOHSS – Human Resource Development Strategy 2008/2012
- 3.12 Ministry of Education: Staff Circular No. 1 of 2012
- 3.13 MOHSS – Staff Establishment 2003
- 3.14 MOHSS Directorate: HRM & GS Annual Report 2011/12
- 3.15 Policy on Establishing New Health & Social Welfare Facilities or Services October 2000
- 3.16 Demographic and Health Survey 2006/07
- 3.17 Summary of Development and Investment Expenditure – Vote Code and name: 13 Health and Social Services MTEF. 2010/2011 – 2014/2015
- 3.18 Development Programmes Estimates of Expenditure 2012/2013 – 2014/2015
- 3.19 Additional Funding for the 2013/14-2015/16 MTEF
- 3.20 challenges in Budget Execution: April-July 2012 – 2012/2013 Financial Year
- 3.21 Master List (Updated 19 June 2012) Transport
- 3.22 MOHSS Staff Establishment 2003
- 3.23 Personnel Procedures Manual Staff Member’s Handbook
- 3.24 Personnel Procedures Manual Operating reference Manual– Manager’s Handbook
- 3.25 Policy of remunerative Work outside Employment January 2007

- 3.26 Fellowship Management Policy November 2000
- 3.27 Ministry of Health and Social Services: Human Resources Development Strategy 2008/2012
- 3.28 MOHSS: Draft human resources for Health – situational Analysis August 2011
- 3.29 MOHSS: Draft Human resources for Health – Policy February 2012
- 3.30 Human resources for Health Draft Strategic Plan; 2012-2021 March 2012
- 3.31 Report of the Study on Incentive and Retention Systems to attract and Retain Health Professionals and Scarce skills t remote/rural and hardship areas in the Public Health sector 2011
- 3.32 MOHSS – Appointment for period 1 July 2001 – 31 July 2012
- 3.33 Medical Doctors in MOHSS 2012
- 3.34 Summary of Key Supply in the MOHSS
- 3.35 MOHSS – Promotions 1 July 2011 – 31 July 2012

4 Health Information System

- 4.1 MOHSS – Malaria Annual Report 2011/2012 May 2012
- 4.2 MOHSS – DSP Annual Report April 2011 – March 2012
- 4.3 MOHSS – National Tuberculosis and Leprosy Programme 2011 Annual Report
- 4.4 MOHSS – National Tuberculosis and Leprosy Programme – Annual Report 2009 – 2010.
- 4.5 MOHSS – National Tuberculosis and Leprosy Programme - Annual Report 2010 - 2011
- 4.6 MOHSS – Report on the 2010 National HIV Sentinel Survey – HIV Prevalence rate in pregnant woman, biannual survey 1992-2010, Namibia
- 4.7 Annual Implementation Progress Report for the National Strategic Framework for HIV and AIDS - 2010/2011
- 4.8 World Health Statistics 2008
- 4.9 World Health Statistics 2009
- 4.10 Health Information Report 2002/2003 – 2004/2005
- 4.11 MOHSS – Health Information Report 1998/1999
- 4.12 MOHSS – Health Information Report 1999/2001
- 4.13 MOHSS – Health Information Report 2000/2001

ANNEXURE G

VISITED HEALTH FACILITIES

Region	Referral /Intermediate Hospitals	Distric Hospitals	Health Centers	Urban Clinics	Rural Clinics
1. Khomas	-Windhoek Central Hospital -Katutura Intermediate Hospital	N/A	-Katutura HC -Khomasdal HC	-Okuryangava clinic -Donkerhoek clinic	Dordabis clinic
2. Kunene	N/A	Opuwo hospital	Okangwati HC	Opuwo clinic	Ohandungu clinic
3. Omusati	N/A	Outapi hospital	Onesi HC	Okahao clinic	Odimbwa clinic
4. Oshana	Oshakati Intermediate hospital	N/A	Okatana HC	Eluwa Clinic	Uukwiyuushona clinic
5. Ohangwena	N/A	- Eenhana hospital - Engela hospital	Odibo HC	Eenhana clinic	Onambutu clinic
6. Oshikoto	N/A	Onandjokwe hospital	Onyaanya HC	Olukonda clinic	Hedimbi clinic

7. Omaheke	N/A	Gobabis Hospital	Otjinene HC	Epako urban clinic	.....
8. Caprivi	N/A	Katima Mulilo hospital	Sangwali HC	Katima Clinic	Chetto Clinic
9. Otjozondjupa	N/A	- Otjiwarongo hospital - Okahandja hospital	Otavi H/C	Orwetoveni clinic	Kalkveld clinic
10. Karas	N/A	Keetmanshoop hospital	.....	Keetmanshoop clinic	Koës clinic
11. Hardap	N/A	Mariental hospital	Aranos H/C	Mariental urban clinic	Rietoog rural clinic
12. Kavango	-Rundu Referral hospital	Nankudu hospital	Sambyu HC	Nkarapammwe clinic	Kandjara clinic
13. Erongo	N/A	Swakopmund hospital	Kuisebmond H/C	Hakhaseb clinic	Spitzkoppe clinic
TOTAL	4	13	13	14	12
GRAND TOTAL : 56					

