

**African Collaborative
for Health Financing Solutions**

**Landscape of Sustainability and
Universal Health Coverage activities in
Namibia**

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List of acronyms

ACS	African Collaborative for Health Financing Solutions
AIDS	Acquired Immuno-Deficiency Syndrome
ARV	Antiretroviral
CBHI	Community-based Health Insurance
CMS	Central Medical Stores
CSO	Civil-society organization
DALY	Disability-adjusted life year
EIMC	Early Infant Male Circumcision
GBD	Global Burden of Disease
GDP	Gross Domestic Product
GFATM	Global Fund to against AIDS, TB and Malaria
GRN	Government of the Republic of Namibia
HFG	Health Finance and Governance project
HIV	Human immuno-deficiency virus
HRH	Human resources for health
ICT	Information and Communications Technology
IHME	Institute of Health Metrics and Evaluation
MoHSS	Ministry of Health and Social Services
NAEC	National AIDS Executive Committee
NASA	National AIDS Spending Assessment
NCD	Non-communicable disease
NEMList	Namibia Essential Medicines List
NHI	National Health Insurance
NMBF	Namibia Medical Benefits Fund
NSF	National Strategy Framework for HIV/AIDS
N\$	Namibian Dollars
OOP	Out-of-pocket expenditure
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PER	Public Expenditure Review
PHC	Primary Health Care
PMDRC	Policy Management, Development and Research Committee
PPP	Public-private partnership
PSEMAS	Public Service Employees Medical Aid Scheme
RCM-TAC	Response Coordination and Management Technical Advisory Committee
RM-TWG	Resource Mobilization Technical Working Group
SDG	Sustainability Development Goal
SHI	Social Health Insurance
SHOPS	Strengthening Health Outcomes through the Private Sector project
SID	Sustainability Index Dashboard
SSC	Social Security Commission
TB	Tuberculosis
THE	Total Health Expenditure
UHC	Universal Health Coverage
UHCAN	Universal Health Coverage Advisory Committee of Namibia
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organisation

Introduction

Sustainable health financing is becoming an increasingly important priority to the Government of the Republic of Namibia due to the current economic climate in Namibia, which has resulted in the contraction of economic growth, a reduction in Government revenues and the need for significant government budget cuts. This situation is further exasperated by the continuous decrease in donor funding for health, especially HIV interventions, which are largely donor-funded. Beyond sustaining the current health response, the government is also committed to the achievement of Universal Health Coverage (UHC) and has made it a priority to make operational progress towards this goal. One of the main objectives of UHC in Namibia is to ensure that the country's most vulnerable populations are able to access essential health services, such as HIV/AIDS prevention, treatment, and care programs, without having to carry an excessive financial burden. To achieve this goal, the country's health system needs to be strengthened further in terms of ensuring equitable access to quality health services to all population groups, while at the same time expanding the fiscal space for health to finance the scale-up of health services.

The African Collaborative for Health Financing Solutions (ACS) has received a buy-in from Namibia for a 2-year period with the aim of supporting the country's advancement towards UHC and sustainable financing for HIV/AIDS. More specifically, ACS as a project aims to assist countries to identify operational challenges in advancing implementation of health financing policies that support movement towards UHC. The project will support building multi-stakeholder processes and collective solutions in and among countries to help solve them, including developing targeted learning agendas, communications opportunities and advocacy and accountability activities. ACS is currently in the process of identifying suitable activities that it can undertake to support Namibia's efforts towards ensuring sustainable financing for the HIV/AIDS response and making progress toward UHC in the country.

This landscape of sustainable financing and UHC in Namibia describes the status of completed and planned activities undertaken in Namibia to drive forward to the sustainability of health and HIV/AIDS and the UHC agenda. It further sets out the key challenges and information gaps that would need to be addressed in order for the country to make operational progress towards a robust health system and sustainable health financing mechanisms required for UHC and the sustainability of the HIV/AIDS response. It provides recommendations on possible activities that ACS could undertake, which would build on the activities undertaken in the past and complement ongoing activities and research.

Sustainability and UHC efforts in Namibia

The sustainability of the health response, and particularly the HIV/AIDS response, has been a high priority for the Government of the Republic of Namibia for a number of years and as such has commissioned various efforts to secure sustainable health financing. Given the high burden of the HIV/AIDS epidemic in Namibia and the response's significant vulnerability due to donor reliance, many of these efforts have focused specifically on the sustainability of the HIV/AIDS response. While many of the efforts to achieve UHC or strengthen the health system in general have included a specific focus on HIV/AIDS, there have also been numerous initiatives that were conducted in parallel to the UHC and overall health system sustainability activities.

The Ministry of Health and Social Services (MoHSS) has the primary mandate for the achievement of UHC and has been working in collaboration with the Social Security Commission (SSC) in past years to define Namibia's path towards its achievement. One of the critical first steps, through which the country gained momentum on issues relating to UHC, was for the MoHSS and SSC to consider the introduction of a National Health Insurance fund. In accordance with the Social Security Commission Act No. 34 of 1994, the SSC has the mandate to establish a Namibia Medical Benefits Fund (NMBF). This fund was envisioned to provide health insurance benefits to the employed population, in line with

the other funds of the SSC, such as the maternity, sickness and disability fund or the employees' compensation fund. This set-up implies that the fund would essentially function as social health insurance, whereby the funds are usually financed jointly by employers and employees through payroll deductions and only those who contribute are entitled to benefits. The challenges that Namibia's healthcare system is facing relating to inequities in health and the limited access to quality health services, particularly by the poor and vulnerable populations, gave rise to the idea that the NMBF should be expanded to a more comprehensive National Health Insurance (NHI), which would allow for the extension of health coverage to these poor and vulnerable populations that do not form part of the employed population typically covered by the SSC.

The concept of pursuing NHI in Namibia was presented at a stakeholder workshop in September 2011, which aimed to provide basic overview and training on the concept of NHI and to engage in consultations with a broad spectrum of stakeholders (both public and private) on the proposed approach to health insurance in Namibia bearing in mind the frameworks and challenges encountered in other countries. The workshop was facilitated by the USAID-funded Health Systems 20/20 project in collaboration with the Social Security Commission of Namibia and Deloitte Consulting South Africa. It was agreed that the feasibility of NHI, including possible financing and operational models, should be explored further by the government through the SSC with the support of an advisory committee comprising a broad range of relevant stakeholders.

Through further discussions between the MoHSS and the SSC, the mandate of the SSC to investigate the options for NHI was expanded even further to address UHC more broadly. As such, the SSC was requested by the MoHSS to take on the mandate for the achievement of UHC in the country. The Universal Health Coverage Advisory Committee of Namibia (UHCAN) was established as a sub-committee of the SSC's board of directors for this purpose to advise and guide the SSC as the Secretariat on matters relating to UHC in the country. The objective of UHCAN was to provide guidance to the MoHSS through the SSC on the development of sustainable systems and policies to achieving UHC in Namibia with a focus on compiling evidence and developing alternative policy approaches specific to the Namibian context. The SSC secured financial support for the UHC activities, the operations of the UHCAN Secretariat and the UHCAN meetings through a grant from the African Development Bank. Furthermore, the USAID-funded Health Finance and Governance project provided technical support to the UHCAN and its Secretariat. Under the guidance of the UHCAN, various background studies were performed to allow the committee to provide evidence-based advice to the MoHSS. These studies included a health financing review, burden of disease study, a unit cost and quality assessment study, an efficiency study and a health system review. The studies and their key findings are discussed in more detail in the next section below. Furthermore, selected members of the UHCAN participated in study tours to Ghana, Germany, Thailand and Mexico to learn from the experiences in these countries in setting up systems and mechanisms for sustainable financing, defining the benefits package and expanding the coverage of pre-payment mechanisms to poor vulnerable populations.

The African Development Bank grant ended in August 2016 and with that most of the activities undertaken through the SSC ceased. As a result, the secretariat role that SSC had been playing for the UHCAN shifted to the MoHSS. The ministry has built on the progress to date and is currently finalizing the necessary ground work to start moving towards the implementation phase. In support of this effort, the World Bank has developed a policy framework for UHC, which summarizes the main health policies taking into consideration the ability of Namibia's economy to sustain UHC, the structural framework of the health system, and the internal capacity of government to manage the proposed system.

In addition to the activities undertaken by the MoHSS and SSC with regard to the UHC agenda, the MoHSS through the Directorate of Special Programs also conducted various studies and received technical assistance to obtain guidance on the sustainability of the HIV/AIDS response. These efforts included the development of a sustainable financing report in 2011, the investment case in 2016, various costing exercises and a HIV/AIDS sustainability framework. Most of these efforts were guided by the Resource Coordination and Management Technical Advisory Committee.

Completed activities and studies

The Government of the Republic of Namibia and its development partners have made significant efforts to secure sustainable financing, move towards UHC and strengthen the health system for improved sustainability. This section summarizes the studies and activities undertaken to date in relation to sustainable financing for health, and specifically for HIV/AIDS and UHC.

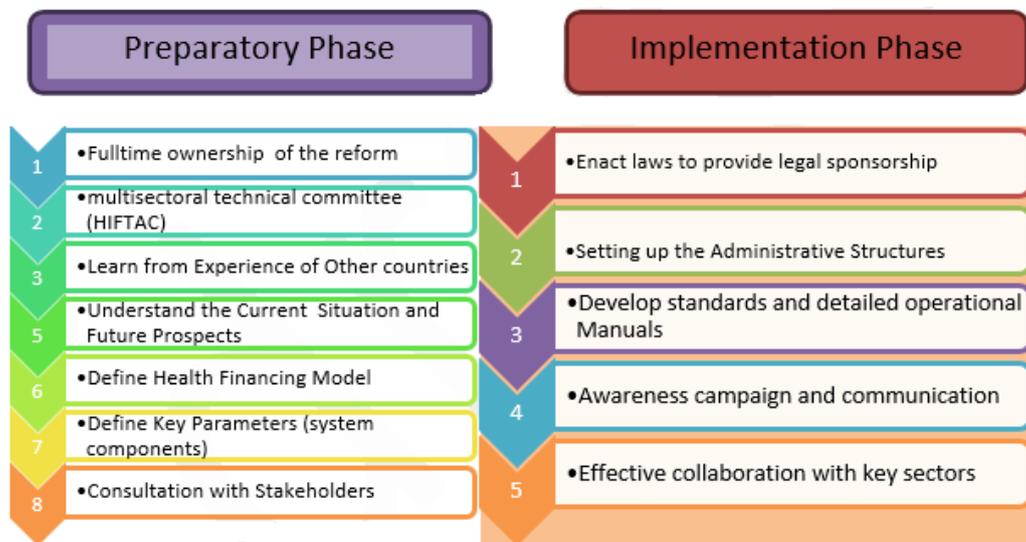
1. Roadmap for Implementation of NHI in Namibia

While the SSC has the mandate to establish the NMBF, it was agreed during the September 2011 Health Insurance Workshop that every effort should be made to look into the overall picture of socio-economic disparities, health systems and the current health insurance market of Namibia and the possibility of NHI being introduced as a suitable mechanism to ensure universal coverage. The roadmap was developed in 2012 and tries to take a comprehensive look at health financing and the proposed solution (NHI) rather than a narrow focus on NMBF. The Roadmap for Implementation of NHI in Namibia contains an integrated and comprehensive overview of the current situation and suggests a sequence of activities that need to be implemented in a systematic manner in order to introduce NHI in the country. The Roadmap aims to provide practical guidance to SSC, MoHSS and other key stakeholders to design NHI that will help the Republic of Namibia achieve universal health coverage. It was developed by the Health Systems 20/20 project of Abt Associates with funding from USAID. The roadmap was submitted to the MoHSS and SSC for their consideration, but was never approved or adopted for implementation due to the decision that financing options should be explored more broadly instead of solely focusing on NHI.

The roadmap provides an overview of the Namibian health sector in terms of national policies and strategies, the country's health status, organization of health services, human resources for health, pharmaceutical system, health information management system and health financing situation. It argues that only a limited portion of the population is covered by health insurance (either the Public Service Employees' Medical Aid Scheme (PSEMAS) or private medical aid funds) as a result of the premiums being unaffordable to the majority of Namibians. Furthermore, the revenue-raising capacity in Namibia is limited mostly as a result of the large informal sector and the high unemployment rate. In addition, the fragmented financing system, the inefficient purchasing arrangements and variable local management capacity particularly at decentralized environments call for the design and implementation of NHI that will ensure appropriate functioning of the existing financing systems and provide coverage for the uninsured.

The overall objective of designing and implementing NHI is to promote equitable access to sustainable and optimum quality health care and increased financial protection for the people of Namibia. In the Namibian context, NHI is a system of health insurance established to ensure universal coverage to all segments of the population. As such, NHI could be a combination of the existing health insurance systems (PSEMAS and private schemes) plus new models of health insurance designed in such a way that the overall system works efficiently while ensuring optimum population and benefits coverage for all people. It could also involve significant reforms, such as converting PSEMAS to SHI for the formal sector employees, establishing CBHI for the informal sector employees, and a system of government subsidies for the unemployed to ensure coverage from either CBHI, SHI or private insurance schemes.

Taking the current context in Namibia into account, this roadmap outlines two major phases of developing and implementing NHI. The two broad phases are preparatory phase and implementation phase (See the diagram below).



There is a strong momentum through the leadership of the Social Security Commission to move the necessary reforms forward that will contribute significantly to universal coverage of health. This momentum has been supported by key stakeholders such as the MOHSS and development partners, but needs to be guided with caution and key decisions should be made based on robust analysis of relevant information and full understanding of their consequences. To this end, this document provides a roadmap to Social Security Commission by elaborating on the concepts, key factors and objectives of a sequence of events that should take place in Namibia.

Although this roadmap was developed in 2012, it was never implemented due to the MoHSS and the SSC changing their focus from introducing NHI to achieving UHC. It was agreed that NHI should be evaluated and assessed as one of the possible health financing options available to Namibia, instead of proceeding without further investigations that would allow the government to make evidence-based decisions. If Namibia does decide to pursue NHI as suitable financing option, this roadmap should be revisited as it could serve as guide for the process.

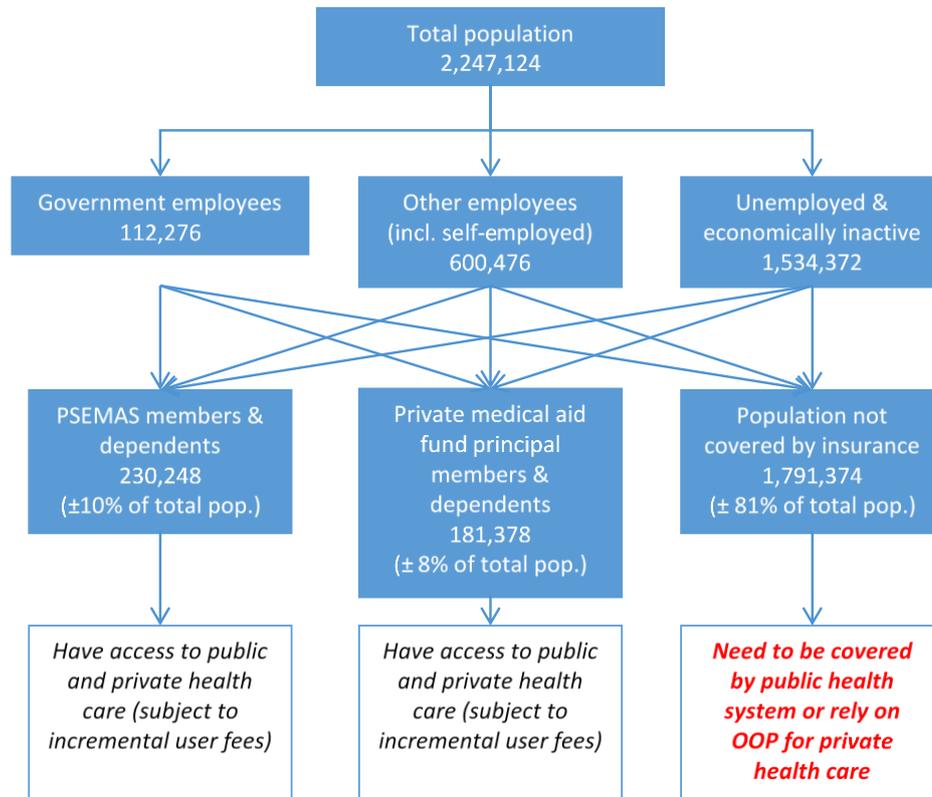
2. Health Financing Review

The Health Financing Review is one of the first background studies that was commissioned by the UHCAN and was conducted by the Health Finance and Governance project of Abt Associates with funding from USAID. The technical lead for the review was Dr. Carlos Avila, who was supported by Elizabeth Ohadi and Claire Jones. The objective of the health financing review was to provide a comprehensive summary of the health financing situation in Namibia to allow the government to have the required evidence to inform the identification of sustainable health financing options to ensure timely and equitable access of quality health services. It includes a review of the fiscal context, health expenditure trends, health financing arrangements and administration. It also assesses the risk pooling arrangements, level of financial risk protection, equity in health financing and use of services, quality of health services, and health system efficiency. The Health Financing Review further analyses the Namibia's status in terms of UHC and the key shortfalls and challenges faced by the country in relation to the achievement of this goal. Finally, it provides guidance on the key decisions that need to be made in order to move towards UHC, including the revenue collection, risk pooling, purchasing mechanisms, population coverage and benefits packages. Recommendations on the way forward and the next steps required to make progress towards UHC are also provided. A summary of the key findings is included below.

The key findings include the following:

- The fiscal space of Namibia indicates that there is potential for increasing financial resources for the health sector in the medium term, although in the short-term the economic conditions are likely to limit the ability of the government to secure and allocate significant additional resources for health.
- While Namibia's 13% of general government spending allocation to health falls slightly below the Abuja target of 15%, it does reflect a strong government commitment to health and the increase in government spending on health over recent years is a strong indicator for health financing sustainability.
- Namibia's dependence on external resources for health has decreased by 13% from 2009 to 2013, but with 8% of Namibia's health expenditures being funded from external resources in 2013 it has the highest dependency in the region, leaving the country's health response being dictated by the availability of external resources.
- Namibia's OOP expenditures are substantially lower than the regional mean, which implies that the potential to cause financial catastrophe for individual households is limited.
- Despite the private medical aid industry being well-established, the population covered through these funds (8% of Namibia's total population) is quite limited compared with international trends toward national health insurance.
- PSEMAS, which covers the public service employees of Namibia does not have to adhere to the same solvency requirements as private medical aid funds since the balance of expenditures that exceed the employee contributions are covered by the Treasury. Only 15% of the total funds required for PSEMAS are paid by the employee contributions, while the remaining 85% is subsidized by the government. The contributions are based on a flat rate regardless of salary level, which makes the contributions highly regressive.
- There are significant differences in per capita budgetary allocations between regions, even after considering the percentage of services provided by referral hospitals as part of the region-specific health services. The MoHSS has drafted a resource allocation formula based on factors including population size, burden of disease, poverty, and cost differences, but no final policy decision has been made on this matter.
- An analysis of staffing in public health facilities found significant disparities between and within regions, while another study found regional differences in the use of skilled providers during delivery, resulting in differences in maternal health outcomes.
- Prior studies show that many of the district hospitals operate at technical efficiency levels well below the efficient frontier, concluding that the health system could reduce the total resources for hospitals by an estimated 26% to 37% if they were to operate more efficiently (Zere et al. 2006). Another study, by Low et al. (2001) found that the referral of patients to intermediate hospitals is not functioning effectively, allowing patients to access these facilities directly, which means that they are treated at higher cost than necessary, the higher-level systems become overburdened by the workload, while lower-level and less costly facilities become underutilized, resulting in inefficiencies.
- In the private sector, there are serious concerns about the escalating costs of health care. The 2012/13 health accounts results show that approximately 37% of total health expenditures were paid by medical aid funds, while in 2008/09 this figure was approximately 28%. Conversely, the percentage of the population covered by health insurance increased only by approximately 1% over the same five-year period. These results imply that the costs of private healthcare are escalating significantly, which is likely to affect the affordability of medical aid packages and ultimately the level of risk pooling in Namibia as members start to resign from the medical aid funds.
- Despite the government's strong commitment to the achievement of UHC, challenges remain in terms of ensuring equity in access, adequate health benefits coverage, and financial protection

particularly for the poor. The figure below illustrates how the Namibian population is currently covered in terms of health services.



- The figure highlights one of the greatest challenges of the health system, which is its fragmentation and differences in health coverage between those who are covered by PSEMAS, those who can afford private medical aid, and those who have neither. Specifically, an estimated total population of 1.79 million or approximately 81% of the Namibian population remains uncovered by a medical aid fund and thus is reliant on either the public health system for access to health services or on OOP payments for private health care. Annual health spending for the 81% of the population without medical aid coverage is US\$209.00 per person, while it is more than three times greater for those with medical aid at US\$700.00 per person. These aspects and other inequities in Namibia need to be considered when defining the population coverage.
- While the public and private health sectors in Namibia are well-established and some progress has been made on the establishment of the NMBF, the Government of Namibia, with the advice of the UHCAN, still needs to decide on the ultimate structure of the health system, revenue collection mechanisms, pooling of funds, purchasing mechanisms, and the population coverage and benefits package.
- In terms of revenue collection, the WHO recommends that health care financing be secured through mandatory prepayments (by means of either a mandatory health insurance system or government spending through taxation) to ensure the sustainability of revenue for health and to achieve the goal of financial risk protection.
- Therefore, the population not covered by a medical aid fund should be covered either through an expansion of the mandatory NMBF or through government spending raised from taxation. The implications of introducing the NMBF or increasing taxation need to be fully analyzed and considered in terms of affordability, effects of on the economy and employment levels, impact on the health system and its capacity to supply health services, implications and continued affordability of medical aid funds, and roles of private health care providers.
- Purchasing models include capitation, fee-for-service and pay-for-performance and can be used as a major lever to achieve desired health goals. Paying for results and value for money are

therefore relevant objectives of a well-functioning purchasing system. Purchasing arrangements should further consider the availability of providers and their levels of quality and efficiency.

- The package of services should be based on criteria including health needs, cost-effectiveness, affordability, financial and social protection, demand and supply, opinion of the scientific community, and social acceptance. It may be decided to have one package of benefits for the entire population or different packages for different population groups based on specific criteria and determinants.

As the way forward, Namibia needs to develop and implement innovative health financing reforms. In order to decide on which reforms to implement and financing options to pursue, the MoHSS should conduct a comprehensive assessment of funding options as part of a feasibility study. Furthermore, one of the most critical aspects of health financing is the relationship between pooling and purchasing. Once the feasibility study has been completed and agreement is reached on the funding options, benefits packages and population coverage, a comprehensive health care financing strategy should be developed to define the health financing model that, integrated with other health system building blocks, will provide accountability and long-term sustainability, and better health for Namibia. Strategies to successfully implement UHC need significant political commitment and support from decision makers, service implementers, and civil society.

3. Actuarial report on the design of the NMBF

The Social Security Act 34 of 1994 provides for the establishment of a NMBF which is to provide for the payment of medical benefits to employees. In order to explore the options of operationalizing this fund, the SSC commissioned the Actuarial and Analytical Solutions Department of Deloitte South Africa to conduct analyses on the fund's feasibility and financing options. The report is a comprehensive consolidation of strategic research, health care expertise and actuarial analysis. It focuses on four key areas including a review of the policy framework, the medical insurance industry and market in Namibia, actuarial analyses of the possible design, structure and financing of the NMBF, and an assessment of possible administration models and the impact of relevant stakeholders.

The NMBF is meant to provide for the payment of medical benefits to employees and requires registration of every employee of every employer, except if he or she is a member of any other medical aid fund or scheme approved by the Minister on recommendation of the Commission. The NMBF is intended to ensure that all employed persons are members of a medical fund. Based on the literature review of international experience, the objectives of the NMBF are consistent with the Bismarck Social Health Insurance (SHI) model where all employed persons form part of a prepaid health arrangement. It is therefore distinct from more universal health systems such as National Health Insurance which is extended to the unemployed population, and in which all have access to healthcare facilities and services irrespective of ability to pay.

The Namibian tax system has undergone continuous reform since independence which has brought about numerous improvements. The tax system is perceived to be equitable and transparent, and after the introduction of the value-added tax in November 2000, tax collection has significantly improved. Countries who have implemented Social/National Health insurance typically have a considerably higher total tax rate. If Namibia is to fund the NMBF through taxes it may need to increase the tax rate to accommodate this, but such an increase in taxation will have many other implications that will need to be considered, including the effect on GDP and economic growth. Alternatively, the government may need to redistribute its current budget to allow for greater spending on health. Decisions will also need to be made on how the NMBF contributions should be collected via individuals and/or employers to ensure that all claim costs and expenses can be covered. The collection of contributions from the self-employed, however, remains challenging due to the variability of the

income, the inability to verify the accuracy of the income stipulated, as well as the difficulty in locating the self-employed.

An overview of the current healthcare environment in Namibia revealed that the Namibian government is the main provider of healthcare services in Namibia, with the private sector and mission facilities playing supporting roles. The total number of beneficiaries covered by medical schemes, including PSEMAS, was approximately 320 000 people during 2010. Given that the total population in 2010 was estimated by the US census bureau to be approximately 2 million, this implies that approximately 1.68 million uncovered Namibians are forced to make use of public health facilities where an out-of-pocket method of payment is required. The NMBF should be designed in such a way to address some of the key challenges faced by the Namibian health system, including geographic and financial access to health care, universal health coverage, equity in health care, its financing and resource allocation, quality of health care, responsiveness, and sustainability.

This report analyzed various benefit packages and membership base combinations, however the optimal combinations are highly dependent on the interpretation of the Social Security Act and the financing constraints of the NMBF. The results of the actuarial costings undertaken shows the expected costs per family per month for three different benefit packages as at the beginning of 2012: a Hospital benefit package at N\$ 1196.68; a Hospital + Day-to-Day benefit package at N\$ 2535.78 and the PSEMAS package at N\$ 998.46. These costs were appropriately adjusted to reflect the expected costs under implementation of a number of different possible NMBF target populations. The Act states that any employed person who is a member of any other medical aid fund or scheme approved by the Minister on recommendation of the Commission is exempt from contributing or becoming a member of the NMBF. Since it is not clear whether or not PSEMAS can be considered a medical fund and therefore whether it will form part of the NMBF, various interpretations were used for analysis purposes. The scenario whereby PSEMAS is considered a medical aid fund and its members are therefore excluded from the NMBF would limit the funds sustainability due to the small target population, although the fund would then be easiest in terms of administration and implementation due to a lack of any reform required. The second scenario assumes PSEMAS is not a medical aid fund and therefore its members would not be exempted from the NMBF. With the broader membership the NMBF would be more sustainable as a result of the larger risk pool, while a reform of PSEMAS would also allow the opportunity to improve its sustainability. The third scenario assumes that the legislation is revised to remove the exemption clause completely, which would entail that all employees become members of the NMBF. This scenario would allow for the greatest risk pool, which would mean that there is scope for extensive risk and income cross-subsidization. However, the need to revise the legislation relating to both PSEMAS and the medical aid industry could prevent this scenario from becoming viable.

Implementing the NMBF at its full membership base level from the outset faces many practical problems and leaves little room for error in terms of administration systems, pricing correctly, collecting contributions and taxes and ensuring optimal service delivery of benefits. It is therefore recommended that a phased approach be adopted by gradually adding various population sub-groups until the target population is reached and the legislation's objectives are met.

4. Burden of disease study

The Global Burden of Disease (GBD) study was another background study initiated by the UHCAN. The GBD study aimed to provide insight into the main drivers of poor health at international, national, and local levels. Coordinated by the Institute for Health Metrics and Evaluation (IHME), GBD measures all of the years lost when people die prematurely or suffer from disability. It estimates healthy years lost from over 300 diseases, injuries, and risk factors from 1990 to 2013. The GBD study in Namibia titled “*Namibia: The State of the Nation’s Health*” was performed through a collaboration between the WHO Namibia Country Office and IHME.

While the life expectancy in Namibia decreased by nine and 12 years, for males and females respectively between 1990 and 2004, mainly due to the HIV/AIDS epidemic, it rebounded and rose by 11 years for females but only by six years for males between 2004 and 2013. Life expectancy for males in 2013 was still below 1990 levels.

The peak of the HIV/AIDS epidemic occurred in 1998, which was followed by a dramatic decline in the number of new cases for both males and females. Rates of death from HIV/AIDS peaked in 2005. By 2013, death rates had more than halved for females, and almost halved for males. Despite Namibia’s progress in the fight against HIV/AIDS, it remains the leading cause of death and premature mortality for all ages, killing up to half of all males and females aged 40-44 years in 2013. Tuberculosis and lower respiratory infections were the next leading causes of death and premature mortality in 2013, behind HIV/AIDS.

Non-communicable diseases (NCDs) as causes of premature mortality, disability, and total health loss (DALYs) rose in importance over the period 2000 to 2013. Significant rises were observed for stroke, low back and neck pain, ischemic heart disease, depressive disorders, COPD, and diabetes. In contrast, significant decreases were observed for some communicable conditions, including diarrheal diseases, neonatal conditions, and malaria. Injuries, including suicide (self-harm), road injury, and homicide (interpersonal violence), disproportionately killed young males in 2013. Almost half of all deaths in males 20-24 years old are from injuries, compared to just 15% for females. Among the injury categories for males 20-24 years old, self-harm was the leading cause of death, followed by interpersonal violence.

Risk factors are key drivers of the diseases and injuries that kill people prematurely. Unsafe sex was the leading risk factor for death for both males and females. Alcohol and drug use was the second-leading risk for males, rising from eighth in 2000. As Risk factors for non-communicable diseases, particularly cardiovascular disease, high blood pressure, poor diet, obesity/overweight remained among the leading risks of death for both males (third, fourth, and ninth in 2013, respectively) and females (second, third, and fourth in 2013, respectively). Despite increased global awareness of health risks of tobacco smoke, it remains a leading risk for males (fifth) and females (ninth).

Compared to other countries in sub-Saharan Africa, only Botswana had a higher life expectancy for both sexes combined in 2013 (66 years versus 61 years for Namibia). In 2013, Namibia had the lowest rate of new cases of HIV/AIDS, and the lowest mortality rate from HIV/AIDS among countries comprising southern sub-Saharan Africa (Botswana, Lesotho, Swaziland, South Africa, and Zimbabwe). Of these six countries in the southern sub-Saharan African region, Namibia had the third-highest rates of injury deaths among males.

5. Unit cost and quality assessment study

The unit cost and quality assessment study was commissioned by the UHCAN as a background study to be used to inform the feasibility study on UHC options. The Health Finance and Governance project of Abt Associates conducted the study with funding from USAID. The quality assessment component of the study was sub-contracted to PharmAccess who facilitated the SafeCare health facility quality assessments. The technical lead for the study was Altea Cico, with the other technical team members being Stephen Musau and Claire Jones. The purpose of the study was to estimate the unit costs of health services, which would in turn provide a basis for the estimation of the total costs of health services to inform the total funding requirements for UHC. The quality assessment component of the study aimed to understand the impact of differences in the quality of health services on the unit costs among health facilities at the same level of care. The study covered health facilities in both the public and private sectors. Furthermore, the study covered health facilities at different levels, including referral hospitals, district hospitals, clinics, and health centers since these facilities provide different packages of health services and have different overhead costs.

The total cost of outpatient care per visit ranges from Namibian dollars (N\$)313 in health centers to N\$1,934 in private health facilities. In public facilities, the average cost of outpatient care is N\$507. On average, staff costs constitute the majority of outpatient costs across all facilities (55%), followed closely by clinical supplies (34%). The total cost of inpatient care per patient day ranges from N\$1,239 in district hospitals to N\$4,265 in private health facilities. In public facilities, the average cost of inpatient care is N\$1,296. On average, staff costs constitute the majority of inpatient costs across all facilities (56%), followed by clinical supplies (31%).

Higher overall facility quality and quality of primary health care and inpatient care scores are correlated with higher outpatient and inpatient unit costs, respectively. Furthermore, higher numbers of visits per doctor, per nurse, and per any type of medical staff are correlated with lower outpatient unit costs. A higher number of beds per doctor is correlated with higher inpatient unit costs, while higher numbers of beds per nurse and per any type of medical staff, as well as higher average length of stay, are correlated with lower inpatient unit costs.

Private facilities had higher outpatient and inpatient costs and scored higher on almost all quality indicators, including overall quality, compared with public facilities.

The findings of the study confirm the link between costs and quality, which suggest that lower costs do not necessarily buy adequate quality. However, due to the low sample size and possible endogeneity, these analyses are not intended not be conclusive, but merely to suggest areas for further investigation. The results do, however, suggest that it is important to take quality considerations into account when making reimbursement decisions. It is recommended that further analysis be carried out to explore how quality improvement efforts impact costs. It is further recommended that financial management systems are improved and further decentralized in order to allow for tracking of expenditure data at facility-level, which would improve the accuracy of conducting similar studies in the future.

6. Efficiency study

The efficiency study of district and referral hospitals in Namibia was another background study requested by the UHCAN to inform the feasibility study on UHC options. The study was performed by the Health Finance and Governance project of Abt Associates with funding from USAID. During the planning and data collection phases of the study the technical lead for the study was Dr. Carlos Avila, but this role was passed to Tesfaye Ashagari for the analysis and reporting phases of the study. Technical team members included Claire Jones, Romana Haider and Enoch Chang.

The objective of this activity was to identify ways of expanding Namibia's fiscal space for health and HIV through technical efficiency gains at district and referral hospitals in the country. The reprioritization and efficient use of resources to create fiscal space in the MoHSS budget was deemed particularly important to secure the continued provision of priority health interventions within the context of the economic downturn in Namibia and the trend of decreasing donor resources as a result of Namibia's classification as an upper-middle-income country. Since hospitals consume a significant portion of Namibia's total health budget, with 59% of public health expenditures being spent at government hospitals alone (2016/17), hospitals are central to achieving improved efficiencies in the public health sector. Data Envelopment Analysis was used to calculate hospital efficiency scores and benchmark the hospitals relative to the group's observed best practice. Interviews were conducted with key staff of selected hospitals to complement the quantitative data collected.

Fifty-two percent of the hospitals included in this study were found to be technically inefficient, which means that they could improve their operations in order to be more efficient. The mean technical efficiency score for these inefficient hospitals was 81%, which means that overall efficiency savings of 19% on inputs could be realized without affecting the output levels. In terms of scale efficiency, the vast majority of hospitals had a scale efficiency score of less than 100%, with a mean scale efficiency score of 71%. This implies that the input–output mix in these hospitals is inefficient. Most of the scale-inefficient hospitals showed increasing returns to scale (IRS), which means that the hospitals' outputs should be increased to reduce the unit costs. Since the outputs are driven by the demand for healthcare services and are mostly out of the control of the hospitals, the size of the hospitals should be reduced to improve the scale efficiency. The scale efficiencies differ between district and referral hospitals and can be improved by strengthening the referral system.

The most significant efficiency savings can be achieved through improved redistribution of clinical staff and allocation of non-salary-recurrent expenditure budgets. Assuming that all facilities would address these inefficiencies, the total savings for the relevant hospitals would amount to 32% in clinical staff costs and 46% in recurrent expenditures. In the short term, there are two critical considerations for the ministry—the reallocation of clinical staff and the introduction of an appropriate resource allocation formula that would allow for resources to be allocated to regions and their respective health facilities and hospitals according to the health needs and utilization of health services.

7. Resource tracking

The 2015/16 and 2016/17 resource tracking exercise was led by the Policy, Planning and Human Resource Development Directorate of the MoHSS with technical support from the HFG project of Abt Associates, WHO, UNAIDS and UNFPA. The methodology used for this exercise combined the Health Accounts and the National AIDS Spending Assessment (NASA) estimations of health and HIV spending, respectively, into one comprehensive and consistent exercise. It aims to provide the government and other stakeholders with key information on the resource flows for the health sector and for the overall HIV/AIDS response.

Total health expenditure (THE) in Namibia in 2015/16 was N\$15,180,629,910, of which 96% was recurrent spending and the remaining 4% of spending was for capital investments. Health care-related items such as social care for HIV-positive people and orphans and vulnerable children (OVC) (not included in THE above) totaled an additional N\$414,473,802. THE in 2016/17 was N\$15,319,679,910, of which again 96% was recurring spending and the remainder on capital investment. Health care-related items such as social care for HIV-positive people (not included in THE) totaled an additional N\$496,147,318. The government of Namibia has consistently made the largest contribution to health spending amounting to 56% in 2015/16 and 63% in 2016/17. The government contribution to healthcare was followed by the private sector at 39% in 2015/16 and 30% in 2016/17, and donors at 6% and 7% in the two respective years.

Of the funding that is managed by government, the majority (59% in both years) is spent on public hospitals. Public health centers and clinics consumed 15% of government-administered spending in 2015/16 and 13% in 2016/17. The majority of health expenditures managed by government are spent on curative care services, with inpatient curative care consuming 33% in 2015/16 and 34% in 2016/17, and outpatient curative care consuming 30% and 31% in the respective years. Spending on preventive care is relatively low, at 9 and 8% in the two years.

In 2015/16, infectious and parasitic diseases received the highest allocation of funds, 23% of THE. This was closely followed by non-communicable diseases (NCDs) and reproductive health, which consumed 20% and 16%, respectively. In 2016/17, the allocation for infectious and parasitic diseases increased to 26% of THE, while spending on NCDs and reproductive health declined to 19% and 14%, respectively. Within the infectious and parasitic disease category, HIV/AIDS and sexually transmitted diseases received the largest proportion of spending, 46% in 2015/16 and 50% in 2016/17. Namibia's disease burden is gradually transitioning from communicable to non-communicable diseases and this trend is reflected in the shares of health expenditures by disease. There is very limited reliance on donor funding for reproductive health and NCDs, with government financing the majority of these expenditures and a significant contribution from the private companies. However, the HIV/AIDS response in Namibia remains significantly financed by donors.

Total recurrent expenditure on the HIV/AIDS response (including health care-related interventions) amounted to N\$1,955,279,116 in 2015/16 and N\$2,366,494,096 in 2016/17. Additional amounts of N\$20,769,030 in 2015/16 and N\$92,050,920 in 2016/17 were spent on capital investments for HIV/AIDS. While the government financed the largest portion of the response in the two financial years, at 47% and 55%, the donor contribution to recurrent expenditure on HIV/AIDS remains significant at 38% in 2015/16 and 36% in 2016/17. The trend of decreasing donor resources is evident in the reduction of the donor contribution to the HIV/AIDS response, from 54% in 2012/13 to 36% in 2016/17.

The resource tracking results allowed for comprehensive analyses that informed the following recommendations:

- It is recommended that a critical review of health spending is performed to address cost-effectiveness, efficiency, access and equity of the health response. Although Namibia's spending on health in terms of THE as a percentage of GDP and THE per capita ratios exceeds its peer countries, its health outcomes as measured by the maternal, under-five, infant, and neonatal mortality rates are all below the average of its peers. This means spending it is not as cost-effective as it could be.
- The government should consider shifting service provision to the lower-level health facilities to improve efficiency and cost-effectiveness and to make the services more accessible. The considerably higher level of expenditure at hospitals in relation to health centers and clinics combined with the low spending on prevention services in relation to overall public spending are an indication that there is insufficient investment in prevention services and that the referral system may not be functioning effectively resulting in an unnecessary work burden on hospitals.
- Namibia should prioritize the development of a country-owned sustainability strategy for HIV/AIDS, which outlines the plan and actions required not only in terms of overall financing, but also, of all the resources required for each component of the response and the capacity of the systems to effectively manage the response without donor support.
- While increasing the domestic funding envelope, the government should also investigate ways to better engage the private sector to finance a greater part of the HIV/AIDS response. The private sector contributions for reproductive health and NCDs far exceed their contribution to HIV/AIDS, despite HIV/AIDS being the leading cause of death in Namibia. Partnership arrangements with private providers and pharmacies could improve accessibility and simultaneously ease the burden on the public health sector.

8. Policy framework for UHC

In 2017 the World Bank conducted a review of policies relating to UHC in Namibia and developed a UHC policy framework based on this review. The UHC policy framework summarizes the main policy actions presented in the Draft Strategic Plan 2017-22 for the Ministry of Health and Social Services, Namibia's 5th National Development Plan for 2017-22, Namibia's Health Accounts 2014/15, a Review of health financing in Namibia and Namibia's 2016 Burden of Disease report. The health policies identified in these documents were analyzed in the context of the ability of the country's economy to sustain UHC, the structural framework of the health system, and the internal capacity of the government to manage the proposed system.

The UHC policy framework was developed based on the functions of the health systems framework, which include leadership and governance, health workforce, health information systems, medical equipment, products and infrastructure, and health financing. The policy actions for each of these functions are outlined below.

Leadership and governance:

- Introduce school health and youth health education programs
- Improve road safety
- Assess health system performance
- Develop public sector referral system
- Strengthen public procurement
- Strengthen health data analysis and reporting
- Establish medical research council
- Define health financing strategy with implementation plan including role of NMBF
- Develop multi-sectoral approach to NCD prevention
- Decentralize health care
- Ensure strong health sector regulatory framework

Health workforce:

- Increase the number of health workers and health extension workers in low income areas
- Assess staff satisfaction
- Improve recruitment procedures
- Build capable workforce
- Accelerate training for and increase the number of health extension workers, nurses, pharmacists and doctors
- Decentralize health staff management and financing to lower levels

Health information systems:

- Ensure that key information about public health services are available online
- Introduce broadband infrastructure in health facilities
- Introduce integrated ICT e-health infrastructure in health facilities
- Synchronize health sector health information system
- Strengthen health data collection

Medical products, equipment, pharmaceuticals, infrastructure:

- Ensure essential products and equipment in health centers and clinics
- Ensure availability of NEMList medicines in health facilities
- Construct new, and renovate and maintain health facilities based on masterplan
- Establish maternal waiting homes
- Develop minimum standards for medical equipment, conduct medical technology assessment and update standardized list of equipment
- Strengthen medicines procurement and management and revisit NEMList to include needed medicines
- Ensure staff accommodation near health facilities in rural areas

Health financing:

- Set progressive PSEMAS contribution rates for government employees
- Apply proxy means tests to identify poor individuals who will receive health and insurance subsidy
- Introduce program-based budgeting
- Include performance and health criteria in budget allocation processes
- Strengthen public financial management in public health facilities to improve transparency
- Increase government spending on health and allocation to PHC
- Increase excise taxation
- Increase contribution payments public employees to PSEMAS
- Improve financial transfers from MVA fund to beneficiaries and hospitals

Service delivery in public sector:

- Improve access to community health care
- Improve provision of ECD
- Improved maternal and newborn health, nutrition and reduce fertility
- Improved immunization
- Improved management of Malaria, TB, HIV/AIDS
- Strengthen prevention and treatment of NCDs
- Improve emergency services
- Improve access to care to reduce waiting time for patients
- Set guidelines for quality of care
- Introduce standard treatment protocol and referral guidelines
- Improve efficiency in service delivery to reduce waiting time for patients

- Strengthen public sector to reduce referrals to private sector
- Invest in prevention to reduce risk factors

Service delivery in private sector:

- Contract with private providers to deliver specific services
- Outsource non-medical and ancillary services to private sector
- Develop strategy for public-private sector collaboration
- PPP for one new health facility

9. National Guidelines of health services integration

In July 2016, the MoHSS issued the national guidelines on health services integration, particularly for sexual and reproductive health and rights, HIV and other services. Support for the development of these guidelines was provided primarily by UNFPA with additional technical support provided by UNAIDS and WHO. The guidelines aim to set standards and procedures in implementing person focused integrated health care delivery at health facilities in Namibia. The guidelines delineate the key steps and procedures on how primary health care facilities can transform services from disease or population centred approach to person focused, integrated approach. The guidelines were developed based on the empirical evidence from 7 pilot sites for the integration of health services in Namibia.

The guidelines quote the WHO definition of health services integration as services that are managed and delivered in a way that ensure that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, at the different levels and sites of care within the health system, and according to their needs throughout the course of their lives. It further defines integration of health services at service delivery level for the users as a means of ensuring that the provision of health care is seamless, smooth and easy to navigate. Users want a coordinated service which minimizes both the number of stages in an appointment, the waiting time to get services and the number of separate visits required to a health facility. They want health workers to be aware of their health as a whole (not just one clinical aspect) overtime. For providers at service provision level, integration is defined to mean that separate services (their management support systems) are provided, managed, financed and evaluated either together, or in a closely co-ordinated way. At System and Policy Level, integration is defined to happen when decisions on policies, financing, regulation or delivery are not in silos. This means not only bringing together different technical programmes, but also considering the whole network of public, private and voluntary health services, rather than looking at the public sector in isolation.

The guidelines describe the benefits of integration and provide various options for models for integration including the onsite models such as a “one-stop” model where comprehensive services are provided in one room, the “super-market” model whereby integrated services are provided by several providers in different rooms in one facility requiring internal referrals, an “off-site” model where integrated SRHR and HIV services: are offered outside the facility through facilitated external referral and the “mixed model” where some services are initiated in one facility and provided in another facility.

The key steps for integration include an assessment, preparation and implementation and the guidelines set out the detailed steps and information requirements that will allow facilities to make informed decisions on how to implement the integration. It provides principles for implementation and tools and guidance for monitoring and evaluation.

A circular was issued by the MoHSS in September 2018 to clarify the purpose of the integration guidelines and highlight that the main priority of the guidelines is that Namibians should obtain the services that they require. Regions should ensure that the necessary skills and equipment are in place

for the integration to be implemented and that orientation and training is provided prior to implementation. It is noted in the circular that the health facilities that have high volumes of ART patients may not benefit from integration with primary health care services as a result of interruptions in services and spreading of limited resources for trained staff. Therefore, integration at these facilities should be delayed until such time that the critical mass has been trained. Furthermore, smaller facilities often already have integrated services by default and the planning, training and implementation of service delivery should continue to be reflective of this situation.

10. Sustainable Financing for HIV/AIDS in Namibia

The sustainable financing for HIV/AIDS in Namibia: Managing the transition towards a new AIDS financing strategy report was prepared for the Ministry of Health and Social Services by Tomas Lievens, Andrew Kardan and Ed Humphrey from Oxford Policy Management with support from UNAIDS in November 2011. The objective of report was to identify ways in which the Government of Namibia can ensure the predictable and sustainable availability of adequate financial resources for the AIDS sector up to 2020.

The financial resource needs for the AIDS Response in Namibia till 2020 were extrapolated using the *Revised Namibia National Strategic Framework 2010-2016 Costing* as a benchmark. The total resource needs were estimated to be approximately N\$ 4,464 million in the year 2020/21. The estimate of resource availability is supported by a macroeconomic framework ensuring consistency in the projections and capturing some of the interactions between HIV and AIDS spending and the economy. It is assumed that government's spending on HIV/AIDS as a percentage of total government spending on health will remain consistent and that the proportion of funding allocated to health in relation to total general government expenditure will remain unchanged. Donor budgets were used to estimate future donor contributions, while private sector contributions were also estimated to increase in line with nominal GDP. The resulting shortfall in funding for the HIV/AIDS response was estimated to commence in 2013 when declines in available resources fail to keep up with the rising resource needs. The gap was forecast to increase rapidly from N\$346m in 2013 to N\$1,360m in 2020. As a share of GDP, the gap increases to a maximum of 0.66% of GDP by 2018.

In order to fill the financing gap, potential alternative sources of funding were explored and assessed. From a number of possibilities, the study only focused on those that had a significant potential for additional resources, which were tested elsewhere and seen as promising by Namibian stakeholders. These included increasing contributions from public sector mainstreaming, the private sector, an airline levy and private health insurance. These additional sources of financing (excluding the health insurance option as it would take a longer time to implement) would reduce the financing gap from 0.6% of GDP to 0.3% of GDP by 2020.

A study comparing the technical efficiencies of AIDS service provision across countries showed that Namibia could improve its efficiency, as it achieved a technical efficiency score of 53%. If the country would have achieved full efficiency in 2007, then almost twice as many AIDS services would have been produced with the same resources; or the same level of services could have been achieved with half the resources. When efficiency gains materialize in the short run it is estimated that Namibia should not have an AIDS financing gap. The difficulty, obviously, is to identify the areas where efficiency gains can be achieved.

The report noted numerous challenges that the country is likely to face in light of the donor transitioning of funding for HIV/AIDS, such as service delivery efficiency and modalities, human resources for health and the integration into the MoHSS staff establishment, a health financing strategy to ensure adequate financing for health and HIV/AIDS, the continued financial sustainability and support for community-based organizations and the establishment of an AIDS Trust Fund.

In terms of next steps to move towards the development of an HIV/AIDS financing strategy, the report recommends that the technical working group is strengthened in terms of its mandate and participation. This enhanced technical working group should then conduct more in-depth analyses and investigations of key identified issues, including the review and validation of resource needs estimates, validation and refinement of the suggestions for alternative financing sources, efficiency savings, private sector involvement, health including AIDS financing, the role and financing of CSOs, and the AIDS Trust Fund.

11. Investment case for HIV/AIDS

The 2016 Namibia HIV Investment Case was developed to provide optimal policy options and program investment scenarios that will maximize impact on HIV incidence and AIDS mortality to end AIDS as a public health threat by 2030. The investment case modelled 3 policy scenarios, a) constant coverage, b) NSF and c) maximum. The investment case's maximum scenario was regarded as the most cost-effective option, despite being the most intensive in the short-term. This rapid scale up of short-term investment under the maximum scenario is expected to yield future savings of US\$ 339 million by 2033 with costs being 66% lower than expected future costs accrued under the constant coverage scenario. To meet the ambitious demands of the maximum scenario, the investment case recommended the development of a financial sustainability strategy as a next step in meeting the short-term and long-term HIV liabilities.

The Investment Case demonstrated that cost-effectiveness varies considerably according to intervention. Sex worker prevention programs, condom distribution, medical male circumcision and mass media save money when long term savings are factored in. Others show little evidence of being cost effective.

In terms of the scope for efficiency gains through improved spending allocations, the analysis shows that reallocating funding to the most cost-effective interventions is not enough to close the expected gap in funding. Other strategies would have to be implemented to improve the general cost effectiveness of the response. Potential strategies to consider further include:

- Identify ways to accelerate scale up and expand coverage of the most cost-effective prevention interventions, which should increase fiscal space over time
- Increase treatment coverage, whilst improving the effectiveness of treatment from at the policy and operational levels to ensure that high adherence and viral suppression rates are achieved
- Realize technical efficiency gains, through strategies identified that include reducing the cost of drug procurement and delivery, reducing clinical attendance for treatment and achieving other service delivery efficiencies at the facility level.
- Improved regional targeting.

12. Sustainability Index Dashboard

In November 2017, PEPFAR Namibia facilitated a stakeholder workshop to produce a Sustainability Index Dashboard (SID). The SID is completed every two years and supports the diagnosis, measurement and tracking of the country's progress in core domains required for a sustainable national HIV/AIDS response and helps guide planning to determine where further investments may be required. The 2017 SID 3.0 was completed using a highly participatory approach in collaboration with UNAIDS and involved wide stakeholder consultation to validate its results. Several sustainability elements showed vulnerabilities, including: commodity security and supply chain, HRH, public access to information, civil society engagement, private sector engagement, epidemiological and health data, and performance data. The critical vulnerabilities of the Namibia health sector in terms of sustainability as identified during the SID exercise are listed below:

Human Resources for Health:

- Reaching crisis level to due skilled staff shortages
- Inadequate distribution of health workers across public and private
- No formal plan to transition donor-supported HRH to the GRN
- GRN not fully using HR data for HRH planning and management
- Fiscal and budget constraints have resulted in a general hiring freeze, subject to waivers

Supply Chain Management:

- Stock outs and low stock for critical commodities and medicines (including ARVs and HIV rapid test kits).
- A new procurement act requires waivers for procurements not covered by centrally processed contracts.

Civil Society Systems and Responses:

- Reduction in participation in the national response due to decreased funding from the Global Fund and no mechanism to transition to domestic funding for key functions.

13. Review of HIV/AIDS sustainability

The draft review of HIV/AIDS sustainability in Namibia was completed in September 2018 through the Health Finance and Governance project. The review was conducted under the guidance of Stephen Musau as technical lead and the lead consultant Steve Cohen. Locally, the team was supported by Claire Jones as technical consultant and Rachel Basirika for administrative and logistical support.

This sustainability review provides a comprehensive assessment of the funding landscape for health and the programs, systems and enabling environment that drive a sustainable HIV/AIDS response. It provides a detailed review of the status quo of the different elements of a sustainable HIV/AIDS response in Namibia and of opportunities to improve sustainability. The review highlights a number of important issues for further interrogation and offers recommendations and options for increasing domestic resources and eliminating inefficiencies that should be explored in the next phase of sustainability planning.

The report defined a sustainable response as being achieved when:

- Populations in need have equitable access to cost-effective and efficient HIV/AIDS services supported by optimized national and regional health systems.
- The country remains on track to achieve medium and long-term milestones toward ending AIDS as a public health threat.
- The level of domestic resources required to achieve and maintain epidemic control is achieved through affordable multi-sectoral budget allocations and private sector contributions, complimented by innovative domestic financing mechanisms.

- Development partners contribute strategically toward funding and program gaps, with predictable levels of investment over the medium term, in accordance with the principal of country ownership.
- Namibia invests at least 30% of resources toward effective prevention interventions and HIV treatment as prevention is achieved through quality HIV care.

Government budget allocations for health and HIV over the medium term have declined in real terms since 2016 and are not expected to increase without a marked economic upturn and/or increase in the public revenue base. At the same time, both PEPFAR and the Global Fund have communicated their intention to reduce their investments in HIV/AIDS programs and to encourage greater domestic ownership of the response. With the decrease in donor funding and the scale up of HIV/AIDS services to achieve epidemic control, the funding gap is estimated to increase from N\$15 million in 2017/18 to N\$61 million in 2020/21. Addressing current inefficiencies in the health system is acknowledged as a critical option to increase the fiscal space for health, particularly since a number of inefficiencies were identified to affect the HIV/AIDS programs, including uneconomical procurement, poor stock control at the regional/ district levels, poor distribution of human resources for health, facility level inefficiencies and expensive centralized training. Other means of increasing the fiscal space for the HIV/AIDS response include the realignment of public health and development partner budgets, increased participation of the private sector, introduction of innovative financing mechanisms, improvement of the cost-effectiveness of service delivery modalities including better geographical and population targeting, strengthening the procurement of medicines and commodities, and the utilization of civil society in service provision.

In terms of transition planning, it is recommended that the government takes the lead in the process, which should comprise a systematic and proactive process with a particular focus on the programs and systems most vulnerable to significant reductions in development partner funding. The most critical areas identified for transitioning include the procurement of ARVs (the government agreed to take over the procurement of all ARVs from the Global Fund to the value of N\$90 million per annum), as well as the other areas identified as vulnerable including the skilled staff shortages reaching crisis level, stock outs and low stock for critical commodities, and decreased funding for, and participation from, civil society.

The next step on the sustainability planning agenda should be the development of a comprehensive HIV/AIDS sustainability strategy for Namibia, which should articulate detailed action-orientated plans and strategies toward a sustainable response and should also serve to guide the institutionalization of sustainability planning, implementation and monitoring into the national HIV/AIDS program and the broader health sector. The sustainability strategy also should evaluate the options for increasing domestic financing and creating efficiency savings, and specify detailed activities for the realization of those options. Further activities that would contribute to a sustainable HIV/AIDS response include transition readiness assessments and transition plans for individual HIV/AIDS programs, the development of an operational framework for implementing the Namibia fast-track/ maintenance strategy, and the strengthening of institutional arrangements to drive the sustainability agenda.

14. Costing of Early Infant Male Circumcision

The HFG project was requested to cost the introduction of early infant male circumcision (EIMC) in Namibia's public sector. While international results have shown that EIMC has numerous advantages over voluntary medical male circumcision as effective HIV/AIDS prevention intervention and requires only half the costs, there is insufficient cost data for considering the roll-out of EIMC in Namibia. The objective of the study is to provide data and information that will inform the ministry of the resource requirements for EIMC roll-out.

The unit costs of EIMC using the AccuCirc, Mogen clamp, and Shang Ring were estimated to be U\$32.48, U\$24.20, U\$31.06 respectively. The device and consumable costs were the major cost drivers, and the device cost itself was the largest portion of the total unit cost. Nurses will perform the procedure, and training will be provided to three nurses per hospital. Variations in staffing costs are due to time required to perform the procedure.

The budgetary impact of piloting EIMC in eight regions, including the costs of training and demand creation, ranges from U\$231,912 to U\$315,531 depending on the chosen device. In the first year of scale-up, the budgetary impact is estimated between U\$349,759 and U\$467,088.

It is suggested that an integrated model may strengthen and complement Namibia's existing maternal, newborn, and child health program, reduce costs, and help piloting and scale-up of EIMC. An integrated service delivery approach is a viable option for Namibia; however, service provider capacity and motivation need careful consideration.

15. Central Medical Stores assessment and turnaround strategy

In 2017, the MoHSS with support from PEPFAR and the Global Fund performed a comprehensive assessment of Central Medical Stores (CMS) with the aim of developing a turn-around strategy, with detailed recommendations to improve the organisation's operations, governance, management and overall capacity.

The assessment showed that CMS has an integrated supply chain with no vertical program separation. A comprehensive and robust information system is in place, which allows for detailed consumption data to be generated for use in the quantification and procurement processes. Furthermore, CMS has strong skills and expertise in-house, which enables them to prepare accurate quantification estimates to inform the procurement processes. However, CMS has in recent years undergone significant management and governance challenges, which has impacted on its service levels. In 2012, the MoHSS management started making changes to the management structure of CMS, denoting its importance within MoHSS, and altering the procurement arrangements to empower Namibian sources. Furthermore, in 2013 hospitals were no longer allowed to procure products through buy-outs (whereby health facilities were allowed to procure pharmaceuticals directly from private pharmacies or other suppliers to prevent stock-outs), which placed significant pressure on CMS in terms of product range and complexity. In 2016/17 the new Procurement Act came into effect, which was implemented without a comprehensively planned transition process in place. This resulted in the paralysis of the CMS procurements system, which required many of the donors assisting the MoHSS in making emergency procurements of ARVs to ensure that stock-outs are limited. In addition to the compromised operations of CMS as a result of the revised procurement arrangements, the infrastructure of CMS has become severely limited in terms of space while critical operational assets have started to fail. Furthermore, the fleet management responsibilities were transferred from CMS to the MoHSS, which adversely affected the maintenance and servicing of these vehicles.

One of the key recommendations to improve the management of CMS was to outsource selected functions to the private sector. Specifically, it was recommended that the transportation, warehousing

and storage operations are outsourced as a whole to ensure the retention of an integrated supply chain and less complex contractor management. It is further recommended that the MoHSS or CMS retain responsibility for the quantification, forecasting and supply planning, procurement, ownership of the physical infrastructure and the computer systems used to operate the integrated supply chain.

Ongoing and planned activities to support UHC and sustainable health financing

There are numerous activities that are ongoing that would inform the way forward in terms of the UHC agenda and ensuring the sustainability of health financing. This section provides a brief overview of the scope and objectives of these ongoing activities, while it also outlines activities that were proposed or considered for implementation, but have not yet started.

1. Extended public expenditure review

The World Bank has been requested by the Ministry of Finance to conduct the country's first Health Public Expenditure Review with an extended health financing assessment for Namibia's health sector. The objective of the public expenditure review is to identify inefficiencies and inequalities within the health sector and inform the government about future health financing options, their resource needs and fiscal impact. More specifically the PER will (i) examine trends in health financing, (ii) analyze issues related to equity and quality in improving health outcomes, (iii) identify health financing options and resource needs for these options, (iv) examine efficiency saving for the sector and (v) estimate the fiscal implications for the government. This PER builds on previous Bank assistance to the development of a UHC Policy Framework in Namibia, and work by other partners including the 2015/2016 National Health Accounts and Health Financing Review conducted with the support of USAID/HFG. Additional data on health financing and performance will be collected from the government and donors to conduct analysis and present options for health financing reforms. Recommendations will focus on measures to strengthen the efficiency and equity in health, on health financing options, the resources needed for these options as well as the fiscal implications for the government. This activity is co-financed by the World Bank, the GFATM and UNAIDS and is expected to be completed by June 2019.

2. National HRH investment plan

Namibia is challenged with shortages of health workers in certain key frontline health worker categories, low number of the Namibian versus non-Namibian health workers, reluctance of medical/health related students in taking up certain occupational careers, limited capacity of teaching hospitals, economic challenges resulting in inability to recruit new graduates, and out-dated/non-cost-effective policies. Therefore, the need was identified for a robust HRH long-term development plan, which spans the entire health system. For the public health sector, this plan will ensure that its health workforce is capable of meeting its operational objectives, that it obtains the right quality and adequate quantity of health workers it requires; makes the optimum use of its health workers, is able to anticipate and manage surpluses and shortages of health workers; and develop multi-skilled, representative and flexible workforce, which enables the Ministry to adapt rapidly to changing operational environment. This plan shall serve as Namibia's National Human Resource for Health Investment Plan, which will be used for the promotion and advocacy for investment in the country's health workforce. Ensuring decent work and improving job quality is a key to health systems strengthening and the attainment of health related and other SDGs. The National Human Resources for Health Investment Plan shall be a ten-year plan, which anticipates to addressing HRH production, equitable distribution and utilization of competent health workers, systems strengthening for effective planning, management, monitoring and evaluation of HRH processes to address health sector needs.

3. Malaria investment case

In collaboration with the MoHSS National Vector-borne Diseases Control Programme (NVDCP), the Global Health Group's Malaria Elimination Initiative (MEI) of the University of California, San Francisco is developing an investment case for malaria that will inform malaria programme budgeting and

strategic planning, domestic and international resource mobilization and advocacy in Namibia for malaria elimination.

The investment case for malaria elimination involves a stepwise estimation of the costs of elimination activities over time and comparing these costs with the purported economic benefits of elimination. A micro-costing approach will be used to capture the financial and economic costs associated with implementing interventions to eliminate malaria in Namibia. The estimated cost and benefits will be used to calculate a return on investment in malaria elimination, based on the direct costs averted to the health system and individual households and indirect costs averted to society (e.g. malaria morbidity and mortality). In addition, the financial landscape for malaria elimination will be assessed in order to determine any financial gaps, and propose mechanisms to mobilize additional funding. Identifying financial gaps and strategizing on mechanisms to mobilize resources will be critically important for achieving national malaria elimination goals in Namibia.

4. Update of the investment case for HIV/AIDS

As mentioned above, an investment case for HIV/AIDS was conducted in 2016 to provide optimal policy options and program investment scenarios that will maximize impact on HIV incidence and AIDS mortality to end AIDS as a public health threat by 2030. Since 2016 treatment and prevention policies and guidelines, unit costs, coverage results and targets have changed, which implies that the results of the investment case are outdated and no longer fully relevant. Therefore, the MoHSS has recently requested UNAIDS to update the fiscal space analysis and policy scenarios of the investment case to incorporate new data and targets.

5. HIV sustainability strategy

The MoHSS recognizes that a HIV-specific sustainability strategy is required as a critical next step in moving the sustainability agenda forward. The HIV sustainability strategy for Namibia is to be developed as the second phase in a two-phase process, following the development of the HIV/AIDS sustainability review as the first phase. The strategy should be comprehensive, following adequate stakeholder consultations and due review and approval processes. As part of the GRN's broader agenda of creating a more sustainable and integrated health response, it is critical that the sustainability planning process for the HIV/ AIDS programme should generate outputs and new pathways that contribute directly towards a more efficient and sustainable Namibian health sector. It is expected that the Namibia HIV sustainability strategy will articulate a roadmap to ensure that the ambitious NSF goals are achieved despite fiscal space constraints and declining financial participation from development partners.

6. Civil Society Sustainability Strategy for Namibia

The development of this civil society sustainability strategy was funded by UNAIDS and the process commenced in 2017. The aim of developing this strategy is to ensure that civil society organizations can continue to play an important role in the HIV/AIDS response once donor support to these organizations ceases. In Namibia there is a need to understand more critically, the Civil Society landscape and to map results that are more clearly attributed to civil society organizations in the HIV response. While government affirms its support of civil organizations, the experience by many if not most organizations is that government and its funding support has generally not been accessible to most civil society organizations. Donor partners have stressed the need for civil society organizations to actively explore sustainability strategies for the future that includes pursuing social enterprise and entrepreneurship opportunities. Opportunities for social contracting with government should also be explored further. It is expected that this strategy is finalized before the end of 2018.

7. ARV willingness to pay

USAID had planned to utilize SHOPS Plus (a USAID-funded project managed by Abt Associates) to conduct a market assessment of the demand for private provision of public ARVs at different price points and determine clients' preferences towards specific areas within Windhoek and/or specific pharmacies for such services to be made available. The assessment was planned to be conducted in two stages: 1) pre-survey rapid assessment and survey design, and 2) survey implementation and reporting. Assessing the feasibility of the private provision of public ARVs was regarded as a potentially valuable element towards increased efficiency and sustainability of the HIV/AIDS response, while also improving the accessibility of these services. One of the main arguments for conducting this willingness-to-pay assessment was the over-crowding and long queues in public ARV clinics. However, the MoHSS has recently implemented changes to its treatment protocols, allowing for the collection of ARVs for 3-month periods for stable patients and the distribution of ARVs through community-based groups. Therefore, the over-crowding and queuing at public ARV clinics is no longer considered as a critical need to be addressed by the MoHSS and the proposed assessment was rejected as a result. This activity is now to be changed to a feasibility assessment for the introduction of PrEP in the private sector, which is to be conducted by SHOPSPlus with funding from USAID. The specific terms of reference for this assessment are still being developed.

8. TB investment case

Similar to the investment case for HIV/AIDS and the investment case for malaria, it has been suggested that another investment case is conducted for the national tuberculosis program. The methodology for the investment case would be in line with the other investment cases as it would aim to estimate of the costs of the response over time and comparing these costs with the economic benefits in order to calculate a return on investment. Furthermore, the investment case would include a review of the financial landscape to determine the financial resource gaps, and investigate mechanisms for resource mobilisation.

9. Investment case for health

The MoHSS is committed to achieving UHC and ensuring the sustainability of the health response as a whole. As such, MoHSS management is concerned about sustainability activities being done in parallel, focusing on individual diseases only, which may compromise the sustainability of the overall health response. Therefore, instead of conducting investment cases for each individual disease or health condition (such as HIV/AIDS, malaria and TB), it was suggested that an investment case for health should be conducted in order to assess the return on investment for all of the diseases and health conditions faced in Namibia. This would also allow for disease-specific responses to be prioritized according to their relative return on investment, which would in turn feed into the development of a benefits package for UHC. The benefits package is one of the key dimensions of UHC and needs to be defined to allow for comprehensive costing and the estimation of resource requirements for the achievement of UHC. The MoHSS has not yet reached a final decision on whether this investment case should be pursued, which means that the scope of work has also not been finalized and no partners have committed to supporting this activity.

10. Health Sector sustainability strategy

Although the health sector as a whole is mostly funded by domestic resources, the sustainability of the health response remains a concern for the MoHSS, particularly in light of the goal of achieving UHC. In order to address this concern, the MoHSS intends to develop a health sector sustainability strategy, which would aim to ensure the sustainability of the health response in light of decreasing donor resources, funding constraints resulting from the current economic climate and the limited risk-pooling through medical aid funds or medical insurance. The sustainability strategy would define the country's resource needs, the operationalization of selected health financing options to meet the resource needs as well as the sustainability of the non-financial health system components. This

sustainability strategy is another proposal that has been made to move the UHC and sustainability agenda forward in Namibia. No decisions have been made on the terms of reference and scope of this activity and commitments to provide the technical support for this activity have not yet been secured.

11. UHC feasibility study

The UHC feasibility study was the key study that was to be undertaken under the UHCAN with all of the background studies providing the necessary data and inputs for this activity. The feasibility study was budgeted for under the SSC's grant from the African Development Bank. However, due to insufficient time to implement the study before the termination of the grant, the study was never conducted. The main objective of the feasibility study was to provide comprehensive information and a base to determine the key design parameters such as target population, benefit packages, required contribution, risk mitigation measures, financing options, institutional arrangement and options of provider payment mechanism for the different segments of the population that ensure the acceptability and sustainability of the schemes. In addition, the study was to provide options of sequencing of implementation / road-map with a specified time frame to reach UHC.

Committees guiding the processes

There are numerous committees tasked with ensuring the sustainability of the health response and the achievement of UHC, or components thereof. Some of these critical committees are discussed in this section, highlighting their roles, responsibilities and their composition.

1. Universal Health Coverage Advisory Committee of Namibia

The UHCAN was responsible for driving the UHC agenda in Namibia under the SSC's mandate of investigating options for the achievement of UHC. It was established as a sub-committee of the SSC's Social Protection Committee, which is a sub-committee of the SSC Board of Directors. The objective of UHCAN was to provide guidance to the MoHSS through the SSC on the development of sustainable systems and policies to achieving UHC in Namibia with a focus on compiling evidence and developing alternative policy approaches specific to the Namibian context. It was established in support of the ultimate objective of achieving UHC in Namibia to consider, research, report and make recommendations on the following:

- Development and implementation of policies;
- Target groups and beneficiaries, the nature and scope or type of funding and administration systems most suitable for the Namibian context;
- Benefit schemes and products, and the basis and criteria based on which they are to be established and operate;
- Differential benefit packages with reference to limitations on mandatory benefits and contributions to support funded health schemes and the resources required for their regulation and implementation;
- Role of both the State as provider of health services and of the funded medical aid industry in Namibia; and
- Any other matter referred to the UHCAN by the Commission, the Social Protection Committee or any other permanent members or on instructions of their appointing institutions.

The UHCAN membership comprised representatives from a wide variety of organizations that are likely to have an interest or be impacted by decisions made by the UHCAN. It included representation from numerous ministries including Health and Social Services, Labor and Social Welfare, Finance, Office of the Prime Minister and the National Planning Commission, as well as various medical, health professions and insurance bodies. The composition of the UHCAN, particularly the organizations represented on the committee as well as the permanent and alternate members, are detailed in Annex A.

2. *National AIDS Executive Committee*

The National AIDS Executive Committee (NAEC) has the mandate to provide technical leadership, facilitate program development and planning, oversee capacity development and technical assistance, partnership strengthening and management of strategic information related to the HIV/AIDS response. The composition of the NAEC is multisectoral with representation from all stakeholders drawn from public and private sectors, civil society and development partners. The committee also reviews program coordination, policies and legislation and makes recommendations to Cabinet for approval and meets on a quarterly basis and reports to the Meeting of Senior Civil Servants and to Cabinet if required. NAEC works through technical advisory committees, sector steering committees, program and specialized committees that may be established from time to time. The specific responsibilities of the NAEC include:

- Ensure harmonisation and alignment of stakeholder's priorities with the national priorities.
- Ensure the existence and availability of an updated National HIV and AIDS policy.
- Ensure joint (multisectoral) development and implementation of the National Strategic Frameworks (NSF), sector and regional plans, and the National Operational Plan.
- Monitor compliance by stakeholders with existing policies, legislation and technical programme guidelines and protocols.
- Commission Joint mid-term review and end term evaluation of the NSF.
- Ensure effective monitoring and reporting on the implementation progress of the NSF.
- Facilitate research to generate new knowledge or data to fill in strategic policy and programme gaps.
- Facilitate resource mobilisation, investments in high impact interventions and tracking of resources for HIV and AIDS.

The NAEC membership comprises the following:

- All Deputy Permanent Secretaries
- Chairperson – Chamber of Mines
- Chairperson – Chamber of Commerce and Industry
- Director – AMICCALL
- Country Director – Centers for Disease Control
- Country Director – Gesellschaft für Internationale Zusammenarbeit
- UNAIDS Country Coordinator
- Country Coordinator – PEPFAR
- Director - Association of Local Authorities' Declaration on HIV/AIDS
- Director – GFATM Programme Management Unit
- Director – Namibia Business Coalition
- Director – Namibia Network of AIDS Services Organizations,
- Representative, Outright Namibia
- Representative, Rights Not Rescue
- Director General – Electoral Commission
- Namibian National Women's Association
- National Union of Namibian Workers
- Representative of a Faith Based Organisations
- Representative of Organisations of people living with HIV
- Representative of the National Youth Council
- Representatives of UN Agencies
- Representative of other Development partners
- Representative – Regional Association of Councils
- Sector Coordinators

3. Resource Coordination and Management Technical Advisory Committee

According to the NSF (2018 -2022), the mandate of the Resource Coordination and Management Technical Advisory Committee (RCM-TAC) is to provide strategic technical support to national and decentralized coordinating structures, in-order to enhance efficiency and effectiveness in all aspects of the response. The roles of the RCM-TAC include:

- Ensure effective coordination and management of the many and diverse implementing partners at national, regional and community levels.
- Provide technical guidance and support in developing and strengthening the capacity of coordinating structures at all levels.
- Provide technical assistance in developing and implementing sustainable financing strategies for the national response.
- Ensure strengthening of strategic partnerships and alliances with development partner's communities and community-based organizations.

The RCM-TAC comprises members from MoHSS, Ministry of Finance, National Planning Commission, development partners and civil society representatives.

The RCM-TAC has created a resource mobilisation technical working group (RM-TWG), which deals with issues of sustainable financing and resource mobilisation. The RM-TWG meets regularly and attends to an “activity plan” with activities related to resource mobilisation and sustainable financing for HIV/AIDS and other communicable diseases.

4. Policy management, Development and Research Committee

The policy management, development and research committee (PMDRC) is one of the key ministerial management committees within the MoHSS that is responsible for policy and research decisions, which would include sustainable financing and other health system design decisions relevant to UHC. The PMDRC is chaired by the Permanent Secretary of the MoHSS, and constituted of Deputy Permanent Secretaries, Directors and Deputy Directors of the Ministry. The PMDRC reports to the Ministerial Steering Committee, which is chaired by the Minister, for review and final ministerial endorsement of reports, recommendations and policy decisions.

The way forward

The activities performed to date provide a very comprehensive picture of the HIV/AIDS and health financing situation in Namibia. The resource tracking exercise provides detailed information on past expenditures and trends on HIV/AIDS as well as health in general, including the source of funding and who manages it, as well as spending by disease, intervention, healthcare provider and inputs. Furthermore, the health financing review provides an in-depth overview of how funding for health and HIV/AIDS is managed and administered, and how the government prioritizes health and HIV/AIDS in relation to its peer countries. The sustainable financing for HIV/AIDS report (2011), the HIV/AIDS investment case, Sustainability Index Dashboard, and the HIV/AIDS sustainability review provide detailed analyses of the sustainability of financing for HIV/AIDS, forecast the financing gap and propose measures to reduce this gap. The unit cost and quality assessment study, combined with various disease or intervention specific costing exercises, such as the EIMC costing, provide baseline data for the estimation of the total costs of health services.

While there is a wealth of information on the current health financing situation and the status of the health system in terms of its strengths, weaknesses and its sustainability, Namibia needs to increase its progress in operationalizing actions to address these findings. The government needs to determine how to respond to the threats to the sustainability of its health response, particularly the HIV/AIDS

response due to its vulnerability as a result of the high level of donor dependency. Various health financing options have been proposed, but decisions are yet to be made in terms of which options to pursue. Furthermore, it is important for the Ministry to regard the sustainability of the health response from a broader perspective beyond just the financial sustainability. The health system in its entirety needs to be sustained, including its HRH, information systems, civil society, procurement and service delivery and the planning for all of these components should be coordinated and moved forward.

In the context of UHC, it is important for Namibia to determine what its priorities are and how the country should move towards UHC within the three dimensions, including health financing, the benefits package and population coverage. While the options relating to suitable health financing mechanisms are critical, these decisions should not be made in isolation. The health financing requirements of a country are closely tied to its benefits package of health services and the population coverage. In order to move towards UHC, the country would thus also need to define its goals in terms of benefits packages and the population coverage to determine the total health financing requirements and what may be affordable. These goals should be informed by the main challenges currently faced by the country, which include inequities in terms of medical aid coverage, limited risk pooling resulting in the possible risk of financial burden or hardship when seeking health services, limited access to quality health services, and inequities in access to health services (for poor and rural populations). These challenges should be reviewed and discussed with relevant stakeholders in order to agree on priorities and country-specific objectives for the health system and the UHC and sustainability agendas.

While sustainability efforts have been driven from various sides and have often focused on disease-specific components, it is recommended that the sustainability challenges are approached from a holistic point of view. It is acknowledged that the greatest vulnerability in terms of sustainability lies with the HIV/AIDS program due to its high-level of donor dependency. However, Namibia has expressed its intention of integrating the HIV/AIDS response into the broader health response. In order to sustain the HIV/AIDS response successfully, the MoHSS feels that the response should be fully integrated into its standard package of primary healthcare services as opposed to being treated as a standalone response, which is making the administration of parallel systems and the management of human resources very complex. Integration of HIV/AIDS services within the broader health response will allow for the overall response to be more streamlined and coordinated, which is expected to reduce the probability of system failures and improve the likelihood of sustainability in all relevant aspects including financing, epidemiology, program optimization, health systems and community systems. Therefore, it is recommended that sustainability planning is addressed at a health system level for all diseases and health conditions with the necessary stakeholder involvement to ensure more coordinated, comprehensive and longer-term planning and improved buy-in. Nonetheless, a specific focus should be maintained on the HIV/AIDS response and continuing the gains made given the vulnerability of the response.

Annex A: UHCAN membership list

No.	Organization	Member	Alternate
1.	Social Security Commission	Mr. Kapara Tjivikua <i>Executive Officer</i>	Mr. Uahatjiri Ngaujake Ms. Emma Goamas Mr. Cons Karamata
2.	Ministry of Labour and Social Welfare	Mr. G. Simataa <i>Permanent Secretary</i>	Ms. Penny Munkawa Ms. Meriam Nicodemus
3.	Ministry of Health and Social Services	Mr. Andrew Ndishishi <i>Permanent Secretary</i>	Mr. Thomas Mbeeli Mr. Charles Usurua
4.	Ministry of Finance	Ms. Ericah Shafudah <i>Permanent Secretary</i>	Ms. Helena Kapenda Mr. Etienne Coetzee
5.	Office of the Prime Minister	Ms. Nangula Mbako <i>Permanent Secretary</i>	Mr. A. Xoagub
6.	National Planning Commission	Mr. Leevi Hungamo <i>Permanent Secretary</i>	Mr. Sylvanus Nambala Ms Hilma Enkali
7.	Namibian Association of Medical Aid Funds (NAMAF)	Mr. Gabriel Mbapaha <i>CEO</i>	Mr. Malakia Mateus
8.	Namibia Financial Institutions Supervisory Authority (NAMFISA)	Mr. Philip Shiimi <i>CEO</i>	Ms. Maria Nakale-Goamas Mr. Tafadzwa Mashozhera
9.	Medical Association of Namibia (MAN)	Dr. D. Weber <i>Chairperson</i>	Mr. Koos du Toit Mr. Tiaan Serfontein
10.	Namibia Insurance Brokers Association (NIBA)	Mr. Kyron Raad <i>President</i>	
11.	Life Assurance Association of Namibia (LAAN)	Mr. Tertius Stears <i>Chairperson</i>	Mr. Callie Schaffer Ms. Christell Loots
12.	Namibia Medical Society (NMS)	Dr. Shitaleni Herman <i>Chairperson</i>	Dr. Wilson Benjamin Dr. Michal Jario
13.	Public Service Employee Medical Aid Scheme (PSEMAS)	Mr. Etienne Coetzee <i>Head of medical aid scheme</i>	
14.	Health Professions Council of Namibia (HPCNA)	Mr. Cornelius Weyulu <i>Registrar</i>	Dr. Jurgen Hoffman Mr. Crispin Mafwila
15.	Namibian Association of Private Hospitals (NAPH)	Ms. Esme Botes <i>Secretary</i>	Mr. Roly Buys
16.	Pharmaceutical Society of Namibia (PSN)	Mr. Benjamin Khumalo <i>President</i>	Mr. Ulrich Ritter
17.	Namibia Private Practitioners Forum (NPPF)	Dr. Dries Coetzee <i>CEO</i>	Mr. Eben de Klerk
18.	Namibia Employers Federation (NEF)	Mr. Tim Parkhouse <i>Secretary General</i>	Mr. Karl Weyhe
19.	Namibia Informal Sector Organisation (NISO)	Mr. Veripi Kandenge <i>Director</i>	Mr. William Karamatha
20.	National Union of Namibian Workers (NUNW)	Mr. Job Minjaro <i>Acting Secretary General</i>	Ms. Loide Shaanika
21.	Trade Union Congress of Namibia (TUCNA)	Mr. M. Kavihuha	Mr. Ralph Makgone Mr Reginald Kock
22.	Namibia NGO Forum (NANGOF)	Mr. Irvin Lombardt <i>CEO</i>	Ms. Celia Kaunatjike Mr. Casper Erichson
Non-voting members			
23.	Polytechnic of Namibia (PON)	Dr. Tjama Tjivikua <i>Rector</i>	Prof. Sylvester Moyo Ms. Cecilie Karokohe
24.	University of Namibia (UNAM)	Prof. Lazerus Hangula <i>Vice-Chancellor</i>	Prof. Peter Nyarango Dr. Jacob Sheehama

25.	United States Agency for International Development (USAID)	Mr. Bedan Gichanga	
26.	Health Finance & Governance Project (HFG)	Ms. Claire Jones	
27.	Strengthening Health Outcomes through the Private Sector (SHOPS)	Ms. Dineo Pereko	
28.	African Development Bank (AfDB)	Mr. Durairaj Varatharajan	
29.	World Health Organisation (WHO)	Prof. Monirul Islam	
30.	International Labour Organisation (ILO)	Mr. Luis Frota	
31.	PharmAccess	Ms. Ingrid De Beer	
32.	PACT Namibia	Dr. S. Posner	
33.	Management Sciences for Health (MSH)	Mr. Evans Sagwa	