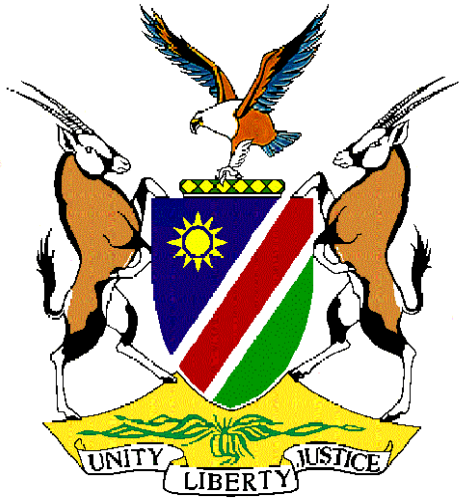
REPUBLIC OF NAMIBIA



Ministry of Health and Social Services

Namibia Resource Tracking for Health and HIV/AIDS: 2017/18

Windhoek, April 2020

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NAMIBIA RESOURCE TRACKING FOR HEALTH AND HIV/AIDS: 2017/18

PEPFAR USAID FROM THE AMERICAN PEOPLE RESULTS FOR DEVELOPMENT Duke GLOBAL HEALTH Innovation Center FEED THE CHILDREN amref health africa SYNERGOS RESADE

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ACRONYMS

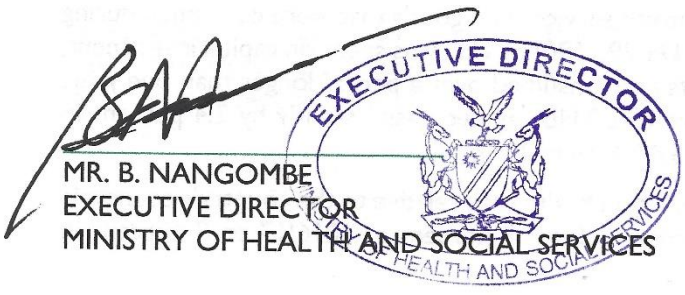
AGYW	Adolescent girls and young women
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
FAP	Funding Agent and Purchaser
GDP	Gross domestic product
HAPT	Health Accounts Production Tool
HFG	Health Finance and Governance
HIV	Human Immunodeficiency Virus
HTC	HIV testing and counselling
IHME	Institute of Health Metrics and Evaluation
INGO	International non-governmental organization
IP	Implementing partner
KP	Key population
MOHSS	Ministry of Health and Social Services
MSM	Men who have sex with men
NAMFISA	Namibia Financial Institutions Supervisory Authority
NASA	National AIDS Spending Assessment
NCD	Non-communicable disease
NGO	Non-governmental organization
NPO	Non-profit organization
N$	Namibian Dollar
OECD	Organization for Economic Cooperation and Development
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PMTCT	Prevention of mother to child transmission
PPHRD	Policy, Planning and Human Resource Development
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
SBCC	Social behavior change communication
SDM	Service delivery modality
SHA	System of Health Accounts
STD	Sexually Transmitted Disease
TB	Tuberculosis
TGF	The Global Fund
THE	Total Health Expenditure
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Program on HIV and AIDS
USAID	United States Agency for International Development
WHO	World Health Organization

FOREWORD

I am honored to present the Namibian resource tracking results for the period from 1 April 2017 to 31 March 2018. Resource tracking provides critical data on the expenditures incurred in Namibia on health and HIV/AIDS within a specified time period, by estimating the total expenditure amount and tracking these expenditures through the entire health system. Continuous resource tracking is significant as it provides data that informs decision making on health financing and programming for institutions such as the government, and non-governmental and development partners.

I am proud of the innovation achieved by the Namibian resource tracking team as the country has managed to successfully merge the System of Health Accounts (SHA) 2011 and National AIDS Spending Assessment (NASA) 2020 methodologies into one combined resource tracking exercise – thereby achieving great efficiencies in implementation as well as improved data quality and consistency. The sources of data included government ministries, non-governmental organizations, development partners, medical aid funds, and private employers. Their contribution to this exercise is greatly appreciated.

The study was conducted by a multidisciplinary technical team made up of staff from ministerial directorates such as the Policy and Planning, Special Programs, Tertiary Health Care and Clinical Support Services, Finance and Procurement, and Primary Health Care Services. We are thankful for the technical support that was provided by African Collaborative for Health Financing Solutions (ACS) project, which is funded by the United States Agency for International Development (USAID). My gratitude goes to Ms. Claire Jones and Ms. Teresa Guthrie of the ACS project for their continuous technical assistance and support in making this exercise a success. The World Health Organization, the United Nations Populations Fund (UNFPA), and the Joint United Nations Program on HIV/AIDS (UNAIDS) also formed part of the technical team and we are thankful for their input.



MR. B. NANGOMBE
EXECUTIVE DIRECTOR
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EXECUTIVE SUMMARY

In an environment where economic pressures and decreasing donor resources require government to make decisions to ensure that resource are allocated in the most effective and efficient manner, it is critical for the Government of Republic of Namibia to have the necessary evidence to inform these decisions. Resource tracking exercises provide sound estimates of past spending including the total amount spent on health, or a specific disease, in the country as well as the flow of these funds through the health system. The data allows for detailed understanding of where the money comes from, who manages these funds and what it is ultimately spent on. This type of information is critical to inform various health financing decisions, including future health financing systems for universal health coverage, strategies to sustain current levels of health financing and to replace the diminishing donor funding, and dealing with the increased demand and cost of health services that come with an aging population, re-emergence of communicable diseases and increasing incidence of non-communicable diseases (NCDs).

This report presents the results of the 2017/18 resource tracking exercise that was conducted in Namibia to estimate the spending on health and the HIV/AIDS response. The exercise used an approach that combines the Health Accounts and the National AIDS Spending Assessment (NASA 2020) methodologies to estimate both health and HIV spending in one comprehensive and consistent exercise. Namibia has successfully combined these two resource tracking methodologies to institutionalize resource tracking in an inclusive manner and fulfill the need for expenditure data, both on health in general and specifically on HIV/AIDS.

Findings

How were health expenditures allocated? The total health expenditure (THE) in Namibia amounted to N$ 15,392,046,540 in 2017/18, of which 97 percent was current expenditure. The current expenditure constitutes all spending on health services and goods that were consumed during the review period. The remaining 3 percent (N$ 421,294,190) of THE was spent on capital investment, which includes goods and services whose benefits are consumed over a period longer than one year. In real terms, the resource tracking results show that THE has decreased slightly by 2.4 percent in 2017/18, from N$15.7 billion in 2016/17 to N$15.4 billion in 2017/18.

THE as a percentage of GDP is a measure of spending on health care relative to the country's economic development, and this indicator has slightly decreased from 9 percent in 2016/17 to 8 percent in 2017/18.

The government contributed 62 percent towards THE, while the private sector contributed 31 percent. The remaining 7 percent was contributed by donors. Overall, the government health spending as a percentage of general government expenditures stood at 15 percent in 2017/18, which implies that Namibia has fully met its commitments in terms of the Abuja declaration.

In 2017/18, the general government managed 49 percent (N$ 7,618,824,050) of health expenditures, which were pooled across the entire Namibian population as public health services are accessible to all. Another significant portion of funds, amounting to 38 percent of THE (N$ 5,779,308,080), was pooled through various medical aid funds, including private schemes at 21 percent and Public Service Employees Medical Aid Scheme (PSEMAS), which covers public service employees, at 18 percent. These resources are pooled only across the beneficiaries of these funds, with private medical aid funds covering 8% of the population and PSEMAS covering another 12%, resulting in per beneficiary spending of N$16,161 for private medical aid funds and N$8,530 for PSEMAS. This compares to a per capita spending of N$3,702 that the government manages to provide health services to the remaining 80%

of the population that are uninsured. These figures indicate misalignment between the allocation of resources and the populations covered by these risk pools.

Public hospitals used the largest portion of THE to provide health services at 33 percent, followed by the private clinics and doctor's offices at 14 percent and private hospitals with 13 percent. Health system administration accounted for 13 percent, while pharmacies had an allocation of 11 percent. The remaining programs, including providers of ancillary services, public health centers and other providers, accounted for less than 8 percent of THE each. The provider with the lowest percentage was providers of preventive programs with only 2 percent, which includes only providers that exclusively provide preventive services and thus does not represent all spending on preventive care.

The largest share of THE was spent on outpatient curative care at 32 percent of THE, followed closely by spending on inpatient curative care at 30 percent. These results indicate a significant bias towards curative care services. Conversely, spending on preventive care amounted to a mere 6 percent of THE in 2017/18. Limited spending on preventive services is likely to result in patients seeking treatment when illnesses become more acute, and therefore more expensive to treat.

Is there adequate financial risk protection? Out-of- pocket (OOP) expenditures are recorded at 8 percent of THE, which is significantly less than the threshold of 20% recommended by WHO as the maximum for OOP to prevent catastrophic health expenditures. Therefore, it can be concluded that there is relatively strong financial protection in Namibia and limited risk of individuals incurring catastrophic health expenditures at the time of seeking healthcare services.

How are government resources spent? The government's commitment to health in Namibia is clearly demonstrated by its significant contribution towards total health expenditures and the achievement of the Abuja target. From public sources of funding, the public hospitals used the largest share of health expenditures at 66 percent. Spending at public health centers and clinics accounted for 11 percent of health spending. Health system administration consumed 20 percent of health spending. In terms of the breakdown of spending by function, curative care services continue to dominate health spending by the public sectors, with outpatient curative care consuming 36 percent and inpatient curative care using 32 percent. The expenditures on governance, health system and financing administration accounted for 18 percent, while spending on preventive care has decreased amounted to only 7 percent.

Is spending by diseases appropriately prioritized and sustainable? Non-communicable diseases received the highest portion of spending at 33 percent, followed by the infectious and parasitic diseases at 28 percent. The expenditures on infections and parasitic diseases mainly comprise spending on HIV/AIDS and other STDs at 64 percent of the total spending on this disease category. This high level of spending evidences the country's commitment towards the HIV/AIDS response, which remains the country's leading cause of death, and the geared-up spending to reach the target of 95-95-95. Namibia's disease burden is gradually transitioning from communicable to non-communicable diseases, and the shares of health expenditures by disease have followed a similar pattern. The share of spending on reproductive health has decreased most significantly from 38 percent in 2012/13 to only 10 percent in 2017/18. While the decrease is in line with the downward shift of both neonatal and maternal disorders in the ranking of causes of death, the maternal and neonatal mortality rates remain high in comparison to Namibia's peer countries, which may indicate that the spending on reproductive health decreased too rapidly.

What is spent on HIV/AIDS? In 2017/18, the total spending on HIV/AIDS reached N$ 2,979,260,45 (US$ 229 million), which included both health and non-health HIV activities, out of which central government contributed 61 percent, domestic corporations contributed 4 percent and households contributed only 2 percent. Bilateral donors contributed 23.1 percent to the total HIV expenditure, which was largely dominated by the USA Government (23 percent). The multilateral donors' contributions made up 10 percent of the total HIV spending, of which 9 percent came from The Global Fund (TGF). The bulk of the funds (66 percent) were managed by public funding agents, while private entities (mostly health insurance schemes) managed 11 percent and international entities managed 24 percent. Care and treatment accounted for the largest share of HIV expenditures at 74 percent, and

within care and treatment spending, the ART program consumed the bulk, which may be justified by the fact that the Namibia is working towards reaching the 95-95-95 goals. The second largest portion went towards HIV testing and counselling (10 percent), followed by HIV prevention (9 percent), and then program enablers and system strengthening with a 5 percent share. Both HTC and care and treatment were predominantly funded by the Government of Namibia (63 percent and 71 percent respectively), which has been important in achieving the 95-95-95 goals and in sustaining these treatment coverage rates. On the other hand, the external funding entities took the lead in funding prevention activities (89 percent), social protection (76 percent), and program enablers and systems strengthening (82 percent).

Policy implications and recommendations

The resource tracking results allowed for comprehensive analyses to be performed on the current health financing situation as well as the trends over time. These analyses have informed the following recommendations:

1. **Manage government investments in health:** As investments by all sectors in health continue to decrease in real terms, it is recommended that the government increases its investment in health until the economy starts showing signs of significant recovery, when private companies again become more financially stable and able to afford greater investments in healthcare. Furthermore, it is critical for the resources that are available for health to be spent and managed as efficiently as possible. There is a need to critically analyze the allocation of public resources, so that resources can be allocated in a more targeted manner that follow the government's priorities, allow for more efficient spending and for resources to be rebalanced from curative to preventive healthcare services, and from services being provided at tertiary healthcare level to primary healthcare. Similarly, the government should also ensure that adequate resources are allocated to maternal and neonatal health, as investments have decreased significantly while health outcomes in this area need further improvement.
2. **Improve cross-subsidization for the healthcare expenditures:** The significant level of spending by medical aid funds and PSEMAS in relation to the populations covered by these funds result in inequities in healthcare in the country. Furthermore, the substantial subsidies that the government pays towards PSEMAS are not only unsustainable for the fund itself, but also work against the principles of solidarity as more public funds are spent on civil servants who generally earn more than the average income of the country, while the member contributions are also not linked to an ability to pay. While it is noted that a reform committee has been established for PSEMAS, it is recommended that the government prioritizes these reforms and takes urgent action to effect change.
3. **Proactively plan for sustainability of the HIV response:** While the government has demonstrated a strong commitment towards the HIV response, specifically to reaching the treatment goals, there is still a significant reliance on donor support. As the government plans for the sustainability of the HIV response and the transitioning from donor funding, it will be important for the government to secure and allocate adequate funding towards HIV prevention to ensure continued effective management of new HIV infections. Only 5 percent of the total HIV spending went towards program enablers and systems strengthening, and 2 percent to social protection and economic support, most of which was for OVCs. Again, public spending on these program components needs to be incorporated in the sustainability plans for the government.

1. INTRODUCTION

1.1 Background of resource tracking in Namibia

In the slow-growing economic climate currently prevailing in Namibia, health financing is becoming increasingly important as the country is under greater pressure to achieve more with limited financial resources. This pressure is further exasperated by the decreasing donor support for priority programs such as HIV/AIDS, tuberculosis (TB), and malaria. While there is a constantly increasing pressure on the existing financial resources, Namibia is striving to move towards universal health coverage (UHC), which is likely to require additional investments in the health sector. These investment decisions should be guided by reliable evidence to ensure that their impact is maximized, and resource tracking provides the critical information required for such decision-making. Resource tracking exercises provide sound estimates of past spending including the total amount spent on health, or a specific disease, in the country as well as the flow of these funds through the health system. The data allows for detailed understanding of where the money comes from, who manages these funds and what it is ultimately spent on. This type of information is critical to inform various health financing decisions, including future health financing systems for universal health coverage, strategies to sustain current levels of health financing and to replace the diminishing donor funding, and dealing with the increased demand and cost of health services that come with an aging population and increasing incidence of non-communicable diseases (NCDs). To increase affordable access to quality health care in the above context, the country will need to focus on equitable allocation and efficient use of available resources. Resource tracking data allows decision-makers to gain a better understanding of the current health financing situation, which will assist them in making decisions about the future direction of health financing in the country.

The methodology used in Namibia for expenditure tracking is unique as it combines the Health Accounts and the National AIDS Spending Assessment (NASA 2020) estimations of health and HIV spending, respectively, into one comprehensive and consistent exercise. Namibia has made a concerted effort to combine these two resource tracking methodologies and has done this successfully. Combining the methodologies has allowed Namibia to institutionalize resource tracking in an inclusive manner and fulfil the need for expenditure data, both on health in general and specifically on HIV/AIDS. This combined approach also avoids duplicating data collection efforts, minimizes the waste of limited resources, and maximizes the potential for accurate and complete survey responses by preventing survey fatigue. The methodology used for the 2017/18 resource tracking exercise was first adopted during the prior round covering 2015/16 and 2016/17 and was further refined for purposes of this exercise.

This is Namibia's seventh round of Health Accounts and the fourth round conducted using the System of Health Accounts (SHA)

Health Accounts: Health Accounts track total health system expenditures, describing how funds are mobilized, managed, and used to purchase and deliver health goods and services. Health Accounts track health expenditures that are incurred with the primary objective to improve, restore or maintain health. It can also track health care-related expenditures that have health as a secondary objective. First published in 2000 by the Organization for Economic Cooperation and Development (OECD), EUROSTAT, and World Health Organization (WHO), the SHA framework was updated in 2011 (OECD et al. 2011). SHA 2011 is now the international standard for national-level Health Accounts estimations. For details on SHA 2011, see the 2011 edition of the System of Health Accounts (OECD et al. 2011) and two technical briefs on the SHA 2011 (Nakhimovsky et al. 2014; Cogswell et al. 2013).

NASA: The NASA methodology seeks to ascertain the flows of the funds used to finance national responses to the HIV epidemic. NASA is not limited to tracking health expenditures; it also tracks non-health expenditures such as social mitigation, education, labor, justice, and other sectors involved in the HIV response. For details on NASA, see: http://www.unaids.org/en/dataanalysis/datatools/nasapublicationsandtools

2011 methodology. The first three rounds of Health Accounts in Namibia covered 11 years of spending, from 1998/99 through 2008/09[1], the fourth and fifth rounds covered the one-year periods of 2012/13 and 2014/15, respectively, while the sixth round covered two years of spending data including 2015/16 and 2016/17. From the 2014/15 Health Accounts round Namibia has made concerted efforts to specifically address spending on the HIV/AIDS response and as such contained additional analyses of HIV spending according to the NASA classifications (MOHSS 2017a). In addition to the Health Accounts estimations, the MOHSS has completed four rounds of NASA with the latest covering the 2013/14 financial year (MOHSS et al. 2014).

This report presents the results of the 2017/18 resource tracking exercise and provides a comprehensive landscape of Namibia's health and HIV financing situation for 2017/18. The data provides insight into the sustainability of Namibia's health financing, particularly for priority diseases; the impact of current spending on key health conditions and priority diseases; and the impact of out-of-pocket expenditure on Namibia's population. These data provide the necessary evidence to make informed strategic funding decisions, determine how to allocate resources more effectively to improve results and how to ensure that money is devoted to areas where there is the greatest need.

1.2 Study objectives

The MOHSS and its Resource Tracking Technical Working Group (RT-TWG) identified various questions that the 2017/18 resource tracking exercise should answer (Table 1). The specific objectives of the exercise were to estimate the amount and flow of health spending in the health system with a particular focus on the spending on the HIV/AIDS response. Further, more detailed analyses looked at the sustainability of financing in light of trends of decreasing donor funding and the economic downturn; levels of risk pooling; contributions by the private sector and the effect of increasing private health care costs; and beneficiaries of health services.

Table 1: Key policy questions

Policy area	Policy question
Sustainability of health financing	How sustainable are the overall resources flowing to the health sector, given the potential decline of donor support as the country transitions into upper-middle-income status?
Sustainability of health financing; spending by disease area	How is declining donor support reflected in funding of priority areas such as HIV, TB, malaria, NCDs, and maternal and child health?
Risk pooling	What share of spending on health is out of pocket?
Relative spending of private sector	What is the role of the private sector in provision of health care? How big is its share of total spending on health?

1.3 Data sources

The aim of resource tracking exercises is to gain a comprehensive view of total health and HIV spending in a country – covering public, private, and donor sources of funds. In order to collect data on all these sources, the RT-TWG, led by the MOHSS, collected primary data from a wide range of sources (Table 2). The primary data was further supplemented by secondary data to fully inform all

[1] The first in 2003 for 1998/99 to 2000/01 (MOHSS 2003), the second in 2008 for 2001/02 to 2006/07 (MOHSS and Health Systems 20/20 2008), and the third for 2007/08 and 2008/09 (Government of Namibia et al. 2010).

relevant analyses. The resource tracking methodological report (MOHSS 2020) provides more detailed information on the methodology, including a comprehensive list of data sources, assumptions, and limitations, as well as the adjustments made to the survey questionnaires to accommodate all the new NASA 2020 vectors and classifications.

Table 2: Primary data sources for Health Accounts and NASA

Data source	Purpose of information
Government ministries	To estimate the flow of resources through government ministries that manage health and HIV/AIDS resources
Donors (both bilateral and multilateral donors)	To understand the level of external funding for health and HIV/AIDS programs in Namibia
NGOs involved in health and HIV	To understand flows of health funds through NGOs that manage health programs, as well as NGOs providing non-health HIV/AIDS services[2]
Private employers	To understand the extent to which employers provide medical insurance through the workplace and, where applicable, which employers manage their own health facilities or provide workplace prevention
Private medical aid funds	To understand total expenditures on health by medical aid schemes through health or any other type of insurance or risk-pooling mechanism

Secondary data was collected from the following sources:

Spending data

- Republic of Namibia Estimates of Revenues and Expenditures from 1 March 2019 to 31 April 2022, for government health expenditure by ministry where detailed information was not provided.
- Ministry of Health and Social Services Financial Distribution Register report for 2017/18, for the detailed expenditures incurred by the MOHSS.
- NAMFISA Annual Report 2018 to confirm total health expenditure by medical aid schemes
- Namibia Household Income and Expenditure Survey 2015/16 report, for data on household expenditures to inform the estimates of household out-of-pocket spending in Namibia. Expenditures for the 2017/18 health expenditure estimates were extrapolated from the 2015/16 survey using population growth and inflation.

Utilization data

- The District Health Information System (DHIS) 2 was used to extract data on the number of outpatient services provided by diagnosis, number of inpatient admissions by diagnosis, number of antenatal care (ANC) visits, number of family planning visits, and the number of immunizations for the 2017/18 financial year.

[2] Extensive efforts were made to include the non-health sector in the HIV assessment, but the response rate was somewhat low.

- The number of HIV testing and counselling (HTC) visits and number of patients on ART was obtained from the Response Monitoring and Evaluation unit within the Directorate of Special Programs[3].

Unit cost data:

- The Namibia Unit Cost and Quality Assessment Study was consulted to estimate the proportional costs that were used in the development of distribution keys between inpatient and outpatient care, between facility levels (i.e., hospitals versus health centers and clinics), and between diseases (Cico et al. 2017). In the case of HIV, all the HIV-direct spending was collected using the NASA 2020 categories and classifications and were fully attributed to their correct HIV activities, so were not subject to the HA distribution keys and estimations. However, these keys were used in the case of the MOHSS shared costs for health care delivery, that could not be directly attributed to HIV, such as overheads, shared salary costs etc. so as to include a share that could logically be attributed to HIV-health services in the MOHSS.

Please refer to the detailed methodological report and manual, which detail the SHA-NASA combined approach.

1.4 Data limitations

Since this exercise aimed to comprehensively meet the data requirements of both the SHA and NASA methodologies, the team made concerted efforts to improve the survey coverage of relevant organizations and services providers within the health sector as a whole and specifically involved in the multi-sectoral HIV/AIDS response. The team focused on identifying organizations that provide non-health HIV services, which may have been neglected during the previous resource tracking exercises that were more focused on the SHA health boundaries. The team consulted various organizations critical to the HIV/AIDS response to identify additional potential respondents, which has resulted in a considerable expansion of the census list of organizations that were surveyed. Similar efforts should be undertaken in future resource tracking exercises to ensure that all relevant organizations in the HIV/AIDS and health sector are included in the survey sample.

The resource tracking team further made concerted efforts to improve the response rates and ensuring quality responses. Response rates have improved significantly during this round of resource tracking with the lowest response rates being experienced among the non-governmental organizations (NGO) at 61%. The NGO surveys sought data only from NGOs that received funding from sources *other than* the President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria, since the expenditures incurred by the NGOs with funding from PEPFAR or the Global Fund were accounted for in the information that the two donors provided in the donor survey. The purpose of this approach was to limit the number of surveys to improve the institutionalization of the resource tracking process. The response rate in this respondent category is not expected to have resulted in significant underestimation of expenditures, since the vast majority of NGO funding is known to come from PEPFAR and the Global Fund, which is all accounted for under the donor questionnaires.

During the current round of resource tracking the team identified inconsistencies in utilization data that were used to inform the development of distribution keys for the 2015/16 and 2016/17 exercise. A comparison of the utilization data for antenatal care services indicated significantly higher figures in the 2016/17 HMIS data, which was used to develop the distribution key. Further investigation indicates that the data for that year was inaccurate as the number services in relation to the size of the Namibian population is not probable. As a result, it is believed that the allocation of spending to antenatal care services under the reproductive health disease category was overstated in previous years due to errors in the DHIS data used to develop the distribution key. Considerable efforts have been made

[3] Data on the number of HIV services provided was used only to estimate the proportionate allocation of salary and overhead expenditures to these services. Salaries for personnel employed exclusively for the HIV response and procurement of medicines and commodities were directly attributed

to ensure accuracy of DHIS data this year, however, the prior years' figures have not been adjusted to correct for these inconsistencies. Therefore, trend analyses on spending by disease category may be distorted and should be interpreted with caution.

The SHA 2011 methodology tracks healthcare-related expenditures separately and does not include these expenditures in its current or capital expenditures tables. Therefore, it should be noted that the figures reported in sections 2 to 4 include health expenditures only (i.e. those that have health as the primary objective) and do not include healthcare-related expenditures such as OVC support or spending on human rights advocacy. The figures included in section 5 of this report are generated using the NASA 2020 methodology, and thus report on all HIV expenditures, including those that are healthcare-related under the SHA 2011 methodology. Therefore, the figures of HIV spending in sections 2 to 4 and section 5 will differ.

2. HEALTH ACCOUNTS KEY FINDINGS

The total health expenditure (THE) in Namibia amounted to N$ 15,392,046,540 in 2017/18, of which the 97 percent was current expenditure. The current expenditure constitutes all spending on health services and goods that were consumed during the review period. The remaining 3 percent (N$ 421,294,190) of THE was spent on capital investment, which includes goods and services whose benefits are consumed over a period longer than one year. Of the THE, 62 percent was contributed by government, while the private sector has contributed 31 percent. The remaining 7 percent was contributed by donors. In comparison to the resource tracking results for the 2016/17 financial year, the government contribution declined slightly by 1 percent, while the private and donors both have increased by approximately 1 percent each. Overall, the government health spending as a percentage of general government expenditures stood at 15 percent in 2017/18, which implies that Namibia has fully met its commitments in terms of the Abuja declaration. The table below present the summary of findings for the resource tracking exercise for the financial year 2017/18 in comparison to the two previous years.

Table 3: Summary of key findings for 2015/16 to 2017/18

Indicator	2015/16	2016/17	2017/18
Total population	2,479,713	2,533,794	2,560,633
Exchange rate (N$/US$1)	13.6282	14.0199	12.993
GDP (current N$)	163,214,835,000	176,835,708,000	183,488,250,000
GDP per capita (current N$)	65,820	69,791	71,657
THE (current N$)	15,620,868,177	15,763,950,627	15,392,046,540
Total current health expenditure (current N$)	14,987,050,760	15,115,975,137	14,970,752,350
Total capital health expenditure (current N$)	633,817,417	647,975,490	421,294,190
THE per capita (current N$)	6,299	6,221	6,011
THE/GDP	10%	9%	8%
Total government health expenditure (current N$)	8,716,363,543	9,902,958,845	9,524,943,240
Current government health expenditure (current N$)	8,106,045,440	9,356,052,270	9,163,680,580
Capital government health expenditure (current N$)	610,318,103	546,906,575	361,262,660
Government health spending as a percentage of total general government expenditure	13%	14%	15%
Who funds health? Key financing sources (% THE)			
Public	56%	63%	62%
Private	39%	30%	31%
Donors	6%	7%	7%

How much do households spend? Household spending (% THE)			
Total household spending (prepayments to medical aid and direct payments to providers) as a % of THE	14%	11%	15%
Household out-of-pocket spending (direct payments to providers only) as a % of total health spending	7%	7%	7%
Who manages health resources? Key financing agents (% THE)			
General government	46%	51%	49%
Medical aid schemes	42%	36%	38%
Corporations (other than insurance corporations)	1%	1%	<1%
NGOs	4%	5%	3%
Households	7%	7%	8%
Donors	1%	0.5%	3%
Where are health funds spent? Key health care providers (% THE)			
Public hospitals	29%	34%	33%
Private hospitals	19%	15%	13%
Private clinics and doctor's offices	10%	10%	14%
Health centers*	7%	7%	7%
Pharmacies	9%	10%	11%
Providers of preventive programs	2%	2%	2%
Providers of ancillary services	10%	7%	7%
Health system administration	12%	13%	10%
Other	3%	3%	5%
What types of health care are consumed? Key health functions (% THE)			
Inpatient curative care	35%	33%	30%
Outpatient curative care	28%	32%	32%
Medical goods	6%	5%	11%
Preventive care	7%	7%	6%
Governance, health system and financing administration	11%	12%	10%
Capital formation	4%	4%	3%
Other	9%	7%	1%

Sources: The population figures are from http://www.worldometers.info/world-population/namibia-population/. Exchange rates and GDP come from the Bank of Namibia website.

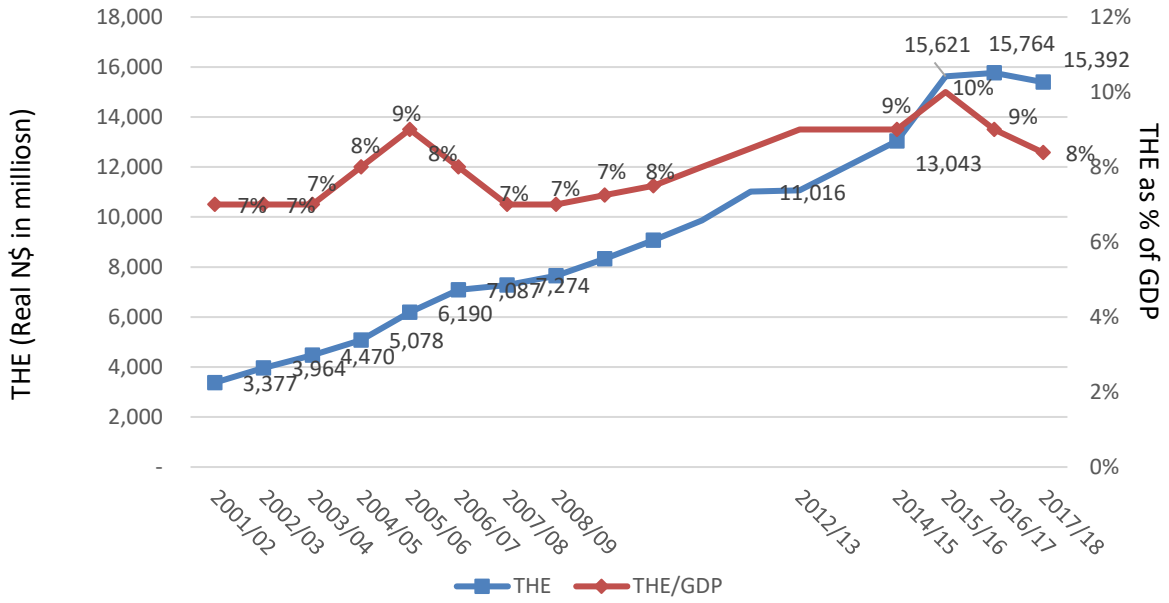
*This includes government-owned health centers and clinics.

2.1 General health expenditures

Figure1 below presents the trend of THE (real and as a percentage of GDP) for the past years. THE includes both recurrent and capital spending on health with the exclusion of health care related spending. In real terms, the resource tracking results show that THE has decreased slightly by 2.4 percent in 2017/18, from N$15.7 billion in 2016/17 to N$15.4 billion in 2017/18. The THE amount for 2017/18 is also lower than the 2015/16 expenditure amount, which was recorded at N$15.6 billion. For the last three consecutive years, THE remained in the same range of N$15 billion. The stagnant spending on health can be attributed to the fact that the allocation in absolute terms by government to the Ministry of Health and Social Services and other relevant ministries has not been increased significantly due to general budget rationing, while the overall economic pressures have further constrained spending by households and private companies.

THE as a percentage of GDP is a measure of spending on health care relative to the country's economic development, and this indicator has slightly decreased from 9 percent in 2016/17 to 8 percent in 2017/18. While the indicator of THE/GDP has remained been between 7 percent and 9 percent in recent years, in 2015/16 there was an increase up to 10 percent. This was the highest THE/GDP recorded thus far. The trend of decreasing THE/GDP (to 8 percent in 2017/18) seems to indicate that spending on health has become less of a priority at a national level during the recent economic downturn, even though the government has increased its spending on health in relation to its general government expenditures.

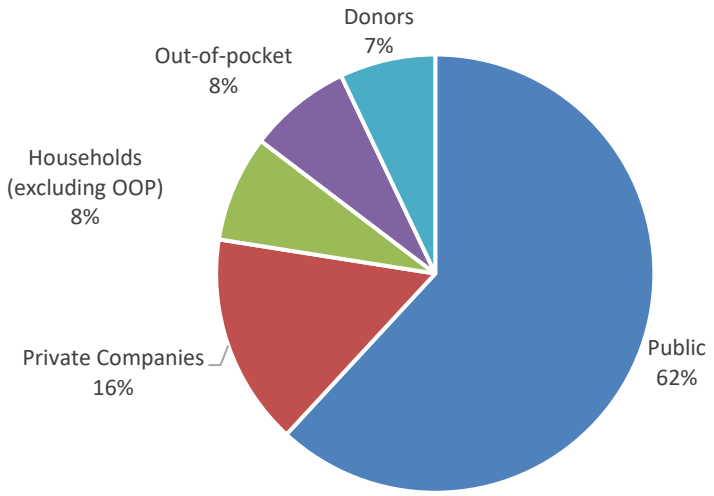
Figure 1. Growth in THE, 2001/02–2017/18



Source: Health Accounts data 2001/02-2017/18.

The government contributed the largest share of THE, constituting 62 percent (Figure 2). This is followed by private companies, whose contribution is noted to be at 16 percent. The household contributions by means of pre-payment and through out-of- pocket (OOP) contribution are recorded at 8 percent each, while the donor contribution is recorded to be the lowest with the total contribution of 7 percent. The OOP contribution to health is noted to be significantly less than the threshold of 20% recommended by WHO as the maximum for OOP to prevent catastrophic health expenditures, implying that there is relatively strong financial protection in Namibia.

Figure 2: Breakdown of THE by source, 2017/18



Risk pooling in health spending is critical as it determines the extent to which individuals will bear the financial burden when they require health care and is therefore considered as one of the key indicators of the level of equity of the health system. Risk pooling across a large group of individuals is important to ensure that the risks are spread evenly to ensure that those who cannot afford healthcare and are the sickest receive support from those who are wealthier and healthier. Therefore, the risk of incurring catastrophic health expenditures as a result of seeking healthcare is spread across the population group.

In 2017/18, the general government, through the Ministry of Health and Social Services, Ministry of Gender, Equality and Child Welfare, Ministry of Education, Arts and Culture and Ministry of Finance, managed 49% of health expenditures. Looking at the trend over recent years, the government has consistently remained responsible for managing the largest portion of health expenditures in the country, ranging from 44 percent to 49 percent in 2015/16 and 2016/17 respectively. There is a clear trend of the government managing an increasing proportion of THE, evidencing that the government is playing an increasing role in the health sector. These resources were pooled across the entire Namibian population.

Another significant portion of funds, amounting to 38% of THE, was pooled through various medical aid funds, including private schemes at 21% and Public Service Employees Medical Aid Scheme (PSEMAS) which covers public service employees, at 18%. These resources are pooled only across the beneficiaries of these funds, with private medical aid funds covering 8% of the population and PSEMAS covering another 12%, resulting in per beneficiary spending of N$16,161 for private medical aid funds and N$8,530 for PSEMAS. This compares to a per capita spending of N$3,702 that the government manages to provide health services to the remaining 80% of the population that are uninsured. There is a disconnect between the spending on healthcare by medical aid funds and the number of people covered by these funds, which is indicative of the inequities that exist within the Namibian health sector. Further exasperating this situation is the fact that there is limited cross-subsidization between the rich and the poor in all these medical aid funds, including PSEMAS. Contributions to the private medical aid funds generally take into account the risk of getting sick but not the ability to pay, while PSEMAS has a flat rate contribution for the High and Standard Option for all members regardless of earnings. This implies that the contributions to medical aid schemes pose a greater financial burden to the poor than to the rich. Furthermore, 85% of the PSEMAS expenditures are currently subsidized by the government, which implies that public funds are used to subsidize the health care of civil servants, who tend to be wealthier than the overall population.

The household contribution to THE increased only slightly by 1 percent since 2015/16 to 8 percent in 2017/18. The donors managed 3 percent of THE, which has increased in comparison to 2015/16 and 2016/17 when these figures stood at 1 percent and 0.5 percent, respectively. The non-governmental organizations managed 3 percent of funding, which is also a decline from 5 percent during the period

of 2016/17. This decrease is indicative of the diminishing role that non-governmental organizations are playing within the health sector as the financial support from donors to these organizations decreases. Private corporations managed less than 1 percent of THE, remaining at a relatively consistent level since 2015/16.

Figure 3: Breakdown of THE by agent, 2017/18

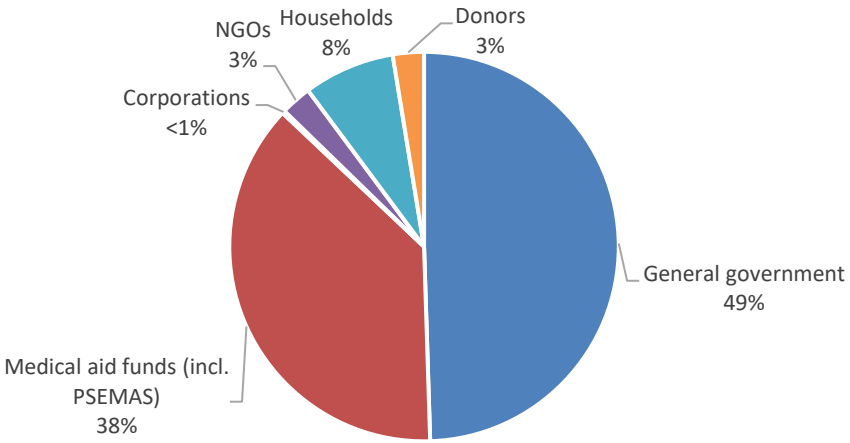
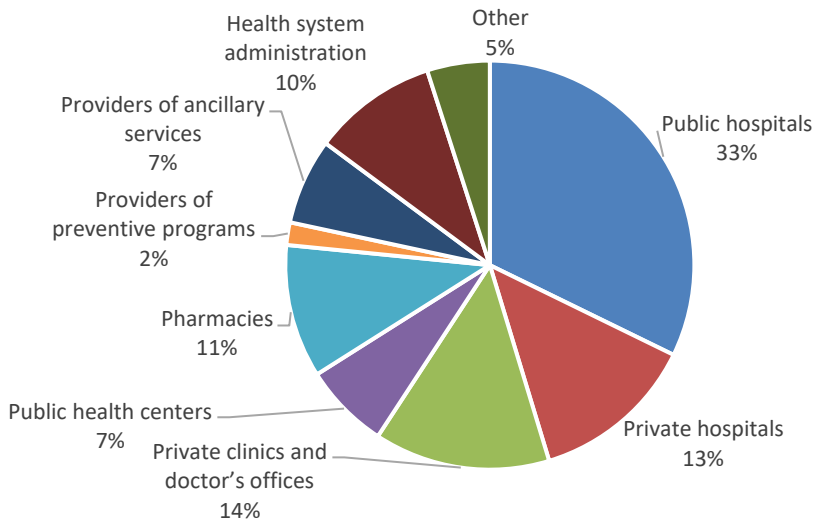


Figure 4 presents the breakdown of the total health expenditure by the provider. Public hospitals used the largest portion of THE to provide health services at 33 percent, followed by the private clinics and doctor's offices at 14 percent and private hospitals with 13 percent. Health system administration accounted for 13 percent, while the pharmacies had the allocation of 11 percent. The remaining programs, including providers of ancillary services, public health centers and other providers, accounted for less than 8 percent of THE each. The provider with the lowest percentage was providers of preventive programs with only 2 percent, which includes only providers that exclusively provide preventive services and thus does not represent all spending on preventive care.

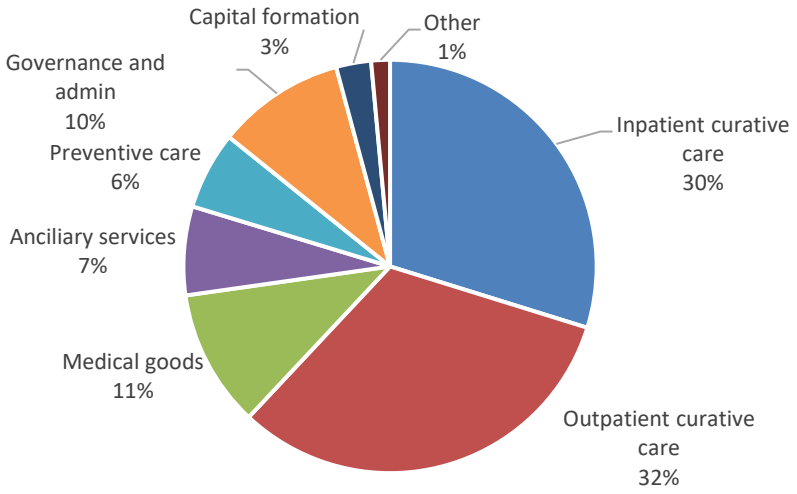
Figure 4: Breakdown of THE by provider, 2017/18



In terms of the breakdown of health expenditures by the type of health service, the largest sum of THE was spent on outpatient curative care, making up 32 percent of THE. This figure is followed closely by spending on inpatient curative care at 30 percent. Combined these two categories comprise

close to a third of THE, which implies that health spending is significantly biased towards curative care services. It is noted that inpatient curative care has decreased slightly in comparison to the previous year's resource tracking results, where the expenditure share stood at 33 percent. This decrease coincides with an increase in spending in medical goods, which increased from 5 percent in 2016/17 to 11 percent in 2017/18. Therefore, the decrease in curative care spending is not necessarily as a result of greater investments in preventive care, which decreased slightly from 7 percent in 2016/17 to 6 percent of THE in 2017/18. The consistently low expenditure rate on preventive services and high level of expenditures on curative care are indicative of an imbalance in the prioritization of prevention versus cure. Limited spending on preventive services is likely to result in patients seeking treatment when illnesses become more acute, and therefore more expensive to treat. Governance and administration consumed 10 percent of THE, which denotes a decrease from 12 percent in the previous year.

Figure 5: Breakdown of THE by function, 2017/18



2.2 Policy implications and recommendations

Acknowledging the wide impact that the constricting economy has had on the availability of financial resources of the country over the last few years, it is noted that the consistent decreases in THE in real terms and decreases in THE/GDP are a cause for concern. If investments in health continue to decrease in real terms while the cost of health products and commodities increase and the population grows, it is likely to have long-term impact on the health and productivity of the Namibian population. The allocation of the government's budget towards health has increased further so that the country has now reached the Abuja target, which implies that the government is still treating health as a major priority within its budget. Therefore, additional investments in health from the private sector should be encouraged. Nonetheless, it is recommended that the government increases its investment in health until the economy starts showing signs of significant recovery, when private companies again become more financially stable and able to afford greater investments in healthcare.

Furthermore, there is a need for improved cross-subsidization for the healthcare expenditures. The significant level of spending by medical aid funds and PSEMAS in relation to the populations covered by these funds result in inequities in healthcare in the country. Furthermore, the substantial subsidies that the government pays towards PSEMAS are not only unsustainable for the fund itself, but also work against the principles of solidarity as more public funds are spent on civil servant who generally earn more than the average income of the country. While it is noted that a reform committee has been established for PSEMAS, it is recommended that the government prioritizes these reforms and takes urgent action to effect change.

In the current economic climate, it is critical for resources to be spent and managed as efficiently as possible. One way of achieving greater efficiencies is to allocate resources more effectively. This is particularly relevant in the context of the allocation of resources between curative and preventive care. Currently the allocation of resources to curative care is more than 8 times the amount that is allocated to preventive care. Since it is more cost effective to invest in preventive care rather than curative care, when it becomes more expensive and complicated to treat illnesses, it is important for the allocation of resources to be rebalanced from curative to preventive healthcare services.

3. ANALYSIS OF PUBLIC SPENDING

The health system is funded by various sources, including the public, private companies, households, and donors. Over the years the public sources have been the dominant source of funding for Namibia. For the period 2017/18, the public sector contributed a total of 62 percent of THE. This amount has decreased slightly from 63 percent in 2016/17 but is nonetheless a demonstration of the government's commitment to the health of the country's population. The contributions by the private sector have been fluctuating over the years. The current resource tracking results show that the private sector contributed 16 percent of THE, which has decreased from 19 percent in 2016/17. The household spending has increased from 11 percent in 2016/17 to 15 percent for the period 2017/18. There seems to have been a shift in spending from private companies to households, which implies that there is greater financial pressure on households to cover health expenditures. This increase in household spending is mostly in the form of prepayments for health expenditures, although the percentage of OOP has also increased by 1 percent in relation to the previous two years. Although donors have communicated their intention to decrease their support to Namibia, the contributions seem to have stabilized at less than 10 percent since 2012/13. In the longer-term the trend of donor support is nonetheless evident as the contribution has decreased to the current 7 percent from a high of 22 percent in 2008/09.

Figure 6: Trends in financing sources, 2001/02–2017/18

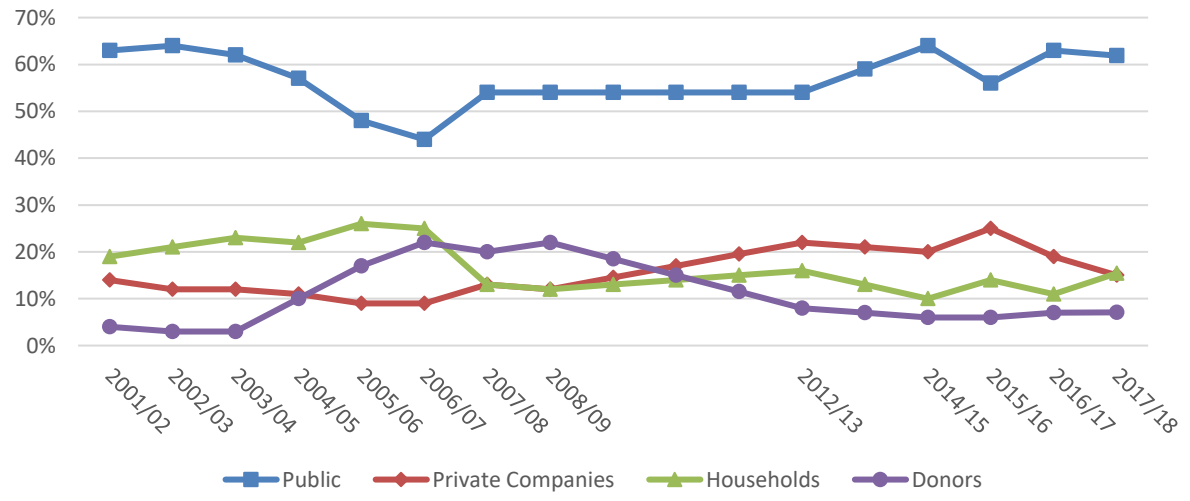


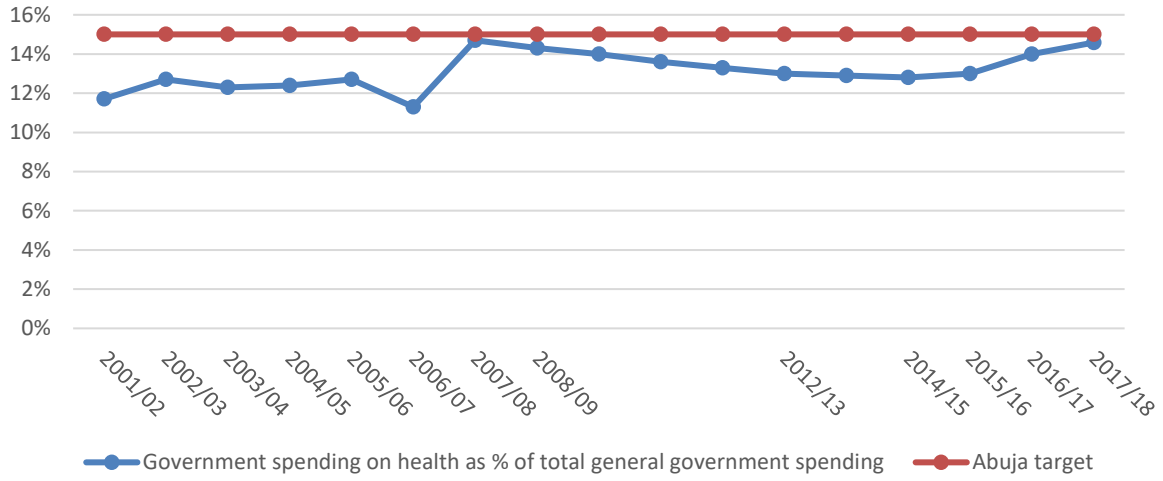
Figure 7 shows the trend of the government's performance in relation to the achievement of the Abuja target. The 2002/03 results showed that the government has spent 13 percent of its budget on health, which decreased during 2004/05 and 2005/06 to approximately 12 percent. By 2006/07, the government expenditures decreased further to 11 percent, which is the lowest percentage ever noted in the resource tracking studies. During 2007/2008, the government met the Abuja targets, recording 15 percent of government spending on health. Since then the government expenditures on health have been demonstrating a decreasing trend up to 2014/15 when the government's contribution to health amounted to 13 percent of total general government spending. Since then the percentage allocation to health has increased again up to the current level of 15 percent in 2017/18, fulfilling the country's commitment towards the Abuja target. It should however be noted that in absolute terms government spending on health has decreased,

ABUJA DECLARATION

In April 2001, the African Union countries pledged and set a target of allocating at least 15% of their annual budget to improve the health sector and urged donor countries to scale up support.

which implies that the achievement of this target can mostly be attributed to the reduction of general government expenditures as a result of the economic downturn.

Figure 7: Government spending on health as a percentage of total government spending in comparison to the Abuja target, 2001/02–2017/18



In contrast to the breakdown of THE by provider as presented in Figure 4, Figure 8 presents the breakdown of spending by provider as paid for by public resources only. From public sources of funding, the public hospitals used the largest share of health expenditures at 66 percent. Spending at public health centers and clinics accounted for 11 percent of health spending. Health system administration consumed 20 percent of health spending, which is consistent with the spending levels in 2016/17. In comparison to the previous year's spending, the expenditure on public hospitals has increased by 7 percent from 59 percent in 2016/17 while spending on public clinics and health centers decreased from 13 percent. This change counteracts the previously noted recommendations that spending should be refocused towards the primary health care facilities, including health centers and clinics to implement a primary healthcare approach.

Figure 8: Breakdown of public spending by provider, 2017/18

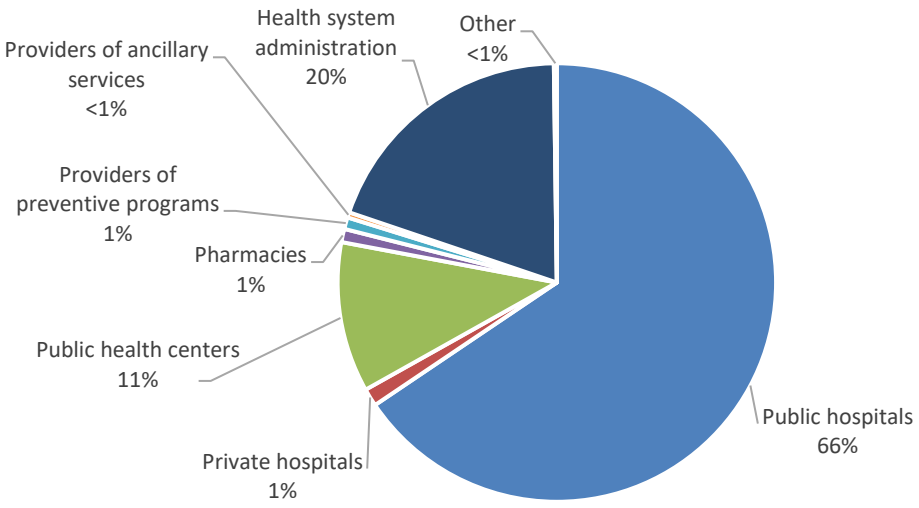
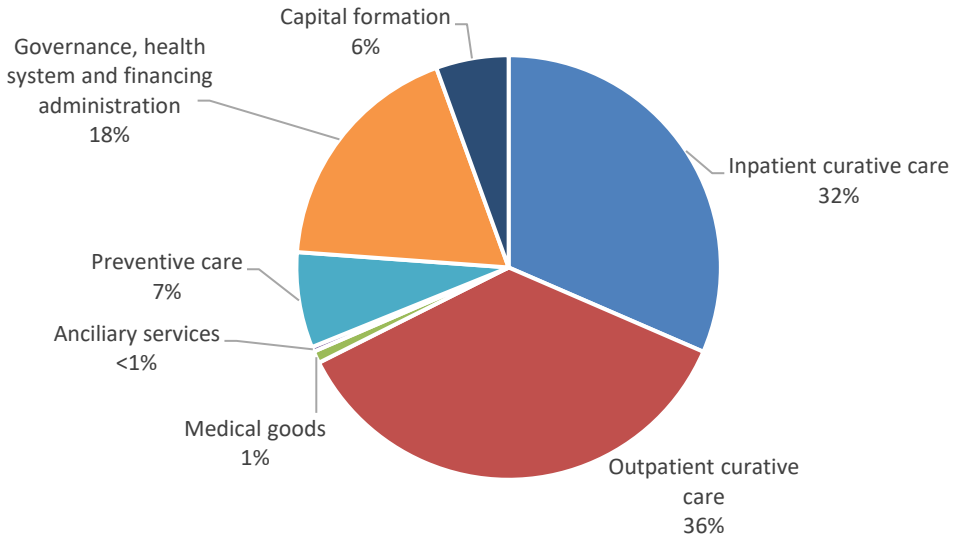


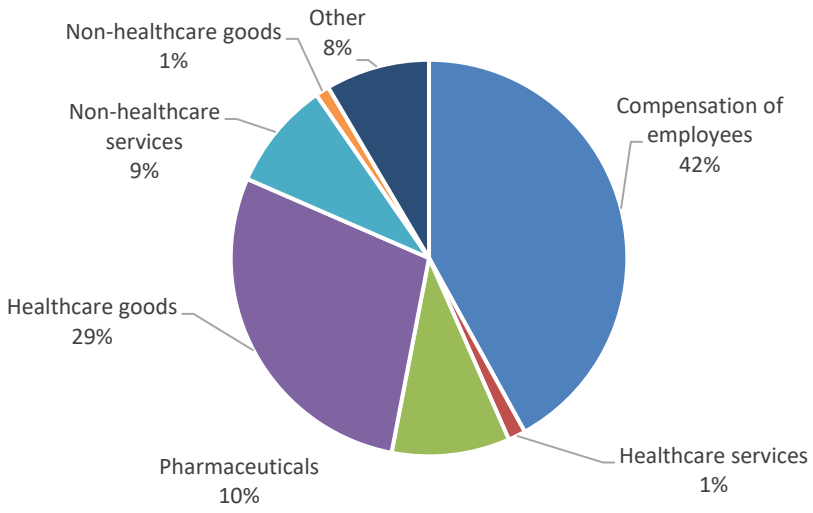
Figure 9 presents the breakdown of spending by function, specifically for the health expenditures managed by the public sector. Curative care services continue to dominate health spending by the public sectors, with outpatient curative care consuming 36 percent and inpatient curative care using 32 percent. In comparison to the previous year (2016/17), spending on inpatient curative care has decreased with 2 percent from 34 percent. Spending on outpatient curative care has increased from 31 percent in 2016/17, demoting a 5 percent increase. The expenditures on governance, health system and financing administration accounted for 18 percent, which has also increased by 4 percent from 2016/17. Spending on preventive care has decreased slightly from 8 percent in 2016/17 to 7 percent in 2017/18, while spending on medical goods remained consistent at 1 percent.

Figure 9: Breakdown of public spending by function, 2017/18



For the public sector, the largest type of expenditure incurred in 2016/17 was compensation of employees comprising 42 percent of total public health expenditures. The second highest category is health care goods, representing 29 percent of total public health expenditures. Pharmaceuticals accounted for 10 percent of public spending, while the spending on non-health care services was estimated to be at 9 percent. The non-health care services account for expenditures incurred on activities such training and research. A total of 8 percent of expenditure were categorized as other, while health care services and non-health care goods each had an expenditure of 1 percent.

Figure 10: Breakdown of public spending by inputs, 2017/18



3.1 Policy implications and recommendations

The government's commitment to health in Namibia is clearly demonstrated by its significant contribution towards total health expenditures and the achievement of the Abuja target. While the government is allocating substantial resources towards health, it is important to ensure that these resources are appropriately allocated to achieve the greatest health outcomes. The government has adopted a primary health care approach. However, the spending patterns do not seem to follow these principles as most of the public spending on health is dedicated to tertiary facilities and curative care services, while spending at primary care facilities and on preventive services is limited. There is a need to critically analyze the allocation of public resources, so that resources can be allocated in a more targeted manner that follow the government's priorities and allow for more efficient spending.

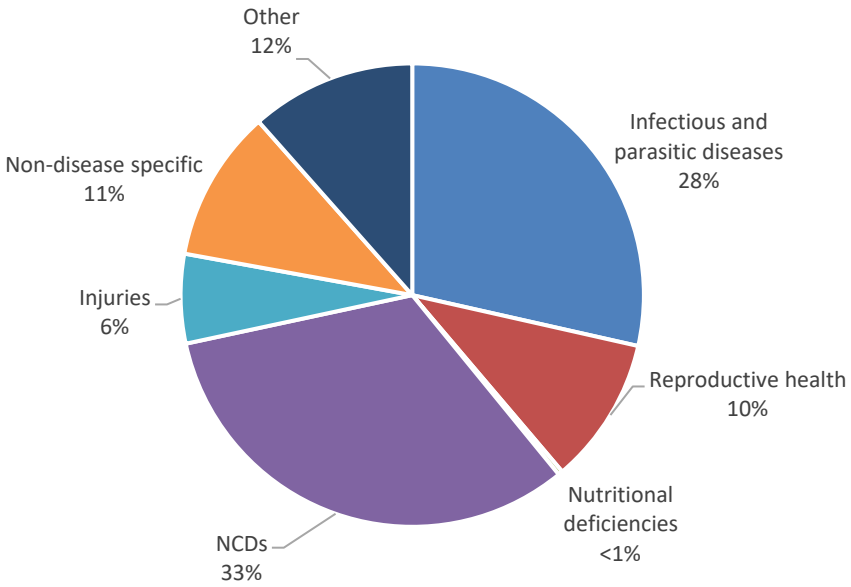
4. SUSTAINABILITY OF DISEASE PRIORITIZATION

One of the key policy questions that the MOHSS wanted the resource tracking information to answer is whether the country's spending by disease or health condition is in line with national priorities and the country's disease burden. The SHA 2011 methodology tracks expenditures by disease or health condition, which allows for this question to be answered.

4.1 Which diseases and health conditions does Namibia spend on?

Figure 11 below shows that non-communicable diseases received the highest portion of spending at 33 percent, followed by the infectious and parasitic diseases at 28 percent. Other unspecified health conditions accounted for 12 percent, while the non-disease specific spending recorded an expenditure of 11 percent. The amount of spending allocated to the non-disease specific classification has declined significantly from 23 percent for during the previous financial years (2015/16 and 2016/17). This may be attributable to the fact that the resource tracking team made concerted efforts to ensure that expenditures are allocated to specific diseases wherever possible. Spending on reproductive health amounted to 10 percent in 2017/18, which has decreased from 16 percent and 14 percent in 2015/16 and 2016/17 respectively. While the team identified inaccuracies in the HMIS data used for the generation of the 2015/16 and 2016/17 results, the low level of spending on reproductive health is nonetheless cause for concern given the country's poor performance in terms of maternal and neonatal mortality indicators. The level of spending on injuries has remained at 6 percent in line with the previous two years.

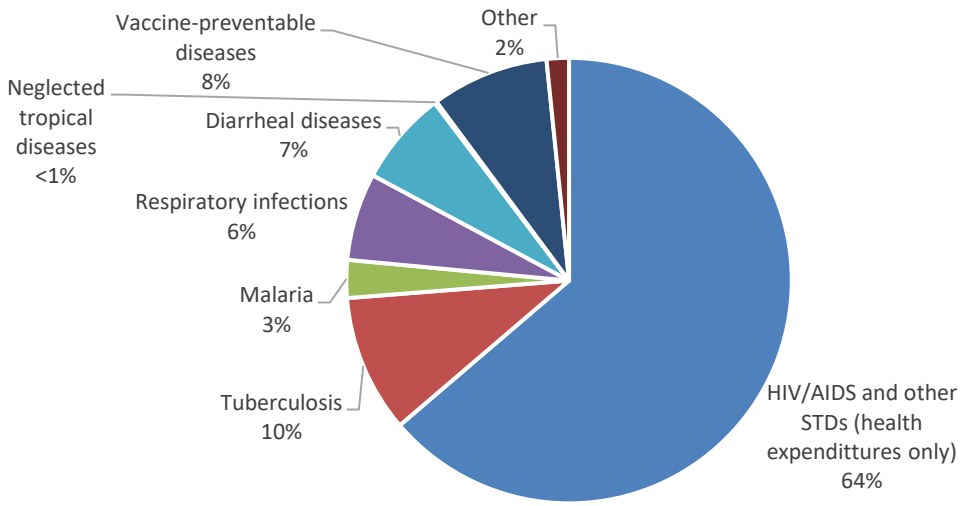
Figure 11: Spending by disease/health condition, 2017/18



The expenditures on infections and parasitic disease mainly comprise spending on HIV/AIDS (only health expenditures included) and other STDs at 64 percent of the total spending on this disease category. This high level of spending evidences the country's commitment towards the HIV/AIDS response and the geared-up spending to reach the target of 95-95-95. Activities leading to the achievement of these targets included expanded and more targeted HIV testing services and the adoption of same day initiation of HIV positive patients on treatment, has all contributed towards the increase in the number of people on ART. Being one of the most common opportunistic infections

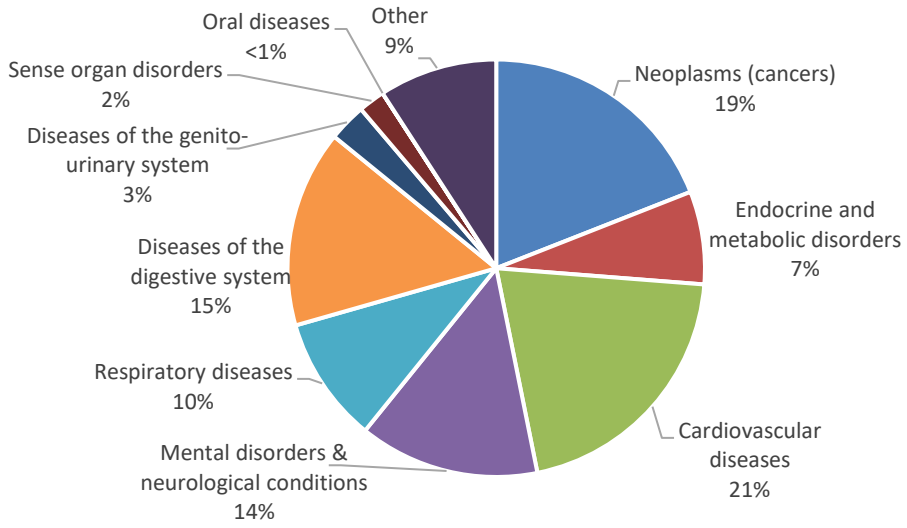
among the HIV patients, spending on tuberculosis follows the spending on HIV/AIDS and other STDs, with expenditures estimated at 10 percent. Vaccine-preventable diseases accounted for spending of 8 percent, while spending on diarrheal diseases stood at 7 percent. Respiratory infections and malaria recorded spending of 6 and 3 percent of the total expenditures in this category, respectively.

Figure 12: Breakdown of spending on infectious and parasitic diseases, 2017/18



The period 2017/18 has noted tremendous increase in spending on non-communicable diseases from 20 percent in 2015/16 and 19 percent in 2016/17 to 33 percent in 2017/18. This significant increase in spending on non-communicable diseases evidences the increasing impact that these lifestyle diseases are having on the Namibian population. Cardiovascular diseases accounted for the spending of 21 percent of expenditures within this disease category, while neoplasms accounted for 19 percent. Diseases of the digestive system recorded spending of 15 percent, followed by spending on mental disorders and neurological conditions at 14 percent. The remaining categories such as respiratory diseases, and endocrine and metabolic disorders used 10 and 7 percent of the resources in this disease category, respectively. Diseases of the genito-urinary system and sense of organ disorders recorded the smallest share of spending at 3 percent.

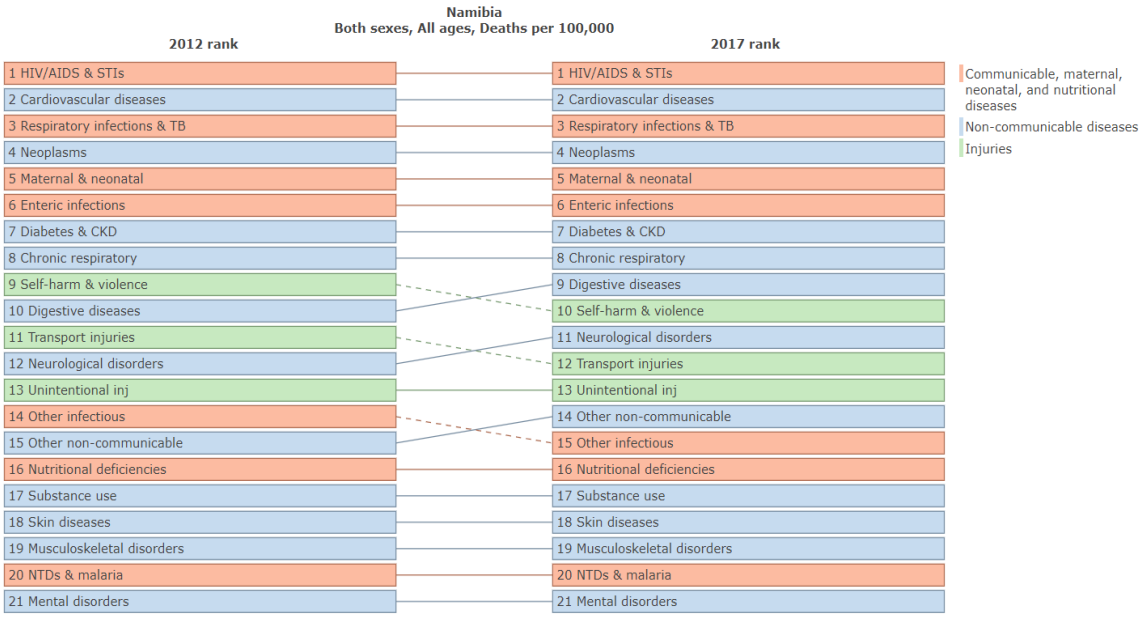
Figure 13: Breakdown of spending on NCDs, 2017/18



4.2 What are the trends in spending by disease?

Figure 14 illustrates the changes in the leading causes of death in Namibia between 2012 and 2017. HIV/AIDS consistently remained the leading cause of death, while communicable diseases, maternal disorders, neonatal disorders, and nutritional deficiencies (as depicted by red colors) also remain critical. This specifically includes diseases like respiratory infections and TB, maternal and neonatal, and enteric infections, which are all among the top 10 causes of death. The diagram also shows that five of the top 10 causes of death fall within the non-communicable diseases' category. Furthermore, three additional non-communicable diseases moved up in the rankings, including digestive diseases, neurological disorders, and other non-communicable diseases. These rankings show that non-communicable diseases are playing an increasingly significant role in Namibia.

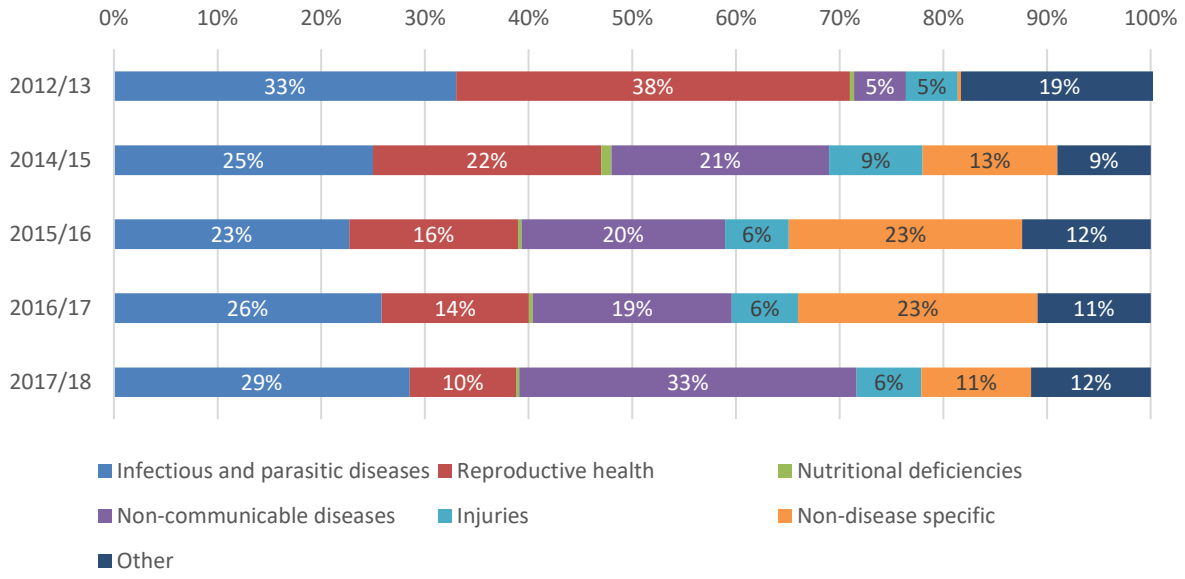
Figure 14: Comparison of cause of death rankings, 2012–2017



Source: IHME Global Burden of Disease visualization hub: https://vizhub.healthdata.org/gbd-compare/

In line with the above-illustrated trend of Namibia's disease burden gradual transition from communicable to non-communicable diseases, the shares of health expenditures by disease have followed a similar pattern. Spending NCDs increased from 19 percent to 33 percent from 2016/17 to 2017/18 but has shown a substantial increase from 5 percent since 2012/13. Nonetheless infectious and parasitic diseases continue to have a significant impact, combined with increased efforts to achieve epidemic control, the spending on this disease category increased from 26 percent in 2016/17 to 29 percent in 2017/18 (Figure 15). A slight decrease in spending is however noted in relation to 2012/13 when spending on infectious and parasitic diseases amounted to 33 percent of THE. The share of spending on reproductive health has decreased most significantly over the years from 38 percent in 2012/13 to only 10 percent in 2017/18. While the decrease is in line with the downward move of both neonatal and maternal disorders in the ranking of causes of death, the maternal and neonatal mortality rates remain high in comparison to Namibia's peer countries, which may indicate that the spending on reproductive health decreased too rapidly. Shares of spending on nutritional deficiencies and injuries have remained relatively constant over the years. Taken together, spending on "non-disease specific" and "other" categories increased by approximately 3 percentage points from 2012/13 to 2017/18. This includes spending that cannot be allocated to a specific disease but benefits health in general, such as expenditures on the Office of the Minister, administrative expenses, and national-level overhead.

Figure 15: Trends in spending by disease, 2012/13–2017/18



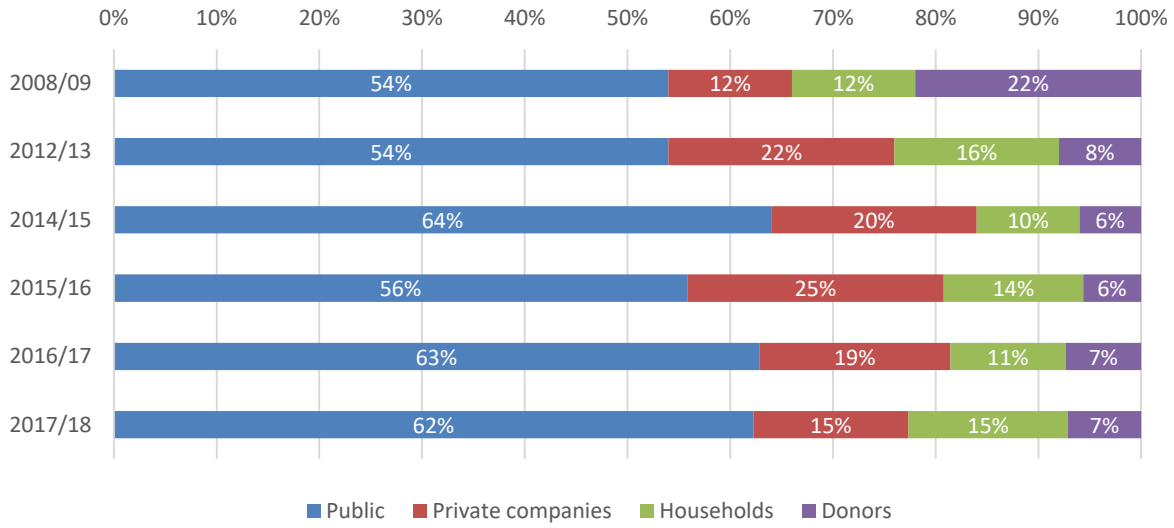
4.3 Is the health response for priority diseases sustainable?

The sustainability of the health response has been highlighted as a major priority for the Namibian government, especially in light of the current economic pressures and the commitment Namibia has made towards the achievement of Universal Health Coverage (UHC). It is critical for the government and key policy makers to consider how the long-term sustainability of the national health response, and specifically the priority diseases, can be ensured.

Namibia's THE as a percentage of GDP has remained relatively constant at around 8 or 10 percent since 2012/13, and this level of spending on health in relation to GDP is one of the highest in a group of similar upper-middle-income countries in the region, where THE as percentage of GDP has averaged 5.2 percent. Furthermore, Namibia is one of the only countries to achieve its commitment to the Abuja target of allocating 15 percent of government spending to health. Figure 16 shows how the shares of health financing from different sources have changed over the years, with the government contribution having increased from 54 percent in 2008/09 to 62 percent in 2017/18, although there is a slight decrease in comparison to 63 percent in 2016/17. Donor contributions decreased from 22 percent to 7 percent over the same timeframe. Spending by private companies increased overall from 12 percent in 2008/09 to 16 percent in 2017/18, although a decrease is noted in comparison to 2015/16 when the contribution from private companies amounted to 25 percent of THE. There is a slight increase in household contributions from 12 percent in 2008/09 to 15 percent in 2017/18. For the last six financial years, the household spending as a percentage of THE has been ranging between 10 and 16 percent.

Since most of the funding for the health sector is derived from the government and household contributions, especially in terms of OOP, have remained relatively low, there is adequate financial protection and limited risk for catastrophic health expenditures. Furthermore, the reliance on donors for the financing of the health response is relatively low and has demonstrated a clear decreasing trend over the last six years, which implies that the current funding mix for the health sector should be sustainable in the longer-term.

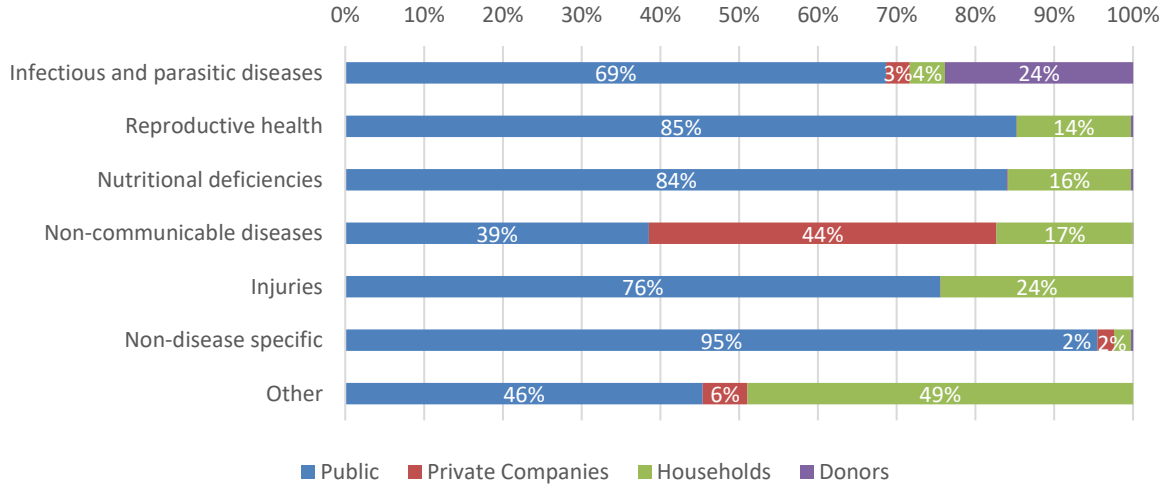
Figure 16: Trends in financing sources, 2008/09, 2012/13, and 2014/15-2017/18



A closer look at the specific disease components supported by donor funding, which is considered to be the least sustainable source of funding for health as the country has limited control of its continued flow, reveals that donor funding is almost exclusively allocated towards the infectious and parasitic disease category. Most donor funding within this category is targeted to support the health interventions of the national HIV/AIDS response. While the donor contributions have been instrumental in moving the country towards the achievement of the 95-95-95 targets and epidemic control, it will be critical for the country to devise financing strategies to ensure the response's long-term sustainability. A more detailed analysis of all HIV expenditures, including health care-related expenditures, is included in Section 5.

Figure 17 further illustrates that there is a strong dominance of private companies contributing towards non-communicable diseases. This includes investments that companies are making in terms of prevention of non-communicable diseases, but also the treatment thereof in in-house health facilities and direct payment towards service providers. It is evident that non-communicable diseases are perceived to have a significant impact on the health of the working population and are thus treated as a priority for private companies.

Figure 17: Sources of funding by disease category in 2017/18



4.4 Policy implications and recommendations

Namibia's health spending is mainly dedicated to non-communicable diseases and infectious and parasitic diseases, comprising 61 percent of THE combined. Within the infectious and parasitic diseases category, 64% of spending or approximately 19 percent of THE is allocated to the HIV/AIDS health response. This allocation of spending is in line with the burden of diseases and the corresponding health priorities of the country, as HIV/AIDS and cardiovascular disease (within the non-communicable diseases category) are the leading causes of death in Namibia. With the growing burden of non-communicable diseases in the country, there is a need to actively manage the allocation of funding towards these diseases to ensure adequate resources are available to combat these conditions and that greater investments are made into the prevention of these diseases rather than incurring excessive expenditures to cure them.

While there is a general alignment between the burden of disease and the health spending, there is a need to reprioritize spending to ensure adequate allocation to reproductive health. The health outcomes of Namibia in terms of its maternal mortality ratio are considerably worse than most of its peer countries (upper-middle income countries in Africa), implying that there is a desperate need to improve health outcomes in this area. Despite this poor performance, spending on reproductive health continues to decrease from 38 percent in 2012/13 to only 10 percent in 2017/18.

The current sources of funding towards health are deemed to be sustainable as there is a relatively low reliance on donor funding. However, there is strong donor reliance for the funding of the HIV/AIDS response, which may pose a risk in terms of the long-term sustainability of the response. Since donors have communicated their intention to gradually transition their funding from Namibia in the medium or long-term, there is a need for the government to manage the transition process and proactively secure alternate sustainable financing options in order to ensure that the great gains made in terms of gaining control of the epidemic are not lost.

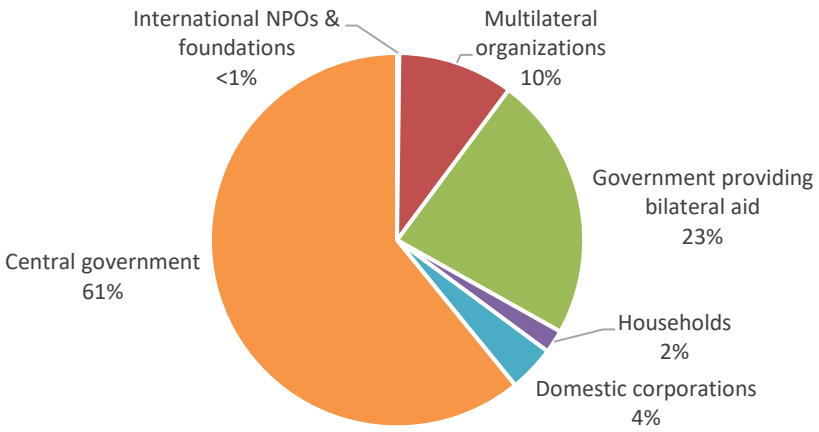
5. NAMIBIA'S HIV/AIDS FINANCING LANDSCAPE: RESULTS OF THE NASA

To ensure that HIV spending is also adequately tracked as part of this exercise, the survey tools were adjusted to collect the HIV spending in Namibia according to the NASA 2020 classifications. This section presents these findings. It is important to note that the NASA approach includes non-health HIV spending (which are coded in SHA as the health-related categories) and attributes capital expenditures to their specific HIV intervention. This means that the HIV totals presented here include these spending items that are usually not included under the SHA recurrent spending amounts. However, the NASA recurrent health-HIV spending is the same amount as is captured in the SHA tables and database for recurrent health-HIV spending.

5.1 Total HIV spending in Namibia: funding entities, revenues, schemes, and funding agents and purchasers

In 2017/18, the total spending on HIV/AIDS reached N$2,979,260,451 (US$ 229 million), which included both health and non-health HIV activities. This amount includes spending on capital to the amount of N$134,691,310, which is equivalent to almost 5 percent of total HIV/AIDS spending. In 2015/16 the total expenditure on the HIV/AIDS response amounted to N$1,976,048,146 and in 2016/17 it amounted to N$2,458,545,016, demonstrating a consistent increase in the expenditure on HIV/AIDS services.

Figure 18: Namibian HIV spending by funding entity, 2017/18



Central government contributed 61 percent towards the total spending on HIV/AIDS, while domestic corporations contributed 4 percent and households (through contributions to health insurance schemes) contributed only 2 percent. Bilateral donors contributed 23 percent to the total HIV expenditure, which was dominated by the USA Government (23 percent), while the Government of Sweden contributed 0.1 percent. The multilateral donors and development partners' contributions made up 10 percent of the total HIV spending, of which 9 percent came from The Global Fund (TGF), 0.2 percent from the UNAIDS Secretariat, 0.1 percent from UNESCO and 0.002 percent from WHO. The other international foundations and INPOs contributed 0.2 percent of the total HIV spending in 2017/18 (Table 4)

Table 4: Total funding for HIV in Namibia by funding entity, 2017/18

Namibian HIV Funding Entities (2017/18)	Total HIV spend (NAD)	Total HIV spend (USD)	% share in 2017/18
Central government	**1 819 523 734**	**140 038 770**	**61%**
Domestic corporations	108 981 172	8 387 684	4%
Households	63 261 454	4 868 887	2%
Governments providing bilateral aid	**692 871 966**	**53 326 558**	**23%**
Government of Sweden	*2 250 158*	*173 182*	*0.1%*
Government of United States	*690 621 809*	*53 153 376*	*23%*
Multilateral Organizations	**289 892 507**	**22 311 437**	**10%**
The Global Fund to Fight AIDS, Tuberculosis and Malaria	*280 280 533*	*21 571 656*	*9%*
UNAIDS Secretariat	*5 755 522*	*442 971*	*0.2%*
United Nations Educational, Scientific and Cultural Organization (UNESCO)	*3 783 653*	*291 207*	*0.1%*
World Health Organization (WHO)	*72 800*	*5 603*	*0.002%*
International NPOs & foundations	**4 729 617**	**364 013**	**0.2%**
Total HIV Spend in 2017/18	**2 979 260 451**	**229 297 349**	**100%**

* These figures include the non-health HIV spending and capital investments for HIV

Direct foreign transfers made up a total of 24 percent, while 61 percent was from domestic government revenue through internal transfers and grants in 2017/18. Over the past 5 years, Namibia has experienced a shift in the health financing landscape as a result of the decline in donor funding. To ensure that there is continuation in HIV service delivery, the government has been stepping in to fill the funding gaps created by the declining donor support. This further demonstrates the government's commitment to the Abuja Declaration target (15 percent of total government expenditure for health). HIV is one the priority diseases, and more public resources have been dedicated to providing HIV services.

The funding agents and purchasers (FAPs) are those entities that manage funds for HIV and purchase the HIV services. Table 5 shows that the bulk of the funds (66 percent) were managed by public FAPs, while private entities (mostly health insurance schemes) managed 11 percent and international FAPs manage 24 percent. Within the public agents and purchasers category, the MOHSS spent 97 percent, the Ministry of Defense, Ministry of Gender Equality and Child Welfare and the Office of the Prime Minister spent 1 percent each, and the Ministry of Education spent 0.1 percent (of the public agents total HIV spend).

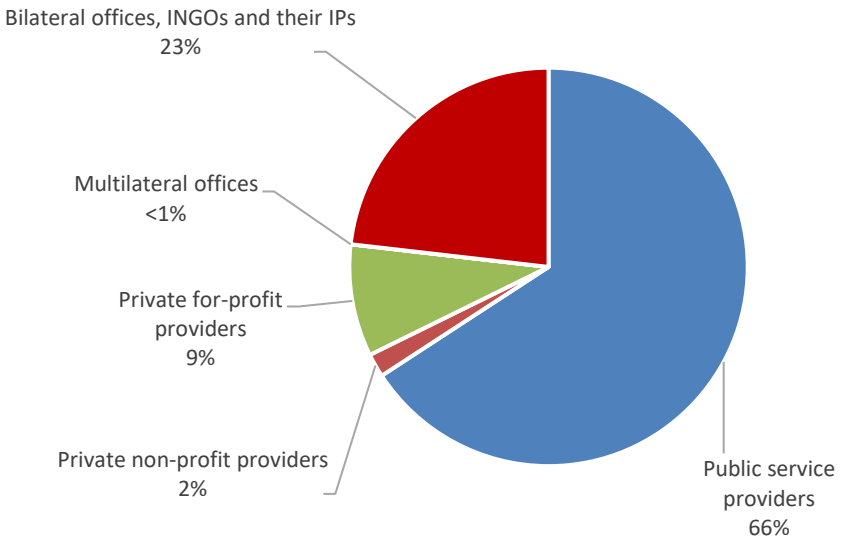
Table 5: Total funding for HIV by funding agent and purchaser, 2017/18

Namibian HIV Agents & Purchasers (2017/18)	Total HIV spend (NAD)	Total HIV spend (USD)	% share in 2017/18
Public funding agents & purchasers	1 958 082 811	150 702 902	66%
Private funding agents & purchasers	320 128 568	24 638 541	11%
International funding agents & purchasers	701 049 072	53 955 905	24%
Total HIV Spend in 2017/18	**2 979 260 451**	**229 297 349**	**100%**

5.2 HIV service providers, services provided (programs and interventions) and their delivery modality

Following a similar trend, 66 percent of the HIV funding was spent by public HIV service providers (Figure 19), while bilateral offices and their implementing partners[4] (IPs) and INGOs spent 23 percent.

Figure 19: Namibian HIV spending by service providers, 2017/18



The types of service providers are broken down in more detail in Figure 20 below. Within the public providers category, public hospitals were the provider that consumed the largest share of HIV expenditures at 46 percent of total HIV spending, followed by public clinics at 12 percent government ministries and entities at 8 percent. The private providers category is broken down further showing that private hospitals and pharmacies consumed the largest portion of spending in this category at 3 percent of total HIV expenditures, while private clinics consumed 1 percent.

[4] Note that the expenditure data provided by PEPFAR did not give details of their funded implementers, and hence these could not be disaggregated into types of providers, as per the usual NASA categories.

Figure 20: Namibian HIV spending by service providers, 2017/18

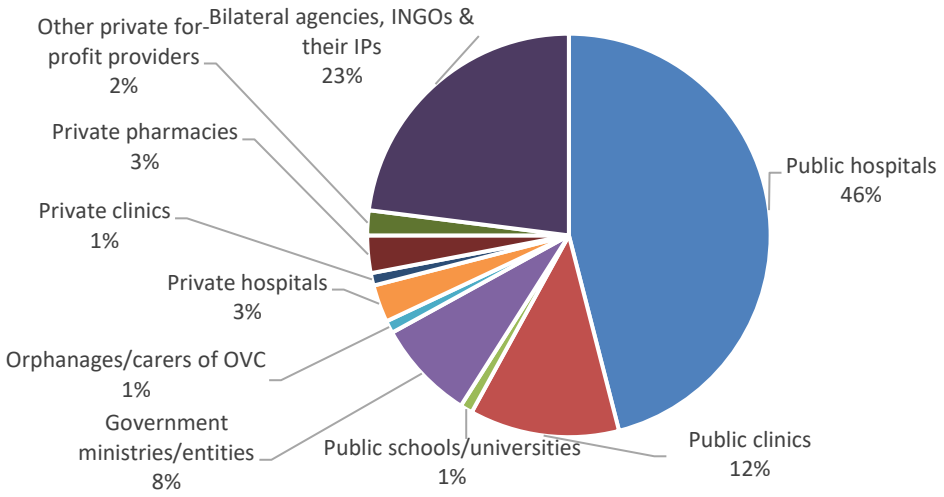
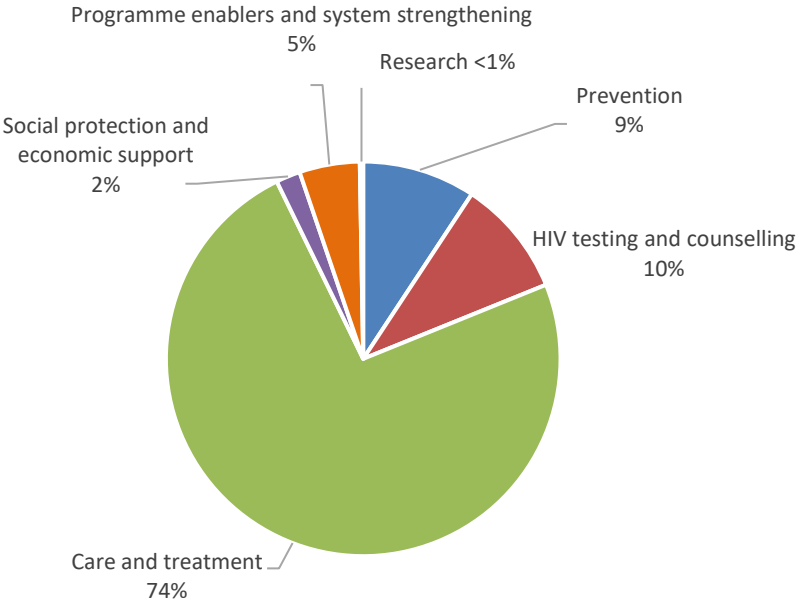


Figure 21 below shows the spending by programmatic areas of the HIV response. During the period under review, care and treatment accounted for the largest share at 74 percent. Within care and treatment, the ART program was the bulk (Table 6), which may be justified by the fact that Namibia is working towards reaching the 95-95-95 goals. The second largest portion went towards HIV testing and counselling (HTC) (10 percent), followed by HIV prevention (9 percent), and then program enablers and system strengthening with a 5 percent share. The social protection and economic support, including social grants given to the Orphans and Vulnerable Children (OVC), took only 2 percent, and HIV related research accounted for less than 1 percent.

Figure 21: Namibian HIV spending by programmatic areas, 2017/18



Under each of these programmatic areas, the spending on each intervention is shown in Table 6 below.

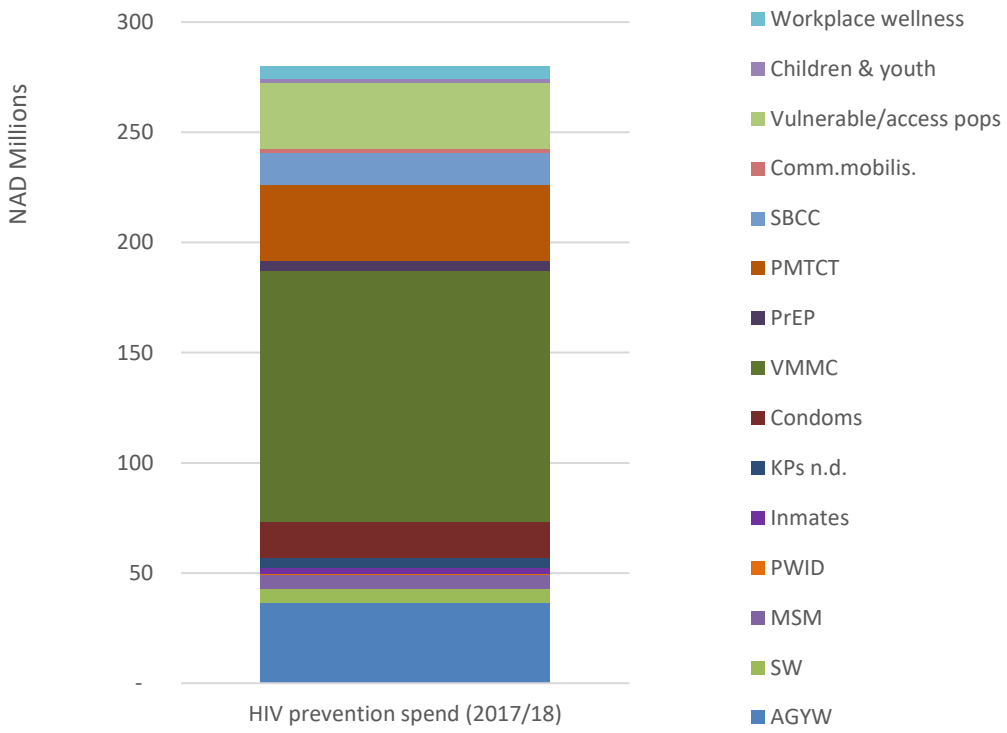
Table 6: HIV spending by interventions, 2017/18

Namibian HIV Interventions (2017/18)	Total HIV spend (NAD)	Total HIV spend (USD)	% share in 2017/18
Prevention*:			
Five pillars	191 522 222	14 742 725	6%
Other prevention interventions	88 401 195	6 803 755	3%
HIV testing and counselling:			
HTC for vulnerable or accessible populations	1 838 255	141 480	0.1%
HTC for general population	13 484	1 038	0.00%
HTC not disaggregated by target population	282 134 134	21 714 318	10%
Care and treatment:			
Anti-retroviral therapy	1 758 513 030	135 343 110	59%
Adherence and retention on ART (incl. support & monitoring)	15 810 483	1 216 846	1%
Specific ART-related laboratory monitoring	10 878 070	837 225	0.4%
Co-infections and opportunistic infections: prevention & treatment for PLHIV and KPs	17 677 608	1 360 549	1%
Palliative care and home-based care	185 704	14 293	0.01%
Care and treatment services not disaggregated	404 223 652	31 110 879	14%
Social protection and economic support:			
Social protection & support for OVCs	57 456 551	4 422 116	2%
Programme enablers and system strengthening:			
Strategic planning, coordination and policy development	8 330 254	641 134	0.3%
Programme administration and management costs	25 174 918	1 937 575	1%
Strategic information	20 604 012	1 585 778	1%
Public Systems Strengthening	35 285 320	2 715 718	1%
Community system strengthening	346 140	26 641	0.01%
Human resources for health (above-site programmes)	13 640 072	1 049 802	0.5%
Programme enablers and systems strengthening not disaggregated	39 242 698	3 020 295	1%
HIV-related research:			
Biomedical research	127 880	9 842	0.0%
Epidemiological research	5 299 087	407 842	0.2%
Socio-behavioural research	2 514 023	193 491	0.1%
HIV-related research not disaggregated	11 659	897	0.0%
Total HIV Spend in 2017/18	**2 979 260 451**	**229 297 349**	**100%**

* See prevention details below.

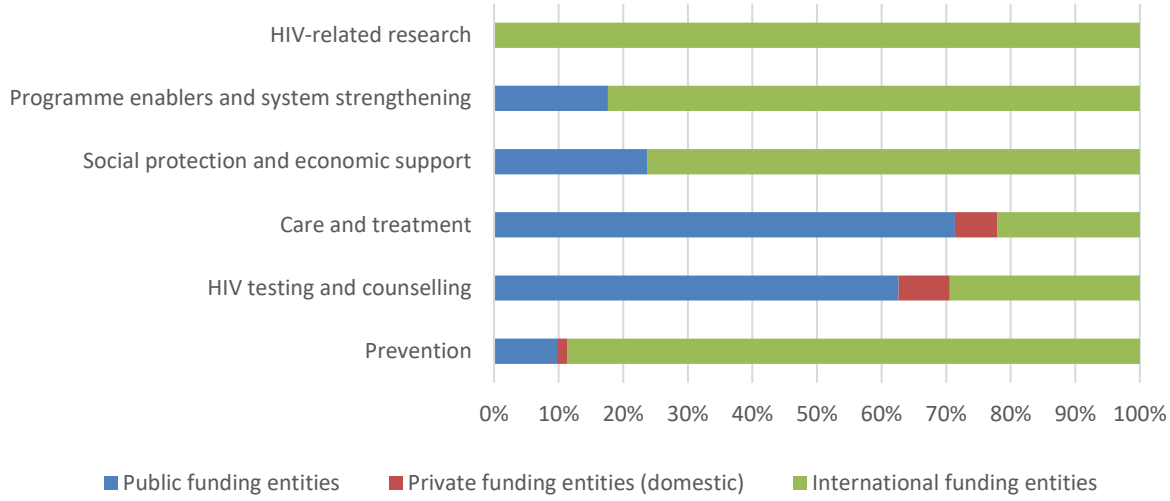
Examining the HIV prevention spending in more detail, Figure 22 shows that spending on all the five pillars of prevention (UNAIDS, 2018) was 68 percent of the total prevention spending, made up of voluntary medical male circumcision (41 percent), interventions for adolescent girls and young women (AGYW) (13 percent), interventions for key populations (KPs) (7 percent) including sex workers, men who have sex with men (MSM), people who inject drugs (PWID), inmates of correctional services, and other key populations, condoms with only 6 percent and PrEP with only 2 percent of the total HIV prevention spending. The other prevention activities (non-five pillars) accounted for 33 percent of the prevention spending, of which PMTCT took the largest share (12 percent of total HIV prevention spending), prevention directed at accessible populations (11 percent), social and behavioral change communications (SBCC) (5 percent), workplace wellness programs (2 percent), community mobilization (1 percent) and prevention for children and youth (excluding AGYW) (1 percent of the HIV prevention spending). Please refer to the annexes for detailed tables of these figures.

Figure 22: HIV prevention spending by activities, 2017/18



Considering the longer-term sustainability of key HIV program areas, Figure 23 shows the contribution to each program area by the funding entities. Both HTC and care and treatment were predominantly funded by the Government of Namibia (63 percent and 71 percent respectively), which has been important in achieving the 95-95-95 goals and in sustaining these treatment coverage rates. On the other hand, the external funding entities took the lead in funding prevention activities (89 percent), social protection (76 percent), and program enablers and systems strengthening (82 percent). The reliance of external funding for HIV prevention efforts may give cause for concern if the GRN wishes to control new HIV infections, in the event of reducing donor funding. All HIV-related research was funded by international sources, possibly indicating a low priority for the GRN, with the other competing demands. Please refer to the annexes for detailed tables of these figures.

Figure 23: HIV programmatic areas by funding entities, 2017/18

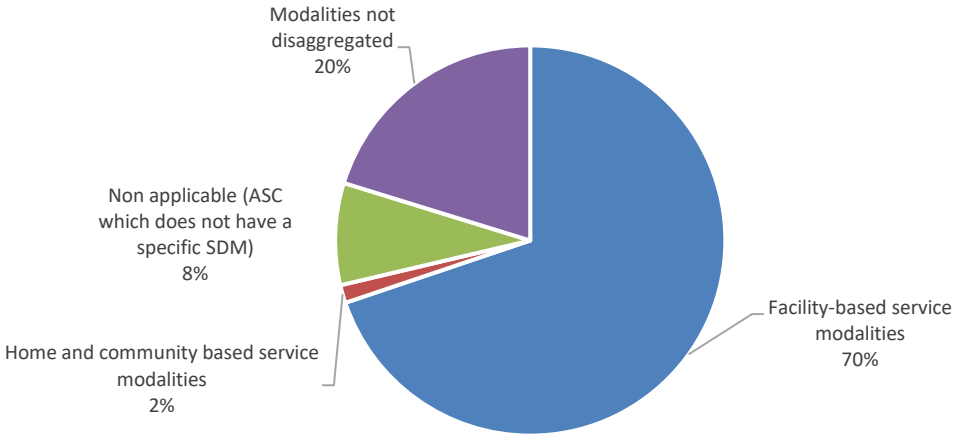


* See annex for GAM Financial indicator 8.1.

A new variable in the NASA 2020 framework is that of service delivery modality (SDM), which indicates another characteristic of certain interventions, where relevant, such as community versus facility-based ART delivery. The SHA questionnaire was adapted to add this variable so that HIV respondents could indicate the SDM for each intervention.

Figure 24 indicates that 70 percent of the total HIV spending was for facility-based interventions, while only 1 percent was labelled as community and/or home-based. There was 8 percent for interventions where an SDM was not applicable, while 20 percent were not disaggregated.

Figure 24: HIV spending by service delivery modality, 2017/18



5.3 HIV spending by production factor and beneficiary populations

The NASA 2020 framework classifies the factors of production (PF) as does the SHA, except that NASA requires additional detail, such as ARVs within the pharmaceutical category, and HIV tests within the laboratory and reagent category. In the 2017/18 SHA-NASA, there was 23 percent of HIV expenditure, which was not disaggregated by PF. Of the total HIV spend, 70 percent was for recurrent

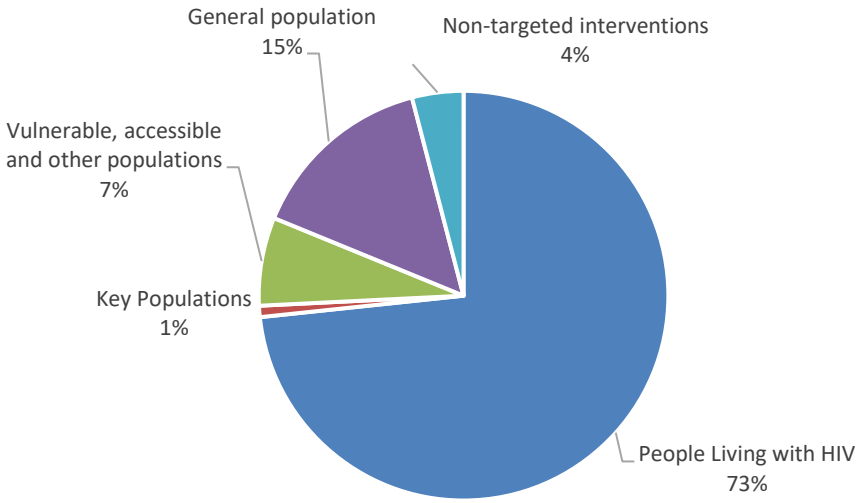
expenditures, while only 7 percent was reportedly for capital investments for HIV purposes. Note that NASA attributes the capital investment to its purpose – disease and intervention – whereas the SHA does not, which explains the variance between the NASA HIV total and the SHA HIV total. Table 7 indicates that 33 percent was spent on personnel costs, while another 11 percent was spent on pharmaceuticals and 5 percent on other medical supplies. Six percent of HIV spending was recurrent not disaggregated, and another 23 percent were not disaggregated at all (either by recurrent or capital).

Table 7: HIV spending by production factors, 2017/18

Namibian HIV Factors of Production (2017/18)	Total HIV spend (NAD)	Total HIV spend (USD)	% share in 2017/18
Current direct and indirect expenditures:	2,078,317,849	159,956,734	70%
Personnel costs	979,299,908	75,371,347	33%
Other operational and programme management current expenditures	1,185,527	91,243	0%
Medical and non-medical supplies			
Antiretrovirals	327,916,851	25,237,963	11%
Other pharmaceuticals not disaggregated	13,243,660	1,019,292	0%
Condoms	16,157,203	1,243,531	1%
Other medical supplies	139,272,399	10,719,033	5%
HIV tests screening/diagnostics	1,761,734	135,591	0%
Other reagents and materials not disaggregated	15,954,894	1,227,961	1%
Non-medical supplies	16,312,797	1,255,507	1%
Other supplies not disaggregated	313,924,082	24,161,016	11%
Contracted external services	17,736,205	1,365,058	1%
Financial support for beneficiaries	129,127	9,938	0%
Training related per diems/transport/other costs	34,400,380	2,647,609	1%
Indirect costs	14,751,781	1,135,364	0%
Current direct and indirect expenditures not disaggregated	186,271,301	14,336,281	6%
Capital expenditures:	215,696,985	16,601,015	7%
Building	105,429,233	8,114,310	4%
Vehicles	481,173	37,033	0%
Information Technology (hard & software)	255,098	19,634	0%
Laboratory & other medical equipment	13,461,900	1,036,089	0%
Non-medical equipment & furniture	**16,041,574**	**1,234,632**	**1%**
Capital expenditure not disaggregated	**80,028,007**	**6,159,317**	**3%**
Production factors not disaggregated	**685,245,617**	**52,739,600**	**23%**
Total HIV Spend in 2017/18	**2,979,260,451**	**229,297,349**	**100%**

NASA categorizes the beneficiaries of each financial transaction, wherever possible. Due to the large portion of HIV spending on treatment and care in Namibia, the direct beneficiaries of these services were people living with HIV (PLHIV), with 73 percent of the HIV expenditure benefitting them. The general population was found to be the second largest beneficiary group with 15 percent of spending, primarily from the prevention efforts. Vulnerable, accessible, and other populations received a 7 percent share, while key populations, made up of sex workers, men having sex with men, inmates and people who inject drugs (PWID), accounted for 1 percent only. Further breakdown of each of these beneficiary populations are provided in the annex.

Figure 25: HIV spending by beneficiary population, 2017/18



5.4 Policy implications and recommendations

The assessment of spending on HIV in Namibia in 2017/18 shows a significant contribution (61 percent) from the Government of Namibia, while 33 percent is contributed by donors. Only 4 percent and 2 percent came from domestic corporations and households, respectively. While the government has demonstrated a strong commitment towards the HIV response, there is still a significant reliance on donor support. In its drive to achieve the 95-95-95 targets, Namibia concentrated 74 percent of the HIV spending in 2017/18 on treatment and care activities, of which the ART program took the bulk (59 percent of total spend). Prevention activities formed only 9 percent of the total, and HIV testing and counselling 10 percent. Of the prevention spending, two thirds went towards the five pillars of prevention, showing important prioritization of the most impactful interventions, although low spending on condoms. External funding supported 89 percent of the prevention activities, while public funds went primarily to treatment and HIV testing and counselling.

As the government plans for the sustainability of the HIV response and the transitioning from donor funding, it will be important for the government to secure and allocate adequate funding towards HIV prevention efforts to ensure continued effective management of new HIV infections. This needs to happen while also maintaining PLHIV on treatment which continues to demand more resources, unless efficiency gains can be made through pooled procurement, reduced ARV prices through shifting regimens and modalities that could potentially reduce costs. Only 5 percent of the total HIV spending went towards program enablers and systems strengthening, and 2 percent to social protection and economic support, most of which was for OVCs. Again, public spending on these program components need to be incorporated in the sustainability plans for the government.

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ANNEX A: CONTRIBUTORS TO THE RESOURCE TRACKING EXERCISE

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UNFPA	Ms. I. Mwaningange	National Programme Officer

ANNEX B: DETAILED HIV EXPENDITURES

Total funding for HIV in Namibia by sources of revenue, 2017/18

Namibian HIV Sources of Revenue (2017/18)	Total HIV spend (NAD)	Total HIV spend (USD)	% share in 2017/18
Government domestic revenue - internal transfers and grants	1 819 523 734	140 038 770	61%
Transfers distributed by government from foreign origin	280 280 533	21 571 656	9%
Voluntary prepayment from individuals/households	63 261 454	4 868 887	2%
Voluntary prepayment from employers	108 800 672	8 373 791	4%
Other revenues from corporations n.e.c.	180 500	13 892	0%
Direct foreign transfers	**707 213 558**	**54 430 352**	**24%**
Direct bilateral financial transfers	*692 871 966*	*53 326 558*	*23%*
Direct multilateral financial transfers	*9 611 975*	*739 781*	*0%*
Direct foreign financial transfers n.e.c.	*4 729 617*	*364 013*	*0%*
Total HIV Spend in 2017/18	**2 979 260 451**	**229 297 349**	**100%**

Total funding for HIV by funding scheme, 2017/18

Namibian HIV Funding Schemes (2017/18)	Total HIV spend (NAD)	Total HIV spend (USD)	% share in 2017/18
Central government schemes	1 958 082 811	150 702 902	66%
Voluntary insurance schemes			
Government-based voluntary insurance	168 716 020	12 985 147	6%
Primary coverage schemes not disaggregated	145 067 563	11 165 055	5%
Not-for-profit organisation schemes	6 164 486	474 447	0%
For-profit enterprise schemes	180 500	13 892	0%
External: foreign development agencies schemes (non-resident)	701 049 072	53 955 905	24%
Total HIV Spend in 2017/18	**2 979 260 451**	**229 297 349**	**100%**

Public agents HIV spending by Ministry, 2017/18

Ministry	Total HIV spend (NAD)	Total HIV spend (USD)	% share in 2017/18
Ministry of Health and Social Services	1 905 446 965	146 651 810	97%
Ministry of Education	1 831 000	140 922	0.1%
Ministry of Defence	23 846 846	1 835 361	1%
Ministry of Gender Equality and Child Welfare	13 671 000	1 052 182	1%
Office of the Prime Minister	13 287 000	1 022 628	1%
Total HIV spending by public agents/purchasers	**1 958 082 811**	**150 702 902**	**100%**

Namibian HIV service provider type, 2017/18

Namibian HIV Service Providers (2017/18)	Total HIV spend (NAD)	Total HIV spend (USD)	% share in 2017/18
Public service providers	1 960 472 254	150 886 805	66%
Private non-profit providers	57 046 266	4 390 538	2%
Private for-profit providers	271 047 323	20 861 027	9%
Multilateral offices	72 800	5 603	0%
Bilateral offices, INGOs and their IPs	690 621 809	53 153 376	23%
Total HIV Spend in 2017/18	**2 979 260 451**	**229 297 349**	**100%**

Namibian HIV spending by service providers, 2017/18

Namibian HIV Service Providers (2017/18)	Total HIV spend (NAD)	Total HIV spend (USD)	% share in 2017/18
Public providers:			
Hospitals	1,383,280,578	106,463,525	46%
Clinics	344,716,221	26,530,918	12%
Schools / universities	20,061,136	1,543,996	1%
Depts. within MOHSS	45,256,349	3,483,133	2%
Other government ministries/ entities	167,157,969	12,865,233	6%
Non-profit providers:			
Schools / universities	140,500	10,814	0%
Orphanages/ carers of OVCs	13,671,000	1,052,182	0%
CSOs / FBOs / other non-profits	43,234,766	3,327,543	1%
For-profit providers:			
Hospitals	76,743,270	5,906,509	3%
Clinics	42,984,199	3,308,258	1%
Laboratories	9,608,118	739,484	0%
Ambulance services	665,675	51,233	0%
Pharmacies	77,202,487	5,941,852	3%
Other private for profit providers	63,843,573	4,913,690	2%
Multilateral agencies / country offices	**72,800**	**5,603**	**0%**
Bilateral agencies, INGOs & their IPs	**690,621,809**	**53,153,376**	**23%**
Total HIV Spend in 2017/18	**2,979,260,451**	**229,297,349**	**100%**

HIV programmatic areas, 2017/18

Namibian HIV Programmatic Areas (2017/18)	Total HIV spend (NAD)	Total HIV spend (USD)	% share in 2017/18
Prevention	279 953 417	21 546 480	9%
HIV testing and counselling	283 985 873	21 856 836	10%
Care and treatment	2 207 228 545	169 882 902	74%
Social protection and economic support	57 456 551	4 422 116	2%
Programme enablers and system strengthening	142 623 416	10 976 943	5%
HIV-related research	7 952 649	612 072	0.3%
Total HIV Spend in 2017/18	**2 979 260 451**	**229 297 349**	**100%**

Namibian HIV prevention spending by activities, 2017/18

Namibian HIV Prevention Activities (2017/18)	Total (NAD)	Total (USD)	% share in 2017/18
Five pillars of prevention:	**191 552 222**	**14 742 725**	**68%**
I. Interventions for AGYW in high prevalence countries (not disaggreg.)	36 362 955	2 798 657	13%
II. Interventions for Key Populations:	**20 800 492**	**1 600 900**	**7%**
Interventions for sex workers (not disaggreg.)	*6 716 360*	*516 921*	*2%*
Interventions for MSM (not disaggreg.)	*6 110 490*	*470 291*	*2%*
Interventions for PWID (not disaggreg.)	*603 253*	*46 429*	*0%*
Interventions for inmates (not disaggreg.)	*2 640 772*	*203 246*	*1%*
Interventions for key populations (not disaggreg.)	*4 729 617*	*364 013*	*2%*
III. Condoms (not disaggreg. By target population)	15 867 223	1 221 213	6%
IV. VMMC	114 238 893	8 792 341	41%
V. PrEP (not disaggreg. By target population)	4 282 659	329 613	2%
Other prevention activities:	**88 401 195**	**6 803 755**	**32%**
PMTCT (not disaggreg.)	34 852 025	2 682 369	12%
SBCC	14 626 615	1 125 730	5%
Community mobilisation	1 434 869	110 434	1%
Interventions for vulnerable / accessible populations (not disaggreg.)	29 922 225	2 302 950	11%
Prevention for children & youth (excluding AGYW)	1 831 000	140 922	1%
Prevention and wellness programmes in the workplace	5 734 461	441 350	2%
Total HIV Prevention Spend in 2017/18	**267 410 671**	**20 581 134**	**100%**

Namibian HIV spending by service delivery modality, 2017/18

Namibian HIV Service Delivery Modality (2017/18)	Total HIV spend (NAD)	Total HIV spend (USD)	% share in 2017/18
Facility-based service modalities	2 080 291 628	160 108 645	70%
Home and community-based service modalities	44 389 273	3 416 399	1%
Non applicable (ASC which does not have a specific SDM)	251 683 838	19 370 726	8%
Modalities not disaggregated	602 895 711	46 401 579	20%
Total HIV Spend in 2017/18	**2 979 260 451**	**229 297 349**	**100%**

Namibian HIV spending by beneficiary population, 2017/18

Namibian HIV Beneficiary Population (2017/18)	Total HIV spend (NAD)	Total HIV spend (USD)	% share in 2017/18
People Living with HIV	**2 197 132 360**	**169 101 236**	**74%**
Adult and young people (aged 15 and over) living with HIV	*1 208 614 411*	*93 020 427*	*41%*
Children (aged under 15) living with HIV	*127 810 051*	*9 836 839*	*4%*
People living with HIV not broken down by age or gender	*860 707 898*	*66 243 970*	*29%*
Key Populations:	**26 518 020**	**2 040 947**	**1%**
PWID	*603 253*	*46 429*	*0.0%*
Sex workers (SW) and their clients	*6 716 360*	*516 921*	*0.2%*
MSM	*6 110 490*	*470 291*	*0.2%*
Inmates	*2 640 772*	*203 246*	*0.1%*
"Key populations" not broken down by type	*10 447 145*	*804 059*	*0.4%*
Vulnerable, accessible and other populations	**207 648 409**	**15 981 560**	**7%**
OVC	*57 456 551*	*4 422 116*	*2%*
Pregnant and breastfeeding HIV-positive women (not on ART) and their children to be born	*34 846 656*	*2 681 956*	*1%*
AGYW in countries with high HIV prevalence	*32 582 865*	*2 507 725*	*1%*
Primary school students	*3 783 653*	*291 207*	*0%*
Secondary school students	*1 831 000*	*140 922*	*0%*
University students	*140 500*	*10 814*	*0%*
Military	*23 846 846*	*1 835 361*	*1%*
Employees (e.g. for workplace interventions)	*18 957 461*	*1 459 052*	*1%*
Vulnerable, accessible and other target populations not broken down by type	*34 202 878*	*2 632 408*	*1%*
General population	**427 146 705**	**32 875 141**	**14%**
Non-targeted interventions	**120 814 956**	**9 298 465**	**4%**
Total HIV Spend in 2017/18	**2 979 260 451**	**229 297 349**	**100%**

ANNEX C: HEALTH ACCOUNTS STATISTICAL TABLES

The statistical tables provided in this section summarize the resource tracking data through a series of two dimensional tables. Each table cross-tabulates spending for two Resource tracking classifications. Unless otherwise specified, these tables summarize recurring health spending only.

Revenues of health care financing schemes (FS) x Financing scheme (HF)

Financing schemes	Revenues of health care financing schemes	FS.1	FS.1.1	FS.2	FS.5	FS.5.1	FS.5.2	FS.6	FS.6.1	FS.6.2	FS.6.3	FS.7	FS.7.1	FS.7.1.1	FS.7.1.2	FS.7.1.3	All FS
	Namibian dollar (NAD), Million	**Transfers from government domestic revenue (allocated to health purposes)**	Internal transfers and grants	**Transfers distributed by government from foreign origin**	**Voluntary prepayment**	Voluntary prepayment from individuals/households	Voluntary prepayment from employers	**Other domestic revenues n.e.c.**	Other revenues from households n.e.c.	Other revenues from corporations n.e.c.	Other revenues from NPISH n.e.c.	**Direct foreign transfers**	Direct foreign financial transfers	Direct bilateral financial transfers	Direct multilateral financial transfers	Other direct foreign financial transfers	
HF.1	**Government schemes and compulsory contributory health care financing schemes**	**6,961.94**	**6,961.94**	**235.59**													7,197.53
HF.1.1	Government schemes	**6,961.94**	6,961.94	**235.59**													7,197.53
HF.1.1.1	Central government schemes	**6,961.94**	6,961.94	**235.59**													7,197.53
HF.2	**Voluntary health care payment schemes**	**2,201.74**	**2,201.74**		**3,577.57**	**1,208.93**	**2,368.64**	**48.35**		**34.28**	**14.07**	**21.02**	**21.02**		**3.59**	**17.42**	5,848.67
HF.2.1	Voluntary health insurance schemes	**2,201.74**	2,201.74		**3,577.57**	1,208.93	2,368.64										5,779.31
HF.2.1.1	Primary/substitutory health insurance schemes	**2,201.74**	2,201.74		**3,577.57**	1,208.93	2,368.64										5,779.31
HF.2.1.1.2	Government-based voluntary insurance	**2,201.74**	2,201.74		**419.38**	419.38											2,621.12
HF.2.1.1.3	Other primary coverage schemes				**3,158.19**	789.55	2,368.64										3,158.19
HF.2.2	NPISH financing schemes (including development agencies)							**14.07**			14.07	**21.02**	21.02		3.59	17.42	35.08
HF.2.2.1	NPISH financing schemes (excluding HF.2.2.2)							**14.07**			14.07	**21.02**	21.02		3.59	17.42	35.08
HF.2.3	Enterprise financing schemes							**34.28**		34.28							34.28
HF.2.3.1	Enterprises (except health care providers) financing schemes							**34.28**		34.28							34.28
HF.3	**Household out-of-pocket payment**							**1,166.92**	**1,166.92**								1,166.92
HF.3.1	Out-of-pocket excluding cost-sharing							**1,166.92**	1,166.92								1,166.92
HF.4	**Rest of the world financing schemes (non-resident)**											**757.63**	**757.63**	**649.49**	**108.15**		757.63
HF.4.2	Voluntary schemes (non-resident)											**757.63**	757.63	649.49	108.15		757.63
HF.4.2.2	Other schemes (non-resident)											**757.63**	757.63	649.49	108.15		757.63
HF.4.2.2.2	Foreign development agencies schemes											**757.63**	757.63	649.49	108.15		757.63
All HF		**9,163.68**	9,163.68	**235.59**	**3,577.57**	1,208.93	2,368.64	**1,215.26**	1,166.92	34.28	14.07	**778.65**	778.65	649.49	111.74	17.42	14,970.75

Institutional Units providing revenues to financing schemes (FS.RI) x Financing scheme (HF)

Financing schemes				Institutional units providing revenues to financing schemes *Namibian dollar (NAD), Million*	FS.RI.1.1 Government	FS.RI.1.2 Corporations	FS.RI.1.3 Households	FS.RI.1.5 Rest of the world	All FS.RI
HF.1				**Government schemes and compulsory contributory health care financing schemes**	**6,961.94**			**235.59**	**7,197.53**
	HF.1.1			Government schemes	**6,961.94**			**235.59**	**7,197.53**
		HF.1.1.1		Central government schemes	**6,961.94**			**235.59**	**7,197.53**
HF.2				**Voluntary health care payment schemes**	**2,201.74**	**2,402.82**	**1,208.93**	**35.19**	**5,848.67**
	HF.2.1			Voluntary health insurance schemes	**2,201.74**	**2,368.64**	**1,208.93**		**5,779.31**
		HF.2.1.1		Primary/substitutory health insurance schemes	**2,201.74**	**2,368.64**	**1,208.93**		**5,779.31**
			HF.2.1.1.2	Government-based voluntary insurance	**2,201.74**		**419.38**		**2,621.12**
			HF.2.1.1.3	Other primary coverage schemes		**2,368.64**	**789.55**		**3,158.19**
	HF.2.2			NPISH financing schemes (including development agencies)				**35.08**	**35.08**
		HF.2.2.1		NPISH financing schemes (excluding HF.2.2.2)				**35.08**	**35.08**
	HF.2.3			Enterprise financing schemes		**34.18**		**0.10**	**34.28**
		HF.2.3.1		Enterprises (except health care providers) financing schemes		**34.18**		**0.10**	**34.28**
HF.3				**Household out-of-pocket payment**			**1,166.92**		**1,166.92**
	HF.3.1			Out-of-pocket excluding cost-sharing			**1,166.92**		**1,166.92**
HF.4				**Rest of the world financing schemes (non-resident)**				**757.63**	**757.63**
	HF.4.2			Voluntary schemes (non-resident)				**757.63**	**757.63**
		HF.4.2.2		Other schemes (non-resident)				**757.63**	**757.63**
			HF.4.2.2.2	Foreign development agencies schemes				**757.63**	**757.63**
All HF					**9,163.68**	**2,402.82**	**2,375.84**	**1,028.41**	**14,970.75**

Institutional Units providing revenues to financing schemes (FS.RI) x Financing agent (FA)

Financing agents	Institutional units providing revenues to financing schemes *Namibian dollar (NAD), Million*	FS.RI.1.1 Government	FS.RI.1.2 Corporations	FS.RI.1.3 Households	FS.RI.1.5 Rest of the world	All FS.RI
FA.1	**General government**	**6,961.94**			**235.59**	**7,197.53**
FA.1.1	Central government	**6,861.67**			**235.59**	**7,097.26**
FA.1.1.1	Ministry of Health	**6,731.89**			**235.59**	**6,967.48**
FA.1.1.2	Ministry of Education	**1.83**				**1.83**
FA.1.1.4	Office of the Prime Minister	**13.29**				**13.29**
FA.1.1.6	Ministry of Defense	**104.35**				**104.35**
FA.1.1.12	Other Central Ministries and Public Bodies	**10.31**				**10.31**
FA.1.3	Social security agency	**100.27**				**100.27**
FA.1.3.1	Social Health Insurance Agency	**100.27**				**100.27**
FA.1.3.1.2	Parastatal insurance organizations	**100.27**				**100.27**
FA.2	**Insurance corporations**	**2,201.74**	**2,368.64**	**1,208.93**		**5,779.31**
FA.2.1	Commercial insurance companies	**2,201.74**	**2,368.64**	**1,208.93**		**5,779.31**
FA.3	**Corporations (Other than insurance corporations) (part of HF.RI.1.2)**		**34.18**		**0.10**	**34.28**
FA.3.2	Corporations (Other than providers of health services)		**34.18**		**0.10**	**34.28**
FA.4	**Non-profit institutions serving households (NPISH)**				**395.09**	**395.09**
FA.5	**Households**			**1,166.92**		**1,166.92**
FA.6	**Rest of the world**				**397.62**	**397.62**
All FA		**9,163.68**	**2,402.82**	**2,375.84**	**1,028.41**	**14,970.75**

Institutional Units providing revenues to financing schemes (FS.RI) x Function (HC)

Health care functions				Institutional units providing revenues to financing schemes *Namibian dollar (NAD), Million*	FS.RI.1.1 Government	FS.RI.1.2 Corporations	FS.RI.1.3 Households	FS.RI.1.5 Rest of the world	All FS.RI
HC.1				**Curative care**	**6,008.76**	**1,474.42**	**1,663.96**	**395.98**	**9,543.12**
	HC.1.1			Inpatient curative care	**2,776.32**	**893.34**	**916.78**		**4,586.44**
		HC.1.1.1		General inpatient curative care	**2,776.32**	**722.98**	**859.99**		**4,359.29**
		HC.1.1.2		Specialised inpatient curative care		**170.36**	**56.79**		**227.15**
	HC.1.2			Day curative care		**200.08**	**66.69**		**266.78**
		HC.1.2.1		General day curative care		**145.63**	**48.54**		**194.17**
		HC.1.2.2		Specialised day curative care		**54.45**	**18.15**		**72.60**
	HC.1.3			Outpatient curative care	**3,232.43**	**378.87**	**680.46**	**395.98**	**4,687.75**
		HC.1.3.1		General outpatient curative care	**3,232.43**	**190.71**	**594.96**	**395.98**	**4,414.08**
		HC.1.3.2		Dental outpatient curative care		**117.23**	**39.08**		**156.31**
		HC.1.3.3		Specialised outpatient curative care		**70.93**	**23.64**		**94.57**
		HC.1.3.nec		Unspecified outpatient curative care (n.e.c.)			**22.79**		**22.79**
	HC.1.4			Home-based curative care		**0.08**	**0.03**		**0.11**
	HC.1.nec			Unspecified curative care (n.e.c.)		**2.03**			**2.03**
HC.2				**Rehabilitative care**		**0.10**	**0.03**		**0.13**
	HC.2.1			Inpatient rehabilitative care		**0.10**	**0.03**		**0.13**
HC.3				**Long-term care (health)**				**16.59**	**16.59**
	HC.3.3			Outpatient long-term care (health)				**3.59**	**3.59**
	HC.3.4			Home-based long-term care (health)				**13.00**	**13.00**
HC.4				**Ancillary services (non-specified by function)**	**554.37**	**289.31**	**196.67**	**28.06**	**1,068.40**
	HC.4.1			Laboratory services		**160.49**	**53.50**	**28.06**	**242.05**
	HC.4.2			Imaging services		**117.69**	**39.23**		**156.93**
	HC.4.3			Patient transportation	**28.12**	**11.12**	**3.71**		**42.95**
	HC.4.nec			Unspecified ancillary services (n.e.c.)	**526.24**		**100.24**		**626.48**
HC.5				**Medical goods (non-specified by function)**	**689.53**	**468.91**	**432.78**	**66.17**	**1,657.39**
	HC.5.1			Pharmaceuticals and Other medical non-durable goods	**689.53**	**383.35**	**404.26**	**66.17**	**1,543.31**
		HC.5.1.1		Prescribed medicines	**689.53**	**383.35**	**258.23**	**66.17**	**1,397.28**
		HC.5.1.3		Other medical non-durable goods			**146.03**		**146.03**
	HC.5.2			Therapeutic appliances and Other medical goods		**85.56**	**28.52**		**114.08**
		HC.5.2.1		Glasses and Other vision products		**74.68**	**24.89**		**99.57**
		HC.5.2.2		Hearing aids		**10.88**	**3.63**		**14.51**
HC.6				**Preventive care**	**489.60**	**14.94**	**17.24**	**414.01**	**935.79**
	HC.6.1			Information, education and counseling (IEC) programmes	**15.12**	**0.18**		**79.34**	**94.63**
		HC.6.1.1		Addictive substances IEC programmes				**1.83**	**1.83**
			HC.6.1.1.nec	Other and unspecified addictive substances IEC programmes (n.e.c.)				**1.83**	**1.83**
		HC.6.1.2		Nutrition IEC programmes				**0.26**	**0.26**
		HC.6.1.3		Safe sex IEC programmes	**15.12**	**0.10**		**72.10**	**87.33**
		HC.6.1.nec		Other and unspecified IEC programmes (n.e.c.)		**0.08**		**5.14**	**5.22**
	HC.6.2			Immunisation programmes	**318.58**			**2.02**	**320.59**
	HC.6.3			Early disease detection programmes	**108.19**	**0.25**		**97.11**	**205.55**
	HC.6.4			Healthy condition monitoring programmes	**42.27**	**4.01**	**16.02**	**0.03**	**62.32**
	HC.6.5			Epidemiological surveillance and risk and disease control programmes		**3.08**	**1.02**	**224.75**	**228.84**
		HC.6.5.1		Planning & Management				**12.39**	**12.39**
		HC.6.5.2		Monitoring & Evaluation (M&E)				**4.58**	**4.58**
		HC.6.5.4		Interventions		**3.08**	**1.02**	**116.73**	**120.82**
			HC.6.5.4.1	Male circumcision		**3.05**	**1.02**	**110.06**	**114.12**
			HC.6.5.4.2	Condom promotion and distribution				**1.41**	**1.41**
			HC.6.5.4.nec	Other and unspecified interventions (n.e.c.)		**0.03**		**5.27**	**5.30**
		HC.6.5.nec		Unspecified epidemiological surveillance and risk and disease control programmes (n.e.c.)				**91.05**	**91.05**
	HC.6.6			Preparing for disaster and emergency response programmes				**0.01**	**0.01**
	HC.6.nec			Unspecified preventive care (n.e.c.)	**5.45**	**7.43**	**0.21**	**10.76**	**23.84**

Health care functions		Institutional units providing revenues to financing schemes *Namibian dollar (NAD), Million*	FS.RI.1.1 Government	FS.RI.1.2 Corporations	FS.RI.1.3 Households	FS.RI.1.5 Rest of the world	All FS.RI
HC.7		**Governance, and health system and financing administration**	**1,421.43**		**13.45**	**107.52**	**1,542.39**
HC.7.1		Governance and Health system administration	**1,342.72**			**107.21**	**1,449.94**
	HC.7.1.1	Planning & Management	**1,341.35**			**69.46**	**1,410.81**
	HC.7.1.2	Monitoring & Evaluation (M&E)				**29.53**	**29.53**
	HC.7.1.3	Procurement & supply management	**1.37**			**8.06**	**9.43**
	HC.7.1.nec	Other governance and Health system administration (n.e.c.)				**0.17**	**0.17**
HC.7.2		Administration of health financing	**78.70**		**13.45**		**92.15**
HC.7.nec		Unspecified governance, and health system and financing administration (n.e.c.)				**0.30**	**0.30**
HC.9		**Other health care services not elsewhere classified (n.e.c.)**		**155.15**	**51.72**	**0.07**	**206.94**
All HC			**9,163.68**	**2,402.82**	**2,375.84**	**1,028.41**	**14,970.75**

Financing scheme (HF) x Health care function (HC)

Health care functions			Financing schemes	HF.1	HF.2	HF.2.1	HF.2.1.1	HF.2.1.1.2	HF.2.1.1.3	HF.2.2	HF.2.2.1	HF.2.3	HF.2.3.1	HF.3	HF.4	All HF
			Namibian dollar (NAD), Million	Government schemes and compulsory contributory health care financing schemes	Voluntary health care payment schemes	Voluntary health insurance schemes	Primary/substitutory health insurance schemes	Government-based voluntary insurance	Other primary coverage schemes	NPISH financing schemes (including development agencies)	NPISH financing schemes (excluding HF.2.2.2)	Enterprise financing schemes	Enterprises (except health care providers) financing schemes	Household out-of-pocket payment	Rest of the world financing schemes (non-resident)	
HC.1			**Curative care**	**5,136.80**	**3,052.97**	**3,031.16**	**3,031.16**	**1,094.35**	**1,936.81**			**21.81**	**21.81**	**1,004.66**	**348.69**	**9,543.12**
	HC.1.1		Inpatient curative care	**2,400.12**	**1,638.99**	1,638.99	1,638.99	447.86	1,191.12					**547.34**		**4,586.44**
		HC.1.1.1	General inpatient curative care	**2,400.12**	**1,411.84**	1,411.84	1,411.84	447.86	963.98					**547.34**		**4,359.29**
		HC.1.1.2	Specialised inpatient curative care		**227.15**	227.15	227.15		227.15							**227.15**
	HC.1.2		Day curative care		**266.78**	266.78	266.78		266.78							**266.78**
		HC.1.2.1	General day curative care		**194.17**	194.17	194.17		194.17							**194.17**
		HC.1.2.2	Specialised day curative care		**72.60**	72.60	72.60		72.60							**72.60**
	HC.1.3		Outpatient curative care	**2,736.69**	**1,145.06**	1,125.28	1,125.28	646.48	478.79			19.78	19.78	**457.33**	**348.69**	**4,687.75**
		HC.1.3.1	General outpatient curative care	**2,736.69**	**894.17**	874.39	874.39	646.48	227.91			19.78	19.78	**434.54**	**348.69**	**4,414.08**
		HC.1.3.2	Dental outpatient curative care		**156.31**	156.31	156.31		156.31							**156.31**
		HC.1.3.3	Specialised outpatient curative care		**94.57**	94.57	94.57		94.57							**94.57**
		HC.1.3.nec	Unspecified outpatient curative care (n.e.c.)											**22.79**		**22.79**
	HC.1.4		Home-based curative care		**0.11**	0.11	0.11		0.11							**0.11**
	HC.1.nec		Unspecified curative care (n.e.c.)		**2.03**							2.03	2.03			**2.03**
HC.2			**Rehabilitative care**		**0.13**	**0.13**	**0.13**		**0.13**							**0.13**
HC.3			**Long-term care (health)**	**13.00**	**3.59**					**3.59**	**3.59**					**16.59**
HC.4			**Ancillary services (non-specified by function)**	**28.12**	**1,012.22**	**1,012.22**	**1,012.22**	**626.48**	**385.74**						**28.06**	**1,068.40**
	HC.4.1		Laboratory services		**213.99**	213.99	213.99		213.99						**28.06**	**242.05**
	HC.4.2		Imaging services		**156.93**	156.93	156.93		156.93							**156.93**
	HC.4.3		Patient transportation	**28.12**	**14.83**	14.83	14.83		14.83							**42.95**
	HC.4.nec		Unspecified ancillary services (n.e.c.)		**626.48**	626.48	626.48	626.48								**626.48**

Health care functions				Financing schemes / Namibian dollar (NAD), Million	HF.1 Government schemes and compulsory contributory health care financing schemes	HF.2 Voluntary health care payment schemes	HF.2.1 Voluntary health insurance schemes	HF.2.1.1 Primary/substitutory health insurance schemes	HF.2.1.1.2 Government-based voluntary insurance	HF.2.1.1.3 Other primary coverage schemes	HF.2.2 NPISH financing schemes (including development agencies)	HF.2.2.1 NPISH financing schemes (excluding HF.2.2.2)	HF.2.3 Enterprise financing schemes	HF.2.3.1 Enterprises (except health care providers) financing schemes	HF.3 Household out-of-pocket payment	HF.4 Rest of the world financing schemes (non-resident)	All HF
HC.5				**Medical goods (non-specified by function)**	**70.05**	**1,441.31**	**1,440.84**	**1,440.84**	**816.26**	**624.58**			**0.47**	**0.47**	**146.03**		**1,657.39**
	HC.5.1			Pharmaceuticals and Other medical non-durable goods	**70.05**	**1,327.23**	1,326.76	1,326.76	816.26	510.50			0.47	0.47	**146.03**		**1,543.31**
		HC.5.1.1		Prescribed medicines	**70.05**	**1,327.23**	1,326.76	1,326.76	816.26	510.50			0.47	0.47			**1,397.28**
		HC.5.1.3		Other medical non-durable goods											**146.03**		**146.03**
	HC.5.2			Therapeutic appliances and Other medical goods		**114.08**	114.08	114.08		114.08							**114.08**
		HC.5.2.1		Glasses and Other vision products		**99.57**	99.57	99.57		99.57							**99.57**
		HC.5.2.2		Hearing aids		**14.51**	14.51	14.51		14.51							**14.51**
HC.6				**Preventive care**	**554.09**	**34.85**	**4.06**	**4.06**		**4.06**	**18.80**	**18.80**	**12.00**	**12.00**	**16.22**	**330.62**	**935.79**
	HC.6.1			Information, education and counseling (IEC) programmes	**51.01**	**0.18**							0.18	0.18		**43.44**	**94.63**
		HC.6.1.1		Addictive substances IEC programmes	**1.83**												**1.83**
			HC.6.1.1.nec	Other and unspecified addictive substances IEC programmes (n.e.c.)	**1.83**												**1.83**
		HC.6.1.2		Nutrition IEC programmes	**0.13**											**0.13**	**0.26**
		HC.6.1.3		Safe sex IEC programmes	**43.91**	**0.10**							0.10	0.10		**43.31**	**87.33**
		HC.6.1.nec		Other and unspecified IEC programmes (n.e.c.)	**5.14**	**0.08**							0.08	0.08			**5.22**
	HC.6.2			Immunisation programmes	**318.58**											**2.02**	**320.59**
	HC.6.3			Early disease detection programmes	**111.76**	**14.32**					14.07	14.07	0.25	0.25		**79.47**	**205.55**
	HC.6.4			Healthy condition monitoring programmes	**42.27**	**4.01**							4.01	4.01	**16.02**	**0.03**	**62.32**
	HC.6.5			Epidemiological surveillance and risk and disease control programmes	**25.01**	**4.20**	4.06	4.06		4.06			0.13	0.13		**199.63**	**228.84**
		HC.6.5.1		Planning & Management	**3.06**											**9.33**	**12.39**
		HC.6.5.2		Monitoring & Evaluation (M&E)	**0.07**											**4.51**	**4.58**
		HC.6.5.4		Interventions	**21.88**	**4.09**	4.06	4.06		4.06			0.03	0.03		**94.85**	**120.82**
			HC.6.5.4.1	Male circumcision	**19.49**	**4.06**	4.06	4.06		4.06						**90.57**	**114.12**
			HC.6.5.4.2	Condom promotion and distribution	**1.41**												**1.41**
			HC.6.5.4.nec	Other and unspecified interventions (n.e.c.)	**0.98**	**0.03**							0.03	0.03		**4.28**	**5.30**
		HC.6.5.nec		Unspecified epidemiological surveillance and risk and disease control programmes (n.e.c.)		**0.10**							0.10	0.10		**90.95**	**91.05**
	HC.6.6			Preparing for disaster and emergency response programmes	**0.01**												**0.01**
	HC.6.nec			Unspecified preventive care (n.e.c.)	**5.45**	**12.16**					4.73	4.73	7.43	7.43	**0.21**	**6.03**	**23.84**

Health care functions			Financing schemes	HF.1	HF.2	HF.2.1					HF.2.2		HF.2.3		HF.3	HF.4	All HF
							HF.2.1.1		HF.2.1.1.2	HF.2.1.1.3		HF.2.2.1		HF.2.3.1			
			Namibian dollar (NAD), Million	Government schemes and compulsory contributory health care financing schemes	Voluntary health care payment schemes	Voluntary health insurance schemes	Primary/substitutory health insurance schemes	Government-based voluntary insurance	Other primary coverage schemes	NPISH financing schemes (including development agencies)	NPISH financing schemes (excluding HF.2.2.2)	Enterprise financing schemes	Enterprises (except health care providers) financing schemes	Household out-of-pocket payment	Rest of the world financing schemes (non-resident)	
HC.7			**Governance, and health system and financing administration**	**1,395.47**	**96.73**	**84.03**	**84.03**	**84.03**		**12.69**	**12.69**				**50.19**	**1,542.39**
	HC.7.1		Governance and Health system administration	**1,387.35**	**12.69**					12.69	12.69				**49.89**	**1,449.94**
		HC.7.1.1	Planning & Management	**1,367.20**											**43.62**	**1,410.81**
		HC.7.1.2	Monitoring & Evaluation (M&E)	**16.54**	**12.69**					12.69	12.69				**0.29**	**29.53**
		HC.7.1.3	Procurement & supply management	**3.62**											**5.81**	**9.43**
		HC.7.1.nec	Other governance and Health system administration (n.e.c.)												**0.17**	**0.17**
	HC.7.2		Administration of health financing	**8.12**	**84.03**	84.03	84.03	84.03								**92.15**
	HC.7.nec		Unspecified governance, and health system and financing administration (n.e.c.)												**0.30**	**0.30**
HC.9			**Other health care services not elsewhere classified (n.e.c.)**		**206.87**	**206.87**	**206.87**		**206.87**						**0.07**	**206.94**
All HC				**7,197.53**	**5,848.67**	**5,779.31**	**5,779.31**	**2,621.12**	**3,158.19**	**35.08**	**35.08**	**34.28**	**34.28**	**1,166.92**	**757.63**	**14,970.75**

Health care provider (HP) x Health care function (HC)

Health care functions				Health care providers / Namibian dollar (NAD), Million	HP.1 Hospitals	HP.1.1							HP.1.2	HP.2 Residential long-term care facilities	HP.2.1 Long-term nursing care facilities	HP.2.2 Mental health and substance abuse facilities	HP.3 Providers of ambulatory health care	HP.3.1 Medical practices	HP.3.2 Dental practice	HP.3.3 Other health care practitioners	HP.3.4 Ambulatory health care centres	HP.3.5 Providers of home health care services	HP.3.nec Unspecified providers of ambulatory health care (n.e.c.)
						HP.1.1.1					HP.1.1.2	HP.1.1.nec											
							HP.1.1.1.1	HP.1.1.1.2	HP.1.1.1.nec														
						General hospitals	Government hospital	Referral hospital	District hospital	Other Government hospital	Private for-profit hospital	Other General hospitals	Mental health hospitals										
HC.1				**Curative care**	**6,742.78**	**6,736.99**	**4,699.25**	**2,954.06**	**1,611.42**	**133.77**	**2,028.96**	**8.78**	**5.79**	**14.90**	**14.38**	**0.52**	**2,660.22**	**913.40**	**165.81**	**624.12**	**956.76**	**0.11**	**0.01**
	HC.1.1			Inpatient curative care	**4,121.43**	4,115.64	2,460.03	1,344.88	998.07	117.08	1,655.61		5.79	**11.74**	11.22	0.52	**413.70**	345.11	9.50		59.10	0.00	
		HC.1.1.1		General inpatient curative care	**4,121.43**	4,115.64	2,460.03	1,344.88	998.07	117.08	1,655.61		5.79	**11.74**	11.22	0.52	**186.55**	117.96	9.50		59.10	0.00	
		HC.1.1.2		Specialised inpatient curative care													**227.15**	227.15					
	HC.1.2			Day curative care	**216.55**	216.55	0.32			0.32	216.23			**3.16**	3.16		**47.07**	32.93			14.14	0.00	
		HC.1.2.1		General day curative care	**157.61**	157.61	0.23			0.23	157.38			**2.30**	2.30		**34.26**	23.97			10.29	0.00	
		HC.1.2.2		Specialised day curative care	**58.93**	58.93	0.09			0.09	58.85			**0.86**	0.86		**12.81**	8.96			3.85	0.00	
	HC.1.3			Outpatient curative care	**2,404.80**	2,404.80	2,238.90	1,609.17	613.36	16.37	157.12	8.78					**2,199.32**	535.25	156.31	624.12	883.53	0.11	
		HC.1.3.1		General outpatient curative care	**2,398.03**	2,398.03	2,238.90	1,609.17	613.36	16.37	150.35	8.78					**1,932.46**	426.47		624.12	881.79	0.08	
		HC.1.3.2		Dental outpatient curative care													**156.31**		156.31				
		HC.1.3.3		Specialised outpatient curative care													**94.55**	94.51				0.03	
		HC.1.3.nec		Unspecified outpatient curative care (n.e.c.)	**6.78**	6.78					6.78						**16.00**	14.27			1.74		
	HC.1.4			Home-based curative care													**0.11**	0.11				0.00	
	HC.1.nec			Unspecified curative care (n.e.c.)													**0.01**						0.01
HC.2				**Rehabilitative care**	**0.11**	**0.11**	**0.00**			**0.00**	**0.11**			**0.00**	**0.00**		**0.02**	**0.02**			**0.01**		
HC.3				**Long-term care (health)**													**3.59**			**3.59**			
	HC.3.3			Outpatient long-term care (health)													**3.59**			3.59			
	HC.3.4			Home-based long-term care (health)																			
HC.4				**Ancillary services (non-specified by function)**																			
	HC.4.1			Laboratory services																			
	HC.4.2			Imaging services																			
	HC.4.3			Patient transportation																			
	HC.4.nec			Unspecified ancillary services (n.e.c.)																			
HC.5				**Medical goods (non-specified by function)**	**0.27**	**0.27**						**0.27**					**0.20**				**0.20**		**0.00**
HC.6				**Preventive care**	**240.28**	**240.28**	**228.34**	**129.83**	**98.51**	**0.00**	**8.82**	**3.12**		**0.04**	**0.04**		**434.75**	**8.11**			**426.61**	**0.00**	**0.03**
	HC.6.1			Information, education and counseling (IEC) programmes																			
		HC.6.1.1		Addictive substances IEC programmes																			
			HC.6.1.1.nec	Other and unspecified addictive substances IEC programmes (n.e.c.)																			
		HC.6.1.2		Nutrition IEC programmes																			
		HC.6.1.3		Safe sex IEC programmes																			
		HC.6.1.nec		Other and unspecified IEC programmes (n.e.c.)																			
	HC.6.2			Immunisation programmes	**145.08**	145.08	145.08	83.26	61.82								**173.50**				173.50		
	HC.6.3			Early disease detection programmes	**66.15**	66.15	66.15	37.93	28.22								**121.51**				121.51		
	HC.6.4			Healthy condition monitoring programmes	**22.30**	22.30	16.12	8.02	8.10		6.18						**35.99**	6.75			29.23		0.01
	HC.6.5			Epidemiological surveillance and risk and disease control programmes	**2.50**	2.50	0.00			0.00	2.50			**0.04**	0.04		**99.08**	1.36			97.70	0.00	0.02
		HC.6.5.1		Planning & Management													**2.68**				2.68		
		HC.6.5.2		Monitoring & Evaluation (M&E)																			
		HC.6.5.4		Interventions	**2.50**	2.50	0.00			0.00	2.50			**0.04**	0.04		**96.40**	1.36			95.01	0.00	0.02
			HC.6.5.4.1	Male circumcision	**2.50**	2.50	0.00			0.00	2.50			**0.04**	0.04		**92.09**	1.36			90.73	0.00	
			HC.6.5.4.2	Condom promotion and distribution																			
			HC.6.5.4.nec	Other and unspecified interventions (n.e.c.)													**4.30**				4.28		0.02
		HC.6.5.nec		Unspecified epidemiological surveillance and risk and disease control programmes (n.e.c.)																			
	HC.6.6			Preparing for disaster and emergency response programmes																			
	HC.6.nec			Unspecified preventive care (n.e.c.)	**4.25**	4.25	0.98	0.62	0.37		0.15	3.12					**4.67**				4.67		
HC.7				**Governance, and health system and financing administration**													**5.21**				**5.21**		
HC.9				**Other health care services not elsewhere classified (n.e.c.)**																			
All HC					**6,983.44**	**6,977.65**	**4,927.59**	**3,083.89**	**1,709.93**	**133.77**	**2,037.90**	**12.17**	**5.79**	**14.93**	**14.42**	**0.52**	**3,104.00**	**921.53**	**165.81**	**627.71**	**1,388.79**	**0.11**	**0.04**

Health care functions				Health care providers	HP.4				HP.5			HP.6	HP.7	HP.8	HP.9	HP.nec	All HP
						HP.4.1	HP.4.2	HP.4.9		HP.5.1	HP.5.9						
				Namibian dollar (NAD), Million	**Providers of ancillary services**	Providers of patient transportation and emergency rescue	Medical and diagnostic laboratories	Other providers of ancillary services	**Retailers and Other providers of medical goods**	Pharmacies	All Other miscellaneous sellers and Other suppliers of pharmaceuticals and medical goods	**Providers of preventive care**	**Providers of health care system administration and financing**	**Rest of economy**	**Rest of the world**	**Unspecified health care providers (n.e.c.)**	
HC.1				**Curative care**								**2.87**	**5.04**	**2.25**	**0.17**	**114.90**	**9,543.12**
	HC.1.1			Inpatient curative care												**39.57**	**4,586.44**
		HC.1.1.1		General inpatient curative care												**39.57**	**4,359.29**
		HC.1.1.2		Specialised inpatient curative care													**227.15**
	HC.1.2			Day curative care													**266.78**
		HC.1.2.1		General day curative care													**194.17**
		HC.1.2.2		Specialised day curative care													**72.60**
	HC.1.3			Outpatient curative care								**0.85**	**5.04**	**2.25**	**0.17**	**75.32**	**4,687.75**
		HC.1.3.1		General outpatient curative care								**0.85**	**5.04**	**2.25**	**0.17**	**75.29**	**4,414.08**
		HC.1.3.2		Dental outpatient curative care													**156.31**
		HC.1.3.3		Specialised outpatient curative care												**0.02**	**94.57**
		HC.1.3.nec		Unspecified outpatient curative care (n.e.c.)												**0.01**	**22.79**
	HC.1.4			Home-based curative care												**0.00**	**0.11**
	HC.1.nec			Unspecified curative care (n.e.c.)								**2.02**					**2.03**
HC.2				**Rehabilitative care**													**0.13**
HC.3				**Long-term care (health)**										**13.00**			**16.59**
	HC.3.3			Outpatient long-term care (health)													**3.59**
	HC.3.4			Home-based long-term care (health)										**13.00**			**13.00**
HC.4				**Ancillary services (non-specified by function)**	**1,068.40**	**42.95**	**242.05**	**783.41**									**1,068.40**
	HC.4.1			Laboratory services	**242.05**		242.05										**242.05**
	HC.4.2			Imaging services	**156.93**			156.93									**156.93**
	HC.4.3			Patient transportation	**42.95**	42.95											**42.95**
	HC.4.nec			Unspecified ancillary services (n.e.c.)	**626.48**			626.48									**626.48**
HC.5				**Medical goods (non-specified by function)**					**1,656.91**	**1,542.83**	**114.08**						**1,657.39**
HC.6				**Preventive care**					**0.37**		**0.37**	**142.10**	**19.86**	**0.52**	**93.14**	**4.73**	**935.79**
	HC.6.1			Information, education and counseling (IEC) programmes								**77.36**	**17.15**		**0.13**		**94.63**
		HC.6.1.1		Addictive substances IEC programmes								**1.83**					**1.83**
			HC.6.1.1.nec	Other and unspecified addictive substances IEC programmes (n.e.c.)								**1.83**					**1.83**
		HC.6.1.2		Nutrition IEC programmes								**0.13**			**0.13**		**0.26**
		HC.6.1.3		Safe sex IEC programmes								**70.19**	**17.14**				**87.33**
		HC.6.1.nec		Other and unspecified IEC programmes (n.e.c.)								**5.21**	**0.01**				**5.22**
	HC.6.2			Immunisation programmes											**2.02**		**320.59**
	HC.6.3			Early disease detection programmes								**17.89**					**205.55**
	HC.6.4			Healthy condition monitoring programmes								**4.00**			**0.03**		**62.32**
	HC.6.5			Epidemiological surveillance and risk and disease control programmes					**0.37**		0.37	**34.91**	**0.45**	**0.52**	**90.97**	**0.00**	**228.84**
		HC.6.5.1		Planning & Management								**9.30**	**0.37**		**0.03**		**12.39**
		HC.6.5.2		Monitoring & Evaluation (M&E)								**4.51**	**0.07**				**4.58**
		HC.6.5.4		Interventions					**0.37**		0.37	**21.10**		**0.41**	**0.00**	**0.00**	**120.82**
			HC.6.5.4.1	Male circumcision								**19.49**				**0.00**	**114.12**
			HC.6.5.4.2	Condom promotion and distribution					**0.37**		0.37	**1.03**					**1.41**
			HC.6.5.4.nec	Other and unspecified interventions (n.e.c.)								**0.58**		**0.41**	**0.00**		**5.30**
		HC.6.5.nec		Unspecified epidemiological surveillance and risk and disease control programmes (n.e.c.)									**0.02**	**0.10**	**90.93**		**91.05**
	HC.6.6			Preparing for disaster and emergency response programmes								**0.01**					**0.01**
	HC.6.nec			Unspecified preventive care (n.e.c.)								**7.94**	**2.25**			**4.73**	**23.84**
HC.7				**Governance, and health system and financing administration**								**2.80**	**1,527.72**	**0.03**	**6.63**		**1,542.39**
HC.9				**Other health care services not elsewhere classified (n.e.c.)**											**0.07**	**206.87**	**206.94**
All HC					**1,068.40**	**42.95**	**242.05**	**783.41**	**1,657.29**	**1,542.83**	**114.45**	**147.77**	**1,552.62**	**15.79**	**100.00**	**326.49**	**14,970.75**

Health care function (HC) x Classification of diseases / conditions (DIS)

Classification of diseases / conditions		Health care functions *Namibian dollar (NAD), Million*	HC.1 Curative care	HC.1.1 Inpatient curative care	HC.1.2 Day curative care	HC.1.3 Outpatient curative care	HC.1.4 Home-based curative care	HC.1.nec Unspecified curative care (n.e.c.)	HC.2 Rehabilitative care	HC.3 Long-term care (health)	HC.4 Ancillary services (non-specified by function)	HC.4.1 Laboratory services	HC.4.2 Imaging services	HC.4.3 Patient transportation	HC.4.nec Unspecified ancillary services (n.e.c.)	HC.5 Medical goods (non-specified by function)
DIS.1		**Infectious and parasitic diseases**	**2,782.03**	**681.71**	**14.19**	**2,086.12**	**0.01**	**0.01**	**0.01**	**16.59**	**185.72**	**39.44**	**8.35**	**0.79**	**137.14**	**278.76**
	DIS.1.1	HIV/AIDS and Other Sexually Transmitted Diseases (STDs)	**1,919.79**	101.38	11.98	1,806.42	0.00		**0.01**	**13.00**	**87.04**	37.67	7.05	0.67	41.66	**148.53**
	DIS.1.2	Tuberculosis (TB)	**326.67**	314.94		11.72		0.01		**3.59**						**0.02**
	DIS.1.3	Malaria	**72.85**	53.88	2.21	16.75	0.00		**0.00**		**3.70**	1.78	1.30	0.12	0.50	**5.87**
	DIS.1.4	Respiratory infections	**153.73**	36.75		116.99					**50.87**				50.87	**66.28**
	DIS.1.5	Diarrheal diseases	**224.21**	141.77		82.44					**29.70**				29.70	**38.83**
	DIS.1.6	Neglected tropical diseases	**6.79**	0.47		6.32										
	DIS.1.7	Vaccine preventable diseases	**24.00**	15.11		8.90					**8.21**				8.21	**10.70**
	DIS.1.nec	Other and unspecified infectious and parasitic diseases (n.e.c.)	**54.00**	17.42		36.58					**6.20**				6.20	**8.53**
DIS.2		**Reproductive health**	**962.24**	**703.13**		**259.11**					**224.09**				**224.09**	**292.22**
	DIS.2.1	Maternal conditions	**800.08**	592.29		207.79					**201.35**				201.35	**262.50**
	DIS.2.2	Perinatal conditions	**132.66**	110.15		22.51					**21.80**				21.80	**28.42**
	DIS.2.3	Contraceptive management (family planning)	**16.36**	0.25		16.11					**0.31**				0.31	**0.45**
	DIS.2.nec	Unspecified reproductive health conditions (n.e.c.)	**13.14**	0.45		12.69					**0.63**				0.63	**0.85**
DIS.3		**Nutritional deficiencies**	**46.45**	**41.45**		**5.00**										**0.01**
DIS.4		**Noncommunicable diseases**	**3,311.65**	**2,187.48**	**242.35**	**881.72**	**0.10**		**0.12**		**546.51**	**194.40**	**142.56**	**13.47**	**196.09**	**822.93**
	DIS.4.1	Neoplasms	**569.43**	366.42	58.67	144.32	0.02		**0.03**		**123.98**	47.06	34.51	3.26	39.16	**188.38**
	DIS.4.2	Endocrine and metabolic disorders	**213.65**	134.62	19.99	59.03	0.01		**0.01**		**48.77**	16.04	11.76	1.11	19.86	**72.68**
	DIS.4.3	Cardiovascular diseases	**599.20**	371.17	49.33	178.67	0.02		**0.02**		**148.83**	39.57	29.02	2.74	77.50	**216.47**
	DIS.4.4	Mental & behavioural disorders, and Neurological conditions	**462.54**	307.70	40.97	113.85	0.02		**0.02**		**72.65**	32.87	24.10	2.28	13.41	**113.40**
	DIS.4.5	Respiratory diseases	**355.17**	272.97	26.44	55.75	0.01		**0.01**		**38.23**	21.21	15.55	1.47		**61.90**
	DIS.4.6	Diseases of the digestive	**529.72**	340.29	46.95	142.45	0.02		**0.02**		**67.89**	37.66	27.62	2.61		**109.93**
	DIS.4.7	Diseases of the genito-urinary system	**142.16**	121.48		20.68										
	DIS.4.8	Sense organ disorders	**99.72**	88.25		11.47										
	DIS.4.9	Oral diseases	**0.06**	0.00		0.06										
	DIS.4.nec	Other and unspecified noncommunicable diseases (n.e.c.)	**340.00**	184.57		155.43					**46.17**				46.17	**60.18**
DIS.5		**Injuries**	**699.24**	**511.17**		**188.08**					**37.16**			**0.32**	**36.84**	**188.62**
DIS.6		**Non-disease specific**	**81.28**	**25.91**		**53.34**		**2.02**			**60.13**			**27.80**	**32.33**	**42.38**
DIS.nec		**Other and unspecified diseases/conditions (n.e.c.)**	**1,660.23**	**435.60**	**10.23**	**1,214.40**	**0.00**		**0.01**		**14.80**	**8.21**	**6.02**	**0.57**		**32.46**
All DIS			**9,543.12**	**4,586.44**	**266.78**	**4,687.75**	**0.11**	**2.03**	**0.13**	**16.59**	**1,068.40**	**242.05**	**156.93**	**42.95**	**626.48**	**1,657.39**

Health care functions		HC.6	HC.6.1							HC.6.2	HC.6.3	HC.6.4	HC.6.5											HC.6.6	HC.6.nec
				HC.6.1.1			HC.6.1.2	HC.6.1.3	HC.6.1.nec					HC.6.5.1	HC.6.5.2	HC.6.5.4						HC.6.5.nec				
					HC.6.1.1.nec												HC.6.5.4.1	HC.6.5.4.2	HC.6.5.4.nec							
Classification of diseases / conditions	*Namibian dollar (NAD), Million*	Preventive care	Information, education and counseling (IEC) programmes	Addictive substances IEC programmes	Other and unspecified addictive substances IEC programmes (n.e.c.)	Nutrition IEC programmes	Safe sex IEC programmes	Other and unspecified IEC programmes (n.e.c.)	Immunisation programmes	Early disease detection programmes	Healthy condition monitoring programmes	Epidemiological surveillance and risk and disease contrd programmes	Planning & Management	Monitoring & Evaluation (M&E)	Interventions	Male circumcision	Condom promotion and distribution	Other and unspecified interventions (n.e.c.)	Unspecified epidemiological surveillance and risk and disease control programmes (n.e.c.)	Preparing for disaster and emergency response programmes	Unspecified preventive care (n.e.c.)
DIS.1	**Infectious and parasitic diseases**	**859.49**	**94.47**	**1.83**	**1.83**	**0.13**	**87.33**	**5.18**	**320.20**	**205.20**	**0.06**	**228.73**	**12.36**	**4.58**	**120.80**	**114.12**	**1.41**	**5.27**	**91.00**	**0.01**	**10.83**
DIS.1.1	HIV/AIDS and Other Sexually Transmitted Diseases (STDs)	**433.91**	94.36	1.83	1.83	0.13	87.33	5.07	0.05	191.09	0.01	137.63	12.26	4.58	120.79	114.12	1.41	5.27			10.78
DIS.1.2	Tuberculosis (TB)	**91.03**	0.09					0.09	0.01	0.00	0.00	90.91			0.00			0.00	90.91		0.01
DIS.1.3	Malaria	**14.25**	0.02					0.02	0.01	14.07	0.00	0.13	0.10		0.01			0.01	0.02	0.01	0.00
DIS.1.4	Respiratory infections	**0.02**							0.01	0.00	0.00										0.01
DIS.1.5	Diarrheal diseases	**0.01**							0.00	0.00	0.00										0.01
DIS.1.6	Neglected tropical diseases	**0.00**							0.00	0.00	0.00										0.00
DIS.1.7	Vaccine preventable diseases	**320.15**							320.08	0.03	0.02										0.01
DIS.1.nec	Other and unspecified infectious and parasitic diseases (n.e.c.)	**0.14**							0.03	0.01	0.03	0.06							0.06		0.00
DIS.2	**Reproductive health**	**53.12**	**0.02**			**0.02**			**0.02**	**0.01**	**47.30**	**0.10**	**0.03**		**0.02**			**0.02**	**0.04**		**5.68**
DIS.2.1	Maternal conditions	**47.34**							0.00	0.00	47.27	0.06	0.03						0.03		0.00
DIS.2.2	Perinatal conditions	**0.02**							0.00	0.00	0.00	0.01							0.01		0.01
DIS.2.3	Contraceptive management (family planning)	**5.69**							0.02	0.00	0.03										5.64
DIS.2.nec	Unspecified reproductive health conditions (n.e.c.)	**0.07**	0.02			0.02			0.00	0.00	0.00	0.02			0.02			0.02			0.03
DIS.3	**Nutritional deficiencies**	**0.16**	**0.11**			**0.11**			**0.02**	**0.00**	**0.00**	**0.02**							**0.02**		**0.01**
DIS.4	**Noncommunicable diseases**	**0.27**	**0.04**					**0.04**	**0.13**	**0.03**	**0.02**										**0.04**
DIS.4.1	Neoplasms	**0.01**							0.00	0.00	0.00										0.01
DIS.4.2	Endocrine and metabolic disorders	**0.02**							0.01	0.00	0.00										0.00
DIS.4.3	Cardiovascular diseases	**0.05**							0.03	0.01	0.01										0.00
DIS.4.4	Mental & behavioural disorders, and Neurological conditions	**0.05**							0.03	0.01	0.00										0.01
DIS.4.5	Respiratory diseases	**0.01**							0.01	0.00	0.00										0.00
DIS.4.6	Diseases of the digestive	**0.03**							0.02	0.00	0.00										0.00
DIS.4.7	Diseases of the genito-urinary system	**0.02**							0.01	0.00	0.00										0.00
DIS.4.8	Sense organ disorders	**0.02**							0.02	0.00	0.00										0.00
DIS.4.9	Oral diseases	**0.00**							0.00	0.00	0.00										0.00
DIS.4.nec	Other and unspecified noncommunicable diseases (n.e.c.)	**0.06**	0.04					0.04	0.00	0.00	0.00										0.02
DIS.5	**Injuries**	**0.05**							**0.00**	**0.00**	**0.00**										**0.05**
DIS.6	**Non-disease specific**	**11.77**							**0.20**	**0.30**	**4.03**										**7.24**
DIS.nec	**Other and unspecified diseases/conditions (n.e.c.)**	**10.93**							**0.03**	**0.01**	**10.90**										**0.00**
All DIS		**935.79**	**94.63**	**1.83**	**1.83**	**0.26**	**87.33**	**5.22**	**320.59**	**205.55**	**62.32**	**228.84**	**12.39**	**4.58**	**120.82**	**114.12**	**1.41**	**5.30**	**91.05**	**0.01**	**23.84**

Classification of diseases / conditions		Health care functions	HC.7	HC.7.1					HC.7.2	HC.7.nec	HC.9	All HC
		Namibian dollar (NAD), Million	Governance, and health system and financing administration	Governance and Health system administration	HC.7.1.1 Planning & Management	HC.7.1.2 Monitoring & Evaluation (M&E)	HC.7.1.3 Procurement & supply management	HC.7.1.nec Other governance and Health system administration (n.e.c.)	Administration of health financing	Unspecified governance, and health system and financing administration (n.e.c.)	Other health care services not elsewhere classified (n.e.c.)	
DIS.1		**Infectious and parasitic diseases**	**137.21**	**137.21**	**107.09**	**29.23**	**0.89**				**11.08**	**4,270.88**
	DIS.1.1	HIV/AIDS and Other Sexually Transmitted Diseases (STDs)	**110.77**	110.77	93.76	16.54	0.47				**9.36**	**2,722.39**
	DIS.1.2	Tuberculosis (TB)	**5.86**	5.86	5.85		0.02					**427.17**
	DIS.1.3	Malaria	**18.96**	18.96	6.24	12.69	0.03				**1.72**	**117.34**
	DIS.1.4	Respiratory infections	**0.06**	0.06	0.04		0.01					**270.96**
	DIS.1.5	Diarrheal diseases	**0.03**	0.03	0.02		0.01					**292.78**
	DIS.1.6	Neglected tropical diseases	**0.01**	0.01	0.01		0.00					**6.80**
	DIS.1.7	Vaccine preventable diseases	**1.18**	1.18	0.92		0.27					**364.24**
	DIS.1.nec	Other and unspecified infectious and parasitic diseases (n.e.c.)	**0.33**	0.33	0.26		0.07					**69.20**
DIS.2		**Reproductive health**	**4.41**	**4.11**	**0.15**		**3.95**			**0.30**		**1,536.08**
	DIS.2.1	Maternal conditions	**4.24**	3.93	0.02		3.91			0.30		**1,315.51**
	DIS.2.2	Perinatal conditions	**0.01**	0.01	0.01		0.00					**182.91**
	DIS.2.3	Contraceptive management (family planning)	**0.16**	0.16	0.13		0.04					**22.98**
	DIS.2.nec	Unspecified reproductive health conditions (n.e.c.)	**0.00**	0.00	0.00		0.00					**14.69**
DIS.3		**Nutritional deficiencies**	**0.16**	**0.16**	**0.12**		**0.03**					**46.78**
DIS.4		**Noncommunicable diseases**	**1.29**	**1.29**	**1.00**		**0.29**				**187.92**	**4,870.69**
	DIS.4.1	Neoplasms	**0.02**	0.02	0.02		0.01				**45.49**	**927.34**
	DIS.4.2	Endocrine and metabolic disorders	**0.14**	0.14	0.10		0.03				**15.50**	**350.77**
	DIS.4.3	Cardiovascular diseases	**0.33**	0.33	0.26		0.07				**38.25**	**1,003.16**
	DIS.4.4	Mental & behavioural disorders, and Neurological conditions	**0.28**	0.28	0.22		0.06				**31.77**	**680.71**
	DIS.4.5	Respiratory diseases	**0.06**	0.06	0.05		0.01				**20.50**	**475.88**
	DIS.4.6	Diseases of the digestive	**0.17**	0.17	0.13		0.04				**36.41**	**744.16**
	DIS.4.7	Diseases of the genito-urinary system	**0.11**	0.11	0.08		0.02					**142.29**
	DIS.4.8	Sense organ disorders	**0.16**	0.16	0.12		0.03					**99.90**
	DIS.4.9	Oral diseases	**0.00**	0.00	0.00		0.00					**0.06**
	DIS.4.nec	Other and unspecified noncommunicable diseases (n.e.c.)	**0.02**	0.02	0.01		0.00					**446.44**
DIS.5		**Injuries**	**8.12**	**0.01**	**0.00**		**0.00**		**8.12**			**933.19**
DIS.6		**Non-disease specific**	**1,390.94**	**1,306.91**	**1,302.24**	**0.29**	**4.20**	**0.17**	**84.03**			**1,586.50**
DIS.nec		**Other and unspecified diseases/conditions (n.e.c.)**	**0.26**	**0.26**	**0.20**		**0.06**				**7.94**	**1,726.62**
All DIS			**1,542.39**	**1,449.94**	**1,410.81**	**29.53**	**9.43**	**0.17**	**92.15**	**0.30**	**206.94**	**14,970.75**

Institutional unit providing revenues to financing scheme (FS.RI) x Gross fixed capital formation (HK)

Capital Account			Institutional units providing revenues to financing schemes *Namibian dollar (NAD), Million*	FS.RI.1.1 Government	FS.RI.1.2 Corporations	FS.RI.1.5 Rest of the world	FS.RI.1.5.2 Multilateral donors	FS.RI.1.5.2.8 Global Fund	FS.RI.1.5.3 Private donors	FS.RI.1.5.3.2 Pharmaceutical companies	All FS.RI
HK.1			**Gross capital formation**	**361.26**		**59.59**	**54.92**	**54.92**	**4.67**	**4.67**	**420.85**
HK.1.1			Gross fixed capital formation	**361.26**		**59.59**	54.92	54.92	4.67	4.67	**420.85**
	HK.1.1.1		Infrastructure	**275.39**		**35.30**	35.30	35.30			**310.69**
		HK.1.1.1.1	Residential and non-residential buildings	**275.39**		**35.30**	35.30	35.30			**310.69**
	HK.1.1.2		Machinery and equipment	**85.87**		**24.29**	19.62	19.62	4.67	4.67	**110.16**
		HK.1.1.2.1	Medical equipment	**48.09**		**2.58**	2.58	2.58			**50.67**
		HK.1.1.2.2	Transport equipment	**14.36**		**5.16**	0.48	0.48	4.67	4.67	**19.52**
		HK.1.1.2.3	ICT equipment	**22.53**		**0.26**	0.26	0.26			**22.78**
		HK.1.1.2.4	Machinery and equipment n.e.c.	**0.89**		**16.30**	16.30	16.30			**17.19**
HK.nec			**Unspecified gross fixed capital formation (n.e.c.)**		**0.44**						**0.44**
All HK				**361.26**	**0.44**	**59.59**	**54.92**	**54.92**	**4.67**	**4.67**	**421.29**

Health care provider (HP) x Gross fixed capital formation (HK)

Capital Account			Health care providers *Namibian dollar (NAD), Million*	HP.1 Hospitals	HP.3 Providers of ambulatory health care	HP.6 Providers of preventive care	HP.7 Providers of health care system administration and financing	HP.8 Rest of economy	All HP
HK.1			**Gross capital formation**	**136.99**	**151.41**	**0.14**	**132.31**	**0.01**	**420.85**
	HK.1.1		Gross fixed capital formation	**136.99**	**151.41**	**0.14**	**132.31**	**0.01**	**420.85**
		HK.1.1.1	Infrastructure	**123.93**	**134.44**	**0.01**	**52.32**		**310.69**
			HK.1.1.1.1 Residential and non-residential buildings	**123.93**	**134.44**	**0.01**	**52.32**		**310.69**
		HK.1.1.2	Machinery and equipment	**13.07**	**16.97**	**0.13**	**79.99**	**0.01**	**110.16**
			HK.1.1.2.1 Medical equipment	**12.42**	**2.21**	**0.12**	**35.92**		**50.67**
			HK.1.1.2.2 Transport equipment		**0.07**		**19.45**		**19.52**
			HK.1.1.2.3 ICT equipment			**0.01**	**22.77**		**22.78**
			HK.1.1.2.4 Machinery and equipment n.e.c.	**0.64**	**14.69**	**0.00**	**1.85**	**0.01**	**17.19**
HK.nec			**Unspecified gross fixed capital formation (n.e.c.)**				**0.44**		**0.44**
All HK				**136.99**	**151.41**	**0.14**	**132.75**	**0.01**	**421.29**

ANNEX D: NASA HIV STATISTICAL TABLES

HIV Funding Entities to Funding Agents and Purchasers (2017/18)

	Namibian Dollars (NAD)				United States Dollars (USD)			
HIV Funding Entities:	**Public agents/ purchasers**	**Private agents/ purchasers**	**Intern. agents/ purchasers**	**Total NAD**	**Public agents/ purchasers**	**Private agents/ purchasers**	**Intern. agents/ purchasers**	**Total USD**
Central government	1 677 802 278	141 721 456		1 819 523 734	129 131 246	10 907 524		140 038 770
Domestic corporations		108 981 172		108 981 172		8 387 684		8 387 684
Households		63 261 454		63 261 454		4 868 887		4 868 887
Governments providing bilateral aid			**692 871 966**				**53 326 558**	**53 326 558**
Government of Sweden			*2 250 158*	*2 250 158*			*173 182*	*173 182*
Government of United States			*690 621 809*	*690 621 809*			*53 153 376*	*53 153 376*
Multilateral Organizations	**280 280 533**	**1 434 869**	**8 177 106**	**289 892 507**	**21 571 656**	**110 434**	**629 347**	**22 311 437**
The Global Fund to Fight AIDS, Tuberculosis and Malaria	*280 280 533*			*280 280 533*	*21 571 656*			*21 571 656*
UNAIDS Secretariat		*1 434 869*	*4 320 653*	*5 755 522*		*110 434*	*332 537*	*442 971*
United Nations Educational, Scientific and Cultural Organization (UNESCO)			*3 783 653*	*3 783 653*			*291 207*	*291 207*
World Health Organization (WHO)			*72 800*	*72 800*			*5 603*	*5 603*
International not-for-profit organizations and foundations		**4 729 617**		**4 729 617**		**364 013**		**364 013**
Total HIV Spend in 2017	**1 958 082 811**	**320 128 568**	**701 049 072**	**2 979 260 451**	**150 702 902**	**24 638 541**	**53 955 905**	**229 297 349**

HIV Funding Entities to Service Providers (2017/18)

HIV Funding Entities by Service Provider (2017/18)	Public service providers	Non-profit providers	For-profit providers	International agencies / their IPs	Total NAD
Central government	1 700 063 336	13 671 000	105 789 398		1 819 523 734
Domestic corporations		140 500	108 840 672		108 981 172
Households	6 844 202		56 417 252		63 261 454
Governments providing bilateral aid:					
Government of Sweden	2 250 158				2 250 158
Government of United States				690 621 809	690 621 809
Multilateral Organizations:					
The Global Fund to Fight AIDS, Tuberculosis and Malaria	243 210 253	37 070 280			280 280 533
UNAIDS Secretariat	4 320 653	1 434 869			5 755 522
United Nations Educational, Scientific and Cultural Organization (UNESCO)	3 783 653				3 783 653
World Health Organization (WHO)				72 800	72 800
International not-for-profit organizations and foundations		4 729 617			4 729 617
Total HIV Spend in 2017/18	**1 960 472 254**	**57 046 266**	**271 047 323**	**690 694 608**	**2 979 260 451**

Namibia HIV Spending: Activity by funding entity (2017/18, USD) = GAM Indicator 8.1

GAM INDICATOR 8.1 (US$)	FE.01 Public Entities		FE.01 Public Entities Total	FE.02 Domestic Private Entitites			FE.02 Domestic Private Entitites Total	FE.03 International Entities										FE.03 International Entities Total	Grand Total
	FE.01.01 Governmental	FE.01.01 Governmental Total		FE.02.01 Domestic corporations	FE.02.02 Households	FE.02.02 Households Total		FE.03.01 Governments providing bilateral aid		FE.03.01 Governments providing bilateral aid Total	FE.03.02 Multilateral Organizations				FE.03.02 Multilateral Organizations Total	FE.03.03 INGOs and foundations	FE.03.03 INGOs and foundations Total		
	FE.01.01.01 Central government							FE.03.01.26 Government of Sweden	FE.03.01.30 Government of United States		FE.03.02.07 The Global Fund	FE.03.02.08 UNAIDS Secretariat	FE.03.02.12 UNESCO	FE.03.02.20 World Health Organization (WHO)		FE.03.03.99 Other INGOs n.e.c.			
ASC.01 Prevention	**2 128 896**	**2 128 896**	**2 128 896**	**245 541**	**78 153**	**78 153**	**323 694**	**173 182**	**13 239 668**	**13 412 850**	**4 915 387**	**110 434**	**291 207**		**5 317 028**	**364 013**	**364 013**	**19 093 891**	**21 546 480**
ASC.01.01 Five Pillars of Prevention	965 346	965 346	965 346	234 458	78 153	78 153	312 611	173 182	8 333 572	8 506 754	4 302 794		291 207		4 594 001	364 013	364 013	13 464 768	14 742 725
ASC.01.01.01 Prevention for adolescent girls and young women (AGYW) and their male partners in settings with high HIV prevalence											2 507 450		291 207		2 798 657			2 798 657	2 798 657
ASC.01.01.02 Services for key populations								173 182	1 033 641	1 206 824	30 063				30 063	364 013	364 013	1 600 900	1 600 900
ASC.01.01.03 Condoms (for HIV prevention) for the general population (excluding KPs and AGYW above)	965 346	965 346	965 346								255 867				255 867			255 867	1 221 213
ASC.01.01.04 Voluntary medical male circumcision (VMMC) for HIV prevention				234 458	78 153	78 153	312 611		6 970 317	6 970 317	1 509 414				1 509 414			8 479 731	8 792 341
ASC.01.01.05 Pre-Exposure Prophilaxis (PrEP)									329 613	329 613								329 613	329 613
ASC.01.02 Other Prevention activities	1 163 550	1 163 550	1 163 550	11 083			11 083		4 906 096	4 906 096	612 593	110 434			723 027			5 629 123	6 803 756
ASC.01.02.01 Prevention of vertical transmission of HIV infection (PMTCT)									2 606 225	2 606 225	76 144				76 144			2 682 369	2 682 369
ASC.01.02.02 Social and behavioural communication for change (SBCC) for populations other than key populations	1 022 628	1 022 628	1 022 628								103 103				103 103			103 103	1 125 730
ASC.01.02.03 Community mobilization for populations other than key populations												110 434			110 434			110 434	110 434
ASC.01.02.04 Programmatic activities for vulnerable and accessible populations				3 079			3 079		2 299 871	2 299 871								2 299 871	2 302 950
ASC.01.02.05 Prevention for children and youth (excluding for AGYW in countries with high HIV prevalence)	140 922	140 922	140 922																140 922
ASC.01.02.07 Prevention and wellness programmes in the workplace				8 004			8 004				433 346				433 346			433 346	441 350
ASC.02 HIV testing and counselling (HTC)	**13 693 990**	**13 693 990**	**13 693 990**	**1 297 967**	**431 809**	**431 809**	**1 729 775**		**6 116 595**	**6 116 595**	**316 476**				**316 476**			**6 433 071**	**21 856 836**
ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	138 941	138 941	138 941	2 540			2 540												141 480
ASC.02.09 Voluntary HIV testing and counselling for general population											1 038				1 038			1 038	1 038
ASC.02.98 HIV testing and counselling activities not disaggregated	13 555 049	13 555 049	13 555 049	1 295 427	431 809	431 809	1 727 236		6 116 595	6 116 595	315 438				315 438			6 432 033	21 714 318

ASC.03 HIV Care and Treatment Care	**121 229 132**	**121 229 132**	**121 229 132**	**6 844 176**	**4 358 926**	**4 358 926**	**11 203 102**		**24 217 519**	**24 217 519**	**13 233 150**				**13 233 150**			**37 450 668**	**169 882 902**
ASC.03.01 Anti-retroviral therapy	114 150 442	114 150 442	114 150 442	6 307 758	4 167 713	4 167 713	10 475 470				10 717 197				10 717 197			10 717 197	135 343 110
ASC.03.01.01 ART for adults	92 080 850	92 080 850	92 080 850								5 092 966				5 092 966			5 092 966	97 173 817
ASC.03.01.02 ART for paediatrics	9 519 294	9 519 294	9 519 294	238 159	79 386	79 386	317 545												9 836 839
ASC.03.01.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment nor for PMTCT	12 550 298	12 550 298	12 550 298	6 069 599	4 088 326	4 088 326	10 157 925				5 624 231				5 624 231			5 624 231	28 332 454
ASC.03.02 Adherence and retention on ART - support (including nutrition and transport) and monitoring											1 216 846				1 216 846			1 216 846	1 216 846
ASC.03.03 Specific ART-related laboratory monitoring	837 225	837 225	837 225																837 225
ASC.03.04 Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs	65 609	65 609	65 609		12 497	12 497	12 497				1 282 442				1 282 442			1 282 442	1 360 549
ASC.03.06 Palliative care											14 293				14 293			14 293	14 293
ASC.03.98 Care and treatment services not disaggregated	6 175 855	6 175 855	6 175 855	269			269		24 217 519	24 217 519								24 217 519	30 393 643
ASC.03.99 Care and treatment services n.e.c.				536 149	178 716	178 716	714 865				2 371				2 371			2 371	717 236
ASC.04 Social protection and economic support (for PLHIV, their familes, for KPs and for OVCs)	**1 052 182**	**1 052 182**	**1 052 182**						**3 339 136**	**3 339 136**	**30 798**				**30 798**			**3 369 934**	**4 422 116**
ASC.04.01 Social protection and economic support for OVC	1 052 182	1 052 182	1 052 182						3 339 136	3 339 136	30 798				30 798			3 369 934	4 422 116
ASC.06 Programme enablers and systems strengthening	**1 934 570**	**1 934 570**	**1 934 570**						**6 240 458**	**6 240 458**	**2 463 775**	**332 537**		**5 603**	**2 801 915**			**9 042 372**	**10 976 943**
ASC.06.01 Strategic planning, coordination and policy development											302 994	332 537		5 603	641 134			641 134	641 134
ASC.06.03 Programme administration and management costs (above service-delivery level)	1 934 570	1 934 570	1 934 570								3 005				3 005			3 005	1 937 575
ASC.06.04 Strategic information									1 060 551	1 060 551	525 227				525 227			1 585 778	1 585 778
ASC.06.04.01 Monitoring and evaluation											63 102				63 102			63 102	63 102
ASC.06.04.02 Operations and implementation science research											452 908				452 908			452 908	452 908
ASC.06.04.03 Serological-surveillance (serosurveillance)									713 621	713 621								713 621	713 621
ASC.06.04.06 Financial tracking and monitoring (National AIDS Spending Assessments -NASA)											9 217				9 217			9 217	9 217
ASC.06.04.98 Strategic information not disaggregated by type									346 929	346 929								346 929	346 929
ASC.06.05 Public Systems Strengthenin									2 159 612	2 159 612	556 106				556 106			2 715 718	2 715 718
ASC.06.05.01 Procurement and supply chain											23 066				23 066			23 066	23 066
ASC.06.05.02 Laboratory system strengthening									2 159 612	2 159 612	164 961				164 961			2 324 572	2 324 572
ASC.06.05.04 Financial and accounting systems strengthening											128 725				128 725			128 725	128 725
ASC.06.05.98 Public system strengthening not disaggregated											239 354				239 354			239 354	239 354
ASC.06.06 Community system strengthening											26 641				26 641			26 641	26 641
ASC.06.07 Human resources for health (above-site programmes)											1 049 802				1 049 802			1 049 802	1 049 802
ASC.06.98 Programme enablers and systems strengthening not disagregated									3 020 295	3 020 295								3 020 295	3 020 295
ASC.08 HIV-related research											**612 072**				**612 072**			**612 072**	**612 072**
Grand Total	**140 038 770**	**140 038 770**	**140 038 770**	**8 387 684**	**4 868 887**	**4 868 887**	**13 256 571**	**173 182**	**53 153 376**	**53 326 558**	**21 571 656**	**442 971**	**291 207**	**5 603**	**22 311 437**	**364 013**	**364 013**	**76 002 008**	**229 297 349**

Namibian HIV programmatic areas by funding entities

HIV Funding Entities by programmatic area (2017/18)	Public funding entities	Private funding entities (domestic)	International funding entities	Total NAD
Prevention	15 118 000	4 205 750	248 086 921	267 410 671
HIV testing and counselling	177 926 009	22 474 972	83 584 893	276 475 781
Care and treatment	1 587 672 855	145 561 904	486 596 531	2 219 831 290
Social protection and economic support	13 671 000		43 785 551	57 456 551
Programme enablers and system strengthening	25 135 870		117 487 545	142 623 416
HIV-related research			7 952 649	7 952 649
Total HIV Spend in 2017/18	**1 819 523 734**	**172 242 626**	**987 494 090**	**2 979 260 451**