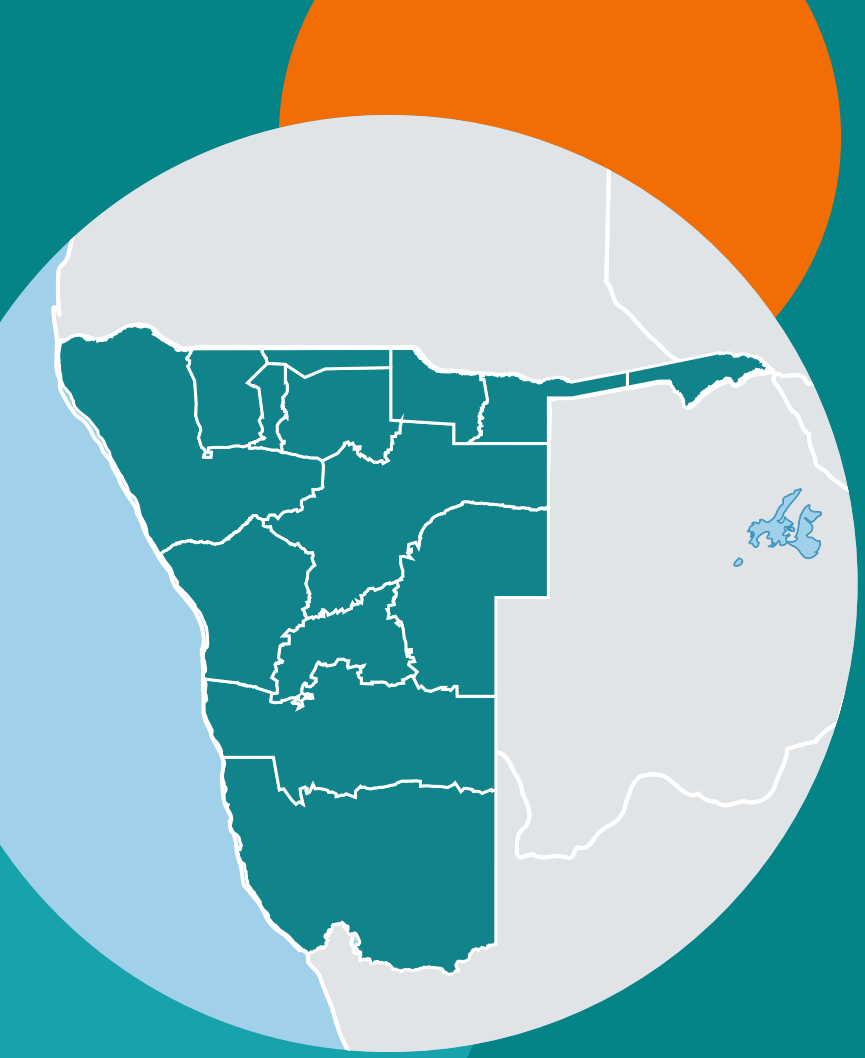

Regional Guide to Sustainable Domestic Malaria Financing in Namibia

Evidence and recommendations for regional Malaria Elimination Task Forces and their partners to improve subnational malaria budget allocations through resource mobilisation advocacy

July 2021

UCSF Institute for Global Health Sciences
Global Health Group

CEGAA

Republic of Namibia
Ministry of Health and Social Services
National Vector-borne Diseases Control Programme

WIPE OUT MALARIA

Recommended citation
Malaria Elimination Initiative. (2021). *Regional Guide to Sustainable Domestic Malaria Financing in Namibia*. San Francisco: Institute for Global Health Sciences, University of California, San Francisco.

Produced in the United States of America. July 2021.

Developed by the University of California, San Francisco, Malaria Elimination Initiative in collaboration with the Centre for Economic Governance and Accountability in Africa and Namibia's National Vector-borne Diseases Control Programme.

The Malaria Elimination Initiative (MEI) at the University of California San Francisco (UCSF) believes a malaria-free world is possible within a generation. As a forward-thinking partner to malaria-eliminating countries and regions, the MEI generates evidence, develops new tools and approaches, disseminates experiences, and builds consensus to shrink the malaria map. With support from the MEI's highly-skilled team, countries around the world are actively working to eliminate malaria.

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Contents

Acronyms

BoN	Bank of Namibia
CEGAA	Centre for Economic Governance and Accountability in Africa
CTC	Cabinet Treasury Committee
DSP	Directorate for Special Programmes
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GDP	Gross domestic product
IRS	Indoor residual spraying
METF	Malaria Elimination Task Force
MoHSS	Ministry of Health and Social Services
MoF	Ministry of Finance
MP	Member of Parliament
MTEF	Medium-Term Expenditure Framework
MURD	Ministry of Urban and Rural Development
NMSP	National Malaria Strategic Plan
NPC	National Planning Commission
NSA	National Statistics Agency
NVDCP	National Vector-borne Diseases Control Programme
OAG	Office of the Auditor General
O/M/A	Offices, Ministries and Agencies
RDCC	Regional Development Coordinating Committee
RACOC	Regional AIDS Coordinating Committee
RHD	Regional Health Directorate
RMT	Regional Management Team
SADC	Southern African Development Community
UCSF MEI	University of California, San Francisco Malaria Elimination Initiative
WHO	World Health Organization

Introduction

In 2020–2021, regional Malaria Elimination Task Forces (METFs) were established in four regions in northern Namibia—Kavango East, Kavango West, Oshikoto, and Zambezi—through the support and partnership between Namibia's National Vector-borne Diseases Control Programme (NVDCP), Regional Management Teams (RMTs), and the University of California, San Francisco's Malaria Elimination Initiative (UCSF MEI). Comprised of multisectoral leaders, the METFs aim to elevate malaria on the regional government's agenda and secure the resources necessary for local malaria response that will accelerate progress toward malaria elimination. However, METF members, many of whom are not malaria or health financing experts, may find that Namibia's malaria domestic financing flows and public sector budget processes to be complicated or difficult to navigate. METF members have an opportunity to influence domestic budgets and mobilise resources by becoming familiar with Namibia's malaria strategy, domestic financing processes at central and regional levels, and the challenges and opportunities to improve domestic financing as a key pillar to accelerating Namibia's elimination of malaria.

In coordination with the NVDCP and with recognition of the need to strengthen capacities on budget-related skills and engagement among regional stakeholders, UCSF MEI introduced a partnership between the RMTs in six of Namibia's malaria-endemic regions (Kavango East, Kavango West,[A] Ohangwena, Oshana, Oshikoto, and Zambezi) and the Centre for Economic Governance and Accountability in Africa (CEGAA) between 2019–2021. The partnership sought to identify key regional challenges in malaria programme financing and develop advocacy strategies to address them. To inform targeted budget requests to regional budgetary authorities, the RMTs in the UCSF MEI/CEGAA-supported regions set out to undertake a comprehensive budget analysis, including historical expenditure review. Major gaps in malaria budget data availability, accessibility, and transparency emerged as key issues impeding budget advocacy efforts, including those to be led by the newly established METFs.

This guide was created to provide the METFs with a shared understanding of:

1. Namibia's current budget structures and processes as they relate to health and malaria
2. The key challenges and specific opportunities for METFs to engage with the budget process to ensure sufficient and sustainable financial resources for malaria response.

A While Kavango East and Kavango West are two separate regions in terms of government administration, they continue to be managed by one Regional Health Directorate.

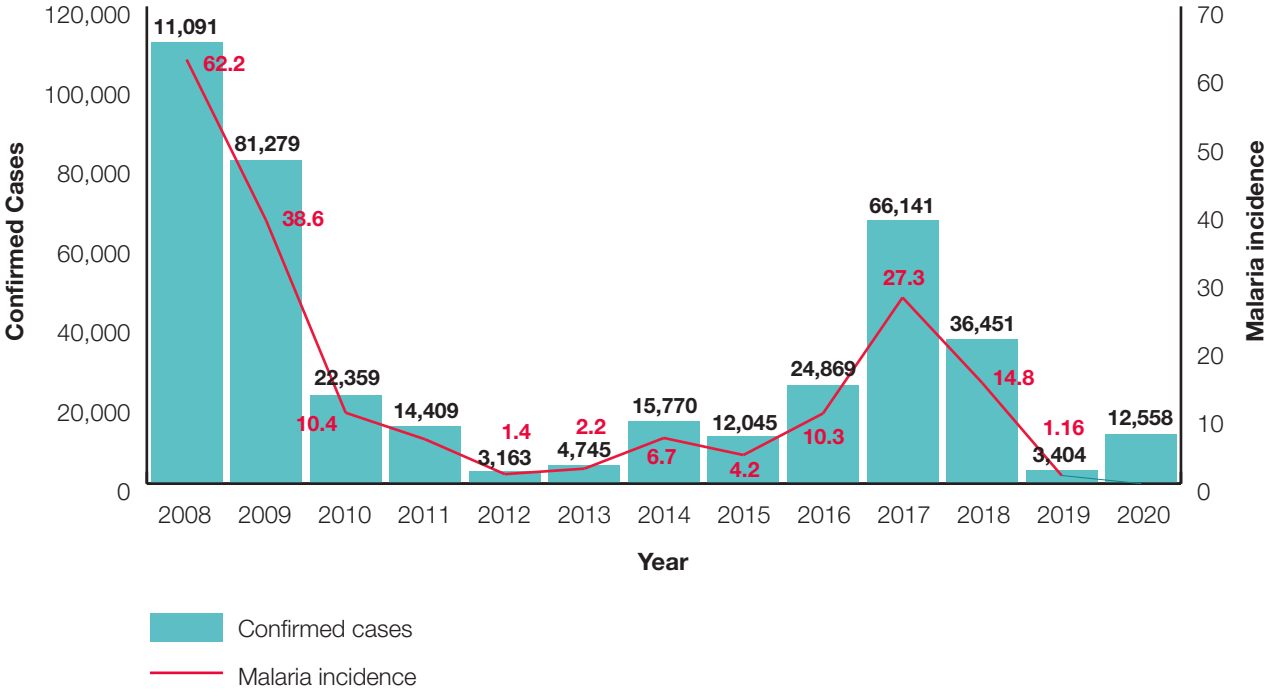
Overview of Namibia's Malaria Programme and Decentralisation Efforts

Namibia's malaria epidemiology and political support

Namibia aims to eliminate malaria by 2022. As one of the 'frontline four' countries in the Southern African Development Community (SADC) Elimination 8, Namibia has made remarkable gains in driving down its burden of malaria, with a decrease in annual reported cases from 66,141 cases in 2017 to 3,404 cases in 2019.[1] However, in 2020, 12,558 malaria cases were reported in the first six months alone, representing a nearly 4-fold increase from the total annual reported malaria cases in 2019.[2] Malaria is concentrated in Namibia's eight northern regions that border Angola, Botswana, Zambia, and Zimbabwe, and the vast majority of malaria transmission occurs in just four of these regions: Kavango East, Kavango West, Ohangwena, and Zambezi.

Despite a recent increase in malaria cases, Namibia has a relatively low malaria burden compared to other infectious diseases like HIV—and more recently, COVID-19—often placing malaria lower on the health agenda of Namibia's national and regional governments. However, Namibia has signalled a strong malaria elimination commitment at the head of state level, as a signatory to the Windhoek Declaration on Eliminating Malaria in the SADC region (2018) and a member of the African Union whose heads of state committed to eliminate malaria by 2030 as articulated in the Continental Development Agenda 2063 and the Catalytic Framework to End AIDS, TB, and Eliminate Malaria in Africa by 2030.[3]

Figure 1. Confirmed malaria cases and incidence in Namibia, 2008–2020



Source: Namibia NVDCP; Presentation, Tsumeb, Namibia: 2021.

Namibia's decentralised health governance structures

Namibia's Regional Health Directorates (RHDs), under the Ministry of Health and Social Services (MoHSS), were created in 1994 to plan and manage all local primary health care services and facilities, giving each region its own administrative, financial, and personnel management capacity.[B] This decentralisation of responsibility to the subnational level is intended to facilitate more equitable distribution of resources for health according to local health needs.[4] The MoHSS remains responsible for policy decisions, guideline development, and provision of general public health services to the population, while the regions have become increasingly responsible for the operational, financial, and technical aspects of their health programming.

The Ministry of Urban and Rural Development (MURD) is responsible for regional governance through Regional Councils and local governance through Local Authorities and plays an important role to coordinate and spearhead the decentralisation process of the Namibian government. Progress in decentralisation of the health sector to local health authorities has been slow and fragmented. Some regions have progressed further than others in the decentralisation process and have reported more autonomy to mobilise and manage financial resources from domestic and international sources. While at different decentralisation stages, all line ministries—with the exception of the Ministry of Education, Arts and Culture which has fully decentralised—are in the process of shifting procurement, accounting, and banking functions from the central ministry in Windhoek to Regional Council offices in each regional capital.

Members of Namibia's Regional Councils and Local Authorities, elected every five years, are key power brokers between local and national levels. Regional Councillors are the only elected politicians with a clear link to their constituents and direct access to the law-making process as the exclusive members of the National Council (upper house of Namibia's Parliament). This unique position enables Regional Councillors to play an increasingly integral role as the malaria programme decentralises. Each region has a Regional Development Coordination Committee (RDCC) composed of the directors of all line ministries present in the region. The Regional Health Director is a member of the RDCC, ensuring coordination between the MoHSS and the Regional Council. At the subregional, or district level, there are District Coordinating Committees (DCC), which are multisectoral committees established to ensure efficient and effective implementation of programmes and projects as directed by the RDCC.

At the core of the Regional Councils' health response and seated within its Community Health Department is the Regional AIDS Coordinating Committee (RACOC). RACOC membership is multisectoral and, despite its AIDS-specific name, has a mandate to coordinate the regional response on all key health and social development issues. They convene stakeholders from across the region on a quarterly basis, conduct awareness activities, and coordinate relevant regional health activities. Part of the RACOC's mandate is to mobilise funds for priority activities through the Regional Council and/or other avenues. Therefore, RACOC members are well positioned to coordinate the implementation of existing resources among partners, identify funding gaps and duplications, as well as elevate the programmatic resource needs of local health implementers to budgetary decision-makers.

Aligned with RACOCs at subregional level are the Constituency AIDS Coordinating Committees (CACOCs), which are responsible for coordinating community-based planning and service delivery for service delivery for priority health issues. The committees are multisectoral with diverse participation from different stakeholders including community-based and non-governmental organisations. The CACOCs operate under the auspices of their Constituency Councils and, in some regions, CACOCs also coordinate other health-oriented activities like malaria awareness campaigns for their constituencies.

Namibia's malaria programme

Namibia's malaria programme is currently led by the NVDCP within the MoHSS. The NVDCP was initially established in 1991 in the Primary Health Care Directorate of the MoHSS and in 2004 was integrated into the Directorate for Special Programmes (DSP), along with the tuberculosis and HIV/AIDS programmes. The DSP was initially set up to administer the three disease programs supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). The positioning of the NVDCP within the DSP improves access to multiple donor funding sources and resource mobilisation efforts from across the domestic budget as well as local and international donors.

B Thirteen regions were established in 1994, with the fourteenth established in 2014 upon the administrative split of Kavango East and Kavango West.

The NVDCP provides strategic vision, coordination, and oversight to the implementation of malaria activities in the regions. Malaria control and elimination efforts are guided by the 2017–2022 National Malaria Strategic Plan (NMSP). The NMSP is intended to guide a cohesive and coordinated malaria response by subnational malaria programme implementers as well as all malaria partners in the country.

The health staff at the subnational level (although not all exclusive to malaria) is larger than the existing organisational structure of the NVDCP, which is highly centralised. Each RHD has an RMT, which is responsible for all regional public health interventions, including malaria. The RMTs are composed of the five managers within the RHD: Regional Health Director, Chief Medical Officer, Chief of Health Programmes/ DSP Focal Person, Chief of Environmental Health, and Senior Accountant.

Across Namibia's 14 regions, there are 35 health districts each with a district coordinating committee answering to the relevant RMT. Malaria services are provided across the range of health facilities, including hospitals (referral, intermediate, and district), health centres, clinics, and community health outreach posts. At community level there are 2,500 community health outreach posts.[5] Figure 2 illustrates the portion of this national structure which is relevant to the malaria programme.

Figure 2. Current organisational structure of the malaria programme in Namibia

Central	Regional	District	Health Facility	Community
• Chief Medical Officer • Chief Health Programme Officer: Vector Control • Senior Health Officer: Case management • Senior Health Officer: Parasitology • Senior Health Officer: Vector control • Monitoring and Evaluation Officer • Administrative Officer	• Chief of Health Programmes: DSP Focal Person • Environmental Health Officer/ Assistant • **Regional Malaria Surveillance Officer and Clinical Mentor***	• Environmental Health Officer/ Assistant	• Nurse • Doctor (where applicable)	• **Malaria Community Health Workers (CHWs)** • Health Extension Workers

Color of text: Position's mandate

Black: Position has malaria mandate in addition to other disease areas

Orange: Position is fully focused on malaria

Font: Position's funding source

Bold: Position is reliant on donor funding

Light: Position is publicly funded

*In some cases, multiple regions and/or districts are covered by one Surveillance Officer and Clinical Mentor

Source: Namibia's National Malaria Strategic Plan 2017–2022;[5] UCSF MEI Malaria Budget Advocacy workshop discussions and interviews

As Namibia's malaria transmission has become more focal and interventions are increasingly targeted to specific high-risk populations, the NVDCP plans to decentralise more functions to subnational levels. The NVDCP has proposed expanding its subnational capacities to address barriers to achieve malaria elimination, especially at district level. Although some restructuring of existing posts has taken place and donor-funded (i.e., short-term) malaria-specific posts have been created to address capacity gaps, the proposed future structure is still not fully in place because of the substantial financial resource requirements.

Key message

As decentralisation continues, subnational malaria programme staff – primarily at regional and district levels – are being delegated greater leadership and management responsibilities covering the operational, financial, and technical aspects of the malaria elimination programme. However, the size of the health and malaria budgets that regions command does not align with the scope of their technical and operational responsibilities. As the malaria programme continues to decentralise management functions, it will be essential for regions to access adequate malaria financing in order for subnational leaders to take ownership of their regional malaria responses.

Namibia's Financing for Health and Malaria

Overall health spending

Namibia's government has steadily increased its health spending as a percentage of total government expenditure. Over the three most recent fiscal years for which data is available (2015/16 through 2017/18), health spending has increased by one percentage point per year, from 13% to 15%.[6] With the 15% allocation of national expenditure to health in 2017/2018, Namibia met the Abuja Declaration[C] target, one of the only countries in Africa to do so.

As Namibia's disease burden shifts from communicable to non-communicable diseases, spending patterns have similarly shifted. Namibia's domestic spending on infectious and parasitic disease decreased slightly, from 33% of total health expenditure in 2012/13 to 28% in 2017/18, whereas spending on non-communicable diseases increased by a larger proportion, from 5% of total health expenditure in 2012/13 to 33% in 2017/18. Non-disease specific spending, including expenditures on administrative expenses and national-level overheads, increased substantially from less than 1% share in 2012/13 health expenditure to 23% share in 2016/17.[6]

After years of economic growth – an average of 4.4% annual gross domestic product (GDP) growth between 1991 to 2015 – Namibia's economy fell into a recession in 2016 from which it has struggled to recover.[7] Largely dependent on investments in mineral extraction and government spending, Namibia's economy has been stymied by decreasing commodity prices, lack of growth in key trade partners, and tight fiscal policy stemming from government's efforts to rebalance public finances. The recent major global economic shocks resulting from COVID-19's disruptions to international and country-level economic activity have further impacted Namibia's economy, with direct effects on the country's GDP and public revenue. Namibia's domestic economy contracted by 7.2% in real terms in 2020 (IMF) and is projected to begin a slow recovery with a modest 2.1% growth rate in 2021.[8]

C In April 2001, the Abuja Declaration was developed by the countries of the African Union with a set of targets aimed to ensure adequate and effective control of HIV/AIDS, Tuberculosis, and other infectious diseases. One target included allocating 15% of annual budget to improvement of the health sector.

This economic contraction – impacting availability of domestic resources for all government priorities, including the health sector and malaria programme – coincides with a simultaneous reduction of donor financing for malaria in Namibia (see Figure 3). Budget shortfalls and acute resource constraints will force decision-makers to make tough trade-offs on what to fund and requires that programmes engage in targeted, evidence-based advocacy to budgetary decision-makers to maintain adequate resource allocations.

Donor funding for health overall has represented a significantly decreased portion of Namibia's total health financing, representing 7% of total health expenditure in 2016/17 down from a peak of 22% in 2008/09. Actual expenditure amounts in real terms were not available.[6,9]

Malaria financing

Government spending on malaria as a proportion of overall health expenditure has remained consistently low, with Namibia's spending on malaria amounting to less than 1% of total health expenditure in 2015 and 2018.[6,9] Namibia's government financing for malaria has progressively increased in recent years, from USD 3.8 million in 2015 to just over USD 5 million per year in 2016 and 2017, to over USD 11 million per year in 2018 and 2019.[1,10] This increased domestic financing for malaria has partially counteracted diminishing donor financing for malaria, however, a funding gap remains to sustain programmatic activities as outlined in the NMSP.

From 2015 to 2019, Namibia funded the majority (78%) of malaria programme efforts through the domestic budget with less than a quarter (22%) from donor sources.[1,10] The primary donor for malaria, over the same time period, was the Global Fund (68% of donor funding), followed by smaller contributions by the WHO and others.[1,10] Global Fund funding for Namibia's malaria response is generally declining in light of the country's upper middle-income classification (Figure 3). While a slight increase in allocation was noted in the most recent malaria allocation (2020–2022) as compared the prior round (2017–2019), it is understood that future allocations will not return to previous higher levels.

RHDs reported that the only malaria-specific funding received is for the wages for temporary indoor residual spray (IRS) operators recruited for local IRS campaigns. These wages have been included in the Global Fund malaria grant and are transferred to the regions to directly administer.

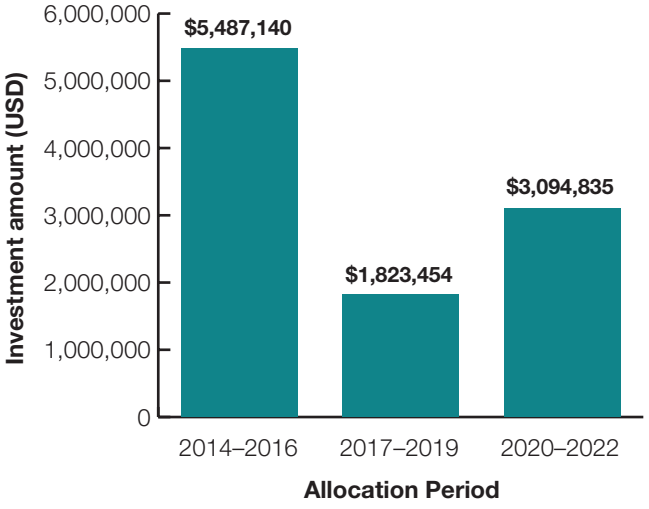
Public financing, received through the national health budget and administered through the regional health budget from the MoHSS central, is not malaria-specific. Standard budget lines include personnel expenditure (e.g., salaries and other personnel costs), and goods and services (e.g., transport related costs, supplies, training costs, and all other regional health facility operational costs).

Other subnational posts are contracted directly by central level MoHSS (regional malaria surveillance officer and clinical mentor) or by local NGOs (malaria community health workers), with no financial administration by the RHDs.

While donor financing is currently a minority of the overall malaria programme budget, there are key activities and human resources that are entirely reliant on donor support. The programme may be increasingly vulnerable if funding levels decrease without adequate time to proactively and gradually prepare for transition. For example, recent lapses in donor funding for malaria in Namibia have resulted in human resource gaps and related operational issues among the malaria surveillance officer and malaria clinical mentor positions. These are the only two malaria-specific positions at sub-national level and are fully funded by the Global Fund. In the 2020–2022 Global Fund grant, even less funds have been availed for human resources, resulting in cuts to malaria-specific personnel in the sub-national program staffing structures.

According to costing done by the NVDCP, current levels of domestic and donor financing committed for 2017 to 2022 are inadequate, with a projected financing gap of over NAD 3 billion (USD 223 million).[12]

Figure 3. Global Fund investments for malaria in Namibia, 2014–2022



Source: The Global Fund Data Explorer: Namibia[11]

Key message

All malaria stakeholders – especially those in malaria endemic regions where the need for the malaria response is greatest – stand to benefit from domestic budget advocacy efforts given the NVDCP's projected shortfall from domestic funding sources for malaria activities and the expectation of a future Global Fund funding transition.

Namibia's national health and malaria budgeting process

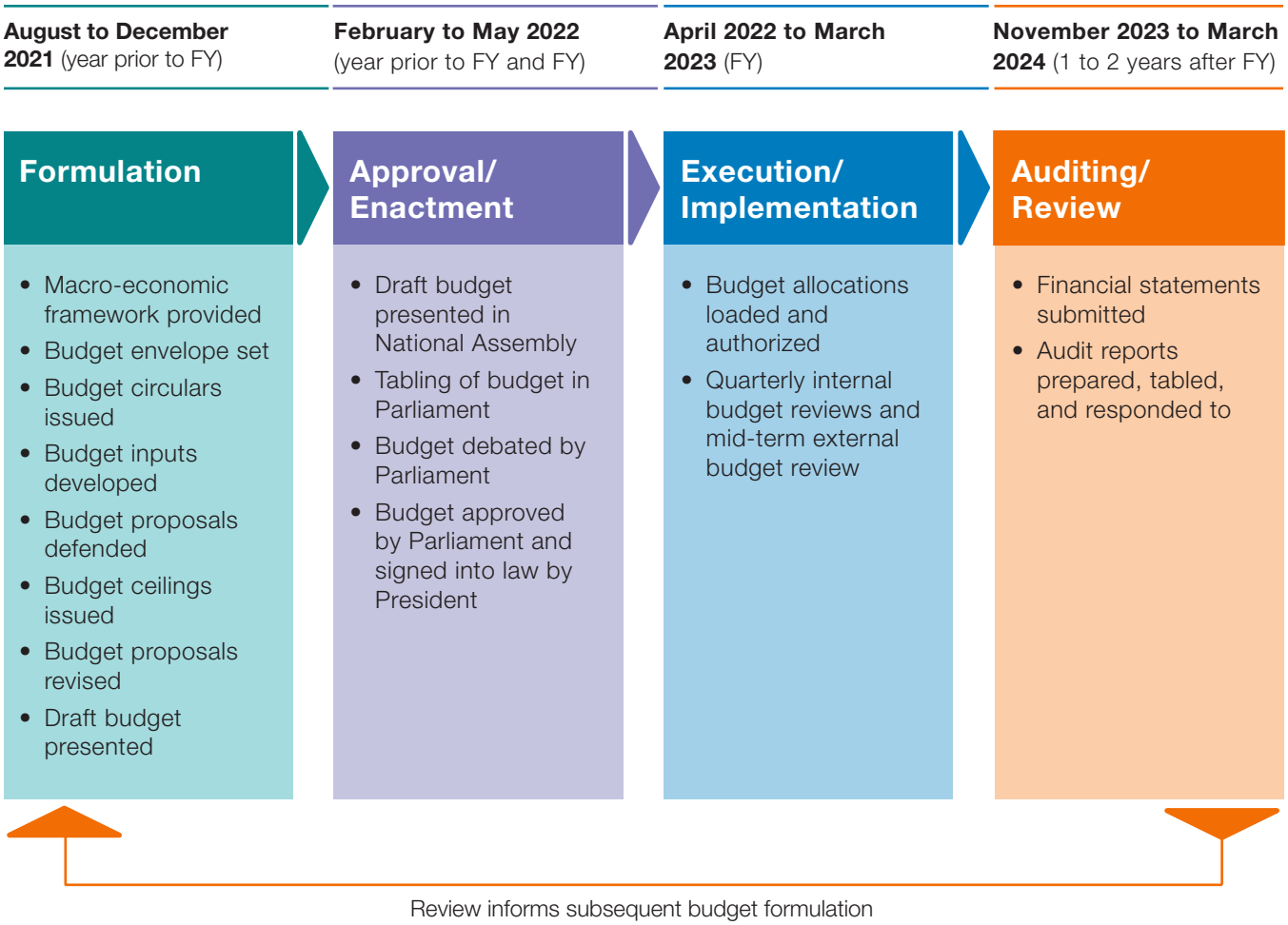
Namibia follows a common budget process comprised of four key phases:

1. Formulation
2. Approval/Enactment
3. Execution/Implementation
4. Auditing/Review

Each ministry follows the same process, aligned with Namibia's fiscal year which runs from April to March. Figure 4 summarises Namibia's annual public sector budget process for health and lists the key activities in each phase. A detailed budget cycle for health, inclusive of stakeholders involved and key concurrent processes, can be found in Annex 2. The budget process summaries reflected in Figure 4 and Annex 2 have been created and adapted from available budget overviews. No clear guidance or summary was available, and there are reported system-wide discrepancies between the planning around national budgeting and the practice of implementing each stage of the budget cycle.

Currently, the government budget development process is anchored in a medium-term expenditure framework (MTEF) that provides aggregate budget ceilings and is used for public sector multi-year budgeting. An aggregate budget ceiling is a top-down, allocative approach where ministries are given

Figure 4. Summary of Namibia's typical public sector budget process for health and malaria – national level, as shown for fiscal year (FY) 2022/23*



Sources: Adapted from Klaus Schade, Economic Association of Namibia[13] and Ms. Elina NP Uugulu, Oshana Regional Health Directorate.[14]

*Note: the COVID-19 pandemic has affected the typical budget process for FY 2021/2022.

a maximum amount within which their budget must be developed. Once set, there is limited flexibility in ministerial allocations as all budget plans must be within the given ceiling.

Namibia's regional health and malaria budgeting process

Currently, there is relatively limited engagement of RHDs in the above-referenced national budget process, despite their increasingly significant role in implementation of health and malaria activities at the regional level. The RMTs are involved in formulating regional budgets and managing actual expenditures as well as identifying opportunities to streamline regional budgets according to changing needs through regional Economising Committees.[D]

D Economising Committees have been established in O/M/As for the purpose of approving expenditure and/or procurement which exceeds a threshold that may be approved by the executive officer (e.g., Head of Directorate). They consider urgent internal requests for goods and services as well as potential re-programming of budget savings. The Economising Committees meet regularly, at least twice per month, and are comprised of at least a chairperson/alternate chairperson and the financial advisor/regional financial advisor.

The Directors and Senior Accountants from the RHDs are responsible for defending their region's health budget during the MoHSS budget hearings in the formulation phase of the budget process. While RHDs are key to assessing the needs specific to their region, budget requests must ultimately align with the priority areas established in the various disease-specific strategic plans – such as the NMSP – as well as other health sector strategies, policies, and guidelines.

The NVDCP engages with regional stakeholders in its annual planning and budgeting activities, including involvement of the Senior Accountants from the RHDs in IRS microplanning activities. The NMSP timeline for budgeting, planning and reporting of annual work plans is aligned with the national fiscal year (April–March) and regional health/malaria stakeholders can utilise the NMSP in collaboration with the NVDCP to coordinate malaria resource mobilisation and budget advocacy efforts.

To ensure availability of sufficient and sustainable resource allocations to address regional malaria needs, it is critical for regional stakeholders to understand the budget process, their role in the process, and opportunities to influence budget decision-making. Table 1 provides a summary of the current role of regional stakeholders in the national public sector budget process as it relates to malaria as well as the key data, challenges, and opportunities in each phase of the budget cycle.

Regional Councils mainly access their financial resources through the national budget under the Urban and Rural Development budget vote channelled through MURD. However, since the launch of the decentralisation policy other sectors project budgets have been increasingly channelled through the Regional Council. As such, Regional Councils have been given additional responsibilities and oversight. Responsibilities include financial administration of key aspects of sectoral budgets (e.g., the budget for capital projects to build education infrastructure at regional level) and budgetary and planning responsibilities for the provision of public services, including for personnel management and human resource development of all line-ministries and local authorities present in the region.

Table 1. Summary of regional engagement with the national health budget process, by budget phase

	Formulation	Approval/ Enactment	Execution/ Implementation	Auditing/Review
Key activities What activities are regional stakeholders involved in?	Minimal (if any) engagement with the central ministerial budget committees to prepare budgets for discussion with MoF.	Regional Councillors elected to sit in the National Council go through a debate process leading to parliamentary approval of the budget. Parliamentary committees scrutinise and debate the budgets, with the line ministries invited to defend their budgets.	O/M/As manage implementation, monitoring, and reporting of their authorised budget allocations.	Minimal involvement unless it is a special audit.
Decision-makers Which stakeholders are engaged?	Regional Directors (of all line ministries) Ministerial Directors of Finance (central level)	Regional Councillors elected to sit in the National Council and Parliamentary Standing Committees.	All relevant O/M/As (including Regional Councils)	OAG Parliamentary Standing Committees
Available data/ data gaps What data/information is used, tracked, or monitored?	Data gaps vary and can include all or some budget-related documents (e.g., budget ceilings, revenue forecasts, final budget, budget circulars to O/M/ As providing budgeting guidelines/ instructions).	Data gaps vary and can include all or some budget-related documents (e.g., budget ceilings, revenue forecasts, final budget, budget circulars to O/M/ As providing budgeting guidelines/ instructions).	Budget execution documents/templates Quarterly Reviews (internal) Mid-Term Budget Review Year-End Accountability Report (if available) Financial Statements (if available)	Financial statements Accountability Reports (if available)
Challenges What challenges do regional stakeholders face?	Regional stakeholders have limited opportunities to influence the budget formulation phase as decision-making is concentrated at national level.	Minimal engagement of RMTs in the budget approval process.	Lack of transparency from central-level accounting officers on regional budget data. Inadequate budget expenditure tracking at regional and central levels to avail real-time budget tracking to information decision-making.	Minimal engagement of regions in the audit/review process.

	Formulation	Approval/ Enactment	Execution/ Implementation	Auditing/Review
Opportunities What opportunities exist for the METFs to mitigate challenges and to engage in regional budget advocacy?	Request that Senior Accountant reviews the past year's expenditure levels to identify financing gaps and inform financial requests. Consult with Regional Council, members of Parliament (MPs), NVDCP and donors on regional priorities, reflections from past year, and current financial needs. Use advocacy platforms, such as media and stakeholder meetings, to disseminate stories from the field to generate support, to educate on key priorities, and to ensure malaria financing is a public interest issue. Monitor financing proposals to ensure malaria funding issues are understood by central-level MoHSS and MOF and included in final requests in the national budget process. Review pre-budget statement and re-confirm pertinent budget issues for malaria with Regional Council, MPs, NVDCP, donors.	Analyse final budget figures and sensitise relevant MPs and their constituencies on malaria funding issues to be considered in the budget debate.	Share financial and non-financial performance data with regional and national stakeholders (e.g., Regional Council, MPs, NVDCP, donors). Ensure internal budget monitoring and internal audits of expenditures are occurring and corrective actions are taken.	Share financial and non-financial performance data with regional and national stakeholders (e.g., Regional Council, MPs, NVDCP, donors).

Challenges and Opportunities in the Malaria Budget Process for Regional Stakeholders

This section outlines three key areas of malaria financing challenges and opportunities in the budget process for Regional Health Directorates and Malaria Elimination Task Forces in Namibia.

1. **Budget monitoring and expenditure tracking**
2. **Transparency and accountability for allocative decision-making**
3. **Sustainable and sufficient financing**

An Action Plan template to outline steps for actionable change is provided in Annex 3.

1. Budget monitoring and expenditure tracking

Challenges

A deficiency of budget and expenditure data, and systems to support public financial management, inhibits understanding of financing gaps and opportunities as well as evidence-informed decision-making by RMTs, RHDs, Regional Councillors, and other regional decision-makers.

- **Approved health budget is by cost category, not by disease.** Each RHD develops and submits one combined health budget with aggregated line items for expenses across disease programmes. The 2019 Namibia Health Sector Public Expenditure Review identified a key challenge related to health expenditure management as the broadly defined categories within the METF, such as 'communicable diseases' and 'non-communicable diseases.'[15] Such aggregation makes it difficult to allocate and track malaria-specific expenditures, hindering ability to understand real funding needs or priorities, especially for the regions where malaria-specific activities are implemented and where specific malaria budgets are needed. Given the lack of specificity in the expenditure framework, time-intensive analyses of MTEFs and supporting documents would be required to identify disease-specific allocations and spending.
- **Increased spending on crosscutting health programmes poses challenges for targeted disease interventions, such as malaria.** The trend of increased spending across health functions makes it difficult to track programme-specific expenditures, thus reducing the quantity and/or quality of evidence that can be used for malaria budget advocacy. Specificity is needed in disease response to ensure allocative efficiency, i.e., that limited resources are allocated to the right combination of interventions with greatest impact on population health outcomes.
- **Monitoring of expenditure data is not streamlined across subnational and national levels.** There is an identified information gap in malaria budget and expenditure data available for analysis, including expenditure and value of donations for malaria commodities, human resources, and interventions across all state and non-state entities responsible for malaria-related expenditure. Multiple entities are responsible for portions of malaria-related expenditures, and there is a lack of centralised data tracking for malaria. There is fragmentation in the way budget data is managed within the region (limited or no malaria-specific record of spending on cross-cutting regional budget lines, e.g., transport, training), at national level within the MoHSS Directorate of Finance (limited consolidated record of expenditure across key health institutions, e.g., Central Medical Stores, National Institute of Pathology), and across donors (numerous local and international donors have separate and often inaccessible budget expenditure data).
- **Limited regional-level capacity for accounting and internal auditing.** Regional level stakeholders are often not adequately capacitated to conduct their own accounting and internal auditing functions and remain heavily reliant on the central ministry, Office of the Auditor General and MoF. Audited financial statements are often not kept for public funds, resulting in lower allocations for regional structures in future budget cycles.

Opportunities and recommendations

With the appropriate data, regional malaria programme managers can build strong performance-based budgets and generate sound financial performance evidence that will support the defence of future budget requests and enhance budget management practice. Access to timely expenditure

data disaggregated by line item would enable regional malaria managers to conduct rigorous budget analyses to inform evidence-based budgets. The absence of financial performance data weakens advocacy 'asks' for sufficient malaria funding.

- Adapt Namibia's HIV/AIDS resource tracking exercise and adopt a malaria-specific resource tracking exercise to report on annual financing patterns.
- Promote adoption of malaria specific costing reports to increase understanding of programme gaps and needs as well as enhance allocative efficiency of available funds.
- Consult and learn from examples of other countries (e.g., South Africa) that have a financial information management system to provide real-time budget tracking and expenditure data for decision-makers.
- Advocate for public financial management capacity strengthening efforts within the regional MoHSS teams.

2. Transparency and accountability for allocative decision making

Challenges

Lack of communication and clarity between all budgetary stakeholders result in stakeholders making some budget decisions without full information.

- **Lack of regional involvement in final budget allocation decision-making.** RHDs consult with districts and other stakeholders to prepare estimate budgets to defend during national health budget hearings within the broader budget formulation process. However, RHDs are not involved in later stages of the national budget process to determine final budget allocations and are often unsure of how certain allocative decisions were made.
- **Budget ceilings are set at national level without consideration of regional health resource needs.** This often results in RHDs receiving less money than the amount put forth in budget requests. Currently, budget ceilings are set by the MoF in consultation with the full cabinet (including the Minister of Health) with limited or no engagement of RHDs. RHDs estimate resource needs and develop budgets to address those needs without the knowledge of what the pre-decided budget ceiling is or how that was established. RHDs present their budget proposals to the MoHSS national budget committees. RHDs then receive budget ceilings within which they should fit their final budgets, meaning they need to revise what they had proposed for expenditure, often requiring cuts to proposed expenditures to fit within the ceiling, which is typically less than what was requested.
- **Unclear ownership of the budgetary process between subnational and national level.** There are multiple stakeholders at regional level with local government, line-ministries, civil society, and private sector accessing resources through various channels. Coordination across these actors for malaria is not present and as such accountability for resource-allocation and spending is fragmented.
- **Unclear roles and lack of budget data recorded among the NVDCP, DSP and MoHSS Finance Department for malaria.** The MoHSS has one main focal point in its Finance Directorate reporting on the finance and administration of donor-funded programs of the DSP. Typically, the funding agencies have separate project management units with more senior/executive focal persons to oversee grant implementation. For example, the MoHSS chief accounting officer (the Executive Director) is the focal point for Global Fund financing. However, the Executive Director is not hierarchically accountable to accounting officials in the RHD, who require oversight into budget allocation and expenditure data. As a result, a disconnect often exists within the MoHSS for finance and administration of donor-funded programs which impacts the extent to which financial records are centralised within the ministry's finance department and therefore accessible to regional stakeholders.
- **It is difficult to receive immediate funds for outbreak response due to approvals needed at national levels.** In the absence of a dedicated malaria fund vehicle or malaria-specific resources at the regional level, RHDs and other stakeholders are often required to follow bureaucratic procedures to request funds for emergency activities which can often delay a rapid disease response.
- **Low citizen participation in the budgeting process.** In the 2019 Open Budget Index, Namibia scored below the threshold for countries considered transparent (i.e., providing sufficient budget information for public scrutiny).

Opportunities and recommendations

Efficient and effective allocative decision-making hinges on streamlined and transparent communication, coordination, and dissemination of information between budgetary stakeholders. Role clarity in the budget process can also enable stronger accountability. In vertical health systems, it

is critical that national health ministries, or its relevant budgeting bodies, not only provide subnational health leaders with access to key budget data, but also increase participation of subnational leaders throughout the decision-making and feedback processes. Engagement of regional leaders is even more important as the malaria programme decentralises, and increased budget development, management, and reporting responsibilities lie at subnational level.

- Leverage Namibia's launch of the Zero Malaria Starts With Me (ZMSWM) Campaign and the national Malaria Communications and Advocacy Strategy 2020–2025 (MCAS) to advocate for a dedicated national malaria fund with fast-tracked access to resources by Regional Councils and RHDs for emergency malaria response activities.
- Identify regional champions or ambassadors (e.g., Regional Governors) to engage senior political officials in the National Council, National Assembly, MoF, NPC and other high-level stakeholders in the budget formulation process to prioritise the proposals from malaria-endemic regions for domestic financing of malaria activities.
- Utilise the ALMA Scorecard for subnational malaria programmes to increase transparency and accountability of core financing metrics and other malaria indicators.
- Source important guidance from the UNAIDS National AIDS Spending Assessments (NASA) on flow of financial resource information from financing origin to the beneficiary population. This tool provides decision-makers with strategic information that allows countries to mobilise resources, strengthen accountability, and improve efficiency and effectiveness of programme implementation. Key pieces of this tool could be modified for use by malaria programmes to improve accountability and transparency.
- Capitalise on current opportunities for engagement of key national stakeholders, such as through MoHSS consultations and parliamentary visits, to share evidence of need for increased malaria-specific domestic financing.

3. Sustainable and sufficient financing

Challenges

Namibia's malaria programme's reliance on donor funding for malaria interventions jeopardizes the long-term sustainability of the malaria response. Donor transition precipitates significant changes in the national malaria programme's finances, governance, management, and implementation. Without adequate planning and establishment of sustainable domestic financing channels, such a transition can disrupt essential programme activities and undermine progress towards elimination.

- **Insufficient funding for malaria elimination programme activities.** The NVDCP projects a significant gap between the financing needed to complete activities outlined in the NMSP and available domestic and donor financing, potentially jeopardizing Namibia's ability to reach elimination by 2022.
- **Gaps in key programme activities and personnel due to unstable donor funding.** The NVDCP has minimal staff in the health HR structure exclusively dedicated to malaria. Previous donor funding made provision for two dedicated malaria personal cadres (the Malaria Surveillance Officer and the Malaria Clinical Mentor). However, funding has been reduced in the current Global Fund grant to accommodate one dedicated position, requiring the roles to be combined into only one dedicated malaria official covering multiple regions or the regions with districts with the highest malaria burden. Given the short-term nature of donor-funded contracts, these staff are faced with compounded job insecurity, resulting in significant staff attrition.

Opportunities and recommendations

Malaria programmes must both improve current budget processes and communication to do more with less in the near term. New localized financial resources, including regional level budgets, should also be identified and utilized. There is abundant opportunity for other regional stakeholders to engage in resource mobilisation efforts.

- Utilise CEGAA budget analysis training modules and tools to conduct a regional analysis of malaria budget needs to inform regional budget proposals.
- Advocate for local resources to fund the dedicated full-time malaria subnational staff positions as laid out in the costed NMSP 2017–2022.
- Engage Regional Council structures, such as the RACOCs, to advocate for increased resources for malaria activities from line ministries and other stakeholders (e.g., the private sector, civil society).
- Keep Economising Committee chairpersons informed of malaria resource needs to identify potential opportunities to reprogramme regional O/M/A funds during the budget implementation/ execution phase.
- Integrate malaria priorities into the Regional Council annual workplan and request financing for priority malaria activities in the Regional Council annual budget.

Annexes

Annex 1: Key resources for Namibia's regional Malaria Elimination Task Forces

Resource	Link
MoF Budget Resources; Namibian Ministry of Finance	https://mof.gov.na/budget
Malaria Webpage; Namibian Ministry of Health and Social Services	https://mhss.gov.na/malaria
Budget Monitoring, Expenditure Tracking, and Budget Advocacy Training; UCSF Malaria Elimination Initiative and Centre for Economic Governance and Accountability in Africa	http://www.shrinkingthemalariamap.org/our-work/advocacy-financing-and-sustainability/malaria-budget-advocacy/budget-monitoring-and
Scorecard Hub; Africa Leaders Malaria Alliance (ALMA)	https://scorecardhub.org
Namibia Resource Tracking for Health and HIV/AIDS: 2017/18; Namibian Ministry of Health and Social Services	https://acs.r4d.org/wp-content/uploads/2020/06/Namibia-Resource-Tracking-Report-2017-18-FINAL.pdf
The Parliamentarian's Handbook: National Budgeting Process in Namibia; Parliament of Namibia	https://cms.my.na/assets/documents/p1ctcvadou1m6lh7dia13a41cs14.pdf
World Malaria Report 2020; World Health Organization	https://www.who.int/publications/i/item/9789240015791
Health budget literacy, advocacy and accountability for universal health coverage: Toolkit for capacity building; UHC2030 and The Partnership for Maternal, Newborn & Child Health	https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/Capacity_building_toolkit/WHO013_UHC2030-capacity-building-toolkit_FINALNEW.pdf

Annex 2: Summary of Namibia's public sector budget process for health and malaria – national level*

Phase	Overview	Timeframe	Key Activities	Institutions Engaged	Concurrent budget planning process relevant to malaria
Formulation	Provision of budgetary framework	August to September (FY-1)	Macro-economic framework provided by key national budget institutions. Budget envelope[E] set by the MoF after considering sectoral factors such as revenue projections, expenditure estimates, and fiscal performance targets.	Bank of Namibia (BoN), Ministry of Finance (MoF), National Planning Commission (NPC), National Statistics Agency (NSA), MoHSS,	Mid-Term Review of the NMSP activities and budgets typically takes place at the mid-point of the 5-year strategic plan
	Issuing of budget circulars	October to November (FY-1)	Budget circulars issued by the MoF to MoHSS providing guidelines.	Regional Directors of Health, Directors of Finance and Planning (MoHSS, MoF, NPC)	
	Preparation of ministerial budget	July to August (FY-1)	Budget inputs developed by MoHSS budget committee.	MoHSS budget committee	
	Budget hearings	September to October (FY-1)	Budget proposals defended by MoHSS to MoF and NPC.	Accounting Officers, MoF, MoHSS	
	Budget ceilings	October to November (FY-1)	Budget ceilings issued by Cabinet Treasury Committee to MoHSS.	Cabinet, MoHSS	
	Budget proposal revisions	November to December (FY-1)	Budget proposals revised by MoHSS to fit within issued budget ceiling.	MoHSS	
	Pre-budget statement	November (FY-1)	Draft budget presented by Minister of Finance.	Minister of Finance	
Approval/Enactment	Tabling of budget	February (FY-1)	Draft budget presented by MoF to the National Assembly chamber of Parliament for approval. Final draft budget presented to Parliament by the MoF.	Minister of Finance	
	Budget debates	February to May (FY-1)	Budget debated by Parliamentary committees, with MoHSS invited to defend their budget.	Parliament, MoHSS	
	Budget approvals	May (FY)	Budget approved by Parliament and referred to the Presidency for signature of the Appropriation Bill.[F] The Appropriation Bill as an Act of Parliament formally passed into law.	President, Ministry of Justice	
Execution/ Implementation	Budget execution	April to March (FY)	Budget allocations loaded and authorised.	Regional Council Executive Teams, Regional Directors of Health, Chairperson of the in-ministry Economising Committees at regional level, MoF	IRS Microplanning for activities and budget typically takes place around June to August every year for the two upcoming malaria seasons (which run from January to December).
	Budget reviews	Quarterly; Mid-term (FY)	Budget implementation managed with quarterly internal budget reviews by MoHSS and mid-term budget review[G] by the MoF.		
	Accountability report	September to January (FY)	Year-end accountability report[H] prepared by MoHSS. Accountability report submitted by MoHSS to MoF for publishing.		
Auditing/ Review	Financial statements	September to October (FY+1)	Financial statements submitted by Accounting Officers to Treasury then to the Office of the Auditor General (OAG).	Accounting Officers, MoF, OAG	Malaria Annual Review, which evaluates progress to implement the NMSP
	Audit reports	November to September (FY+1 to FY+2)	Audit reports prepared by OAG. Audit reports tabled in Parliament. Audit reports reviewed by Parliament and actions taken on by Parliamentary Standing Committee on Public Accounts as recommended by OAG.	OAG, Parliament, Parliamentary Standing Committee on Public Accounts	

*Note: the COVID-19 pandemic has affected the typical budget process starting in FY 2021/2022.

continued from previous page

Sources: Adapted from Klaus Schade, Economic Association of Namibia[14] and Ms. Elina NP Uugulu, Oshana Regional Health Directorate.[15]

E Budget ceilings refer to the total allowable expenses by each administrative structure (e.g., national ministry, regional directorate, district, etc.), whereas budget envelopes indicate the split between ministries or programs (as a share in total resources).

F Once the Appropriate Bill is signed it becomes the Appropriate Act, allowing government to start spending.

G Mid-term budget review includes macro-economic review at global, regional, and domestic levels. Fiscal policy review presented, including expenditure and revenue, and a medium-term outlook of the budget for the next two years.

H Accountability report provides a review of actual expenditure, achievements versus targets, with explanations for any deviations and corrective actions to be taken.

Annex 3: Action plan template to identify and address budget challenges

The Action Plan template is a simple tool for regional METFs to use to plan and act on budgetary processes and challenges related to malaria. While some overarching challenges and opportunities have been identified in this document, the most pressing challenge may be unique in each region. This table helps to lay out those challenges as well as specific ways to address them.

Instructions

- Incorporate the action plan template into a regional METF meeting for discussion and inputs from all members
- Consider starting with just one or two key problems to focus on at a time
- Share the action plan with the NVDCP to determine potential avenues for collaboration

Problem	Objective	Activities	Targets/ Audiences/ Actors	Outcome Indicators	Timeline to Complete
Example: Unclear ownership of the budgetary process between subnational and national level. There are multiple stakeholders at regional level with local government, line-ministries, civil society, and private sector accessing resources through various channels.	Understand roles and responsibilities in current budgetary process	Map out budgetary process inclusive of which stakeholders are accountable for collecting each piece of budget data. Note any current gaps in data and agree upon who should be responsible for its collection.	RHDs, NVDCP, regional government	Clear map of budget process with persons responsible for data collection or inputs at each stage	3 months

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