International Journal of Science and Social Science Research [IJSSSR] ISSN: 2583-7877

Analysing the challenges of decentralized health services in Namibia: A case study of Erongo Region

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Abstract —The Namibian Government has aimed at creating a needs-based and cost-effective health care system. The means to carry out this aim has been to decentralize the health sector in order to increase lower-level responsibility, accountability, and participation. This research paper set out to analyse the decentralised health care services in Namibia, as perceived by patients and hospital staff in selected hospitals in the Erongo Region. The study employed both quantitative and qualitative research methods. The quantitative methods were used to establish the perceived roles, functions and impact of the decentralisation policy on staff and patients. Qualitative methods were used to assess challenges faced by patients. The population for this study was based on the selected number of towns in the study area. The study used a purposive non-probability sampling method. Moreover, the study targeted 30 respondents who were purposefully selected from different towns in the Erongo Region. The findings of this study indicate that: Generally, the number of cases referred to Walvis Bay and Swakopmund hospitals from the district hospitals have decreased, there are some cases referred to the district hospital which can effectively be handled at the different health centres, and efficiency of service delivery is perceived by both staff and patients to have improved at the general hospitals.

Keywords: Decentralisation, Health service, quality, efficiency and effectiveness.

I. INTRODUCTION AND BACKGROUND OF THE STUDY

I.I. INTRODUCTION

Decentralisation policies are producing an ongoing restructuring of the public sector all over the world. This study will concentrate on the background information, literature review that will bring out the context of the research study by scrutinising what other researchers and writers have done in relation to this topic and also to recommend what should be done to address the issues raised in this research study. This research study will also highlight the specific methodology, findings, discussion and conclusion.

I.II. BACKGROUND

Prior to the Namibian independence and democratisation in 1990, the policies of apartheid were practiced in Namibia in all the sectors, including the health sector. At that time, the health system was based on a traditional medical model that concentrated on curative and hospital based health services. This resulted in poor health services rendered since there were extreme income disparities between the different tribes and this fact was reflected in the way the health services were delivered. Namibia had a population of 1.433 million at independence and in southern Africa, it was the least-populated country at the time (IPPR, 1990).

After Namibia gained its independence, the government put in place policies to decentralise the health services so that all Namibians could benefit from these services. The government implemented the decentralisation policies of 1998 to address the backlog in terms of health services delivery that existed before independence. The government is therefore committed to the health sector as a fundamental human right by creating one health system out of the racially and tribally fragmented policies of the apartheid government. Then the Ministry of Health and Social Services (MoHSS) implemented policy reforms that were based on a central role for the primary health care (IPPR, 1990).

The ministry of health also put various health programmes in place, i. e. for HIV/AIDS, tuberculosis, and malaria into one consolidated primary health care program with the assistance of UNFPA so that this programme could better target the intended patients. As an example, the ministry of health and social services rolled out a programme that distributed ARVs and this resulted in a decrease in the mortality rates of HIV/AIDS patients.

II. LITERATURE REVIEW

II.I. INTRODUCTION

A literature review is when a researcher studies and evaluates the appropriate literature that is related to the topic that a researcher has decided to investigate. A literature review will also survey the literature about the chosen topic, synthesise the information that one finds related to the chosen topic, scrutinise and analyse the information obtained, indicate the shortcomings of the perspectives about the research topic, and direct the researcher in the course for additional research in areas not explored.

A literature review also indicates that a researcher comprehends the research topic by displaying knowledge about how one's research ties in with the insights that already exists (Ghita, 2014).

II.II. THEORETICAL FRAMEWORK

Decentralisation in Namibia first featured in the SWAPO Election Manifesto to ensure that democratic regional and local authorities would be set up in rural and urban areas for the empowerment of grassroot people so that they can make their own decisions that affect their lives (SWAPO Party Manifesto, 1989). The government launched the Decentralisation Policy in March 1998 to "enhance and guarantee participatory democracy, improve rapid sustainable development, and improve the capacity of the government to plan and administer development" in all the regions and local authorities in Namibia (Iyambo, 1998). However, Dr Nickey Iyambo later mentioned that the decentralisation did not live up to the expectations of Namibians.

Iyambo,1998 argue that "decentralisation in Namibia aims to devolve agreed responsibilities, functions, and resource capacity to regional and local levels of government, within the framework of the unitary state. It has of necessity, and as part of a strategy, to be phased in gradually and systematically" (Iyambo, 1997).

This study intends to determine whether the national government has genuinely decentralised powers to the local and regional councils in terms of decision-making, personnel and funding. It will also explore the tangible impact of the policy of decentralisation in providing effective and efficient service in the health sector. Over the past 24 years, there was a disconnect between the political intention of the national government to decentralise powers, the legislation on decentralisation, and manner the policy was implemented (Conyers, 2007)In addition, there was unwillingness to devolve power completely to the regional and local governments. There was no definite timeframe during which the devolution of power was to take place, moreover, the line ministries did not fully cooperate with the regional and local authorities to implement the policy of decentralisation due to lack of financial and human resources in the ministry (Siyanga, 2007). Therefore, local and regional councils were unable to successfully implement their action plans.

The benefits of decentralisation are as follows: (a) improved service delivery in terms of transforming from the bureaucratic systems of the national government to a more responsive and better trusted regional and local representatives of the people who live close to their constituencies (Keulder, 17); (b) better efficiency due to governance where political decisions are directly linked to the affected people (Ribot, 2002); (c) decentralisation can also remove an immense burden from the central government so that it can focus more efficiently on national issues, improve the cost-effectiveness where regional and local politicians will manage their own resources and affairs, and create a direct link between the revenue, the expenses, and the service that will lead to effective utilisation of resources (Iyambo, 1997); and (d) decentralisation enhances the reach of the national government by extending its political and administrative penetration to better implement its policies where government services have not reached (Tsamareb, 2005).

The Namibia National Health Accounts (2003) of the MoHSS state that Namibia had been allocating a big portion of its GDP to the health sector since independence, as compared to other Southern African countries, to address the huge backlog in the health sector brought about the colonial apartheid policies. More than 80 percent of the Namibian population resides within a 10 kilometers radius of a government health facility. Moreover, Namibia is huge and the population density is two (2) people per square kilometers and this makes the cost of running a health facility in Namibia prohibitively high and it dramatically decreases the value of every dollar allocated. To overcome this problem, the government created outreach services.

The paper found that in 2015 that the Erongo health directorate budget stood at N$160 million and 60 percent was allocated to operational costs. The capital expenditure budget was controlled by the MHSS in Windhoek. It also revealed the Erongo regional health directorate had health facility advisory committees where clients and patients could express their views, opinions, and concerns, and the directorate also established a working relationship with the regional and constituency politicians.

III. METHODS

III.I. RESEARCH DESIGN

The study employed both quantitative and qualitative research methods. The quantitative methods were used to establish the perceived roles, functions and impact (and associated factors) of the decentralization policy by staff and patients. Qualitative methods were used to assess the experiences of, and challenges faced by patients. The aim of the research study was to generate data in determining and evaluating the effect of decentralisation in the Erongo Region and the level of perceived efficiency in the same. (Sekaran U. & Bougie, R. 2013). In order to achieve the aforementioned objectives, a survey study was done since it is a suitable method of collecting views of respondents in the target population. Th set of objects studied involved sampling of conveniently selected hospital staff members and patients. Interviews conducted through the questionnaires were used to elicit various views and perceptions of the impacts on decentralisation of health services in the Erongo Region.

III.II. POPULATION

The research population consisted of 50 patients and 39 staff members from different hospitals in the selected towns in the Erongo Region.

III.III. SAMPLE SIZE

The study used a purposive non-probability sampling. The study targeted 30 respondents who were purposefully selected from different towns in the Erongo Region. Five (5) from Swakopmund, Five (5) from Walvis Bay, Five (5); from Henties Bay Five (5) from Omaruru, Three (3) Arandis, Two (2) from Karibib and Five (5) from Usakos.

The researcher used multiple instruments and techniques that are applicable in both qualitative and quantitative (mixed method) data collection. Therefore, instruments such as questionnaire, semi-structured interviews and documentation were employed in this study. Document analysis is very important as it provides the researcher a general background on the subject of investigation (Parpala, A., & Lindblom-Ylänne, S. 2012). The study used surveys and individual interviews to collect data that enabled the researcher to obtain an understanding of individual service quality perceptions.

III.IV. DATA COLLECTION PROCEDURES

Both primary and secondary methods were used to collect data from respondents. This was done for the reason that management of the hospitals were reluctant to allow inspection of hospital records by the researcher. Structured questionnaires were used to collect primary data on selected defined topics in the questionnaire. Two questionnaires were distributed to staff and patients. Primary data was collected through structured questionnaires administered by the researcher with the help of hospital staff members.

III.V. DATA ANALYSIS

The data collected from the survey was analysed using SPSS (Statistical Package for Social Sciences) and R-software. Data cleaning was done for accuracy and consistency before it was entered. A systematic analysis of the data was carried out for the various unknown variables and parameters related to the proportion of those referred patients in relation to those coming directly to the hospital, frequency of patients being referred to provincial hospitals with cases that can effectively be dealt with at the district hospitals, and efficiency in the patient referral system. The statistics captured from the analysis include measures of central tendency.

III.VI. RESEARCH ETHICS

Research ethics refers to the use of fundamental principles of ethics to research tasks to design and implementation of the research study, the respect for other people and the society at large. It also refers to the utilization of all the resources and outputs, the scientific misconduct and research laws. Research ethics also refers to principles of morality that gives direction to the researchers to perform their research honestly and to avoid any intentional negative influence or impact on the participants in the research study. This is done with the aim of giving the outcome of the research study the credibility, validity and acceptance that it deserves.

To avoid plagiarism, a researcher must stick to the ethical guidelines throughout the study report to keep misconduct at bay. As part of presenting the report of this research study, a researcher must introduce herself plus the aims and objectives of the study to the respondents. The respondents should give their consent that they will willingly participate in the study. If they prefer to remain anonymous and confidential, the researcher should them to do so. It is also essential that the identities of the respondents

are kept confidential and all owners of the material that were used in the research study are clearly referenced and judiciously acknowledged.

IV. FINDINGS

The study found that a total of 89 survey respondents were interviewed using a semi-structured questionnaire. The researcher deliberately attempted to have an equal number of males and female respondents from each selected town in the study area. Therefore, from each hospital sampled, at most one adult male and one adult female were selected and interviewed. Out of the total number of 89 survey respondents, 43 respondents were males (48.3%) and 46 respondents were females (51.7%). The frequency distribution of the sex of survey respondents by town is reflected in the Table II below.

Table I The respondents by town according to gender

	TOWN			
GENDER	**WALVIS BAY**	**OMARURU**	**SWAKOPMUND**	**TOTAL**
MALE	(16) 53.3 %	(13) 44.8%	(14) 46.7%	(43) 48.3%
FEMALE	(14) 46.7 %	(16) 55.2%	(16) 54.3%	(46) 51.7%
TOTAL	(30) 100%	(29) 100%	(30) 100%	(89) 100%

*Percentages reflected in all the tables are column percentage

IV.I. AGE DISTRIBUTION OF THE RESPONDENTS

The analysis of the age distribution of the survey respondents was done in five age-group categories. This was done to ensure that all major age groups of adult community members are reflected in the analysis. The age group distribution of the respondents is reflected in Table II below.

Table II The age distribution of the respondents

Age group	**Frequency**	**Percentage**
15 – 24	26	29.2
25 – 34	20	22.5
35 – 44	22	24.7
45 – 54	15	16.9
55 +	6	6.7
Total	**89**	**100**

Despite the fact that government hospitals operate as the main health service facilities, their effectiveness is mostly dependent on several factors that are identified in this section. Their performance mostly depends on the efficiency of the regional clinics

and lower level health facilities which determine the number of cases referred and therefore, efficiency of the decentralisation health policy.

IV.II. CROSS-TABULATION OF THE RATINGS BY HOSPITAL STAFF ON THE EFFECT OF THE DECENTRALIZATION OF HEALTH BY TOWN

Table III

Name of Town	Staff ratings of changes in the proportion of referrals									
	Highly Increased		Moderately Increased		Not Affected		Highly Decreased		Highly Increased	
	No	%	No	%	No	%	No	%	No	%
Walvis Bay	4	10.3	1	2.6	3	7.7	5	12.8	0	0
Swakopmund	2	5.1	4	10.3	5	12.8	3	7.7	0	0
Omaruru	0	0	3	7.7	1	2.6	8	20.5	0	0
Totals	**6**	**15.4**	**8**	**20.6**	**9**	**23.1**	**16**	**41**	**0**	**0**

As shown in table III above, the number of cases referred to the government hospitals have highly decreased as shown by the highest frequency 16 (31%) by the hospital staff from the different towns.

IV.III. PERCENTAGE DISTRIBUTION OF REASONS FOR SEEKING TREATMENT AT THE PARTICULAR HOSPITAL

Table III

Name of Town	Reasons for coming to the particular hospital									
	Specialised Treatment		Proximity		Emergency (Accidents)		Relationship with staff		Totals	
	No	%	No	%	No	%	No	%	No	%
Walvis Bay	7	17.5	6	15	2	5	0	0	**15**	**37.5**
Swakopmund	4	10	4	10	1	2.5	1	2.5	**10**	**25**
Omaruru	6	15	1	2.5	4	10	4	10	**15**	**37.5**
Totals	**17**	**42.5**	**11**	**27.5**	**7**	**17.5**	**5**	**10**	**40**	**100**

In table IV above, the major reasons given by the patients for seeking treatment in these hospitals in the different towns were: Specialized Treatment at 17 or 42.5% and Proximity at 11 or 27.5%, respectively.

Relative frequency analysis of ratings on effect of decentralisation on reasons for referrals reveal that Omaruru Hospital had the highest rate of increase in minor surgery and accidents/assault, (as mentioned by 20 or 27.6% and 13 or 18.3% respectively), while Walvis Bay had 12 or 16% 5 or 7.0% and Swakopmund had 7 or 9.5% and 5 or 6.0%, respectively. This indicates that some of the cases referred to Government Hospitals can effectively be handled at the regional or lower District Hospitals - that is, if these lower health facilities are well equipped and are effective in referring only cases that cannot be handled at that level.

These is a need for a change in the administration of referral cases so that patients who can be treated at local clinics and hospitals with adequate capacity to treat them can have confidence in seeking assistance at these facilities rather than to demand that they be referred to bigger hospitals. If most of the cases are referred to Windhoek more than necessary, this puts a lot of logistical pressure in terms of ambulance and personnel services and also on the infrastrure of the Windhoek hospitals. Decentralisation policy should be implemented to the fullest to make a meaningful impact on the targeted community

V. DISCUSSION

Various studies have documented the need to monitor and evaluate the decentralisation of Health Services. Thus, this study highlights the ratio of direct and referral patients as determined by the passage of accessing services. Such as cases commonly referred to the Hospitals which can be effectively handled at the regional hospitals; and the levels of efficiency as measured by the time it takes for a patient to be attended to at various treatment stages as well as availability of certain services and supplies.

Majority of both Hospital staff and Patients rated Self Preference (Referral) as having highly increased since the implementation of the decentralisation policy. Majority of the Hospital staff indicated that referrals from the District Hospitals have Moderately Decreased. Of the total number of cases, the need for specialised treatment was cited by both hospital staff and patient respondents as a major reason for patient referrals.

Referrals due to Accidents/Assaults were also indicated to have highly increased. The majority of staff respondents, indicated that these two types of cases can be handled effectively at the District Hospitals. Referrals due to Accidents/Assaults were indicated to be highest at Walvis Bay hospital. Lack of specialised staff and equipment at the District Hospitals, understaffing at the Hospitals and the impact of HIV/AIDs were quoted as some of the reasons affecting efficiency at the Hospitals. Efficiency was indicated by staff to have moderately increased and this was supported by majority of the patients, who were attended to within one hour at the various stages of the treatment process.

VI. RECOMMENDATIONS

The researcher has identified several recommendations to improve the quality of health services to the residents of the Erongo Region.

Recommendation 1: It has been suggested that there is a need for further research about the nature of donor funding for public health care and its related implications for community participation at regional level.

Recommendation 2: There is a need for government to investigate the strategies that its hospitals have developed to achieve their goals of providing accessible, acceptable, and equitable health care services for all citizens in the country. If these strategies are found to be ineffective, the government should adjust these strategies to achieve the aims and objectives of decentralization.

Recommendation 3: The government needs to conduct a thorough research on the effects of the decentralization on the quality of health care services at the District Hospitals, Health Centers, and Clinics, since these are the levels where implementation of health sector reforms has begun.

Recommendation 3: For the decentralization process in the health sector to be effective and efficient, there is a great need for the government to acquire better skills, expertise, resources, and capacity building.

Recommendation 4: It is also recommended that the mobile technology be utilized more by those who seek treatment at the clinics and hospital so that the patients can find out in advance if the treatment they require is offered at the health facilities which they intend to visit, to save cost and time.

Recommendation 5: Finally, the government needs to run continuous health awareness campaigns to educate the public about health-related issues, such as the outbreak of diseases, pandemics, and also about vaccines and new ways of avoiding infections and how to provide treatments to the general public of the Erongo Region.

VII. CONCLUSION

The overall efficiency in the Erongo region's health service delivery has improved in the district hospitals. However, findings of this study indicate that the hospitals are handling some cases that can be effectively dealt with at the district hospitals, and patients who prefer to seek treatment directly at the hospital, rather than district hospitals and lower level health facilities such as clinics. This is likely to affect the efficiency and hence quality of service delivery at the provincial hospitals. This study also shows that equipping the district hospitals and lower level health facilities, and improving staffing of specialised staff cadre at the hospitals may improve performance of the hospitals. It is of utmost importance to note that from the findings of this study, it is not conclusive that improvement efficiency of service delivery at the provincial hospitals is solely due to decentralisation.

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