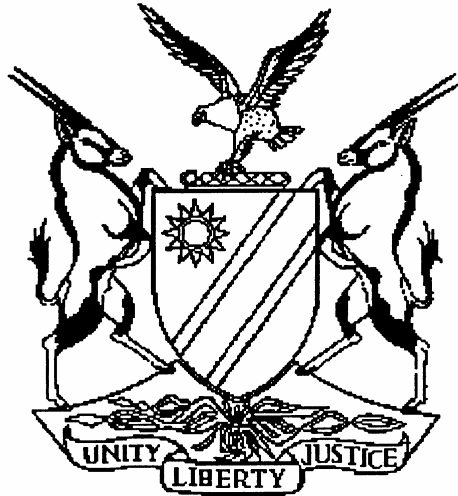
REPUBLIC OF NAMIBIA



Performance audit report of the Auditor General

on the

Ministry of Health and Social Services

The Referral System

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EXECUTIVE SUMMARY

I am authorised to carry out performance audits in terms of Section 26 (1) (b) (iv) of the State Finance Act, (Act 31 of 1991) which reads as follows: (The Auditor General) "may investigate whether any moneys in question have been expended in an efficient, effective and economic manner." Performance auditing may be defined as examining whether government ministries are "doing the right thing" and doing this "in the right and least expensive way".

This report on the hospital referral system in the Ministry of Health and Social Services is the third performance audit report which I present to the National Assembly.

- The referral system was formulated and introduced by the Ministry of Health and Social Services as part of the Primary Health Care strategy to give equal opportunity to all patients to obtain the necessary treatment. Our findings indicate that the referral system is not working efficiently nor effectively. This has resulted in inadequate support to district hospitals, health centres and clinics from the regional hospitals and the Windhoek State Hospital Complex (WSHC).

The most significant findings are the inefficiency of the booking system, the continuous decrease in accepted referrals at the Windhoek State Hospital Complex and the fact that some regions are more privileged than others in terms of accepted referrals.

The problems below are other major findings identified:
- Health facilities follow different referral procedures, e.g. clinics and district hospitals in the Central and South refer directly to the national referral hospital while health facilities in the North East and North West refer through their respective regional hospitals. This is due to rules laid down by WSHC which override the policy of the Ministry on the referral system and therefore Windhoek State Hospital Complex is becoming less of a national referral hospital and more of a regional and district hospital.
- According to regulations promulgated under the Hospital Ordinance Act, 1972 (MOHSS no. 43, 1993), health facilities are classified into groups but resources, e.g. transport, equipment, staff etc, are not distributed according to such classifications.

- The requirement to become a regional medical officer (RMO) is a one year course in public health but this does not form part of the normal medical studies in South Africa where most Namibian medical officers are trained. Consequently four out of the thirteen RMO posts are filled by foreigners, only one is filled by a Namibian and eight remain vacant.
- As a result of poor transport arrangements the waiting period for treated patients to go back to their regions from WSHC could be as much as 6 days.
- Time worked by district surgeons on sessions and procedures are not well monitored. This indicates a lack of control.

In view of the identified problems above, there is room for improvement. The purpose of the recommendations below is to improve the referral system. The Ministry should consider the implementation of these recommendations as a matter of urgency.

Recommendations

- The roles and classifications of all health facilities should be clearly defined and resources allocated accordingly.
- Some specialised wards/departments should be opened up at all Regional hospitals.
- The Windhoek State Hospital Complex should support the establishment of specialised services at Regional hospitals through providing in-service training and regular visits by specialists.
- The responsibility for transport should be decentralised to the Regional level.
- The booking system at the Windhoek State Hospital Complex should be abolished in view of the low and declining number of accepted referrals.
- The roles and classifications of all health facilities should be clearly defined and resources allocated accordingly.
- A strategy should be defined for how to appoint more Namibian Regional Medical Officers and Principal Medical Officers.
- The policy that doctors should visit clinics needs to be written down for it to become effective in all regions.
- Feedback from the referral hospital to the referring hospital is important particularly to improve communication and to assist the referring hospitals and should be the responsibility of the referral hospital.
- The fee structure should be reviewed in order to encourage people to go to the clinics first and through the referral system as required.
- A decision should be made whether out-patient departments at district hospitals should/could be turned into clinics.

CHAPTER 1

BACKGROUND

1.1. HISTORICAL BACKGROUND

The MOHSS[1] was run on an ethnically and fragmented basis prior to independence. After independence all of the responsibilities and functions of the Ministry were integrated into one national health service which was operated along primary health care principles.

A single MOHSS head office with a high powered Directorate for PHC[2] was established at central level. At the regional level the health services were rationalised under a regional director in each of the four health regions-the North West, North East, Central and the South. The orientation of the health service at all levels was according to the PHC approach. There were however some shortcomings apparent in this structure that needed to be addressed. Some of the shortcomings were in the area of overall policy development, analysis and planning, human resources planning, the management and co-ordination of external assistance, health systems research and the monitoring of service quality. The structure also allowed for multiple communication lines between the national level and the other levels.

A new structure had to be developed in order to overcome these shortcomings. This new structure had to ensure that the health system was able to deliver comprehensive integrated health services based on primary health care. Consultations were held between representatives of the MOHSS taken from the national, regional and district levels. After these consultations and subsequent consultations at the central level the following hierarchical structure for the MOHSS was established:

1. At National Level the headquarters of the MOHSS are situated.
2. At Regional Level there are 4 Regional Health Directorates together with 13 operational health regions according to the 13 new political and administrative regions.[3]
3. At District Level there are 34 health districts.

---

[1] Ministry of Health and Social Services
[2] Primary Health Care
[3] North West = Oshana, Omasati,, Ohangwena, Oshikoto
South = Hardap, Omaheke, Khomas, Karas
Central = Erongo, Otjozondjupa, Kunene
North East = Caprivi, Kanango

1.2. GOALS AND OBJECTIVES

The health policy of the Government after independence defines its goal as the achievement of: ”Health for all Namibians by the year 2000 and beyond”. This should be done through the PHC approach which includes improvements in nutrition, safe water supplies, sanitation, adequate housing, maternal and child care services, immunisation, prevention of epidemics, health education and curative services. The emphasis is to ensure that there is equity in the providing of health services and that these services are accessible and affordable to all Namibians. The accessibility of servicing was to be guaranteed by an efficient referral system through which even the most disadvantaged groups of the population could benefit from the specialised services made available at the best equipped hospitals.

The main objectives of the MOHSS are to oversee all Government policies and operations in regard to health and social services to ensure that the objectives are achieved and policies are implemented. The main objective of the Department of Health Care Services is to administer comprehensive integrated health care services. The main objectives of the Department of Planning and Administrative Support Services are to provide management and administrative support services and to co-ordinate and control effective health planning, human resource development programmes and social work services. These main objectives are supplemented by detailed objectives of the different directorates within these departments.

1.3. SCOPE OF ACTIVITIES OF MOHSS

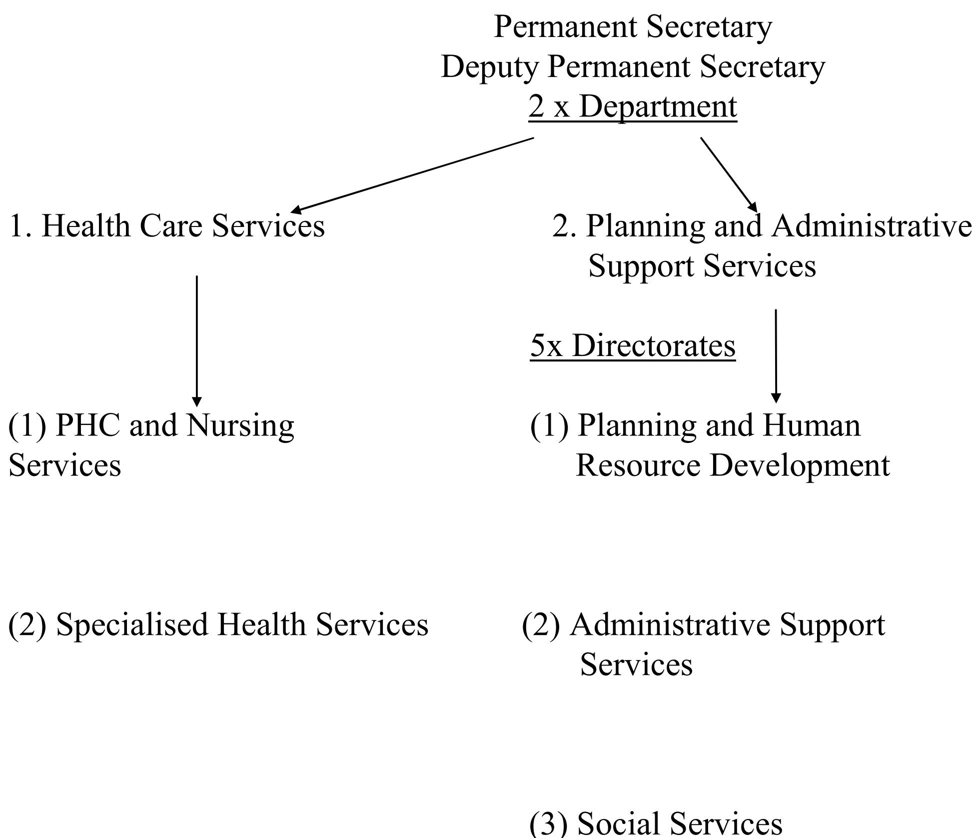
“The Ministry of Health and Social Services provides a full range of health services, including promotive, preventive, curative and rehabilitative services. Social Welfare Services include conventional social work, as well as developmental social work as a new emphasis.”

The following table shows the health facilities of the Ministry excluding the Windhoek Central Hospital Complex which is the national referral hospital:

	North West	**North East**	**Central**	**South**	**Total**
Regional hospitals	1	1	1	1	4
District hospitals	9	4	10	6	29
Health centres	9	6	3	4	22
Clinics	76	55	35	39	205
	95	66	49	50	260

1.4. ORGANISATIONAL STRUCTURE

The organogram at central level is as follows:



At the regional level there are four Regional Health Directorate Teams responsible for each of the 4 health directorates. At the regional operational level there are 13 Regional Health Management Teams. There are two main committees at district level. There is the District Health Co-ordinating Committee which is the overall managerial authority at district level. Secondly there is the District Hospital Management Committee which is the managerial authority at the district hospital level.

1.5. BUDGET

MOHSS is a large Ministry in terms of scope of operations and it is one of the largest employers of civil servants. The total expenditure for the fiscal year 1995/96 amounted to N$ 678 530 000. The estimates for the 1996/97 and 1997/98 fiscal years were N$ 744 424 000 and N$ 834 261 000 respectively.

1.6. STAFFING

The operations of the Ministry are labour intensive, therefore personnel costs are large. During the 1995/1996 financial year the expenditure for personnel represented 40% of the total budget for current expenditure. A total of more than 9 000 staff is employed by the Ministry according to the estimate of revenue and expenditure for the financial year ending 31 March 1998. This number includes 1 300 registered nurses and more than 200 medical doctors.

2.1. THE PRE-STUDY

Problems in the public health sector are often discussed in the newspapers and in public debate. Some examples that have been brought up by the press are as follows:

- Long queues at hospitals.
- Overcrowding of the Katutura State Hospital over the weekends.
- Negligence of hospital staff.
- Alleged mistreatment of patients.

All of the above could be indications of poor performance of at least some of the health facilities and this prompted my Office to carry out the prestudy on the public health sector.

It was also found that the general public are not well acquainted with hospital procedures and often demand to see doctors first before they are screened by nurses. They are of the opinion that they will receive better treatment if they are seen by doctors.

The following problems were identified at hospitals visited:

1. Poor utilisation of available resources.
2. The budget is not adequately distributed.
3. Staffing policies are not effective.
4. Support services are inadequate.
5. The referral system does not function properly.

From the above it was decided to select the “referral system” as the audit objective for the main study. The referral system plays a large role in the attainment of the overall objective. It is also closely linked to problems relating to utilisation of resources, distribution of funds and staffing problems.

It was decided to focus on the following issues during the main study:

- How long does it take to refer patients between the different health facilities?
- Are district hospitals adequately staffed?
- Do Namibians in different regions have equal chances of referrals for secondary and tertiary care?

The audit involved the Ministry of Health and Social Services, excluding the directorate for social services. Due to the fact the regions differ in many aspects like culture, traditional beliefs and weather conditions all four health regions were visited.

2.2. METHODOLOGY AND SOURCES OF INFORMATION

2.2.1 Documents and statistics

The Integrated Health Care Delivery report that was launched by the Ministry in 1995 was studied. Annual reports from regions and districts as well as some reports from district and Roman Catholic hospitals were also studied. The establishments of the different health facilities were analysed.

2.2.2 Interviews

A total of 204 professionals at different levels were interviewed (see annexure 1). This included interviews with medical officers, specialists, nurses, directors and health inspectors. Interviews were also carried out with the Under Secretary and with the first Permanent Secretary of the Ministry of Health and Social Services after independence.

2.2.3 Observations

Observations were made in hospitals, health centres and clinics. A total of 85 health facilities including the national referral hospitals, all 4 regional hospitals, 25 district hospitals, 13 health centres and 41 clinics were visited. The audit included observations on how available resources are distributed in the various regions. It was also observed in which manner patients are received and referred between different health facilities. The out patient department (OPD) at the regional and national referral hospitals were compared with the nearby clinics.

The performance audit pre-study was completed in August 1996 and the fieldwork for the main study was completed in April 1997, both studies were carried out by:
Ms Monica Hummel - Chief Auditor
Ms Modesta Tshimwehatsho Iiputa - Auditor
Mr Theo Beukes - Auditor
Ms Justina Ndahafa Sheya - Snr Assistant Auditor

CHAPTER 3

THE PRIMARY HEALTH CARE STRATEGY

3.1 GENERAL

The Government of Namibia is committed to uplifting the standard of living of its people and has outlined policies to ensure that there is equal access to basic services for all Namibians, as guaranteed by the Hospitals and Health Facilities Act, 1994 (Act 36 of 1994).

At independence, health care was identified as one of the four sectors requiring priority attention (others being education, agriculture and affordable housing). A health policy was adopted which has as its main goal the equitable provision of health services for all Namibians by the year 2000 and beyond.

Primary Health Care is the first level of contact between individuals and the national health system. It depends on other sectors such as education and agriculture to help communicate basic preventive messages, and to help communities become more involved in the provision and improvement of local health services.

3.2 OBJECTIVES

The Primary Health Care Programme aims to ensure that all Namibians, including those living in previously disadvantaged regions and isolated communities, have equal access to basic health care, and that preventive services are free, with a fee structure for non-PHC services which is low enough for everyone to be able to afford.

Primary Health Care programmes in Namibia and world-wide aim to promote:
- education on health problems and key methods of prevention
- adequate nutrition, including breast feeding
- family planning
- mother and child health
- immunisation
- prevention and control of locally endemic diseases
- appropriate treatment of common diseases and conditions
- sanitation and safe water supply
- control of common communicable diseases
- the provision of essential drugs

3.3 PREVENTIVE AND CURATIVE CARE

3.3.1 Preventive Care

Despite the specialised and specific functions of some health facilities e.g. hospitals, all health facilities should provide the following service functions in order to prevent diseases and promote health.

a) Community activities which help the community to prioritise its needs and to implement, monitor and evaluate the activities carried out to meet these needs.

b) Plan and implement strategies that raise community awareness, disseminate appropriate health information and mobilise communities to take action that promote health and development.

c) Environmental sanitation, including safe water supplies, safe food preparation and safe work places.

d) Maternal and child health, including family planning services such as ante natal care, deliveries, post natal care including growth monitoring, immunisation, food and micro-nutrient supplements and health education.

e) School health services activities focusing on:

- the early detection of health problems and disabilities,
- health education for children and teachers,
- encouraging a healthy school environment,
- the provision of preventive and promotive health services to school children.

f) Control of communicable diseases, promotion and support of control activities against the common important local diseases such as Malaria, AIDS, TB, etc.

g) Health information system to collect, analyse, report and disseminate health information.

3.3.2 Curative Care

This involves comprehensive care and includes assessment, diagnosis, planning for intervention, monitoring progress and promoting rehabilitation.

Curative care involves common diseases, as well as first aid, emergency treatments and the possibility to refer serious cases to secondary and tertiary care.

The health service structure is based on the principle that every Namibian should have access to primary health care of an acceptable minimum standard and an equal chance of referral for secondary and tertiary care.

Decentralisation of the sector is also at the heart of the new system, which introduced regional health directorates shortly after independence.

The referral system plays an integral role in this, with simple complaints dealt with at community level, more complicated cases sent to the clinic and serious problems referred to the district hospital. District hospitals refer cases to regional hospitals and regional hospitals refer cases which need specialised treatment to the National Referral Hospital. This screening process and a well functioning referral system will allow scarce and highly trained personnel to concentrate on those cases most in need of their expertise.

If the referral system does not work it will not only entail an inefficient use of the specialised resources but also increase the pressure on the limited resources available for preventive care services.

3.4 TYPES OF HEALTH FACILITIES WITHIN THE REFERRAL SYSTEM

Underneath is a description of the health facilities which are included in the referral system.

a) Health post:

This is the most peripheral unit and should be manned by a health worker who comes from the community in which the health post is located. Its functions are health education and promotion including environmental sanitation, treatment of simple injuries and common diseases, to serve as regular visiting point for outreach services and supervision of the community's own resource persons.

b) Small clinic

This is the smallest health facility permanently staffed by a salaried health worker. It should provide maternal and child care services, family planning services, nutrition promotion, treatment of common diseases and basic emergencies as well as training and supervision of the community's own resource persons.

Equipment should include furniture, storage facilities for medicines and clinical supplies, radio/telephone, medical equipment and cold chain equipment.

c) Large clinic

This is a larger facility in terms of size, range of services provided and staffing. It should have a maximum of three beds.

It should provide routine maternity services for low risk cases, outreach/mobile services including school health services, the provision of oral health, mental health, eye care services, rehabilitation services and social services.

A large clinic should be staffed by at least one registered nurse and enrolled nurses. It should provide service for 40 hours per week and be available for emergencies on a 24 hour basis. Additional staff allocations should be provided as workload increases.

d) Health centres

i) A *rural health centre* is a facility that is bigger than a large rural clinic but smaller than a district hospital. It should have a maximum of ten beds. In-patient care provided by a rural health centre is for normal deliveries, short illnesses which require observation up to a maximum of 48 hours.

ii) *Day care health centres* are usually found in larger municipal/urban areas and provide day care. They do not admit patients but normally have the benefit of more regular visits by a medical practitioner.

Equipment as for the clinic plus equipment for maternity, X-ray, laboratory, operating theatre equipment and equipment for in-patient care should be available.

e) District hospitals

District hospitals are classified as class C hospitals and are the ultimate referral point at district level. They should provide essential back-up services and support to the health centres and clinics.

A district hospital should provide comprehensive care (promotive, preventive, curative and rehabilitative) on a 24 hour basis and render the following services:

- diagnosis and treatment of common diseases and injuries;
- casualty service for the immediate treatment of injuries, medical and surgical emergencies;
- maternal and child health care services;
- basic diagnostic facilities for X-ray and laboratory investigations;

- basic operating theatre to enable the performance of common surgical procedures to the standard required to perform caesarean operations;
- social work, oral health, mental health, basic rehabilitation services, etc.
- storage of drugs and clinical supplies;
- medical doctors and nursing staff should play a major role in education and training of health workers and participate in community education on health matters;
- district hospitals should also provide logistics and support to primary health care services at health centres and clinics.

Equipment should include X-ray and ultrasound equipment, anaesthetic machines, intensive care unit (ICU) or high care facilities and equipment for in-patient care.

f) Regional hospital

Regional hospitals are classified as class B hospitals and the objective of the regional hospital is to provide regional specialised health care services and to function as a referral hospital for the relevant health region.

Included in the specialised services are basic specialist services in paediatrics, obstetrics and gynaecology, general and orthopaedic surgery, internal medicine, psychiatry and anaesthesia, diagnostic and case management facilities for the basic specialities, in-service and pre-service training as well as the provision of district hospital services to the community which it serves.

Equipment should include X-ray and ultrasound equipment, anaesthetic machines, ICU or high care facilities and equipment for in-patient care.

g) National referral hospital

Windhoek State Hospital Complex (Katutura Hospital which is classified as a class B hospital and Windhoek Central Hospital which is classified as a class A hospital) serves as the national tertiary referral centres for the whole of Namibia. Katutura hospital also serves as a district hospital for the Khomas region as well as a regional hospital for the South health region.

Services which are rendered by the national referral hospitals are as follows:

- Specialists such as paediatricians, physicians, obstetricians and gynaecologists, general surgeons and oncologists. Services of cardiothoracic surgeons, neuro surgeons and plastic surgeons should be provided on a visiting basis.
- Specialist support teams for the above, such as intensive care, operating theatres, etc.

- Specialist technical staff providing a full range of diagnostic services, such as medical laboratory services, radiological services, nuclear medicine, etc.
- Specialist staff providing a full range of case management services, e.g. pharmaceutical services, rehabilitation services, etc.

CHAPTER 4

THE REFERRAL SYSTEM

4.1. DEFINITION OF REFERRAL SYSTEM

The referral system is a process in which patients are referred from one health facility to another on the basis of the complexity of their condition.

The district level that includes clinics, health centres and district hospitals is the first entry point into the referral system. A patient who has been referred from a clinic or a health centre to a hospital is called a referral or a referred patient. If a patient can not be treated at district level because of lack of facility, expertise or other reasons, he/she is referred by the medical officer to the regional level which offers basic specialised services. If the condition of the patient can not be treated at regional level then the patient is referred to the national referral hospital which offers advanced specialised health care services. This system is designed to give equal opportunity to all patients to obtain the necessary treatment.

4.2. TYPES OF REFERRALS

There are two types of referrals namely cold cases and emergency cases.
Emergency cases are cases in which the condition of the patient is critical and the patient is referred immediately. Transport should be available to take emergency cases from the referring health facility to any referral health facility. Emergency referrals are brought to the national referral hospital by ambulance.

Cold cases are referrals whose health condition does not require immediate attention. Cold cases from clinics are referred to regional or district hospitals. No bookings are made in these cases. Patients referred to the national referral hospital go through the booking office at Katutura hospital.

4.3. THE BOOKING PROCEDURES

The three referral steps (clinic to district hospital, district to regional hospital and regional hospital to national referral hospital) described above have been modified to allow district hospitals in the Central and South health regions to book directly to the national referral hospital. No bookings from clinics or health centres should be considered. See rules and regulations for the booking office in annexure 3.

On a particular day each week, the regional hospital or district hospital either phones or faxes the names and diagnosis of the patients they wish to refer the following week through to the booking office. The booking office then presents these names to the respective departments/wards. The department/ward then indicates to the booking office which of the patients should come and this information is fed back to the hospital concerned.

Booking of patients should be done strictly between 10h00-12h00 every day. As far as possible the same person should book patients to ensure consistency in bookings. Feedback from wards to the booking office should be done not later than 14h00 to enable the office to compile bus lists and give feedback to districts and regions within an hour. This will enable these hospitals to trace patients in time for the bus. Districts and regions should ensure that the patients accepted are actually on the bus. Extra efforts should be made to accept patients waiting for longer than four weeks for admission.

Bookings are also done for follow-up cases. All wards should keep records of follow-up dates of patients and communicate these to the booking office on a daily and/or weekly basis to ensure that the patients are accepted in time for a follow-up. New bookings should be accepted keeping in mind the follow-up patients. No bookings are made for emergency cases.

In order to improve on the referral system, the national management meeting held by the Ministry during September 1996 at Rundu discussed the possibility of a quota system. This was set to be investigated by the management of the WSHC. According to the Superintendent of the Katutura hospital the investigation has been put on hold to concentrate on the separating of duties of the Katutura hospital and Windhoek Central hospital. The Minister has appointed a committee responsible for investigating ways of implementing this division.

4.4. THE REFERRAL SYSTEM MECHANISM

To facilitate the smooth functioning of the referral system there is a need for auxiliary services such as transport. It is the obligation of the Ministry to provide free transport to referred patients from the referring health facility to the referral hospital and back.

For the diagnosis of each patient to be clearly defined, each patient must have a health passport. The history of the patient should be entered into the health passport by the screening nurse from the day that the patient first visited a health facility. The health passport must therefore be carried at all times when a person visits any health facility.

If the patient is to be referred, the preliminary diagnosis of the patient in addition to the history of the patient should appear in the passport which the patient will take to the doctor.

One other form of communicating information is the referral letter. This letter should be completed by the referring health worker and should be sent with the patient to the health facility to which the patient is being referred. There is a part in the referral form where the medical practitioner at the referral hospital should give feedback. This part should be returned to the referring health facility with the patient when he/she is discharged. See annexure 4 for a copy of the referral letter.

4.5. TARIFFS

All patients who come to a referral hospital without being referred, should pay the required fees. These patients will be seen and treated by nursing staff and referred to a doctor only if the nurses feel it is warranted. Non emergency cases who are not referred and can not pay the required fees should not be attended to at the hospitals. These patients must seek assistance at the nearest clinic. They will be referred by the clinics to the hospital, should there be a need, without further charge.

Fees for treatment at a state hospital are:

Health facility	**Treatment fee**	**Follow-up fee**	**Admission fee**
	N$	N$	N$
National referral (class A)	24.00	9.00	36.00
Regional hospital (class B)	9.00	7.00	24.00
District hospital (class C)	6.00	4.50	16.00
Health centre (class D)	6.00	4.50	10.00
Clinic (class E)	3.00	1.50	7.00

These fees include medicines. It is important to note that a referred patient only pays at the first health facility he/she visits and is transported to the referral health facility and treated at that specific health facility without further charge. The fees system thus encourages patients to go to the clinic first.

CHAPTER 5

HUMAN RESOURCES

5.1. INTRODUCTION

MOHSS has a large field of operations and scope resulting therein that the costs of personnel are very high. Human resources include all medical, non-medical and administrative personnel within the Ministry.

5.2. AVAILABILITY OF MEDICAL PROFESSIONALS

According to the Medical Board of Namibia the following doctors are registered in the country:

Fully registered doctors = 262
Conditionally registered doctors = 67
Total *329*

Out of these 129, or 49%, of the fully registered doctors are residing in Windhoek.
Doctors who have been conditionally registered must work under supervision by a more senior doctor for at least two years. For a doctor to be fully registered with the Medical Board he/she should have completed six years of medical training at an accepted medical school and be an intern for one year at an accepted hospital.

5.3. ESTABLISHMENT: DOCTORS

The Ministry has the following number of posts for doctors on its establishment:

Health Region	***Vacant Posts***	***Filled Posts***	***Total Establishment***	***% Vacant***
North West	24	57	81	30
North East	12	10	22	55
Central	16	19[4]	35	46
South	27	89[5]	116	23
Total	***79***	***175***	***254***	***31***

[4] Includes district surgeons
[5] Includes Windhoek State Hospital Complex

The number of doctors actually working for the Ministry in Namibia is as follows:

	Posts filled			
Health Region	***Namibians***	***Foreigners***	***Volunteers***	***Total***
North West	23	34	27	84
North East	0	10	10	20
Central	13	6	6	25
South	56	33	11	100
Total	***92***	***83***	***54***	***229***

In addition to the medical doctors a large number of nurses are employed within the Ministry:

Health region	**Registered nurses**	**Enrolled nurses**	**Nursing assistants**	**Total**
North West	421	291	511	1223
North East	107	89	159	355
Central	164	76	367	607
South[6]	626	247	623	1 496
Total	***1 318***	***703***	***1 660***	***3 681***

5.4. DISTRIBUTION OF HUMAN RESOURCES

The Directorate for Planning and Human Resource Development is responsible for distributing staff. All the staff have been distributed according to the present establishment. The whole process of distributing human resources is under review. The installing of a computerised personnel data base is currently under way. This data base would enable management to review the placement of human resources on an annual basis.

Volunteers are allocated in different ways. Regional directors may request volunteers with specific skills. Some volunteers are attached to vacant posts in order to overcome the shortage of medical doctors. Others need to be under supervision by senior doctors or specialists and are therefore placed at one of the major hospitals.

Half of the doctors, or 118 out of 229, are concentrated at Oshakati Regional Hospital and the Windhoek State Hospital Complex.

[6] Includes Windhoek State Hospital Complex

5.5. TRAINING

Training is the responsibility of the four health directorates. Each directorate in consultation with its respective districts, determines and identifies its training needs.
This includes basic training for registered nurses and paramedical professionals, post-basic training for interns and degree, certificate and diploma courses in nursing and paramedical professions. There is also in-service training for all grades of health workers. It also includes links with the University and regional hospitals, and the setting of standards and treatment protocols for quality assurance.

The medical training committee is responsible for the assessment of candidates who apply for scholarships at medical universities to become doctors. Plans for all the different types of training are sent to the Office of the Prime Minister every six months.

There is a total of 26 interns at WSHC. Most of these interns come from Stellenbosch University in South Africa. A total of 40 to 50 applications are normally received for these 29 intern posts. There are also 4 to 5 Namibian doctors specialising in internal medicine and an unknown number of Namibians studying at medical schools in South Africa.

According to circular no 34 DF 1994 of the MOHSS, all Namibian and foreign junior doctors with less than 3 years hospital post-internship experience are required to perform compulsory district hospital service for at least two years.

The final year students who are on in-service training are sent to do the internship in Oshakati or Windhoek hospitals where there are specialists. After this the interns are sent to work in the periphery. If they wish they may, however, stay on one more year at the training hospital before going out to the periphery for at least two years. Most of these students are from the Windhoek area and they do not want to work in the periphery where there are no specialists and because of difficulties in arranging housing, schooling for children, jobs for spouses, etc. They prefer to work as private doctors and pay the bursary back.

The Ministry does not force these interns to work in the periphery. Clinics in Windhoek are also classified as peripherals and most doctors would prefer to work at clinics in Windhoek rather than going to rural hospitals.

5.6. RECRUITMENT

Staff is recruited after vacant posts have been advertised. The Ministry is experiencing a shortage of Namibian doctors. In order to overcome this problem the Ministry has decided to recruit from outside Namibia, specifically West and East Africa.

This is done in the following way:

- through the local embassies in Namibia
- through the foreign doctors currently working in Namibia
- through volunteer organisations

The health directorates are responsible for the selection of doctors. The foreign doctors are appointed on a contract basis for usually two years. These foreign doctors can receive an extension of the contract if no Namibians are available to fill the posts.

Students who received bursaries are mostly from schools in the Windhoek area. This has the effect that these qualified medical doctors don't want to work in the rural areas. The Ministry is looking into this problem by having discussions with South African universities in order to introduce a bridging year. This would enable students from the rural areas to study to become medical doctors.

5.7. DISTRICT SURGEONS

District surgeons are appointed by the Ministry to try and overcome the shortage of medical doctors in the districts. These districts surgeons are private general practitioners who reside within a specific district.

The regional directors determine the number of sessions to be contracted out to the district surgeons. One session represents a particular number of hours per week (at the present 6) that the doctor is contracted to work in the hospital. The regional directors or their representatives normally approach the private doctors in the district to find out if they are willing to perform the duties of a district surgeon. A contract is signed between the Ministry and the doctor. The period of acting as district surgeon should be stipulated in the contract.

The advantages of having district surgeons are that these district surgeons usually are well-equipped and sufficiently experienced to handle surgery and to administer anaesthetics. Often the volunteers and foreign state doctors are not familiar with these areas. This is one of the reasons why cases are sometimes referred that could otherwise have been treated at the district hospitals.

District surgeons are used only in the Central and Southern regions where most general practitioners live and work.

CHAPTER 6

DISTRICTS

6.1. THE ROLE AND FUNCTIONS

The district level assumes a peripheral front-line role in the public health system. DHCC is the overall authority at the district level. Its main functions are to facilitate the coordination of activities at district level and to ensure the maintenance of a harmonious working relationship and functional intergration of the various components of the district health system. The districts include district hospitals, health centres, large clinics, small clinics and health posts.

6.2. REFERRALS FROM CLINICS AND HEALTH CENTRES

The clinic is the smallest health facility permanently staffed by salaried health workers rendering PHC services to the community. Health centres are bigger than clinics and staffed by at least one registered nurse and other nursing staff. The functions and responsibilities of clinics and health centres are described in detail in paragraph 3.4

Patients are screened by nurses at the clinics. If they are unable to treat the patients they refer them to the health centre if there is any. In most cases they refer to the nearest district or regional hospital because there are no health centres in the nearby vicinity. At the health centres patients are screened by nurses. Only some health centres have doctors. Patients at health centres are referred by doctors when necessary. Each clinic should refer its patients to the district hospital within the same district. Referrals from clinics where doctors only visit for supervisory purposes are made by registered nurses or another responsible person at the clinic. Doctors in the North West do not visit clinics to treat patients but to supervise the work done by nurses. Hence they do not refer patients from clinics. Emergencies are referred to any hospital anytime.

In the Engela district, in the North West region, patients bypass clinics and go to Engela hospital demanding to see doctors at casualty after hours. These patients are told to go to the clinic the next morning. Unnecessary referrals are made when patients demand to see doctors at the hospital and only use the clinic to get free transport to the hospital. Many patients do not want to be treated by nurses at clinics. Twelve clinics in South and Central health regions are referring direct to the national referral hospital bypassing district and regional hospitals.

Clinics in the South and Central health regions have telephones but clinics in the northern health regions only have radio communication which is not reliable at all. Most clinics in the South and Central health regions do communicate with district hospitals. They are able to contact doctors at regional or district hospitals for advice unlike in the northern regions.

Clinics in the North East health region are run by nursing assistants who would need to talk to doctors at hospitals but are unable to do so because of radios that are not working. These clinics in the North East health region are in the areas that are most affected by malaria and diarrhoea.

Different transport problems are experienced in all four regions. Clinics do not have permanent vehicles allocated to them, only health centres and district hospitals. The clinics in Windhoek and some large towns have transport running from the clinic to the hospital, although the residents have access to vehicles, e.g. taxis and municipal buses. In cases of accidents they have municipal ambulances and fire brigades.

6.3. REFERRALS FROM DISTRICT HOSPITALS

A district hospital is the ultimate referral point at district level and provides essential back-up services and technical support to the health centres and clinics that are in more direct contact with individuals, families and communities. District hospitals provide comprehensive care (promotive, preventive, curative and rehabilitative) on a 24 hour basis.

According to an unwritten policy of the Ministry, doctors should visit clinics in their districts. Doctors at some districts do not visit clinics at all while in other districts they visit clinics for supervisory purposes only. Doctors in the South visit clinics to treat patients. The Out Patient Department (OPD) at district hospitals differs. The hospitals in the South do not treat patients at OPD while it is happening in the northern and central health regions.

The OPD at hospitals in the South is closed when clinics are open. They are insisting that patients go to the clinics. The OPD at some hospitals is functioning as clinics, e.g. Khorixas hospital and Luderitz hospital. Referrals from clinics are received through casualty before they are seen by doctors.

District hospitals that refer their patients to regional hospitals do not book in advance. They are having a schedule when to refer patients, e.g Andara and Nankudu refer their patients every Tuesday to Rundu. Ombalantu refers the same day to Oshakati and Oshikuku refers on Thursdays. This only applies to cold cases. Emergency cases are referred on a daily basis.

District hospitals in the South and Central health regions are referring directly to the national referral the same way as regional hospitals in the North West and North East. This is the procedure that was set up by the national referral hospital. The district hospitals in the South book direct because Katutura is acting as the regional hospital for the southern health region. In the central health region Otjiwarongo hospital is not rendering the services of a regional hospital. Therefore all district hospitals in the region are referring to the national referral hospital.

Lack of communication is a problem. Medical officers at some district hospitals and staff at clinics do not communicate concerning the diagnosis of the patients. Sometimes the referring medical officers at district level are unable to discuss possible improvements in their services with doctors from regional hospitals. Information in the patient's passport is not always clear. Sometimes wrong diagnoses are done. The medical officers at district hospitals will want to get a second opinion from medical officers at regional hospitals but they do not get any feedback from these doctors. Patients are sometimes coming back without being treated.

Patients are experiencing a communication problem with their medical officers. They do not understand the officials who often cannot understand the local language spoken in the area. Therefore when they come back to their district hospital they are unable to tell the medical professionals about their diagnoses and pass on feedback from the regional hospital, e.g. San people from Tsumeb hospital. The feedback in the passport is often inadequate and patients will want to know what is going to happen to them afterwards. In one case the district hospital was not even aware of what kind of diseases could be treated at the regional hospital.

Some district hospitals in the North West and North East are experiencing a problem with outreach services. If the car is out for immunisation they are not able to take emergencies from clinics because there is only one vehicle available, e.g. Tsandi hospital and Oshikuku hospital. Many vehicles at district hospital level are non operational because they are not repaired on time. The people at district hospitals are blaming the directorate for the delays in repairing of vehicles.

6.4. EQUIPMENT

The lack of equipment in district hospitals is increasing the number of referrals to regional and national referral institutions. Many patients are referred because of lack of equipment, e.g. X-ray and anaesthetic machines. Onesi health centre has a theatre without material so they cannot make use of this theatre. Okatana health centre, Tsandi and Okahao hospitals were not having working X-ray machines. At the time of our visit they had to refer their patients to the regional hospital. Some of the disadvantaged hospitals are still not as well equipped as other hospitals. According to the hospital act, hospitals are classified in categories depending on the availability of equipment and services rendered at the hospital. Andara hospital is classified in the same category as Swakopmund hospital but the facilities and services at these hospitals differ. Arandis health centre and Aranos hospital were the health facilities most underutilised. Arandis has 42 beds but there was only one patient in the health centre. In Aranos hospital the wards were half empty during our visit.

Hospitals in the South are empty compared to the hospitals in the northern health regions, e.g. Ombalantu hospital, Tsandi and Onandjokwe were found with patients sleeping under beds therefore there is unequal distribution of resources in hospitals. Engela hospital is having a new and modern X-ray machine that is not used at all. Patients are referred to Oshakati for X-ray examination.

Clinics in the South are better equipped than health centres in the Northern Regions, e.g. Berseba clinic is having more beds and better buildings in comparison to Bukalo and Mupini health centres.

6.5. STAFF

The staff situation at district hospitals is very poor. The district hospitals were complaining about the shortage of staff at their hospitals. Many district hospitals do not have enough medical officers due to the large number of vacant posts. Operations cannot be carried out at these hospitals. Nineteen posts of PMO are filled by foreigners who are responsible for planning and human resource management in the district. Most of these posts are at hospitals in the North East and North West. It was also observed that 74% of doctors at district level are foreigners.

			DISTRICT DOCTORS				
			FILLED POSTS			ALL	
REGION	POSTS	VACANCIES	NAMIBIANS	FOREIGN	VOLUNTEERS	DOCTORS	% NAMIBIANS
North West	40	16	4	20	19	43	9%
North East	12	7	0	5	5	10	0%
Central	31	15	10	6	6	22	45%
South	23	7	9	7	3	19	47%
TOTAL	106	45	23	38	33	94	24%

The above table is showing the number of foreign, volunteer and Namibian doctors per region at district hospitals. Half of the Namibian doctors are district surgeons.

Some staff members are not at their work stations as indicated on the establishment, e.g. nurses from Nakayale health centre were found to be working at Kamaku hospital. The North Eastern directorate has an establishment for staff indicating among other things, which clinic posts were filled with registered nurses. When the clinics were visited, nursing assistants were in many of these posts. These nursing assistants are alone without any supervision and support from medical officers and registered nurses at district hospitals.

	Clinics in North East	
	Establishment	**Observation**
Registered nurses	6	4
Enrolled nurses	4	2
Nursing assistants	0	4

The above table indicates the number of clinics which should be headed by the mentioned professionals according to the establishment and posts actually occupied according to our observations.

Most qualified staff do not want to work in the remote areas due to lack of proper accommodation. Accommodation for nurses is not evenly distributed. At hospitals such as Nankudu,Tsandi and Okahao the low standard of accommodation makes the recruitment of qualified staff (registered nurses) very difficult. Consequently nurses do not stay long in these areas. This affects the referral system because the hospital has to work with unqualified staff causing unnecessary referrals and wasting of resources.

Clinics are sometimes closed when they are not supposed to be closed. During the visits it was observed that Kapako clinic, Witvlei clinic and Sangwali clinic were closed during official working hours.

CHAPTER 7

REGIONS

7.1. DEFINITION OF REGIONS

The regional level is an intermediary level between district level where the implementation is taking place and the national level where policy formulation is taking place.

The MOHSS is divided into four health regions, namely North West, North East, South and Central. It is also divided into thirteen political regions. It is the ministry's aim to phase out the four health regions and remain with the thirteen regions. To ensure smooth transition from operating on the basis of the four health regional offices to thirteen, the four health regions must continue to exist while the new thirteen operational offices are being established and consolidated.

The four health regions are run by regional directors and the thirteen regions should be run by regional medical officers. Each of the four health regions has a regional hospital i.e. North West-Oshakati; North East-Rundu; South-Keetmanshoop and Central-Otjiwarongo.

The functions of the health regions have to be looked at from two different angles:
a) The regional health directorate level corresponding to the four regional directorates.
b) The regional operational level corresponding to the thirteen operational health regions.

The overall functions of the regional directorates are as follows:
- The translation of national policies into operational strategies.
- Co-ordination and control of the provision of health services.
- Provision of technical and management support to health services at the regional operational level and
- Provision of specialised health care services.

The functions of a regional hospital are the provision of specialised basic services, these are discussed in more detail in chapter 3 paragraph 3.4(f).

7.2. REFERRAL PROCEDURES

Clinics should refer their patients to the district hospitals in their regions. The district hospitals should refer their patients to the regional hospitals in their respective regions. The regional hospitals will in turn refer their patients to the National Referral Hospital (WSHC). Some of the interviewees in Windhoek firmly believe that this is what is actually happening. The above mentioned procedure is similar to the one described in the Integrated Health Care Delivery (IHCD) document. Interviews with senior officials thus indicate that bookings to the national referral should only be made by regional hospitals. However a document on the rules and regulations for the booking office at WSHC (see annex 3) clearly states that the district hospitals in the South and Central health regions are allowed to bypass the regional hospitals and refer direct to the National Referral Hospital.

Although the Integrated Health Care Delivery document states clearly the procedures to be followed, there are many channels through which patients are being referred to the national referral. The policy on the referral system is interpreted in different ways, and the ways this policy is practised also vary. There is even disagreement between officials within the MOHSS and those at the health facilities on which hospitals of the Ministry are regarded as regional referral hospitals.

During the fieldwork it was noted that district hospitals in the South and Central refer direct to the National Referral Hospital. The regional referral hospitals in these regions are therefore just a stopover for the transport and accommodation of patients in transit to WSHC. Some of the staff interviewed at regional hospitals said that these hospitals are classified as district hospitals.

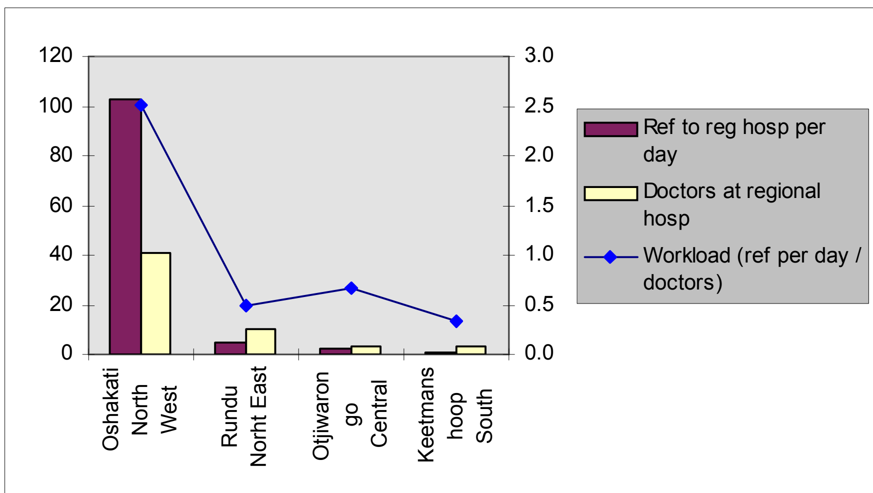
The regional hospitals in the North West and North East follow the referral procedures as laid down by the IHCD document, except for Katima Mulilo and Tsumeb hospital which sometimes refer direct to WSHC.

The data below is reflecting admitted referrals at Rundu, Otjiwarongo and Keetmanshoop regional hospitals for the period between the 01/10/96 and 28/02/97. For Oshakati the data refer to 16/03/97 to 22/03/97 and include non-admitted as well as admitted patients.

Region	Regional hospitals	No of district hospitals per region	District hospitals referring to regional hospitals	Referrals to regional hospitals per day	Doctors at regional hospitals	Workload (ref per day / doctors)
North West	Oshakati	9	10	103	41	2.5
North East	Rundu	4	4	5	10	0.5
Central	Otjiwarongo	10	6	2	3	0.7
South	Keetmanshoop	6	2	1	3	0.3

This table shows that Oshakati and Rundu hospitals are rendering referral services to all the district hospitals in their respective regions thus being proper regional referral hospitals.

Oshakati hospital is also serving a district hospital from another region, namely Opuwo. District hospitals in South and Central all refer to WSHC and only sometimes to the regional hospital in their respective region.



Oshakati hospital receives the most referrals from its district hospitals, while Keetmanshoop hospital receives the lowest number of referrals. The work load on referred patients at Keetmanshoop is the lowest among all the regional hospitals.

7.3. COMMUNICATION

At three of the regional hospitals visited, staff complained that the feedback they receive from Windhoek on referred patients is very poor and sometimes late. This makes it difficult for the hospital to know what to do with the patients when they return from Windhoek. There are also complaints that sometimes patients are referred but they return home without treatment. This criticism is aimed at regional hospitals and the National Referral Hospital. Patients are sometimes placed in the

wrong unit or even treated by junior doctors. This indicates poor communication methods.

A referral letter is used at some hospitals. This letter is completed with the details of the patient when a patient is referred to a referral hospital. It should also be completed by the doctor at the referral health facility when the patient is discharged. However this letter is not regularly used.

7.4. TRANSPORT

All the transport arrangements for the referred patients (cold cases) are made in Windhoek. All the busses are stationed in Windhoek. This means that patients can not always leave WSHC immediately after they are discharged as the bus leaves for each region only once a week. At the same time district and regional hospitals are also complaining that the number of patients accepted in Windhoek per week is too low. The National Referral Hospital indicated that this is caused by a lack of beds. Keeping discharged patients for a week in hospital may contribute to this situation. It is also costing the MOHSS money and other resources.

Unlike at national referral, transport in the regions (between district hospitals and regional hospitals) is stationed at the referring health facility and is arranged by the referring health facility. This way people can go home when they are discharged. No bookings are done when patients are referred to regional hospitals. In emergency situations the referring health facility uses its own vehicles to take referred patients to the National Referral Hospital.

It was obvious during our visits to the regions that vehicles are not evenly distributed. Some regions, for example the South health region seems to have more transport facilities in relation to their population than other regions. Some of the vehicles that are used as ambulances are not well equipped for such functions and they sometimes have to transport critically ill patients over long distances during which medical care will be needed. A large number of non-operational vehicles where identified. The four regional directorates are responsible for repairing vehicles in their respective regions. The procedure taken before a car is repaired is long and cumbersome, although each regional directorate has its own budget. The decision to repair a vehicle is taken in Windhoek.

After numerous consultations with officials at the transport office at the MOHSS, they could not provide us with accurate information on the total number of cars in the Ministry and where they are stationed. No proper records on vehicles are kept at

the MOHSS. This indicates an administrative weakness. Some of the data presented by the MOHSS indicates that more than half of the vehicles may be stationed in Windhoek.

7.5. ACCOMMODATION OF PATIENTS

The regional directorate is responsible for the provision of technical and management support to health services at the regional operational level. This includes budgeting, financial management, logistics and supplies, etc.

Rundu and Otjiwarongo hospitals are experiencing lodging problems. They say WSHC does not inform them of how many patients are discharged. These patients will have to spend a night at the above mentioned hospitals before going to their homes.

The table below shows the allocation of beds per political and health region. It shows that the South health region including WSHC has the highest bed allocation while the North West has the lowest bed allocation in relation to its population. Accommodation problems for staff at clinics and district hospitals mentioned in Chapter 6 paragraph 6.5 are also the responsibility of the regional directorates in the respective regions.

Pol.regions	**Health reg**	**Beds**	**beds/pop*1000**
Oshana	Northwest	785	5.0
Omusati	Northwest	702	3.2
Oshikoto	Northwest	510	3.4
Ohangwena	Northwest	518	2.5
	Northwest Total	**2 515**	**3.4**
Kavango	Northeast	776	5.7
Caprivi	Northeast	332	3.2
	Northeast Total	**1 108**	**4.6**
Kunene	Central	276	3.7
Erongo	Central	459	7.1
Otjozondjupa	Central	457	3.8
	Central Total	**1 192**	**4.6**
Omaheke	South	91	1.5
Hardap	South	294	3.8
Khomas	South	1 383	7.1
Karas	South	318	4.5
	South Total	**2 086**	**5.2**
	Grand Total	**6 901**	**4.2**

7.6. HOSPITAL EQUIPMENT

During visits to the different regional hospitals it was noticed that some regional hospitals had equipment that is not used while other hospitals are in need of this equipment. Medical officers from Rundu Regional Hospital for instance go to Nyangana Roman Catholic hospital to use their equipment or take it to Rundu. This indicates inefficiency in the distribution of State equipment. For more information about the different types of hospital equipment refer to Chapter 3.

According to regulations promulgated under the Hospitals Ordinance Act, 1972 (MOHSS no. 43, 1993) health facilities are classified into groups, i.e. class A to E. It seems however that equipment is not distributed according to these classifications.

There is very little difference in capacity between district and regional hospitals, for example Katima Mulilo (district hospital) and Rundu (regional hospital), or between Swakopmund (district hospital), Walvisbaai (district hospital) and Otjiwarongo (regional hospital).

Our general observations indicate that Keetmanshoop is under utilised. The number of patients attending is low in relation to the capacity of this particular hospital. Nevertheless some staff members at this hospital said that they have a lack of equipment.

Rundu Regional Hospital is not equipped as a regional hospital at the moment (no ICU and insufficient theatre equipment). Senior officials in this hospital said that more equipment and human resources need to be brought in, in order for this hospital to become a proper regional referral hospital.

Otjiwarongo hospital is well equipped, it should therefore be easy to transform this hospital into a functioning regional referral hospital. The regional directorate office is still studying the duties of this hospital. A decision has to be made whether it should be a regional referral hospital, a district hospital or both.

In comparison with other regional hospitals, Oshakati hospital is up to standard as a regional referral hospital, staff at the hospital however still think the hospital should be expanded to cope with the increasing workload.

7.7. STAFF

Interviews indicate that there are serious staff shortages (doctors and nurses) at regional hospitals. Regional hospitals claim that their establishments in terms of nurses are full but they are still experiencing staff problems. This they say is because the establishment of MOHSS has not been updated to handle the increasing population. Secondly some registered nurses on the establishment are used to do administrative work e.g. in PHC.

Otjiwarongo and Keetmanshoop regional hospitals use district surgeons in their hospitals to compensate for the shortage of state doctors. These are private practitioners who work for the Government on a contract basis. This system is only

used in the South and Central regions. The North East and North West regional hospitals make use of volunteers.

This is clearly illustrated in the table below.

Hospital	Total posts	Filled posts	Vacant posts	Volunteers	Posts filled by district surgeons
Oshakati	41	33	8	8	-
Rundu	10	5	5	5	-
Otjiwarongo	4	2	2	1	2
Keetmanshoop	4	3	1	0	2
Total	59	43	16	14	4

Regional Medical Officers (RMO) are key players in the regional planning process. They chair the Regional Health Management Team (RHMT). There are thirteen RMO posts of which only five are filled. Four out of the five RMOs are foreigners. This hampers the continuity of planning in a region because they may leave before their plans are put into practice. Planning at regional level is crucial because the Ministry is trying to transform the four health regions into thirteen.

At the moment only seven RHMTs are functioning. Five are run by the above mentioned RMOs, while the other two are run by a Principal Medical Officer and a Primary Health Care Supervisor.

The general feeling at regional hospitals is that resources should be decentralised and that regional hospitals should be empowered to handle more cases. Four specialists are regularly flown to Keetmanshoop from Windhoek to carry out specialised services. Three specialists go out every sixth week and one every third month.

CHAPTER 8

THE NATIONAL REFERRAL HOSPITAL

8.1. DESCRIPTION OF THE NATIONAL REFERRAL HOSPITAL

Windhoek Central Hospital and Katutura Hospital together called the Windhoek State Hospital Complex (WSHC) form the national referral hospital. The WSHC has a capacity of 1 383 beds. This is the last point in the referral system. All the regional hospitals and some district hospitals refer to this complex. It is stated clearly in the rules and regulations for the booking office that bookings from clinics and health centres will not be considered, however bookings from some clinics and health centres are accepted at WSHC. Katutura hospital serves as a district hospital for Windhoek district and in practice as the regional hospital for the South. The specialised services rendered by WSHC are discussed in more detail in Chapter 3 paragraph 3.4(g).

A study carried out by representatives of the two hospitals suggests that Katutura Hospital should remain a district hospital for the Windhoek district and a regional hospital for the South, while Windhoek Central Hospital should become the only national referral hospital. The roles of these two hospitals are still being investigated.

8.2. THE BOOKING SYSTEM

The booking office is at Katutura Hospital. This office is responsible for the booking of referred patients from all over the country to Katutura and Windhoek Central Hospital. Officials responsible for bookings at most of the regional and district hospitals do not know who is in charge of the booking office and are assuming that this person does not have any medical knowledge. This assumption came about because in some cases serious cold cases are overlooked while less critical cold cases are admitted. However the person in charge of the booking office is a registered nurse assisted by a secretary who has some nursing background.

The booking procedures are as such that regional hospitals, district hospitals, clinics and health centres fax or call the booking office with the list of the names, diagnoses and age of their patients to be booked. The registered nurse in the office entries this information in a register. She then allocates the names to different wards according to the diagnosis given and contacts the nurses in the respective wards by phone to give them the names and diagnosis of the booked patients. The registered nurse in charge of the ward will give this list to the medical officer in the ward the next morning when he/she does morning rounds. Selection of the patients who will be admitted is then done in the ward.

There is a general confusion at district and regional hospitals in the South and Central on the number of patients to be booked per week. Interviewees at some hospitals said that they are restricted to booking only seven people per week, but on the other hand some have never heard of this restriction. At an interview with the registered nurse at the booking office she confirmed that all hospitals in South and Central are only allowed to book seven patients per week. Our investigations show that more than seven patients were booked from some hospitals in the two regions per week. It was also clear that more than seven patients in one week from one hospital have been accepted into WSHC. The regional hospitals in the North East and North West regions are allowed to book any number of patients. It should be noted that, irrespective of the number of bookings, there are no guarantees that the booked patients will be accepted by WSHC. The booking system does not apply to emergency cases. Emergency cases are admitted through the casualty department.

8.3. THE SELECTION PROCESS

The selection of booked patients is done by the medical officer in the ward. Specialists are not involved in the selection process. The referring hospitals however are under the impression that the selection is done in the booking office and doubt the ability of the person in the booking office to select referred patients.

Selection is done on the basis of the availability of beds and the severity of the case. Some referring hospitals however argue that selection on the basis of the severity of the case is not effective because the medical doctors in the referring hospitals do not discuss the diagnosis of each case with those in Windhoek to be able to choose the most serious cases. During a visit to the booking office it was also discovered that the information noted down by officials in the booking office is hardly sufficient to enable the doctor to make his/her selection of patients on the basis of the severity of each individual case.

After the selection has taken place, the nurse in the ward will give the list of names of those who have been selected to the registered nurse in the booking office by telephone. The booking office will then pass this information on to the referring hospital. Hospitals are complaining that the feedback from the booking office comes late. Consequently they can not pass the message to those who have been selected on time. Most patients live far from the hospitals.

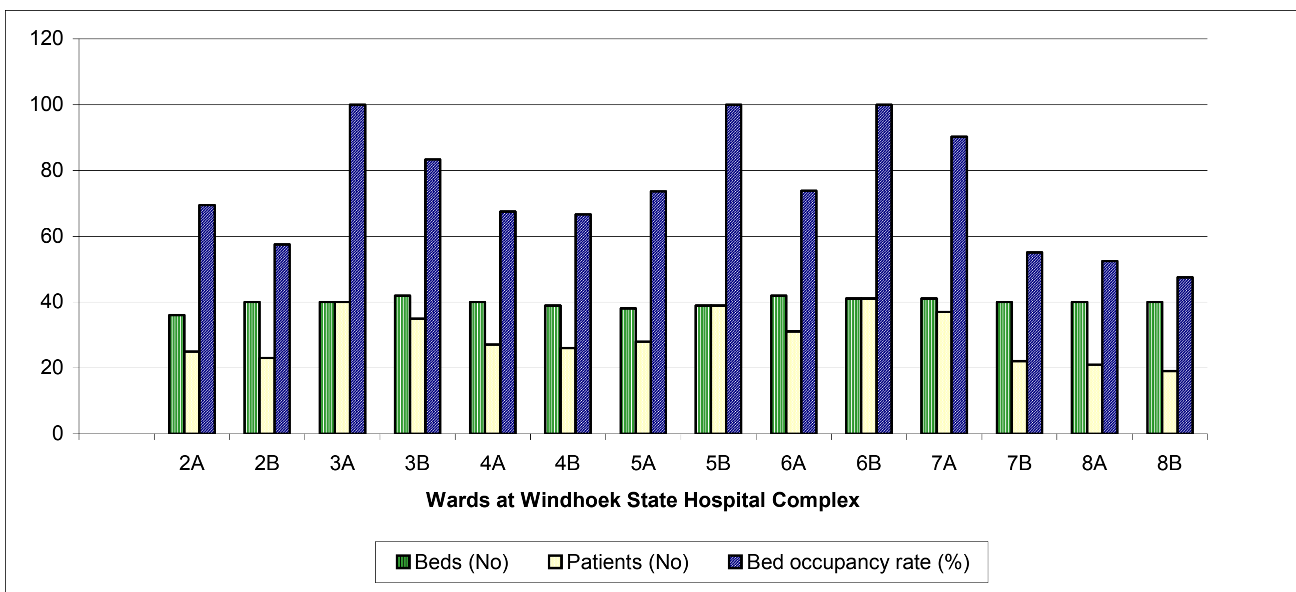
There are serious communication problems, sometimes the person giving the information from the referring hospital does not understand the diagnosis of the patient and information can be misinterpreted or misunderstood. This often brings about a situation where a patient is accepted at the national referral but his/her name does not appear on the bus list prepared by the booking office. A patient can also be allocated to a wrong ward/section because of a wrong diagnosis.

Work is duplicated at the national referral hospital were patients referred from clinics and health centres around Windhoek are screened again by a nurse at Katutura hospital.

8.4. BED OCCUPANCY RATE

WSHC has 1 383 beds. If each patient stays in hospital for seven days then that means this hospital has the capacity of admitting more than 70 000 patients per year (calculated as 1 383 x 365 ÷ 7 = 72 113). The ideal occupancy rate worldwide is about 85%. This would correspond to just over 60 000 patients per year for WSHC (72 113 x 85% = 61 296). According to our statistics 7 748 referred patients were accepted between 1 February 96 and 30 June 97. This represents less than 10% of the optimal capacity of WSHC. One can then conclude that the booking office is dealing with less than 10% of the patients that can be admitted in WSHC. The booking office is not involved in the control of the other categories of patients, who represent more than 90% of all patients admitted at WSHC when utilised to full capacity for example in-patients from around Windhoek, self referrals and emergencies.

The table below shows the beds occupancy/utilisation at Katutura Hospital during our visit on the 24th and 25th of April 97. Only three wards out of fourteen were being fully utilised.



8.5. WAITING PERIODS

Patients sometimes have to wait long periods before they are admitted. The national referral hospital says this is because of the lack of beds. The average waiting period for those who

can not immediately be admitted ranges between two weeks and two months. Patients living in rural areas go to the referring hospital every week to see if they have been accepted. After two or three refusals patients sometimes just disappear or refuse to be booked again. All wards should keep a record of follow-up dates of patients and communicate it to the booking office on a daily and or a weekly basis to ensure that patients are accepted in time for follow-up. Despite this instruction follow-up cases are also sometimes delayed.

As a result of poor transport arrangements, patients have to wait a whole week in WSHC for transport to return to their regions. This also contributes to the long periods patients have to wait to be accepted at WSHC.

8.6. REFERRALS FROM DIFFERENT REGIONS AND DISTRICTS

The tables below show referrals to WSHC from regional hospitals, district hospitals, clinics and health centres for the period February 96 to June 97. It was mentioned in Chapter 4 paragraph 4.3 that according to the rules and regulations for the booking office, no bookings from clinics and health centres will be considered. The table clearly shows that a large number of referrals are actually being made from clinics and health centres. It is also clear that Central health region refers more patients in relation to its population than the other regions. There are no referrals from the Khomas region because this is where the national referral hospital (WSHC) is based.

Referrals per health region

Political Region	Health Regions	Health facilities	Feb'96	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec'96	Jan'97	Feb	Mar	Apr	May	June	Total	ref/1000 pop
Oshana	North West	Oshakati	136	138	157	144	141	140	120	145	64	102	39	73	38	89	84	51	109	1770	
Omusati	North West																			0	
Oshikoto	North West	Tsumeb	26	28	20	8	11	33	36	10	37	9	3	11	13	13	7	21	14	300	
Ohangwena	North West																			0	
	North West Total		162	166	177	152	152	173	156	155	101	111	42	84	51	102	91	72	123	2070	2.8
Kavango	North East	Rundu	87	78	47	74	39	75	42	18	90	75	0	87	32	24	54	32	72	926	
Caprivi	North East	Katima Mulilo	21	23	13	31	31	50	49	40	49	32	0	37	16	21	22	43	71	549	
	North East Total		108	101	60	105	70	125	91	58	139	107	0	124	48	45	76	75	143	1475	6.1
Kunene	Central	Khorixas	35	26	30	33	20	50	30	37	42	18	7	25	26	12	28	21	20	460	
		Outjo	25	14	21	48	26	41	13	24	41	15	14	17	18	23	27	23	30	420	
		Opuwo	69	62	27	62	62	93	48	53	105	60	0	56	36	44	30	40	57	904	
Erongo	Central	Arandis	3	3	8	10	3	8	2	19	16	10	4	12	13	2	6	5	23	147	
		Karibib clinic	12	11	14	8	8	10	2	10	7	7	1	17	4	4	6	7	9	137	
		Swakopmund	28	39	33	36	26	51	27	43	37	32	8	20	26	21	21	33	24	505	
		Usakos	15	15	16	23	12	42	13	28	29	27	3	6	11	9	12	15	18	294	
		Walvis Bay	56	45	63	62	48	62	23	36	48	54	0	30	15	31	12	36	36	657	
		Otjimbingwe	3	2	1	4	0	7	0	1	0	1	0	14		2	6	1	5	47	
		Omaruru	29	23	24	24	15	37	30	38	27	33	6	17	20	14	30	14	27	408	
Otjozondjupa	Central	Grootfontein	24	40	24	31	34	70	23	27	38	20	18	9	34	24	27	17		460	
		Okahandja	27	9	9	13	20	22	9	0	16	13	2	5	11	4	8	7	12	187	
		Otjiwarongo	27	33	37	26	26	40	30	28	32	16	0	20	8	16	42	22	28	431	
		Otavi	2	1	0	4	0	5	31	5	5	1	0	4	0	4	10	2		74	
		Okakarara	6	12	12	23	20	57	12	44	0	17	4	14	7	13	16		11	268	
	Central Total		361	335	319	407	320	595	293	393	443	324	67	266	229	223	281	243	300	5399	20.9
Omaheke	South	Gobabis	33	27	27	36	35	37	27	15	38	28	0	30	20	18	24	22	21	438	
Hardap	South	Aranos	13	4	7	0	9	6	8	8	6	3	5	9	12	1	11	10	12	124	
		Gibeon	26	11	11	14	7	1	0	0	0	0	0	0	0	4	0			74	
		Kalkrand	3	0	0	0	0	2	2	0	1	0	0	3	0	0	4	4	9	28	
		Mariental clinic	23	28	18	12	7	0	0	26	54	37	8	16	30	15	49			323	
		Maltahöhe	11	18	12	23	16	11	5	4	9	16	7	10	13	4	14	8	8	189	
		Mariental	24	16	26	38	23	51	34									11	31	254	
		Stampriet	3	0	1															4	
		Rehoboth	0	1	1	1	0	1	0	0	2	0	2	3	1	0	0	5	1	18	
Khomas	South																			0	
Karas	South	Bethanie	15	6	6	4	0	15	2	3	8	19	7	10	4	7	20	7	2	135	
		Keetmanshoop	29	25	33	29	34	30	25	23	52	34	8	18	36	21	53	31	24	505	
		Oranjemund					8	4		0	0	0	0		0	0	0	1	5	18	
		Noordoewer	12	6	13	11	5	11	7	7	4	18	5	8	8	0	15	8	5	143	
		Karasburg	32	30	23	18	30	44	30	13	38	23	9	17	30	18	40	25	31	451	
		Luderitz	17	14	14	25	24	26	14	23	22	32	9	25	18	16	36	19	23	357	
	South Total		241	186	192	211	198	239	154	122	234	210	60	149	172	104	266	151	172	3061	14.6

✷In calculating the percentage of referrals in relation to the population living in the South health region, the population of the Khomas political region was excluded due to the fact that there are no referrals from the Khomas region.

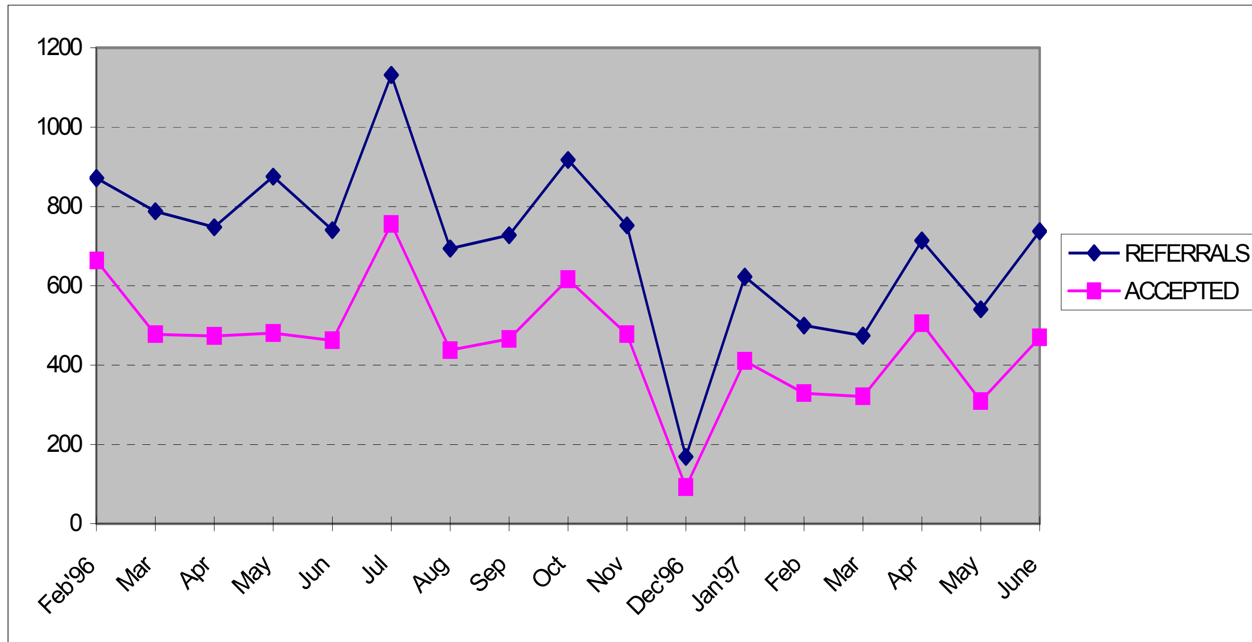
According to the above table, the Central health region refers more patients in relation to its population than all the other regions. The North West health region refers the lowest number of patients in relation to its population. With 70% of acceptances in the South health region and 68% in the North West health region in comparison to 60% and 61% in the Central and the North East health region respectively, the South and North West health regions are the most advantaged regions in terms of acceptances. In relation to its population the Central region remains the most privileged also in terms of accepted referrals, closely followed by the South health region. For accepted referrals see table below.

Accepted referrals per health region

Pol.regions	Health reg	Health facility	feb	mar	apr	may	jun	jul	aug	sep	oct	nov	dec	jan	feb	mar	apr	May	June	Total	accept/10000 pop
Oshana	North West	Oshakati hospital	101	88	121	69	93	104	77	92	52	79	17	40	22	75	68	46	88	1232	
Omusati	North West																			0	
Oshikoto	North West	Tsumeb hospital	23	18	9	3	11	22	28	8	24	4	0	11	8	13	6	13	5	206	
Ohangwena	North West																			0	
	North West Total		124	106	130	72	104	126	105	100	76	83	17	51	30	88	74	59	93	1438	1.9
Kavango	North East	Rundu hospital	69	55	31	45	27	50	33	13	54	39	0	42	12	15	33	20	40	578	
Caprivi	North East	Katima hospital	15	15	5	18	26	29	29	12	34	19	0	36	5	9	16	18	35	321	
	North East Total		84	70	36	63	53	79	62	25	88	58	0	78	17	24	49	38	75	899	3.7
Kunene	Central	Khorixas hospital	26	10	15	15	15	32	14	10	29	11	0	20	16	5	12	1	17	248	
		Outjo hospital	22	7	9	31	10	22	10	29	11	0	20	16	5	12	13	16	13	246	
		Opuwo hospital	47	29	16	31	27	30	28	25	64	35	0	29	24	32	25	12	28	482	
Erongo	Central	Arandis health centre	2	3	4	8	2	8	2	10	10	4	1	7	9	1	5	3	13	92	
		Karibib clinic	11	5	11	5	5	10	0	8	6	4	1	9	3	4	6	6	3	97	
		Swakopmund hospital	20	26	22	19	16	36	12	29	23	19	4	14	20	14	13	16	10	313	
		Usakos hospital	13	10	11	15	7	19	7	21	19	18	2	0	10	7	11	13	13	196	
		Walvis Bay hospital	37	26	43	44	24	36	10	33	34	29	0	21	11	18	7	14	19	406	
		Otjimbingwe clinic	3	2	1	4	0	7	0	1	0	0	0	2	0	2	6	1	4	33	
		Omaruru hospital	25	13	15	18	9	25	15	26	20	22	3	12	20	8	22	5	8	266	
Otjozondjupa	Central	Grootfontein hospital	20	28	14	16	31	59	19	18	29	11	4	1	16	13	13	10	22	324	
		Okahandja hospital	19	4	4	8	5	9	8	0	5	0	1	2	8	4	3	4	6	90	
		Otjiwarongo hospital	22	24	29	16	14	27	29	16	13	11	0	20	8	11	28	16	21	305	
		Otavi clinic	2	0	0	3	0	3	0	3	5	1	0	3	0	2	7	2	2	33	
		Okakarara hospital	3	5	5	11	7	38	6	20	0	7	1	8	3	5	8		6	133	
	Central Total		272	192	199	244	172	361	160	249	268	172	37	164	153	138	179	119	185	3264	12.6
Omaheke	South	Gobabis hospital	22	17	13	19	27	31	19	14	31	15		13	12	9	20	11	13	286	
Hardap	South	Aranos hospital	11	1	5		9	4	7	4	6	3	2	8	11	1	10	2	4	88	
		Gibeon clinic	19	9	4	9	4	1		0	0	0	0	0	0	4	0			50	
		Kalkrand clinic	3				2	2		0	1	0	0	3	0	0	2	3	6	22	
		Mariental clinic	19	16	12	6	4			20	43	32	2	16	22	10	37			239	
		Maltahöhe health centre	10	11	7	9	14	10	4	2	5	10	6	8	10	4	11	4	6	131	
		Mariental hospital	19	10	10	18	13	41	18									5	20	154	
		Stampriet clinic	3		1															4	
		Rehoboth hospital		1	1	1		1		0	1	0	1	3	1	0	0	4	1	15	
Khomas	South																			0	
Karas	South	Bethanie health centre	14	1	6	4		15	2	1	3	16	6	8	3	5	18	6	1	109	
		Keetmanshoop hospital	22	17	21	18	22	16	22	19	47	30	6	16	27	15	40	21	14	373	
		Oranjemund clinic					4	4										1	2	11	
		Noordoewer clinic	8	1	5	7	3	7	4	5	4	15	3	8	7	0	11	2	4	94	
		Karasburg hospital	20	19	14	4	18	36	27	9	28	19	8	14	23	13	29	23	29	333	
		Luderitz hospital	14	7	9	7	13	22	8	18	15	25	4	20	13	10	25	11	17	238	
	South Total		184	110	108	102	133	190	111	92	184	165	38	117	129	71	203	93	117	2147	10.2

✷In calculating the percentage of accepted referrals in relation to the population living in the South health region, the population of the Khomas political region was excluded due to the fact that there are no accepted referrals from the Khomas region.

The following graph shows the relationship between booked referrals and accepted referrals. It also clearly shows that as the number of referrals decreases, accepted referrals also decrease. One would expect the number of acceptances to be more stable since it should be based on the capacity of the WSHC rather than on the number of referrals made.



A comparison between the period February to June 1997 and the same period the previous year indicates a decrease of 24% in accepted referrals. Out of the total of 7 748 patients accepted in WSHC, only 32% came from the four regional referral hospitals, 12% came from clinics and health centres while 56% came from district hospitals. WSHC is thus becoming less of a national referral hospital.

8.7. STAFF

The establishments of Windhoek Central hospital and Katutura hospitals have been combined into one establishment for the WSHC. According to senior officials at the WSHC the establishment of doctors is as follows:

	Total posts	Filled posts	Vacant posts	Volunteers	Total doctors
Specialists	26	19	7	-	19
Medical officers	60	47	13	8	55
Total	86	66	20	8	74

The total medical staff at WSHC including medical superintendents, 8 volunteers and 26 interns is 103. WSHC has a total of 491 registered nurses, 145 enrolled nurses and 392 nursing auxiliaries.

CHAPTER 9

QUALITY OF SERVICES

9.1. THE STANDARD OF QUALITY

The standard of quality of services should be set by the RHDT and RHMT. They are also responsible for defining the standards and indicators for quality assurance in clinics and health centres. The RHMT is responsible for planning the in-service training for clinics and health centre staff based on the input from DHCC.

9.2. CLINICS AND HEALTH CENTRES

Large clinics and health centres should be staffed by at least a registered nurse and enrolled nurses who provide full time services for 40 hours per week and are available for emergencies on a 24 hour basis. Additional staff allocation should be provided as work load increases.

Most of the clinics in the North East are run by nursing assistants or enrolled nurses. This is causing a large number of referrals to district and regional hospitals. Most of the nursing assistants are inexperienced and these clinics are only visited for supervisory purposes by doctors and even these visits are rare. The work done by nursing assistants is not monitored and therefore they are not able to improve on their services because they do not receive any feedback from medical officers at district hospitals. Clinics in the North West are run by registered nurses but unnecessary referrals are made due to the large number of visits to the clinics. One registered nurse is unable to handle the population alone.

9.3. DISTRICT HOSPITALS

The quality of service at district level is often poor. The staff members are not able to produce better services due to lack of equipment and lack of staff. The highest quality of service is produced in the districts where the number of patients or population is small. The work load for nurses at district and regional hospitals increased after the introduction of primary health care when some staff members were taken out to do outreach services or perform administration duties. Their posts have to remain unfilled and those who are working in the hospital have to combine PHC duties with work in the wards.

Medical officers at district hospitals sometimes cannot do any operations because there are only two doctors and one doctor cannot carry out surgery alone if the other doctor is on leave. Therefore they have to refer to the regional hospital.
The medical officers do not get clear feedback on the patients whom they are referring. The work done by medical officers at district level does not improve because medical officers at regional hospitals rarely give any feedback or a second opinion when requested. The specialists do not visit district hospitals to supervise the work done by medical officers.

9.4. THE MEDICAL BOARD AND THE NURSING BOARD

The Medical Board is responsible for the standard of training and for registration of doctors in the country. They do not supervise work done by doctors but they measure it through the patients' complaints. The Medical Board has a disciplinary committee but they are in transition, trying to get their own legislation. The Medical Board does not measure the quality of service from doctors and they do not do any inspections on the services rendered. There are doctors whose qualifications are fully recognised by the Medical Board but some doctors are only registered with the Ministry or only conditionally (see chapter 5).

The Nursing Board is responsible for the standard of training of nurses through controlling educational programmes. They have a disciplinary committee. Disciplinary hearings are done when a case is brought to their attention either by a family member of the patient or the general public.

Both disciplinary committees consist of nine members of which one member is from the public.

The work of the nurses is monitored by a task force at hospitals. Matrons are also part of the task force. Inspections are not carried out on the work done by nurses.

9.5. MONITORING OF WORK

The hours worked by medical officers are monitored by the medical superintendent.

The junior medical officers are supervised by specialists at the specialised hospitals. In other hospitals the work of junior medical officers and medical officers is monitored by the PMO. Doctors are complaining that they cannot improve their work

because the specialists do not give them feedback on the work done on patients. They are also not told on which areas they should concentrate in order to improve on their services.

District surgeons act as PMOs at some hospitals and their work is monitored by matrons who are at the same time working under their supervision. The hours worked by district surgeons are always changing and this is causing friction between them and the full time doctors. Monitoring of claims for sessions and procedures done by district surgeons is poor.

The specialists are not involved in the selection of patients at the national referral hospital. The qualification and experience of the medical officers who are selecting patients at the national referral are the same as medical officers at regional hospitals. Some of the patients referred from district or regional hospitals are referred by specialised medical officers and specialists. In some cases the referred patients have been treated by medical officers without seeing a specialist at the national referral hospital.

The nursing assistants at the clinics are unable to improve on the treatment of patients because their work is not monitored. Sometimes the nursing assistant is left alone at the clinic without any help from, or even communicating with doctors and registered nurses.

CHAPTER 10

CONCLUSIONS

Below are the major findings which require the immediate attention of the Accounting Officer. Other findings, although minor, are included in the chapters and they also need attention. The general public is well informed about the referral system but the findings mentioned below are the reasons why the referral system is not working as efficiently and effectively as planned.

MoHSS and WSHC

- Health facilities follow different referral procedures, e.g. clinics and district hospitals in Central and South refer directly to the national referral hospital while health facilities in the North East and North West refer through their respective regional hospitals.
- Accepted referrals are less than 10% of the capacity of the Windhoek State Hospital Complex. Acceptances appear to be made more on the basis of referrals booked, than on the basis of the capacity of WSHC.
- Windhoek State Hospital Complex is becoming less of a national referral hospital and more of a regional and district hospital.
- According to regulations promulgated under the Hospital Ordinance Act, 1972 (MOHSS no. 43, 1993), health facilities are classified into groups but equipment is not distributed according to such classifications.
- A decrease of 24% in accepted referrals over the period of February to June 1997 in comparison to the same period in 1996 has been observed.
- The fees system does not encourage the use of the referral system as there are no major differences between fees paid at different health facilities.
- WSHC is able to give support to regional hospitals in terms of specialised services, however this support is only given to the South health region.
- The unwritten policy on doctors to visit clinics is not being followed strictly in the different health regions.
- The requirement to become RMO is a one year course in public health and this does not form part of the normal medical studies in South Africa where most Namibian medical officers are trained. Consequently four out of the thirteen RMO posts are filled by foreigners and only one is filled by a Namibian.
- The foreign RMO's are appointed on a contract basis. This hampers the continuity of planning in a region because they may leave before their plans are put into practice.

- The following communication problems where identified:
    1. The referral letter is not regularly used when patients are referred.
    2. Complaints were raised from more than half of the health facilities visited, that the feedback on referred patients received from WSHC and other hospitals is very poor and it comes too late.
    3. Sometimes patients are referred but they return to their regions without treatment, are placed in the wrong units and or treated by junior medical officers.
    4. Relying on the patient to give feedback rather than on the referral hospital does not work in practice.
- The following transport problems identified have a negative influence on the referral system:
    1. The procedures taken before a car is repaired are long and cumbersome because decisions to repair vehicles are taken in Windhoek.
    2. The transport officer at the MOHSS could not provide us with accurate information on the total number of cars in the Ministry and where they are stationed.
    3. Transport for referred patients is centralised to Windhoek, this increases the waiting period at WSHC.
- As a result of transport arrangements the waiting period before treated patients can go back to their regions from WSHC could be as much as 6 days.

Regions
- Time worked by district surgeons on sessions and procedures are not well monitored.
- In relation to its population the Central health region remains the most privileged in terms of accepted referrals, closely followed by the South health region.
- There are many non-operational vehicles in all four health regions.
- Some vehicles that are used as ambulances are not well equipped for such purposes.
- Transport is not distributed according to needs among the four health regions.
- Staff is not distributed according to needs among the four health regions.
- Qualified staff is centralised in the urban areas due to a lack of proper accommodation facilities in rural areas.

Districts and Clinics
- Clinics do not have regular access to transport facilities.
- Clinics in the North East health region do not have proper communication facilities such as radio/telephones. Work on the installation of radios in the North East is not completed.

- Nursing assistants in the North East are working alone without any supervision and support from medical officers and registered nurses at district hospitals.
- OPD is treated differently in different regions e.g. sometimes OPD is at the clinic and sometimes at the hospital, in some regions OPD is only open when the clinics are closed.

CHAPTER 11

RECOMMENDATIONS

I am of the opinion that an improved referral system within the public health sector would not only increase the accessibility to specialised health services for all Namibians but also, at the same time, ensure a better utilisation of resources. Furthermore I believe that determined and concerted action taken in a number of areas could greatly contribute to improve the present situation. National policies will have to be clarified and properly implemented. Regional hospitals have to be strengthened in order to fulfil the role designated to them within the referral system. District hospitals and clinics need increased support from the central and regional levels in order to render acceptable services to their patients. A comprehensive strategy change will take time before it can fully be implemented, but I believe that steps can and should be taken immediately to address some of the issues concerned. I am of the opinion that the following areas need to be given immediate attention:

- The roles and classifications of all health facilities should be clearly defined and resources allocated accordingly.
- The ongoing revision of the staff establishment should be finalized and the criteria for allocation of staff must be defined.
- A strategy should be defined for how to appoint more Namibian Regional Medical Officers and Principal Medical Officers. This may require a review of the entry and promotion requirements for these posts, for example by considering appointing Primary Health Care Supervisors as Regional Medical Officers.
- The policy that doctors should visit clinics needs to be written down for it to become effective in all regions.
- Feedback from the referral hospital to the referring hospital is important particularly to improve communication and to assist the referring hospitals and should be the responsibility of the referral hospital. There should also be a clear policy on how this feedback should be given, i.e. referral letter or passport.
- The fee structure should be reviewed in order to encourage people to go to the clinics first and then through the referral system as required.
- A decision should be made whether out-patient departments at district hospitals should/ could be turned into clinics.

In my opinion the regional level could be strengthened as follows:

- Some specialised wards/departments should be opened up at all Regional hospitals.
- The Windhoek State Hospital Complex should support the establishment of specialised services at Regional hospitals through providing in-service training and regular visits by specialists.
- The responsibility for transport should be decentralised to the Regional level.
- The booking system at the Windhoek State Hospital Complex should be abolished in view of the low and declining number of accepted referrals.

The Regional hospitals should:

- Co-ordinate and monitor referrals from District hospitals;
- Communicate with Windhoek State Hospital Complex on availability of specialists, referrals and feedback on diagnoses and pass the information thus received on to the District hospitals in the Region;
- Arrange transport of referral and emergency cases to and from Windhoek State Hospital Complex;
- Monitor the quality of medical services rendered by doctors (including district surgeons and volunteers) at the District hospitals.

In my opinion the support to the District level could also be improved as follows:

- Improve all kinds of communication;
- Attend to non-functional radios;
- Ensure regular visits to clinics by doctors;
- More support and back-up from regional hospitals and timeous feedback.

WINDHOEK, March 1998

DR F TJINGAETE
AUDITOR GENERAL