Republic of Namibia

Ministry of Health and Social Services

SOCIAL CONTRACTING FOR HEALTH SERVICES POLICY

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CONTENTS

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The Social Contracting Policy and Implementation Action Plan's development was successfully conducted because of the commitment, cooperation, and collaboration of several actors and stakeholders. The Ministry of Health and Social Services (MOHSS) extends its sincere appreciation to the different organizations and stakeholders who contributed to the development of its policy at both the national and regional levels.

The MOHSS acknowledges the leadership and direction provided by Deputy Executive Director Petronella Masabane during the policy development process. Special appreciation goes to the technical staff from the Directorate of Special Programs, who worked tirelessly to ensure multisectoral participation and engagement of all stakeholders. The MOHSS also extends its gratitude to the co-chairpersons of the technical working group (TWG) on social contracting, Advocate John Walters, our former Ombudsman and Mr Sandie Tjaronda, Executive Director of NANASO, for the energetic leadership of the committee, for facilitating inclusive and honest dialogue, and for providing profound advice on the legal and regulatory requirements as well as ensuring that the voice of civil society was prominent in shaping this policy.

The multi-sectoral TWG provided much-needed input, expertise, and financial resources to make the development of the policy a success. Critical stakeholders that formed part of the TWG, such as USAID and its LHSS project, UNAIDS and other UN Agencies, the Global Fund to Fight AIDS, Tuberculosis and Malaria, PEPFAR, CDC, Positive Vibes, NANASO, Intrahealth Namibia, the Walvis Bay Corridor Group, the Ministry of Finance and Public Enterprises, the National Planning Commission, and many more, availed high-quality expertise and other valuable resources. The Ministry expresses its utmost gratitude to USAID who, through the LHSS project, provided essential financial and technical support to drive the policy development.

Within MoHSS, the focused, dedicated and expert input by staff members from national and regional Directorates ensured the adoption by the Cabinet of a policy that is inclusive and grounded in the mandate of the Ministry of providing affordable and accessible health services for all Namibians and those who find themselves on the soil of our beloved country. The Regional Management of the MoHSS deserves special mention for mobilizing communities and their representative organisations and leaders to make their voices heard and included in the policy.

The Ministry further acknowledges the excellent work of the technical advisor of USAID's LHSS Project, Mr. Munyaradzi Mareke, who led the drafting of the policy and Dr. Puleng Letsie from UNAIDS, who provided much-needed input on best cases from other countries.

Last but not least, a hearty word of thanks to the Secretariat for a sterling job in ensuring that tight deadlines were adhered to and quality documents were delivered.

I am excited that the Government of the Republic of Namibia now has the tools to expand the delivering of services to everyone, everywhere in partnership with Civil Society Organisations.

Ben Nangombe

EXECUTIVE DIRECTOR

FOREWORD

It is my pleasure to present to you this Social Contracting for Health Services Policy, which demonstrates the Government of the Republic of Namibia's commitment to ensuring the provision of affordable, accessible, and equitable health services through strong multisectoral partnerships. This policy will enable the government to contract with civil society organizations (CSOs) to provide essential health services in line with government priorities. This is a key step toward leveraging existing partnerships with civil society organizations and ensuring their active participation in the social and economic development agenda as set out in our Harambe Prosperity Plan.

As the country progresses toward universal health coverage, ensuring that no one is left behind is a key priority. While progress has been made in providing affordable and accessible health services, the country acknowledges both the challenges that lie ahead and lagging commitments. Since independence, Namibia has made progress in fighting communicable diseases, including HIV/AIDS, for which the country was the first in the region to achieve epidemic control. With support from development partners, CSOs, and other stakeholders, the government has worked hard to ensure that health services are available throughout the entire country, including at community levels.

As the country continues to enhance delivery of health services and addresses emerging priorities such as noncommunicable diseases, mental health, and other challenges, it is even more imperative that we continue to hold hands with all our partners. Furthermore, all these challenges, compounded by the impact of the COVID-19 pandemic, put pressure on our financial resources to address the demands of efficiency and value for money in health care if we are to achieve our goal of healthy lives for all Namibians. Sustaining progress while ensuring equitable and accessible services for all remains an important agenda item within the country's Vision 2030. This continues to require a multisectoral and collaborative approach, leaving no one behind in both financing and accessing these services.

The government recognizes social contracting as one of the innovative approaches to drive greater efficiency in the use and allocation of domestic resources and in partnering with CSOs as active providers, especially for lagging priorities. Implementation of this policy, along with strong guidelines and governance structures, will ensure strong collaboration, engagement, and participation of our CSOs, communities, and all stakeholders as we strive to ensure good health for all.

Dr. Kalumbi Shangula (MP)

MINISTER OF HEALTH AND SOCIAL SERVICES

Acronyms

CSO	Civil Society Organization
GRN	Government of the Republic of Namibia
IEC	Information, Education, and Communication
M&E	Monitoring and Evaluation
MEL	Monitoring, Evaluation, and Learning
MOF	Ministry of Finance
MOHSS	Ministry of Health and Social Services
NCDs	Noncommunicable Diseases
NGO	Non-Governmental Organization
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PFM	Public Financial Management
PLHIV	People Living With HIV
SADC	Southern African Development Community
SOP	Standard Operating Procedure
TB	Tuberculosis
TWG	Technical Working Group
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Program on AIDS/HIV
USAID	U.S. Agency for International Development
NANASO	Namibia Network of AIDS Service Organizations
COVID -19	Coronavirus disease (**COVID**-**19**)
HIV	Human Immuno Deficiency Virus
US	United States

GLOSSARY OF TERMS

Social Contracting: Process through which the government will contract with civil society organizations (CSOs) to provide health services that the government has a responsibility to provide.

CSOs: For the purpose of this policy proposal, civil society is deemed to encompass all public activity by individuals, their voluntary organizations, the private sector, and their relationships with each other as well as with the government. Under the current legal and regulatory framework, CSOs have the option to be registered and operate as:

- **Voluntary associations:** Under common law, with very few regulatory requirements. All such voluntary associations need to be membership-based, and this must be reflected in their constitutions and by-laws.
- **Trusts and foundations**: Trusts Moneys Protection Act, 1934 (No. 34 of 1934), where the trust deed is a more formal legal document that is registered with the Master of High Court. Trusts are never membership organizations but are governed by a board of trustees appointed by the trust.
- **Section 21 of Companies Act, 2004 (No. 28 of 2004 as amended):** Companies not for gain, not having a share capital, as part of the Companies Act, where the most formal legal document defines the rights and obligations of members, and more- public reporting about the management and finances of the organization is required. It should be noted that all voluntary associations would in principle have the opportunity to establish and register as a Section 21 of Companies Act, No. 28 of 2004.
- **Welfare organizations:** National Welfare Act, 1965 (Act 79 of 1965) as amended, administered by the Ministry of Health and Social Services. This arrangement relates to the special recognition of an organization as a welfare organization and being set up under any of the three possibilities above.

Key populations: Groups at increased risk of HIV, irrespective of country epidemiological context, because of their specific high-risk behavior.

Vulnerable groups: Population groups, individuals, and communities who are at higher risk of failing to access adequate and affordable health services because of socioeconomic or political factors.

Payment for performance: The practice of paying providers for delivering public services wholly or partly on the basis of achieved results.

EXECUTIVE SUMMARY

The Government of the Republic of Namibia (GRN) has made progress in addressing the health needs of its population; however, the increasing burden of diseases and population growth, coupled with slowed economic growth, is putting pressure on government spending, raising the need for cost-efficient approaches to deliver services. COVID-19 has slowed economic growth, and increased government resources are needed to address the pandemic, which puts pressure on the limited health envelope. Spending on medicines, including vaccines, human resources for health, and other hospital care, has also increased. To comprehensively address all these challenges and reach all community sectors, the government will have to identify innovative, cost-efficient approaches to deliver services at a lower cost and more efficiently. Furthermore, the transition out of Namibia of development partner support as the country attained upper-middle-income status has increased the focus on ensuring sustainability. The shift in donor funding will have a negative impact on civil society organizations (CSOs) and the services they provide to complement government efforts, as these entities largely depend on grants from development partners.

Social contracting is a process through which the GRN will form an agreement for CSOs to provide health services that the government has a responsibility to provide. This innovative approach will be coupled with payment-for-results models that ensure the government rewards the contracted CSOs for actual work done and results achieved, with adequate indicators to assess both quality and quantity of services delivered. Furthermore, social contracting will help strengthen the role of key stakeholders in health service delivery, especially the GRN, CSOs, and communities. Such strong partnerships are essential as the GRN adopts universal health coverage (UHC) reforms, working to ensure no one is left behind in accessing affordable and quality health services. The policy recognizes the multisector collaboration that exists between the GRN and CSOs, especially in the delivery of HIV/AIDS services, which has enabled the country to attain epidemic control. The policy will further strengthen this essential partnership and ensure funding is available for CSOs to continue playing their crucial role.

The Social Contracting Policy is guided by principles adopted over time with guidance from the Joint United Nations Program on HIV/AIDS (UNAIDS), which has led development and learning on social contracting from other countries. These principles included strong adherence to national regulatory frameworks, transparency and accountability, equity, and independence of CSOs through mutually beneficial partnerships. These principles guided the development of the policy's main objectives, which are:

1. Establish a framework for institutionalizing social contracting in Namibia.
2. Expand health and social services provision and ensure affordable and equitable access for all.
3. Define efficient and sustainable mechanisms to finance social contracting.
4. Strengthen multisectoral engagement and coordination between the GRN, CSOs, and communities for delivery of health and social services.
5. Strengthen reporting and monitoring, evaluation, and learning (MEL) of social contracting mechanisms.

The attainment of these objectives is guided by a strong Implementation Action Plan that will establish institutional capacity within the Ministry of Health and Social Services (MHSS) and governance platforms. This institutional mechanism includes building capacity for social

contracting across key departments at both national and subnational levels, while building support and buy-in across multiple stakeholders. Furthermore, the framework will create a robust process for selection of interventions to be delivered through social contracting, including routine assessments of service delivery gaps and mapping of CSO capacity. . The policy also establishes strong mechanisms for using domestic financing to support social contracting, including identifying appropriate budgets and developing strong public financial management (PFM) frameworks and systems for accountability of public funds disbursed to CSOs.

MEL is a key pillar in the successful implementation of the policy. The implementation plan will ensure that a strong framework for monitoring and evaluation (M&E) is developed. The framework includes adequate qualitative and quantitative indicators that measure outputs, outcomes, and overall impact on health and well-being. Pay-for-performance models will be explored and appropriate models used in financing, tracking, and rewarding CSOs in the social contracts. Learning and adaptation are essential to the success and institutionalization of social contracting, and the implementation plan recognizes this.

The policy sets out an ambitious and innovative approach to deliver services, which, if followed and implemented well, will help Namibia progress toward UHC. The policy recognizes the significant work, stakeholder engagement, buy-in, and consensus needed to successfully implement social contracts. Through a strong step-by-step process outlined in the objectives and implementation plan, with adherence to principles of social contracting, this task can be achieved.

INTRODUCTION

The MOHSS is mandated to ensure equitable, accessible, and affordable health services for all Namibians. Delivering on this UHC mandate requires effective and efficient use of available domestic and external resources. To achieve this, the MOHSS is working to ensure sustainability and value for money within the health sector through implementing innovative approaches and reforms in purchasing, such as social contracting and payment for results. Sustainability in funding and service delivery is vital, especially for diseases like HIV, where the country is moving toward achieving epidemic control in all population groups. Furthermore, emerging diseases, including noncommunicable diseases (NCDs) and mental health disorders, are putting increasing pressure on the available resources, raising the need for more-efficient approaches to delivering services. Social contracting and payment for results are some of the approaches moving the MOHSS from passive purchasing of health services toward strategic allocation while leveraging key strengths in other stakeholders, such as CSOs.

Social contracting is a process through which the GRN will contract with CSOs to provide health services that the government has a responsibility to provide. Social contracting will leverage the existing partnership with civil society to expand the provision of essential health services for all, in line with UHC goals of leaving no one behind. To ensure efficiency and accountability, the MHSS will monitor performance through payment-for-results mechanisms and pay only for achieved results. Beyond ensuring continuity and sustainability in essential service delivery, social contracting will enhance collaboration and participation of civil society in health while also strengthening the capacity of local organizations to complement government efforts in health service delivery.

PROCESS/DEVELOPMENT METHODOLOGY

The Directorate of Special Programs within the MHSS led the development of the policy, supported by a multisectoral technical working group (TWG). The process began in 2017 with a feasibility study on CSO social contracting, conducted with the synthesis of evidence from pioneer countries. This was followed by a national CSO consultative meeting in September 2018 to explore CSOs' comparative advantages in health service delivery. CSOs led both processes, with participation from the GRN, especially the MOHSS, and other health development partners, such as UN agencies, the Global Fund, and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). A multisectoral delegation, including the government and CSOs supported by UNAIDS, conducted a learning visit in India in 2019.

Subsequently, the MOHSS formed a TWG in 2021 to lead all processes, including guiding consultations. The TWG facilitated various virtual and physical meetings and working sessions to develop a concept note on social contracting. The TWG presented this concept note to the Minister of Health and Social Services in August 2022, seeking approval to develop a policy to guide social contracting. This was followed by a writing workshop the TWG conducted in Otjiwarongo. In October and November, the TWG conducted consultations with all 14 regions, with inputs from subnational stakeholders consolidated into the draft policy.

The TWG held key informant interviews with health workers, community leaders, development partners, and CSOs that deliver health services. At a stakeholder validation meeting held in November, the TWG presented the draft policy to stakeholders and thereafter to MHSS approval committees and the minister for subsequent approval by the cabinet.

BACKGROUND

The GRN has made progress in addressing the health needs of Namibians, but the increasing burden of diseases and population growth, coupled with slowed economic growth, is putting pressure on government spending and raising the need for cost-efficient approaches to deliver services. COVID-19 has slowed economic growth and increased government resources needed to address the pandemic, putting pressure on the limited health envelope. Spending on medicines, including vaccines; on human resources for health; and on other hospital care has also increased. To comprehensively address all these challenges, the government will have to identify innovative, cost-efficient approaches to deliver services at a lower cost, more efficiently, and be able to reach all sectors of the community.

Furthermore, the reduction in development partner support as the country attained upper- middle-income status has increased the focus on ensuring sustainability. The shift in donor funding will have a negative impact on civil society organizations (CSOs) and the services they provide to complement government efforts, as these entities depend largely on grants from development partners. The Global Fund indicated its intention to transition out of Namibia. This decline in funding has impacted the delivery of services, especially at the community level. In 2023, the Global Fund will discontinue financing for 200 community health workers, putting at risk the delivery of vital essential services like tuberculosis (TB) contact tracing, malaria prevention, and HIV treatment and prevention support.

CSOs are critical in providing basic services, especially for vulnerable people, key populations, and hard-to-reach communities. CSOs are complementing the GRN's efforts to deliver essential services, capitalizing on the following strengths:

- Specific population groups face barriers to services offered at government facilities because of policies, laws, untoward practices, perceptions, and preferences. Such barriers include stigma and discrimination based on gender, age, or sexual diversity, and hours of operation. These barriers are more pronounced for vulnerable people, key populations, and hard-to-reach communities. CSOs have provided differentiated services through models such as use of peer educators, community health workers, outreach, and mobile services to address these gaps.
- The large geographical spread across the country makes it difficult for some groups to access facility-based services. CSOs have a comparative advantage in providing these services because of their broad network and presence in hard-to-reach communities, such as remote rural communities and informal settlements in urban and peri-urban areas.
- Because of their nature and size, the operational efficiency and flexibility of CSOs have enabled them to provide mobile services for migratory communities and decongestion services in overcrowded facilities. CSOs have a strong ability to support government responses in emergencies with more agility and adaptability. This is critical in cases where the public response can be slow because of bureaucracy and other challenges.

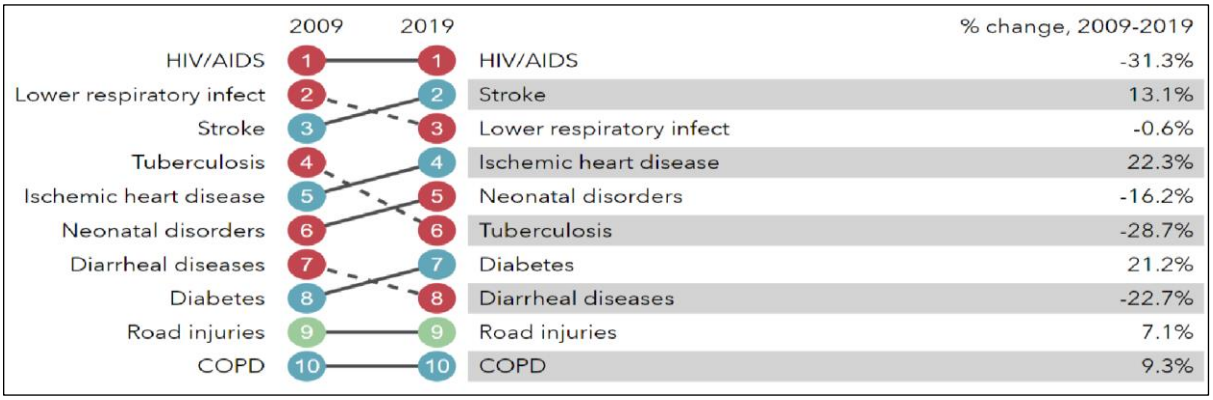
Finally, no policy framework exists to guide the MHSS in contracting with CSOs to deliver health services with direct funding from the domestic budget. Current financing for faith-based organizations and other CSOs is based on bilateral arrangements without a broad policy framework that the MHSS can use to expand such contractual arrangements to other CSOs. In addition to existing procurement laws, the policy will need to provide clear objectives and expected outcomes for social contracting arrangements.

SITUATIONAL ANALYSIS: HEALTH STATUS IN THE CONTEXT OF SOCIAL CONTRACTING

Namibia has made significant progress in improving its citizens' health and well-being. The country's strategic documents, such as National Development Plan 5 (2017/2018–2021/2022), and Ministerial National Strategic Plan (2017/2018–2021/2022), emphasize improving access to affordable and equitable health services. The recent Health Sector Review (2020) and the Assessment Report on the implementation of the 2014 Essential Health Services Package (2022) show that the country's life expectancy at birth improved from 60.92 years in 2014 to 64.49 years in 2022, and that the population grew from 2,243,001 in 2014 to 2,567,012 in 2022 (per the United Nations estimates). The maternal mortality rate of 385 maternal deaths per 100,000 live births in 2013 declined remarkably to 195 maternal deaths per 100,000 live births in 2020. The infant mortality rate declined from 31.75 in 2016 to 30.73 in 2020. Furthermore, the country has made significant progress in fighting HIV and is now poised to reach epidemic control.

Despite the improvements in life expectancy at birth, the leading causes of death have not changed significantly. Figure 1 shows that HIV/AIDS remains the most significant driver of mortality, and other conditions like TB continue to cause illness and death. Furthermore, the country is now facing a double burden, with NCDs such as stroke, heart disease, and diabetes rising to prominence between 2009 and 2019. As countries continue addressing ongoing communicable disease priorities, more resources and efficiencies will be required to also address the emerging burden of NCDs.

Figure 1. Top Causes of Death in Namibia (2019)



Source: Global Burden of Disease, Institute for Health Metrics and Evaluation, 2022.

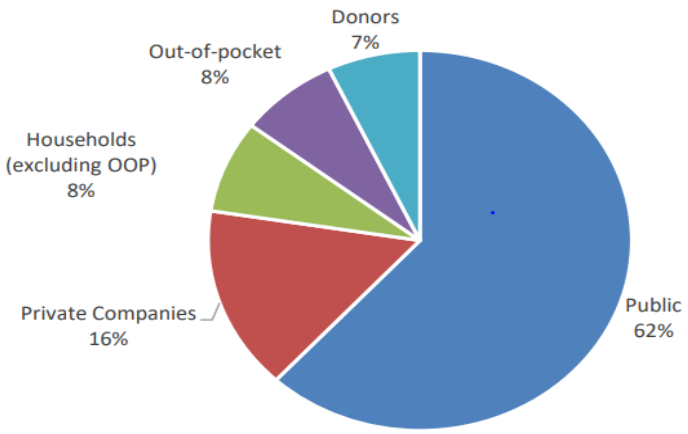
FINANCING FOR HEALTH SERVICES

In addressing the disease burden highlighted above, the GRN has shown significant commitment, providing more than 62 percent of total health expenditure, supported by development partners (providing 7 percent of total health expenditure); with private citizens and corporations providing the balance (32percent; Health Sector Resource Tracking Report, 2017/18). This funding for health is primarily channeled through the MHSS, which provides comprehensive services for more than 80 percent of the population in public facilities from the community level to the referral hospitals. The high level of funding by the GRN is consistent across most disease areas, including HIV, malaria, and TB, where development partners also provide complementary financing. For example, in 2017/2018, the total spending on HIV/AIDS reached $229 million, or 2,979,260,45 Namibian dollars (N$), of which the GRN contributed 62 percent (Health Sector Resource Tracking Report, 2017/18). However, disease areas such as NCDs, mental health, and maternal

health primarily depend on domestic funding in the private sector, especially in facilities used by the poor and vulnerable groups.

As shown in Figure 2, donors contribute about 7 percent to total health expenditure annually. This funding is mainly allocated to communicable diseases such as HIV/AIDS, TB, and malaria. In 2017/18, donors contributed more than 30 percent of the funding for HIV/AIDS, mainly from the United States government and the Global Fund. The GRN primarily focuses on financing HIV/AIDS, malaria, and TB treatment. Donor funding is focused on prevention activities (89 percent), social protection (76 percent), and program enablers and systems strengthening (82 percent; Health Sector Resource Tracking Report, 2017/18).

Figure 2: Financing for Health Services



Source: Health Sector Resource Tracking Report (2017/18).

Development support from external partners is primarily implemented through CSOs. In 2017/18, public HIV service providers provided 66 percent of the funding, while bilateral offices, their implementing partners, and international non-governmental organizations (NGOs) spent 23 percent. The large envelope from development partners implemented through local and international NGOs demonstrates the capacity within the CSO sector to manage and account for funds and provide essential services—both critical factors for social contracting.

External donors, including the Global Fund and PEPFAR, have historically provided an anchor source for funding for public health programs. However, as external financing diminishes in Namibia, a more significant share of funding responsibility will need to come from domestic sources, primarily the government and the private sector. Based on current indications from donors and the GRN, funding for HIV response is expected to fall to 27 percent by 2025 compared to the estimated level as of 2018 based on the analysis presented in the HIV investment case. The investment case shows that partners such as PEPFAR are focusing on sustainability and building the capacity of local organizations to provide essential health services. The Global Fund has slowly started transitioning out of the country, with funding for the 2018 to 2020 period at $37,106,905 (N$450 million), compared to the $100 million (N$1.4 billion) in the previous funding cycle. The Global Fund indicated its intention to transition out of Namibia by 2023, effectively reducing its funding further, although this may be extended to counter the impact of COVID-19 on service delivery. Transition by development partners may result in significant funding gaps, especially for prevention services and those targeted at vulnerable people, key populations, and hard-to-reach communities, such as males, adolescent girls, and young women.

In addition to the expected decline in funding from development partners, the rising burden of NCDs, mental health disorders, and expanding population raises the need to create efficiencies in health spending while mobilizing more money for health. The Health Sector Review (2021) highlighted the need for the MOHSS to identify opportunities for efficiencies, including innovative approaches to deliver services more efficiently and at a lower cost. The review also recognizes the need for a multisectoral approach and leveraging opportunities within the private sector, including CSOs. The MOHSS identified priority disease areas requiring additional resources, innovative approaches to sustain or catalyze action, and achievement targets. This includes priorities like HIV, where maintaining epidemic control is essential; TB and malaria, where progress has been made but the country still faces a high burden; and NCDs, where more resources are still needed to address the emerging threat. These areas are discussed in more detail below, showing opportunities for partnership with civil society through social contracting.

HIV EPIDEMIC AND RESPONSE

Namibia has made significant progress in fighting the HIV epidemic and is now poised to reach epidemic control. Namibia ensured that 90 percent of people living with HIV (PLHIV) ages 15–64 years know their HIV status, 98 percent of PLHIV know their status on antiretroviral therapy, and 91 percent of PLHIV on antiretroviral therapy are virally suppressed (“90-98-91”). Prevention efforts contributed to a decline in new HIV infections from more than 10,000 annually in 2010 to fewer than 6,000 in 2018 (Spectrum Goals 2019). Gaps in coverage are prominent among those older than 25 who are unaware of their HIV-positive status and are not on treatment, especially men. Young women ages 15 to 24 years face a disproportionate burden, including a significant proportion of new infections. In 2017, young women accounted for 17 percent of new infections compared to 9 percent among males of the same age.

The national response also prioritized key populations—such as sex workers, men who have sex with men, transgender people, and people who inject drugs—who face a disproportionate burden of HIV. For example, the prevalence of HIV in sex workers exceeds 40 percent, compared to the national average of 12 percent (UNAIDS 2021). These populations need specific support to access and maintain regular contact with health services because of stigma, discrimination, and punitive laws and policies that may inhibit access. In line with the country’s National Strategic Framework for HIV and AIDS Response (2016/2017–2021/2022), such disparities in prevalence and risk for the different population groups demonstrate the need for new approaches if epidemic control is to be sustained. Furthermore, this unequal disease burden reflects the need for differentiated models to ensure that appropriate interventions reach all population groups. Civil society, including community-based organizations, key population groups, faith-based organizations, and PLHIV support groups, is central to complementing government efforts and expanding differentiated and closer care services for such groups.

TB EPIDEMIC AND RESPONSE

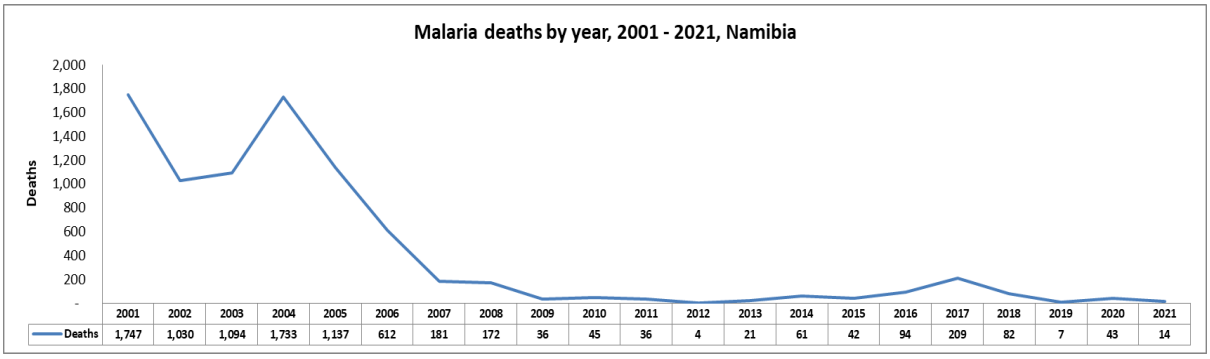
Namibia is among the top 10 countries with the highest TB incidence globally. The World Health Organization (2020) estimates a TB treatment coverage of 56 percent, potentially missing 44 percent of TB cases nationally. TB and HIV co-infection remains high, with more than 30 percent of new cases known to be among PLHIV. As with HIV, disparities exist in the TB epidemiological burden. Men (ages ≥15 years) are disproportionally affected by TB (57 percent) compared to women in the same age range (33 percent). TB among children ages 0–14 represents 10 percent of all notified TB cases but maybe higher because of under-diagnosis and underreporting.

A comparison of regions shows that the highest proportions of the national TB burden are in Khomas, at 17 percent, Erongo, at 10 percent, and Omaheke, at 9 percent. The high proportion in these regions may be because of increased access to diagnoses and case finding in these regions. Five regions (Erongo, Kunene, Omaheke, Otjozondjupa, and Zambezi) achieved a treatment success rate above 90 percent, with other regions below 88 percent. Oshana had the lowest treatment success rate, at 79 percent. This disparity in treatment success rates is attributed to community-based TB care pioneered through CSOs. Erongo pioneered clinic-based TB field community workers who have provided direct observation for every TB treatment dose in all patients diagnosed with TB since 2005. (This was funded initially by the KNCV TB Foundation.) Omaheke pioneered a health extension program for TB through Community Health Care Services Namibia (COHENA) in 2004. Kunene pioneered the national health extension worker program. This demonstrates the effectiveness of differentiated models of care, including the use of community health workers to support treatment adherence, especially in rural communities with support from CSOs. Funding limitations have prevented the full rollout of these initiatives in other regions.

MALARIA EPIDEMIC AND RESPONSE

Namibia has set an ambitious agenda to eliminate malaria as part of its national and regional development plan under the Southern African Development Community (SADC) Malaria Elimination Regional Initiative for 2015–2020. Figure 3 shows that efforts to eradicate the disease have rapidly decreased malaria deaths.

Figure 3: Malaria Deaths by Year in Namibia



	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Deaths	1,747	1,030	1,094	1,733	1,137	612	181	172	36	45	36	4	21	61	42	94	209	82	7	43	14

Source: National Malaria Strategic Report, 2022.

Significant challenges for malaria control and elimination in the communities include high levels of refusals of indoor residual spraying and low use of insecticide-treated nets. Such challenges require a robust response with support from all local, regional, and national actors, including the continued role of CSOs, especially at the community level through community health workers.

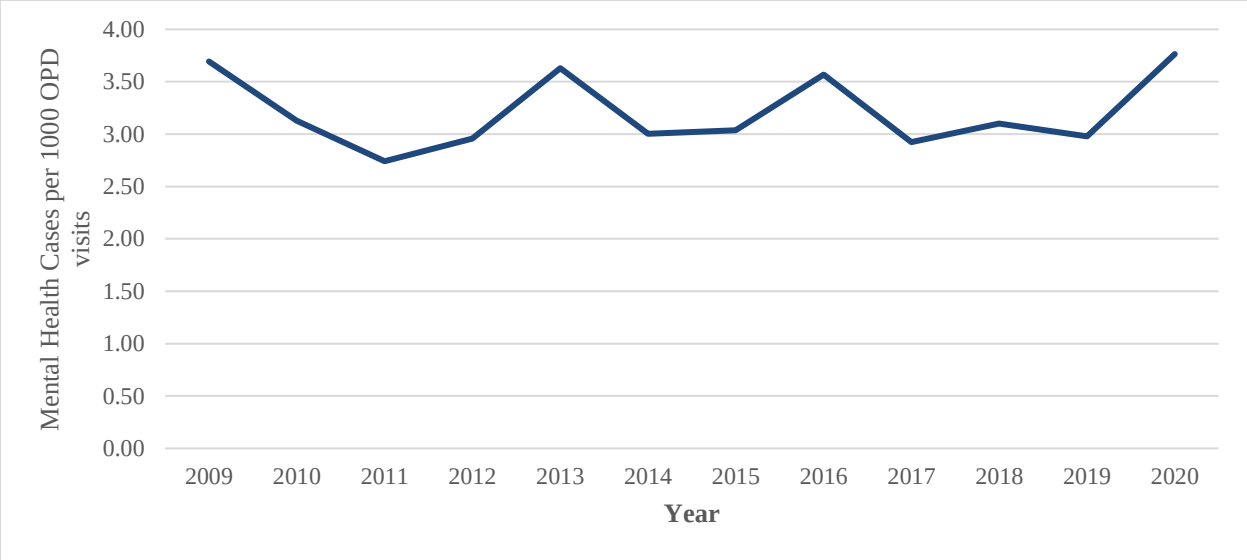
NCDS, MENTAL HEALTH, AND OTHER EMERGING PRIORITIES

Over the last two decades, Namibia has identified NCDs as an emerging threat to progress in addressing mortality and morbidity from communicable diseases. The MOHSS 2017/18–2021/2022 strategic plan is targeted to reduce the incidence of the top five NCDs causing deaths—dental disorders or diseases, neurological diseases or disorders, hypertension, asthma/bronchial spasm, and pelvic inflammatory disease. The Health Sector Review (2020) shows that between 2016 and 2020, hypertension cases decreased by 5.6 percent and asthma/bronchial spasms decreased by 16.8 percent. Neurological system diseases or disorders

increased by 39.7 percent, followed by pelvic inflammatory disease, which increased by 14.3 percent. Dental disorders and/or disease increased by 4.4 percent. Diabetes incidence increased from 145 cases per population to 163. Mental health disorders per 1,000 also increased marginally. The upward trend is synonymous with global trends, where NCDs are increasing.

Mental health disorders have become a significant threat to health and well-being, putting many facilities under strain, as specialized skills are required to manage facilities and focus on community support. Figure4 illustrates the trends in mental health disorders in the country. Mental health cases per 1,000 outpatient visits increased slightly, by 0.63, from 3.13 in 2009 to 3.76 in 2020. The cases have been on a fluctuating trend from 2009 to 2020.

Figure 4: Mental Health Cases per 1,000 Outpatient Visits (OPD), 2009–2020



Source Health Information System, 2020.

The increase in NCDs, including mental health problems, highlights the emerging priorities within the health sector, with many new conditions requiring a mix of facility and community interventions to address them. The MOHSS and stakeholders recognize that multisectoral approaches are needed if these emerging diseases are to be effectively and efficiently addressed. Such collaboration includes the active role of CSOs at all levels, including national, regional, and community-based organizations.

The role of CSOs and NGOs in HIV service delivery

The Namibian civil society sector is comparatively well developed in the context of sub-Saharan Africa, but its sustainability is still evolving. In 2012–2015, nearly half of about 600 registered CSOs worked in health (including HIV). CSOs in Namibia are one of the fastest entities to respond to people's needs and provide services in places and to populations that are hardest to reach through government health agencies. Within the health sector, CSOs partner with the government to deliver essential services across many diseases and strategic priorities, including HIV; TB; malaria; and maternal, neonatal, and child health. A significant part of the national HIV response has been driven by civil society from its earliest days, with community-based organizations leading advocacy efforts to expand access to treatment and care for all in need, regardless of location or socioeconomic status. Private not-for-profit providers include faith-based

organizations, charities, NGOs, and community-based organizations, all eligible for social contracting, presenting a wide choice for potential partners.

Through sustained investments from development partners in delivering health services, CSOs have developed the capacity and competence to efficiently complement government efforts in service delivery, especially in reaching vulnerable, hard-to-reach communities. The Global Fund and PEPFAR are the largest funders for CSOs, while some smaller entities also receive other discrete grants. Most CSOs focus on prevention services, targeting services that are under-provided at facility levels, with a strong focus on community reach.

As development partner support declines, many CSOs will be unable to fill the gap in service delivery that they have traditionally addressed, complementary to government efforts. The key areas of competence within the CSO sector thus provide potential opportunities for partnership and funding from the government to sustain and expand service delivery, especially at the community level.

Rationale For Social Contracting Policy

This Policy and Implementation Action Plan will guide social contracting for CSOs to deliver essential health services in line with national health priorities. The Social Contracting Policy will guide the MOHSS and other relevant stakeholders to contract with CSOs to provide essential health and social services to Namibia's population, especially vulnerable people, key populations, and hard-to-reach communities. These communities would face significant access barriers in the absence of CSOs and the role they play. The policy will guide social contracting in health service delivery for 10 years and be reviewed after 5 years to ensure it aligns with national program goals.

Alignment With Legislative Frameworks

Namibia has ratified or acceded to national, regional, and subregional agreements. Article 144 of the Constitution of the Republic of Namibia states that these agreements are binding upon Namibia and part of Namibia’s domestic laws. The Social Contracting Policy is aligned with these agreements and the national legal and regulatory framework.

International Frameworks

The Social Contracting Policy is aligned with the following international agreements:

i. The Universal Declaration of Human Rights (1948), which guarantees the right to health for everyone

ii. The International Convention on the Elimination of All Forms of Racial Discrimination (1966), which prohibits racial discrimination based on race, color, descent, and national or ethnic origin

iii. The International Convention on the Elimination of All Forms of Discrimination Against Women (1979), which guarantees equality to women and prohibits discrimination against women in the field of health care

iv. The International Covenant of Economic, Social, and Cultural Rights (1966), which guarantees the right of the highest attainable standard of physical and mental health care to everyone

v. The Convention on the Rights of the Child (1989), which guarantees enjoyment of the highest attainable standard of health to children and their families, as well as the right to access such health care service

vi. The Convention on the Rights of Persons with Disabilities (2006), which guarantees to people with disabilities the right to enjoy the highest attainable standard of health without discrimination

vii. The UN Sustainable Development Goals (2015), which require Namibia to end the epidemics of AIDS, TB, and malaria by 2030 (Goal 3.3)

REGIONAL FRAMEWORKS

At the regional level, the policy is aligned with these policy documents:

i. The African (Banjul) Charter on Human and Peoples' Rights (1986) guarantees every individual the right to enjoy the best attainable state of physical and mental health.

ii. The African Charter on the Rights and Welfare of the Child (1999) guarantees every child the right to enjoy the best attainable physical, mental, and spiritual health.

iii. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003) prohibits discrimination against women; guarantees women's right to adequate, affordable, and accessible health services; and guarantees the protection of women with disabilities.

iv. The African Union Agenda 2063 requires Namibia to have healthy and well-nourished citizens.

SUBREGIONAL FRAMEWORKS

At the subregional level, the policy is aligned as follows:

i. The SADC Protocol on Health (2004) requires Namibia to develop approaches for the prevention and management of HIV/AIDS to be implemented in a coherent, compatible, harmonized, and standardized manner. It also mandates the country to establish efficient mechanisms for effectively controlling malaria, develop strategies for sustaining TB, and harmonize TB control activities and HIV/AIDS programs where appropriate.

ii. The SADC Protocol on Gender and Development (2008) requires Namibia to ensure universal access to HIV and AIDS treatment for infected women, men, girls, and boys.

iii. The SADC (Maseru) Declaration on HIV/AIDS (2003) requires Namibia to mitigate the impact of HIV/AIDS by harmonizing policies and strategies and undertaking joint programs in the priority intervention area, including prevention, treatment, care support, nutrition, and food security.

NATIONAL POLICY FRAMEWORK

At the national level, the policy is aligned with Chapter 4 of Namibia's Vision 2030 on people's quality of life, the Social Transformation Pillar of the Fifth National Development Plan, the Social Progression Pillar (Goal 3) of the second Harambee Prosperity Plan, and the National Policy on HIV/AIDS (2007). Further, the policy is aligned with national policies and frameworks:

i. The National Strategic Framework for HIV and AIDS Response in Namibia (2017/2018 to 2021/2022) aims to establish multisectoral responses to effectively move the country toward HIV epidemic control while mitigating the impact of the pandemic on the population.

ii. The Sustainability Framework for the HIV/AIDS Response in Namibia (2020) seeks to establish efficient approaches to deliver essential HIV care while achieving value for money and high population outcomes.

iii. Namibia's laws and statutes govern CSOs, public procurement, PFM, transparency, and other requirements. These are further outlined in the legal section of this document.

GUIDING PRINCIPLES

The MOHSS has established the following principles to ensure the policy is guided by effective governance, financing, and award mechanisms for social contracting. Adherence to these principles will ensure that regardless of the structure, form, and approach adopted for social contracting, the basic elements for efficiency and effectiveness in the use of public resources are met, while extending the delivery of health services in line with UHC goals. The principles are outlined as follows:

1. **Adherence to regulatory frameworks:** Ensure that all social contracting processes adhere to all relevant policies, guidelines, laws, and regulations, among others.
2. **Transparency:** Ensure a free and fair process for social contracting, with equal opportunities for all eligible NGO and CSO providers throughout the application, tendering, and awarding process.
3. **Accountability:** Ensure high levels of accountability for all funds contracted to CSOs and NGOs in line with all aspects regarding PFM rules and Namibia's legal and regulatory frameworks for public procurement.
4. **Equity:** Ensure that all Namibians have access to essential health services on an equitable basis and that all social contracting processes and mechanisms are inclusive.
5. **Efficiency:** Ensure that all social contracting processes apply to allocative and technical efficiency in using funds and delivering services.
6. **Pay for performance:** Ensure that a results-based M&E framework is the basis for paying for achieved targets.
7. **Participation and inclusiveness**: Ensure the vocal and active involvement of all relevant stakeholders and beneficiaries by centralizing beneficiaries' rights and needs in every social contract.
8. **Coordination:** Improve the collaborations among all relevant stakeholders, including building and strengthening trust among government, civil society, and communities.
9. **Decentralization:** Decentralize the delivery of essential services to the subnational level, including making resources available to regions to contract with CSOs with active community presence.
10. **Independence:** Ensure cooperation and contracting while safeguarding the independence and autonomy of CSOs.

POLICY DIRECTION: SOCIAL CONTRACTING IN NAMIBIA

VISION

All people of Namibia enjoy good health and social well-being by accessing universal, inclusive, equitable, and efficient quality services delivered through the social contracting mechanism.

MISSION

Advance the delivery of comprehensive health and social services to all citizens of Namibia by implementing effective social contracting methods aligned with UHC principles.

GOAL

Establish robust guidelines for the government's contracting with CSOs to provide equitable, accessible, and affordable health care to all, sustained through domestic financing mechanisms.

POLICY OBJECTIVES

Social contracting is essential in providing a platform through which the MOHSS can engage with and provide funding to CSOs to achieve goals and targets as outlined in national strategic plans. Through this policy, the government will provide a framework under which funding will be disbursed to CSOs to deliver quality health and social services that are affordable and accessible, ensuring no one is left behind, in line with the vision for UHC. Specifically, the objectives of the policy are as follows:

1. To establish a framework for institutionalizing social contracting in Namibia.
2. To expand health and social services provision and ensure affordable and equitable access for all.
3. To define efficient and sustainable mechanisms to finance social contracting.
4. To strengthen multisectoral engagement and coordination among the GRN, CSOs, and communities for health and social services delivery.
5. To strengthen reporting and MEL social contracting mechanisms.

STRATEGIES FOR SOCIAL CONTRACTING POLICY

The government will focus on the following strategies to achieve this policy's set vision and objectives:

OBJECTIVE 1: TO ESTABLISH A FRAMEWORK FOR INSTITUTIONALIZING SOCIAL CONTRACTING IN NAMIBIA.

Strategy 1: Develop the governance mechanisms for social contracting in Namibia.

Appropriate governance structures, with clear roles and responsibilities, will be established to guide the implementation, monitoring, and oversight of social contracting. This will include strengthening current institutional arrangements within the MHSS, strengthening the capacity of actors, and establishing approaches for coordination and oversight. Among other activities, this will include:

- Conducting advocacy and communication on social contracting
- Defining clear roles and responsibilities for institutional arrangements to guide social contracting
- Developing implementation guidelines, manuals, and standard operating procedures (SOPs) for social contracting

Strategy 2: Strengthen institutional capacity to implement social contracting.

The policy calls for solid institutional capacity to execute all the functions for efficient and sustainable arrangements. To achieve this, training and capacity development for managers within the MHSS and other responsible entities will be conducted to enhance functions, such as finance, procurement, monitoring, reporting, and results-based management of contracts under social contracting. This will include transparency.

- Assess existing national and subnational institutional capacity to implement social contracting within the MOHSS and other relevant stakeholders on areas such as finance, procurement, and monitoring.
- Develop capacity-building plans in line with the results of the assessment. This will include ensuring adequate staffing, training, and continuous improvement of social contracting procedures.

OBJECTIVE 2: TO EXPAND HEALTH AND SOCIAL SERVICES PROVISION TO ENSURE AFFORDABLE AND EQUITABLE ACCESS FOR ALL.

Strategy 1: Strengthen the provision of essential health services, especially at the primary care level.

The policy seeks to maintain and expand the provision of health and social services by leveraging areas where CSOs have a comparative advantage. Furthermore, the policy aims to address emerging unmet needs because of changing development partner support, and ensure essential interventions defined in the Essential Health Services Package continue to be provided. To achieve this, gaps in service delivery, especially at the primary care level, will need to be identified, primarily where CSOs can effectively deliver such services. To achieve this, the MHSS will:

- Review service delivery and coverage gaps across all diseases areas and regions to identify areas with the highest unmet need.

- Conduct an annual programmatic assessment to identify interventions that can be delivered through CSO-led approaches to address unmet identified needs.
- Define performance targets (output, outcome, and impact) required to measure effectiveness in the delivery of such services.
- Consult communities and other key stakeholders on proposed social contracting approaches and their ability to meet the needs of targeted population groups.

Strategy 2: Enhance the delivery of essential health services for vulnerable, marginalized, and hard-to-reach communities.

Enhancing service delivery for priority groups for whom provision lags significantly will require particular focus on identifying these groups and the unique services they need. This will include identifying what services these groups are missing or have challenges accessing. The MHSS will also determine how CSOs can play an active role in addressing such gaps. To achieve this, the MHSS will:

- Map priority groups for service delivery based on different program priorities, including hard-to-reach and vulnerable groups.
- Identify critical interventions that CSOs currently provide, or that they could provide by targeting selected groups.
- Assess any factors hindering service delivery through social contracting to such groups and develop appropriate response strategies.

Strategy 3: Identify CSOs with the capacity to deliver health and social services.

Social contracting aims to leverage capacity and competence within CSOs to deliver services. Mapping capacity within CSOs on a routine basis against identified needs and interventions to be delivered is essential to ensure that only capable entities are contracted with. To achieve this, the MHSS will:

- Map existing CSOs with the capacity to deliver health and social services at all levels, including at the community level.
- Develop an evaluation framework and assess the capacity of such CSOs to provide identified services in line with program goals, approaches, and community needs. The evaluation framework should align with policy principles, ensuring equity and fairness in selecting CSOs.

OBJECTIVE 3: TO DEFINE EFFICIENT AND SUSTAINABLE MECHANISMS TO FINANCE SOCIAL CONTRACTING.

Strategy 1: Mobilize sustainable financing to procure services through social contracts.

Social contracting aims to mobilize adequate domestic financing to ensure the sustainable delivery of essential health services. Such services should be delivered through CSOs complementing MHSS efforts at all levels, with funding provided through the annual budgets. To ensure such funding is available, resource mobilization will be required, with the development of investment cases demonstrating the benefits of social contracting for efficiency and health outcomes compared with traditional approaches. To achieve this, the MHSS will:

- Review budgetary processes to identify opportunities to allocate resources for social contracting.

- Identify key stakeholders at national and regional levels to be engaged as champions for resource mobilization.
- Develop annual investment cases to motivate funding to implement social contracting, especially highlighting the benefits of the approach over traditional approaches.
- Lobby and advocate for resources to implement social contracting and address identified service gaps.
- Identify other potential funding sources, including development partners and the private sector, and lobby for funding.

Strategy 2: Develop mechanisms to enhance efficient disbursement, monitoring, and accountability of financial resources contracted to CSOs.

The success of social contracting will largely depend on solid systems to disburse, track, and ensure accountability of funding provided to CSOs from the MHSS. This will include the disbursement and recording of funds in line with PFM, ensuring accountability and transparency through strong financial reporting linked to achieving results. To achieve this, the MHSS will:

- Review PFM requirements for contracting and develop a finance procedures manual, and build capacity to ensure compliance during social contracting.
- Develop models for monitoring implementation and paying for performance.
- Develop and implement systems to ensure accountability and transparency in public funds, including audits, project assessments, and independent evaluations.

OBJECTIVE 4. TO STRENGTHEN MULTISECTORAL ENGAGEMENT AND COORDINATION BETWEEN GRN, CSOS, AND COMMUNITIES FOR HEALTH AND SOCIAL SERVICES DELIVERY.

Strategy 1: Map and identify existing governance and coordination platforms and build their capacity to support the social contracting implementation.

The success of social contracts requires strong platforms for engagement and coordination among the MHSS, civil society, and other multisectoral stakeholders. This will support the building of trust necessary for effective contracting and enhance the identification of opportunities, strengths, and needs that can be efficiently addressed through social contracting. To achieve this, the MHSS will need to:

- Identify multisectoral structures at national and regional levels that can support social contracting, and enhance their capacity to provide engagement and coordination.
- Strengthen information sharing among multisectoral stakeholders with an interest in social contracting.
- Strengthen community feedback on service delivery and ensure communities are included in coordination and engagement platforms.

Strategy 4: Conduct stakeholder sensitization to institutionalize social contracting in Namibia.

All relevant stakeholders, including government, CSOs, local authorities, the private sector, and communities, will be sensitized on social contracting. Activities to achieve this will include:

- Developing information, education, and communication (IEC) materials for educating and informing stakeholders on the social contracting process, benefits, and approaches
- Disseminating policy, guidelines, and other relevant documents to programs and regions to ensure full knowledge and capacity to identify interventions as well as funding for social contracting
- Engaging programs and regional leadership to streamline social contracting into routine contracting and programming approaches

OBJECTIVE 5. TO STRENGTHEN REPORTING AND MEL FOR SOCIAL CONTRACTING.

Strategy 1: Strengthen the reporting and MEL environment for social contracting.

Through the M&E framework, the impact of social contracting on service delivery and patient outcomes will be effectively recorded, monitored, and tracked. This will include strengthening systems for M&E governance at all levels, including the community, to provide the required data to assess the performance of entities contracted by the MHSS. Furthermore, the success of pay-for-performance mechanisms depends on the availability of robust reporting, monitoring, and evaluation systems that provide timely and accurate qualitative and quantitative performance data. To achieve this, the MHSS will:

- Develop an M&E framework to track social contract implementation effectively. The framework will include qualitative and quantitative indicators to track outputs, outcomes, and overall impact on providing affordable and accessible health services.
- Strengthen the role of governance platforms to support M&E functions, including creating mechanisms to enhance transparency and accountability in performance- based on performance data.
- Develop comprehensive data collection and reporting tools well linked to routine health information systems used by different programs and regions.
- Conduct routine and ad hoc community assessments on the quality of services and patient evaluation.

Strategy 2: Strengthen learning and adaptation in the implementation of social contracting.

Social contracting is a new approach when implemented with domestic financing; hence, continuous learning and adaptation by the MHSS and other stakeholders will be required. This will include:

- Continuous evaluation of implementation approaches and their impact on service delivery for targeted interventions
- Dissemination of results on impact and processes, with continuous redesign to improve effectiveness
- Routine building of capacity of all stakeholders on social contracting approaches

IMPLEMENTATION ARRANGEMENTS/FRAMEWORK

INSTITUTIONAL ARRANGEMENTS

The GRN will ensure the participation of stakeholders at different levels of the social contracting process. Such stakeholders will include various departments and units within the MOHSS, other government ministries and agencies at national and regional levels, CSOs, and development partners. These institutional stakeholders will perform different roles and functions based on their mandate to ensure the success of social contracting. The success of social contracting in Namibia will depend on the strengths of governance and managerial structures developed to ensure transparency, accountability, and trust among the different state and nonstate actors.

Table 1 provides guidance on the roles each stakeholder is expected to play across the social contracting process. During implementation, the routine evaluation will assess the strengths and weaknesses of each stakeholder in effectively supporting the social contracting process and capacity building inherently included in various activities.

Table 1: Roles and Responsibilities of Stakeholders in Social Contracting

Actor	Roles/Responsibility
MOHSS	• Lead the implementation of the social contracting process, including providing oversight, coordination, and leadership. • Provide contract management, including selection, award, monitoring, and closeout. • Lead reporting, MEL, and research to support social contracting.
Ministry of Finance (MOF)	Provide expertise in budgeting, procurement, and financial management in line with PFM requirements.
Ministry of Justice (Office of the Attorney General)	Provide legal expertise in contract management.
Ministry of Gender Equality, Poverty Eradication, and Social Welfare	Strengthen access to and coverage of social services and provide technical support.
Ministry of Education, Arts, and Culture	Provide technical expertise and coordination on interventions affecting population groups of school-age children.
Ministry of Higher Education, Training, and Innovation	Provide technical expertise and coordination on interventions affecting population groups in higher institutions.
Ministry of Urban and Rural Development	Provide expertise in community services.
Ministry of Sports, Youth, and National Services	Provide technical expertise guidance on interventions affecting population groups falling within the mandate of the ministry (youth, adolescents, etc.).
National Planning Commission	Coordinate the development, revision, and evaluation of existing public policies regarding social contracting in Namibia.
Office of the Prime Minister	Advise on programmatic issues and coordination with other line ministries.
Ministry of Agriculture, Water and Land Reform	Coordinate and collaborate on nutrition and related interventions under health.
CSOs	• Deliver services as awardees of government contracts in line with agreed procedures. • Provide advice on best practices and approaches to delivering services. • Support coordination and engagement with the MHSS. • Link communities to the MOHSS, especially for the hard-to-reach sector.
Private for-profit entities	The private sector will be engaged for purposes of co-financing as well as providing technical support.
Development partners	Provide co-financing and technical support toward the introduction, operationalization, and M&E of social contracting.
United Nations agencies	Provide technical and financial support for social contracting.

Actor	Roles/Responsibility
Beneficiaries/communities	Fully participate in social contracting arrangements as beneficiaries.

The GRN will ensure the MHSS is staffed with personnel who have relevant skills to execute the required managerial functions to implement social contracting agreements successfully. This includes PFM, legal, health service delivery, community engagement, M&E, and other relevant skills. Where appropriate, these roles will be performed by existing functions within the ministry. Annual capacity development plans will be developed and funded explicitly in each arrangement.

Social Contracting Steering Committee

The steering committee on social contracting will be composed of senior leadership and management of the MHSS, MOF, and partners working in the health and social space. The deputy executive directors of the MHSS will chair the committee, which will report to the executive director of the MHSS. The steering committee will be a permanent coordination mechanism of the Social Contracting Policy, with the Directorate of Special Programs providing secretariat services. The steering committee will have the following responsibilities:

- Supervise the implementation of the Policy and its Implementation Action Plan.
- Mobilize adequate resources for the implementation of social contracting arrangements.
- Provide oversight in implementing specific social contracting arrangements throughout the process from inception to closeout.
- Ensure efficient and effective use of resources, including evaluating value for money and potential benefits of proposed contracts.
- Ensure that all actors perform their responsibilities satisfactorily.

Membership in this committee will be at senior levels to ensure the committee has adequate authority and a mandate to enforce transparency and accountability mechanisms in social contracting arrangements. The MHSS, guided by the TWG, will appoint permanent and ad hoc members to the steering committee on an ongoing basis as defined by the terms of reference to be drawn up.

TWG of Social Contracting

The social contracting TWG will be constituted by different stakeholders drawn from the MHSS, ministries and agencies, CSOs, development partners, UN agencies, the private sector, and other organizations, such as patient interest groups, and academics. The TWG will provide technical guidance on prioritization and implementation oversight as well as on M&E. Among different roles, the TWG will be responsible for:

- Leading processes for identifying social contracting funding priorities
- Organizing dialogue and consultations among all actors involved in social contracting
- Leading decisions concerning financing adjustments in social contracting
- Leading implementation of evaluation of social contracting
- Providing recommendations on how engagement and performance of CSOs can be improved, how government can improve value for money, and other issues that contribute toward effectiveness of the social contracting mechanism

IMPLEMENTATION APPROACH

Guided by the principles and objectives outlined above, the GRN will identify services to be delivered through social contracting. The contract process will be broken down into four main phases: pre-award, award, post-award/implementation, and closeout. To ensure effective contracting, a detailed social contracting manual will be developed to guide this process with clear guidelines, manuals, and checklists for every stage of the process.

PRE-AWARD PHASE

To guide this process, the MHSS, along with other stakeholders, will:

- Conduct a review of health service delivery and identify bottlenecks and lagging indicators, especially those that CSOs can efficiently deliver through a social contract.
- Engage with the MOF to understand available resources and prioritize the different services.
- Ensure that, in line with the above principles, only services that fit closely within the criteria will be selected for contracting.
- Ensure the contracting process is in line with public sector procurement processes laid down, with adequate oversight from the established governance structures to support this process.
- Conduct a pre-award assessment, including a review of various contracting models, and compare these models against the needs and maturity of CSOs to determine the best approach. Multiple approaches may be used in contracts between different services and partners.
- Develop clear terms of reference and scope of work for each proposed social contract.

AWARD PHASE

During this phase, the government will:

- Ensure that identified entities are appropriately evaluated, with adequate dialogue to establish a clear understanding of service delivery gaps and expectations for each contracting party.
- Ensure that communities know the services and quality to be delivered through this arrangement.
- Work with the MOF to ensure that the selected partners have adequate systems to manage public resources; the MHSS will evaluate capacity to deliver services.
- Develop and enter into effective and well-reviewed binding contracts with clear responsibilities, deliverables, and procedures for conflict resolution and termination of arrangements.

POST-AWARD/IMPLEMENTATION PHASE

After the successful award, the government will:

- Provide adequate funding and other resources, including access to data for the selected CSOs, to ensure efficient delivery of quality, affordable, and accessible HIV services.

- Develop and strengthen the CSOs and other governance platforms necessary for effective implementation at both national and subnational levels through a capacity development plan.

CLOSEOUT PHASE

At the end of each social contract arrangement with a CSO provider, the government will:

- Conduct an end-of-project evaluation or learning review (based on grant size) with adequate comparison of baseline and final impact indicators to fully assess and document each contract's impact on service delivery in line with the principles and objectives outlined above.
- Document and disseminate lessons learned for continuous improvement in future contracts.
- Document community and user experiences as direct beneficiaries of each contract.
- Assess achievements against needs identified at the onset of the contract to determine suitability for extension or renewal. Where an unmet need still exists, procurement regulations will guide the government to decide on renewal or extension procedures.

RISK MANAGEMENT

The GRN, through the various governance platforms, will identify, measure, and assess risk to the implementation of each social contracting arrangement. This will aim to determine macro- and micro-factors that may negatively impact the expected delivery and impact of the policy. The principles and objectives outlined above will guide the risk assessment. The GRN will aim to ensure that each arrangement provides the highest level of care to the people of Namibia while ensuring resources are used efficiently, achieving value for money for every dollar invested.

For each social contract, a risk assessment will be conducted and a mitigation plan developed. This will be presented to the steering committees with active monitoring of actions taken to address severe and adverse risk factors. Where risks are assessed as too high and without suitable measures to address these, the GRN will institute measures to safeguard service delivery and funding, including termination of such agreements.

LEGAL AND REGULATORY FRAMEWORK

Article 95 of the Constitution of the Republic of Namibia creates the mandate to guide social contracting, as the state promises to actively promote and maintain the welfare of the people by adopting policies to ensure fair and reasonable access to public facilities and services for all. Guided by the Constitution, the National Welfare Act, 1965 (Act No. 79 of 1965), the Companies Act, 2004 (Act 28 of 2004, Section 21), and the Financial Intelligence Act, 2012 (Act No. 13 of 2012) will define CSOs eligible for social contracting. More specifically:

- Section 16 of the National Welfare Act requires welfare organizations that derive funds or receive financial assistance from the state or local authority or collect money from the public to be registered with the National Welfare Board.
- Section 21 of the Companies Act provides for nonprofit associations to be incorporated as a company limited by a guarantee.
- Section 39 (2) of the Financial Intelligence Act requires accountable and reporting institutions not supervised or regulated by anyone to register their prescribed particulars with the Financial Intelligence Center for the purposes of supervising compliance with the Act.

- Section 2 of the Public Procurement Act sets out the objects of the Act, which, inter alia, are to promote preferential treatment in the allocation of the procurement contracts to Namibian persons who have been economically or educationally disadvantaged by past racial discriminatory laws and practices.
- Section 72 provides that the minister may prescribe any nature of procurement supporting government programs to be reserved exclusively for categories of local suppliers.
- Rules 54(1) of the Public Procurement Regulations mandates the minister to invite bidders and suppliers that meet certain criteria to apply for registration to be eligible to participate under national or exclusive preference. Registration requires particulars, such as value-added tax number, Social Security registration number, and entity registration number.

This legal framework will guide the development of criteria for selecting CSOs and other welfare entities that will be part of this policy mechanism.

Furthermore, the policy will ensure all financial arrangements are compliant with other legislation, including the State Finance Act, 1991 (Act no 31 of 1991). The provisions of these Acts, among other existing legislation, legal pronouncements, and guidance, will strengthen the role and functions of institutions and actors participating in the policy implementation. The policy and other guiding documents developed will provide detailed explanations and requirements to satisfy compliance with these Acts.

RESOURCE MOBILIZATION

The government recognizes that the benefits of contracting with civil society to provide health and social services are significant for individuals' and national development. The policy will adopt a mix of efficiency savings (in existing health budgets) and additional measures to expand fiscal space to finance social contracting arrangements. The MHSS will mobilize resources from available budgets, engage the MOF for additional allocations, and lobby other potential funding sources at all health system levels to identify resources required to implement the policy. Furthermore, development partners have committed significant resources to support social contracting, including supporting initial investments needed at the onset of policy implementation to develop tools and models for contracting the country can adopt.

REPORTING, MEL FRAMEWORK

The MHSS will develop MEL systems to ensure that allocated resources are used per the approved proposals, enhancing prudent management of resources and promoting accountability and high-quality service delivery. An MEL framework for the overall policy and specific contracts will be developed and implemented.

For each contract, indicators to track the expected outputs will be established. Furthermore, mechanisms to record and track these indicators will also be strengthened, ensuring each element is measurable and relevant to the overall objective of advancing the provision of quality health services and efficient use of public funding.

Each social contracting arrangement will include an M&E framework, developed during the proposal development process and finalized and agreed upon during the contracting process. To the extent possible, indicators will be collected across multiple awardees to compare achievement and costs. The information will be presented through program dashboards, providing visual indicators of individual projects and fund strategy achievements. Project achievements will be

monitored monthly, quarterly, and annually by submitting monthly updates and quarterly and annual reports.

Furthermore, the internal audit office within MHSS will conduct annual audits and value for money assessments of the social contracts to ensure CSOs are adhering to PFM regulations and best management practices.

Learning and evaluation will also include the engagement of communities to solicit feedback on the quality of services. Community engagement will use traditional platforms, local governance platforms, and various interest groups for patients and key populations.

As social contracting is a new approach in Namibia, the MEL plan will focus on continuous learning and adaptation of the approaches used across each element. Lessons learned will feed into the capacity development plan for all structures enacted to manage social contracting.

ADVOCACY AND DISSEMINATION (COMMUNICATION STRATEGY)

The policy will be launched at the national level, with participation from the government, civil society, the private sector, and development partners to raise awareness among diverse stakeholders and the general public. Advocacy and customized IEC material relevant to diverse groups to remove barriers such as language will be developed. Copies will be printed and distributed to all key national and regional stakeholders. The launch will be supplemented by broader distribution across multiple media, including television, radio, and government websites. A simplified and user-friendly version of the policy will be created to enhance awareness and encourage active engagement in the policy's implementation and demand generation.

The simplified version of the policy will be translated into braille and local languages. The government will employ electronic channels (for example, social media) and build a feedback link using existing platforms like the National Information Center and strategic partners, such as the Ministry of Information, Communication, and Technology; Regional AIDS Coordinating Committee; Constituency AIDS Coordinating Committee; regional councils; and the Ministry of Gender Equality, Poverty Eradication, and Social Welfare's web page to encourage comments on the policy. Advocacy could include strategic champions for social contracting, including those from the legislature; traditional structures.

CONCLUSION

Namibia has committed to ensuring that all people have access to affordable health services without suffering financial hardship. This vision requires a multisectoral approach that ensures that available resources, best practice evidence, and high-impact interventions are delivered. Furthermore, making progress on the attainment of the UHC vision requires ensuring equity. This policy sets out a case for solid multisectoral partnerships, especially between the MOHSS and civil society, in providing affordable and accessible quality care. The policy aims to ensure that existing partnerships and delivery approaches serving many communities, especially the most vulnerable, are protected while expanding coverage of services. CSOs have been a central stakeholder in delivering health services, as evidenced through progress in areas such as HIV, where the country is among the first in the region to reach epidemic control. Implementing social contracting is necessary to realize efficiency in using resources and providing services closer to those who need them and in a more acceptable way.

Over the next 10 years, implementation of this policy should ensure that the government spends scarce resources efficiently through CSOs who have the capacity to deliver many services at

lower costs, and who many times achieve more-significant impact on communities. Directing resources through such innovative approaches is logical and efficient and builds trust among government, CSOs, and communities, which is essential to empowering recipients of health care services. This policy sets out an ambitious approach that requires all stakeholders' buy-in, engagement, transparency, and accountability in spending government resources. Incremental policy implementation with adequate measures to learn and document such learning is essential. Furthermore, the policy supports the overall government's goal of evidence-based decision-making through strong M&E platforms that pay providers based on measurable performance.

IMPLEMENTATION ACTION PLAN

SOCIAL CONTRACTING POLICY IMPLEMENTATION ACTION PLAN, 2023 TO 2027																
Policy Objective 1: Establish a framework for institutionalizing social contracting in Namibia.																
Strategy	Activity	Output	Key Indicators	Indicator Definition	Baseline	Timelines and Targets per Year					Budget (Namibian Dollars)					Actors/ Responsible Entity
					2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2023/24	2024/25	2025/26	2026/27	2027/28	
Strategy 1: Develop the governance mechanisms for social contracting in Namibia	Strengthen the current social contracting TWG to enable it to become a more multisectoral committee to guide the implementation of the policy.	High stakeholder engagement, buy-in, and oversight over social contracting to ensure alignment with principles and objectives	Number of minutes of TWGs compiled; minutes of other subnational structures on social contracting	TWG meetings held with multistakeholder participation and effective decision- making	6	12	12	12	12	12	NAD 80,000.00	NAD 85,000.00	NAD 85,000.00	NAD 90,000.00	NAD 90,000.00	MOHSS, TWG, CSOs, all stakeholders
	Constitute a national multisectoral steering committee for accountability and governance. Membership to comprise staff at management level, CSOs, and private sector. Chaired by the MOHSS executive director.	High-level buy-in by policy- and decision-makers on social contracting, and strong oversight by national leadership to ensure accountability and transparency.	Number of minutes of steering committee meetings/number of sectors/groups of stakeholders represented in the steering committee	Steering committee minutes, terms of reference, and other reports produced by the steering committee in line with its duties	0	4	4	4	4	4	NAD 12,000.00	NAD 12,000.00	NAD 12,000.00	NAD 12,000.00	NAD 12,000.00	MOHSS (Directorate of Special Programs), Steering Committee
Strategy 2: Strengthen institutional capacity to implement social contracting.	Assess existing institutional capacity to implement social contracting within the MOHSS and other relevant stakeholders in areas such as finance, procurement, monitoring, etc.	Gaps in capacity of people and systems to implement social contracting identified and appropriate response plans including capacity building included	Number of assessment reports/program and ministry reports/steering committee and TWG reports	Assessments reports or any other routine reports/strategies identifying gaps and strengths in areas relevant to social contracting	0	1	1	1	1	1	NAD 120,000.00	NAD 120,000.00	NAD 150,000.00	NAD 180,000.00	NAD 200,000.00	MOHSS, TWG

	Develop the SOPs, guidelines, and other operating manuals to guide social contracting at national and subnational levels.	Social contracting arrangements implemented in line with best practice, national regulations, and achieving efficiency and value for money	SOPs operational and being used/staff trained to implement social contracting in line with policies/number of social contracts implemented in line with manuals	SOPs developed/audit reports on compliance/number of staff/CSOs trained on procedures	0	100%	100%	100%	100%	100%	NAD 120,000.00	NAD 10,000.00	NAD 5,000.00	NAD 5,000.00	NAD 5,000.00	MOHSS, TWG, CSOs, MOF
	Develop annual implementation plans for social contracting.	Implementation of social contracting in line with policy and broad national priorities	Number of annual plans/quarterly work plans from individual social contracts	Reports submitted to senior management/annual work plans of the MOHSS identifying and including social contracting (annual plus quarterly)	0	5	5	5	5	5	NAD 48,000.00	NAD 48,000.00	NAD 48,000.00	NAD 48,000.00	NAD 48,000.00	MOHSS, TWG, Steering Committee
	Develop, strengthen, implement capacity-building plan in line with results of the assessment. This will include ensuring adequate staffing, training, and continuous improvement of social contracting procedures.	Adequate capacity to identify gaps, mobilize funding, and implement contracts efficiently and effectively within MOHSS and awardees	Quarterly and annual capacity development plans/training manuals developed or amended/ annual capacity-building budgets disbursed (requires separate targets and definition)/no. of staff trained and mentored on /system guidelines	Reports, processes, and any tools to improve capacity for effective social contracting	0	4	4	4	4	4	NAD 100,000.00	NAD 0.00	NAD 0.00	NAD 100,000.00	NAD 100,000.00	MOHSS, TWG, CSOs, MOF

Policy Objective 2: Expand provision of health and social services to ensure access for all.																
Strategy	Activity	Output	Key Indicators	Indicator Definition	Baseline	Timelines and Targets per year					Budget (Namibian Dollars)					Actors/ Responsible Entity
					2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2023/24	2024/25	2025/26	2026/27	2027/28	
Strategy 1 :Strengthen the provision of essential health services, especially at the primary care level.	Review service delivery and coverage gaps across all diseases and regions to identify areas with highest unmet need, including for vulnerable and underserved groups.	Priority service delivery gaps identified across multiple programs/regions in line with the Essential Health Services Package and national strategic priorities	Service delivery/access/availability/utilization gaps identified across different program areas (if possible have the different program areas separated)	Assessment reports/briefs/proposals investment cases presented to social contracting governance structures as potential areas for social contracting	0	4	4	4	4	4	NAD 0.00	NAD 0.00	NAD 0.00	NAD 0.00	NAD 0.00	MOHSS, CSOs
	Conduct programmatic assessment to identify interventions that can be delivered through CSO-led approaches to address unmet needs identified.	Percentage of interventions in Essential Health Services Package priority interventions for social contracting identified	Number of interventions identified at different levels and targeted for social contracting	Assessment reports/briefs/proposals investment cases presented to social contracting governance structures as potential areas for social contracting	0	5%	5%	10%	10%	10%	NAD 0.00	NAD 0.00	NAD 0.00	NAD 0.00	NAD 0.00	MOHSS, CSO, TWG
	Define performance targets (output, outcome, and impact) required to measure effectiveness in delivery of such services.	Performance targets for priority interventions defined	Percentage completion on defining performance targets	Baseline assessment reports for potential interventions for social contracting	0	10%	50%	100%	100%	100%	NAD 0.00	NAD 50,000.00	NAD 0.00	NAD 0.00	NAD 50,000.00	MOHSS, CSO, TWG
	Consult communities and other key stakeholders on proposed social contracting approaches and their ability to meet needs of targeted population groups.	Stakeholders' inputs incorporated into potential social contracting arrangements	Number of community/civil society consultations	Consultation reports, community feedback forms, etc., from communities on potential interventions for social contracting	0	4	4	4	4	4	NAD 100,000.00	NAD 200,000.00	NAD 200,000.00	NAD 200,000.00	NAD 200,000.00	MOHSS, CSOs, Regional Councils
Strategy 2: Enhance the delivery of essential health services for vulnerable, marginalized, and hard-to-reach communities.	Map priority groups for service delivery based on different program priorities, including hard-to-reach and vulnerable groups.	Percentage of needs of priority groups lagging behind in line with UHC goals and national priorities are identified and separately	Priority population groups for service delivery identified in line with UHC principles/national priorities	Equity mapping and program assessment reports presented to social contracting steering and TWG committees	0	20%	40%	60%	80%	100%	NAD 0.00	NAD 0.00	NAD 0.00	NAD 0.00	NAD 0.00	MOHSS, CSOs

	Identify key interventions that are currently provided by CSOs or have potential for provision by CSOs targeting these selected groups.	considered to ensure equity	Priority interventions for potential social contracts identified	Literature review, program assessments, learning visits, proposals from CSOs, etc., providing opportunities for contracting approaches	0	20%	40%	60%	80%	100%	NAD 0.00	NAD 0.00	NAD 0.00	NAD 0.00	NAD 0.00	MOHSS, CSOs
	Assess any factors hindering service delivery through social contracting to such groups and develop appropriate strategies to respond.	Percentage of root causes of service delivery gaps identified			0	20%	40%	60%	80%	100%	NAD 0.00	NAD 0.00	NAD 0.00	NAD 0.00	NAD 0.00	MOHSS, CSOs
Strategy 3: Identify CSOs with capacity to deliver health and social services.	Map existing CSOs with capacity to deliver health and social services at all levels, including at community level.	Identify the right CSOs for social contracts and ensure they have capacity, track record, and acceptance from communities to deliver essential services	Mapping reports on CSO capacity/technical proposals from CSOs bidding for social contracts	Reports from assessments of capacity, MOHSS, and other stakeholders on CSO capacity/bids submitted as part of the social contracting process (1 per quarter)	0	4	4	4	4	4	NAD 500,000.00	NAD 0.00	NAD 0.00	NAD 30,000.00	NAD 0.00	MOHSS, Steering Committee
	Develop evaluation framework and assess capacity of such CSOs to provide identified services in line with program goals, approaches, and community needs.	Selection of CSOs with the right skills and eliminating potential for inefficiencies in the selection process/building transparency through established criteria	Criteria/scoring sheets for selection of CSOs measuring capacity in all aspects in line with social contracting best practice and national regulations	Reports for technical evaluation committees, manuals for evaluating bids, minutes of steering committees, etc. (1 per quarter)	0	4	4	4	4	4	NAD 0.00	NAD 50,000.00	NAD 50,000.00	NAD 50,000.00	NAD 50,000.00	MOHSS, Steering Committee

Policy Objective 3: Define efficient and sustainable mechanisms to finance social contracting.																
Strategy	Activity	Output	Key Indicators	Indicator Definition	Baseline	Timelines and Targets per Year					Budget (NAD)					Actors/ Responsible Entity
					2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2023/24	2024/25	2025/26	2026/27	2027/28	
Strategy 1: Mobilize sustainable financing to procure services through social contracts.	Review budgetary processes to identify opportunities to allocate resources for social contracting	Funding for social contracting mobilized through GRN annual budgetary processes	Percentage of total amount of on-budget funding for social contracting/number of social contracts per year	Resources mobilized from domestic funding to support social contracting and number of social contracts entered	0	0	30%	100%	100%	100%	NAD 0.00	NAD 0.00	NAD 0.00	NAD 0.00	NAD 0.00	MOHSS, TWG, Steering Committee
	Identify key stakeholders at national and regional levels to be engaged as champions for resource mobilization.										NAD 0.00	NAD 0.00	NAD 0.00	NAD 0.00	NAD 0.00	MOHSS, TWG, Steering Committee

Policy Objective 3: Define efficient and sustainable mechanisms to finance social contracting.																
Strategy	Activity	Output	Key Indicators	Indicator Definition	Baseline	Timelines and Targets per Year					Budget (NAD)					Actors/ Responsible Entity
					2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2023/24	2024/25	2025/26	2026/27	2027/28	
	Develop annual investment cases to motivate for funding to implement social contracting, especially highlighting benefits of the approach over traditional approaches		Number of investment cases for social contracting developed	Proposals to mobilize funding for social contracting developed and presented to policy-makers to lobby for funding at all levels	0	1	2	3	4	5	NAD 100,000.00	NAD 150,000.00	NAD 200,000.00	NAD 300,000.00	NAD 300,000.00	MOHSS, TWG, Steering Committee
	Lobbying and advocacy for resources to implement social contracting and address needs identified			Lobbying and advocacy materials to motivate for social contracting developed							NAD 0.00	NAD 0.00	NAD 0.00	NAD 0.00	NAD 0.00	MOHSS, TWG, Steering Committee
	Identify other potential sources of funding, including development partners and private sector, and lobby for funding	Funding for social contracting mobilized from other development partners and private sector	Investment cases/proposals presented to development partners and other stakeholders	Proposals to seek funding developed, clearly defining expected benefits and returns from social contracts	0	2	4	6	8	10	NAD 50,000.00	NAD 75,000.00	NAD 50,000.00	NAD 0.00	NAD 0.00	MOHSS, TWG, Steering Committee, Development Partners
Strategy 2: Develop mechanisms to enhance efficient disbursement, monitoring, and accountability of financial resources contracted to CSOs.	Review PFM requirements for contracting, develop finance procedures manual, and build capacity to ensure compliance during social contracting.	Social contracts implemented with accurate, transparent, and accountable tracking and reporting of funds	Finance manuals developed/number of officers capacitated to implement social contracts in line with PFM	Finance manuals developed and staff at various levels in MOHSS and CSOs capacitated to use the manuals in line with PFM regulations	0	1	1	1	1	1	NAD 400,000.00	NAD 500,000.00	NAD 3,000,000.00	NAD 300,000.00	NAD 700,000.00	MOHSS. MoF, TWG
	Develop models for monitoring implementation and paying for performance.	Social contracts implemented with CSOs rewarded based on performance, including qualitative and quantitative achievements based on nature of services contracted	Number of models of pay for performance evaluated/implemented	Briefs/presentations to stakeholders' policy-makers on models of pay for performance evaluated against each social contracting opportunity	0	1	2	3	4	5	NAD 216,000.00	NAD 0.00	NAD 0.00	NAD 216,000.00	NAD 0.00	MOHSS, TWG, CSOs

Policy Objective 3: Define efficient and sustainable mechanisms to finance social contracting.																
Strategy	Activity	Output	Key Indicators	Indicator Definition	Baseline	Timelines and Targets per Year					Budget (NAD)					Actors/ Responsible Entity
					2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2023/24	2024/25	2025/26	2026/27	2027/28	
	Develop and implement systems to ensure accountability and transparency in public funds, including audit, project assessments, and independent evaluations.	Value for money, high population outcomes, and impact achieved from social contracting	Assessment and evaluations of social contracts conducted	Reviews during and after implementation of social contracts to measure impact on and efficiency on resource use, patient outcomes, and stakeholder collaboration, etc.	0	1	1	1	1	1	NAD 10,000.00	NAD 10,000.00	NAD 10,000.00	NAD 10,000.00	NAD 10,000.00	MOHSS, TWG, Steering Committee

Policy Objective 4: Strengthen multisectoral engagement and coordination between GRN, CSOs, and communities for delivery of health and social services.																
Strategy	Activity	Output	Key Indicators	Indicator Definition	Baseline	Timelines and Targets per Year					Budget (Namibian Dollars)					Actors/ Responsible Entity
					2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2023/24	2024/25	2025/26	2026/27	2027/28	
Strategy 1: Map and identify existing governance and coordination platforms and build their capacity to support social contracting implementation.	Identify multisectoral structures at national and regional levels that can support social contracting and enhance their capacity to provide engagement and coordination. Strengthen information sharing between multisectoral stakeholders with interest in social contracting.	Strong institutional and governance platforms to support social contracting	Minutes of meetings from governance platforms	Governance platforms convened and routinely meeting with broad multisectoral representation	12	24	24	24	24	24	NAD 30,000.00	NAD 5,000.00	NAD 18,000.00	NAD 5,000.00	NAD 5,000.00	MOHSS, TWG, Regional Councils

Policy Objective 4: Strengthen multisectoral engagement and coordination between GRN, CSOs, and communities for delivery of health and social services.																
Strategy	Activity	Output	Key Indicators	Indicator Definition	Baseline	Timelines and Targets per Year					Budget (Namibian Dollars)					
					2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2023/24	2024/25	2025/26	2026/27	2027/28	Actors/ Responsible Entity
	Strengthen community feedback on service delivery and ensure communities are included in coordination and engagement platforms.	Effective community feedback and participation in social contracts	Number of community representatives in social contracting governance platforms/number of community feedback reports	Evidence on active participation of communities and soliciting of feedback from communities (quarterly meetings)	0	4	4	4	4	4	NAD 80,000.00	NAD 100,000.00	NAD 150,000.00	NAD 200,000.00	NAD 200,000.00	MOHSS, Regional Councils, CSOs
Strategy 2: Conduct stakeholder sensitization to institutionalize social contracting in Namibia.	Develop IEC materials for educating and informing stakeholders on the social contracting process, benefits, and approaches.	Buy-in and support of social contracting from stakeholders	Percentage of IEC materials developed and distributed to stakeholders	Multimedia IEC developed through different channels and approaches targeting different stakeholders at all levels	0	50%	100%	100%	100%	100%	NAD 500,000.00	NAD 15,000.00	NAD 15,000.00	NAD 15,000.00	NAD 15,000.00	MOHSS /TWG
	Disseminate policy, guidelines, and other relevant documents to programs and regions to ensure full knowledge and capacity to identify interventions, as well as funding for social contracting.	Active buy-in from programs and implementation of social contracts with fidelity	Number of social contract proposals from regions and programs annually	Interventions identified and proposals to implement activities through social contracts by MOHSS teams	0	1	5	10	10	10	NAD 0.00	NAD 0.00	NAD 0.00	NAD 0.00	NAD 0.00	MOHSS, TWG, Steering Committee, CSOs
	Engage programs and regional leadership to streamline social contracting into routine contracting and programming approaches.	Social contracting implemented along with other programming approaches	Number of social contracts integrated with other service delivery processes	Social contracts implemented as part of other routine services and not as standalone projects, with funding from MOHSS	0	1	2	3	4	4	NAD 0.00	NAD 0.00	NAD 0.00	NAD 0.00	NAD 0.00	MOHSS, TWG, Steering Committee, CSOs

Policy Objective 5: Strengthen reporting, monitoring, evaluation, and learning for social contracting.																
Strategy	Activity	Output	Key Indicators	Indicator Definition	Baseline	Timelines and Targets per year					Budget (Namibian Dollars)					Actors/ Responsible Entity
					2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2023/24	2024/25	2025/26	2026/27	2027/28	
Strategy 1: Strengthen the reporting and M&E environment for social contracting	Develop an M&E framework to effectively track implementation of social contracts. The framework will include both qualitative and quantitative indicators to track outputs, outcome, and overall impact on the goal of providing affordable and accessible health services for all.	Effective M&E of all social contracts	Percentage completion of M&E framework with adequate indicators to facilitate pay for performance	M&E framework with clear indicators to track social contracts	0	0	50%	75%	100	100	NAD 156,000.00	NAD 30,000.00	NAD 0.00	NAD 0.00	NAD 0.00	MOHSS, TWG
	Strengthen the role of governance platforms to support M&E functions, including creating mechanisms to enhance transparency and accountability in performance, based on performance data.	Strong governance platforms with clear oversight on social contracts, data, reporting, and accountability	Performance reporting indicators/frameworks developed	Frameworks and indicators to ensure performance-based tracking of procurement contracts and facilitate pay for performance	0	0	20%	40%	60%	60%	NAD 0.00	NAD 0.00	NAD 0.00	NAD 0.00	NAD 0.00	MOHSS, TWG, Steering Committee, CSOs
	Develop comprehensive data collection and reporting tools that are well linked to routine health information systems used by different programs and regions.	Timely and accurate data on implementation of social contracts	Reporting rates and completeness of reports on social contracting	Completeness and timeliness of performance data from social contracts	0	0%	50%	100%	100%	100%	NAD 50,000.00	NAD 30,000.00	NAD 60,000.00	NAD 0.00	NAD 0.00	MOHSS, TWG, Steering Committee, CSOs
	Conduct routine and ad hoc community assessments on quality of services and patient assessment.	Timely and accurate data on quality/community satisfaction on services provided under social contracts	Number of community quality assessments conducted	Community assessments conducted based on agreed timelines in social contracts	0	0	4	4	4	4	NAD 0.00	NAD 0.00	NAD 0.00	NAD 0.00	NAD 0.00	MOHSS, TWG, Steering Committee, CSOs, Regional Councils
Strategy 2: Strengthen learning and adaptation in implementation of social contracting.	Continuous evaluation of implementation approaches and impact on service delivery for targeted interventions.	Continuous improvements in social contracting contracts based on past experiences	Number of evaluation reports	Evaluation reports conducted at the end of each social contract	0	0	1	1	1	1	NAD 50,000.00	NAD 75,000.00	NAD 15,000.00	NAD 80,000.00	NAD 80,000.00	MOHSS, TWG, Steering Committee, CSOs, Regional Councils
	Dissemination of results on impact and processes with continuous redesign to improve effectiveness.			Dissemination and learning reports (will need a separate indicator on dissemination)	0	0	1	1	1	1	NAD 0.00	NAD 0.00	NAD 0.00	NAD 0.00	NAD 0.00	MOHSS, TWG, Steering Committee, CSOs, Regional Councils

Policy Objective 5: Strengthen reporting, monitoring, evaluation, and learning for social contracting.																
Strategy	Activity	Output	Key Indicators	Indicator Definition	Baseline	Timelines and Targets per year					Budget (Namibian Dollars)					Actors/ Responsible Entity
					2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2023/24	2024/25	2025/26	2026/27	2027/28	
	Routine building of capacity of all stakeholders on social contracting approaches.	Enhanced knowledge on social contracting	Capacity development plans	Plans developed to build capacity and enhance future social contracting	0	0	1	1	1	1	NAD 100,000.00	NAD 5,000.00	NAD 0.00	NAD 0.00	NAD 0.00	MOHSS, TWG, Steering Committee, CSOs, Regional Councils

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