

**Human Capacity
Development
Assessment for
Public Sector
Pharmaceutical
Services in
Namibia:**

***Strategies to Scale
Up HIV/AIDS
Programs and ART
Therapy***

Management Sciences for Health
is a nonprofit organization
strengthening health programs worldwide.



This report was made possible through support provided by the U.S. Agency for International Development, under the terms of Cooperative Agreement Number HRN-A-00-00-00016-00. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the U.S. Agency for International Development.

April 2006

Human Capacity Development Assessment for Public Sector Pharmaceutical Services in Namibia: Strategies to Scale Up HIV/AIDS Programs and ART Therapy

Printed April 2006



This report was made possible through support provided by the U.S. Agency for International Development, under the terms of cooperative agreement number HRN-A-00-00-00060-00 and HRN-A-00-00-00014-00. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the U.S. Agency for International Development.

About RPM Plus

RPM Plus works in more than 20 developing and transitional countries to provide technical assistance to strengthen medicine and health commodity management systems. The program offers technical guidance and assists in strategy development and program implementation both in improving the availability of health commodities—pharmaceuticals, vaccines, supplies, and basic medical equipment—of assured quality for maternal and child health, HIV/AIDS, infectious diseases, and family planning and in promoting the appropriate use of health commodities in the public and private sectors.

About the Management and Leadership Program

The Management and Leadership (M&L) Program is a five-year program aimed at improving the health of women, children, and men around the world by improving the management and leadership performance of health organizations. M&L works with organizations that provide family planning, primary and reproductive health care, maternal and child health services, AIDS-related services, and treatment for infectious diseases. Staff members work with ministries of health, international and national programs, nongovernmental organizations, other public and private organizations, and urban and rural health care centers.

Suggested Citation

Management Sciences for Health. 2006. *Human Capacity Development Assessment for Public Sector Pharmaceutical Services in Namibia: Strategies to Scale Up HIV/AIDS Programs and ART Therapy*. Submitted to the U.S. Agency for International Development by the Rational Pharmaceutical Management Plus Program and the Management and Leadership Program. Arlington, VA: Management Sciences for Health.

Rational Pharmaceutical Management Plus
Center for Pharmaceutical Management
Management Sciences for Health
4301 North Fairfax Drive, Suite 400
Arlington, VA 22203 USA
Telephone: 703-524-6575
Fax: 703-524-7898
E-mail: rpmpplus@msh.org
Web: www.msh.org/rpmpplus

Management and Leadership Program
Management Sciences for Health
784 Memorial Drive
Cambridge, MA 02139
Telephone: 617-250-9500
Fax: 617-250-9090
Web: www.msh.org/mandl

CONTENTS

ACKNOWLEDGMENTS	v
ACRONYMS.....	vii
GLOSSARY OF TERMS.....	ix
INTRODUCTION	1
Objectives	1
Limitations of the Assessment.....	2
Summary of Recommendations.....	2
BACKGROUND	5
HUMAN RESOURCES CONSTRAINTS AFFECTING CAPACITY OF PHARMACISTS AND PHARMACIST’S ASSISTANTS TO SCALE UP HIV/AIDS PROGRAMS	7
GAPS THAT EXIST IN THE PROVISION OF HIV/AIDS SERVICES BY PHARMACISTS AND PHARMACIST’S ASSISTANTS.....	13
Current Vacancies Plus New Positions Needed.....	13
Staff Death and Illness Caused by HIV/AIDS.....	15
The Central Medical Stores	16
SHORT- AND LONG-TERM RECOMMENDATIONS TO ADDRESS THE ISSUES.....	17
Filling Staffing Gaps.....	17
Increasing Staff Retention.....	19
Enhancing Staff Performance	20
Providing In-Service Training	20
Strengthening Medical Stores.....	21
IMPLEMENTATION STRATEGY AND ACTION PLAN.....	23
HR Task Force for the Pharmaceutical Sector.....	23
Approach to Implementation	23
HUMAN CAPACITY DEVELOPMENT FRAMEWORK.....	25
ANNEX 1. SCOPE OF WORK.....	27
ANNEX 2. DOCUMENTS REVIEWED.....	31
MoHSS Policy—General.....	31
HIV/AIDS-Related Documents	31
Pharmaceutical Sector Strategic Documents	31
Pharmacy Staffing in Namibia.....	31
Staffing Needs.....	31
MoHSS Human Resources Development.....	32

ANNEX 3. PEOPLE INTERVIEWED 33

ACKNOWLEDGMENTS

The important role that pharmacists and pharmacist's assistants play in the delivery of antiretroviral therapy in the public sector is widely recognized by officials within the Ministry of Health and Social Services (MoHSS). We want to thank the people with whom we met who were very generous with their time (see Annex 3). We also had excellent support from the Technical Working Group put together for the purpose of guiding the work of the assessment team, the Rational Pharmaceutical Management Plus Project Team, Management Sciences for Health (MSH) in Windhoek, and the U.S. Agency for International Development Namibia Health Team, as well as from the Oshikoto Regional Pharmacist, Barbara Matengu. We were also able to review a wide range of related studies and reports (see Annex 2). Several of those reports (for example, *An Assessment of the Public Sector Drug Supply System of the Republic of Namibia* [MSH 2003] and *Strategic Human Resources Plan for Namibia, 2000–2010* [Division of Human Resources Development, MoHSS, July 2000]) have addressed the shortage of health staff resources, including pharmacists and pharmacist's assistants, and have made important recommendations. In this report we intend to add emphasis to some of those earlier findings and also to suggest other strategies that need to be considered.

The authors would like to acknowledge the assessment and strategy development work conducted by—

Elena Decima	Senior Program Manager, Management and Leadership Program, Management Sciences for Health
Jennie Lates	Pharmaceutical Management Advisor, Rational Pharmaceutical Management Plus Program, Namibia National Medicines Policy Co-ordination, Ministry of Health and Social Services, Namibia
Justin Nyondo	Managing Partner, Management International, Malawi
Mary O'Neil	Principal Program Associate, Management and Leadership Program, Management Sciences for Health

ACRONYMS

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral
CDC	U.S. Centers for Disease Control and Prevention
CMS	Central Medical Stores
DH	district hospital
GRN	Government of the Republic of Namibia
HCD	human capacity development
HIV	human immunodeficiency virus
HR	human resources
HRM	human resources management
HRD	Human Resources Development
IH	Intermediate Hospital
LMS	Lutheran Medical Services
MoHSS	Ministry of Health and Social Services
MS	Medical Stores
MSH	Management Sciences for Health
MTP III	Third Medium-Term Plan
NAD	Namibian dollar
PMO	Principal Medical Officer
RMS	Regional Medical Store
RPM Plus	Rational Pharmaceutical Management Plus [Program]
UNAM	University of Namibia
USAID	U.S. Agency for International Development

GLOSSARY OF TERMS

Human Capacity Development (HCD) Plan: A comprehensive and multisectoral strategy to increase human capacity to manage and deliver health services. This strategy focuses on identifying and finding solutions to personnel barriers in policy, human resources management, partnerships, and leadership. Sustainable human capacity for health services depends on the cooperation and work of several ministries, agencies, and sectors, not just the MoHSS.

Human resources management (HRM): HRM is the integrated use of systems, policies, and practices to plan for necessary staffing levels and to recruit, motivate, develop, and maintain employees so that the organization can meet its desired goals. HRM concerns the internal, organizational management systems and is one of the key building blocks of a comprehensive HCD strategy. HRM provides the means by which institutions can translate an HCD strategy into effective human resources practice.

Human resources for health (HRH): The stock of all individuals involved in safeguarding and contributing to the prevention, promotion, and protection of the health of populations. These resources comprise skilled and unskilled persons working in formal (public, private, faith-based organizations) and informal health care sectors, including traditional healers, volunteers, and community caregivers. Nonmedical staff members providing administrative, management, planning, monitoring, and evaluation services are also included.

Workforce planning: A process to establish the quantity, quality, different cadres, and location of health workers required to meet the human resources requirements of the organization. It also involves a strategy for the recruitment, deployment, and retention of those workers.

Stakeholders: The diverse group of organizations and actors that have a responsibility or a vested interest in the human capacity of the health sector. Stakeholders include relevant ministries as well community and civil society groups and the donor community.

Short vs. long term: For the purpose of this report, short-term recommendations are those that are considered urgent and essential to begin addressing specific priority issues and accomplish some results quickly. Long-term actions are those that are equally important but may require more time to negotiate and implement.

INTRODUCTION

This report presents the findings and recommendations of a Human Capacity Development (HCD) Assessment of the Namibian pharmaceutical services to support the scale-up of HIV/AIDS programs, with an emphasis on antiretroviral therapy (ART). The assessment is the first comprehensive and logical step that is necessary to assess and identify both short- and long-term solutions for addressing the country's shortage of pharmacists and pharmacist's assistants. It is funded through the President's Emergency Plan for AIDS Relief, and it examines primarily the level of need for practicing pharmacists and pharmacist's assistants within Namibia for achieving the 2-7-10 targets¹ and the goals of the Republic of Namibia as set out in the National Strategic Plan on HIV/AIDS, Third Medium Term Plan (MTP III), 2004–2009. A team constituted by Management Sciences for Health (MSH) undertook the assessment in January and February 2005.

Objectives

The objectives of the assessment were to—

1. Verify the number of pharmaceutical staff members needed to scale up HIV/AIDS services—with an emphasis on ART—and identify key issues leading to staffing shortages
2. Assess the capacity of the human resources management (HRM) system within the Ministry of Health and Social Services (MoHSS) to adequately staff ART programs, including recruitment, training, supervision, and retention of pharmacy staff
3. Assess the capacity of the MoHSS in-service training program to increase the quality, planning, and standardization of training activities
4. Assess the capacity of the preservice training institutions to respond to the supply side of pharmaceutical services
5. Develop an HCD strategy that includes both short-term emergency recommendations and more sustainable long-term recommendations

For more details of the scope of work, please refer to Annex 1.

¹ The goals of the President's Emergency Plan are to treat 2 million, prevent 7million infections, and mitigate impact in 10 million (thus, 2-7-10 targets).

Limitations of the Assessment

This assessment is partly limited by the time available to the consultants to meet with the wide range of stakeholders and hospitals in such a complex environment. It is also limited by the unavailability of staff caused by conflicting priorities and workload. Although not strictly a limitation, obtaining exact data on the number of people who train to become pharmacists was difficult because the MoHSS system does not record those who do not receive a government bursary.

Summary of Recommendations

Policy/Financial	Human Resources Management
<p>Short term:</p> <ul style="list-style-type: none"> • Establish a minimum of 10 bursaries/grants for students pursuing pharmacy degree, earmark at least 2 for pharmacist's assistants • Develop two-year community service requirement, in lieu of bonding • Permit part-time employment for pharmacists • Create a new cadre of pharmaceutical technician as a promotional step for pharmacist's assistants • Finalize policy to permit pharmacists to work in both private and public sectors • Increase the number of pharmacist's assistant students that a pharmacist may supervise • Install computer tracking systems at ART sites • Install Internet facilities in all district hospitals to enhance learning <p>Long term: Streamline the employment process and improve HR linkages between the central and regional levels</p>	<p>Short term:</p> <ul style="list-style-type: none"> • Contract a marketing firm to develop and implement a marketing campaign to recruit more candidates for pharmacy program • Increase the number of pharmacist's assistants being trained • Restart program at Oshakati • Contract with outside recruitment firm to secure more foreign pharmacists • Provide a central-level monitoring mechanism • Implement the HIV/AIDS workplace program developed by MoHSS • Use pharmacist's assistants for counseling ART patients • Review role pharmacists play in hospital pharmacy to make optimum use of the limited resources • Provide intensive English-language training for Cuban pharmacists • Review in-service training to improve availability and meet needs of pharmacy staff • Introduce best practices program for pharmacists and pharmacist's assistants to share knowledge • Provide leadership development programs for managers at all levels • Reconsider staffing mix at medical stores to include more management skills <p>Long term: Introduce distance learning and computer-aided instruction to in-service training</p>

Leadership	Partnerships
<p>Short term: Create a climate of teamwork and support at all ART sites</p> <p>Long term: Improve multisectoral collaboration for strengthening human resources capacity in all areas of health</p>	<p>Short term:</p> <ul style="list-style-type: none">• Partner with the Pharmaceutical Society of Namibia to market pharmacy and support more students in training• Enlist assistance of District Coordinating Committees to develop formal partnerships with community groups who can provide needed human capacity in ART <p>Long term: Work with the two Education Ministries and UNAM to improve science education at the secondary level</p>

BACKGROUND

As soon as medicines became available for ART, the Government of the Republic of Namibia (GRN) decided that hospitals across the country should provide ART services as soon as possible. To facilitate implementation of the GRN decision, the MoHSS developed a Model of Care that calls for one doctor, one nurse, and one pharmacist for each 600 patients and one counselor for each 300 patients.

Starting with a few pilot sites, ART services are being rolled out against a background of rapid change in both health service delivery and human resources development following Namibia's independence in 1990. Restructuring of the MoHSS was finalized in 2003, and several studies have been undertaken in the area of human resources development. Of critical importance to the current assessment are two strategic plans for human resources that have been developed: the first one is for the years 2000–2005, and the second one (in draft) extends the time frame to 2010. In addition, decentralization is under way in an effort to improve the delivery of services at the regional and district levels. Now, with 13 regions defined and regional health teams in place (although not all teams are fully staffed), the MoHSS expects to provide increased access and quality of health services to all parts of the country. These efforts are important to the current challenge faced by the health sector in providing HIV/AIDS services and, in particular, ART to the estimated 250,000 adults and children who are infected.

The effect of the HIV/AIDS pandemic poses a critical challenge to the strides the country has made in education, health, and economic development since independence. The burden of HIV/AIDS on the health service delivery system and the demand it places on human resources is enormous and will be felt many years into the future. In addition to increasing the workload for existing health staff, HIV/AIDS significantly increases both preservice and in-service training needs because the HIV/AIDS clinical competencies for the existing staff have not developed at a pace commensurate with the ART rollout. Although Namibia has the capacity to train nurses, counselors, and pharmacist's assistants, it depends heavily on foreign doctors and pharmacists to provide many of those services.

Growing commitment exists among a wide range of development partners to support the health sector and the implementation of the National Strategic Plan on HIV/AIDS, MTP III, 2004–2009. The MTP III rightly treats HIV/AIDS as a “complex development issue that requires full and active participation of all Namibians—its leaders, government departments, and civil society at large”; however, the lack of skilled human resources is a major obstacle to fulfilling the goals set out in this plan.

Although this HCD assessment and strategy development does not focus on the private sector, it is important to note that approximately 50 percent of the people currently receiving ART in Namibia are being served by the private sector. Because of the severely skewed distribution of private services geographically, as well as their increasing costs, this number is not expected to increase. Most of the private services are clustered in Windhoek and do not reach large numbers of the population in other geographic areas. In addition, some doctors in private practice are dispensing ART medicines, but there is no practical way to estimate the effect of their activities.

HUMAN RESOURCES CONSTRAINTS AFFECTING CAPACITY OF PHARMACISTS AND PHARMACIST'S ASSISTANTS TO SCALE UP HIV/AIDS PROGRAMS

Currently, 31 sites are providing services for either prevention of mother-to-child transmission of HIV/AIDS or ART or both of these services. According to the HIV/AIDS Strategic Plan, the MoHSS plans to provide ART through 35 sites across the country before the end of 2005. ART services in hospitals visited by the assessment team were organized according to best use of existing staff members. The Model of Care recommended by MoHSS has not been applied at the hospital level because of the rapid rollout of the ART program. Provision of ART services in the hospitals is guided by staff availability, space on hand, and demands of the population. Many district hospitals are relying on a pharmacist's assistant because no pharmacist is available. Pharmacist's assistants in Namibia have historically assumed a higher level of responsibility in the pharmacy because of the lack of pharmacists, but with the introduction of ART—which is a complex regimen of treatment—the role of a trained pharmacist becomes key to maintaining a successful ART program, especially as demand increases daily.

The Model of Care recommended by the MoHSS does not provide any guidance on the ancillary management systems and procedures that are required to support the prescribed clinical ratios. The model fails to address what else is needed apart from staff. As a consequence, the majority of the hospitals visited had serious deficiencies in terms of management systems and procedures to support the effective delivery of ART services.

Consider one ART site visited, a referral hospital. It has 2,570 people on ART who must see the pharmacist every month. The hospital expects the number of people on treatment to increase by at least 1,000 in the next year. Currently, the ART pharmacy serves approximately 80 people per day, staffed by one pharmacist and one pharmacist's assistant. They have no computer system to track patients and no telephone or transport to seek out people who have begun ART but then stop coming to collect their medicines. The staff members at this hospital are barely coping with the current demand and do not have the capacity to track defaulters. It is hard to imagine how they will be able to scale up ART services without additional pharmacy help.

Despite the different approaches taken in establishing ART programs as rapidly as possible, all of the hospitals in the public sector have human resources (HR) constraints with regard to pharmaceutical services that compromise delivery of ART services. Such HR constraints include the following—

- **Vacant positions**

Lack of pharmaceutical staff and, in some cases, a lack of adequate numbers of established posts that can be used to appoint staff members if they are available. ART sites draw on health staff, including pharmacists and pharmacist's assistants, from other units in the facilities, leaving those facilities understaffed in turn. In many of the hospitals we visited, the pharmacy services and counseling for ART were being provided by a pharmacist's assistant. In the case of ART, that situation should be considered equivalent to a vacancy, because the provision of ART requires the more-skilled oversight of a pharmacist.

- **Reliance on foreign pharmacists**

Approximately 90 percent of the filled pharmacist’s positions are filled by foreigners who are on two- to three-year contracts. Because the country will be reliant on foreign pharmacists for some years into the future the current system of recruiting and tracking these contacts needs to be improved.

- **Limited graduation of trained pharmacists**

Largely because of a perceived low status of pharmacists compared to medical doctors and dentists, students have limited interest in pursuing a degree in pharmacy. Of 515 students pursuing health and social welfare–related training programs at the University of Namibia (UNAM) in financial year 2003/04, only about 0.3 percent, or 2, chose pharmacy for further training. Table 1 provides comparative data on health-related training.

Table 1. Health and Social Welfare–Related Studies at UNAM, 2003/04

Area of Study	Number of Students per Year of Study				Total	Percentage
	4th	3rd	2nd	1st		
Nursing Science	51	53	114	135	353	68.5
Radiography		7	5	10	22	4.2
Social Work	16	13	12	30	71	14
Pre-Med			28	38	66	13
Pre-Pharmacy			2		2	0.3
Pre-Physiotherapy				1	1	0.1
Total	67	73	161	214	515	100.1

Source: Ministry of Health and Social Services, Division of Human Resource Development, *Annual Report 2003/04*.

- **Limited training of pharmacist’s assistants**

Currently, the MoHSS provides training for pharmacist’s assistants only at Windhoek Central Hospital. People who live in other regions may not be able to get to Windhoek for training. Another factor limiting the number of people who are trained is the policy of limiting to two the number of trainees a pharmacist tutors.

- **Inadequate in-service training**

Both pharmacists and pharmacist’s assistants have not benefited from systematic and well planned in-service training interventions. Except for training to do with implementation of the ART program, pharmacists and pharmacist’s assistants have had little chance recently of attending refresher programs to upgrade their skills. Shortage of staff and lack of time to organize and conduct such refresher courses have impeded their implementation. In a dynamic environment such as now exists in Namibia, the need for refresher programs cannot be overemphasized. Also, given the nature of the ART program, those involved in its administration need to learn from each other and share best practices where those exist.

It was also observed that the little training that has been conducted involving pharmacists and pharmacist's assistants has not been sensitive to the work schedules of hospital-based staff, who in many cases work without alternates or associates. The training was observed to be largely based in Windhoek, which poses challenges to the participation of pharmacists and pharmacist's assistants in distant places.

The MoHSS has recently embarked on training to upgrade the knowledge and skills of its staff members in middle management. Few of its pharmacists and none of the pharmacist's assistants have benefited from that training. Because they are responsible for managing a demanding and critical part of a hospital that directly affects patients, their participation in such training could help increase efficiencies in this area.

Many hospitals visited have basic facilities that can accommodate training of staff to a certain degree but were found to lack modern learning tools such as Internet and on-the-job aids and kits that could enhance or reinforce continuous learning.

Pharmacist's assistants, in particular, lack in-service training opportunities that could help them manage pharmacies more effectively. Despite the critical need for every hospital, including district hospitals, to have a pharmacist, the government is unlikely to be able to attain this goal in the foreseeable future. Pharmacist's assistants are going to manage district hospital pharmacies for a long period to come. Currently, the gap between pharmacist's assistants and pharmacists in terms of knowledge and skills is quite wide. Even though in many district hospitals, the pharmacist's assistants do the work of the pharmacists, they do it with only the knowledge they gained during their pre-service two-year certificate course. Obviously, their knowledge is not comparable to that gained by pharmacists in their four-year degree course. The pharmacist assistant's knowledge and skills in such areas as pharmacology, management, and procurement is not as strong as needed. Consequently, the quality of work in those areas cannot be guaranteed, especially with the introduction of a highly drug-intensive program like ART, where antiretrovirals (ARVs) have to be in steady supply if treatment is to be successful.

- **Language barriers**

Most English-speaking foreign pharmacists require a translator to communicate with patients. Cuban pharmacists are extremely limited in their ability to contribute needed capacity to the pharmacy sector because of their limited English skills and the lack of Spanish-English translators.

- **Rapid turnover of pharmacists and pharmacist's assistants**

Pharmacists and pharmacist's assistants frequently leave the public sector for better pay and conditions of service in the private sector. Pharmacist's assistants also move laterally to other government departments because of better promotion prospects.

Increasing the supply of pharmacists and pharmacist's assistants will not resolve staffing problems if steps are not taken to make pharmacists and pharmacist's assistants more effective on the job and to increase their retention rates within the public sector. A number of issues were identified in this assessment that contribute to ineffectiveness and turnover of pharmaceutical staff—

- *Salary:* Although salary is often cited as a disincentive to enter pharmacy as opposed to medicine or dentistry in the public sector, the differences are not as large as might be expected. The entry-level salary for pharmacists is 105,000 Namibian dollars (NAD) per year, as compared to medical doctors and dentists at NAD 130,000. At the higher end, a chief medical officer can earn up to NAD 215,000, whereas a chief pharmacist is capped at NAD 175,638. The differences in salary between pharmacists, and medical officers and dentists is, however, a cause for dissatisfaction among the pharmacists already employed by the MoHSS. It appears particularly unfair that an entry-level medical officer or dentist receives the same salary as a Principal Pharmacist who has worked a minimum of five years.

Pharmacist's assistants, at a starting salary of NAD 52,900, earn more than all of the other certificate holders, such as enrolled nurses, radiographic assistants, and medical rehabilitation workers. The main issue confronting pharmacist's assistants is the lack of upward mobility, even as they often find themselves assuming the duties of a pharmacist, especially at district hospitals. In addition to the lack of a career ladder, pharmacist's assistants at the district hospital often work in isolation and as a cadre are often neglected when it comes to in-service training.

- *Lack of a career ladder for pharmacist's assistants:* Currently, pharmacist's assistants have only one promotional grade, that of senior pharmacist's assistant. Those consulted during this study unanimously cited this limitation as a key factor in seeking other work. Many have opted to change to other careers or simply resign from the public service for employment in the private sector.
 - *Excessive workload:* As a consequence of not having pharmacists to staff the pharmacies in the majority of district hospitals, pharmacist's assistants are for the time being performing that role. This situation has led to an excessive workload that will only become more demanding with the rollout of ART.
 - *Housing:* Many health managers mentioned that lack of adequate housing can be a deterrent to recruiting both pharmacists and pharmacist's assistants. Hospitals that can offer decent housing are much more likely to be successful in recruiting staff to the facility.
- **Working conditions of pharmacists and pharmacist's assistants**
 - *Deployment to rural areas:* Currently, about 48 percent of pharmacists working with the MoHSS (including those paid by the U.S. Centers for Disease Control and Prevention [CDC] and the U.S. Agency for International Development [USAID] as well as Cuban volunteer pharmacists) are in the Khomas region where the capital city is located. The rest are distributed among the remaining 12 regions—the majority in referral health facilities, leaving district hospitals under the care of pharmacist's assistants.

- *Limited training opportunities:* Pharmacist's assistants bemoaned the lack of training opportunities for their cadre and cited it as another major reason for opting out of the profession. (Refer to the previous section on in-service training for more on this issue.)
- *Inefficient use of pharmacists' time to counsel patients on ARVs:* The time required of the pharmacist to counsel patients is time taken from other priorities and results in inefficient use of the pharmacist in facilities that have one. Although counseling patients on medicine use is central to the role of the pharmacist, this process can consume up to 30–45 minutes for people starting ART. With the expected increase in people seeking ART, it is impractical to expect the pharmacist to provide individual medicine counseling, especially when the foreign nationals, even if they speak English, require a translator. It is more cost-effective to allow the pharmacist to oversee the ART pharmacy, ensure accurate dispensing of medicines, and in the larger hospitals train other pharmacy staff on ART and train pharmacist's assistants to be effective medicine counselors.
- *Lack of a computerized data-tracking system, telephone, and transport:* The lack of supporting infrastructure in terms of computerized systems and telephone, as well as transport, has resulted in work overload and a poor use of the specialist skills of the pharmacist and the pharmacist's assistants who spend hours doing record keeping by hand. It also results in poor tracking of treatment defaulters.

The lack of computers and absence of training on a tracking software system for ART patients contributes to the ineffective use of pharmaceutical staff in the face of the rapidly increasing demand for services. Tracking ART patients and use of ARVs by hand is long and tedious and can contribute to long delays in tracking defaulters. Equally important in this regard is the availability of a telephone and transport to ensure that people who are defaulting on their treatment are investigated as quickly as possible. The lack of transport and telephone has also contributed to long work hours spent following up on patients.

- *Lack of organized partnerships with community volunteers:* Community volunteers are used to some extent to provide much-needed services, such as translation for foreign pharmacists and adherence support for patients, but volunteers by nature are not always reliable. A more organized system of contracting with community volunteers or organizations and using nonmonetary incentives could significantly expand the reliability of community capacity to provide needed ART support.
- *Leadership:* Finally, in a resource-poor environment, improved leadership and management are the keys to increased productivity. While we met many professional and committed health managers and pharmaceutical staff, improving leadership and human resources management can improve the workplace climate by ensuring more-equitable personnel policies and encouraging teamwork and collaboration.

GAPS THAT EXIST IN THE PROVISION OF HIV/AIDS SERVICES BY PHARMACISTS AND PHARMACIST'S ASSISTANTS

The MoHSS will face serious challenges in implementing the new plans because of staffing shortages. Currently, an alarming shortage of trained pharmacists and pharmacist's assistants exists at the 31 functioning sites. Of 193 pharmacists registered in Namibia, 89.7 percent are working in the private sector, leaving the public sector hospitals seriously handicapped. Of 48 established posts for pharmacists in the MoHSS, only 31 are filled. Of those, 5 are filled by Namibians while the rest are staffed by foreigners on contracts with the MoHSS or funded by donors. In addition to the current vacancy of 17 pharmacists' posts, the staffing levels for pharmacists recommended by the Model of Care for ART will require 26 more pharmacist's positions to be established.

The picture is somewhat more encouraging with the pharmacist's assistants' cadre, which has 80 established posts, 70 of them filled. These overall staffing gaps demand attention because the role of the pharmaceutical staff is essential to the success of the ART program. Their duties within the ART program include ensuring that the right medicines are available in sufficient quantities, counseling the patient on the proper use of the medication, monitoring adherence, and tracking defaulters—or people who begin ART and then stop. All of these activities are critical not only to save lives, but also to prevent resistance from developing and new strains of the AIDS virus being unleashed that could reverse all the gains that are currently being made.

In reviewing the following data, one should keep in mind that ART is a lifelong treatment. Although the highest demand on pharmacy services is in serving new patients, the need for services continues as long as a patient continues with ART. In other words, the demand for pharmacy services will continue to increase as more and more people begin treatment.

Current Vacancies Plus New Positions Needed

Table 2 illustrates the current established posts for pharmacists and pharmacist's assistants and the number of those posts that are vacant. The vacancies listed here are not all the MoHSS vacant posts but take into account staff employed by development partners working in the MoHSS. Approximately 18 of these positions are currently filled by pharmacists and pharmacist's assistants funded by CDC and USAID. In most of the regions, the only pharmacist (and correspondingly the only established post) is the regional pharmacist, who is not attached to any district hospital and cannot be counted as "available" for pharmacy services at the ART centers.

The last column summarizes the total number of pharmacists needed by 2008 in the 35 ART centers to be open by the end of 2005. It combines the current vacancies with new pharmacist's positions projected by MoHSS. These "new" positions are not currently in the staff establishment; that is, 18 of the established posts are vacant and 26 new posts need to be established, for a total of 44 pharmacists required to meet the existing targets for ART.

Table 3 records the actual number of people on ART at the facilities visited by the consultant team, compared to the regional targets for 2004 and 2008. Interestingly, in the majority of the cases, by January 2005 the regions are close to or surpass the targets projected for them by the end of 2004.

Table 2. Current Staffing Situation and Predicted Needs

Column title? Level/Region/Location??	Current Pharmacist Vacancies	Current Pharmacist's Assistant Vacancies	Current Regional Pharmacist Vacancies + ART Needs for Scaling Up
Central Level	3	0	3
Hospital Staff in Each Region			
Caprivi	0	0	2.2
Erongo	0	1	1.7
Hardap	0	1	0.5
Karas	0	1	0.8
Kavango	0	2	2.3
Komas	6	3	11.3
Kunene	0	1	0.3
Ohangwena	0	1	2
Omaheke	0	1	0.6
Omusati	0	2	2.9
Oshana	2	1	5.1
Oshikoto	0	0	2.2
Otjozondjupa	0	1	2.3
All Medical Stores	3	0	3
Regional Management Teams	4	0	4
Totals	18	15	44.2

Table 3. Numbers of Current and Projected ART Patients

Hospital or Region	Facility	Region	Region
	Current ART Patients from January 2005 Visit	Projected Patients on ART by 2004	Projected Patients on ART by 2008
Onandjokwe LMS	350		
Oshikoto		446	2,232
Engela DH	246		
Ohangwena		0	2,026
Oshakati IH	2,570		
Oshana		590	2,951
Otjiwarongo DH	150		
Okakarara DH	0		
Otjozondjupa		0	1,854
Omusati		571	2,213
Omaheke		0	506
Kunene		0	267
Katutura IH	1,200		
Windhoek Central	0		
Khomas		1,049	4,181
Kavango		466	2,334
Karas		156	783
Hardap		91	459
Omaruru DH	12		
Erongo		328	1,643
Caprivi		440	2,203

Notes: DH = District Hospital; IH = Intermediate Hospital; LMS = Lutheran Medical Services

Staff Death and Illness Caused by HIV/AIDS

Accurate data are hard to obtain on how HIV/AIDS affects the health of the workforce, but statistics gathered by the MoHSS indicate a 50 percent increase in the number of deaths in the last year. One can assume that many of those deaths are related to HIV/AIDS. In addition, the number of losses has more than doubled from one year to the next, with the biggest jump in “resignations” (see Table 4). If this trend is consistent, it should be considered when planning for the next five years.

Table 4. Summary of Staff Losses by Reason, 2002/03 and 2003/04

Reason	Financial Year 2003/04		Financial Year 2002/03	
	Number of Staff	Percentage of Total Staff Losses	Number of Staff	Percentage of Total Staff Losses
Resignations	224	42.5	82	35.3
Death	93	18	63	26
Retirement	65	12.3	38	16
Transfer to other government unit	92	17.5	28	12
Medical discharge	35	6.6	11	5
Dismissal	18	3.4	12	2.1
Total	527	100*	234	100*

Sources: MoHSS Division of Human Resources Development (HRD), Director of Policy, Planning, and HRD, *Annual Report*, July 2004.

* Numbers may not add to 100 percent due to rounding.

The Central Medical Stores

The Central Medical Stores (CMS) forms a vital link in the ART chain that prevents disruption of treatment. The CMS and the Oshakati Regional Medical Store (RMS) are not immune to the staffing issues that are facing the ART sites. These facilities are facing the same challenges in filling vacant positions for pharmacist and pharmacist's assistant (Oshakati RMS has a 45 percent vacancy rate). All systems and procedures are only as good as those who operate them, and having a strong team at the CMS and RMS that is well trained to manage the procurement and distribution of medicines is critically important.

The general level of established posts at these facilities appears adequate, although there are critical vacancies. As with other health units, the majority of the pharmacist's positions are filled by foreigners on two-year contracts. In addition, management problems clearly exist at each of these facilities. Procurement and inventory systems are not adhered to on a regular basis: stock records are not maintained, and invoices are currently not produced at all at Oshakati RMS. The overall organization of work should be reviewed because staff members appeared to be sitting around in between deliveries and other staff members were unclear about their roles. Such issues lead to a lack of productivity and teamwork.

SHORT- AND LONG-TERM RECOMMENDATIONS TO ADDRESS THE ISSUES

Filling Staffing Gaps

Short-Term Recommendations

Training Namibian Pharmacists

It is well recognized that Namibia needs to train more pharmacists, but currently only two or three government-subsidized pharmacists graduate each year. The number of pharmacists who train without support from GRN is hard to determine but appears to be very low. Although producing additional Namibian-trained pharmacists is a long-term process, an immediate and vigorous campaign should be undertaken to identify strong candidates from among school leavers and increase the number of bursaries offered to them.

Develop a marketing campaign: An outside marketing firm could be hired to work with the Division of Pharmaceutical Services, the Pharmaceutical Society, the Division of Human Resources Development (HRD), and the Information, Education, and Communication Department to plan the campaign to enroll more students in the pharmacy program. Likely candidates and their families would be contacted directly by a member of the marketing committee and provided with information about the positive benefits of a career in pharmacy and the availability of a bursary.

Provide full bursaries: The awarding of a full bursary, or grant, would act as a strong incentive. This campaign could be based on a partnership with the private sector, and corporations could be enlisted to support a candidate in their corporate name. The Pharmaceutical Society already provides partial fellowships of NAD 10,000 to students who want to pursue a career in pharmacy, and the society's help could be enlisted in the campaign to recruit new sponsors.

Institute mandatory community service: Along with this campaign to rapidly increase the number of Namibian students in pharmacy programs, a review of mechanisms to ensure that the graduating pharmacists commit to serving in the public sector for at least two years is recommended. Bonding is not always a mechanism that can be enforced. In some countries, withholding the "credential" or final registration until the individual has completed two years of mandatory community service has worked well.

Allow part-time employment: MoHSS is encouraged to consider reinstating the option of part-time employment. Some anecdotal evidence suggests that there are trained pharmacists in the community who would be interested in part-time employment.

Contracting Foreign Pharmacists

Although the MoHHS and donors have done much to attract foreign pharmacists, it is recommended that this effort be increased and centrally monitored to meet the needs of ART

scale-up. MoHSS and CDC estimate that 26 additional pharmacists will be needed by 2008 to address the HIV/AIDS crisis.

Realistically, the country will need to depend on foreign nationals to fill pharmacy posts for an estimated 20–30 years, depending on the number of Namibian pharmacists that are trained. If the government can increase the number of graduates to 10 per year, then the MoHSS can expect to have an adequate supply of Namibian pharmacists by 2035. If the number of graduates can be increased to 20 per year, the MoHSS can expect to meet this goal by 2025. (These figures take into account two years' compulsory community service with the MoHSS, and assume thereafter 75 percent of the pharmacists will move to the private sector.)

Strengthen recruitment strategy: Recruitment of foreign nationals tends to be faster and more effective if done in batches and assisted by an outside professional recruitment agency. MoHSS should target countries where trained pharmacists work at lower pay scales than those offered in Namibia, such as Egypt, Kenya, and Zimbabwe. Recruitment specialists should be contracted to travel to those countries and recruit directly on the ground as the regional competition for trained pharmacists increases. Namibia is a signatory to the Commonwealth Code of Practice for International Recruitment of Health Workers; therefore all strategies used to speed up recruitment of foreign nationals must abide by this code.

Training Pharmacist's Assistants

The added advantage of filling the vacant pharmacist's positions (discussed above) is that it increases the MoHSS capacity to train additional pharmacist's assistants and thus minimizes the existing shortages in that cadre as well.

Increase the number of pharmacist's assistants being trained: Assuming that some of the foreign-trained pharmacists can be accredited as tutors by the Namibian Pharmacy Council, then it is possible to consider restarting the pharmacist's assistant training program at Oshakati Hospital.

Increase the number of trainees that a pharmacist can supervise: Reconsider the existing rule that limits a pharmacist to supervising the practical training of only two pharmacist's assistants at a time. With a more-efficient use of pharmacists in the ART clinic, they could reasonably train at least three much-needed pharmacist's assistants.

Long-Term Recommendation

Strengthening science education at the secondary level is an imperative for the future sustainability of health professionals in Namibia. MoHSS and the two ministries concerned with education, including the Science Department at UNAM, should form a task force to develop strategies for improving science education. Such strategies could include introducing computers into the curriculum and science classrooms at the secondary level and creating grants to encourage creativity among science teachers.

Increasing Staff Retention

Short-Term Recommendations

Develop a career ladder for pharmacist's assistants: To develop a stronger career ladder for pharmacist's assistants, a new cadre of "pharmaceutical technician" should be developed as a third year of training for pharmacist's assistants that leads to a diploma. The additional year of training can be taken right after completion of the current two-year pharmacist's assistant program, or it can be pursued on its own at a later time. It is suggested that this additional year of training be provided by the National Health Training Centre and that the curriculum include courses in management, logistics, procurement, and more in-depth pharmacology.

The course content for the one-year course could include the following—

- Basic sciences (chemistry and microbiology)
- Medicines and the human body
- Advanced dispensing practice
- Health services management
- Quantitative methods and research
- Procurement (stock control)
- Logistics
- Legal environment

Provide bursaries for pharmacist's technicians to train for pharmacy: It is strongly recommended that one or two bursaries or grants be designated for pharmacist's assistants who want to study to become pharmacists.

Approve locums between public and private sector: The MoHSS is encouraged to continue working on a policy to allow public sector pharmacists to do locums in the private sector and also to allow private sector pharmacists to do locums in the public sector.

Implement an HIV/AIDS workplace prevention program: The MoHSS, with input from the Department of Personnel Management, should implement an HIV/AIDS workplace policy and awareness program as quickly as possible to reduce the number of staff members who become infected.

Long-Term Recommendation

Conduct periodic salary reviews: In order to ensure that the gap in salary between the public and private sector does not increase, the MoHSS should conduct periodic salary reviews and address gaps that are seen to have become a barrier to retaining pharmacists and pharmacist's assistants in the public sector.

Enhancing Staff Performance

Short-Term Recommendations

Develop cost-effective translation services: Identify the most effective option for providing translation support to English-speaking foreign pharmacists. Options may include use of volunteers or better use of counselors and pharmacist's assistants.

Provide intensive English-language training: Provide more-intensive English-language training to Cuban pharmacists. It is worth the time and investment to ensure that these volunteers have the language skills to enable them to achieve their full potential and hence contribute fully to providing pharmaceutical services.

Install computer tracking systems: Install computerized tracking systems in all ART sites in order to minimize the time spent on these tasks by skilled professionals and paraprofessionals.

Adjust job descriptions for pharmacists: Consider rewriting the job description for pharmacists who staff ART clinics to minimize the responsibility for providing medicine counseling. In many facilities this function is already being carried out by pharmacist's assistants who have the needed language skills.

Develop formal partnerships with community volunteers: Enlist the assistance of the District Coordinating Committees to develop formal partnerships with community groups who can assume much-needed roles at the ART clinic and the hospital, such as handling routine tasks on the wards to free doctors, nurses, and pharmacists to concentrate more fully on HIV/AIDS; and "partnering" with people in their community on ART to ensure adherence and regular appointments with the clinic for follow-up.

Develop leadership skills: Provide leadership development programs for managers at all levels.

Long-Term Recommendation

Strengthen and modernize human resources management: Assess the HRM system at the facility level and take steps to develop more-streamlined procedures and a supportive approach to managing staff. This improvement could decrease the current long delays in promotion, transfer, and career opportunity and ensure a performance management system that addresses inadequate performance and acknowledges good performance.

Providing In-Service Training

Short-Term Recommendations

Provide and use technology: Installing Internet facilities in all district hospitals will enhance learning and the exchange of information. Technology can also be used to produce and provide job aids and kits for health staff that would help reinforce continuous learning.

Update the organization of in-service training: Review the organization of in-service training to make it more sensitive toward the work schedules of pharmacist's assistants and the geographical spread of hospitals, as well as to improve the link between training and practice.

Develop new curriculum: Introduce an annual best practices refresher program for pharmacists and pharmacist's assistants. The program could also address the management and supervisory skills needed by pharmacists and pharmacist's assistants. Two separate programs could be mounted, one for pharmacists and the other for pharmacist's assistants.

Promote learning exchange: Mount other shorter programs at the Regional Health Training Centres that are aimed at enhancing sharing of knowledge and experiences among pharmacists and pharmacist's assistants based in that area.

Long-Term Recommendation

As a long-term measure, the MoHSS should introduce distance learning and computer-aided instruction to its in-service training capacity.

Strengthening Medical Stores

Short-Term Recommendations

Strengthen management systems: In general, stronger management systems should be put in place at the medical stores. Pharmacists are certainly needed to ensure that the right medicines get purchased, stored, and distributed, but the nature of the work of these facilities also requires a strong management hand.

Review staffing structure: The time allocated for the assessment was insufficient to allow an in-depth review of the staffing of the various medical stores. Therefore, it would not be appropriate to make concrete recommendations here on an ideal staff structure. However, the current Rational Pharmaceutical Management (RPM) Plus project support to Pharmaceutical Services includes reviewing the current medical stores staffing and making recommendations for changes to strengthen the medical supplies system. Discussions on this matter have already started and we therefore recommend that the outcome of these discussions be referred to when considering HCD needs for medical stores.

IMPLEMENTATION STRATEGY AND ACTION PLAN

HR Task Force for the Pharmaceutical Sector

It is unreasonable to expect that the Division of HRD, the Division of HRM, and the Public Service Commission have the capacity to pay special attention to tracking the status of vacancies in positions for pharmacists and pharmacist's assistants or to contracting with foreign nationals. Nevertheless, it is reasonable to expect that an HR Task Force could focus on these critical cadres and alert the established hiring authorities when critical action must be taken to ensure that ART clinics do not suffer a setback. This task force can also help ensure that adequate numbers of new students are being identified and prepared for training.

We suggest that this task force be small but include representatives from the Directorate of Special Programs; the Department of Policy, Planning, and Human Resources Development; the Department of Public Service Management; the Ministry of Health Office of Personnel Administration; the Public Service Commission; the National Health Training Centre; the University of Namibia Pre-Pharmacy Program; and the Pharmaceutical Society of Namibia. The task force should make it a routine practice to consult with the Regional Pharmacists on the status of their efforts to strengthen pharmaceutical services nationally.

Approach to Implementation

In view of the various recommendations made under this assessment, a practical approach to implementation will be necessary. It should be based on the comprehensiveness of the recommendations and take into account the players that need to be involved in facilitating successful implementation.

Key Steps in the Implementation Process

Table 5 outlines the key steps to be undertaken in implementing all the approved recommendations.

Table 5. Key Steps in Implementing Recommendations

Task	Responsible Officer	Time
Establish an HR Task Force for the pharmaceutical sector	Director for Tertiary Health Care and Clinical Support Services	Immediately after acceptance of the report by MoHSS
Prepare a draft prioritized, costed implementation plan/schedule	ART/Pharmaceutical Human Resources Committee	To be determined
Review the implementation plan/schedule	Policy Management Development and Review Committee and the Ministry Management Committee	To be determined
Prepare a final implementation schedule based on priorities set by the MoHSS Policy Management Development and Review Committee	ART/Pharmaceutical Human Resources Committee	To be determined

Key Success Factors

Successful implementation of the various recommendations will largely depend on the creation of an enabling environment. Such an enabling environment would be facilitated by a number of factors, including the following—

- Senior management commitment and support: At this level, a need exists for shared vision in terms of achieving the objectives for which the assessment was commissioned. Commitment and support at this level must be expressed in three ways: by initiating change, by providing resources, and by monitoring progress.
- Responsive monitoring, review, and evaluation: Feedback to the HR Task Force on the implementation of the various recommendations will be necessary to make whatever adjustments may be deemed necessary.

HUMAN CAPACITY DEVELOPMENT FRAMEWORK

The HCD consultant team used the HCD Framework as an approach for capturing the recommendations made in this report. The HCD Framework, developed in partnership with USAID, is based on the understanding that an integrated and comprehensive response is needed to address the global priority of human capacity development. The framework provides a pathway for governments and health ministers to address human capacity development in a sustained way through a multisectoral approach that addresses barriers to HCD in four relevant components: policy and financial requirements, human resources management, partnerships, and leadership.

Component	Goal	Factors That Affect Achievement of the Goal
Policy and financial requirements	Multisectoral collaboration streamlines the employment process in government, and appropriate human resource policies and plans support HCD.	<ul style="list-style-type: none"> • Health expenditures • Salary structures • National civil service rules • Government policies and structure for HRM (such as centralized hiring and firing) • Incentives to prevent migration of health staff • Authorized scopes of practice for health cadres (categories of health workers, such as laboratory technicians)
Human resources management	HRM systems are in place that result in adequate and timely staffing, staff retention, teamwork, and good performance.	<ul style="list-style-type: none"> • HRM capacity in health facilities, local governments, and local health offices • Personnel systems: planning, recruitment, hiring, transfer, promotion, firing • Staff retention strategies • Training • Human resources information systems • Workplace programs for HIV prevention
Partnerships	Planned linkages among sectors; districts; and nongovernmental, community, and religious organizations increase human capacity.	<ul style="list-style-type: none"> • Number and types of linkages among the public sector, private sector, and community networks • Collaboration between the MoHSS and ministries of finance and education
Leadership	Managers at all levels demonstrate that they value health workers and provide staff with leadership to face challenges and achieve results.	<ul style="list-style-type: none"> • Visionary leadership • Advocacy for reform of human resources policies • Leadership development for managers at all levels

ANNEX 1. SCOPE OF WORK

Scope of Work

Human Capacity Development (HCD) Assessment of Namibia Pharmaceutical Services to Support the Scale up of HIV/AIDS programs

Consultants: **Mary O’Neil**, Senior Program Officer, Management and Leadership Program, Management Sciences for Health, USA
Elena Beatriz Decima, Senior Program Officer, Management and Leadership Program, Management Sciences for Health, USA
Justin W. Nyondo, Managing Partner with Management International, Malawi

Level of Effort: Up to a maximum of two months

Consultancy Period: January–February 2005

Purpose of HR Assessment:

This assessment is the first comprehensive and logical step that is necessary to assess, identify, and implement both short-term and long-term solutions to the shortage of pharmacists and pharmacist’s assistants in scaling up HIV/AIDS services including treatment programs in Namibia’s national health system. This assessment is funded through the President’s Emergency Plan for AIDS Relief and therefore it examines primarily the level of need for practicing pharmacists and pharmacist’s assistants within Namibia for achieving and maintaining an expanded response to HIV/AIDS that will achieve the 2-7-10 targets under the Emergency Plan and the goals of the republic of Namibia Third Medium Term Strategy MTP III for HIV/AIDS

This assessment is based on three components:

1. HR pharmaceutical personnel capacity to scale up HIV/AIDS programs and services
2. HRM systems capacity to absorb, train, supervise, and retain pharmacy staff
3. National capacity to train pharmacists and pharmacists’ assistants and adapt curricula to include HIV/AIDS, leadership and management

Objectives:

1. To verify number of health staff needed in the health sector to scale-up HIV/AIDS programs, with particular emphasis on human resources for pharmaceutical management of HIV/AIDS-related pharmaceuticals, and identify key issues around staffing shortages (i.e., attrition, vacancy rates, turnover, motivation etc).
2. To assess the HRM system capacity of the Ministry of Health sites to adequately staff HIV/AIDS programs, retain staff, absorb and train new and existing pharmaceutical personnel and contribute to the overall productivity of the system.
3. To assess the capacity of the MOHSS in-service training program to increase quality, planning, and standardization of training activities.
4. To assess the capacity of the pre-service training institutions to respond to staffing and training issues in pharmacy.

Context and Background

Shortages of health workers, especially pharmacists and pharmacists’ assistants and weak human resource capacity are repeatedly assessed as the biggest constraint to service provision in the health sector. Chronic

under funding, coupled with weak management and better incentives in the private sector and in other countries, contribute to health workers moving gradually out of the public sector. HIV/AIDS has also taken a direct toll on the public workforce and contributed to deteriorating working conditions. Various initiatives have been developed in Namibia to scale-up programs to control major killing diseases and strengthen the health sector and Government response. Successful implementation of such initiatives will greatly depend on the capacity of the Government to ensure adequate numbers of trained pharmaceutical personnel and appropriate management.

This assessment and the recommendations it will produce is viewed as the first step toward strengthening the capacity of pharmaceutical personnel for the scale-up of HIV/AIDS. The next step will include coming to agreement on which recommendations to implement and followed by implementation of these recommendations. While this assessment is focused on the scale-up of HIV/AIDS services, it is understood that improvements in the management of human resources within the Namibia health system will benefit the delivery of health services in general.

Similar to other countries, human resource capacity development and management are crucial and sensitive issues in Namibia. In order to be successful,

- This assessment needs to reflect a consensus among the main stakeholders and therefore should not be restricted to an MSH/RPM Plus initiative.
- Similarly the full involvement and leadership from the Ministry of Health and Social Services is fundamental so that the recommendations of the assessment be endorsed and enforced. The Ministries of Finance, Education and Home Affairs, as well as the Public Service Commission will also need to be strongly involved.

Tasks

Planning and Preparation Phase

A first step in this assignment will be to appoint a Human Capacity Development (HCD) Technical Working Group composed of representatives from the MoHSS and RPM Plus Namibia, by the MoHSS in collaboration with RPM Plus Namibia and USAID Namibia. The HCD TWG's mandate would be to approve the SOW and guide and monitor the consultants during their work. The HCD TWG would play a fundamental role in advocating and helping to implement the recommendations of the assessment. Having most stakeholders and partners on board will ensure that the strategies and recommendations are owned by all parties and given the highest priority by all.

1. The Namibia HCD TWG will need to undertake the following preparatory activities:
 - Circulate and discuss the SOW with critical mass of stakeholders to ensure agreement and clarity on expected outputs.
 - Identify 'chief client', institutional home or holder of the HR Assessment in Namibia and ensure they are adequately aligned and engaged.
 - Identify local individual who will be available to work alongside the technical consultants throughout the assessment period. The team will be required to assist in identifying relevant sources of HR policy and data; decide on sample of health facilities and educational institutions to be targeted in the assessment, develop a schedule of visits and contribute to final report. HR, logistics and costing skills are helpful on this team.
2. Review list of relevant documents and reports for the health sector that describe, human resource management (pay management, performance appraisal), training strategies and plans, institutional development, public sector reform, public private mix relationship (regulation, outsourcing of services, contractual arrangements and agency) etc. existing in-country for the last 3 to 5 years and

prepare a bibliography together with a critical review that highlights areas which need to be further assessed and where there are gaps in information.

3. Review existing data on human resources in health with an emphasis on pharmaceutical personnel needed to implement HIV/AIDS strategy.
4. Review staffing norms, job descriptions, responsibilities, relationships and availabilities of personnel for the management of HIV/AIDS-related pharmaceuticals and services.

Assessment Phase

The following activities are illustrative of tasks to be undertaken by the consultant team during the assessment phase:

1. Review all relevant HR data and pre-service statistics.
2. Review HIV/AIDS operational strategy and identify the numbers and types of cadres required to implement it.
3. Using a participatory tool/instrument with questions, conduct interviews with health staff, especially those linked to pharmacy.
4. Hold meetings and focus group discussions with a diverse range of HR stakeholders in all sectors of the national health system
5. Meet with selected training institutions and interview managers and faculty.
6. Use the “HCD framework” to assess and analyze data collected in the assessment
7. Formulate both short and long term recommendations and cost elements that require costing
8. De-brief draft findings and recommendations with stakeholders agreed to in advance.

Outputs:

The main outputs of this assignment will be—

- A comprehensive report clearly outlining the current HR situation in regard to pharmacists, pharmacists’ assistants, HR constraints, and gaps that exist in the provision of HIV/AIDS services and a set of short and long term recommendations to address issues. A bibliography together with a critical review on documents existing in HCD and human resource management will be included as an appendix, along with ‘maps or graphs’ with closest approximations on numbers and trends of the existing human resources for managing HIV/AIDS programs.
- Specific recommendations for competencies required, staffing norms, job descriptions, responsibilities, and relationships for the management of HIV/AIDS-related pharmaceuticals and services.

Follow-up:

Following the assessment, the MoHSS, MSH RPM Plus, MSH M&L, USAID Namibia, and other key stakeholders will review the recommendations and make decisions on those recommendations that constitute a priority for immediate action, and those recommendations that are a priority to be addressed in order to achieve long term sustainability. This should lead to strategies as well as a plan of action and budget for the time frame 2005-2008 for the priority areas agreed to. An implementation plan and operational budget will then need to be developed and resources identified to implement it.

ANNEX 2. DOCUMENTS REVIEWED

MoHSS Policy—General

MoHSS Integrated Health Care Delivery: The Challenge of Implementation, January 1995

HIV/AIDS-Related Documents

MoHSS Guidelines for Anti-Retroviral Therapy—First Edition, April 2003

MoHSS Guidelines for Prevention of Mother-to-Child Transmission in Namibia, December 2004

MoHSS Postexposure Prophylaxis Guidelines, 2004

National Strategic Plan on HIV/AIDS, Medium Term Plan III, 2004–2009

MoHSS HIV/AIDS Workplace Programme Plan, 2005–2006

Pharmaceutical Sector Strategic Documents

National Drug Policy

National Pharmaceutical Master Plan (1999–2004)

Review of Namibian National Pharmaceutical Master Plan, Workshop Report, August 2004

MoHSS, Division of Pharmaceutical Services, *Annual Report 2003/04*

MoHSS, Division of Pharmaceutical Services, *Annual Plan 2004/05 and 2005/06*

Aboagye-Nyame, Francis, Akhlaghi, Laila, Dias, Vimal. 2003. *An Assessment of the Public Sector Drug Supply System of the Republic of Namibia*. Submitted to the U.S. Agency for International Development by the Rational Pharmaceutical Management Plus Program. Arlington, VA: Management Sciences for Health.

Pharmacy Staffing in Namibia

Summary of Pharmaceutical Services Staffing: MoHSS, January 2005

Pharmaceutical Services Staff Establishment, June 2002

Staff Establishment of Pharmacists, October 2000

Job Descriptions: Regional & Hospital Pharmacists & Pharmacist's Assistants

Salaries for MoHSS Pharmacy Staff, 2004

Extract of Pharmacy Register, September 2004

Staffing Needs

MoHSS, Development of Indicator of Staffing Needs for Health Facilities, 1997

Directorate of Special Programmes, Proposal for Staffing Needs to Meet WHO 3x5 Goal, December 2003 (Excel sheets)

MoHSS Human Resources Development

MoHSS Human Resources Development Annual Report of financial year 2001/2002

MoHSS Human Resources Development Annual Report of financial year 2003/2004

Draft HR Plan situation analysis report

MoHSS, Division of Human Resources Development, Five-year strategic plan for Human Resources 2000–2005

DRAFT Strategic Human Resources Plan for Namibia 2000–2010, July 2000

ANNEX 3. PEOPLE INTERVIEWED

Ministry of Health and Social Services, Head Office

Dr. Shangula, Permanent Secretary
Dr. Forster, Under Secretary: Health & Social Welfare Policy
Mr. Platt, Acting Under Secretary: Policy Development & Resource Management
Mrs. D. J. Tjipura-Tjiho, Acting Director: Tertiary Health Care & Clinical Support Services
Mr. J. Gaeseb, Acting Deputy Director: Pharmaceutical Services
Mr. G. Habimana, Chief Pharmacist: Central Medical Stores
Ms. C. Usiku, Deputy Director: Human Resource Development
Mrs. L. Nashixwa, Deputy Director: Human Resource Management
Dr. T. Kenyon, Country Director CDC representing Dr. Goraseb, Deputy Director: Special Programs
Mrs. M. Mushimba, Acting Director: (Primary Health Care), Head of Division Disability Prevention and Rehabilitation

Ministry of Health and Social Services, Regions and Hospitals

Windhoek Central Hospital

Mr. Joseph Rushubiza, Chief Pharmacist: Windhoek Central Hospital

Katutura Intermediate Hospital

Mr. F. Mbikayi, Pharmacist in Charge
Mr. Akufuna Inyambo, Pharmacist's Assistant
Ms. Yolaine Celpedes, Cuban pharmacist
Ms. Gwendoline Tenga, ART pharmacist

Omaruru District Hospital

Dr. Fred M. Chulu, Acting Principal Medical Officer (PMO) ("taking care of position")
Mrs. F.C. Mapenzi, Pharmacist's Assistant
Mr. J. Kamorga, Control Officer
Ms. L. V. Tjijenda, PHC supervisor
Ms. W. P. Mutawamo, PRN
Dr. I. Zulu, Medical Officer (M.O.) in charge of ART

Otjiwarongo District Hospital

Dr. T. Zaranyka, Acting PMO
Ms. Emilia T. Nangombe, Senior Pharmacist's Assistant
Mr. Thomas Lazarus, RN ART counselor
Mr. Franz Kaluttoni, RN ART counselor
Ms. Ixlilma Kosmos, Chief registered nurse (RN)
Dr. J. Ambayi, M.O. ART doctor
Mrs. C. Kuhanga, Principal RN (PRN)

Otjozondjupa Regional Management Team

Dr. Laura Brandt, Chief Medical Officer
Mr. William Ndyetabula, Regional Pharmacist
Ms. Olita Tauya, Personnel officer

Okakarara District Hospital

Mr. I. Sheehama, PRN (Acting District Coordinating Committee Chair & Matron)

Dr. Nhau, Medical Doctor
Ms. Angelica Muti, Pharmacist's Assistant
Mr. F. Mukendwa, RN
Mr. S. Tjituri, Social Worker/HIV counselor
Ms. A. Nakambunda, PRN (PHC Supervisor)

Onandjokwe Lutheran Hospital

Dr. Petrov, Principal Medical Officer
Mrs. E. Despaigne Torres, Pharmacist
Mr. Emmanuel Passura, Pharmacist
Mr. Nader Ayoub, Pharmacist
Mr. Kefas Hamakali, Senior Pharmacist's Assistant
Mr. Josef Shivute, Pharmacist's Assistant
Mr. Zach Stednick, U.S. Peace Corps volunteer (assists with computerized record keeping/monitoring in highly active antiretroviral therapy program)
Mrs. Barbara Matengu, Regional Pharmacist, Oshikoto Region (MoHSS)

Engela District Hospital

Miller Nyandiwa, Pharmacist (ARV)
Dr A.A. Alagba, PMO
Juliet Bulemela, Regional Pharmacist, Ohangwena Region

Oshakati Intermediate Hospital

Dr. K. V. Amutenya, Senior Medical Superintendent
Dr. D. W. Dennar, Chief Medical Officer
Ms. R. Shitaleni, Pharmacist in Charge
Ms. M. Tshimweetheleni, Senior Personnel Officer
Dr. G. Mafara, ART MO
Mr. Greatjoy Mazibuko, ART Pharmacist
Ms. Beata Johannes, ART Pharmacist's Assistant
Ms. Anna Amupanda, ART Data Clerk

Oshakati Medical Stores

Mr. Msafiri F. Kweba, Chief Pharmacist: Oshana Region

Ministry of Health and Social Services, Training Institutions

National Health Training Centre

Ms. L. Hiskia, Acting Head
Ms. N. McGarry, Pharmacist's Assistants' Training Course Coordinator
Mr. C. Weyulu, Senior Programme Administrator: Continuous Education

Otjiwarongo Regional Health Training Centre

Ms. Agatha Kuthedze, Senior Health Programme Administrator: Continuous Education

Oshakati Regional Health Training Centre

M. K. N. Uusiku, Senior Health Programme Administrator, Functional Head

Other Organizations

Catholic Health Services

Sister Otilie Kutenda, Head
Ms. Patricia Götz, Chief Pharmacist
Mr. Christian Volkmar, Director of Administration

Mediclinic Hospital

Mr. Sherif Moustafa, Pharmacy Manager

Management Sciences for Health, Rational Pharmaceutical Management Plus Program, Namibia

Jude Nwokike, Country Team Leader
Dawn Pereko, Senior Program Associate
Ruusa Iita, Office Manager
Senorita //Gowases, Administrative Assistant

Office of the Prime Minister, Department Public Service Management

Mr. A. Kessler, Director: HRM
Mr. C. C. Tjikusere, CPSA: HRM
Mr. M. Andreas, HIV Unit OPM
Mr. H. Marenga, Policy Analysis, HIV/AIDS unit
Ms. E. Gawas, Liaison Office

Pharmaceutical Society of Namibia

Secretary: Mrs. Karen Brockmann

United States Agency for International Development

Kirk Lazell
Cathy Thompson
Lahya Shiimi
Madaline Feinberg
Christophina Amakali

University of Namibia

Dean of Science: Professor E. Kirem

