Health Workforce "Innovative Approaches and Promising Practices" Study

Strategy for the Rapid Start-up of the HIV/AIDS Program in Namibia: Outsourcing the Recruitment and Management of Human Resources for Health

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Acronyms

ART	Antiretroviral Therapy
ARV	Antiretroviral
CC	Community Counselors
CDC	Centers for Disease Control and Prevention
CHS	Catholic Health Services
FBO	Faith-Based Organization
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HR	Human Resources
HRD	Human Resources Development
HRH	Human Resources for Health
HRM	Human Resources Management
HRP	Human Resources Provider
I-TECH	International Training and Education Center on HIV
LMS	Lutheran Medical Services
MC	Management Contract
MOHSS	Ministry of Health and Social Services
MOU	Memorandum of Understanding
MSH	Management Sciences for Health
NEDICO	New Dimensions Consultancy
NIP	Namibia Institute of Pathology Ltd.
NRCS	Namibia Red Cross Society
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother-to-Child Transmission
PSC	Public Service Commission
RPM Plus	Rational Pharmaceutical Management Plus
SDC	Service Delivery Contract
UNAM	University of Namibia
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing

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Executive Summary

In response to the HIV/AIDS crisis, Namibia's public health sector is carrying out a comprehensive strategy to rapidly hire and deploy professional and non-professional health workers with the aim of providing comprehensive care, counseling and testing, as well as antiretroviral therapy (ART) and prevention of mother-to-child transmission (PMTCT).

The primary goal is to provide ART to as many as possible of the 210,000 people living with HIV in Namibia by creating new positions that will cover all 13 regions of the country, including all 35 public hospitals. The Ministry of Health and Social Services (MOHSS) realizes that the usual government recruitment procedure is slow and that severe staff shortages in current positions mean that no one is available to be redeployed.

The MOHSS, in collaboration with the Centers for Disease Control and Prevention (CDC) and USAID/Namibia, has therefore initiated a mix of contractual arrangements resulting in the rapid hiring and deployment of more than 500 health and non-health workers over a two-year period through support from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). By mid-2006, these workers were providing ART in the public sector to 26,000 people, compared with 500 people in 2004.

The key innovations and promising practices are:

- Rapid recruitment of health and non-health workers through a variety of contractual arrangements with multiple organizations, covering management and service delivery as needed. A key feature is a management contract with a local human resources provider (HRP) from the private sector for recruitment and human resources (HR) management of health service providers and support staff assigned to MOHSS health facilities.
- Harmonization of salaries of all workers hired through CDC and Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) mechanisms with MOHSS pay scales and benefits packages.
- Close coordination between the MOHSS and donors on hiring and deploying health service providers and lay health workers.

These approaches have been successful in a short time. Hiring and deploying so many staff, with minimal turnover for those recruited by the private sector HRP, is a major accomplishment and could not have been done through regular government recruitment. Providing ART services has undoubtedly saved many lives, and the government recognizes the need to integrate these services into the mainstream. This recruitment success is due in large part to the availability of foreign health service providers drawn to the attractive salary packages in Namibia and the country's economic and social stability.

One challenge to this approach to expanding service delivery is selecting the contractual arrangement that will make the health service provider most effective and ensure both contractor accountability and clarity of stakeholder roles. Arrangements include management contracts (with the HRP focusing only on hiring and human resources management), service delivery contracts (which include the HR and technical work) and ones combining management and service delivery. Each arrangement has pros and cons, and it is important to consider them carefully. Another challenge is ensuring the longer-term sustainability of these efforts. All of those interviewed agreed that outsourcing for human resources for health (HRH) through management contracts is a short-term solution and that it is critical to tackle longer-term solutions to Namibia's shortage of health workers.

Some of the long-term issues that Namibia faces are:

- A severe shortage of health professionals in its rural facilities
- A heavy reliance on foreign health professionals to fill positions, due in large part to lack of medical and pharmacy schools in the country, limited capacity to train nurses and an inadequate number of Namibians qualified to do the work or willing to serve outside urban areas
- The time it takes to recruit government workers through the Public Service Commission (PSC)
- Lack of staff and experience in the MOHSS Division of Human Resources Development (HRD).

For other countries in Africa wishing to emulate what Namibia has accomplished, the challenges are to:

- Identify an organization that can deliver the same level of service that the private sector Namibian HRP has provided
- Attract health providers from their own countries or from other countries with a competitive salary package
- Consider the pros and cons of outsourcing government services to the private sector when contract management capacity may be weak, choices may be limited and corruption may compromise the process
- Select the contractual arrangement, whether a management contract or a service delivery contract, that best fits the situation and ensures clarity of roles and accountability from all parties.

1. Introduction

The Namibian government has been cognizant for several years of the critical need to improve heath service delivery to all its 13 regions. The advent of the HIV/AIDS pandemic and the push for an ART program have made this need more urgent. In 2004, with the support of the CDC, the MOHSS developed a plan to use PEPFAR resources to ensure that by 2008 a total of 30,000 people with advanced HIV infection would receive ART from public- and private-sector providers. This number would represent about 50% of the people needing ART. By contrast, in the first quarter of 2004 only 500 people were receiving ART. The MOHSS and CDC, realizing that lives were at stake and that the regular hiring process would take too long, decided they needed to come up with innovative solutions.

One challenge was that there were no government-established positions for voluntary counseling and testing (VCT), ART and PMTCT. Establishing government positions is a lengthy process, requiring several steps. The MOHSS also lacks an adequate number of personnel with expertise who can work in conjunction with the PSC to meet the monumental human resources needs within the Ministry. Furthermore, it is not possible to use health workers from established positions, given the vacancy rates in the MOHSS. The gaps are even greater when taking needs into account. For example, there are 46 current pharmacist posts, with only 12 of those posts filled.

The following table shows current vacancy rates for established posts and vacancy rates once positions are added for the scaling up of ART.

	Vacancy rates for current posts	**Vacancy rates with ART posts added**
Chief medical officers	39%	50%
Nurses	3%	13%
Pharmacists	61%	78%
Pharmacist assistants	26%	63%

Setting up new positions and interacting with the PSC is made even more difficult by the lack of experience in the MOHSS Division of HRD. The two most senior staff recently retired in two successive years, leaving inexperienced staff in charge of the division.

Another challenge is the dearth of Namibian health professionals in the health system, particularly in rural, underserved areas. As a result, many health professionals serving in the MOHSS are from other countries. For example, 90% of MOHSS pharmacist positions are currently filled by foreigners.[1] This problem is compounded by Namibia's lack of any medical schools or institutions for training pharmacists. The University of Namibia (UNAM) offers pre-medical and pre-pharmacy programs, after which graduates pursue their studies in other countries, primarily South Africa. In addition, UNAM, which provides training to nurses, and the National Health Training Center, which trains pharmacist assistants, produce too few graduates to meet the demand.

RPM Plus Program. Strengthening the pharmaceutical sector of Namibia to support the scale-up and expansion of HIV/AIDS programs: RPM Plus strategic plan 2004-2008. Submitted to USAID by the RPM Plus Program. Arlington, VA: Management Sciences for Health, 2006.

One reason for the personnel shortages is that not enough Namibian graduates of the secondary school system meet entrance requirements for pre-medical and pre-pharmacy programs. The failure to meet requirements may be blamed on secondary schools' insufficient numbers of math and science teachers. Recognizing this problem, the MOHSS is investing GFATM money in training secondary school teachers in math and science in nearby countries, such as Zimbabwe.

Another factor leading to shortages in HRH is the private sector's tendency to attract the few Namibian physicians graduating from medical schools abroad. In 2006, 18 medical school graduates returned from South Africa after going through the pre-medical program at the UNAM. However, there is no guarantee that they will serve in government positions. The Namibian government is addressing this concern through proposed regulations requiring a two-year internship and two years of rural service in exchange for scholarships. Even after these regulations take effect, it will take years before Namibian doctors can fill vacant government positions. The private sector also attracts Namibian nurses, pharmacists and laboratory technicians. These health professionals may consider public service, but the long waiting time for government positions discourages many of them, and they too turn to the private sector for employment.

There are, however, opportunities for the ART program in Namibia. Most African countries pay low salaries that lead many health professionals to look for employment outside their own countries. The MOHSS offers high salaries compared with most African countries, and Namibia offers a stable environment with good infrastructure. For example, in Kenya, a senior-level physician can earn US$2,500 per month. In Namibia, the same position can pay US$4,300 per month, plus generous monthly allowances for car and lodging. As a result, many health professionals from other countries are seeking work in Namibia. There are scores of unemployed nurses in Kenya; Namibia has been able to recruit nurses there, with over 100 nurses to have started work in Namibia. In Zimbabwe, the economic downturn has caused many people to seek employment elsewhere. In 2004, the CDC in Namibia had many job applicants, including physicians, nurses and other health professionals, most of them from Zimbabwe. The MOHSS and the CDC recognized that employing some of these applicants would make it possible to rapidly expand the ART program.

2. Presentation of the Promising Practice

2.1 Overview

The MOHSS, in collaboration with the CDC, opted for the outsourcing of recruitment and human resources management (HRM) functions with the aim of rapidly rolling out the ART and PMTCT programs, mainly in the underserved areas of the country. Their goal was to recruit and train staff in ART, PMTCT and VCT and assign them to dedicated facilities, many of them new, in order to ensure confidentiality for patients and focus on ART-related activities. These facilities are hospitals, health centers and clinics run by the MOHSS or faith-based organizations (FBOs).

This paper focuses mostly on the innovative approach to setting up a management contract with a private sector HRP. It includes other contractual arrangements because they provide a

comprehensive view of the management of the ART program and examples of contract options, including management, service delivery and blends.[2]

2.2 Activities to Implement the Promising Practice

In 2005 the CDC developed a Cooperative Agreement[3] with Potentia to provide human resources services. This agreement followed a one-year task order started in 2004 with Potentia through Family Health International for the same services.

The Cooperative Agreement clearly outlines the responsibilities of the various partners in this agreement, with the CDC undertaking the following:

- In collaboration with the MOHSS, identify hospital sites that need designated health professionals, to be provided by the HRP
- Provide technical assistance to contracted health professionals to build capacity for VCT, PMTCT and ART services
- Collaborate with the HRP in adapting to the Namibian context measures including but not limited to design, program materials, quality assurance, monitoring and evaluation and recommendations
- Monitor project performance and budget.

Potentia is responsible for the following:

- Advertising and recruiting for a short list of potential candidates for all identified positions, including physicians, nurses, pharmacists and data entry clerks
- Hiring professional staff
- Providing personnel support and human resources management
- Under the guidance of MOHSS and CDC staff, liaising with health facilities as personnel are assigned to promote smooth introductions of the professionals
- Ensuring that new recruits participate in appropriate training, maintaining performance evaluation records, providing assistance in disciplinary action in concert with the MOHSS and reporting results to the MOHSS/CDC
- At the beginning and end of their contracts, arranging relocation and travel assistance for foreign nationals and their dependents with the necessary documentation for repatriation, and arranging transportation for airport pick-up and departures.

In a Cooperative Agreement, CDC staff work in collaboration with counterparts in the partner agency on program activities, beyond routine grant monitoring.

Arrangements between Potentia and the Rational Pharmaceutical Management (RPM) Plus Program as well as I-TECH are similar. Potentia advertises for positions based on specifications from its client and develops a short list. The client conducts interviews with candidates and makes selection decisions, and Potentia manages the HR aspects, while the client is responsible

[2] For a useful reference on SDCs and MCs for HRH see Loevinsohn B, Harding A. Buying results? Contracting for health service delivery in developing countries. *Lancet*. 2005;366:676–81.
[3] Under Section 307 of the Public Health Service Act, [42 U.S.C. Section 2421], as amended.

for day-to-day technical supervision. The MSH RPM Plus and I-TECH projects pay these employees through Potentia.

Arrangements with FBOs are more standard in terms of the contractual setup, such as the service delivery contracts with Catholic Health Services (CHS) and Lutheran Medical Services (LMS), yet they are significant because FBOs now serve approximately 20% of all people on ARVs in Namibia. They also show that Namibia is not new to outsourcing arrangements, because these arrangements began in 2003, preceding the contract with Potentia by more than a year. In these service delivery contracts, CHS and LMS are responsible for recruitment, deployment, human resource management and technical supervision of each category of staff. The MOHSS pays the salaries, in this case with PEPFAR funds, and the Capacity Project provides financial management and medical technical assistance and support as well as training to ensure quality of ART and PMTCT services.

An example of an innovative service delivery contract is the arrangement between the Namibia Institute of Pathology (NIP), the MOHSS and CDC to recruit, train and deploy five medical technologists and five laboratory assistants. The NIP is a parastatal organization to the MOHSS that operates solely on a fee-for-service basis. It provides the MOHSS with a discount on laboratory services, subsidized by fees charged to its private-sector clients. In addition, NIP is creating its first position for a scientist, who will train on the job for two years with a CDC-seconded scientist. The NIP Board, which does not have to go through the PSC hiring process, is committed to creating establishment positions for every position that is donor-funded, in order to ensure that positions will continue after donor funding ends.

An arrangement with the Namibia Red Cross Society (NRCS) is a blend between a management contract and a service delivery contract. The arrangement with the MOHSS stipulates that the NRCS will participate in the recruitment of community counselors (CC), including interviewing. The NRCS is responsible for administering salaries, benefits and performance evaluation, as well as setting up a Technical Committee and reporting CCs' results. Therefore the NRCS is to be involved to some extent in the technical aspect of the CCs' work, while the MOHSS provides supervision through its nurse health workers. The NRCS plans to have 15 regional coordinators to provide support to CCs in areas such as stress management. All parties concerned are to ensure that CCs honor their agreement to serve for one year after their six-week training, and to participate in refresher training twice per year.

An arrangement with Lifeline/Childline Namibia to provide training to CCs, initially with PEPFAR funds through Family Health International and then through the Capacity Project, is a training-oriented service delivery contract. Until recently the organization provided training for CCs posted to MOHSS facilities, as well as CCs with faith-based organizations such as CHS, LMS and others. The former relationship ended recently, while the latter continues. In addition, Lifeline/Childline has its own counselors who work for a stipend.

The CDC also encouraged other projects funded under PEPFAR to use the same HRP. Both MSH in the RPM Plus project and I-TECH have used Potentia to hire 56 staff for the rapid start-up of their activities in Namibia, including 14 pharmacy staff for the former and 42 staff, mostly clinical tutors, for the latter. These arrangements are in close coordination with the MOHSS, most often governed by a Memorandum of Understanding (MOU) that clearly describes the roles and responsibilities of each party.

Key characteristics of the contractual arrangements:

Parties in Contract	Type of Contract	Recruitment	HR Management	Supervision	Technical Assistance
CDC and Potentia	MC	Potentia	Potentia	Potentia and MOHSS	CDC
MOHSS and CHS	SDC	CHS	Capacity Project	CHS	Capacity Project
MOHSS and LMS	SDC	LMS	Capacity Project	LMS	Capacity Project
MOHSS and NRCS	Blend of MC and SDC	MOHSS and NRCS	NRCS	NRCS and MOHSS	NRCS, MOHSS and CDC
MOHSS and Lifeline/Childline	Blend of MC and SDC	MOHSS and Lifeline/Childline	Lifeline/Childline	MOHSS	Lifeline/ Childline
MOHSS, CDC and NIP	SDC	NIP	NIP	NIP	CDC
RPM Plus and Potentia	MC	Potentia	Potentia	RPM Plus	RPM Plus
I-TECH and Potentia	MC	Potentia	Potentia	I-TECH	I-TECH

In addition to its collaboration with the CDC, the MOHSS is working with the GFATM to hire 45 staff through New Dimensions Consultancy (NEDICO), a local project management firm. Similar arrangements started in 2003 with the Mapilelo Programme in the Caprivi, where the MOHSS entered into an agreement with NEDICO to manage outcomes, including management of human resources. This program is supported by Bristol Myers Squibb Foundation. Furthermore, in 2005, the GFATM Round 2 program in Namibia adopted a similar approach through outsourcing the hiring of medical and other personnel to simultaneously increase coverage and quality of the ART program, drawing on lessons learned from the initial public-private arrangement with Potentia.

3. Achieved Results

3.1 Summary

The hiring and deployment of more than 500 health and non-health professionals for the ART program from 2004 through 2006 has contributed to raising the MOHSS's goal of 30,000 people receiving ART by 2008. By July 2006, 26,000 people were receiving ART, and the goal has been raised to 70,000 by 2008, which is expected to represent nearly 70% of those projected to be in need of ART by that time.[4] The mechanisms that the MOHSS and CDC used to rapidly expand HRH hiring are:

- The management contract[5] with Potentia, resulting in the hiring of 85 health professionals and 19 support staff from October 2004 through June 2006 at 24 sites.

[4] Ministry of Health and Social Services, Republic of Namibia. Namibian HIV/AIDS situation and gap analysis executive summary. Windhoek, Namibia: Ministry of Health and Social Services, 2006.

[5] These contractual arrangements have different names such as the Cooperative Agreement with the CDC. The use of the terms management contract or service delivery contract is intended to describe the typology referred to in HRH literature that makes it possible to compare and contrast these arrangements.

Another 12 are in the pipeline, six in each of the two categories. There is low turnover, with only three of 100 of those recruited having left over the first 20 months of operation.

- The service delivery contract with CHS to add ART services to four of its health facilities, resulting in 75 new staff, including 28 health professionals, 20 counselors (full-time equivalent), eight administrators/accountants plus support staff; and the service delivery contract with Lutheran Medical Services (LMS) for 30 new staff in one facility, including 14 health professionals, eight counselors and eight support staff, all within a span of two and a half years.

- In the service delivery contract with NIP, two medical technologists have been deployed and the rest are undergoing training and are to be deployed within two years, which will make it possible to reach the goal of five medical technologists and five laboratory assistants in that period of time. The NIP is also on track to set up its first scientist position.

- The management contract between MOHSS and the NRCS, resulting in the hiring, training and deployment of 174 lay health workers as CCs, with another 325 to be in the pipeline by the end of 2007. From April 2005 to April 2006 the turnover was only 6.4%. There are many testimonials to the counselors' significant contributions to increasing the quality of care offered to HIV-positive patients, alleviating the load on health service delivery staff and helping to translate for foreign doctors unfamiliar with local languages.

- The management contract with Lifeline/Childline Namibia, resulting in 47 CCs trained in late 2005 with at least 48 undergoing training in 2006. The careful selection process for CCs at three major stages of training ensures that those remaining will be able to handle the most challenging counseling situations. Frequent support and learning meetings for counselors demonstrate the continuing concern for quality as well as the care Lifeline/Childline has for the well-being of the CCs.

3.2 Meetings and Interviews

The Capacity Project team met with or interviewed 28 people during and after its two-week consultancy from July 10-20, 2006. The interviewees included staff at the national, regional, district and local levels of the MOHSS, CDC, Potentia, the NRCS, NIP, CHS HIV/AIDS Program, Lifeline/Childline; project staff from RPM Plus, I-TECH, Capacity Project and GFATM; health service practitioners in the field; and officials from USAID. The interviews took place in Windhoek and the Northwest Region.

All of the people interviewed attested to the success of the rapid recruitment and deployment of health and non-health service providers through each of the mechanisms and organizations cited above. They also stressed the temporary nature of the management contract approach to recruiting and managing human resources. It is clear that all of the organizations involved are in frequent communication with one another and coordinate their efforts closely under the leadership of the MOHSS.

4. Discussion and Perspectives

4.1 Facilitating Factors

These factors have facilitated success in hiring and deployment:

1. The Namibia MOHSS's leadership and commitment to rapidly building up the human resources necessary to scale up the ART program and other related services.

   This commitment includes the willingness to consider arrangements other than the conventional government hiring process. It also includes the foresight to extend to all areas of the country services such as counseling and testing, enrollment in comprehensive HIV/AIDS care, ART for adults and children and PMTCT.

2. The CDC Cooperative Agreement (management contract) with Potentia to hire and support health professionals and its performance in fulfilling the terms of the contract:

   The Cooperative Agreement clearly spells out the respective roles and responsibilities, and each party can focus on what it does best: Potentia on HRM; the MOHSS on selection and supervision; and CDC on technical assistance. Most of these aspects work very well though there are some issues highlighted in the constraints section below.

3. The performance of Potentia in placing and managing health professionals, which can be attributed to the following:

   Potentia's business model involves staying focused on what it does well and managing its growth. Only four of the eight staff in Potentia are devoted to the hiring and management of the 156 staff working on behalf of the PEPFAR-funded program, a ratio of about one to 40. The company says no to requests that do not match its area of expertise, such as hiring for information technology positions; it also offers outsourcing services without additional cost to the client, such as a shuttle to meet arriving staff at the airport, visa and work permit facilitation, legal services and temporary accommodations. Potentia feels that it has empowered other small businesses in Namibia through this process. Its business model has allowed it to fill all the positions requested by the MOHSS and CDC, maintaining the 99% placement success rate it has had since the company's inception in 1998.

   Potentia's commitment to the well-being of the staff it hires means that salaries are paid on time 100% of the time; this commitment also involves attending to family needs, such as trying to keep families in the same site where possible, visiting people who are hospitalized, making sure everyone has medical coverage and staying in touch through frequent visits.

   The company's commitment to performance involves orienting everyone to Namibian labor law, and, in consultation with the MOHSS, issuing written warnings where necessary and terminating employment for some employees after a disciplinary hearing.

4. The service delivery contract with CHS[6]:

   To build short-term capacity, CHS conducts frequent training programs, which staff see as a benefit both to help them perform their functions and to add to their marketability.

   CHS conducts regular staff meetings, uses other open communications methods to empower the staff and responds to ideas and issues that people raise.

   CHS maintains a comprehensive filing system for personnel records, helping to address performance issues and track due dates for visas and work permits.

   CHS quickly responds to needs that emerge in the field to move the ART program forward. When new facilities are needed, when a support group needs funding for gardening projects or when there is a need for milk formula to support PMTCT activities, CHS moves quickly to obtain funding from donors.

5. The Government's management contract with the NRCS:

   The NRCS is present in the region and has experience managing health workers, including extensive experience with volunteers. Its credibility as a national institution and as a member of a well-respected international network is important.

   The possibility that CCs may transition to a career in the Namibia Red Cross, which provides regular training and advancement opportunities, is also a factor.

6. The relationship between NIP, the MOHSS and CDC:

   The NIP Board is committed to establishing and maintaining positions so that they will continue after the end of donor funding. The NIP is therefore making strides towards improving its services and skills in order to meet the rapidly rising demand to ensure quality assurance for VCT sites.

4.2 Constraints

The constraints listed here came from program managers and health workers employed by Potentia in the field. It is important to note that the MOHSS and other stakeholders are aware of these issues, and in most cases they are trying to address them. The MOHSS has formed a subcommittee on human resources that is seeking solutions to the short- and long-term issues mentioned below.

For the MOHSS/CDC arrangement with Potentia:

- Lack of a career ladder or differentiation between levels of experience, meaning that junior and senior physicians receive the same salary
- The challenge of reporting to two entities
- The uncertainty of funding from year to year

[6] The Capacity Project did not have a chance to interview staff from LMS; this organization's accomplishments are therefore not as well documented as those of CHS.

- The high vacancy rate for existing positions in the MOHSS. Where there is a severe shortage of medical staff in the hospitals, Potentia-hired staff is called upon to fill the gap, which may take them away from their responsibilities in the ART program. This contribution is not reflected in the paperwork they fill out showing their ART caseload. Yet they serve the rest of the hospital as much as they can because of their commitment to patients and in order to maintain good relations with the MOHSS staff at the facility.
- The lack of a direct relationship between Potentia and the MOHSS, because the contractual arrangement is between CDC and Potentia. In situations where there are issues between the MOHSS and Potentia-hired staff, Potentia relies on the MOHSS to address them because these staff members are to be viewed and managed in the same manner as MOHSS staff in the same positions. The lack of a direct relationship between the MOHSS and Potentia complicates any situation when disciplinary action may be warranted for a Potentia employee. Potentia uses a monitoring checklist approved by the MOHSS to determine if the staff it oversees have produced the results for which they are responsible. CDC continues to work with Potentia and the MOHSS to increase the Ministry's comfort with its role in overseeing employees hired through the Potentia mechanism.
- The lack of so-called "establishment" positions for HIV/AIDS related programs
- Uncertainty regarding the ability of the MOHSS to carry the program beyond PEPFAR funding
- The heavy reliance on medical staff from other countries, mostly Zimbabwe. All 35 physicians hired through the Potentia management contract are foreigners.

For the CC program:

- Few of the 174 CCs qualified to conduct Rapid Testing. This requires successfully conducting 50 tests under supervision; some CCs at lower volume sites experience difficulties conducting this many tests in a short period of time, which can result in a deterioration of the skills that they gained in training.
- The relatively low salary of N$1,200 per month.[7] There is a move to increase this amount to N$1,500, which is still not competitive with salaries offered by some NGOs. In some cases, NGOs have offered as much as N$5,000 per month, attracting a few CCs away from the program.
- The lack of benefits may cause people to leave the program for other employment. The MOHSS is looking at ways to integrate CCs into the government workforce, which would give them job security and benefits.
- The stress level associated with the job of counseling HIV-positive patients
- The lack of supervision, given that only eight of 15 Red Cross regional coordinators are currently deployed. The other positions are hard to fill because of the paucity of qualified candidates.
- The different interpretations of the contract between the NRCS and the MOHSS. The NRCS sees it more as a service delivery contract, whereas staff in the MOHSS stated in interviews that they view it as a management contract. As a result, NRCS staff are seldom included in the selection process for CCs, although the wording of the contract stipulates that they are to be involved.

[7] The current exchange rate is around N$7 to US$1. Readers of this report from other countries such as Malawi, where salaries for registered nurses average US$50 per month, may think that the $170 per month that CCs currently receive is not so low. This helps to explain why Namibia has little difficulty attracting health workers from other countries.

For the CHS HIV/AIDS Program:

- Concern that the compression in the CHS management structure ordered by USAID will hamper the effectiveness of what currently is a well-functioning system
- The 10% turnover rate, which stems from the difficulty of retaining staff in rural hospitals where services and social amenities are few. There is also less of a service orientation by staff, some of whom are more focused on earning money than devoting themselves to the job of helping others.
- The tendency of the current generation of job seekers to "job hop." Evidence suggests that the current generation entering the job market is less committed to staying with an organization for a significant period of time.

The constraints listed below relate to longer-term systemic and policy issues, such as the government's recruitment systems, the lack of a performance-based system and the degree to which the government can outsource.

The government's recruitment system:

There is no clear accountability for performance in recruitment. The PSC and the MOHSS have identified weaknesses on both sides that hamper timely recruitment. The MOHSS does not currently have the personnel capacity to give human resources the attention it requires.

The lack of a performance-based system:

There is no proper performance appraisal system. The existing tools, if ever used, are outdated. Appointments are based on qualifications and not competencies. The Public Service Commission Act and restrictive Labor Laws make it difficult to discipline staff and to separate them for poor performance. All staff up to the level of the Secretary of Cabinet are union-based. As a result, staff are not disciplined for poor performance. The implication is that unions make it difficult for managers to discipline employees by invoking grievance rules, which lead to lengthy formal exchanges with the unions and are unpleasant for managers, who prefer not to go through what they see as painful and time-consuming processes. This problem leads to various forms of employee misconduct, including taking leave without regard to the impact on service delivery.

Outsourcing by the Government of Namibia:

In the 1990s there was a push in the government across several sectors to create quasi-governmental organizations and to contract for services. Success has been mixed. For the MOHSS, the NIP example has been very positive; however, contracting for services such as catering for health facilities has been very problematic. Correcting poor performance or ending contracts is not easy, which illustrates the need for better safeguards and stronger contract management capabilities.

4.3 Lessons Learned

Several lessons have been learned in the two years the PEPFAR-funded program has been operational in Namibia:

1. In a country like Namibia with a vibrant private sector and a sound economy, it is possible to outsource the hiring and management of HRH to a HRP. Yet with the

exception of South Africa, it may be difficult for other African countries to identify a local HRP.

There are other firms similar to Potentia in Namibia that provide HR services primarily to the private sector, which is a sign of a healthy HR environment with both capacity and competition. Although none of the people interviewed could name similar HRP organizations in other African countries, with the exception of South Africa, there is a network of HR professionals in Southern Africa. Each country has a Personnel Practitioners Board, and many countries have a relationship with the South Africa-based Institute of Personnel Management. It might therefore be easier for countries in Southern Africa to identify or develop local HRPs than it might be for the rest of sub-Saharan Africa.

2. Government institutions move too slowly in recruiting staff for critically needed positions.

   HRM by government institutions is hampered by poor communication between government entities, lack of sufficient or qualified staff responsible for HRD, poorly designed recruitment criteria and inadequate performance management systems.

3. When outsourcing, it is important to consider the type of contractual arrangement and its implications.

   In the case of a management contract, the contracting organization has full control over service delivery and the selection of staff. For service delivery contracts, the contractor has those responsibilities. The situation in which the contracting organization collaborates with the contractor in the selection of staff mixes features of the two mechanisms and can lead to differing interpretations of each party's role.

4. Projects can use a HRP for rapid start-up, yet this approach provides only a temporary solution.

   The Namibian government is comfortable with the current outsourcing arrangement for recruiting and managing HRH because it is a short-term solution. In the longer term, the government plans to step in to create new positions where needed and to ensure the integration into its workforce of staff hired in such temporary arrangements.

5. Close collaboration between the government and donors to harmonize HR practices can lead to greater retention, averting the "poaching" of staff in the short term and increasing the likelihood that staff will remain for the medium to long term.

   The MOHSS took a leading role in working with all parties in the ART program to ensure that salaries and benefits are consistent. This approach creates not only a more stable environment for recruitment, selection and retention, but also goodwill and an atmosphere of collaboration rather than competition between various organizations. This approach can create a positive forum to overcome the wariness that often exists between the government and the private sector.

6. Public institutions have had mixed experiences in outsourcing for services. One challenge is the degree to which the government has the capacity to enter into and manage contractual relationships with the private sector.[8]

   On one hand, contracts need to have clearly spelled out roles, quality indicators and sanctions for poor contractor performance. On the other hand, the government needs the capacity to manage contracts in order to ensure good performance and sanction poor performance. These skills are in short supply in the public sector in most sub-Saharan African countries, including Namibia. Where there is capacity to manage contracts in the private sector, the government can rely on firms for those services. In Namibia, the principal recipient of the GFATM grant is using a project management firm to manage its funds and its contracts. Part of the success of this process is the degree of transparency ensured through the involvement of international organizations such as the World Health Organization and CDC in the contractor-selection process.

4.4 Recommendations

These recommendations are intended for Namibia and other countries interested in replicating or adapting the approach used in Namibia to outsource HR recruitment and management services.

For Namibia:

1. Increase collaboration between the MOHSS and the PSC to speed up the hiring of government staff for critically needed positions. In order to do so it would be useful to conduct a review of the roles of the PSC and the MOHSS HR Division, as well as the relationship between them, in order to improve communication and recruitment processes.

2. Upgrade the skills and experience of the MOHSS Division of HRD, and ensure that it is fully staffed and supported by decision-makers and program staff.

3. Increase the number of nationals working in the health professions by developing a comprehensive HR strategy with government and non-government organizations offering primary and secondary education. This strategy should ensure that graduates have the necessary qualifications for pre-medical and pre-pharmacy training.

4. Strengthen contract management skills within the government. Use a variety of resources to assist the government in contract management and to ensure transparency. Develop a training program for all government staff involved in contracting, including program, administrative and finance staff.

For other African countries:

1. Use a mix of contracting approaches with different providers to maximize the potential for recruiting and retaining health workers. When doing so it is important to harmonize

[8] Palmer, N. The use of private-sector contracts for primary health care: theory, evidence and lessons for low-income and middle-income countries. *Bulletin of the World Health Organization*. 2000;78(6):821-9.

salaries and benefits across all organizations involved, both to ensure greater retention and to reduce shortages due to poaching of staff from organizations that pay more.

2. Select the contracting approach—management contract or service delivery contract—that is most appropriate to the current setting. Ensure that roles of various stakeholders are clear from the start, and build in plans for the long term.

3. Consider the pros and cons of government contracting for HR services to expedite hiring and to alleviate the burden of salaries on government.

4. Consider using management support from the private sector. To ensure greater transparency, involve international or multilateral organizations and civil society in selecting contractors.[9] In addition, consider strengthening contract management skills within the government as described above in recommendation four for Namibia. To make sure that people can apply these skills, some countries may need to enact and/or enforce laws and policies related to transparency in government contracting for private services.

[9] Loevinsohn B, Harding A. Contracting for the delivery of community health services: a review of global experience. Washington, DC: The World Bank's Human Development Network, 2004.

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