REPUBLIC OF NAMIBIA
MINISTRY OF HEALTH AND SOCIAL SERVICES

NATIONAL HUMAN RESOURCES FOR HEALTH STRATEGIC PLAN, 2020 – 2030

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SEPTEMBER 2019

PREFACE

The Government of the Republic of Namibia has, since independence, made concerted efforts to improve the health and social wellbeing of the people of Namibia through the implementation of various strategic health policies and initiatives. These efforts have resulted in significant improvements in HIV epidemic control, increased life expectancy, better disease management, improved maternal health outcomes, child survival and health outcomes across different indicators overall. These improvements are also associated with increases in the number of skilled health workers in the country since independence. Nevertheless, the Namibian health system continues to face increased human resources for health demands as it moves towards the attainment of Vision 2030. In pursuit of the national vision which is underpinned by the 5th National Development Plan (NDP5) and MOHSS Strategic Plan, the Government of Namibia has signed onto global pacts the Sustainable Development Goals (SDGs) and Universal Health Coverage (UHC). To attain the ambitious 13 targets of SDG 3, the Ministry of Health and Social Services (MoHSS) recognises that having an adequate and equitably distributed functional health workforce is a prerequisite. Against this backdrop, the MoHSS commissioned a Situation Analysis and Health Labour Market projections to inform the development of a national HRH Strategic Plan to guide health workforce interventions in support of the efforts to achieve NDP5, the SDGs UHC and vision 2030.

The Plan envisages that by 2030, Namibia will have a quality fit-for-purpose health workforce that is equitably distributed and efficiently utilized to address the health needs of the population towards the attainment of Universal Health Coverage. In this pursuit, four strategic objectives with the corresponding set of interventions have been adopted from the Global Strategy on Human Resources for Health (GSHRH).

i. Align health workforce production capacity and quality to match population health needs and economic demand,
ii. Optimise the health workforce recruitment, distribution, retention and utilisation in the public sector towards achieving UHC,
iii. Improve efficiency in health workforce management to catalyse health system performance,
iv. Increase investment in health workforce information and evidence generation for use in decision-making

The implementation of this Strategic Plan requires the concerted efforts of various institutions and stakeholders involved in the production, employment, utilization, regulation and financing of the health workforce in Namibia, including those within the government, non-governmental organisations, development partners and users of health services. Every stakeholder has specific roles and responsibilities that feed into their organizational strategies which benefit of the Namibian health system. The MoHSS for its part, is committed to the implementation of this Strategic Plan and shall utilise it as a reference document for HRH planning, implementation, monitoring and evaluation across the sector.

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DR. KALUMBI SHANGULA (MP)
MINISTER

ACKNOWLEDGEMENT

The HRH Strategic Plan: 2020 – 2030 was developed in three phases. First, a conceptualization phase started in November 2017, which involved capacity building from the World Health Organisation (WHO) in HRH planning and data management. This was followed by an analytical phase in which WHO and IntraHealth provided technical support for elaborate data collection, stakeholder interviews, and Technical Working Group Sessions to conduct a comprehensive situation analysis and health workforce demand and supply projections, adopting a comprehensive labour market approach. The results of both the situation analysis and the health workforce projections were presented at various fora for input and validation. These efforts culminated in a two-day stakeholder's forum drawn from academic institutions, regulatory agencies, quasi-government health institutions, the private sector, the Office of the Prime Minister (OPM), line ministries and development partners. The input, feedback and suggestions received from the various engagements were consolidated into a draft Strategic Plan, which underwent rigorous review at various levels. Broad objectives, strategic interventions, implementation arrangements and a selection of indicators for assessing the performance were agreed upon.

The Government of Namibia and the Ministry of Health and Social Services is grateful to all development partners who provided financial and technical support during the development of this Human Resources for Health (HRH) Strategic Plan. Special appreciation goes to the United States Agency for International Development (USAID) through the UTAP project, implemented by IntraHealth Namibia, the World Health Organization (WHO) Regional Office for Africa through the country office for Namibia and the Intercountry Support team for Eastern and Southern Africa (IST/ESA). Without this support, the development of the Human Resources for Health Strategic Plan would not have been possible.

The Ministry is equally grateful to all stakeholders who provided required data and information on human resources for health in the country, participated in the validation workshop of the HRH Situation Analysis Report, HRH Requirements and Supply Projection Report as well as the HRH Strategic Plan Validation and Consensus-building Workshop. A list of names of the participants from these stakeholders is hereto attached as Annexure.

Special appreciation goes to Ministry's HRH Technical Working Group for the groundwork and coordination it provided under the leadership of the Directorates of Human Resources and Policy and Planning. These directorates played a strategic role in mobilising resources and facilitating and organising stakeholders and Technical Working Groups' consultative meetings and sessions that led into the finalisation of the HRH Strategic Plan.

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MR. BENETUS T. NANGOMBE
EXECUTIVE DIRECTOR

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LIST OF ABBREVIATIONS

AIDS	-	Acquired Immune Deficiency Syndrome
CHN	-	Community Health Nurse
CHW	-	Community Health Worker
DSA	-	Daily subsistence allowance
EWP	-	Employee Wellness Programme
GDP	-	Gross Domestic Product
GSHRH	-	Global Strategy on Human Resources for Health
HALE	-	Health adjusted life expectancy
HCMS	-	Human Capital Management System
HIV	-	Human Immunodeficiency Virus
HR	-	Human Resources
HRH	-	Human Resources for Health
HRIS	-	Human Resource Information System
HRM	-	Human Resources Management
HPCNA	-	Health Professions Council of Namibia
HPP	-	Harambee Prosperity Plan
IST/ESA	-	Intercountry Support Team for Eastern and Southern Africa
M&E	-	Monitoring and Evaluation
MoE	-	Ministry of Education
MoF	-	Ministry of Finance
MoHSS	-	Ministry of Health and Social Services
NDP5	-	Namibian National Development Plan
NHPF	-	National Health Policy Framework
NHWA	-	National Health Workforce Accounts
NPC	-	National Planning Commission
NSA	-	Namibia Statistics Agency
NSFAF	-	Namibian Students Financial Assistance
OMAs	-	Offices, Ministries, and Agencies
OPM	-	Office of the Prime Minister
PEPFAR	-	President's Emergency Plan for AIDS Relief
SADC	-	Southern Africa Development Community
SDG	-	Sustainable Development Goals
SOE	-	State Owned Enterprise
ToR	-	Terms of Reference
TWG	-	Technical Working Group
UHC	-	Universal Health Coverage
UN	-	United Nations
USAID	-	United States Agency for International Development
UTAP	-	USAID Technical Assistance Program
WHO	-	World Health Organisation

SECTION ONE

1.0 BACKGROUND

This section outlines the high-level statements of the Ministry of Health and Social Services (MOHSS) which this strategic plan is aligned with. These high-level statements include the stated mandate, mission, and vision of the MOHSS.

1.1 Mandate of the MOHSS

The mandate of the Ministry of Health and Social Services, derived from Article 95 of the Namibian constitution, calls upon the state to ensure that citizens have the right to fair and reasonable access to public health facilities and services by following the law. These rights are further enshrined in various government policies and legislation on the protection of the health and welfare of the people of Namibia.

The mandate of the Ministry of Health and Social Services is therefore "to oversee and regulate public, private, and non-governmental sectors in the provision of quality health and social services, ensuring equity, accessibility, affordability and sustainability".

1.2 Mission

The mission of the Ministry of Health and Social Services is to "provide integrated, affordable, accessible and equitable quality health and social welfare services that are responsive to the needs of the population[1]"

1.3 Vision

The vision of the Ministry of Health and Social Services is to be a leading provider of quality health care and social services according to international standards.

1.4 Purpose of the HRH Strategic Plan

The purpose of this plan is to assist the Ministry of Health and Social Services in establishing and coordinating priority interventions for HRH to respond to population health needs. It outlines the HRH needs of the health sector and sets out systems for equitable deployment and productivity of health workforce for quality health service delivery in line with the mandate of MOHSS and UHC and SDGs agendas.

1.5 Strategic Goal of the HRH Strategic Plan

The strategic goal of the HRH strategic plan is to attain quality and adequate level of production of a fit-for-purpose health workforce that is equitably distributed, retained, and efficiently utilized to address the health needs of the population towards the attainment of universal health coverage by 2030.

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[1] Ministry of Health and Social Services MOHSS, *MOHSS Strategic Plan, 2017/2018 – 2021/2022* (Windhoek, Namibia: Ministry of Health and Social Services, 2017).

1.6 Organisation of the Strategic Plan

The strategic document has been developed based on analyses of the policy environment, strategic direction of the health sector as well as the current and emerging challenges confronting the health workforce situation in Namibia. The rest of the document is organised as follows:
Section two: Global agenda and national policy context
Section three: Strategic direction and priority interventions
Section four: National health workforce needs and supply projections
Section five: Implementation arrangements
Section six: Cost of implementing the strategic plan
Section seven: Monitoring and evaluation plan

1.7 Process for Developing the HRH Strategic Plan

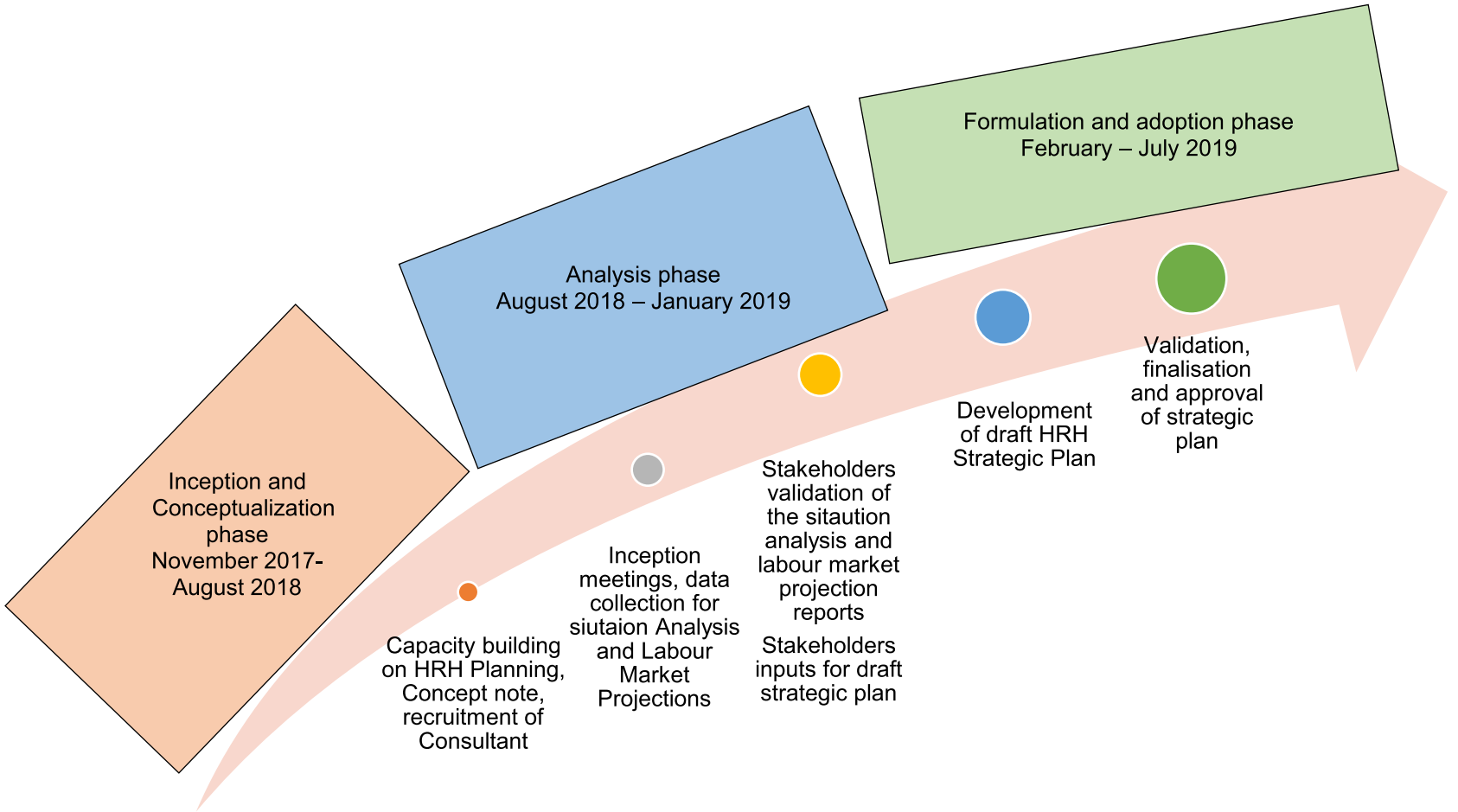
This strategic plan builds on the broad policy and strategic direction of the government and MOHSS and aligns with existing structures and processes in the health sector. The development of this plan was conceived and executed in three phases: conceptualisation, analysis, and formulation (see graphic on the following page).

The conceptualisation phase started in November 2017 and was comprised of capacity building in HRH planning and data management with technical support from WHO. This was followed by the development of terms of reference for the assignment. Subsequently, technical support was received from WHO and IntraHealth to commence the second phase, analysis.

The analytical phase involved elaborate data collection, stakeholder interviews, and technical working group sessions to conduct a comprehensive situation analysis. These activities were followed by the creation of health workforce demand and supply projections, adopting a comprehensive labour market approach. The results of both the situation analysis and the health workforce projections were presented at various fora for input and validation. These efforts culminated in a two-day stakeholder forum.

In the final phase (formulation and adoption), the input, feedback, and suggestions received from the various engagements were consolidated into a draft strategic plan, reviewed by the MOHSS, and validated through consultations in which the broad objectives, strategic interventions, implementation arrangements, and a selection of indicators for assessing the performance were agreed upon.

Figure 1: Process for Developing the HRH Strategic Plan



SECTION TWO

2.0 GLOBAL AGENDA AND NATIONAL POLICY CONTEXT

This section highlights the Namibia's broad policy direction which underpins the development of the HRH strategic plan. First, the global HRH agenda is outlined, followed by relevant national policies and strategies of the Republic of Namibia.

2.1 The Global Strategy on Human Resources for Health (GSHRH)

Towards the ambitious global aspiration of attaining universal health coverage and the Sustainable Development Goals (SDGs), the World Health Assembly (including Namibia) in 2016 adopted the Global Strategy on Human Resources for Health: Workforce 2030 (GSHRH)[2]. The strategy builds on target C of SDG 3 which calls on countries to substantially increase health financing and the recruitment, development, training, and retention of the health workforce. The GSHRH encourages countries to align their HRH policies, strategies and operational plans with:

i. Optimizing the performance, quality and impact of the health workforce to accelerate progress towards UHC and the SDGs
ii. Aligning investment in HRH with the current and future needs of the population and health systems to maximize job creation and economic growth
iii. Strengthening the capacity of institutions at regional and national levels for effective public policy stewardship, leadership, and governance on HRH
iv. Strengthening data, evidence, and knowledge for cost-effective policy decisions.

In this context, countries are advised to "build planning capacity to develop or improve HRH policy and strategies that quantify health workforce needs, demands and supply under different future scenarios … in order to manage health workforce labour markets and devise effective and efficient policies that respond to today's population needs while anticipating tomorrow's expectations" (p.25). This global guidance has been taken into consideration in developing this strategy.

2.1.2 Roadmap for Scaling up the Human Resources for Health for Improved Health Service Delivery in the African Region

In 2013, the 66nd session of the WHO Africa Regional Committee made a resolution adopting a roadmap for scaling up HRH for improved health service delivery in the region[3]. The roadmap was built on various national, regional, and global efforts and outlines six strategic areas with a corresponding number of strategic interventions. The strategic areas of the roadmap are:

i. Strengthening health workforce leadership and governance capacity.
ii. Strengthening HRH regulatory capacity.
iii. Scaling up education and training of health workers.
iv. Optimizing the utilization, retention, and performance of the active health workforce.

[2] WHO, 'Global Strategy on Human Resources for Health: Workforce 2030', 2016.
[3] WHO/AFRO, 'WHO Regional Office for Africa Survey on HRH Profiles, Inputs World Health Report - 2006', *World Health Organisation, Africa Regional Office*, 2006.

v. Improving health workforce information and generation of evidence for decision making.
vi. Strengthening health workforce dialogue and partnership.

For implementation, countries were encouraged to identify the priority interventions that were relevant to their context and develop or update their HRH policies and/or strategies accordingly.

2.2 National Policy Context

Nationally, several governmental or ministerial policies, strategies, and plans may impact or be impacted by the HRH strategic plan. The thrust of these strategic documents has been considered in developing this strategic plan. Some of these strategic documents are Vision 2030; the National Development Plan 5 (2017-2022); the Harambee Prosperity Plan (2016-2020); National Human Resources Plan (2010-2025) by the National Planning Commission; National Health Policy Framework (2010-2020); MOHSS Strategic Plan (2017/2018-2021/2022) as well as programmatic plans of the MOHSS.

2.2.1 National Development Plan 5 (2017-2022)

The fifth Namibian National Development Plan (NDP5), a five-year national development blueprint for the period 2017-2022, outlines the development strategy aimed at improving the living conditions of the citizenry. NDP5 builds on the successes, achievements and challenges of the four previous five-year development plans to chart a course toward the cumulative targets outlined in Vision 2030. NDP5 hopes to achieve inclusive, sustainable, and equitable economic growth, build capable and healthy human resources, ensure a sustainable environment, enhance resilience, and promote good governance through effective institutions. NDP5 envisages that all Namibians will have access to quality health care and an increased health adjusted life expectancy (HALE) of 67.5 years by 2022. It also aims to:

i. Improve talent management (HR development, recruitment and retention)
ii. Attain specific health workforce targets of a doctor per population ratio of 1:1457; nurse per population of 1:270 and pharmacist per population ratio of 1: 2289 by 2021/2022.

2.2.2 Harambee Prosperity Plan (HPP) 2016-2020

The Harambee Prosperity Plan is an action plan aimed at accelerating development in the clearly defined priority areas of effective governance, economic advancement, social progression, infrastructure development, and international relations and co-operation. HHP commits the government to specific maternal and child health targets to significantly reduce the infant and maternal mortality rate by 2020. In this pursuit, the government committed itself to "… initiate a rapid recruitment process to ensure a basic minimum of staffing levels at each hospital."[4]

[4] Government of Republic of Namibia, *Harambee Prosperity Plan: Namibian Government's Action Plan towards Prosperity for All* (Windhoek, Namibia: Government of Republic of Namibia, 2015).

2.2.3 National Human Resources Plan 2010 – 2025

Under the auspices of the National Planning Commission (NPC), the National Human Resources Plan (2010-2025) was designed to correct the structural mismatch between skills and available jobs. The plan anticipates a shortage of skilled health and social workers, projects the country's health and social workforce demand to outgrow its supply capability by a margin of three folds at the end of the year 2025 and calls for targeted scaling up of training to meet the future health workforce demand.

2.2.4 National Health Policy Framework, 2010-2020

The National Health Policy Framework (NHPF) 2010-2020 sets out the strategic agenda and need to consolidate achievements in improving access to care, dealing decisively with emerging and re-emerging diseases, and promoting efficiency and source funding for the health and social services sector of Namibia. It also outlines specific HRH strategic interventions—some of which have largely been undertaken, while other outstanding relevant ones have been highlighted in this HRH Strategic Plan for attention.

2.2.5 Ministry of Health & Social Services Strategic Plan, 2017/2018 – 2021/2022

The five-year MOHSS Strategic Plan (2017/2018-2021/2022) details clear, measurable and relevant activities geared towards "making Namibia a healthy nation in which all preventable infectious and parasitic diseases are controlled and people enjoy a high standard of living with access to quality health and other vital services. The main objective of the talent management pillar is to ensure the hiring of qualified and competent healthcare providers capable of delivering quality health care services. It has a focus on senior and district managers whose skills and competencies are assessed independently and where skills gaps are identified, appropriate training is provided. It also explores ways of increasing the number of Namibian trained health. Significantly, it seeks to implement a new and responsive staff establishment to address population health needs.

SECTION THREE

3.0 STRATEGIC DIRECTION AND PRIORITY INTERVENTIONS

Based on the situation analysis, health workforce projection exercise, and stakeholders' dialogue, four strategic objectives were identified to address the current and emerging challenges of the labour market in a manner that would be responsive to the population health needs. These strategic interventions would facilitate the achievement of the main strategic goal:

By 2030, produce a quality and adequate functionally fit-for-purpose health workforce that is equitably distributed and efficiently utilized to address the health needs of the population towards the attainment of universal health coverage.

The four strategic objectives are to:

1. Align health workforce production capacity and quality to match population health needs and economic demand
2. Optimise the health workforce recruitment, distribution, retention, and utilisation in the public sector towards achieving UHC
3. Improve efficiency in health workforce management to catalyse health system performance
4. Increase investment in health workforce information and evidence generation and use to support decision-making.

Strategic Objective 1: Align health workforce production capacity and quality to match population health needs and economic demand

Rationale: As a result of ongoing efforts to increase the production of health workers, Namibia's health workforce density has been comparatively impressive. Nevertheless, the production levels are still sub-optimal, with overconcentration in some professional disciplines at the expense of others. For instance, 21% of the overall training effort is on HIV/AIDS while the allied health professions received only 10% despite the stated need by the MOHSS. Also, there were wide variations in the content of curricula of different institutions training the same type of health professionals, thus producing the same health professionals of varying quality of skills. Furthermore, there is a significant mismatch between the level of supply of, need for, and demand for health workers. For instance, the HRH projection exercise showed a cumulative economic capacity (economic demand) of N$7.8 billion in both public and private sectors in 2018 which is expected to increase by 38.5% to N$10.8 billion by 2024 and to N$16.8 billion by 2030. But the expected supply would exceed the cumulative fiscal space by 27% in 2019 which may gradually clear by 2026/2027. This situation presents a challenge: skilled health workers who may paradoxically not be employed due to limited fiscal space even though their services are needed. If not addressed, this 'paradoxical surplus' could become negative feedback for curtailment of health workforce production which would exacerbate the need-based shortage.

The production of specialist health professionals has also not matched the growing population health needs. The health workforce projection exercise showed a significant shortage of doctors, nurses, pharmacists and allied health professionals, alongside huge inequities in the distribution of those available.

The strategic shift in this regard is to implement a coordinated programme of workforce production that meets the population health needs in terms of both the numbers and the quality of training. Thus, the MoHSS and its partners/stakeholders will aim to implement a coordinated programme of quality health workforce production based on population health needs through the following strategic policy interventions:

Strategic interventions:

1.1 Annually update the projection of the numbers of various health workers needed in Namibia to identify priority areas as a guide for academic institutions and individuals.
1.2 Institute annual multi-stakeholder dialogue with academic and training institutions to plan the numbers and priority areas for student intake based on the projected needs of the health sector (both public and private).
1.3 Collaborate with SADC and other African regional academic/training institutions, professional associations, HPCNA, MoE and other relevant stakeholders to review and harmonise the various training curricula to reflect desired skills and competencies that address the population health needs and contemporary issues in health service delivery.
1.4 Increase the training of specialist health professionals by following projected needs to address the ageing specialist workforce as well as the epidemiologic and demographic transition of the country. The MOHSS should:
    1.4.1 Explore the feasibility of increasing the domains of training postgraduate specialists in Namibia to reduce the cost of foreign training
    1.4.2 Upgrade the post-basic and post-graduate certificate and diploma programmes in specialised fields into recognised specialisation programmes.
    1.4.3 Collaborate with NSFAF to refocus the foreign scholarship scheme towards the training of specialists and other cadres not being trained locally.
    1.4.4 Develop a specialist mentorship and succession plan to seamlessly replace the ageing medical specialist workforce.
1.5 Impress upon academic institutions to introduce programmes for the training of health professionals whose training is not adequately available in Namibia.
1.6 Promote the utilisation of centres of excellence in the SADC and African region as well as academic collaborations to facilitate the training of highly skilled health professionals.
1.7 Identify additional health facilities for accreditation to serve as clinical internship training sites. In this regard, a collaboration with well-established accredited private health facilities could be considered.
1.8 Support the HPCNA to strengthen the licensing examination system for all health professionals prior to their professional registration with the HPCNA and ensure that the renewal/maintenance of practice licenses is linked to evidence of continuous professional development and practice.
1.9 Encourage HPCNA to improve the system of registration for all prospective Namibian students who wish to undertake health professional training abroad. This will enable the country to track the number of students pursuing various programmes for efficient planning and monitor the quality of training being rendered to the students.

1.10 Encourage HPCNA to develop/review scope of practice for all health-related professions underpinned by detailed task analysis. The HPCNA could enforce the same to streamline the practice of various health workers.

1.11 Explore the feasibility of training community health nurses who would focus on community-based health care to strengthen the primary health care system. This would strengthen the supervision and effectiveness of the existing community health workers.

1.12 Encourage HPCNA to improve the system of registration for all health professionals.

Strategic Objective 2: Optimise the health workforce recruitment, distribution, retention and utilisation in the public health sector towards achieving UHC

Rationale: Following concerted efforts to increase the production of health professionals, the health sector has been recording significant increases in the aggregate health workforce availability. However, there is apparent inequitable distribution of health and social infrastructure which inevitably drives inequity in HRH distribution. Distribution of aggregate health workforce numbers continues to be skewed as more health professionals are found in the private sector which is said to be serving only 20% of the population, leaving 80% being catered to by the 38% of health professionals who work in the public health sector. Additionally, many health workers, especially the highly skilled ones, are unwilling to accept postings or accept job offers at deprived areas as there are no adequate compensatory policy and monetary incentives for working in these areas. There also appears to be no standard metric, adopted by the MOHSS, for measuring and tracking inequity in HRH distribution.

Consequently, there is an urgent need to shift strategy towards optimising health workforce distribution, retention, and utilization through the following strategic interventions:

Strategic interventions:

2.1 Consider a flexible staffing norm for the proposed MOHSS structure to build in an adjustment formula to accommodate future changes (increase or decrease in workload levels). In this regard, there should be a defined adjustment formula for adjusting the staffing of health care facilities which will also enable the realisation of HRH efficiency gains at large hospitals when the PHC system is strengthened.

2.2 Make the strong health and economic case to the OPM and MOF to advocate for the approval of the MOHSS proposed staffing norms (structures) to support the attainment of UHC (coverage index could improve from 0.59 to at least 0.70), inclusive of incremental implementation aimed at ensuring financial sustainability (implement between 43% and 80% of the additional positions in the revised structure).

2.3 Conduct an annual facility-by-facility health workforce gap analysis using the agreed structure (staffing norms) to develop a facility-by-facility annual recruitment and distribution plan which should be dialogued with the OPM/MOF for inclusion in the budget for each financial year.

2.4 Engage the private sector in a dialogue to develop a memorandum of understanding for ethical recruitment and dual practice from the public to the private sector and vice versa.

2.5 In line with the draft health professions bill, support the HPCNA to implement compulsory community service by new health professionals.

2.6 Dedicate a portion of admissions to academic/training institutions exclusively for students who would accept posts in rural and underserved areas.

2.7 Develop and implement a performance-based, deprived area incentive scheme to attract and retain staff in underserved areas. The scheme should be built around non-financial incentives.
2.8 Develop a task-sharing policy to guide the use of task-sharing initiatives for increased service delivery coverage, especially in deprived areas and disciplines. This could be linked with the proposed review of the scope of practice.

Strategic Objective 3: Improve efficiency in health workforce management to catalyse health system performance

Rationale: Although the centralised control and management of human resource management processes, policies, and guidelines have received satisfactory ratings by stakeholders, there are still lingering concerns of undue delays in various processes due to layers of bureaucratic procedures. Relevant HRH policies and guidelines affecting staffing management have also not been widely disseminated to staff, especially those in the rural and hard-to-reach areas, whilst at the same time job descriptions are not in tune with current trends as reflected in the professional scopes of practice, and training needs assessments not regularly conducted in tandem with institutional needs. Weak supervision and a lack of enforcement of performance standards have been identified as some of the challenges inhibiting staff motivation and productivity.

Improving the management of the health workforce for increased motivation and productivity thus requires a paradigm shift via the following key strategic interventions:

Strategic interventions:

3.1 Strengthen institutional leadership and governance capacities at all levels including the HRH units of regional and district health management teams as well as health facilities management teams.
3.2 Update job descriptions in line with the professional scope of practice to reflect current trends of health needs and professional advancement and disseminate to employees.
3.3 Accelerate the development of a competency-based framework for all health professionals with the view of strengthening performance management at all levels of health care delivery.
3.4 Streamline in-service training and development to make it inclusive and responsive to institutional needs including a comprehensive training needs assessment in collaboration with relevant stakeholders.
3.5 Accelerate the implementation of an employee wellness programme (EWP) that includes occupational health and safety measures.
3.6 Adopt an acceptable metric for routine monitoring of equitable HRH distribution.
3.7 Strengthen partnerships among relevant stakeholders in the planning, production, and management of HRH by:
    - Enhancing the HRH coordination mechanism by strengthening the HRH stakeholder's forum, membership of which includes the private sector (both faith-based and private-for-profit) and other bodies external to the ministry.
    - Discussing all new policies and programmes on HRH to examine the HRH implications for integration into the HRH plan and annual HRH programme of work.
3.8 Advocate for a review of the service delivery model with the view of strengthening primary health care as a vehicle for accelerating the attainment of UHC. To this end,

the MOHSS should consider training community health nurses/officer to supervise the existing CHWs to improve health system efficiency.

3.9 Integrate currently vertically development partners funded health services programmes into main health system to be part of the workload related staffing norms for health facilities so as to ensure sustainability after the end of the development partners' funding.

Strategic Objective 4: Increase investment and collaboration in health workforce information, evidence generation and use for decision-making.

Rationale: Following the need to improve health workforce information availability and reliability to support decision making, the OPM initially developed a human resource information management system (HRIMS) and later replaced it with the human capital management system (HCMS) for use by all government institutions for the collection, storage and analysis of HR data. The HCMS, however, does not take into account private sector data or workers not paid by the central government, and the system has suffered significant operational setbacks over time resulting in an intermittent suspension of its operations.

Consequently, the MOHSS currently lacks a single source of validated HRH information detailed enough for holistic analysis to support sector-wide decision making. Health workforce data is fragmented in standalone excel workbooks and systems held by the various facilities, directorates, and regions who manually compile and submit the data when requested. The situation is also compounded by inadequate capacity at the various levels to accurately and reliably compile and analyse HRH information to support decision making.

Based on these findings, it recommended that the MOHSS makes a strategic shift to increase investment in health workforce information and evidence generation and use for decision-making by implementing the following interventions:

Strategic interventions

4.1 Urgently develop/adopt a human resource information system (HRIS) to address the HRH information needs of the ministry and track the deployment of the workforce. It should be made clear that the system would be interoperable with the HCMS.

4.2 Build the capacity of human resource practitioners and managers in HRH data management and evidence generation and use for decision-making.

4.3 Implement the National Health Workforce Account (NHWA) and use the indicators for measuring the progress of HRH interventions.

- Produce annual state of HRH reports for policy discussions as well as policy briefs on success stories in HRH problem-solving.

4.4 Conduct operational HRH research to address current and emerging challenges.

4.5 Establish a national health workforce observatory to enhance the integrated analysis of collected health workforce data as well as serve as a conduit for HRH research.

4.6 Undertake a health workforce survey across the entire health sector once every five years to detail the health workforce and productivity.

SECTION FOUR

4.0 NATIONAL HEALTH WORKFORCE NEEDS AND SUPPLY PROJECTIONS

This section highlights health workforce needs and supply projections using a comprehensive labour market approach[5], incorporating the needs of the private sector, quasi-government institutions and faith-based healthcare providers that are subsidized by the government. The methods and assumptions used follow established and validated frameworks[6]; details of which are contained in a separate and elaborate report[7].

4.1 Labour Market Dynamics: Imbalances but Job Creation Opportunities for Economic Growth

Labour market projections showed that in aggregate terms, the demand and supply ratio is about 75% which is a demonstration of at least a 25% mismatch between need and supply, which varies widely and is most pronounced amongst specialised health workers. About 59% of the needed general practitioners, 63% of pharmacists, 48% of enrolled nurses, 64% of registered nurses, and 16% to 41% of the required allied health professionals are supplied. In terms of economic demand, the public sector in 2018 potentially had a fiscal space of N$3.047 billion for HRH, combined with a private sector's capacity of N$4.77 billion.

The cumulative economic capacity for HRH in both the public and the private sectors was estimated at N$7.8 billion which is expected to increase by 38.5% to N$10.8 billion by 2024 and N$16.8 billion by 2030. Meanwhile, the cost of the health workforce to be supplied in the labour market is conservatively estimated to exceed the cumulative economic capacity by 27% from 2019 which may gradually clear by 2026/2027.

This situation presents a potential challenge of skilled health workers who may paradoxically not be employed due to limited fiscal space even though their services may be needed. If not addressed, this 'paradoxical surplus' could become negative feedback for curtailment of health workforce production which would exacerbate the need-based shortage.

provides details of the expected aggregate labour market dynamics up to 2030. From a job creation perspective, the situation provides job creation opportunities in the health sector which, when pursued, could stimulate inclusive economic growth and social protection[8].

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[5] Angelica Sousa and others, 'A Comprehensive Health Labour Market Framework for Universal Health Coverage', *Bulletin of the World Health Organization*, 91 (2013), 892–94 <https://doi.org/10.2471/BLT.13.118927>.

[6] *Health Labor Market Analyses in Low- and Middle-Income Countries: An Evidence-Based Approach*, ed. by Richard M. Scheffler and others (The World Bank, 2016) <https://doi.org/10.1596/978-1-4648-0931-6>; Barbara McPake, Anthony Scott, and Ijeoma Edoka, *Analyzing Markets for Health Workers: Insights from Labor and Health Economics* (The World Bank, 2014) <http://elibrary.worldbank.org/doi/book/10.1596/978-1-4648-0224-9> [accessed 11 June 2016]; James Avoka Asamani and others, 'Forecast of Healthcare Facilities and Health Workforce Requirements for the Public Sector in Ghana, 2016–2026', *International Journal of Health Policy and Management*, 0.0 (2018) <http://www.ijhpm.com/article_3525.html> [accessed 7 August 2018].

[7] MOHSS, *Health Workforce Projections for Namibia*.2018-2030

[8] WHO, 'Working for Health and Growth: Investing in the Health Workforce', 2016.

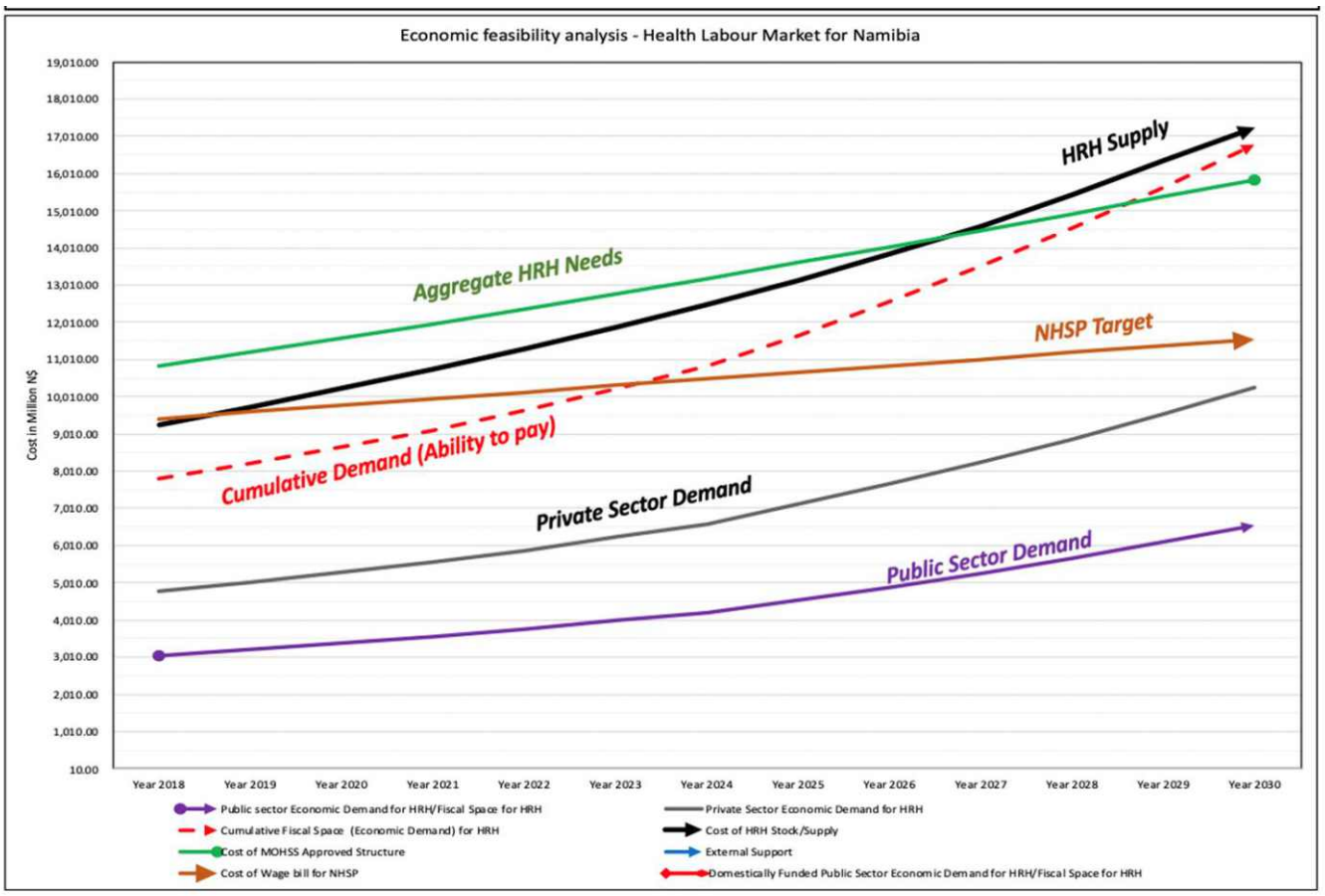

Figure 1: Economic Feasibility Analysis of the Namibia Health Labour Market

In the comprehensive situation analysis report, econometric analysis of available Namibian data revealed that for every unit increase in essential health workers per 1,000 population, *cecteris paribus*, there is a corresponding improvement in overall life expectancy at birth of 2.78 years to Namibians which in turn accelerates GDP growth rate of the national economy by 1.67% for every year of life expectancy added. Therefore, increasing investment in the production and absorption of more health workers who are equitably distributed can be an important strategy for improving both health outcomes and economic fortunes in Namibia.

4.2 Baseline Workforce Gaps for Selected Categories

Table 1**: Baseline Workforce Gaps for Selected Categories in the Namibian Health Sector** shows the baseline health workforce gaps analysis for selected categories of the workforce. The selection of these categories was based on the availability of supply-side data which should be deemed as an example for conducting an annual gap analysis for the development of recruitment plans. Overall, the average staff availability ratio for these categories of staff is about 75% which demonstrates a 25% mismatch between need and supply of the health workforce. In other words, at the aggregate level, there is at least a 25% need-based shortage of health workers. This need-based shortage is more pronounced amongst specialised health workers. It is worth noting that as of 2018, the country had just 59% of the needed general practitioners (medical officers), 63% of pharmacists, 48% of enrolled nurses, and 64% of registered nurses, but very low availability rates ranging from 16% to 41% for the allied health professionals. Similar gaps analyses need to be conducted annually for health facilities,

districts, and regions to inform operational human resource planning and management decisions.

Table 1: Baseline Workforce Gaps for Selected Categories in the Namibian Health Sector

CATEGORY OF STAFF	2018				2024		2030	
	Baseline Need	Baseline Supply	Labour Market Gap	Demand-Supply Ratio	Labour Market Gap	Demand-Supply Ratio	Labour Market Gap	Demand-Supply Ratio
Medical Specialist - Oncology	11	1	-10	9%	-17	7%	-24	7%
Radiographic Assistant	305	48	-257	16%	-300	18%	-347	20%
Pharmacist Assistant	1,909	319	-1,590	17%	-1,937	18%	-2,311	20%
Dietician	135	29	-106	22%	-118	25%	-129	28%
Dental Technician	149	37	-112	26%	-116	30%	-121	35%
Medical Specialist - Emergency Medicine	11	3	-8	26%	-14	22%	-20	21%
Audiologist	21	7	-14	32%	-26	27%	-38	25%
Medical Specialist - Cardiology	11	4	-7	35%	-13	29%	-19	27%
Occupational Therapist	217	82	-135	39%	-143	43%	-148	50%
Dental Therapist	147	58	-89	41%	-87	47%	-83	55%
Medical Specialist - Neurology	10	4	-6	41%	-5	52%	-3	69%
Medical Specialist - Family Medicine	80	33	-47	42%	-54	45%	-59	50%
Medical Specialist - Family Medicine	80	33	-47	42%	-54	45%	-59	50%
Medical Specialist - Paediatrics	81	38	-43	47%	-48	51%	-51	57%
Enrolled Nurse	8,985	4,237	-4,748	48%	-5,303	52%	-5,648	57%
Medical Specialist - General Surgery	87	42	-45	49%	-49	53%	-50	60%
Medical Specialist - Obstetrics & Gynaecology	86	43	-43	51%	-47	55%	-47	62%
Psychological Counselor	132	62	-70	56%	-10	93%	35	122%
Medical Officer	1,831	1,024	-807	59%	-632	71%	-585	78%
Social Worker	837	507	-330	61%	-361	65%	-364	71%
Pharmacist	980	598	-382	63%	-395	67%	-472	68%
Medical Specialist - Otorhynolaryngology (ENT)	12	8	-4	64%	-9	56%	-13	53%
Registered Nurse	13,478	8,712	-4,766	64%	-6,534	60%	-8,885	55%
Medical Specialist - Cardiothoracic surgery	11	8	-3	69%	-7	59%	-12	55%
Medical Specialist - Urology	17	13	-4	75%	-7	71%	-9	72%
Physiotherapist	209	155	-54	76%	-30	87%	5	102%
Medical Specialist - Neurosurgery	11	10	-1	87%	-5	73%	-8	69%
Emergency Care Practitioner	1,193	1,049	-144	87%	-279	80%	-455	71%
Radiographer	240	203	-37	88%	2	101%	21	106%
Medical Specialist - Nuclear Medicine	3	3	0	92%	1	117%	2	155%
Medical Specialist - Trauma and Orthopaedic Surgery	29	30	1	100%	-4	92%	-6	90%
Dentist	145	174	29	123%	64	139%	117	162%
Medical Specialist - Ophthalmology	10	18	8	165%	7	137%	7	127%
Medical Specialist - Anaesthesiology and Critical Care Medicine	22	39	17	169%	16	143%	17	134%
Environmental Health Practitioner/Assistant	142	228	86	178%	234	247%	351	295%
Medical Specialist - Radiology	21	37	16	179%	21	178%	30	185%
Medical Specialist - Internal Medicine	20	41	21	201%	27	199%	38	207%
Medical Specialist - Radiation Oncology	9	17	8	208%	14	264%	21	351%

SECTION FIVE

5.0 IMPLEMENTATION ARRANGEMENTS

5.1 The Role of the Stakeholder

Implementation of this strategic plan would require the concerted efforts of various institutions and stakeholders involved in the production, employment, utilization, regulation, and financing of the health workforce in Namibia. Every stakeholder would have specific roles and responsibilities that would feed into their organizational strategies and plans to ensure the full implementation of the components of the HRH strategic plan.

The MOHSS will provide leadership in the implementation of the strategic plan, especially the coordination of efforts and the facilitation of dialogue around the implementation of all the components of the plan. Thus, the activities will be initiated by the MOHSS with support from other key stakeholders. The ministerial HRH technical working group will devise mechanisms to support the day-to-day management of implementation and report to the deputy executive director through the director of human resources. The HRH Stakeholders Forum (or advisory committee) which has membership beyond the MOHSS, and the health sector would deliberate on issues referred to it by MOHSS to provide technical advice and build consensus where needed to enable the MOHSS and other relevant bodies to act .

The issues discussed and agreed upon by the stakeholders' forum shall be considered to have been accepted by all concerned players in the HRH landscape. The execution of decisions made by the stakeholders' forum shall be tracked in the form of an aide-memoire to enhance peer-to-peer accountability.

The key stakeholders involved in the implementation of the strategic plan and their roles are outlined in Table 2**: Role Clarification for Stakeholders in Support of Implementing the HRH Strategic Plan** below.

Table 2: Role Clarification for Stakeholders in Support of Implementing the HRH Strategic Plan

Organization	Existing roles related to HRH	Expected areas of increased focus on the HRH Strategic Plan
Ministry of Health & Social Services	HRH policy and strategy development, HRH planning, maintaining suitable HRH database track distribution, day-to-day human resources management, initiation of HRH policy dialogue with all relevant stakeholders	Coordinating the national structures/forums related to HRH e.g. HRH TWG, creating enabling policy and legal environment, advocating for appropriate resources for the implementation of the plan as well as facilitating monitoring and evaluation of the plan
Office of the Prime Minister (OPM)/ Public Service Commission	Setting and regulating recruitment, selection, promotion and terms and conditions for public servants, as shown in the general orders and regulations; setting the government staff establishments	Approval of MOHSS staffing norms and structures and additional posts and approval of incentive scheme
NSFAF	Facilitating the award of scholarships for training of health workers in short supply	Award of scholarships for the training of health-related programs especially specialists and other deprived cadres.

Organization	Existing roles related to HRH	Expected areas of increased focus on the HRH Strategic Plan
Ministry of Finance	Mobilizing and providing public finance Setting the budget ceilings for Offices, Ministries, and Agencies (OMAs)	Prioritizing HRH financing and the financing of health in general to meet the Abuja Declaration of 15% of MTEF.
Ministry of Basic Education Ministry of Higher Education and Innovation	The highest responsible body for education, training and funding or facilitating funding for academic/training institutions	Collaborate with the Ministry of International Relations to facilitate collaborative training of health personnel between Namibian Universities and others in the Region.
National Council for Higher Education	Setting standards for higher education	Guidance for the development of, and approval of proposed curricula
Ministerial HRH Technical Working Group and the HRH Advisory Committee	Providing technical advice on HRH related issues to the MOHSS and relevant stakeholders	Coordinating input, resources and effort of different stakeholders involved in HRH activities in the health sector.
Health Professions Council of Namibia (HPCNA)	Registration, licensure, drafting the scope of practice, and standards of care	Revising professional scope of practice, strengthening of council's legislation, strengthening licensing examination and approval of curricula.
Academic/Training Institutions	Pre-service, in-service and postgraduate training	Introduction/modification of programmes to address population health needs Balance intake with projected needs Collaborate with MOHSS on strategies to improved skills and knowledge of health workers Link a portion of intake to vacancies in rural and under-served areas
The private sector, mission health facilities, and other stakeholders	Employment of health workers	Collaborate with MOHSS to ensure equitable distribution of health workers and ethically reciprocal dual practice, and mentoring of interns to address service delivery gaps
Development Partners (WHO, USAID, Global Fund, UNFPA, UNICEF, PEPFAR etc.)	HRH capacity-building and standardization	Provide technical and financial assistance for the implementation of specific activities in the HRH strategy and its annual operational plans. Providing HRH-related capacity-building and standardization with international benchmarks (Especially from WHO)

5.2 Medium-term Implementation Framework

Although it is anticipated that this strategic plan would be implemented over a ten-year period, a framework for medium-term implementation is presented in this section to align with the overarching strategic plan of MOHSS which ends in 2021/2022 as well as the NDP5. It is anticipated that by 2023/2024, these fundamental strategic documents would have been reviewed which would guide the development of another medium-term implementation framework for this strategic plan.

The medium-term implementation framework as shown in Table 3**: Medium Term Implementation Framework 2020-2023** identifies the main actors/stakeholders for each strategic intervention, and tentative implementation milestones, as well as the means of verification, shall guide the development of annual implementation plans or programmes of work to support the day-to-day implementation of the strategic intervention.

Table 3: Medium Term Implementation Framework 2020-2023

Strategic Objectives	Main Interventions	Timeframe					Main Actors	Milestones	Means of Verification
		2020	2021	2022	2023	2024 & Beyond			
1. Align health workforce production capacity and quality to match population health needs and economic demand.	1.1 Annually update the projection of the numbers of various health workers needed in Namibia						MOHSS	Projections updated annually	HRH Projection Update Report
	1.2 Institute an annual multi-stakeholder dialogue with academic and training institutions to plan the numbers and priority areas for student's intake based on projected needs of the health sector (both public and private).						MOHSS, Academic institutions, HRH Advisory Committee	Annual meeting held (May/June); Academic institutions aligning intake to agreed need	Activity report
	1.3 Collaborate to review and harmonise the various training curricula to reflect desired skills and competencies that address the population health needs and contemporary issues in health service delivery.						Academic/training institutionsHPCNA, MoE, MOHSS, professional associations	Harmonised curriculum developed by 2022	Availability of harmonised curriculum
	1.4 Increase the training of specialist health professionals by following the projected needs to address the ageing specialist workforce challenge as well as the epidemiologic and demographic transition of the country. In furtherance the Training institutions, MOHSS and HPCNA should:								
	1.4.1 Explore the feasibility increasing the domains of training postgraduate specialists in Namibia to reduce the cost of foreign training						Training institutions, MOHSS HPCNA, MoE	Specialities to be trained locally mapped by end of 2020; Curricula developed by 2022	Report; Curriculum document

Strategic Objectives	Main Interventions	Timeframe					Main Actors	Milestones	Means of Verification
		2020	2021	2022	2023	2024 & Beyond			
	1.4.2 Upgrade the post-basic and post-graduate certificate and diploma programmes in specialized fields into recognised specialization programmes.						Academic/training institutions, HPCNA, MoHSS, MoE	Curricula revised by 2022; Implementation by 2023	Report; Curriculum document
	1.4.3 Collaborate with NSFAF to refocus the foreign scholarship scheme towards training of specialist and other cadres not being trained locally.						MoHSS, NSFAF		
	1.4.4 Develop and implement a specialist mentorship programme and succession plan to seamlessly replace the ageing medical specialist workforce.						MoHSS	Ageing specialist identified and succession plan developed by end of 2020	Succession plan
	1.5 Training institutions to introduce programmes for the training of health professionals whose training is not adequately available in Namibia.						Training institutions, HPCNA, MoHSS, MoE, Council of Higher Education	Curricula developed by 2021; Implementation from 2022	Report; Curriculum document
	1.6 Promote the utilisation of centres of excellence in the Region as well as academic collaborations to facilitate the training of highly skilled health professionals.						Academic/training institutions, MoHSS, MOE, Ministry of International Relations and Cooperation	Memoranda of Understanding with relevant institutions	MOU
	1.7 Identify additional health facilities for accreditation to serve as clinical internship training sites. In this regard, a collaboration with well-established private health facilities should be considered.						MoHSS, HPCNA, Private Health Institutions	Additional clinical training sites accredited by 2021	Accreditation report

Strategic Objectives	Main Interventions	Timeframe					Main Actors	Milestones	Means of Verification
		2020	2021	2022	2023	2024 & Beyond			
	1.8 Support the HPCNA to strengthen the licensing examination system for all health professionals before their professional registration with the HPCNA and ensure that the renewal/maintenance of practice license is linked to evidence of continuous professional development and practice.						HPCNA, Academic/training institutions, MOHSS, Professional Associations	The framework adopted by 2022 and implementation started by 2023	HPCNA report
	1.9 Encourage HPCNA to improve the student registration and tracking system.						HPCNA, MOHSS	Foreign student tracking system functional	HPCNA report
	1.10 Encourage HPCNA to develop/review the scope of practice for all health-related professions underpinned by detailed task analysis. The HPCNA should enforce the same to streamline the practice of various health workers.						MOHSS, HPCNA	The revised scope of practice completed by 2022 for all regulated health professionals	Scope of practice
	1.11 Explore the feasibility of training Community Health Nurses/officers who would focus on community-based health care to strengthen the primary health care system. These would strengthen the supervision and effectiveness of the existing Community Health Workers.						(Administrative for MOHSS Decision) Academic/training institutions, MOHSS, HPCNA, MoE, Council of Higher Education	Consensus by 2020; Curriculum developed by 2021; training starts by 2022/2023	Curriculum; HPCNA report
2. Optimise the health workforce recruitment, distribution, retention and	2.1 Consider a flexible staffing norm for the proposed MOHSS structure to build in an adjustment formula to accommodate future changes (increase or decrease in workload levels).						MOHSS, OPM, MoF, WHO	Adjustment formula for staffing norms developed; Technical justification submitted to OPM and adopted by 2020	Proposed norms

Strategic Objectives	Main Interventions	Timeframe					Main Actors	Milestones	Means of Verification
		2020	2021	2022	2023	2024 & Beyond			
utilisation in the public health sector towards achieving UHC.	2.2 Make a strong health and economic case to the OPM and MoF to advocate for the approval of the proposed staffing norms (structure) of the MOHSS to support the attainment of UHC with the view of incremental implementation aimed at ensuring financial sustainability (implement between 43% and 80% of the additional positions in the revised structure).						MOHSS, OPM, MoF	Staffing norms adopted by 2020	Adopted staffing norms/approved structure
	2.3 Conduct annual facility-by-facility health workforce gap analysis using the agreed structure (staffing norms) to develop a facility-by-facility annual recruitment and distribution plans which should be dialogued with the OPM/MoF for inclusion in the budget for each financial year.						MOHSS, OPM, MoF	Annual HRH gaps	Annual recruitment plan
	2.4 Engage the private sector in a dialogue to develop a memorandum of understanding for ethical recruitment and dual practice from the public to the private sector and vice versa.						MOHSS, Private Health Institutions	Consensus meeting with the private sector by 2020; MOU by 2021	Activity report; MOU
	2.5 In line with the draft health professions bill, support the HPCNA to implement compulsory community service by new health professionals.						Academic/training institutions, MOHSS, HPCNA, MoE, Council of Higher Education	Consensus built by 2023; implementation from 2024	Reports

Strategic Objectives	Main Interventions	Timeframe					Main Actors	Milestones	Means of Verification
		2020	2021	2022	2023	2024 & Beyond			
	2.6 Dedicate a portion of admissions into training institutions exclusively for students/staff members who would accept to take up employment in rural and underserved areas.						MOHSS, Training Institutions		
	2.7 Develop and implement a performance-based, deprived area incentive scheme to attract and retain staff in underserved areas. The scheme should be non-financial incentives.						MOHSS, OPM, MoF, Professional Associations	Technical proposal submitted to OPM by 2020/2021	Reports
	2.8 Develop a task-sharing policy to guide the use of task sharing initiative for increased service delivery coverage, especially in deprived areas and disciplines.						MOHSS, HPCNA	Task sharing policy/guidelines developed	Policy/guideline document
3. Improve efficiency in health workforce management to catalyse health system performance.	3.1 Strengthen institutional leadership and governance capacities at all levels including the HRH units of regional and district health management teams as well as health facilities management teams.						MOHSS, Development Partners	Capacity building roadmap for HR Practitioners & Managers developed by 2020/2021; 50% of HR Practitioners and Managers capacity built by 2022	Reports
	3.2 Update job descriptions in line with the professional scope of practice to reflect current trends of health needs and professional advancement and disseminate same to employees.						MOHSS, OPM, HPCNA, Professional Associations	Scope of Work developed by 2021; revised job descriptions completed by 2023; Performance metrics agreed by 2024	Reports

Strategic Objectives	Main Interventions	Timeframe					Main Actors	Milestones	Means of Verification
		2020	2021	2022	2023	2024 & Beyond			
	3.3 Accelerate the development of a competency-based framework for all health professionals with the view of strengthening performance management at all levels of health care delivery						MOHSS, HPCNA, Professional Associations, Development Partners	Competency framework developed for all regulated health professionals by 2021	Reports
	3.4 Streamline MOHSS in-service training and development programs to make it inclusive and responsive to institutional needs including a comprehensive training needs assessment in collaboration with relevant stakeholders.						MOHSS, HPCNA, OPM, Professional Associations, Training Institutions, Development Partners	Training needs assessment conducted and develop TOR to engage stakeholders by 2021. Engage stakeholders 2022	Reports
	3.5 Accelerate the implementation of the Employee Wellness Programme (EWP)						MOHSS, OPM, Development Partners	50% of the required staff recruited.2021 EWP Committee formalized and established. Develop EWP Plan by 2020.	Reports
	3.6 Adopt an acceptable metric for routine monitoring of equitable HRH distribution						MOHSS, all stakeholders	Annual equity indices reported	NHWA/ HRH Reports
	3.7 Strengthen partnerships among all relevant stakeholders in the planning, production, and management of HRH:						MOHSS, all stakeholders	Regular scheduled meetings held	Minutes of meetings
	a) *Enhance the HRH coordination mechanism by strengthening the HRH stakeholders' forum*								

Strategic Objectives	Main Interventions	Timeframe					Main Actors	Milestones	Means of Verification
		2020	2021	2022	2023	2024 & Beyond			
	a) *Discussed all new policies and programmes by the Ministerial TWG on HRH to examine the HRH implications for integration into the HRH plan and annual HRH programme of work.*								
	3.8 Advocate for a review of the service delivery model with the view of strengthening primary health care as a vehicle for accelerating the attainment of UHC.						MOHSS, WHO, MoF, OPM, Training Institutions	CHN/CHW training adopted/enhanced	Training reports/statistics /NHWA
	4.1 Urgently develop/adopt a Human Resource Information System (HRIS) that is fit-for-purpose to address the HRH information needs of the ministry and also track the deployment of the workforce.						MOHSS, Development Partners	HRH Information system developed and implemented by 2020	Functional HRH Information System
4: Increase investment in health workforce information, evidence generation and use for decision-making.	4.2 Build the capacity of Human Resource Practitioners and Managers in HRH data management, evidence generation and use for decision-making.						MOHSS, Development Partners	Capacity building roadmap developed by 2020; 50% of HR Practitioners and Managers capacity built by 2022	Reports
	4.3 Implement the National Health Workforce Account (NHWA) and use the indicators for measuring the progress of HRH interventions.						MOHSS, Stakeholders, Development Partners	Regular scheduled meetings held. Annual reporting on WHO NHWA platform. Annual state of HRH reports produced	NHWA

Strategic Objectives	Main Interventions	Timeframe					Main Actors	Milestones	Means of Verification
		2020	2021	2022	2023	2024 & Beyond			
	4.4 Conduct operational HRH research to address current and emerging challenges.						MOHSS, WHO, DPs, Private Sector, NSA	At least one HRH operational research every year	Reports
	4.5 Establish a national health workforce observatory to enhance the collection and integrated analysis of health workforce data as well as serve as a conduit for HRH research.						MOHSS, Advisory Committee, Development Partners	Functional HRH observatory established	Minutes of meetings; Reports
	4.6 Undertake a comprehensive health workforce survey across the entire health sector once every 5 years to detail the health workforce and productivity.						MOHSS, Development Partners, NSA	HRH Survey every 3-5 years	Reports

SECTION SIX

6.0 COST OF IMPLEMENTING THE HRH STRATEGIC PLAN

The HRH Strategic Plan includes a budget detailing the breakdown of the costs for implementing each of the strategies objectives including the wage bill of the estimated public sector HRH needs.

6.1 Costing Approach

A macro-costing approach[9] was used in identifying cost elements based on discussions with the HRH TWG on standard practice with the MOHSS. As a guiding principle, the conservative approach was used to estimate the cost from the perspective of MOHSS. Therefore, the main cost drivers considered for the analysis include:

- Conference package (residential and non-residential)
- Snack and lunch for office meetings
- Technical assistance (national and international consultants)
- Daily subsistence allowance (DSA)/per diem
- Printing
- Computers, server
- Staff cost (salaries of new staff recruitment and existing wage bill)

The costing, however, excludes the day-to-day running cost of the HRH departments of the MOHSS and its decentralized structures as well as the ancillary cost incurred locally at the health facilities.

[9] Stephen Morris, Nancy Devlin, and David Parkin, *Economic Analysis in Health Care* (John Wiley & Sons, 2007).

Table 4: Cost of Implementing the Strategic Plan for the Public Health Sector

Strategic Objective and Cost Drivers	Estimated Initial Cost	Estimated 5-Year Aggregate Cost
1. Align health workforce production capacity and quality to match population health needs and economic demand	**2,503,926,000**	**12,519,343,500**
External Meeting/Training/Conference	**0**	**0**
Office Meeting	25,500	51,000
Printing	0	0
Staff cost	52,500	52,500
Technical Assistance	2,503,848,000	12,519,240,000
2. Optimise the health workforce recruitment distribution retention and utilisation in the public sector towards achieving UHC	**174,021,121**	**869,326,246**
Allowance	0	0
External Meeting/Training/Conference	0	0
Office Meeting	19,840	19,840
Printing	192,500	262,500
Staff cost	173,808,781	869,043,906
Technical Assistance		
3. Improve efficiency in health workforce management to catalyse health system performance	**905,210**	**1,202,710**
External Meeting/Training/Conference	106,250	403,750
Office Meeting	0	0
Staff cost	0	0
Technical Assistance	798,960	798,960
4 Increase investment in health workforce information evidence generation and use for decision making	**2,644,870**	**8,335,070**
External Meeting/Training/Conference	369,750	1,211,250
Office Meeting	6,400	32,000
Printing	52,500	262,500
Procurement	0	0
Technical Assistance	2,216,220	6,829,320
Grand Total	**2,681,497,201**	**13,398,207,526**

6.2 The Estimated Cost

Based on the aforesaid approach and assumptions, it is estimated that the cost of implementing this strategic plan would require N$2.68 billion at the initial period, which would increase five-fold over five years. It is expected that the bulk of this estimated cost (93.4%, N$ 2,503,847,001) would be spent to maintain the current wage bill and also pay the salaries of new staff, leaving only N$ 177,649,201 (6.6%) to be spent on all other activities such as meetings, conferences, technical assistance, printing, and procurement.

In Table ***4: Cost of Implementing the Strategic Plan for the Public Health Sector*** , the expected expenditure is broken down by strategic objective which shows that the second strategic objective (to optimize the health workforce recruitment distribution retention and utilization in the public sector towards achieving UHC) would require 95% of the estimated cost, while the fourth strategic objective would require only 0. 1% of the estimated cost. Additional details of the proposed expenditure disaggregated by specific strategic interventions are outlined in the appendix.

6.3 Resource Mobilisation

In implementing the plan, the MoHSS would incorporate these estimates into its overall resource mobilisation plan to ensure that the plan is well-resourced to achieve its intended purpose. The plan would be shared with development partners as the HRH priorities of the government, and then development partners could indicate the interventions/areas that they could support and the extent of support that could be availed for implementing them. Development partners are thus entreated to plan their HRH support and activities considering this plan. On an annual basis, an operational plan or programme of work would be developed by MoHSS and the elements that remain unfunded from development partners would then be submitted to the Ministry of Finance as part of the global MoHSS budget for consideration in the annual government budget allocation.

SECTION SEVEN

7.0 MONITORING AND EVALUATION PLAN

7.1 Introduction

The monitoring and evaluation of this strategic plan will form part of MoHSS' commitment to prudent management and accountability practices within the health sector. This monitoring and evaluation (M&E) framework seek to place HRH M&E within a broader health sector management and accountability framework. It provides direction for the development of annual HRH operational plans and how such results could be showcased to stakeholders as part of the accountability and transparency processes.

The main goal of the M&E framework is to have a coordinated and effective mechanism that supports evidence-based HRH decision-making and accountability in the health sector.

Monitoring of the key milestones of this plan will be done on quarterly basis by the ministerial HRH TWG; the outcome indicators analysed and reported annually while a mid-term review of the plan will be done in 2023 to coincide with the review of the MoHSS health sector strategic plan (2017/18 -2021/22) and NDP 5 to inform possible revision of the strategies.

7.2 Mechanism for Collaborative Data Collection, Storage, Analysis and Dissemination

Monitoring and evaluation of the plan including reporting on progress will also be the responsibility of the MoHSS through the ministerial TWG on HRH and HRH stakeholder's forum in line with agreed indicators. All relevant stakeholders and institutions are entreated to report the relevant data periodically within the framework of the national health workforce observatory. The success of this M&E plan builds upon five critical pillars:

1. Stakeholder collaboration and accountability
2. Timely, reliable, and accurate data
3. Comprehensive data repository
4. Timely analysis and use of information
5. Feedback, supportive monitoring, and supervision

M&E Pillar 1: Stakeholder collaboration and accountability

- MoHSS shall engage its stakeholders through the HRH stakeholders' forum twice a year and as may be required from time to time.
- Stakeholders and institutions shall submit relevant reports and data through the HRH information system to be established and/or using an agreed reporting template.
- Routine data from Mission Health Facilities, Private health services and State-owned Enterprises (SOE's) will be routed through a designated focal point at the MoHSS.
- Mission Health Facilities, Private health services and SOE's shall share their HRH data with the Regional Health Administration of their catchment area to facilitate local dialogue.
- The MoHSS will provide support to private providers to obtain comprehensive data with the utmost confidentiality.

M&E Pillar 2: Timely, reliable, and accurate data

- MOHSS and its other stakeholders shall submit the relevant HRH-related data and reports to the MOHSS based on agreed reporting timelines
- The stakeholder shall be requested to submit special reports on the implementation of planned activities, programs, and projects arising from this plan using an agreed upon monitoring tool.
- All stakeholders shall ensure that all data submitted are validated.

Table 5: Definition of Timeliness of Data/Report Submission

No.	REPORTING FREQUENCY	DUE DATE
1.	Monthly	10th of the preceding month
2.	Quarterly	15th of the preceding month at the end of the quarter
3.	Mid-year	End of October
4.	Annual	Beginning April of the preceding year

M&E Pillar 3: Comprehensive data repository

- The MOHSS, with the consent of OPM, will urgently establish an HRH information system of comprehensive HRH data reporting, monitoring, and evaluation, managed by MOHSS.
- Data from this repository will be the main source of information for international HRH data reporting on the NHWA data platform of WHO.
- Requests for data from the MOHSS shall be through a formal request to the executive director of MOHSS.

M&E Pillar 4: Timely analysis and use of information

- A data analysis subcommittee of the HRH forum will support the MOHSS as may be needed to collate, analyse, and interpret the data from all institutions and stakeholders and generate reports and measure agreed indicators annually.
- The analysed data will be validated during the June/July HRH forum, which will also discuss the implications of the results for revision of the strategic intervention and formulation of new strategies.

M&E Pillar 5: Feedback and dissemination

- The MOHSS shall provide feedback to the reporting institutions about the quality of the data and reports (completeness, accuracy, and timeliness). Where there are issues for clarification, the institutions shall respond to the feedback according to agree upon timelines.
- The MOHSS will periodically disseminate updated information on the HRH situation through the HRH forum and/or annual state of HRH report.

Table 6: Proposed Indicators for Monitoring the HRH Strategic Plan

No.	Indicator	Measurement		Target				
			Baseline (2018)	2020	2021	2022	2023	Data Source(s)
	Objective 1: Align health workforce production capacity and quality to match population health needs and economic demand							
	The stock of HRH (aggregate and specific categories)	Percentage increase in the stock of HRH					>24%	NHWA, HPCNA
	The proportion of national HRH needs to be trained locally	Percentage HRH supply from local training institution as a percentage of projected national needed					>80%	NHWA; HRH observatory
	Increase in enrolment for cadres in short supply	Percentage increase in enrolment for cadres in short supply (as defined in this strategic plan or agreed at stakeholder's forum)					>20%	Training institutions, NCHE, HPCNA
	Number of medical, pharmacy and allied health students offered admission and linked to vacancies in deprived areas	Percentage of students (medicine, pharmacy, allied health) offered admission linked to deprived areas.					>5%	Training institutions
	New programmes introduced (that used to be unavailable)	Percentage of new programmes to address shortages identified in the national HRH strategic plan					>20%	Training institutions
	Additional clinical training sites (including private sector)	Percentage of additional clinical training sites accredited					>80%	HPCNA
	Objective 2: Optimise the health workforce recruitment, distribution, retention and utilisation in the public sector towards achieving UHC							
	Total HRH spending as a proportion of Current (Total Health Expenditure (public and private)	Total HRH spending/ Current Health Expenditure	≥29%	≥30%	≥30%	≥35%	≥35%	National Health Account; NHWA
	Vacancy rates in the public sector (per staff category)	The proportion of approved post unfilled	<29%	<25%	<22%	<20%	<15%	NHWA; MoHSS Annual reports
	Staff availability ratio (aggregate and per category)	The proportion of projected HRH need that is met by the level of supply		>65%	>65%	>65%	>75%	Annual HRH gap analysis report;

No.	Indicator	Measurement		Target				
			Baseline (2018)	2020	2021	2022	2023	Data Source(s)
								NHWA; HRH observatory
	Attrition rate (aggregate and per category)	The proportion of the health workforce that exit employment			>2%	>2%	>2%	Annual HRH gap analysis report; NHWA; HRH observatory
	Staffing norms implementation rate (public sector)	The proportion of additional positions (as per staff establishment) filled		<43%	<48%	<50%	<55%	OPM HCMS; MoHSS reports
	Crude geographical Equity: Doctor to population	A region with highest ratio/a region with lowest ratio	24.7	<23	<20	<15	<10	Annual HRH gap analysis report; NHWA; HRH observatory
	Equity geography: Nurse to population	A region with highest ratio/region with the lowest ratio		<1.9	<1.85	<1.8	<1.75	Annual HRH gap analysis report; NHWA; HRH observatory
	Proportion of the health workforce retained in deprived areas (health sector)	Number of health workers in deprived areas as a percentage of the total						NHWA, HRH Observatory, MoHSS Annual report
	Health worker unemployment rate	Proportion of registered health workers not employed but actively seeking employment					>5%	MoLIREC, HPCNA, NHWA, Workforce survey,
	Objective 3: Improve efficiency in health workforce management to catalyse health system performance							
	Doctor, nurse and midwife per 1,000 population (national and regional) – Separate public and private	Total number of doctors, nurses and pharmacists divided by population per 1,000					>5.6	Annual HRH gap analysis report; NHWA; HRH observatory
	Health worker absenteeism	Average number of days health workers were absent from work						Workforce survey
	Doctor: Population ratio (public sector) – National and Regional	Number of doctors /populations				1:1457	1:1457	MoHSS HIMS & NSA

No.	Indicator	Measurement		Target				
			Baseline (2018)	2020	2021	2022	2023	Data Source(s)
	Nurse: Population ratio (Public sector) – National and Regional	Number of nurses/populations				1:280	1:280	MoHSS HIMS & NSA
	Citizens satisfaction with health worker attitude	Citizens negative ratings of health workers attitude	65%				<30%	Citizens' satisfaction surveys, NSA
	Health workforce satisfaction rate	Proportion of health workers who are satisfied with their working conditions					70%	Health Worker job category-specific survey
	Objective 4: Increase investment in health workforce information, evidence generation and use to support decision-making.							
	The extent of NHWA implementation	Number of NHWA modules reporting at the WHO data platform (Country maturity assessment)					90%	NHWA data platform

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APPENDIX 1: DETAILED COST ESTIMATES – DISAGGREGATED BY STRATEGIC OBJECTIVES, INTERVENTIONS AND COST CLASSIFICATION

Strategic Objective and Cost Drivers	Estimated Initial Cost	Estimated 5-Year Aggregate Cost
1. Align health workforce production capacity and quality to match population health needs and economic demand	**2,503,925,001**	**12,519,338,505**
1.1 Annually update the projection of the numbers of various health workers needed in Namibia		
1.2 Institute an annual multi-stakeholder dialogue with academic and training institutions to plan the numbers and priority areas for student intake based on projected needs of the health sector (both public and private).		
1.3 Collaborate to review and harmonise the various training curricula to reflect desired skills and competencies that addresses the population health needs and contemporary issues in health service delivery.		
1.4 Increase the training of specialist health professionals in accordance with the projected needs to address the ageing specialist workforce challenge as well as the epidemiologic and demographic transition of the country. In furtherance the MoHSS should:		
External Meeting/Training/Conference		
Printing	52,500	52,500
Staff cost	2,503,847,001	12,519,235,005
1.5 Academic institutions to introduce programmes for the training of health professionals whose training is not adequately available in Namibia.		
External Meeting/Training/Conference		
1.6 Promote the utilisation of centres of excellence in the Region as well as academic collaborations to facilitate the training of highly skilled health professionals.		
Non-Cost item		
1.7 Identify and accredit additional health facilities to serve as clinical internship training sites. In this regard, a collaboration with well-established private health facilities should be considered.		
1.8 Support the HPCNA to strengthen the licensing examination system for all health professionals prior to their professional registration with the HPCNA and ensure that the renewal/maintenance of practice license is linked to evidence of continuous professional development and practice.		
External Meeting/Training/Conference	25,500	51,000
1.9 Encourage HPCNA to improve the student registration and tracking system.		
1.10 Encourage HPCNA to develop/review scope of practice for all health-related professions underpinned by detailed task analysis. The HPCNA should enforce same to streamline the practice of various health workers.		
1.11 Explore the feasibility of training Community Health Nurses/officers who would focus on community-based health care to strengthen the primary health care system. These would strengthen the supervision and effectiveness of the existing Community Health Workers.		
External Meeting/Training/Conference		
Printing		
Technical Assistance		

Strategic Objective and Cost Drivers		
2. Optimise the health workforce recruitment distribution retention and utilisation in the public sector towards achieving UHC	**174,021,121**	**869,326,246**
2.1 Consider a flexible staffing norm for the proposed MoHSS structure to build in an adjustment formula to accommodate future changes (increase or decrease in workload levels).		
Office Meeting	9,600	9,600
Printing	175,000	175,000
2.2 Make a strong health and economic case to the OPM and MOF to advocate for the approval of the proposed staffing norms (structure) of the MoHSS to support the attainment of UHC		
2.3 Conduct annual facility-by-facility health workforce gap analysis using the agreed structure (staffing norms) to develop a facility-by-facility annual recruitment and distribution plans which should be dialogued with the OPM/MOF for inclusion in the budget for each financial year.		
Printing	17,500	87,500
2.4 Engage the private sector in a dialogue to develop memorandum of understanding for ethical recruitment and dual practice from the public to private sector and vice versa.		
2.5 Institute compulsory community service by all new health related graduates as a prerequisite to be registered as independent practitioners. These regulations should be enforced by HPCNA.		
2.6 Dedicate a portion of admissions into academic/training institutions exclusively for students who would accept to take up posts in rural and underserved areas.		
2.7 Develop and implement a performance-based, deprived area incentive scheme to attract and retain staff in underserved areas. The scheme should also include non-financial incentives.		
2.8 Engage OPM to institute a preferential promotion concession for those serving more than an agreed number of years in the rural and hardship areas. In this regard, the MoHSS shall develop a technical proposal and submit to OPM for consideration.		
Office Meeting	10,240	10,240
2.9 Develop task-sharing policy to guide the use of task sharing initiative for increased service delivery coverage especially in deprived areas and disciplines. This could be linked with the proposed review of the scope of practice.		
2.10 Sustainably increase the recruitment of skilled health workers into the public health sector.		
Staff cost	173,808,781	869,043,906
3. Improve efficiency in health workforce management to catalyse health system performance	**905,210**	**1,202,710**
3.1 Accelerate the alignment of HRH functions into one directorate in line with the recommendations of the Presidential Commission of Enquiry.		
3.2 Strengthen institutional leadership and governance capacities at all levels including the HRH units of regional and district health management teams as well as health facilities management teams.		
External Meeting/Training/Conference	63,750	191,250
3.3 Update job descriptions in line with professional scope of practice to reflect current trends of health needs and professional advancement and disseminate same to employees.		
Technical Assistance	798,960	798,960

Strategic Objective and Cost Drivers		
3.4 Accelerate the development of a competency-based framework for all health professionals with the view of strengthening performance management at all levels of health care delivery		
3.5 Streamline in-service training and development to make it inclusive and responsive to institutional needs including a comprehensive training needs assessment in collaboration relevant stakeholders.		
3.6 Accelerate the implementation of Employee Wellness Programme (EWP) including occupational health and safety.		
3.7 Adopt an acceptable metric for routine monitoring of equitable HRH distribution		
3.8 Strengthen partnerships among all relevant stakeholders in the planning, production, and management of HRH:	42,500	212,500
External Meeting/Training/Conference		
4 Increase investment in health workforce information evidence generation and use for decision making	**2,644,870**	**8,335,070**
4.1 Urgently develop/adopt a Human Resource Information System (HRIS) that is fit-for-purpose to address the HRH information needs of the ministry and also track the deployment of the workforce.	318,750	956,250
External Meeting/Training/Conference		
4.2 Build the capacity of Human Resource Practitioners and Managers in HRH data management, evidence generation and use for decision-making.		
4.3 Implement the National Health Workforce Account (NHWA) and use the indicators for measuring the progress of HRH interventions.		
4.3.1 Conduct operational HRH research to address current and emerging challenges.	6,400	32,000
Office Meeting	35,000	175,000
Printing		
4.3.2. Conduct operational HRH research to address current and emerging challenges.	17,500	87,500
Printing	399,480	1,997,400
Technical Assistance		
4.4. Establish a national health workforce observatory to enhance the integrated analysis of collected health workforce data as well as serve as a conduit for HRH research.	51,000	255,000
External Meeting/Training/Conference	399,480	1,997,400
Technical Assistance		
4.5 Establish a national health workforce observatory to enhance the collection and integrated analysis of health workforce data as well as serve as a conduit for HRH research.		
4.6 Undertake a comprehensive health workforce survey across the entire health sector once every 5 years to detail the health workforce and productivity.	1,417,260	2,834,520
Technical Assistance	**2,681,496,202**	**13,398,202,531**
Grand Total	**2,503,925,001**	**12,519,338,505**

APPENDIX 2: NAMES OF THE PARTICIPANTS FROM STAKEHOLDERS VALIDATION MEETING

No	Name & Surname	Institution/Organisation/Region
1	S Amwaama	Ministry of Health and Social Services
2	R Diergaardt	Dietetic Association
3	H Mouton	Ministry of Health and Social Services
4	E Namakasa	Ministry of Health and Social Services
5	S Ndakolo	Ministry of Industrial Relations & Employment Creation
6	R Bock	IntraHealth International Namibia
7	P McQuide	IntraHealth International
8	S Van Der Walt	International University of Management
9	L Van Der Westhuizen	University of Namibia
10	N Shoopala	Centres for Disease Control
11	D Lee	United States Agency for International Development
12	G Garises	Namibian Oncology Centre
13	M Mathambala	Potentia Namibia
14	J Veii	Ministry of Health and Social Services
15	M Titus	IntraHealth Namibia
16	F Amaambo	University of Namibia
17	H Haihonya	Ministry of Health and Social Services
18	J Shatilwe	Ministry of Health and Social Services
19	B Katjivena	Ministry of Health and Social Services
20	S Nakamhela	Ministry of Health and Social Services
21	M Likukela	Office of the Prime Minister
22	A Benjamin	National Health Training Centre
23	T Mbeeli	Ministry of Health and Social Services
24	T Uutsi	National Council for Higher Education
25	C Usiku	Ministry of Health and Social Services
26	M Brantuo	World Health Organisation
27	M Tsheehama	National Planning Commission
28	A Ngeema	Ministry of Industrial Relations & Employment Creation
29	P Kanyimba	Ministry of Health and Social Services
30	R Nakanyala	Office of the Prime Minister
31	T Ukola	Ministry of Health and Social Services
32	F Tjituka	Ministry of Health and Social Services
33	E Katamba	Ministry of Health and Social Services
34	A Uakurama	Ministry of Health and Social Services
35	P Kosmas	World Health Organisation
36	B Nangombe	Ministry of Health and Social Services
37	C Apollus	Ministry of Health and Social Services
38	J Asamani	World Health Organisation
39	A Haihambo	Ministry of Health and Social Services
40	L Nghipandulwa	Ministry of Health and Social Services
41	S Mbangu	National Planning Commission
No	**Name & Surname**	**Institution/Organisation/Region**
42	S Kadhila-Amooma	Ministry of Health and Social Services
43	A Isaacs	Ministry of Health and Social Services
44	W Haraseb	Office of the Prime Minister

45	C Nashenda	Namibia Society of Physiotherapy
46	M Mukesi	Namibia University of Science and Technology
47	L Shikongo	IntraHealth Namibia
48	M Black	Ministry of Health and Social Services

NATIONAL HUMAN RESOURCES FOR HEALTH STRATEGIC PLAN, 2020 – 2030

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REPUBLIC OF NAMIBIA
MINISTRY OF HEALTH AND SOCIAL SERVICES