Ministry of Health and Social Welfare

Final Evaluation Report for Human Resource for Health Strategic Plan 2009 - 2013

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Executive Summary

The global shortage and crisis in HRH is increasingly recognized as a factor impairing health system performance particularly in developing countries. The history of Human Resource for Health Strategic planning in Tanzania can be traced back to in 1996 when the first plan was developed. So far three different HRHSP have been developed the last one being the HRHSP 2008 -2013.

In 2012 the midterm evaluation for HRHSP III was conducted to establish whether the progress in implementation is as planned. This report presents findings from the final evaluation of the 2008-2013 Human Resource for Health Strategic Plan, which was commissioned by MOHSW with the financing support from JICA- the HRH development project to Ifakara Health institute (IHI). The key focus of this evaluation is to provide an objective assessment of the implementation of the Strategic Plan in relation to its defined objectives, activities and expected outputs and planning assumptions in these five years.

The evaluation applied both qualitative and quantitative approaches. *Key informant interview and document review were the main data collection methods.* All qualitative data was analysed manually using a thematic and subject grouping technique and some of Quantitative data were analysed using STATA computer software.

Among key findings from the evaluation includes the fact that HRHSP 2008-2013 was found to be responsive to these strategic frameworks and the key seven strategic objectives proved relevant for creating expected value. It was established by almost all respondents that the strategy and its objectives are still very relevant. Harmonization of HRH planning with the overall health planning process was however found to be problematic area.

The evaluation unveiled the serious commitment on addressing key HRH issues in the country by the Government. It was noted that the Government of Tanzania made three major commitments in the global health workforce conference took place in Brazil – September 2013 – (Box 1). Despite this commitment, the country is still struggling in ***service delivery situation*** contributed significantly by HRH issues. Still the urban – rural inequity prevails whereas medical professionals found in urban are five times more than professionals found in rural areas where 70% of population live. Working conditions for HRH are yet to be significantly improved. These and other factors have continued to translate to low performance of the health system institutional delivery is still low (52%), coverage of Emergency Obstetric Care the coverage for Basic Emergency Obstetric care BEMOC is still low at 20% for dispensaries, 39% for health centres.

***Health Financing Context is still unfavourable*.** Although records indicate that Total Health Expenditure Per Capita increased from $26 to $37, the government contribution 63% to 37%. As a result HRH is still ill financed.

Decentralization and Human Resources Recruitment Process ishampered by many factors. Evidence indicate that granting autonomy to LGAs over their own personnel did not work as expected.

As far as success in***Implementation Mechanism of the strategy*, several issues were explored.** ***Coordination mechanism*** was among them and it was established that the technical working group (TWG) is the key structure that brings together HRH actors in planning how to operationalize the

strategy. It is used as forum for gathering progress, sharing information and planning accomplishments. Challenges of this approach included lack of transparency of finances by actors, attendance of all actor in TWG meetings and problems in implementation especially on recruitment where multiple actors are involved and coordination proved to be difficult. At district level it was found that there is no a clear mechanisms to coordinate HRH actors.

Monitoring, Evaluation and Learning were found to mainly rely onHMIS, OPRAS analysis for staff performance and field visits. The strategy was monitored through meetings of the TWG. Monitoring was not systematic to assess overall activities but rather concentrated only on activities which had been favoured by actors. The monitoring has been reported by some respondents as weak due to the fact that Strategic Objectives (SOs) Committees do not report to the TWGs on progress every month as planned. The Mid–term evaluation also provided an additional monitoring and evaluation input. In addition, it was found that, in ***strengthening HRH Research and Development***the research efforts are ill coordinated and the focus is more on identifying the "*what questions"* and limited researches focused on operational research to answer "*how and why questions".*

Communicating the strategy and Dissemination of Midterm evaluation findings of HRHSP 2008-2013was found to be unsatisfactory. The dissemination of the strategy mostly depended on integrating it with other activities within the ministry due to financial constraints. As a result channels for communicating strategies and reports were taken by chance and not deliberately planned due to limited funding. Ultimately, the popularity of the strategy remained better known at national than district and lower levels.

Lessons were also drawn from***HRH Planning. Establishing HRH requirement was successfully conducted by the*** MOHSW (with support from JICA) which enabled development and rolling out of HRIS and TIIS systems. The two information systems were set to enable training institutions and health facilities manage HRH information. ***Similarly in strengthening leadership and stewardship in HRH,*** the focus was to develop capacity of leaders in the Health and Social Welfare sector advocacy and resource mobilization. A number of activities have been implemented as steps in strengthen leadership and stewardship successfully.

On the other hand improvement in ***Education, Training and development for HRH*** was also given an emphasis. However, the majority of the existed workforce (43%) was MCH Aide and Medical Attendants who entered into services with standard seven certificates whose career development was difficult to implement. There were plans to encourage and support the upbraiding of these cadres to meet the acceptable qualifications. Alongside this, ***Continuous Professional Development***(CPD) was found to be not adequately emphasized. CPD is mostly confined that class room based. Distance learning and telemedicine are at their infancy. CPD is not well related and integrated into service provision and practice and thus not reflected in the allocation of health care budgets.

Despite these implementation challenges in education and training***, training outputs*** have been remarkably fair**.** The number of enrolled students doubled. Governmental support for candidates applying for the loan from the loan board this has always helped to maintain a reasonable flow of applicants training. In addition, Tanzania is harnessing Public Private Partnership in training and the contribution of non-public - non-government institutions

In improving ***Workforce Management and Utilization***, ***reviewing recruitment procedures to reduce bureaucracy*** has been done.BMAF published a booklet highlighting recruitment bottlenecks. Several discussions have been conducted regarding how best to improve recruitment process. Among

important issues considered include ***Retention*** whereby evidence show that about 53% of skilled staffs in the districts are intending to leave services (HRH research synthesis commissioned by GIZ in 2011). Closely related to this, the ***Performance Management and Reward Systems*** are still not optimized to bring motivation to HRH. Still promotion and career advancement are awarded arbitrarily considering staff working experiences despite the introduced Open Performance Review Appraisal System (OPRAS) since 2004. Health workers and supervisors are reluctant to use OPRAS.

Generally, the evaluation found that, while the MOHSW and partners are embarking on HRHSP IV, there are a lot of lessons to be drawn from HRHSP III. The SOs are still relevant and findings from mid-term and final evaluation of HRHSP III are essential resources and inputs towards development of HRHSP IV and its corresponding plan of action.

Conclusions and Recommendations

Key Areas of Recommendations	**Conclusion**	**Recommendations**
Relevance of the strategic objectives and strategies	HRHSP (2008-2013) is still a relevant strategy. However, there is a limited attention to Social Welfare human resource issues	Development of the next strategic plan should reflect much on what has been planned in the current strategy BUT also add the Social Welfare Human Resource component
Accomplishment of Strategic Objectives	Accomplishment by strategic objectives is good about 80%.	• In future implementation of HRHSP SOs should take recognition of employers in Local authorities Regions, Councils) where HRH needs / demands stem. • There is a need for the Government to improve HRH funding to enhance implementation of planned objectives • The forthcoming strategic plan should reflect needs as well as feasibility in terms of time and financing – should be more strategic and realistic • Operational planning should be conducted to enhance translation of the strategic plan into actions
Coordination of stakeholders	The mechanisms which were put into place provided an enabling environment to coordinate stakeholders and facilitated many activities to be implemented in the HRHSP	• The PPP need more involvement so as to augment more resources in HRH production and deployment. • Improve coordination among HRH actors at all levels for both public and private
Research and Development	Limited achievement is recorded in research	• Research priorities be identified by involving more actors in the Districts, Private health sector, and FBOs so as to tap their potential and resources needed to conduct research • Research institutions should be active participants in developing HRH research proposal that answer key strategic questions of decision makers

Key Areas of Recommendations	Conclusion	Recommendations
		• Government and development partners should set aside research funding to promote evidence based HRH policies and plans
Recruitment	Although efforts to improve recruitment challenges has been made coordination problem still exist	• Attention be paid to Social Welfare Human Resource in training, development, deployment and distribution. • The staffing levels guideline need to be gauged with the WHO guideline which addresses the Workload Indicator for Staffing Needs (WINS) so as to ensure that no over staffing is done to health facilities with far less Workload in terms of Burden of Diseases and population. • Recruitment Authorities (MHOHSW, Councils) should prepare succession plan using the HRH-IS to match the attrition rate • Coordination of actors in recruitment process should be strengthened • Capacity of LGAs to manage recruitment process should be developed to reduce avoidable mistakes in recruiting staff • Increase wage bill so that it matches the need to avoid the emerging tendencies of not absorbing fully produced Doctors. • The staffing levels guideline need to be gauged with the WHO guideline which addresses the Workload Indicator for Staffing Needs (WINS) so as to ensure that no over staffing is done to health facilities with far less Workload in terms of Burden of Diseases and population. • Disseminate and enforce utilization of the new staffing levels guideline the Public Service Pay and Incentive Policy of 2010
Performance Management	Although OPRAS is an official performance appraisal system its uptake is unacceptably low	• Orientation of managers and staff on OPRAS should be done • Address issues leading to limited functionality of OPRAS • Enforce performance appraisal at all levels • Re-align line managers to adhere to performance management ethics
Training and Development	There has been a lot of effort to increase training intake ,development of HRH both pre and In-	• Increase intake for Laboratory Technicians and Pharmaceutical Technicians to alleviate their acute shortage

Key Areas of Recommendations	Conclusion	Recommendations
	service, BUT the there is still a big gap to fill required posts	• Create a smooth and enabling environment for the private sectors to participate in the production of HRH in the country
HRH retention	There have been good practices by Development Partners, and LGAs/Councils in devising retention packages for HRH.BUT in other employment authorities these are lacking	• Operationalize the Public Service Pay and Incentive Policy through providing financial allocations specifically for HRH Retention
Monitoring and Evaluation	• There was no robust monitoring and evaluation framework guiding learning for HRHSP implementation	• The future HRHSP should be embedded with robust M&E framework that will guide monitoring and learning • M&E results should be disseminated to all stakeholders and follow-up made for implementing recommendations. • Decentralize HRH M&E to council level so that it can track easily and timely HRH issues of specific to localities. •

List of Abbreviation

BMAF	Benjamin William Mkapa Foundation
CCHP	Comprehensive Council Health Plans
CHMT	Council Health Management Team
CIDA	Canadian International Development Agency
DC	District Council
DHS	District Health Secretary
DMO	District Medical Officer
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit www.giz.de
HMIS	Health Management Information System
HRD	Human Resource Development
HRH	Human Resources for Health
HRHIS	Human Resources for Health Information System
HRHSP	Human Resources for Health Strategic Plan
JICA	Japan International Cooperation Agency
MDGs	Millennium Development Goals
MOH&SW	Ministry of Health and Social Welfare
OPRAS	Open Performance Appraisal System
PMORALG	Prime Minister's Office Regional Administration and Local Government
RHMT	Regional Health Management Team
RMO	Regional Medical Officer
R-RHMT	Regional Referral Hospital Management Team
TWG	Technical Working Group
USAID	United States Agency for International Development
WHO	World Health Organization

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Section One: Introduction and Background

Introduction

This is a final evaluation report for the 2008-2013 Human Resources for Health Strategic Plan (HRHSP). JICA/MOHSW Human Resources Development Project to Ifakara Health Institute (IHI) commissioned the evaluation. The evaluation was conducted from November 2013 to Mid January 2014. The report is organised in 4 sections. Section one gives a background of HRH strategic planning in Tanzania, the midterm evaluation findings and the objectives of the 2008-2013 HRHSP final evaluation. Section two describes the evaluation approach and methodology. Section three outlines key findings of the final evaluation. Section four draws major conclusions, recommendations and key strategic areas for the forthcoming HRHSP 2014-2019.

Background of HRH Strategic Planning in Tanzania

Human resource for health (HRH) is one of theimportant components of the health system. The global shortage and crisis in HRH is increasingly recognized as a factor crippling health systems and jeopardizing curative, preventive and health promotion efforts. Health workforce is also known to absorb a great share of the health budget both the total and recurrent expenditures. Human resource planning is an entry point to define and address health workforce issues. The history of Human Resource for Health Strategic planning in Tanzania can be traced back to in 1996 when the first plan was developed. The second one was developed in 2008 and the next one will be the third health sector HRH strategic plan expected to cover the period between 2014 and 2019. The first HRH strategic plan(1996- 2001) focused mainly on elevating HRH issues to a level of recognition in the health sector reforms and decentralization. The second was the strategic plan 2008-2013 which to a larger extent adopted what was stipulated in the previous plan with addition of aspects such as public private partnership. The 2008-2013 had the following strategic objectives:

S.O 1: To improve HRH Planning and Policy Development Capacity
S.O 2: To strengthen leadership and stewardship in HRH
S.O 3: To Improve Education, Training and development for HRH
S.O 4: To improve Workforce Management and Utilization
S.O 5: To build and Strengthen Partnerships in HRH
S.O 6: To strengthen HRH Research and Development
S.O 7: To Promote adequate financing of HRH strategic Plan

HRHSP 2008-2013 – Midterm Evaluation

In 2012 the midterm evaluation was conducted to establish whether the progress in implementation is as planned. The following were conclusions and recommendations

Table 1: Midterm Evaluation Conclusion and Recommendations

Assessment Area	Conclusion	Recommendations
Strategy relevance	The evaluation concludes that HRHSP (2008-2013) is still a relevant strategy in the current Health System context at all levels; the contents are relevant and comprehensive.	Development of the next strategic plan should reflect much on what has been planned in the current strategy
Strategy Design	The design of the HRHSP was good, the strategic areas were well thought of and process involved a range of relevant stakeholders in HRH	1. There is a need to revisit the HRHSP Strategic Objectives and activities so that priority is assigned to those which can be implemented in line with foreseeable resources within the Health system.
Organisation of Strategy implementation	1. Implementation of the strategy is well organised in terms of structures for coordination and reporting of the progress. 2. The lack of formal annual plans have probably influenced how much is achieved in implementations as there are no deadlines for accomplishing task and the extent to which the strategy is financed and distribution of actors to addressing all strategic objectives. 3. Tracking progress is concluded to be less robust as the key forum for tracking progress is the HRH technical working group. Less is done outside this forum 4. Financing: The strategy received due attention from actors and the financing though not enough but much has been done in this area and this is positive and commendable.	1. There is a need to recast the implementation plan for the remaining period taking into account priority activities, abilities of actors , resources availability and time 2. Devise mechanism for tracking progress other than TWG 2. The strategy needs more support financially so as to realize envisaged milestones.
Achievement of strategic objectives	1. The Ministry of Health and Social Welfare, RHMTs, CHMTs and Development Partners have attempted the implementation of all Strategic Objectives and the implementation is still on-going for almost all planned activities. 2. The fact that at the beginning there were no operational plan and no	1. There is a need for the Strategic Objectives teams to link with Districts CHMTs, Regions-RHMTs so as to decide on which activities need to be implemented at which level in priority order. Otherwise there will be duplication and efforts will bear no tangible results. 2. Improve coordination among MOHSW and POPSM /POMLARG on HRH Information System, ceiling and funding 3. Research priorities be identified by involving more actors in the Districts

Assessment Area	Conclusion	Recommendations
	targeted funds for implementation, implementation could not start at the very beginning of 2008, rather later in the 2009/10 period. However the implementation status of most of the strategic objectives is impressive especially those having a booster from Development Partners' funding.	where HRH variety of problems are being faced 4. Efforts should be devoted in strengthening Distance learning areas by also taking advantage of the expanding E-learning programmes so that more health workers can access learning without necessarily relying on Institutionalized learning programmes

HRH 2008-2013 Final Evaluation objectives

The final evaluation of the 2008-2013 Human Resource for Health Strategic Plan was commissioned by MOHSW with the financing support from JICA- the HRH development project. The key focus of this evaluation is to provide an objective assessment of the implementation of the Strategic Plan in relation to its defined objectives, activities and expected outputs and planning assumptions in these five years. The main objectives are (Annex 1 –TOR):

- To review the implementation of Human Resource for Health Strategic Plan to identify progress made against planned targets and activities, accomplishments and challenges for the period of 2008-2013.
- To document successes, challenges and lesson learnt during the implementation period documented with a view to identifying factors that contributed to success or failure.
- To make specific comments on recruitment, distribution, retention, performance management, investment in the HRH infrastructure (space, housing, learning materials, equipment), staffing situation, opportunities for public/private partnership for training and funding for the HRH plans.
- To identify specific lessons learned through implementation of the current plan and come up with recommendations for the new plan 2014-2019.

Section Two: The Evaluation Approach and Methodology

Approach

The evaluation applied both qualitative and quantitative approaches. Quantitative data gathered included achievements against planned targets. Qualitative data enabled the evaluation together information that explains how things were done and why the situation is as it is.

Data collection methods

The main approach in executing this assignment was through ***key informant interview and document review.*** A significant amount of the information on the strategy implementation was captured through document review, the key informant interview method was employed to extract specific learning on enabling factors and barriers that had made the strategy a success or fail, describing the process by which the strategy was implemented and soliciting opinions and recommendations for future improvements. The description below elaborates how each method was used.

Key Informant Interviews

Interviews were conducted at national, regional and district levels. At national level development partners, MOHSW and POPSM officials were interviewed. The key informants at regional level were Regional Health Management Team members and at council were Council Health Management Team members and District Health Management Team members.

Documentary Review

Policies, strategies, reports and studies were consulted. A review guide and checklist was prepared for the sake allowing extraction of quantitative data such as HRH recruitment rates, retention rates, attrition rates, funding amounts and trends to the strategy as well as distribution patterns of HRH in various regions.

Study areas

A strategic selection of study areas have been decided purposefully following the government commitments made at Global Health Conference where five regions were identified as areas with serious crisis. These are Rukwa, Singida, Tabora and Shinyanga. This was done after agreement made by members of HRH Technical Working Group. In each region two districts were purposively selected representing urban and the other rural

The following regions were selected purposely for this evaluation; Rukwa, Singida and Tabora. However two clusters (Municipal council and District council) in each region were purposely selected for this evaluation. Tools were developed to capture key information from the respondents.

Data analysis

All qualitative data was analysed manually using a thematic and subject grouping technique and some of Quantitative data were analysed using STATA computer software.

Section Three: Evaluation Findings

Introduction

This section highlights evaluation findings according to the major areas of interest of this evaluation outlined hereunder.

- The health systems context and how it influences HRHSP implementation
- Continued Relevance of the strategic Areas
- Implementation Mechanism
- Accomplishment status of planned activities
- Lessons learned
- Conclusions and recommendation

The Health Systems Context

Policy and Strategic Frameworks

The country has multiple strategies and policies that are set to address key issues with reference to health service delivery. These serve as Macro and Micro guidance for planning and delivery of health services. They generate a collective focus towards the overall development vision of the country (MOHSW 2013). The relevant documents for the health sectors are: Tanzania vision 2025 (1999 – 2025), Tanzania Five Year Development Plan (FYDP) 2011/12-2015/6 and The National Strategy for Growth and Reduction of Poverty 2010 – 2015 (MKUKUTA II). Since MKKUKUTA is set also to focus country's attention to the Global Millennium Development Goals (MDGs), majority of the MKUKTA indicators are health indicators. The implication for these strategic frameworks is that they call for the stronger HRH planning and policies, rational distribution for human resources, improving and managing HRH performance as well as target and strategic HRH production in order to meet health targets and attain envisaged health gains.

On the other hand there are policies from Presidents office Public Service Management that influence HRH management matters. These include pay and incentive policies; the code conducts, as well as other HR management issues in standing orders and other documents. However, it was found that given the existing crisis employing HRH who are over 45 years will be one of the strategies to cab the crisis. This is because there are health workers who worked with private when there was a freeze in employment on the government side. They would love to join government but fail to get employed due to age limits. Considering increasing deployment in public service of health workers over 45 years will be a strategic solution. Another challenging part in this areais the retirement age. In health professional training- for example there are specialists who spend 10 year in training- letting this people retire at age 60 means that the country is losing a huge investment in terms money and time as well as accumulated experience. On top of this few young doctors dare to undergo such long term specialisation trainings. Considering extending the retirement age is another strategic issue for discussion.

HRHSP 2008-2013 was found to be responsive to these strategic frameworks and the key seven strategic objectives proved relevant for creating expected value addition of HRH systems to the

overall strategic framework of the country. Translating the strategic plan into operations would need among other things a sound planning capacity for HRH planning. However, the challenge is the identification of what capacity should exist at what level (Pemba and Mshana 2012). Moreover HSSP III midterm evaluation found that there are several plans in health sector with insufficient linkages. Harmonization of HRH planning with the overall health planning process is another problematic area. For example HRHSP ends 2013 whereas the Health Sector Strategic Plan III ends 2015. In many occasions, dichotomies between the two processes are the norm.

The final evaluation noted a serious commitment on addressing key HRH issues in the country. It was noted that the Government of Tanzania made three major commitments in the global health workforce conference took place in Brazil – September 2013 – (Box 1). The next HRH strategic plan should indeed give these commitments a serious consideration and planning to make them happen.

Box 1: National Commitment made in GHW Conference in Brazil September 2013

Commitment	Specific Issues
Increase the availability of skilled health workers at all levels of health service delivery from 46% to 64% by 2017 based on Staffing levels of 2013:	i. The government of Tanzania commits to increase the density of health worker to population ratio of the districts with below national average of 1.47 health workers per 1,000 populations in 5 regions (Kigoma, Tabora,Rukwa, Shinyanga and Singida) from 0.73 health worker per 1,000 population to the national average. ii. The government of Tanzania commits to continue increasing production of skilled Health and Social workers from 6,291 in 2012 to 9,000 by 2017. iii. The government of Tanzania commits to rationalize employment permits for health and social workers based on production and needs in all areas of technical profession.
Increase financial base (Other Charges and Private sector investment) to operationalize the pay and incentive policy by 2017 in order to promote retention, productivity and quality of health services.	
Develop and implement a Task Sharing Policy on HRH by 2017	i. Tanzania Ministry of Health and Social Welfare commits to develop an operational guideline based on consolidated 2013 WHO guideline on task sharing to enhance existing Production and Quality Assurance Systems by 2015 ii. The government of Tanzania commits to implement a system-wide approach that includes representation from other departments across different health cadres including professional associations, regulatory bodies, training institutions, accreditation bodies and policy makers to decide on common areas for task sharing across healthcare cadres by 2017

The service delivery Situation

According to Service Availability Readiness Assessment Report- the General Service Readiness index is 42% with private facilities doing better than government (SARA report 2013). The scores in areas

like immunization, Family planning, STIs, Antenatal Care Services and MPTC ranged from 50% - 80%. Availability of blood transfusion services scored less than 30%. Professionals found in urban are five times more than professionals found in rural areas where 70% of population live. Although the report did not conclude whether staff and training are the main problems, the findings remain important for HRH strategic planning especially in addressing the problems of staff distribution between urban and rural areas.

Working condition is an important factor influencing HRH performance and motivation. According to SARA (2013) availability of amenities ranged between 26% (dispensary) to 67% (hospital), basic equipmentfrom 17% (dispensary) to 58% (hospital) and facilities with basic standard infection precaution elements ranging from 43% (dispensary) to 68% (hospital)- (SARA 2013). The more the situation gets improved the better for HRH performance and retention.

Child mortality is declining (81/1000 live births) and there is likelihood of Tanzania to meet the MDG target of 54/1000 live birth (MOHSW 2013). However, slow progress is recorded on neonatal mortality reduction (DHS 2010). The gap between rural and urban in terms of skilled attendance is huge. Only 42% of women in rural areas were delivered by skilled personnel while 83% of urban women were delivered by skilled personnel. On the other hand institutional delivery is still low (52%)- out of these deliveries 8 out of 10 occur in public facilities (DHS 2010).With regard to coverage of Emergency Obstetric Care the coverage for Basic Emergency Obstetric care BEMOC – 20% of dispensaries and 39% of HC and CEMOC - 73% of hospitals (SARA, 2012). It is therefore very important to ensure facilities conducting deliveries are wellstaffed with skilled personnel.

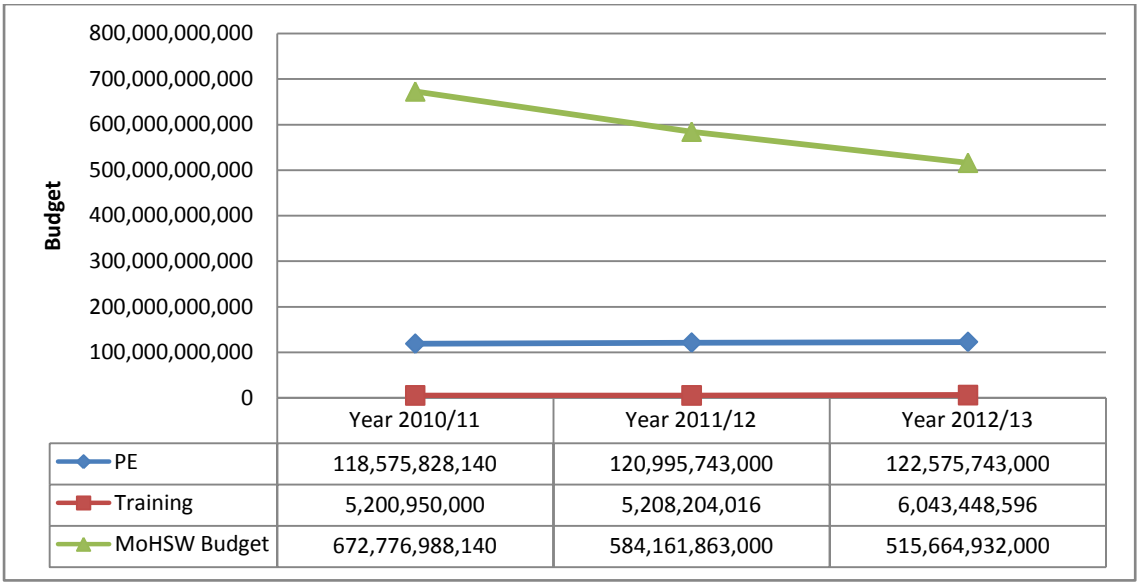
Health Financing Context

Although records indicate that Total Health Expenditure Per Capita increased from $26 to $37- The government contribution dropped in both relative and absolute terms from $16.5 to $14.7, or from 63% to 37% ,The most critical factor driving health system performance, the health worker, was neglected and overlooked for long. Of late, there is a growing awareness that human resources rank consistently among the most important system barriers to progress. Paradoxically, in countries of greatest need, the workforce is under “attack” from a combination of unsafe and unsupportive working conditions and workers departing for greener pastures. While more money and drugs are being mobilized, human resources for health, remains underfunded. This is contributed by the underfunding of the health sector. The Abuja declaration recommends allocation of 15% of national budget to health sector. The health sector financing is considerably improving although it is still below the Abuja declaration targets Table 7. Still human resources for health is ill financed.

Table 2: Total Health Expenditure as a per cent of national government budget (three years trend)

Year	Budget (Billions)	Total Health Expenditure as % of national government budget
2012/2013	1,288.8	10%
2011/2012	1,209.1	10%
2010/2011	1,206	12%

MOHSW’s commitment to adding budget for HRH activities is vivid, but it is impinged by limited budget. For example since 2010/11 MOHSW has increased enrolment to training institutions but the training budget did not increase to cope with the increased enrolment – Figure 8.



	Year 2010/11	Year 2011/12	Year 2012/13
PE	118,575,828,140	120,995,743,000	122,575,743,000
Training	5,200,950,000	5,208,204,016	6,043,448,596
MoHSW Budget	672,776,988,140	584,161,863,000	515,664,932,000

Decentralization and HumanResources Recruitment Process

Although literature on decentralisation internationally indicate that centrally transferred civil servants have no personal stake in the success of devolution, decentralisation of this function to local authorities have less success stories. For example in Tanzania the Government policy on local government reform in the area of human resources stated - Government policy on administrative decentralisation involves "de-linking local authority staff from their respective ministries". It goes on to state that LGAs "will be fully responsible for planning, recruiting, rewarding, promoting, disciplining, development and firing of their personnel. The councils will be the appointing authorities and employers for all local government personnel (including teachers, health staff, agricultural staff etc.)". LGAs will "employ the Council Director, the department heads and will adopt staffing plans and budgets.- However the implementation of this policy is hampered by many factors.It is proved that granting autonomy to LGAs over their own personnel did not work as expected. In 2002 and 2003 the government created changes by introducing Act No. 8 of 2002, and the Public Service Regulations of 2003 that, in some respects reversed – the Government policy on local government reform in the area of Human resource. This has not solved the challenges completely. Other problems emerged. The recruitment process became cumbersome and actor's coordination is also a challenge. For example the steps to be followed in recruitment process for councils and regional level facilities are many- See Annex 1. Challenges reported in this area include:

- Local authorities requesting cadres that are not in the market for example Assistant Medical Officers
- Ministry of Health and social welfare get involved in the recruitment process after the permissions are granted
- Councils getting permissions for cadres they have not requested
- There are also sentiments on centrally recruited medical attendants- some respondents felt sending a medical attendant who is a resident of Dar-es-salaam to Kigoma is not well received as this is less skilled cadre that could be limited to local recruitment
-

Continued Relevance of the strategic Areas

It was the interest of this evaluation to establish whether the 2008 - 2013 strategic areas are still relevant and worth considering in the forthcoming strategic plan. It was established almost all respondents still find the objectives are relevant. The plan is still relevant to address the HRH issues such as recruitment, management, development and retention of the Human Resources for Health. Reasons given with regard to its relevance are listed in Box 2. However there were concerns that were related to the extent of inclusion of relevant actors and the position of councils and regions (Box 1).

Box 2 Relevance of 2008-2013 HRH Strategic Plan's Strategic Objectives

Reasons given for being relevant are	**Reasons given for being partially irrelevant are:**
• Recognized by all HRH stakeholders as it provides a Vision. • It addresses comprehensively HRH aspects from production to retention. • Aimed at reaching minimum HRH requirements in Tanzania. • Indicators in the plan are relevant pointing to the means of overcoming the HRH crisis. • Was a timely response to the HRH crisis	• Did not address Social Welfare Human resources. • Was more Top-down rather than Bottom-Up. The Districts/Councils were inadequately involved in its creation and implementation.

Implementation Mechanism of the strategy

Coordination mechanism

At national levels the structures that are key for planning, follow up of progress and advising the department on how best to address HRH issues are: Health Workforce Secretariat, TC-SWAP and the HRH Technical Working Group (TWG). The technical working group is the key structure that brings together HRH actors in planning how to operationalize the strategy. It is used as forum for gathering progress, sharing information and planning accomplishments. The coordinating point for this strategy development was the Directorates of Human Resource Development. The working group is divided into teams. These teams are responsible for following up the progress and also they take part in implementation of the strategic objectives.

Roles and responsibilities of SO teams are:

- Develop bi-annual implementation plans of the respective strategic objective s of the national HRHSP
- Coordinate the effective implementation of identified priorities within their respective SO.
- Prepare and submit to the Health Work Force Secretariat monthly and quarterly progress reports.
- Liaise and involve relevant stakeholders on specific HRH areas in the respective so.
- Present updates on specific operational issues and challenges, and opportunities0 emerging in the SO and provide practical suggestions.

The involvement of other actors started from within the Ministry of Health and Social Welfare by engaging other directorates such as personnel and Administration, Policy and Planning, Other Ministry of Health and Social Welfare Programs. Other ministries were also involved. These include Prime Minister's Office Local Government Administration and Presidents Office Public Service

Management. Others who get involved include Private for Profit Organizations, Private Non for Profit organisations, Ministry of Health and Social welfare Training Institutions and development partners. The division of teams are listed in table 4.
Regional Health Management Teams and Council Health management Teams are the key actors for implementation. However, the experience show that leaving the HRH issues within the health department alone waters down its strategic importance. It was noted that when the agenda is taken as a council agenda the gains are higher- the case of Kigoma Municipal

Table 3 : SO Teams and their Focus

Team	Strategic Objectives	Team Members /Progress made so far
Team 1.	**SO 1:** Human Resource Planning and Policy Development and **SO 6:** Human Resource Research and Development	• The team was formed since 2009. • The team did not develop an operational plan at the beginning, instead each member chose an area of interest • Just of recent i.e. 2011, the team has developed an operational plan on both SO 1 and 6.This plan is intended to be implemented in partnership between MOHSW and JICA , THRP(Tanzania Human Resource Project funded by INTRAH-HEALTH) , BMAF,ECSA/CDC,GIZ,CIDA/HWI-CT,NIMR/IHI
Team 2.	**SO 2:** Strengthening Leadership and Stewardship **SO 4:** Workforce Management and Utilization	• The team currently has no operational plan for the SO 2 and 5. The team has a meeting plan. • Team members include: Representatives from MOHSW, CIDA, BMAF, INTRAH-Health, SIDA, Holland, CSSC and GIZ.
Team 3	**SO 3:** Education, Training and Development **SO 5:** Partnership in Human Resource	**Team members** • I-TECH, CIDA, GIZ, APHT, USAID
Team 4.	**SO 7:** Human Resource Financing.	**Team members comprise** • Policy planning staff • Chief accountant Office representative • CIDA • APTHA The team has operational plans on SO 7 for Jan 2010 to June 2011 and July -Dec2011, Jan 2012 Jun 2012 and Jan -Jun to 2013.

In practices there have been strengths and some recorded limitations with regard to coordination- these include

Advantages of HRHTWG

- Joint planning: Although the strategy was comprehensive in addressing key issues in HRH, the financing of all the wishes of the strategy was not easy. The coordination and collaboration of actors in HRH created opportunities to address issues that could not be implemented without partnership and commitments. One of the coordination mechanisms used included mapping of HRH activities and conducting annual reflection meetings to assess the implementation of the strategy and agreeing on who is going to do what.
- Since the M&E framework was not as robust to gather development at council and of development partners in HRH issues. The coordination actors and meetings enhanced sharing of valuable information

- The initiatives of actors in HRH also made it possible the gathering and consolidation of Tanzania commitments that was made in Brazil during the global health workforce conference
- The coordination enabled a conducive environment for tapping technical expertise of HRH partners- there have been valuable technical inputs in various areas of implementation

Challenges

- Lack of transparency of finances
- Attendance of all actor in Technical Working Group meetings has been a challenge
- Problems in implementation especially on recruitment where multiple actors are involved and coordination proved a challenge

At district level it was found that there is no a clear mechanisms to coordinate HRH actors, it was established that at district level there is a person who is entrusted with the role of coordinating Public Private Partnership.

Monitoring, Evaluation and Learning

The strategy has a whole section that explains the objectives of monitoring and evaluation. It explains that the existing information system will be used this include HMIS, OPRAS analysis for staff performance and where possible field visits will be conducted. The strategy was monitored through meetings of the Technical Working Groups. The monitoring of the SOs did not work from the start of HRHSP implementation. For example 200/09,2009/10, 2010/11 periods were missed. Monitoring was not systematic to assess overall activities but rather concentrated only on activities which had been favoured by actors. The monitoring has been reported by some respondents as weak due to the fact that SOs Committee do not report to the TWGs on progress every month as planned. The Ministry involving sampled Regions and Districts conducts the M&E. This is against what is stated in the M&E framework, which states that RHMTs and CHMTs should be doing their own HRH M&E and sending their reports to MOHSW; instead the reporting is done by development partners if they appear to be having a project in those Districts. Although the Mid–term evaluation was conducted at the end of 2011, this was a bit late from actual midterm of the HRHSP. This might have made recommendations made not have ample time for implementation prior to the Final Evaluation.

There is a big difference between the midterm evaluation to the time when this final evaluation was conducted in terms of information availability at HRD department; this is enhanced much by the HRHIS and TIIS. Another remarkable achievement is that, more questions are generated in Technical Working Group that will shape further the information requirements for HRH. HRD capacity to monitor is strengthened in several ways. The establishment and operationalization of HRHIS and TIIS is a commendable achievement. In addition one of the staff under HRD department studied M&E at a master's level as one of the efforts to strengthen the MO&E department. The evaluation also recorded a great turnaround in learning where HRH research synthesis was conducted and good recommendations were provided in this piece of work that guides learning and research in HRH even better. It was realised that the TWG created a stronger partnership that enhanced MOHSW to gather experiences from councils and other programmers. Some of these experiences were shared in various fora locally and internationally. For example the leadership support in Kigoma was found a good example of making HRH issue not a departmental issue but rather a council concern. The same strategy may be used to elevate HRH agenda nationally- moving it from being a ministerial concern to a developmental concern that is shared nationally.

Communicating the strategy and Dissemination of Midterm evaluation finding of HRHSP 2008-2013

The midterm evaluation found that the dissemination of the strategy mostly depended on integrating it with other activities within the ministry due to financial constraints. The practice has been slotting a time in fora such as DMOs, RMOs meetings to disseminate the strategy. The snag of this kind of mechanism is limited dialogue between the intended targets and disseminators of the strategy regarding what are expected and how can it be achieved. The same evaluation also established that the inception, and dissemination issues were not adequately planned for. Although the strategic plan indicates the operational plan, it was not clear how other levels would be operationalizing the strategy. It was also not clear at this stage that was potential funders for the strategic objectives.

The final evaluation also noted that dissemination was still poor as the HRH strategic Plan 2008-2013 is known mainly by the Health Secretaries and facilities are having some copies: however they have never been used for whatever HRH purposes. The District Health Management Team members failed to mention any relevancy of the document since majority of them has never seen the document. Some of the leaders in regional level are not aware of the existence of the plan because they were not oriented on its existence and utilization of the plan.

It was further noted that dissemination of midterm evaluation findings ended up at national level and less was done to disseminate the findings to lower levels. Task Force working Groups and HRH day, stakeholders' meeting but did not have representatives from Regional and Districts Councils Teams. Also it was revealed that some SOs team members and other stakeholders did not receive Mid-Term evaluation report.Mkapa Foundation funded the HRH Action group in Morogoro to implement Mid-Term Evaluation recommendations. A Consultant from Kenya was hired to prepare the action plan to implement the recommendations as well as unaccomplished activities. For those who came into contact with recommendations of midterm evaluation reported that they are feasible if the department was averagely funded.

The evaluation also noted that the channels for communicating strategies and reports were taken by chance and not deliberately planned and this is due to limited funding. It was further noted that at MOHSW there are two key units one dealing with the region coordination and the other dealing with district coordination- but the links between the HRD departments strategically with these two units is fade. If this link was strengthened access to districts and regions would have been made easier.

Translating the strategic Plan into Action

The operationalization of this plan depended much on what councils could do. It was learnt in this evaluation that the strategic plan document highlighted activities to be conducted under each objective in each year. It further indicated list of quick wins in each strategic objective. This is a list of key activities envisaged to produce rapid and significant results. However, the actions at council level remained routine- paying salaries, allowances, and leaves. Limited innovations were recorded in areas of welcoming new recruits. It was further noted that attempts to integrate HRH issues in Councils Comprehensive Health Plans were made- and the revise CCHP guideline consist of HRH issues from situation analysis chapter.

Financing of the Strategy

It was not by the midterm evaluation that the plan would have been financed through government own source from both central and also at Local Government Authority (LGA) level. Centrally the plan was to incorporate into MTEF and at LGA level to advocate for its incorporation into Comprehensive Council Health Plans (CCHP). To ensure the later is happening, HRD departments participated in developing the reviewed CCHP guideline to incorporate specific indicators such as attrition, gap and

capacity building. Another envisaged source of funding for this strategy was development partners. It was envisaged that other supporters will join the implementation and this will be achieved through dissemination of the strategy.
The final evaluation noted that at national level the financing of the strategy was not deliberate. It remained as routine as it was for many things except for the recruitment and training which had been one of the political agenda as well. This is contributed by the underfunding of the health sector.

Accomplishment Status of Planned Activities

Accomplishments by objectives on this report were gathered from national level. Respondents at district and regional level found it difficult to segregate by objectives, as majority were not familiar with the strategy as mentioned in the earlier sections of this report. Although there were financial difficulties HRHSP 2008-2013 is implemented more 70% - Figure 1.

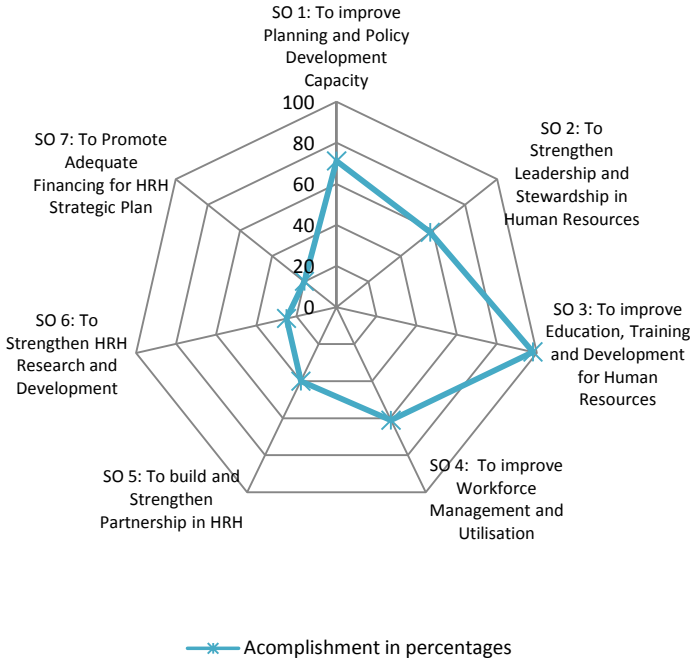


Figure 1: Accomplishment of Strategic Objectives

Accomplishment by Objectives

S.O 1: To improve HRH Planning and Policy Development Capacity

The planaimed at strengthening HRH planning and development of succession plan from central MOHSW to facility level. Another area of focus was to strengthen the existing information system, the Strategic Plan envisaged to improve coordination and networking of existing human resource data collection systems to ensure quality and reliable human resource data at all levels. MOHSW in this area also planned to conduct a systematic review of existing policy guidelines to improved operational efficiency. HR planning capacity and development of successionplans at MOHSW central, regional and district level in terms of skills and knowledge through the use of technology and improved working environment was set as a priority in this area. The following were achieved

HRH Planning

Establishing HRH requirement

Several developments took place in this area. The Ministry with the support from JICA developed and rolled out HRIS and TIIS systems. The two information systems were set to enable training institutions and health facilities manage HRH information. The systems are capable of assisting users to collect quality information and help them generate varieties of reports from individual staff reports to country aggregate. HRHIS has covered all 25 Regions and 158 Districts/Councils. The database has covered both Public and Private Institutions. So far 94.8% of Public sector employees Database has been covered and 74.6% Private sector employees Database have collected. With regard to TIIS 100% tutors' Database has been covered

The existing challenges include:

- Difficulties in collecting HRH data from private and FBO facilities
- Since the system is computerised- power supply to some councils is challenging and sometimes the information are not updated.
- Familiarity of these tools by HR managers is minimal
- Motivation to utilize the system is low.

Picture HRIS screen

- Establishment of Training Institutions/ University producing health workers Information System..

Data Reliability

Using the HRHIS and TIIS – it has been very possible for MOHSW to gather who is available in health and social welfare facilities as well those in training institutions. There are some discrepancies still between what information is captured in HMIS (MTUHA) and HRHIS- this is because several issues including updating in HRHIS – this is one of key issues to be considered in the next strategy. Harmonisation of HRH information is still a problem.

Policy and guidelines

In the domain of HR policy, a group of policies focusing on training, career pathways and staffing norms were developed and introduced over the last ten years. Instrengthening the establishment of HRH demand, MOHWS finalised New staffing levels Guideline for Ministry of Health and Social Welfare Health service facilities, Health Training Institutions and Agencies. This will be operational from 2014-2018. It has been endorsed and disseminated at all levels to guide planning for personnel Emoluments. HRH sub plans such as production plan is underway. The plan is meant to guide HRH production in terms of numbers and cadres with reference to demand emanating from various health strategies. Scheme of services is developed is in final stages.

Strengthening HRH Planning Capacity

There has been a considerable effort to strengthen HRH planning through capacity building at national level. However there are some limitations in this area:

- Devolution of this role to other levels is limited. Councils concentrate more on Personnel Emolument budgeting that HRH planning. Even when human resource planning is attempted, it usually addresses the projection of staff numbers leaving uncovered important areas like HRH policies and management systems.
- Harmonization of HRH planning with the overall health planning process is another problematic area.

HRH Policy

The challenging part in this area include

- Delayed finalisation of drafted policies and guidelines that also influenced their dissemination.
- Limited link exist between the policy process and existing evidences to avoid making ad-hoc decisions.
- The last five years also recorded limited emphasis on evaluation of existing policies and guidelines. HRH matters are mult-sectoral. There are several policies and guidelines that are developed in other ministries that influence the management of HRH. Harmonising, cross-referencing and analysis of influence these policies to HRH is limited.

S.O. 2: To strengthen leadership and stewardship in HRH

In this area the focus was develop capacity of leaders in the Health and Social Welfare sector advocacy and resource mobilization. A number of activities have been implemented as steps in strengthen leadership and stewardship. The activities were implemented through partners and government financing.

- needs assessment in leadership and management
- Conduct management and leadership training programs to central and RHMTs
- Train leaders in communication and advocacy skills
- Develop advocacy and communication strategy in HR
- Advocate HR policies, guidelines, circulars and other issues at all level
- Strengthen HRH Working Group at central level and establish HRH Working Groups at regional and district levels

S.O 3: To Improve Education, Training and development for HRH

The plan envisaged addressing setbacks of training institution in order to increase enrolments and enhance quality of training. On the other hand the majority of the existed workforce (43%) was MCH Aide and Medical Attendants who entered into services with standard seven certificates. There were plans to encourage and support the upbraiding of this cadre to meet the acceptable qualifications. The following has been accomplished

- HRH Master training /production Plan is in stage three Draft. This is for both Pre-and Ina service trainee.
- A clear guideline for developing competence-based curricula is developed based on National Technical Awards (NTAs).
- A lot of effort has been put in ensuring that training institutions meet NACTE standards. Under this domain a number of curricula have been reviewed or developed
- A number of institutions have been fully registered and accredited while others have provisional registration by NACTE.
- Distance education programme has been developed and is continuing under support of I-TECH.
- Some RHMTs developed Training Plans, which is used to provide support to health workers who have obtained chances to attend further training.

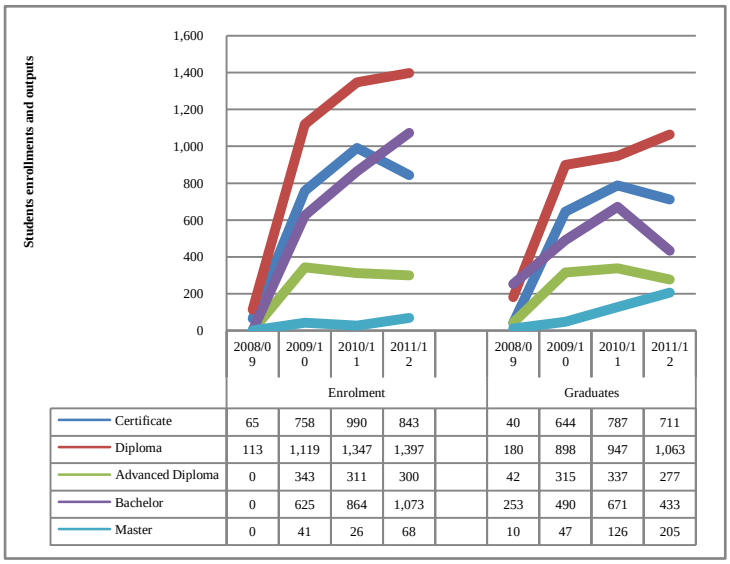
Continuous Professional Development

CPD concept is not adequately emphasized. There is a nation-wide provision and management of in-service training. CPD is mostly confined that class room based. Distance learning and telemedicine are at their infancy. The accessibility to the short courses is also not well it is common to find health workers who have not been refreshed for periods of 5 years or more. The mission and outcome of CPD is not clearly defined and publicized and wide stakeholder involvement is not much. CPD is not

well related and integrated into service provision and practice and thus not reflected in the allocation of health care budgets. Medical schools and health training institutions usually focus on basic and qualification programs. Their role in CPD is not clear- Zonal training centres are the organs entrusted to manage CPD programs but this role is overtaken by their primary functions. There is hardly any emphasis in the curricula that inculcate a culture of lifelong learning that enables the student to appreciate in the future the importance of CPD for their practice and career. There is no system to support or recognize participation of health workers in CPD activities whether inside or outside the country. Certificates and credits gained from these activities do not usually count towards the promotion of individual health worker or inform, in a systematic manner, the integration of relevant expertise into the workplace.

Training outputs

The number of enrolled students doubled. In 2005 - 4914 students were enrolled to join various trainings. In 2010 the number of enrolled students 8956 in 2010– Figure 18. The pool of applicants for medical specialization has increased substantially as a consequence of expansion in basic medical education in the country. Governmental support for candidates applying for the loan from the loan board this has always helped to maintain a reasonable flow of applicants training. Tanzania is harnessing Public Private Partnership in training and the contribution of non public institution in increased enrolment is remarkable - about 28% of all postgraduate enrolment is from non government institutions.



	Enrolment					Graduates			
	2008/09	2009/10	2010/11	2011/12		2008/09	2009/10	2010/11	2011/12
Certificate	65	758	990	843		40	644	787	711
Diploma	113	1,119	1,347	1,397		180	898	947	1,063
Advanced Diploma	0	343	311	300		42	315	337	277
Bachelor	0	625	864	1,073		253	490	671	433
Master	0	41	26	68		10	47	126	205

The ministry through the Department of Social Welfare has introduced the cadre of Social Welfare Assistants for the purpose of strengthening social welfare workforce at the lower levels. The practitioners of this cadre are not only supposed to effect the social welfare services at ward level but also the presence of social welfare Assistants (SWA) will promote the service delivery programs and initiatives in the social welfare institutions. Therefore in order to increase the production of this particular cadre the ministry through its department of social welfare has introduced a one-year certificate social welfare Assistants training program at Kisangara social welfare training centre in mid 2012.

Table 4: Social Welfare Enrolment

Cadres	2008/2009	2009/2010	2010/2011	2011/2012
Certificate in Social Work	94	117	114	111
Diploma in Social Work	151	137	114	204
Bachelor in Social Work	244	225	435	278
Postgraduate Diploma in Social Work	28	39	23	15
Total	**517**	**518**	**686**	**608**

The NACTE requirements and Existed cadres

Changes in NACTE influenced the patterns of health workers training as well as their recognition in scheme of services. Some of the acquired training are not considered now due to such changes. In health services acquiring specialization at postgraduate level is not as easy as other fields. It was for this reason that MOHSW embarked on developing middle level cadres to increase access to some specialized service- for example AMO- ophthalmology- did a lot of activities that ophthalmologists did. In other areas AMOs did lots of work that gynecologist did. Currently the added specialized qualifications are less counted.

Challenges in Training

Despite the recorded success the health training institutions face several challenges. These include: Shortage of teachers, shortage of clinical instructors at teaching hospitals. Due to the critical shortage of staff trainees get limited exposure time with clinical instructors and they are used as additional workforce to absorb the increased workload.

Other challenges facing training are related to the overall system of updating the trainers on new development in service delivery emanating from new evidence. Tutors get limited exposure to new or improved management of certain diseases consequently the new graduates go to service with limited knowledge with regards changes in practice.

S.O 4: To improve Workforce Management and Utilization

The following were key areas of focus on workforce management and utilisation.

- Revision of scheme of service while taking into account what is ideal and what is feasible currently.
- Support the emergency hiring initiative and devise other alternatives that will further minimize human resource shortage and distribution disparities.
- Assess Recruitment bottlenecks and collectively discussed by various ministries for enhancing flexibility and sustainability in recruitment process.

Review recruitment procedures to reduce bureaucracy

A lot of efforts have been done on this area. BMAF published a booklet highlighting recruitment bottlenecks. Several discussions have been conducted regarding how best to improve recruitment process. Though several factors can be associated to the failure of filling the approved posts, the noted

factors in this assessment is unclear roles on who is responsible for filling the granted permission. The respondents at the regional and district levels appear to consider that it is a sole responsibility of the MOHSW to post the staff to the approved post. Regional and local government therefore feel less responsible to seek for applicant to fill the approved post. They mainly keep on waiting for staff to be posted from the ministry. It is doubtful if this is supposed to be the experience; since the Tracking Report clearly indicate that "....government has lifted the employment freeze and allowed Councils to recruit direct health workers.... however, most of the councils particularly the rural ones, failed to acquire the required number of skilled staff" (MOHSW, 2010). It is for this reason that the MOHSW was called to help council in the recruitment process by posting staff to the Districts based on the hiring permit received from POPSM. It was learnt by this evaluation that in National HRH conference conducted September 2013- Coordination issues were discussed and appeared as of the conference recommendations – Box – 2.

Box 2: National HRH Conference Recommendations on interministerial coordination

Inter-Ministerial Coordination Group (MOHSW, PMO-RALG, Education, POPSM, MOF)

- Improve coordination across four key ministries: MOHSW, PMO-RALG, POPSM and MOF *Continue quarterly inter-ministerial meetings, include senior MOF participation*
- *Identify an entity or individual who is accountable to follow up decisions from inter-ministerial discussions and agreed-upon next steps*
- *Develop communication mechanism to advise and provide feedback to established technical working groups: HRH TWG, National CHW task force, HRH Task* Sharing task force, national pay for performance task force, etc.

Track and monitor recruitment for improvement

The development of software Lawson has improved HRH DATABASE for hastening electronic salary entry within a month or two from Councils to POPSM thereby motivating new employees who could have otherwise absconded. It was also learnt that since the establishment of the Primary Health Service Development Program(PHSDP) there has been increased both in funded posts and posted staff from 6,437 approved post in 2007/08 to 7028 posted staff in 2011/12 . The increased numbers has been due to increased rate of reporting up to 63% and retention of 83% of the health workers reporting rate. This is according to 2007 – 2010 Tracking study.

It was established that HRM priority areas incorporated in the CCHP as milestones -recruitment, retention and capacity buildinghas increased councils response to addressing HRH matters-there are evidences of creativity in addressing HRH matters at council level- Box 3.

Box 3: Strategies used by councils to reduce abscond of newly posted staff

- Provision of accommodation or house rent to entitled health workers
- Provision of loans as salaries to new recruits
- Provision of mattresses to new health workers
- Allocating health workers in work stations which are comparatively better than others
- Councils leadership involvement in receiving and also escorting new recruits to work stations

The evaluation noted some practical limitations influencing staff motivation negatively such as

a) Lack of clear mechanism of reimbursement for transport and communications for staff that support patients living in hard to reach areas.
b) Inconsistent supply chain management for basic supplies and equipment which is delivered to health centers, dispensaries, and hospitals.
c) Limited attention to non-financial incentives that include promotions, continuing education, and recognition awards.
d) Budget Ceiling for PE is very limited compared to the demand
e) Prolonged salary delays for newly recruited HRH.
f) Cumbersome Recruitment process - many actors in the process and not well coordinated

Outcomes of recruitment Process strengthening

The number of available staffs is still low. The shortage is about 58% compared to 65% in 2008. The country is still in crisis. For example the health workforce shortage at National, Consultant, Zonal and Specialist Hospitals amounts to 62%. Muhimbili National Hospital is having a shortage of 3,411 health workers that is (60%) of its requirements followed by Bugando with a shortage of 1526 (59%). Muhimbili Orthopedics Intitute and Mirembe referral Hospital have gaps of more than 60%. Kibong'oto Hospital (7%), KCMC and Mbeya refrral (35%) are less affected – Table 7.

Table 5: HRH Availability by level of care

Level of Care	Required	Available	Deficit
Regional and District level Facilities	146,767	61,141	85,626
Zonal Referral Hospitals	5,345	3,095	2,250
Specialised Hospitals	1,562	782	780
Muhimbili National Hospital	5,664	2,253	3,411
Total	**159,338**	**67,271**	**92,067**

The evaluation noted that there are key critical cadres that are in serious shortage and their production is low as well. These include assistant pharmaceutical technologists and assistant laboratory technologists. There has been a serious cry on drugs shortage and also complains on failure of ILS due to quantification problems. If the shortage of assistant pharmaceutical technologists more than 80% then challenges in drug quantification, storage and management should be expected. On the other hand there has been lots of complain on quality of data generated from dispensaries. This problem would have been emanated by having skilled personnel in record keeping but the number of medical recorders at dispensaries is insignificant.

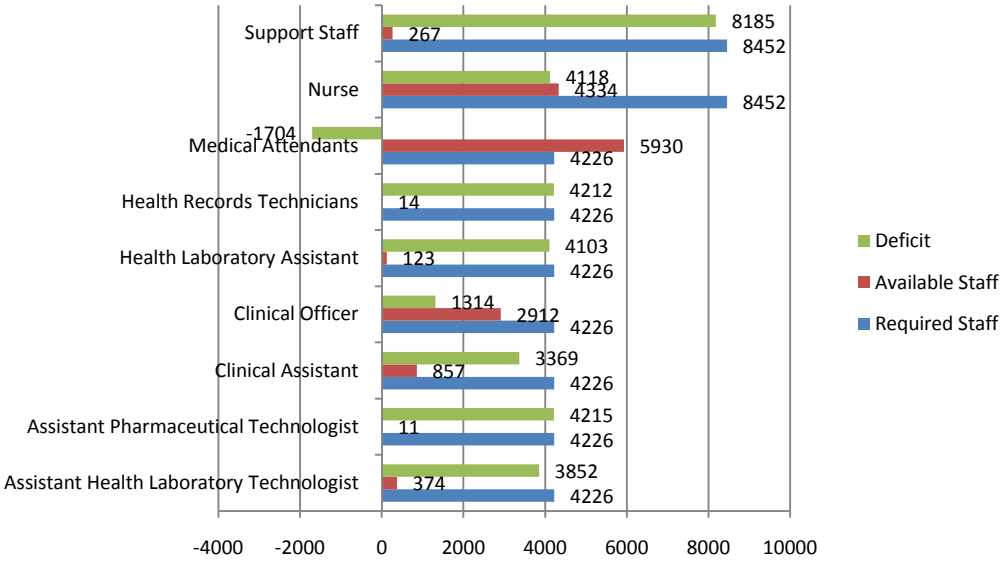


Figure 2: Staff availability by level of care

Staff availability trend (2010/11-2012/13) for academic staff in training institutions is declining. To reduce the intensity of academic staff shortage, the health training institutions use part time teachers from nearby hospitals or from other institutions. Although this strategy helps to reduce burden to existing teaching staff, the capacity to engage teaching staff has been declining annually from 2010/11 to 2012/13- Figure 3.

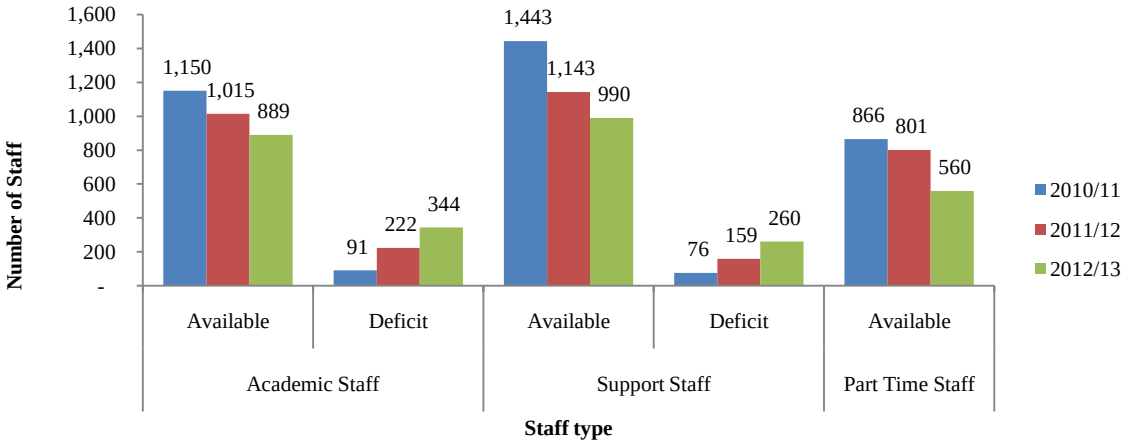


Figure 3: Availability of staff in health training institutions

A total of 437 social workers are available in the country, which is 13% of the requirement. The available social welfare workers are distributed in various levels of the government departments and institutions. The number of social welfare workers deployed in the public sector differs between regions. This is determined by presence of relevant social service institutions and also the number of districts, which have already enlisted the cadre in their human resources recruitment need.

Retention

According to HRH research synthesis commissioned by GIZ in 2011, about 53% of skilled staffs in the districts are intending to leave services as indicated by one of the studies reviewed. The magnitude of retention problem is not well established. The existing records are drawn from specific studies. The HRH synthesis recommended that, apart from the various "one-time focused studies on attrition" there is a need to have in place an institutionalised system for continuously and regularly tracking such trend, targeting at least all key cadres of health workers in order to monitor movement within the country (brain circulation) and out of the country (brain drain).

Performance Management and Reward Systems

The Performance Appraisal and Reward Systems in Tanzania show a record of some successes, shortcomings and challenging issues. For example still promotion and career advancement are awarded arbitrarily considering staff working experiences despite the introduced Open Performance Review Appraisal System (OPRAS) since 2004. Health workers and supervisors are reluctant to use OPRAS. One of the major reasons identified to contribute to such reluctance is lack of job description to facilitate development of realistic objectives, and inadequate knowledge and skills to implement OPRAS. On the other hand there is a pay and incentive policy developed by POPSM in 2010. The operationalisation of this policy is slow- as its dissemination is low as well.

Establish a registration mechanism for all health cadres

Currently there are registration mechanisms for majority of cadres but the lower clinical cadres are not on this mechanism. It was also learnt that the enforcement of registration and licensing is increasing.

S.O 5: To build and Strengthen Partnerships in HRH

This strategic plan recorded an expansion of partnership in addressing HRH activities. This enhanced the recorded success in implementing the strategy. The engagement of private for profit in the HRHTWG is commendable as their involvement has improved insight of the working group on issues regarding private providers. It was learnt that support to strategic objectives was uneven. This depended much on the areas of interest of partners. This did not affect the coverage of implementation as few partners interested covered majority of activities – Figure 4.

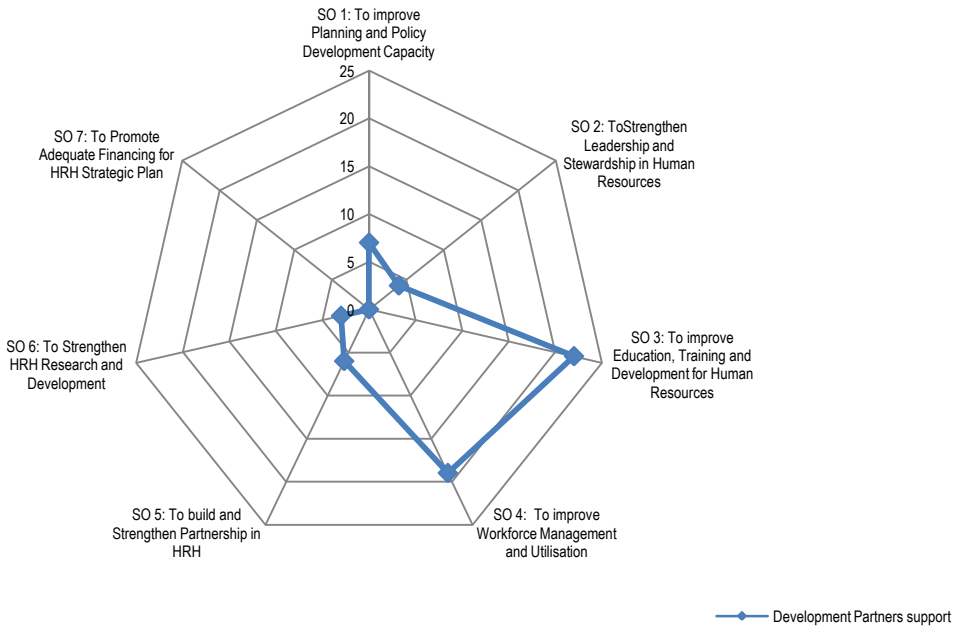


Figure 4 : Partners Support by Objective

However there were reported challenges of partnership these include

- Inadequate participation of partners in HRHTWG meetings
- Limited transparency
- Limited coordination

S.O 6: To strengthen HRH Research and Development

The situation analysis revealed that there are several researches conducted regarding HRH by development partners, research institutions and by the MOHSW commissioning universities or research institutions. It was also noted that the HRH technical working group asked for synthesis of all existing researches which form as an initial data base of what evidence exist. However, it was realised that the research efforts are ill coordinated and the focus is more on identifying the "*what questions"* and limited researches focused on operational research to answer "*how and why questions"*. Moreover, the HRH Technical Working Group is expected to save as a platform at national level but there are limitations in terms transferring the knowledge gathered to regions and councils.

S.O 7: To Promote adequate financing of HRH strategic Plan

The objective was meant to raise HRH agenda and attract financing of the strategy. The dissemination of HRH strategic plan and detailed budget to relevant government ministries and development partners was conducted integrating it into various national meetings and gatherings. There was limited achievement in this strategic objective in terms of implementing the planned activities. The same was noted in midterm evaluation. The midterm evaluation recommended considering finance as a cross cutting issue and not a strategic objective.

Lessons learned

1. Partnership is Key success factor for achieving HRHSP objectives
2. Development partners have contributed a lot in achieving the planned activities
3. Addressing HRH issues multsectoral collaboration is crucial
4. Production concentrated on clinicians and nurses and limited attention to pharmaceuticals, eye care workers, laboratory assistants and medical recorders
5. Harmonizing policies of different sectors is important- for example in The concept of middle level providers in health with NACTE standards
6. Local leadership influence HRH retention
7. Although decentralization requires LGAS to manage recruitment but the lesser involvement of MOHSW would worsen the crisis

Conclusions and Recommendations

Relevance of the strategic objectives and strategies

Conclusion
HRHSP (2008-2013) is still a relevant strategy. However, there is a limited attention to Social Welfare human resource issues

Recommendations
Development of the next strategic plan should reflect much on what has been planned in the current strategy BUT also add the Social Welfare Human Resource component

Accomplishment of Strategic Objectives

Conclusion
Accomplishment by strategic objectives is good about 70%.

Recommendations
a) In future implementation of HRHSP SOs should take recognition of employers in Local authorities Regions, Councils) where HRH needs / demands stem.
b) There is a need for the Government to improve HRH funding to enhance implementation of planned objectives
c) The forthcoming strategic plan should reflect needs as well as feasibility in terms of time and financing – should be more strategic and realistic
d) Operational planning should be conducted to enhance translation of the strategic plan into actions

Coordination of stakeholders

Conclusion
The mechanisms which were put into place provided an enabling environment to coordinate stakeholders and facilitated many activities to be implemented

Recommendations
The private sector needs more attention as the problems faced by the private sector is different from what other public sector face. In order to augment more resources in HRH production and deployment issues influencing private sector in the business operations that are supervisory and regulatory need attention and mutual agreement in order to create a win –win situation.

Research and Development

Conclusion
Limited achievement is recorded in research as most HRH research agenda are driven by the agenda of the funder and less attention is given in addressing key HRH research issues that are locally generated.

Recommendation
a) Research priorities be identified by involving more actors in the Districts, Private health sector, and FBOs so as to tap their potential and resources needed to conduct research
b) Research institutions should be active participants in developing HRH research proposal that answer key strategic questions of decision makers
c) Government and development partners should set aside research funding to promote evidence based HRH policies and plans

Recruitment

Conclusion

Although efforts to improve recruitment challenges has been made coordination problem still exist

Recommendations

- Attention be paid to Social Welfare Human Resource in training, development, deployment and distribution.
- The staffing levels guideline need to be gauged with the WHO guideline which addresses the Workload
- Indicator for Staffing Needs (WINS) so as to ensure that no over staffing is done to health facilities with far less Workload in terms of Burden of Diseases and population.
- Recruitment Authorities (MHOHSW, Councils) should prepare succession plan using the
- HRH-IS to match the attrition rate
- Coordination of actors in recruitment process should be strengthened
- Capacity of LGAs to manage recruitment process should be developed to reduce avoidable mistakes in recruiting staff
- Increase wage bill so that it matches the need to avoid the emerging tendencies of not absorbing fully produced Doctors.
- The staffing levels guideline need to be gauged with the WHO guideline which addresses the Workload Indicator for Staffing Needs (WINS) so as to ensure that no over staffing is done to health facilities with far less Workload in terms of Burden of Diseases and population.
- Disseminate and enforce utilisation of the new staffing levels guideline the Public Service Pay and Incentive Policy of 2010

Performance Management

Conclusion

Although OPRAS is an official performance appraisal system its uptake is unacceptably low. Other performance appraisal issues such as Pay for Performance approach exist but there are mixed feelings on its scale up

Recommendation

a) Orientation of managers and staff on OPRAS should be done
b) Address issues leading to limited functionality of OPRAS
c) Enforce performance appraisal at all levels
d) Re-align line managers to adhere to performance management ethics
e) The P4P approach in performance management be implemented with caution otherwise it might compromise Professionalism and work ethics in pursuit of monetary incentives.
f) Start improving performance management practices from the training institutions so that graduates emerge with pre-requisite competencies. This will happen through properly equipping TIs with skill laboratories and supervision during clinical rotations.
g) Allocate adequate finances to implement OPRAS and supportive supervision at all levels.
h) Re-align line managers to adhere to performance management ethics.

Training and Development

Conclusion

There has been a lot of effort to increase training intake, development of HRH both pre and In-service, BUT the there is still a big gap to fill required posts

Recommendation

a) Increase intake for Laboratory Technicians and Pharmaceutical Technicians to alleviate their acute shortage

b) Create a smooth and enabling environment for the private sectors to participate in the production of HRH in the country

HRH retention

Conclusion

There have been good practices by Development Partners, and LGAs/Councils in devising retention packages for HRH but in other employment authorities these are lacking

Recommendation

Operationalize the Public Service Pay and Incentive Policy through providing financial allocations specifically for HRH Retention

Monitoring and Evaluation

Conclusion

There was no robust monitoring and evaluation framework guiding learning for HRHSP implementation

Recommendation

a) The future HRHSP should be embedded with robust M&E framework that will guide monitoring and learning
b) M&E results should be disseminated to all stakeholders and follow-up made for implementing recommendations.
c) Decentralise HRH M&E to council level so that it can track easily and timely HRH issues of specific to localities.

Annexes

Annex 1:Recruitment Process for Staff under Regional Hospitals

Step 1: Regional Hospital initiates request and sends it to Regional Administrative Secretary's Office

Step 2: RAS Office sends request for recruitment of HRH for Regional Hospital based on Regional MTEF send to POPSM

Step 3: President's Office Public Service Management (POPSM) scrutinises the sectors request and forward it to Ministry of finance for financing the posts- the list that is sent adheres to the MOF ceilings (PE) sent to POPSM

Step 4: Ministry of finance reviews the request in relations to the ceilings set for personnel emoluments – MOF send the list of the funded posts back to POPSM who send to sectoral ministries in form employment permits in this case MOHSW

Step 5: President's Office Public Service Management (POPSM) Receives the Approved posts from MOF and sends this to MOHSW

Step 6: Ministry of Health Social and Welfare receives the approved posts from POPSM and Recruit and post the m to RAS

Step 7: RAS Office sends reported staff to regional hospital

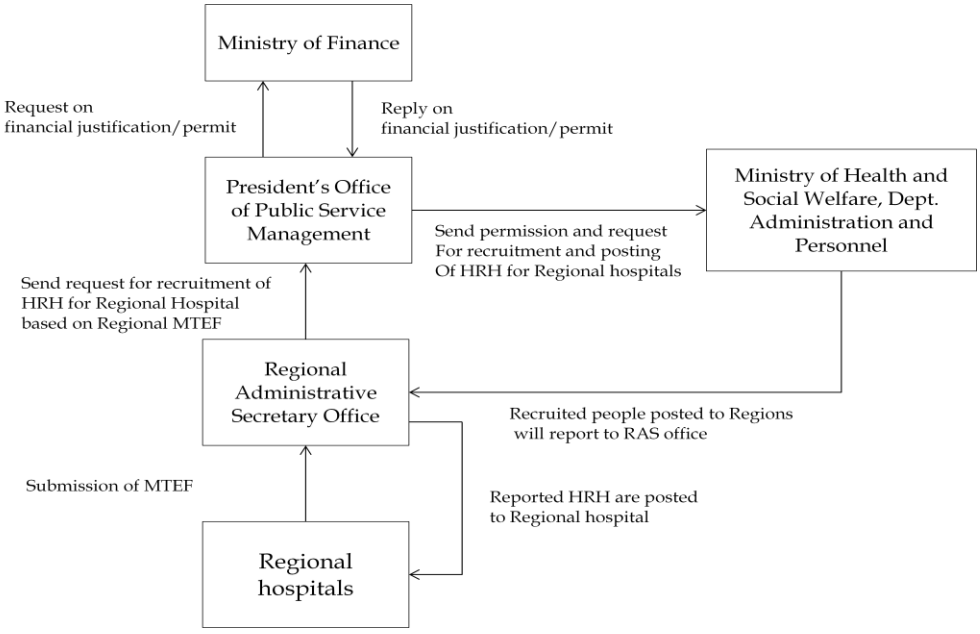


Figure 5: Recruitment Process for Regional Hospitals

Annex 2: Recruitment Process for Staff under District Hospitals

Step 1: Public and FBO Health Facilities, initiates request and send it to Regional Administrative Secretary's Office

Step 2: Council Health Management Team (CHMT), incorporate into Comprehensive Council Health Plan and sends to Council Director's office

Step 3: Council Director's Office send compiled HR request to Regional Administrative Secretary's Office

Step 4: RAS Office send request for recruitment of HRH for Regional Hospital based on Regional MTEF send to POPSM

Step 5: President's Office Public Service Management (POPSM), Scrutinises the sectors request and forward it to Ministry of finance for financing the posts- the list that is sent adheres to the MOF ceilings (PE) sent to POPSM

Step 6: Ministry of finance, review the request in relations to the ceilings set for personnel emoluments – MOF send the list of the funded posts back to POPSM who send to sectoral ministries in form employment permits in this case MOHSW

Step 7: President's Office Public Service Management (POPSM) receives the Approved posts from MOF and sends this to MOHSW

Step 8: Ministry of Health Social and Welfare, receives the approved posts from POPSM and Recruit and post the m to RAS

Step 9: RAS Office send reported staff to respective councils

Step 10: Council Director's Office send reported staff to CHMT

Step 11: Council Health Management Team (CHMT), allocate the staff to respective facilities

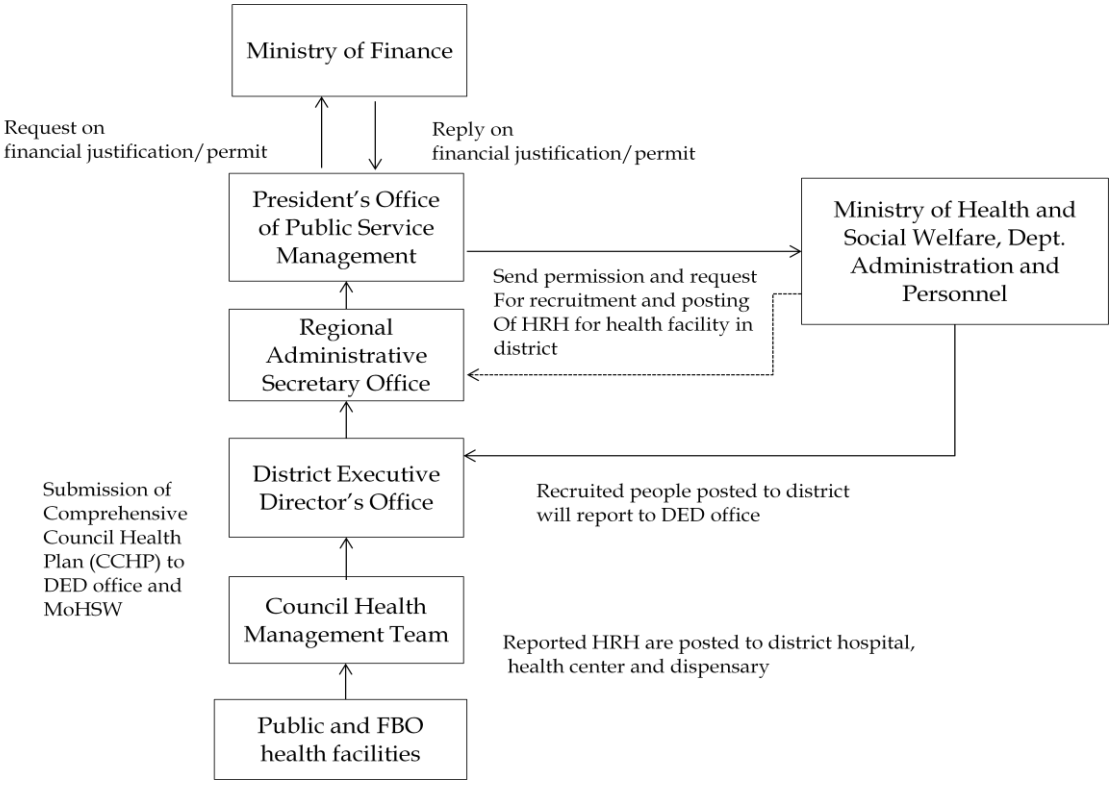


Figure 6: Recruitment Process at council level