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Ministry of Health and Social Welfare

Mid Term Review of the Health Sector Strategic Plan III 2009-2015

Human Resources for Health

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AIHA	American International Health Alliance
AMO	Assistant Medical Officer
ART	Anti retroviral Therapy
BMAF	Benjamin Mkapa AIDS Foundation
CA	Clinical Assistant
CAG	Controller and Auditor General
CBD	Community Based Distributor
CBE	Community Based Education
CCHP	Council Comprehensive Health Plan
CE	Continuing Education
CEmOC	Comprehensive Emergency Obstetric Care
CEPD	Continuing Education and Professsional Development
CHMT	Council Health Management Team
CHSB	Council Health Services Board
CHW	Community Health Worker
CIDA	Canadian International Development Agency
CO	Clinical Officer
CPD	Continuous Professional Development
DE	Distance Education
DED	District Executive Director
DHRO	District Human Resources Officer
DHS	Demographic and Health Survey
DMO	District Medical Officer
DP	Development Partner
EN	Enrolled Nurse
FBO	Faith Based Organization
FP	Family Planning
GBV	Gender Based Violence
HFGC	Health Facility Governing Committee

HIV	Human Immunodeficiency Virus
HQ	Headquarters
HRH	Human Resources for Health
HRHIS	Human Resources for Health Information System
HSSP III	Health Sector Strategic Plan III
HTI	Health Training Institute
HW	Health Worker
ICT	Information Communication Technology
IHI	Ifakara Health Institute
IT	Information Technology
I-TECH	The International Education and Training Centre for Health
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
LGAs	Local Government Authorities
M&E	Monitoring and Evaluation
MDAs	Ministries Departments or Agencies
MO	Medical Officer
MOFEA	Ministry of Finance and Economic Affairs
MOHSW	Ministry of Health and Social Welfare
MUHAS	Muhimbili University For Health and Allied Sciences
NACTE	National Council for Technical Education
NGO	Non Governmental Organization
OPRAS	Open Performance Review and Appraisal System
P4P	Payment for Performance
PHSDP	Primary Health Services Development Programme (popular in Kiswahili as– Mpango wa Maendeleo ya Afya ya Msingi (MMAM)
PMORALG	Prime Minister's Office Regional Administration and Local Government
POPSM	President's Office – Public Service Management
PPP	Public Private Partnership
RCH	Reproductive and Child Health
RHMT	Regional Health Management Team
RMA	Rural Medical Aid
RMO	Regional Medical Officer
SAs	Service Agreements
TB	Tuberculosis

TIIS	Training Institutions Information System
TOT	Training of Trainers
TQIF	Tanzania Quality Improvement Framework
TWG	Technical Working Group
ZHRCs	Zonal Health Resources Centers
ZRC	Zonal Resources Center

1. Introduction

The health sector commenced the implementation of HSSP III amidst severe understaffing. By the end of 2010, the sector was reported to have had a total staff number of 47,627, the majority of them being medical attendants and allied health professionals. Addressing this Human Resources for Health (HRH) challenge was imperative during the implementation of HSSP III. As such efforts were gathered not only in the supply of human resources but also in deployment, recruitment and retention of health workers. Problems and challenges were however faced in production, attraction and retention of health professionals

This report provides the findings in the area of HRH of the Mid Term Review teams for the Health Sector Strategic Plan III (HSSP III). The findings include literature review, visit assessment from three regions (Geita, Lindi, Mbeya) to identify progress and challenges on the ground. A common checklist, to ensure comprehensive coverage, guided Field visits. Also various interviews were carried out to get views of members of the HRH Technical Working Group (TWG) and other stakeholders from relevant Ministries, NGOs and development partners.

The findings provide progress and challenges in HRH planning, production and the process of training (pre-service, in-service and continuous education), HRH availability, utilisation and applied health research for planning and advocacy. Finally there are recommendations suggested to address HRH issues.

2. HSSP III Health Strategic Objectives and Expected Results

The HSSP III strategic objectives and related expected results are displayed in Table 1below.

Table 1 HSSP III Strategic Objectives and Expected Results

Strategic Objective	Expected Results
1. Develop policies and regulations on human resources for health & social welfare, coherent with government policies	Available policies and strategies
2. Strengthen HRH planning	Availability of HRH plans in districts and hospitals Availability of accurate HRIS information
3. Maximise effective utilisation of HRH	Strong leadership, coordination and partnership is implemented at all levels (government inter-sectoral and private sector) in order to remove bottlenecks and reduce bureaucracy in HRH management HR tasks of recruitment, management and retention are implemented at the appropriate level by appropriate Ministries, Departments or Agencies (MDA) Recruitment and retention of health staff in LGAs, hospitals and training institutions is improved, reducing the HRH shortage Productivity and effectiveness of health staff is improved through improvement of attitude and performance based systems.
4. Increase production and improve quality of training (pre-service, in-service and continuous education) with support of ZRCs.	Production of required health workforce increased, in order to match with demands in health sector (both in numbers as well as in competencies of graduates) The private sector is increasingly engaged in HRH development and utilization All regions and districts have adopted standardized Work Based Training of workforce (Continuing Professional Development, CPD) All training institutions have up-to-date curricula and are fully accredited Zonal Resources Centres (ZRCs) function autonomously, providing capacity building services to regions and districts
5. Improve use of Human Resource for Health applied research for planning and advocacy.	Relevant HRH studies are implemented, contributing to improvement of planning and management of HRH

3. Findings and Issues by Strategic Objective and Crosscutting Issues

The overall assessment of this component reveals the following levels of achievement as shown in Table 2 below.

Table 2 Overall Assessment by Strategic Objective

Strategic Objective	Brief Note on Assessment
1. HRH policies	Notable achievements in HR policy work (insufficiencies in draft notwithstanding), weakness in enforcement of regulations, variations in pace of reforms and a National Multi-sectoral Steering Committee that needs strengthening.
2. Strengthen HRH planning	Beginning seriousness in HR planning is noted with possibilities to be strengthened by an already designed HRIS and TIIS still challenged to harmonize and link with other HR information system.
3. Maximise effective utilisation of HRH	Government initiated an innovative pay for performance scheme and recently endorsed it as an approach for improving motivation and performance in the health sector. In preliminary analysis of P4P evaluation it is reported to have shown several positive effects and multiple challenges.[1] Bottlenecks and bureaucracy in HR management is still prevalent given weakness in National Steering Committee (erratic attendance of key members in Technical working group), leadership, coordination and partnership insufficiencies at various levels, and variations in putting on gear sound HR management practices among MDAs and other stakeholders.
4. Increase production and improve quality of training	Supply of health workers has increased generally but with unbalanced mix thus with fewer production of some cadres such as pharmaceutical technicians, specialist, laboratory technicians and health officers. Also production is not in line with other development plans.
5. Improve use of HRH applied research	There is considerable research in HRH with various recommendations, which have not been implemented due to lack of mechanisms to do so.

The documented implementation of Open Performance Review and Appraisal System (OPRAS) reveals limited application of the tool by management[2]. According to Benjamin Mkapa Foundation (BMAF), "Government introduced the use of OPRAS in July 2004, through Establishment Circular number 2 of 2004". It was designed to enhance public servants' accountability and efficiency with the aim of improving services delivered to the public. The system derived its policy orientations from the Public Management and Employment Policy (1998), the Public Service Act (2002), revised in 2008, and its attendant regulations (2003). However the implementation of OPRAS does not seem to be effective in improving the performance of health workers.

[1] MOHSW in collab with IHI, NIMR and WHO. Sept 2013. Analytical Review of Performance of the HSSP III 2009-2015. Pp 87-88.

[2] BMAF, 2011. Implementation of OPRAS in Public Health Services in Local Government Authorities. Lessons learnt from Coaching and mentoring visits conducted by BMAF under THRP in 54 districts.

Table 3 HRH per Population in Tanzania: 2008 versus 2012

HRH Cadre	2008	2012
Medical Officer	0.3	0.5
Assistant Medical Officer	0.4	0.4
AMO and MO together	0.7	0.9
Nurse/Midwife	2.6	4.8
Pharmacist/pharmacy technician	0.15	0.13

Health worker per 10,000 population. Sources: 2008 HMIS, 2012 HRHIS

3.1 HRIS Establishment

The HR Technical Working Group (TWG) managed to establish and orient users to a Human Resources for Health Information System (HRHIS) and a Training Institutions Information System (TIIS). However the HRHIS is experiencing some flaws, which are being adjusted. According to HRH PER of 2010, the HR gap (24%) identified at district by LGAs, differs drastically with that put forward by MOHSW (60%) and the 37% gap found in the 11 LGAs reached in a survey. The MTR analytical performance report notes that "HMIS data also provide information on annual trends during 2009-2012 for a large number of cadres, but data are less complete for most cadres. Completeness of the register is difficult to estimate in the absence of a census of health workers". Field visit findings during this MTR noted there has been a modest improvement in total available HR but still confirmed existence of significant HR gaps (40-50% in Lindi, more than half of requirements in Geita and 45% in Mbeya). This raises a question whether the staffing norms used in calculations was the same and whether in all settings data took in account all health staff or professionals only. A need for harmonization through job evaluation and revisit of staff establishment, was suggested by the HR-PER. Subsequently MOHSW reviewed staffing norms, that have recently been submitted to POPSM for endorsement. At the same time PMORALG and MOHSW engaged in developing human resource information systems that run in parallel (HRIS, TIIS under MOHSW and HRIS under PMORALG-DED). It is not clear whether the system parameters have been categorised in a manner that facilitates comparability and hence help validation through these systems. As such there is no evidence of linkage between these existing systems.

There are challenges on accuracy of HRIS, which depends on alertness of individuals entering data. For example there could be double entries where a staff member recorded at one station happens to offer part time services at another facility, and thus a risk that staff member may be recorded twice. Access rights and data adjustment, which is a centralized function may be challenging to accuracy of information. For example this can happen when there is a need to remove staff falling under a district where there has been a split of an already existing district.

There are problems regarding up-to-date data for planning at district level. This relies on aggregation of health facility and staff files records, which are subject to error when staff files are not easily accessible to HR focal persons for updating. For example in Mbeya City Council it was noted that there is a weakness in updating HRH files and job descriptions. However where computerization has taken place data entry compliance is high. During a progress Review Meeting on HRHIS and TIIS held this year, Mbeya region had done well in data coverage (125%), whereby, HRH Data from the Public had reached 104% and Private and FBO, 107%. In Chunya district data coverage was 134% for private and FBOs while 110% was public sector coverage[3]. However there is a need for explaining rates going beyond 100%, as this raises questions about the accuracy and reliability in the system. Also districts have reported incompleteness of HRIS. For example there is a gap, especially from reported low compliance, of private

[3] Mbeya Regional Health Forum July 2013. HRH Presentation.

for profit health facilities, unreliable HRIS due to connectivity problems and lack of linkages between HRIS, iHRIS under PMORALG -DED and FBO HRIS in Lindi report. Mbeya key informants on HR noted that the introduction of HRIS under PMORALG and that by Intrahealth (USAID) do perform similar functions and hence duplication of effort. The huge disparity between PMO-RALG data and HRH PER survey data in 2011 on one hand, and MoHSW data on the other, reinforces the need to conduct a sector staff audit and a thorough staff establishment exercise in LGAs[4].

HR plans are available in those districts where HR Focal Persons are well established in their posts and where they have been trained in HRIS use. District HRH data was clearly observed to contribute to LGA MTEF in Rungwe District in Mbeya, and in Lindi region. However there is an exception in Geita where it is reported that there are no District HR Focal Persons.

In addition, the trainee's information is now entered into the TrainSMART data base. ZHRCs have the ability to enter all participants of various training in the Zone in the TrainSMART database and can crosscheck proposed participants to avoid repeated participation of individual on the same training.

3.2 Maximising the Effective Utilization of HR

This section provides information on maximizing effective utilization of HRH under subsections of coordination of actors in HRH responsibilities, attraction of health workers to work stations, recruitment procedures and retention strategies.

Coordination of actors in HRH

There are various actors with HRH responsibilities. POPSM is responsible for keeping oversight on staff establishment, schemes of service and promotions, and issuing approval of vacancies against which postings are based. LGAs and MDAs are responsible for lodging requests to POPSM for staff to fill their local needs. LGAs are also responsible for recruiting posted staff that report for duty. MOHSW has been assigned the role of posting staff in accordance with POPSM-approved vacancies. MOFEA allocates funds for salaries as per approved vacancies and activates the salaries through the employees' data captured using the Lawson computerized system. Problems experienced in this complex system require collaboration, coordination and cooperation that is efficient and effective and yet upholding the scope and limits set by sector mandates. An effective national coordinating body for HRH is not yet in place to coordinate these interrelated activities. Also the HRH TWG, which worked well initially, is currently facing attendance problems across relevant sectors. As a result the tracking of HR retention and attrition is not robust enough to endow health work force stabilization within the sector. Analysis[5] shows that there is no formal benefits management system that tracks individual employment benefit needs; perceived lack of attention to non-financial incentives resulting to de-motivation and demoralization of health workers (see further reflection under Performance of the Health workforce below).

Attraction of health worker to work stations

Observations from various studies indicate that health workers are not attracted to work in rural areas, in Tanzania. For example an observation from the HRH PER[6] notes, that the number of HRH professionals generated and available in the country is inadequate for LGAs, especially in the rural areas. Also a significant proportion of HRH professionals posted by the MoHSW to LGAs do not report to their stations. A study commissioned by the MoHSW in 2010, covering 17 regions of mainland Tanzania

[4] URT, MOHSW 2011. PER – Human Resources for Health pp 16.
[5] Mshana, E. Petit et al. Synthesis of Human Resources for Health Studies conducted 2000-2011. Tanzania
[6] URT. MOHSW 2011. Public Expenditure Review 2010: Human Resources for Health

showed that only about 65 percent of those posted to the LGAs reported and remained in their working stations. Similarly from the HRH PER Survey, only 66 percent of posted staff reported to the LGAs and remained to provide services. Factors that influence attraction and stay behaviour include provision of housing, and other essential items. In Mbeya provision of food, household equipments and transport facilities to newly employed health staff was an attraction. Also in Mbozi and Ileje, availability of staff houses at health facility level and provision of transport monthly for staff posted to remote areas to collect their salaries was an attraction to health workers. In Lindi region some key informants noted that health workers are now happy to work in the south because of the of tarmac road that connects the Southern regions of Tanzania and Dar es Salaam, and also that there is good communication - the situation which was different a couple of years ago.

Table 4 Factors that influence staff retention

Ser #	Motivating factor	Scores in %
1	Working environment (availability of houses, availability of working equipments, essential social services	42
2	Timely inclusion in Salary payroll and get paid quickly	25
3	Timely payments of personal effect	8
4	Timely payments of Subsistence allowance	25

Source: MOHSW 2011. The 2007/8-2009/10 Posted Staff Tracking Report

Figures from the table above indicate that working environment is the top factor that motivates staff to stay in their new duty stations. The situation recorded at 2010 is shown in table 5 below:

Table 5 Status of Health Work Force by cadre

Cadre	Establishment	Available	Deficit	%Deficit
Specialist doctors	229	96	133	58.1
Nurse/ NW/PHN II	20,373	9,241	11,132	54.6
Radiographers	197	97	100	50.8
Clinical officers	11,316	5,655	5,661	50.0
Pharmacist/technicians	621	311	310	49.9
AMO/ADO	2,407	1,295	1,112	46.2
Health officers	1,823	990	833	45.7
Laboratory technicians	821	480	341	41.5
Asst. clinical officers/ MCH aides	760	451	309	40.7
Medical doctors	748	469	279	37.3
Nursing officers/PHNA	6,559	4,381	2,178	33.2
Health secretaries	269	196	73	27.1
Others/medical attendants	24,154	18,891	5,263	21.8
Total	**70,277**	**42,553**	**27,724**	**39.4**

Note: NW= Nurse-midwife, PHN=Public Health Nurse, AMO=Assistant Medical Officer, ADO=Assistant Dental Officer, PHNA=Public Health Nurse Assistant. Source: Tanzania Health System Assessment Report 2010

These figures do not include Community Health Workers since they are at present not categorized as formal health cadre; their total number for the country is not known because of inconsistencies in reporting.

Staff recruitment process

As noted in the coordination subsection, there are several actors involved in the health worker recruitment process. As such coordination and dialogue among the Ministries involved (PMORALG, POPSM, MOFEA and MOHSW) is essential for clarity and shared understanding on key policies such as pay policy and age restrictions in recruitment. According to a key informant at BMAF, the policy restriction on recruitment of a health worker above 45 years limits the ability to get experienced

workers from the market. As such focusing on mainstreaming young graduates tends to utilize a mobile and unpredictable group in terms of stability. Also after recruitment, most staff does not get job orientation and induction to internalize their roles, tasks and responsibilities. The lack of this essential priming input leaves staff disoriented in their initial employment as they learn haphazardly on the job about their working environment, linkages with other staff and output expected from them[7]. Despite these hurdles there has been more workers employed so far.

Table 6 Number of health workers for selected cadres

Core cadre category	2011	2012	Density per 10,000 population (2012)
Medical officers	1,123	1,353	
Medical specialists	1,099	916	
Total medical doctors	**2,210**	**2,269**	**0.5**
Assistant medical officer	1,561	1,868	0.4
Clinical officer	4,780	6,006	1.4
Paramedical practitioners (AMO, Clinical Officer)	**6,341**	**7,874**	**1.8**
Nurses / midwives	21,252	21,736	5.0
Total doctors / nurses /midwives	23,462	24,005	5.5
Total health professionals	**29,803**	**31,879**	**7.3**
Skills mix (ratio nurses / clinicians)	2.5	2.1	

Source: MOHSW in collab with IHI, NIMR and WHO. Sept 2013. Analytical Review of Performance of the HSSP III 2009-2015. (from 2011 (National HRH profile) and 2012 (HRHIS)

Tables 5 and 6 above show the health system heavily dominated by paramedical practitioners and nurses: But a major systemic issue of concern is the inequity in distribution of these workers (geographical remoteness and by regional population densities), and the absence of a complete census of the health work force by health facility that would inform planning and redistribution. The Human Resources for Health Country profile for 2011[8] reported an increase of the total number of health workers from 47,000 in 2006 to 56,000 in 2011. In this sense the total number represented 42% of requirement compared to 35% registered at initiation of HSSP III. The HRH profile for 2012[9] recorded a total of 64,449 health workers in the health sector (52% availability using 1999 staffing norms or 36% availability based on new staffing norms total requirement of 177,215). Closing the sizeable gap in availability of health professionals was therefore a critical focus of the HSSP III, yet sector expansion of health facilities (under the PHSDP) was not done in harmony and close coordination with the HR professionals deployment and recruitment. In tracking deployment of health workers a Sikika study[10] found a low (4%) net effect of gap closure in surveyed districts between 2008 and 2009. Inequity in favour of urban areas, relatively high attrition amongst pharmacy cadre, clinicians and radiographers and financial neglect of the sector were key observations from this survey (ibid). Trends in recruitment show overall management of the recruitment effort was effective at the level of 71.9% of granted positions (see table 5 below). As further elaborated in section 3.4 (equity) below, there is strong evidence that

[7] URT, MOHSW 2011. Public Expenditure Review 2010: Human Resources for Health
[8] URT, MOHSW 2012. Human Resources for Health Country Profile 2011
[9] URT. MOHSW 2013. Human Resources for Health Country Profile 2012/2013.
[10] Sikika 2009. Deployment tracking survey. Human Resources for Health in Tanzania.

health workers are neither distributed equally in relation to needs and rational demand nor equitably by rural/urban, gender and population densities.

Table 7 Health workers recruitment: trend 2005 - 2012

Year	New Positions Granted by PO-PSM/Treasury	Number of Graduates Posted by MOHSW for Recruitment by Councils	% of Posted staff for recruitment among positions granted
2005/2006	1,677	983	58.6
2006/2007	3,890	3,669	94.3
2007/2008	6,437	4,812	74.8
2008/2009	5,241	3,010	57.4
2009/2010	6247	4090	65.5
2010/2011	7471	6326	84.7
2011/2012	9,391	6,400	68.2
2012/2013	8,602	Not yet done	

Source: Human Resource for Health Country Profile 2012/2013

According to key informants there has been a repeated gap between POPSM approved post and MOHSW posted; there has been a gap between requested by LGA and approved by POPSM, as well as a gap between number of applicants and approved posts. Whether or not absorption of trained professionals is limited by the wage bill or other considerations needs to be researched and brought to light, especially now when production has significantly increased. Also a need to track and document the fate of those not absorbed.

Performance of the health workforce

The influence of salaries and benefits on HR performance is not as obvious as the influence on mobility and retention from other factors (refer to earlier discussion on attraction above table 3). For example it was noted that most of PEs to MOHSW staff is paid in form of salaries. The HR-PER 2010 indicates that "in 2009/10 MOHSW salaries accounted for 68 percent of Personal Emoluments. Other benefits were domestic per diems (10%), internship (8%), extra duty (4%), foreign per diems (3%), moving expenses (1%), housing (1%), medical and dental refunds (1%), and honoraria (1%). The rest made up the remaining 3 percent. Specific salary data by HRH categories such as for medical doctors, nurses and allied professions were not available. However, like in all other government institutions, salaries for HRH professionals in Tanzania are generally considered low and this has been the main reason cited during the survey to contribute to HRH staff to leave public sector.

Variations in performance and attitudes seem to be influenced by other factors such as availability of medicines, supplies, allowances, supportive supervision, leadership and mentoring, CPD and isolation. According to a recent assessment report[11] "Staff morale is a challenge given a heavy workload, with limited appreciation or incentives. Upon interviewing nurses in Mtwara, there was overall agreement that there has been a shift in attitude toward and care for patients, most nursing roles, beyond providing medicines and injections, have been shifted to relatives, such as washing and dressing patients, accompanying them to the toilet, and offering a bedside talk and/or counselling".

Synthesis of HRH research[12] observes the following factors rated highly as commonly de-motivating and hence negatively affecting retention: i) workload paired with staff shortage, ii) lacking career progression goals/plans; iii) poor infrastructure/poor working environment/unavailability of working commodities/poor housing & lack of transport; iv) lack of supportive supervision; v) low salaries.

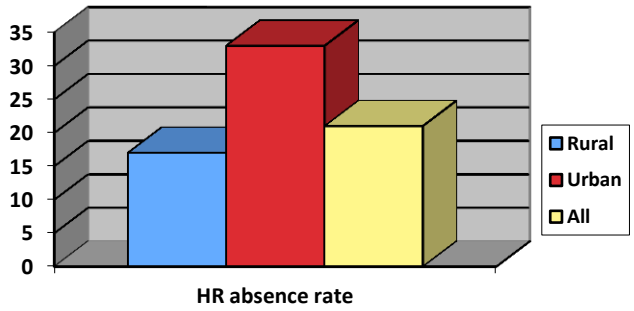
[11] Musau, S. et al. 2011. Tanzania Health System Assessment 2010 Report.
[12] Mshana, E. Petit et al. Synthesis of Human Resources for Health Studies conducted 2000-2011. Tanzania

The potential to enhance performance through application of the Open Performance Review and Appraisal System (OPRAS) has been insufficiently realized. Limited utilization of the OPRAS led to violation of objectives, scope and intent of Public Service Pay and Incentive Policy (October 2010)[13]. Interview findings from BMAF, MTR field visits in Geita, and Mbeya noted there is absence of commitment at senior management level to enforce the system, given the situation sanctions or rewards related to OPRAS are not implemented.

The PER – HRH of 2011 made the following observations on HRH productivity and quality:

1. The Africa Economic Research Consortium study found HRH staff absence rate in Tanzania to be rampant and widespread especially in the urban areas.

Figure 1 HRH absence rates



Source: Pilot in Education and Health Care in Africa, Feb 2011: African Economic Research Consortium

2. Diagnostic accuracy in urban areas was in general better than in rural areas at 68 percent and 53 percent respectively.
3. An in depth assessment of midwives competencies in the provision of maternal, newborn and child health care in Tanzania[14] showed that midwives did not have enough practical skills to provide quality maternal and newborns care.

A significant portion of the problems faced could be addressed through more determined supportive supervision and mentoring – where supervision has been taken seriously there have been positive results. For example in Iramba supervision controlled supplies stock- outs through effective audit and in Chunya there was attainment of high performance on immunization. The CAG Performance Audit Report of 2009 questioned the usefulness of some supervision in the form it was conducted then. Change in practice is probably still awaited, considering the recent DMOs and RMOs annual conference in 2013 questioning the impact of supervision in the LGAs health care service provision.

Room for optimism can be appreciated from some independent reports on LGAs performance. For example the Local Government Development Grant (LGDG) system contributes to increased access to local services in a manner that in case one adheres to the standards given by the various sectors confirms equitable results (MDF Report). Performance assessment is reported to have improved LGA management tremendously. According to the same report, in theory LGRP II and LGDG are reinforcing each other mutually, but in practice LGRP II has not come off the ground yet. Some LGAs have begun to put in place attraction and retention measures (staff houses, equipment, IPC inputs etc).

[13] URT, President's Office, Public Service Management. Public Service Pay and Incentive Policy. 2010. Pp 24,30 and 35.
[14] MoHSW "Invest in Midwives" study (2011).

HRH Management

Human resource management is a rare skill in the health sector. According to staff responsible for HR at districts and regional levels it is only Health Secretaries who get HR management in their training and get support from the DHRO who is responsible for all staff in the district. Also it was observed that DMOs are not trained in HR management except in tailor made in-service courses. As such HR Management practices at district level tend to be limited and practiced poorly. There is lack of accountability as noted through unclear duties and responsibilities, unmonitored productivity per staff per unit of time and through unchecked absenteeism (for example see Mbeya MTR field report p.9). HR Focal persons met were at forefront in criticizing the OPRAS tool instead of analyzing and recommending how it could be put to better use. Geita and Mbeya MTR field reports noted limited use of OPRAS at districts. The Analytical Review of Performance of the HSSP III 2009-2015 at mid-term has not covered management of the health workforce.

Some informants noted that graduates should be given life skills training to enhance their commitment to serve hand in hand with other measures such as strengthening leadership and management and creating conducive working environment particularly in paying attention to underserved areas.

3.3 Production of health workers

In this section there is an elaboration on whether there is increased production and improvement of quality of training (pre-service, in-service and continuous education) with support of ZHRCs. The outline of the presented findings is on expected result on production of required health workforce, engagement of private sector in HRH development and utilization, adopted standardized Continuing Professional Development, (CPD) Status of curricula and accreditation of training institutions, functionality of Zonal Health Resources Centres (ZHRCs) and finally the implementation and use of HRH studies in planning and management of HRH.

Production of required health workforce

Student population has been increasing over years. This increase in enrolment is necessary for enhancing the ability to support the health services in the country. There has been an increase of enrolment of students from 6201 in the year 2009/10 to 6746 in 2012/13 (See Table 8). This development is purposely done to be able to get adequate health workers for MMAM requirements.[15][16]

Table 8 Number of Entrants and Outputs for Nursing and Allied Health students(2009-2013)

Cadre	Enrolment				Output			
	09/10	10/11	11/12	12/13	09/10	10/11	11/12	12/13
Nursing	3354	4595	4332	3598	2793	3093	2987	NA
Allied Health	2847	3494	3602	3148	2299	2744	2375	NA
Total	6201	8089	7934	6746	5092	5837	5362	NA

Source: Human Resource for Health Country Profile 2013

[15] Public Health Expenditure Review : Human Resourse For Health 2011

[16] MOHSW Primary Health Services Development Programme- MMAM 2007 – 2017

In 2011, there were 134 training institutions of which half were government. Half (68) were nursing and midwifery training institutions.[17] There are eight medical schools, two from the government, 4 not for profit and 2 for profit. By 2012, 56 of the 134 training institutions had been fully accredited by NACTE. In addition, 14 had received a provisional license[18]. The output of training institutions in 2012 was high for doctors and non-physician clinicians. In 2012, 830 physicians graduated, which is 37% of the total number of physicians working in 2012. If these medical doctors can be absorbed by the labour market, the medical doctor densities would increase very rapidly. There is however an absorption capacity issue in Tanzania. For other cadres the output of training institutions is more in proportion to the numbers currently employed. For AMO, CO and nurses/midwives the output of training institutions was 13%, 9% and 12% respectively of the numbers working[19].

There are various initiatives to ensure candidates joining the training centres are selected from hard to reach areas. For example there are student grants provided by BMAF through Global Fund support to 116 students from 35 District Councils who are studying health middle level courses such as Nurses, Assistant Nursing Officers, Clinical Officers and Clinical Assistants. These courses started in 2012 and the first batch of 81 graduates (2 year courses) is expected to complete their studies this year (2013) while other 35 students (3 year courses) will complete their studies in 2014. [20]

Postgraduate training

Concurrent with the increased enrolment of students for postgraduate studies (See Table 9) the MOHSW was supporting infrastructure and equipment for specialized cares in regional, zonal and national referral hospitals.

Table 9 Summary of Pstgraduate students (Year 2012/13)

Country of Training	Year 1	Year 2	Year 3	Year 4
In country	104	142	143	26
Abroad	6	6	19	4
Total	110	148	162	30

Source: Human Resource for Health Country Profile 2013

Tutors

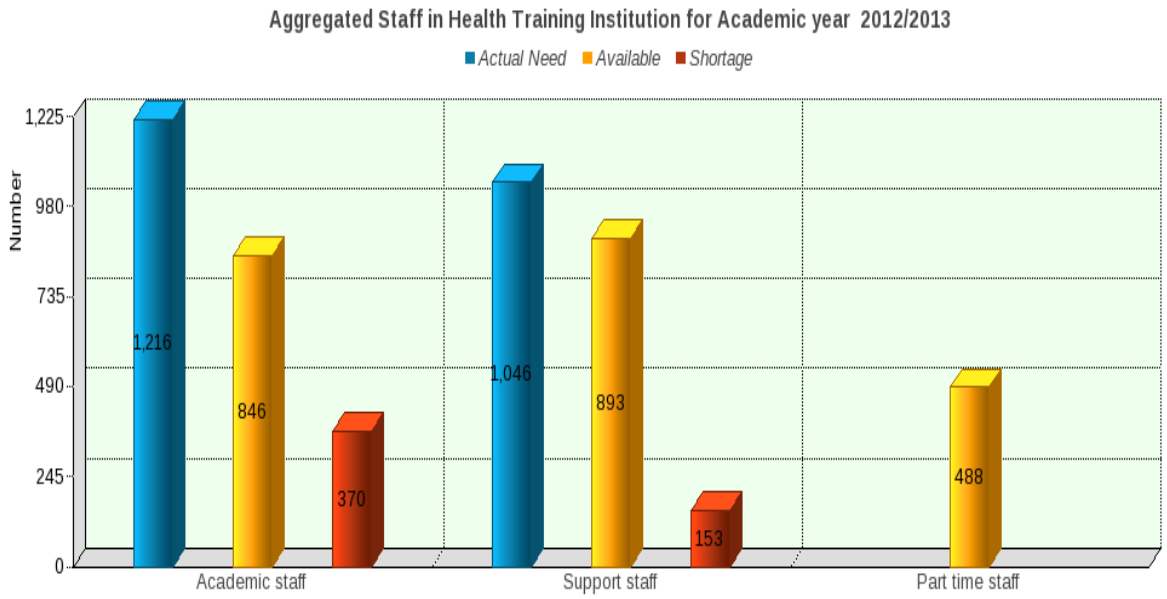
Partners have been on the forefront to support teacher training. In particular BMAF under GFR[9] recruited 137 tutors for 2 year contract (2011-2013) and placed them in 44 Health training institutions: To-date 116 out of 137 are at different stages of mainstreaming process into Government employment. There are also 35 part time tutors who are working in 16 Health training institutions[21]. Also I-TECH through tutor hiring project had employed a total of 63 tutors in two years contract and deployed them to 32 Health Training Institutions of MOHSW. The agreement is to mainstream all of these tutors into the government system by the end of their contract. As part of professional development, I-TECH provided training on diploma in teaching methodology for 9 tutors at CEDHA where a one year program teacher training course is offered. I-TECH also provided leadership and management training to 24 tutors through a five days training course.[22]

[17] Public Health Expenditure Review : Human Resourse For Health 2011
[18] Mid term Analystical Review of Performance of the Health sector Strategic plan Plan III (2009-15)

[19] ibid
[20] BMAF personal communication
[21] ibid
[22] I-TECH Personal communication

I-TECH, AIHA and JHPIEGO are developing harmonized capacity building packages for tutors of Health Training Institution on key areas as identified by MOHSW. This is to prevent duplication of efforts among partners. The implementations of these packages are under the Steering Committee appointed by MOHSW to oversee the housing of these courses, their implementation and accreditation. However there is still a shortage of trainers as shown in figure 2.

Figure 2 Aggregated staff in Health Training Institutions for the Academic Year 2012/13



Source: Human Resource For Health Country Profile 2013

CHW and social workers

There are initiatives to reintroduce Community Health Workers (CHWs) into the health system. For example Ifakara Health Institute (IHI) has a project that has trained 150 CHWs who were selected by their communities.[23] These CHWs were trained for 9 months in preventive, promotive and curative services. They are currently deployed into fifty villages in three districts of Rufiji, Kilombero and Ulanga. They are paid a salary and provided working tools. This project is experimental and tries to assess the impact of the intervention. The challenge is the extent to which this system will be sustainable after the project support ends.

Also there is an initiative by Intrahealth project that has introduced a para - social worker cadre to provide services in social services in the community. The challenge here is the slow process to hire this cadre into the Health and Social Welfare sector.

Engagement of private sector in HRH development and utilization

With regard to the institutional arrangements, there is a big difference between private institutions and government institutions. The private institutions have their own staffing, budget, finances, select their own candidates, determine their own fees, etc. Government institutions are highly dependent on MOH SW-HQ. Staff is directly under the ministry. The MOHSW determines the budget, the subventions, and selects candidates and determines the cost-sharing fees for students. There is, however a new initiative

[23] Introducing Community Health Agents to facilitate accelerated progress towards achievement of MDGs 4 and 5 in Tanzania:The Connect Project

to support the private institutions where by CIDA supports a project for private schools to bid for mini-projects for developments in training centres. The project has a steering committee and an executive secretariat that will oversee its implementation.

Continuing Education and Professional Development (CEPD)

There are various CEPD providers in the country with varied levels of competences. Also there is inconsistency in providing certificates after CEPD training indicating lack of standards in acknowledging what participants go through in CEPD course. There are no systems in place to accredit those providing CEPD. This is an area that needs to be addressed when developing criteria for evaluating CEPD and acquiring credit points. Re-licensing is not normally practiced and where practiced academic updating is not a requirement.

There are policies from various stakeholders such as the MOHSW that encourage developments in CEPD. However others initiatives such as the Primary HealthService Development Programme (PHSPD) increase demands of health worker to other pressing priorities. International links are currently encouraging developments in the quality of training programmes.. On the other hand high prevalence of HIV/AIDS Malaria and TB and considerable incidence of non-communicable diseases require innovative CEPD to address the health situation. Also the current critical staff shortage and heavy demand for health services mean that it is difficult for health professionals to find time to attend educational activities.

Although there is a range of options available that include technology use such as online lectures, use of e-mails linkage to online resources, internet-dependent course, not all participants have full access to IT resources. Also the training facilities face challenges of weak IT infrastructure, high cost and restricted access. Similarly funding poses a serious challenge for adequate coverage of CEPD to clients and sustainability of CEPD including its accreditation. This raises the question of equity when accreditation is to be compulsory to all health workers, as developments in CEPD should involve all health workers.

There is also the Centre for Distance Education, which falls under the Continuing Education/Continuing Professional Development (CE/CPD) Unit of the MOHSW. Currently the centre has eight staff, whereby apart from the three who started, there is Health secretary, nurse tutor, two tutors and an accountant. The centre has been strengthened in terms of office equipment, health learning materials, vehicles, computers, photocopiers and printers. It has managed to develop Distance Education Upgrading courses for Clinical Assistant to Clinical Officers, MCHA/Nurse Assistant to Enrolled Nurse, Enrolled Nurse to Registered Nurse and District Health Management modular Course. The centre has also developed DE bridging course for CA/RMA to CO and NTA level 6 course materials. About 60 tutors been trained on DL teaching skills. These trained tutors are recruited from the study centres in collaboration with ZHRCs. Currently 478 HWs qualified to become COs and 202 HWs qualified to become EN through DE system in 10 study centres. From 2009, with the support of I-TECH the Centre has managed to conduct Tanzania Distance Learning Assessment, E- Learning and feasibility assessment and developed National DE implementation guideline.

The main challenges facing the centre include limited resources allocation from MOHSW to support DE activities at CDE, ZHRCs and Study Centres[24]. The centre is receiving limited support from MOHSW causing challenges at ZHRCs and study centres - key implementers of the programme. There is lack of working space at the centre and inadequate ICT infrastructure because technological advancement in delivering Distance Learning i.e. e-Learning is inevitable.

[24] Petit-Mshana E; Pemba SK ; Petit P Synthesis of Human Resources for Health Studies Conducted 2000 – 2011. 2010

Status of curricula and accreditation of training institutions

With regard to the quality assurance of training, NACTE formulates standards for Health Training Institutions (HTI). In 2009 I-TECH embarked on innovative approach in supporting the MOHSW to develop standardized training materials to complement the curricula. A total of 40 modules and Practicum Guides for NTA levels 4, 5 and 6 including Practical procedure books for NTA levels 4, 5 and 6 were developed and distributed to all training institutions. Also over 300 full and part time tutors were oriented on the use of these training materials. In 2011 I-TECH with guidance from NACTE, supported the MOHSW to review and transform curricula for Allied Health Training Institutions from knowledge to CBET. The curricula involved were those for Dental Technician, Medical Records, Physiotherapy and Environmental Health. So far 56 (42%) of a total 134 health training institutions are fully accredited by NACTE[25].

MUHAS faculty set out to identify specific competencies for students to achieve by graduation, engage stakeholders to understand adequacies and inadequacies of current curricula and to restructure and review curricular introducing competencies[26]. The Tanzania Commission for Universities accredited the curricula in September 2011, and the Faculty started implementing with first year students in October 2011.

Functionality of Zonal Health Resources Centres (ZHRCs)

There have been efforts to provide capacity to ZHRC. For example a total of 269 ZHRC faculty were trained in teaching methodology and training coordination. All ZHRCs have since implemented teaching methods TOTs in their respective zones, and improved training skills have been observed. In addition, 22 were trained in M&E, and 196 in HIV and TB/HIV content. I-TECH-trained ZHRC faculty have assisted MOHSW and HIV partners to implement TB/HIV and ART trainings and TOTs. All eight ZHRCs have held stakeholders' meetings, which has led to raised visibility and improved coordination. Since these meetings, HIV development partners have requested to implement training through the ZHRCs. Assessment visits have built trust and commitment and have identified systems gaps to be addressed through further technical assistance. HIV development partners can now benefit from partnering with a relatively strong, well-coordinated, de-centralized MoHSW structure – the ZHRCs. I-TECH programmes continue to build the capacity of this already-existing MoHSW structure. This key strategy ensures that training can be effective, sustainable and can reach all health care workers nationwide.

However there are gaps in ZHRCs ability to realize their roles[27]. There are no clear separation of division of roles between health training centres and ZHRC. There has been inadequate financing of the ZHRC. ZHRCs were introduced but they are not well recognized into the MOHSW organogram as well as in the PMO-RALG organogram; making them lack the mandate to oversee and supervise the HTIs, Regional and District health authorities. Furthermore ZHRCs are under Assistant Director – Continuing Education (AD-CE) but headed by a principal of the hosting institute who is in most cases under the Assistant Director Allied Health (AD-AH) or Assistant director Nursing Education (AD-NE). This also makes it difficult in terms of human and non human resource allocation, mobilization and utilization i.e. the ZHRC have one or two staff – mostly depend on the staff from hosting HTI, financial

[25] Mid term Analystical Review of Performance of the Health sector Strategic plan Plan III (2009-15

[26] Ngassapa et al Curriculum Transformationon Health professionsEducation Journal of Public Health Policy(2012) pp33

[27] Human Resources for Health in Tanzania, Baseline Report, SIKIKA, September, 2010

resources – depend on projects or write-ups and there is hardly any money from the Government. ZHRC are mostly understaffed to undertake the required roles

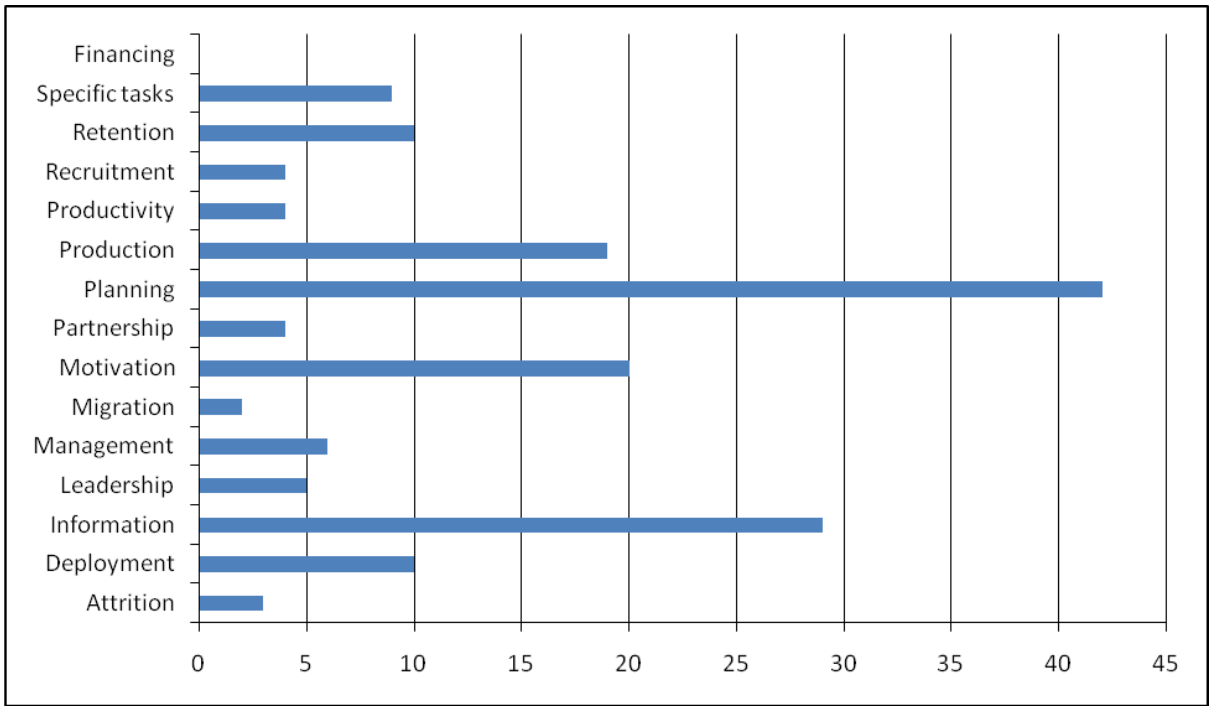
Similarly there is no link between the MOHSW through the ZHRC with regions and districts in the areas of training and human resource development. There is no mechanism to coordinate quality training in pre-service and in-service in the Zones. Still there is weak mechanism to strengthen district and regional capacity. There is no supportive supervision conducted to health training institutions in the ZHRC. There is no established human resource and trainer's inventory. There are no established Health Resource Centres (Libraries) in training institutions and health facilities and no established and strengthened ICT to improve quality training.

Implementation and use of HRH studies in planning and management of HRH

More than 167 documents (See figure 3) on HRH research were synthesized by Mshana-Petit et al[28]. for recommendations. Areas that were seen to be well covered in research were in recruitment process and bottlenecks, retention, deployment, incentives, TEHIP, NETTS-ZORO Evaluation Needs based, 'Gold Standard' plan studies and HRH conceptual frameworks.

Recommendations were on various themes. There are recommendations on policy and planning to build policy and planning capacity to encompass much more than training individual staff, improve the capacity and status of professional regulatory bodies and to strengthen leadership/stewardship. Also there were recommendations on addressing the CME / Continuing Education / on job training System, review student admission policies in favor of staffing rural / hardship areas.

Figure 3 Number of reviewed research documents per theme



Source: Petit-Mshana E; Pemba SK ; Petit P Synthesis of Human Resources for Health Studies Conducted 2000 – 2011.

[28] Petit-Mshana E; Pemba SK ; Petit P Synthesis of Human Resources for Health Studies Conducted 2000 – 2011. 2010

The need to streamline /decentralize the student selection process, follow through on incentive packages in a consistent way, follow-up on hiring bottleneck studies toward a functional well coordinated recruitment system and tackle mal-distribution of staff in a multi-, supra-sectoral way were also recommended. On HRH partnership structure which is mainly at central level, it was suggested to replicate this at the other levels of health system, namely zonal, regional and district/council levels where planning and management of HRH remain weak. There were suggestions that partnerships with academic and research institutions, as well as with health professionals' bodies (professional councils and associations) be strengthened. Finally there was a suggestion to be cost conscious on HRH issues. However there were no recommendations on how these recommendations are going to be implemented

It was proposed that future research should include multi-factoral HR projection studies using models. There were also proposals for studies on requirements for specialized 'small' cadres, studies on best forms of partnership and the functioning of present partnerships.

3.4 Cross cutting issues

Quality

The aim to have in place a disciplined health workforce that observes ethical standards has not yet been attained. Roll out of the TQIF[29] has reached some hospitals (tertiary, regional and district): Health Centres and Dispensaries have not yet been reached. All staff need to be literate and skilled in quality improvement approaches. Yet improvement of Human Resources through quality pre-service and in-service training is not coordinated, making those who graduate out of date in various current issues in health.

Performance based management has been emphasized, but the lack of funds that has hindered the P4P initiative and trivial attention given to OPRAS have negated what could potentially be gained. Institutionalization of coaching, supervision and mentoring has not been attained. Routine supervision is done quarterly which by virtue of its workload does not make time for adequate planning, data collection, coaching, feedback and follow up. Accreditation of Health training institution is slow. This implies the lack of quality standards required by the training centres to get full accreditation. Similarly training centres providing short courses need to be accredited to ensure quality of training provided. There is limited and poor quality of supervision conducted to Health training Institutions. Dependency on central supervision (which is often limited) causes the observed poor supervision. This calls for delegation of some of the central roles to ZHRCs. Inadequate funding to training centres limits the quality of training in areas such as infrastructure, libraries, classrooms and skill laboratories. Indebtedness of training schools affects the learning environment as it destabilizes faculty and student upkeep. Poor funding of training schools and weak professional bodies limits their influence to health workers in CPD and enhancing ethical standards among health workers respectively.

Gender

The intensity of collaboration between Health Professionals and Social Welfare Officers was expected to increase attention to gender issues such as Violence Against Women and Gender Based Violence: Also care assurance to vulnerable individuals and groups (who are often women, children/orphans, persons with disability, stigmatized HIV/AIDS victims).

The cry from Social Welfare has been "..limited attention given to Social Welfare issues and low functionality of Social Welfare Officers due to organizational and budgetary constraints at LGAs level".

[29] URT. MOHSW 2011.Tanzania Quality Improvement Framework

Specific issues such as women empowerment, gender equality and constructive male involvement have been attended to a limited extent. The DHS 2010 findings on magnitude of GBV revealed 39.6% of women (15-49 years) had ever experienced physical violence since age of 15 years. Collaboration with the Police and Social Welfare to put in place mitigation, corrective and preventive measures for such violence has only just begun driven by NGO/DP projects.

Gender Focal Persons are in place at various departments and sensitization to gender concepts has been done. Women in Tanzania face many issues similar to their East African peers: they work longer hours, are paid less, have fewer years of education, and have less decision-making power than their male counterparts[30]. RCH program efforts to advance specific interventions on gender have therefore been of merit. GBV response, male involvement in RCH/FP (reversing male opposition) through FP/HIV integration have received attention even though these interventions have yet to gain firm ground at operational settings. Issues that still remain insufficiently addressed are specific interventions to uphold the rights of women in health and sexual reproductive health of boys and girls (youths) to enhance safe sex practices and reduce risks of acquiring HIV infection. Innovative interventions addressing these issues still remain largely among NGO/Partners projects.

Equity

There are challenging equity concerns regarding HRH. For example there are more health workers in numbers and of higher training and experience in urban centres compared to rural areas. Some cadres such as laboratory technicians, pharmacists and health officers are fewer compared to other cadres that are hardly found in some facilities where they are needed. Qualified dentists are insufficient in numbers and largely deployed in urban settings.

The Analytical Performance Report of July 2013 painted the following picture:

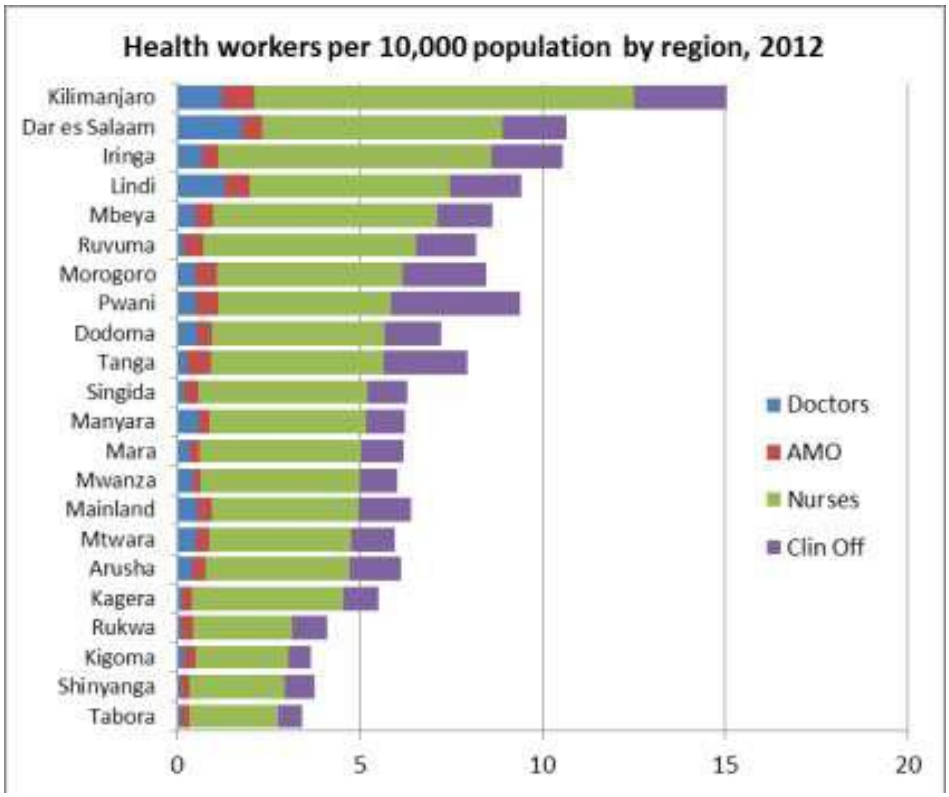
"…*A major increase in doctors during 2006-201 who were generalist medical practitioners went up from 447 to 1,121 and specialist medical practitioners from 130 to 1,099, totaling 2,210 physicians".*

The 2012 data showed a similar number of medical doctors but considerably less medical specialists. This was assumed to be due to lack of coverage of the national referral hospitals. Therefore, the 2011 figure was used as a density of 0.51 per 10,000 population. Also 69% of the medical doctors and over 90% of the medical specialists are working in urban districts. This inequity in favour of urban areas could largely be due to the location of secondary and tertiary referral hospitals in urban areas. Its negative effect is seen in many rural health facilities been run by less qualified personnel and overwhelming proportion of dispensaries run by unsupervised attendants leading to poor service delivery, in rural and hard to reach areas.

30USAID, 2012.Gender Assessment for the Tanzania CDCS.

Regional inequity in density of HRH has been noted in MTR performance analytical work as shown below:

Figure 4 Regional Inequity in HRH



Source: MOHSW/MTR Analytical Report 2013

Mwanza, Shinyanga, Tabora regions have high population but relatively low proportion of health human resources density when compared to low populated Lindi for example.

Deliberate efforts made by FBOs and some NGOs, notably by BMAF, to create attraction conditions for realizing more health professionals become available and retained in remote and under-privileged areas/ districts have made a mark. Sharing of lessons and experiences from these initiatives is being realized but the seriousness in learning and assimilation from the lessons is still quite limited.

Service Agreements (SAs) introduced to enable sharing of resources under the PPP arrangement have assisted FBOs to access staff support and other resources. However assessment of the functionality of the SAs has not been done: RHMTs and CHMTs in Mbeya observed at their recent Regional Health Forum that the SAs have not been reviewed since their introduction. Some studies have documented migration of health professionals from the private to the public sector mainly due to unequal access to pension and other benefits[31],[32]. An urgent need to harmonize key employment conditions, such as benefits and pension schemes, but also workload, management practices and opportunities for career

[31] Nils Gunnar Songstad et al 2012. Why do health workers in rural Tanzania prefer public sector employment? *BMC Health Services Research* 2012, **12**:92 doi:10.1186/1472-6963-12-92. **ISSN** 1472-6963

[32] Patrik Tabatabai et al 2013. The internal migration between public and faith-based health providers: a cross-sectional, retrospective and multicentre study from southern Tanzania. Tropical Medicine and International Health volume 18 no 7 pp 887–897 july 2013.

development across the decentralized health system has been pointed out[33]. Levelling the field to ensure equity of access to health professionals irrespective of whether they serve in public or private health facilities should register a positive health development move. This requires a robust legislation and regulatory framework to make it work in a manner that the health professionals will be accountable for optimal productivity wherever they practice.

Community ownership

The community ownership of health facilities is not materialised. The Health Facility Governing Committees (HFGC) are not functioning as they should due to lack of funding and due to inadequate understanding of their roles. All public training centres do not have boards, which could be a good link to the community to enhance ownership and support. However GOT is committed, through its policies, to empower individuals and families at the community level to take ownership of their own health outcomes and become more involved in health promotion, prevention and care. Health facility committees are tasked with strengthening community-level decision making about facility matters, including funding-related decisions. Functionality of these committees varies. In Geita the MTR team observed that Village and Ward Development Committees are active in villages and wards but availability and functioning of Health Facility Governing Committees (HFGC) varies. In Lindi and Mbeya there was limited appreciation of community level action despite the presence of active HFGC and Hospital Board members. Enhancing utilization of the HFGCs has been observed to have beneficial effects. For example in Mbeya and Lindi Regions they are involved in verifying arrival of medicines and supplies.

Vertical programs and NGOs tend to have more community level interventions including HBC, 'expert patients', mother-to-mother peer educators, CBDs and CHWs. Publicly run CHW initiatives tend to be less visible. However through task shifting CHWs complement the already short-staffed health sector as well provide the care continuum required in a comprehensive health care system.

Coherence in health services planning and implementation

The CCHP is the tool that fosters coherence at districts by limiting fragmentation that would result from Vertical Program initiatives. So far this seems to be working well in terms of planning as well as implementation except for some Development Partners whose support is not channelled through government systems. The devolution of powers intended by the country's decentralization policy has not yet attained its optimum: tendencies to dictate decisions and instructions from above have continued, to the extent that LGAs vocalize that some of their priorities are changed when their CCHPs are submitted to higher levels for assessment and support. When Regions are by-passed in the exercise of CCHPs assessment their credibility and motivation are undermined. Centralization within decentralization, undesirable as it may be, continues to manifest and more so at district level where participation of Health Centres and Dispensaries in the CCHP process is still quite limited.

Complementarity in governance

Fitting the health agenda into LGAs administrative procedures seems to be working despite challenges related to control over specific accounts, personnel and stock management issues. Harmonization and dialogue to enable better understanding and foster efficiency is critical. There is need to ensure availability of funds to address stock out problems as they occur, meet personnel retention measures such as extra duty allowances, leave travel, housing – funds are either short or delayed. Involvement of HFGC and CHSBs in key planning and management decisions is happening but with variations in the way this is practised. The Lindi and Geita MTR teams reported variable functioning of HFGCs, while in Mbeya these committees are active. Similarly Hospital Board members' active participation in the

[33] Op cit. pp 896.

Regional Health Forum in Mbeya was notable. To effectively perform HR leadership and oversight functions, the MOHSW is expected to work in partnership with other service providers and line ministries that have HR management responsibilities. The HSA 2010 report[34] notes that:

"The implementation of previous HRH strategic plans did not proceed as intended, primarily for two reasons: uncoordinated effort and little funding. Future plans must address these issues, but this calls for development of strong HR management, leadership skills, and stewardship at central, regional, and district levels."

Within the PPP arrangement FBOs and other private health service providers should be invited to carry out joint planning including the HR component of plans. Some districts follow this to a fuller extent compared to others. Incidentally, some districts find it easier to work with FBOs, more than private for profit providers. Service Agreements with private providers have been put to use but their implementation has lagged behind- as noted in Mbeya RHF. There is limited collaboration between HRH TWG and the PPP TWG centrally. Similarly there is insular tendency of work among TWGs who tend to work without sharing of information. As a result the benefits of complementary governance are not realized.

[34] Musau, S. et al. 2011. Tanzania Health System Assessment 2010 Report pp 63

4. Crosscutting SWOC Annalysis

This section illustrates key strengths, opportunities, weaknesses and challenges in the HRH system as shown in Table 10.

Table 10 Strengths Opportunities Weaknesses and Challenges

Strengths	Opportunities
▲ Increased production/supply capacity ▲ Availability of accrediting bodies and clear procedures ▲ Availability of the TQIF roll out strategy	▲ Decentralized health planning and budgets ▲ Complementary health funding ▲ Availability of investing DPs ▲ High level policy thrust towards PHDP
Weaknesses	**Challenges**
▲ Production unlinked to infrastructure and other health systems developments ▲ Unlinked HR information systems ▲ Slow establishment of accreditation and credentialing system ▲ Limited staff attraction to work stations and limited productivity ▲ Poor HRH leadership and management ▲ HRH planning, forecasting, career development, and succession planning capacity insufficient. ▲ HRH TWG not adequately linking with other TWGs.	▲ High levels of indebtedness among training institutions. ▲ Complexity of HR management in terms of policy, regulation, ethics enforcement, deployment, recruitment, productivity, planning, organizational efficiency, retention etc in light of these functions been in different sectors. ▲ Disjointed intra-departmental and inter-departmental communication and collaboration

There are various policies, plans and initiatives to enhance the production, CPD, recruitment, distribution and retention of health workforce. In this area some developments have been observed but the results could be better if some measures are observed. For example there is over-centralization of policy development, lack of clear dissemination mechanism and inadequate monitoring of policy implementation resulting in poor adjustments of implementation. Similarly strategic plans are not clearly articulated and translated at operational level thus failing to align lower level roles with national strategic plans. Equally, there is over-centralization of activities leaving various schools and districts almost fully reliant on central decision-making. This denies lower level opportunity to exercise their potential for problem solving and decision-making. Limited control of funds at health centres and dispensaries is a live example.

Plans for various systems are made without considering related plans. This insular planning is not effective particularly as health services provision is reliant on other systems such as supply of right numbers and mix of cadres, availability of infrastructure such as theatres (for CEmOC for example) and availability of drugs, water, electricity and housing for staff. Comprehensive, and not insular, planning of human resources is thus required. This should be reflected in the future HRH strategic plans. Development Partners conduct various HRH development initiatives, which are useful but they lack

coordination and mechanism for scaling up or sustaining modalities. This results in making them temporary and ineffective.

Training centres are not well resourced, not organized under ZHRC, accreditation not complete and supervision is irregular. Also quality health workers require that they get accredited CPD, leadership and supportive supervision. Most supportive supervision lacks a good system. There are few trained supervisors, inadequate tools and resources. When conducted supervision is mainly fault finding and routinely conducted lacking objectives for specific health facilities. There is limited problem solving, training, proper feedback and follow up.

5. Recommendations

Prioritization of the following recommendations is essential so that phased implementation is carried out according to what is practical and feasible within the remaining period of HSSP III: Activities that will not be possible to implement during this phase of HSSP period will then be earmarked for HSSP IV.

Coordination

- MOHSW should explore new ways to network and dialogue effectively with POPSM, PMORALG, and MOFEA on key HRH policies, strategies and enforcement of existing regulations. There is need to learn from Education Sector's experience in working with LGAs. Lessons from good performing LGAs (in terms of MMAM targets, HR attraction and retention) should be captured systematically, shared and scale up strategy devised – this should be a key agenda at inter-ministerial coordination and consultative meetings.

Performance management

- Public Service Pay and Incentive Policy of 2010 should be followed by operational guidelines to help the health sector and LGAs in implementation, particularly in terms of guiding towards harmonized retention packages.
- OPRAS should be linked to P4P and actual commitment to finance the latter with a requirement that senior management at various levels be held accountable for implementing and enforcing the use of these tools. This linkage shall also avail an opportunity to address remaining weaknesses in HRIS including harmonization with other information systems with the ultimate intent to enhance evidenced based planning and implementation decisions.
- There is need to strengthen HRH task management and action follow up teams at National, Regional and LGA levels to undertake analyses of factors that hamper effective discharge of HR management practices and generate context specific solutions to attain higher levels of HR performance. Quality of in-service training and performance at workplace need to be enhanced by improving the systems of accreditation and supervision, performance management and staff productivity (responsibility of MOHSW, PMORALG and MOFEA)
- At the outset there should be leadership to foster an interim inter-professional working group for legislature to establish a bill of CPD to Parliament. Once passed, the law should facilitate and guide health worker learning and that CPD will have an integrated and inter disciplinary orientation. It should be clear in the law that an overall CPD Agency is formed by representatives from key CPD stakeholders including Health Professional councils, Regulatory bodies (NACTE and TCU), MOHSW, and PMORALG and Professional associations. (Responsibility of MOHSW, PMORALG, NACTE, TCU, professional organizations)
- There is need to decentralize Accreditation Centres to support the Central Accreditation Agency. While accreditation is being developed the exercise of developing CPD should be continuing as accreditation of non formal aspects of CPD are more challenging for accreditation. Health workers should accept CME as a moral and ethical obligation to continue lifelong learning in order to maintain and improve their competence and performance without waiting for legislation or sanction to force them into mandatory CME.

ZHRC

- There is need to establish a clear structure of ZHRC within the MOHSW structure. Similarly there should a budget line to support the activities of the ZHRC. The capacity of Zonal Resource Centres should be built so that they can effectively support health training institutions to improve the quality of education and develop continuing education programmes for improvement of health services delivery at regional and district level.

Production and deployment

- The production of health workers should be well planned to include staff mix and to take into consideration all other plans including infrastructure development.
- There is need to restructure training institutions to develop multi cadre training centres which will realize cost efficiency in training.
- There should be full utilization of approved posts while collaborating with LGAs for enhanced attraction of staff to work stations and its retention.

CEPD

- The centre should implement national distance education activities through the transformed Centre for DE, which is semi-autonomous with a mandate to provide training to health and social welfare workers. This will require adequate staffing, equipment including advanced technologies in the delivery of DL training.
- The distance-learning programme should be developed to maximize the use of Information and Communication Technology (ICT).

HRH research

- There should be a concerted effort to identify areas brought forward by HRH research as recommendations to be prioritized and planned for implementation.
- Tracer studies geared to understand factors influencing absorption, deployment, retention and attrition should be prioritized by HRH –TWG for implementation by academia and researchers in collaboration with HRH Focal Points.

Crosscutting issues

- In order to ensure equity in distribution of qualified health workers in Tanzania, a national regulation and legislation of the pension schemes and other benefits is required in the context of PPP framework. Also conduct an HR census against actual needs to inform equity of distribution and make a strong case for systematic redistribution of qualified health professionals. The HRH TWG should take responsibility to assign focal points to initiate and manage these tasks and report on concrete outputs.
- Initiatives in HRH from various projects should be documented and strategies for their institutionalization be developed.
- Recruitment of health workforce should be decentralized, and attraction and retention strategies be developed with equity in focus. This will to reduce health workforce gaps and mal-distribution affecting the rural areas.
- HR focal point staff (Health Secretaries) should be given space and sufficient authority to deal with individual staff productivity and efficiency in discharging their duties as a way to maximize utilization of health professionals.

- Work environment improvement is an important entity for quality assurance in service delivery and attraction of staff. In this regards the Health Sector should address Planned Preventive Maintenance (PPM) more comprehensively by studying the Schools Maintenance Project of MOEVT. By using lessons and experience from there a Health PPM for countrywide should be designed and applied. This should be included in HSSP IV (responsible: DPP Infrastructure). In the immediate term CHMTs should advise LGAs to make this provision in health facility construction planning (responsible: DMOs).
- The Sector has drafted a comprehensive strategy to roll out the TQIF nationally. Phasing of this draft strategy should pick immediate and intermediate term priorities to be presented for Stakeholders' consensus and immediate action decisions. The intermediate term priorities could be a menu for inclusion in HSSP IV. Within this roll out supportive supervision, mentoring and accreditation steps should be taken up from the outset (responsible: Directorate of HQA).
- A number of issues stand to benefit from opening up working modalities across TWGs for regular sharing of information and dialogue for problem-solving. For example equity issues, gender sensitivity, community ownership, staff attraction and productivity, governance, and the challenges faced in HRIS need to be addressed and solutions generated within the inter-TWG framework for consultation and dialogue.