

# Tanzania Human Resource Capacity Project

Human Resources for Health Management  
through District Strengthening Initiatives:

**A Comprehensive Approach, Achievements  
and Lessons Learned (2009-2013)**



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## Acronym & Abbreviations:

AIDS	-	Acquired Immune Deficiency Syndrome
AKF	-	Agakhan Foundation
BMAF	-	Benjamin William Mkapa HIV/AIDS Foundation
CCHP	-	Comprehensive Council Health Plan
CDC	-	Centre for Disease Control
CIDA	-	Canadian International Development Agency
CHMTs	-	Council Health Management Teams
DMO	-	District Medical Officer
FY	-	Financial Year
GOT	-	Government of Tanzania
HRH	-	Human Resource for Health
HRHTWG	-	Human Resources for Health Technical Working Group
HRM	-	Human Resource Management
HIV	-	Human Immunodeficiency Virus
HSSP III	-	Health Sector Strategic Plan
HRSP	-	Human Resource Strategic Plan
HS	-	Health Secretaries
IH	-	IntraHealth International
ITECH	-	International Training and Education Centre for Health
MEVOT	-	Ministry of Education and Vocational Training
MOFEA	-	Ministry of Finance and Economic Affairs
MoHSW	-	Ministry of Health and Social Welfare
M&E	-	Monitoring and Evaluation
NSGRP	-	National Strategy for Growth and Reduction of Poverty
NSSG	-	National Support Supervision Guidelines
OPRAS	-	Open Performance Review and Appraisal System
POPSM	-	President's Office Public Service Management
PMO-RALG	-	Prime Minister's Office Regional Administration and Local Government
PMP	-	Performance Monitoring Plans
PHSDP	-	Primary Health Services Development Program
RMO	-	Regional Medical Officer
SO	-	Strategic Objectives
THRP	-	Tanzania Human Resource Capacity Project
TORs	-	Terms of Reference
USAID	-	United States Agency for International Development
ZHRCs	-	Zonal Health Resource Centers

## Executive Summary:

The Tanzania Human Resources Capacity Project (THRP) is an initiative implemented by consortium of partners that have a common goal of improving the health and social welfare workforce of Tanzania. The Benjamin William Mkapa Foundation (BMAF), in collaboration with Intrahealth International (IHI), led the initiative and worked closely with the Ministry of Health and Social Welfare (MoHSW) and Prime Minister's Office Regional Administration and Local Government (PMORALG) to address the Human Resources for Health (HRH) crisis.

The overall goals of the project was to support the public and private sectors in building and maintaining an effective workforce and Human Resources (HR) management systems for the improvement of Tanzania's health and social welfare services.

The project was designed to respond to a human resource crisis in the health sector that the MoHSW has been facing since the 1990s. The severe shortage of health workers at all levels is compounded by multiple factors that challenge workforce retention and productivity which poses formidable challenges to high quality health service delivery.

Project implementation, which started in 2009 and continues through December 2013, was through a coalition of partners, each addressing specific components. These are IntraHealth International, the Benjamin William Mkapa HIV/AIDS Foundation (BMAF), the Christian Social Services, Aga Khan Foundation, and the University of Dar es Salaam/Computer Sciences Department (UDSM/CSD. Responsibilities of each of the implementing partners are detailed in the THRP Project Design Document.<sup>1</sup>

This report documents the comprehensive approaches, achievement and lessons learned on the specific THRP components implemented by the BMAF. These are assisting the MoHSW and PMORALG to orchestrate the implementation of the HRH Strategy and the HR components of the HSSP III, as requested by the MOHSW and strengthen the capacity of the national and local government authorities to predict, plan for, and recruit the health and social welfare workforce. Others are improving the deployment, utilization, management, and retention of the health and social welfare workforce and increase productivity of the health and social welfare workforce.

A number of evaluation criteria for this analysis includes: relevance and strategic alignment of the project, efficiency and effectiveness as well as its impact, potential for sustainability and lessons learned.

Through BMAF interventions under THRP, Tanzania has witnessed improved ability of LGAs to attract, recruit and retain health workers in the districts, as well as strengthened human resources management capacity. Various guidelines were developed and approved by the MoHSW with the view of improving HRH management. The analysis identified the following key achievements among others:

1. Improved ability of LGAs to attract, recruit and retain health workers, especially in underserved districts,
2. Implementation of local incentives packages as one of the means to attract and retain health works,
3. Improved HRH budgets in LGAs,
4. Improved use of OPRAS in the districts,
5. Increased technical capacity of district authorities to manage improve human resources,
6. Inclusion of human resource check list in the MOHSW National Supportive Supervision Guidelines, and
7. Development of a national pool of HRH experts who may be utilised by the government in subsequent HRH interventions in wide range of areas.

The assessment results indicate that THRP interventions implemented by BMAF in 54 districts represent useful approaches that have generated effective and practical alternatives in resolving some of the HRH challenges and contributed to realization of HSSP III objectives as originally planned.

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<sup>1</sup>Intrahealth International, Inc, Tanzania Human Resources Capacity Project , Project Background Document (2009)

Strategic recommendations are made for sustaining project results. They include utilizing THRP innovative strategies to scale up similar interventions in the 86 non-THRP districts and sustaining improved systems and structures. Actions must be directed to utilizing a pool of national HRH experts, effective utilization of developed guidelines, and strengthening oversight supervision of improved health management systems.

# Section 1 - Background and Context:

## 1.1 Introduction

Tanzania's Ministry of Health and Social Welfare (MoHSW) developed the National Human Resource for Health (HRH) Strategic Plan (2008 -2015) to guide the government, development partners and different players in the health sector on key interventions to combat the country's HRH crisis. The USAID-funded Tanzania Human Resource Capacity Project (THRP) commenced in 2009 with the aim of accelerating the implementation of this strategic plan and the HR component of the Health Sector Strategic Plan (HSSPIII). The project, under the technical leadership of IntraHealth International worked with a coalition of partners and their institutional comparative advantage on different but complementary HRH interventions. The project built upon the existing government systems and infrastructure, worked within the country's policy framework, and engaged with many partners to improve HR planning, monitoring and management.

BMAF interventions under THRP were designed mainly to address the challenges that Tanzania was facing in strengthening systems for recruiting, attracting, managing and retaining its health and social welfare workforce especially in the districts. It thus contributed to all four components of the THRP, namely:

1. Assist the MoHSW and PMORALG to orchestrate the implementation of the HRH Strategy and the HR components of the HSSP III, as requested by the MOHSW;
2. Strengthen the capacity of the national and local government authorities to predict, plan for, and recruit the health and social welfare workforce;
3. Improve the deployment, utilization, management, and retention of the health and social welfare workforce;
4. Increase productivity of the health and social welfare workforce.<sup>2</sup>

The purpose of this report is to provide health sector stakeholders in Tanzania and elsewhere, an account of the achievements and lessons learned under the THR. It provides an overview of program objectives, design and informs strategies, approaches, and lesson learning platforms. Other documented key messages include:

- a) The constraints and/or difficulties in implementing the project, and where appropriate, how they were addressed during project implementation,
- b) Lessons learned that may have implications on future interventions or sustaining the achievements,
- c) Best practices identified over the course of the project implementation as well as monitoring and evaluation, and
- d) Prospects for post-phase out sustainability and suggested interventions that may need to be added or emphasized to enhance the prospects of sustainability.

The analysis is structured in five sections. The first section covers the context, objectives, approach and analysis methodology. Section two examines the situation of the health sector in Tanzania (before THRP) and the premises under which the project was designed. It briefly covers the health sector policy and framework, as it relates with THRP, with reference to health sector strategies and plans. Section three presents a review of THRP implementation. It takes a detailed account of strategic interventions, methodologies and processes designed to achieve the project's intended objectives. Achievements and lessons learned are outlined against each strategy, methodology, or tactic. Section four presents analytical results of THRP. It specifically focuses on what differences have been realised from implemented activities, including district capacity to manage and sustain the

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<sup>2</sup> Intrahealth International, Inc, Tanzania Human Resources Capacity Project , Project Background Document (2009)

results. It also addresses institutional and governance issues those which are enablers or hindrances to sustaining the results. Policy issues relating to continuity and sustainability of results are reported. Section five provides conclusions and gives remarks. The sections include proposed ways to sustaining achieved results.

## 1.2 Objectives and Scope of Document Review

This analysis is aimed at providing the evidence that links the impact of THRP activities with improved health systems in Tanzania:

- a) Reviewing the internal and external factors that influenced project implementation, including technical, managerial, organizational, institutional, socio-economic and political factors,
- b) Reviewing documented effectiveness of the project partnerships formed,
- c) Determining the efficiency and effectiveness of the overall project implementation, and
- d) Identifying any spillover effect emanating from the THRP, determining which project outputs had a multiplier effect.

## 1.3 Approach and Methodology of Document Review

A detailed review of project documents and relevant literature was undertaken. A list of the documents reviewed is appended to this report including project studies, assessments and project activity reports. This review concentrated on five criteria for analysis:

- i. **Relevance:** The main focus was to review the project's concept and design against the overall objectives of supporting the implementation of HR components of the HSSP III. The alignment between THRP objectives and HSSP III components has been documented as well as the relevance of the project design within the framework of health systems strengthening.
- ii. **Achievements:** In reviewing the achievements of the project, the focus was on efficiency and effectiveness of project implementation processes with particular attention to the strategies, methodologies and related implementation tactics. For the purpose of this review efficiency entails ascertaining the extent to which the project results were attained in terms of quantity and timeliness against the plans. On the other hand, effectiveness is the extent to which the project achieved its stated results and purpose in a sustainable way. Efforts made in capacity building of future implementers and appropriateness of laid down strategies and assumptions are key factors for effectiveness.
- iii. **Sustainability:** The main focus was to document evidence on whether the impact, outcomes or changes brought about by the project are likely to continue after project closure and whether they can be sustained.
- iv. **Lessons Learned:** These are learning points emerged during project implementation that might improve design and implementation of other similar projects. In particular, the main lessons that emerged in terms of efforts to ensure and secure sustainability, knowledge sharing and partnerships have been documented.

## Section 2 – Project Background, Design and Strategic Alignment

### 2.2 THRP Background and Context

The fragility of Tanzania's health system and the insufficiency of its health workforce was gaining increasing attention, just like in other countries in Africa. Deficiencies were evident in planning, developing, and supporting the health and social welfare workforce as well as various management systems. LGAs were mostly affected by these gaps<sup>3</sup>.

From 2006, the USAID-funded global Capacity Project through IntraHealth International supported the Government of Tanzania (GOT) on multiple fronts to address HRH challenges, including, but not limited to, supporting the development of the HRH strategic plan; assessing bottlenecks in hiring; reviewing HR shortages for reproductive health services; initiating the development of new social worker cadres to respond to the needs of orphans and vulnerable children; collaborating on human resources information system (HRIS) initiatives; and leading and documenting productivity and retention improvement interventions on mainland and in Zanzibar.

THRP, which followed the Global Capacity Project in 2009, continued to support the government in its efforts to address the challenges that Tanzania faced in recruiting and managing an adequate health workforce that comprises a complex system of public and private professional cadres in the formal sector and paraprofessional cadres among others in the non-formal sector. The project commenced in 2009 and was implemented for over four years in 54 districts.

### 2.3 Health sector diagnostic brief before THRP

Tanzania faced a severe shortage of qualified health professionals. LGAs, especially underserved areas were mostly affected. According to Health Sector Strategic Plan III, overall staffing levels across the cadres countrywide were 53,214 (35%) of the actual requirements of 82,277 in 2006. Deficit in district hospitals was 15,094 (67%), while in Health Centres and Dispensaries the shortages were (7,008) 59% and 20,996 (69%) respectively.<sup>4</sup>

With the implementation of the Primary Health Services Development Program (PHSDP) 2007—2017, and anticipated doubling of health facilities by 2017, Tanzania's health and social welfare worker shortage loomed even larger. At the same time, Tanzania struggled with attracting and retaining the right staff with the right skill mix, particularly in underserved areas, to respond to the serious health and social challenges posed by HIV/AIDS, malaria, maternal and child morbidity and mortality, and other diseases that severely curtail life expectancy.<sup>5</sup> Mal-distribution of health workers had an adverse impact, especially in districts and underserved areas. For example, 51% of all practicing medical doctors in 2006 were in Dar es Salaam.<sup>6</sup>

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<sup>3</sup> See the 'Tanzania Human Resourced Capacity Project', Project Background Document issued by IntraHealth International in partnership with Training Resources Group, Management Sciences for Health, Benjamin Mkapa AIDS Foundation Christian Social Services Commission of Tanzania, and other collaborating partners in June, 2009.

<sup>4</sup> Ministry of Health and Social Welfare, Strategic Plan (2006 – 2013)

<sup>5</sup> See the Ministry of Health and Social Welfare Strategic Plan (2008 – 2013). Also refer to the Primary Health Services Development Programme - PHSDP (2007 – 2017).

<sup>6</sup> See the Tanzania Annual Health Sector Review (2006)

In Tanzania's decentralized health system, human resources are central to planning, managing, and delivering health services at District level. However, in addition to staffing shortages, the health system at that level faced many human resource challenges including weaknesses in human resource planning, recruitment, deployment, training, performance, staff motivation, and staff development.

An expanded HRM role, especially at the district level, was needed to transform the outdated view of human resources as mainly an administrative function to one where the human resources staff works closely with managers to support the health goals of the district and to assure that the right staff with the right skills are hired, deployed, motivated and retained as to meet the intended goals.

However, most of the districts in Tanzania lacked HR qualified professionals with the necessary knowledge, skills and expertise to establish effective HRM systems. In fact, a four country study that was conducted by AMREF and MSH in 2009 to document the role and experience of health managers with HRM responsibilities revealed that 78% of respondents in such positions in Tanzania expressed the need for training and skills in the following six HRM areas: HR policy, performance management, managing staff training, HR data systems, HR strategy development and general leadership and management.

## **2.4 The need for Strategic Interventions**

In response to many challenges facing the sector, IntraHealth International, funded by USAID proposed a technical approach that was comprehensive, multi-faceted, and multi-sectoral across public, Faith Based Organisations (FBO) and private sectors to address the gaps.

THRP co-leaders IntraHealth International and BMAF conducted a baseline study to examine the issues and dynamics surrounding human resource management (HRM) systems and practices in 13 districts in 2010. The study assisted in to understand the situation and to determine benchmarks from which progress were to be measured during project implementation. They include specific areas of interventions such as recruitment and retention, work climate, and improvement in the planning and management of HR systems at the district level.<sup>7</sup>

The key assessment findings of the baseline study include:

- i. The absence of stand-alone HRM annual operational plans and sustainable budgets to support HRM activities. The Comprehensive Council Health Plan (CCHP) of each district included an HRM section, but lacked detail and is used to fulfill the budgeting exercise rather than for planning purposes. Previous programs, especially those focused on recruitment, were hampered by continuing bureaucratic procedures involving several ministries and multiple steps in recruitment, deployment and management, resulting in major gaps between those recruited and those actually reporting to post<sup>8</sup>. Additional measures were needed such as designing, implementing and managing task-sharing among current and proposed cadres, both to increase efficiencies as well as to promote job enrichment.
- ii. Severe shortage of skilled health workers in assessed districts, with an overall vacancy rate of 45% in the 2009/10 financial year. The shortages were observed for professional cadres (i.e., doctors, nurses, pharmacists) than non-professional cadres (i.e., medical attendants).
- iii. Absence of Training Needs Assessments (TNAs) to guide training plans in all surveyed districts, despite availability of training opportunities.

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<sup>7</sup> Tanzania Human Resource Capacity Project: Baseline Study. HRH Management Systems at District Level. 2011.

<sup>8</sup>See the MOHSW Tanzania, HRH hiring process and bottleneck information, report of a study issued in April 2006.

- iv. The Open Performance Review and Appraisal System (OPRAS) was not implemented appropriately in the districts although many staff members are aware of it. Seventy percent of health workers interviewed reported they had not done performance reviews with their supervisors in 2009. There are no formal established mechanisms for rewarding or sanctioning staff based on performance. The only mechanism for rewarding staff that is common to all districts is the best worker and hard worker award.
- v. Lack of local incentive packages developed for health workers. Commonly mentioned incentives provided on an ad hoc basis (depending on fund availability) include night duty allowances, responsibility allowances, and housing allowances.

The identified health sector challenges, called for widening focus of interventions and designing specific solutions, including initiatives to enhance the ability of LGAs to attract, recruit and retain health workers and reducing vacancy rates, reviewing the systems and procedures for hiring and posting of health personnel to LGAs. Others were devising mechanisms for tracking posted workers in LGAs, staff utilization strategies as well as performance planning, review systems and improving supportive supervision in order to strengthen quality management.

Long-term HRH sustainability requires several things, but one key action is the growth of a more 'professional' group of HRH people at the district level in general and within service delivery units in particular (both government and FBO) who have a deeper level of HR knowledge. The overall purpose of such a district strengthening program is stated as follows:

- i. To develop and strengthen the HRM capacity (knowledge, skills and practices) of selected district teams so that they are able to not only build and advocate for appropriate HR strategies but also implement solutions to some of the HRM challenges that the districts face.
- ii. To develop and support a critical mass of HRH champions and knowledge brokers with the right skills and "clout" to articulate the issues and build and advocate for appropriate strategies and HRM systems to tackle some of the pressing HRM challenges that their districts face.

## **2.5 THRP Strategic Alignment with National Priorities**

The THRP goal of addressing the challenges that Tanzania was facing in developing an adequate health and social welfare workforce and strengthening the delivery of health and social services through various means is consistent and adequately aligned with national strategies and priorities.

For example, cluster II of the National Strategy for Growth and Reduction of Poverty (NSGRP) addresses improvement of quality of life and social wellbeing. Specific operational targets to be achieved under this cluster include infant and child health; child nutrition; maternal health; HIV/AIDS; and human resources management<sup>9</sup>. Clearly, these aspects are directly or indirectly articulated under THRP. Districts strengthening initiative, which dealt with improving the capacity of the district to manage human resources for health in the districts is one of them.

Tanzania Development Vision (2025) is yet another strategic reference for assessing project's strategic alignment. The vision has identified health services as among the top priorities in the Country's development agenda. Evidently, the major focus of THRP is to improve health service delivery through human resources for health interventions.

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<sup>9</sup> Refer to the National Strategy for Growth and Reduction of Poverty (NSGRP) 2005 or Mkukuta in Kiswahili.

Millennium Development Goals (MDGs) targets to reduce infant and maternal mortality rates, and combating HIV/AIDS Malaria and other diseases. These can only be achieved at the districts level, if the problem of adequacy of number and quality of health workers is addressed, as well as strengthened health management systems. These were key concerns of THRP activities.

The THRP is clearly aligned with the Human Resources for Health Strategic Plan (HRHSP). Among the seven specific objectives of HRHSP, BMAF in the past four years implemented activities that aimed at contributing towards five of the HRHSP seven strategic objectives: SO1 – To improve HP Planning & Policy Development Capacity

- a. SO3- To strengthen Leadership and Stewardship in HRH
- b. SO4 - To improve workforce management and utilization
- c. SO5 To build and Strengthen Partnership in Human Resource for Health
- d. SO6- To strengthen Human Resource Research and development:

Contribution of THRP partners to HRHSP is summarised in Annex A.

## **2.6 Technical Approach**

Structured approaches, methodologies and various tactics were employed by BMAF during implementation of the project. Appropriate strategies were designed to address key objectives. Under each strategy, a number of specific activities were designed and various tactics were undertaken to ensure efficiency and effectiveness of interventions.

Some of the key success factors of THRP which were imbedded in project design are briefly explained below:

- I. Use of coalition of local partners with local presence, experience and knowledge of local policy environment reduced learning time, leveraged resources and improved ownership,
- II. Mainstreaming of the project within existing government systems and structures ensured ownership and sustainability,
- III. Preparation of a pool of local HRH experts and Training of Trainers (TOT) leveraged resources, fastened rollout plans and improved local resource base for implementation and sustaining change,
- IV. Involvement of local consultants in various assessments and project leveraged resources and widened local skills base,
- V. Blend of skills which combined local and foreign experience ensured integration of HRH best practice in various interventions.

In implementing interventions, BMAF employed various strategies that were aligned with overall project objectives and operated under two tier system constituted of central government ministries and LGAs; in order to foster ownership and sustainability.

### **THRP Technical Design and Alignment**

Human Resources for Health Management through district strengthening initiative was designed to work with central ministries and LGAs. At central ministries BMAF mainly worked with MoHSW and PMORAL. Specific central level activities included reviewing and developing various guidelines such as HR-specific planning guidance into the annual CCHP Planning guideline, developing an Orientation Package for health workers to be

used in LGAs and a Supportive Supervision check-list for HR. Further, central ministries involved strengthening the HWF secretariat, enhancing HRH coordination and developing the capacity of HRH local experts.

Sharing of THRP best practices and advocating for policy improvement are other key aspect of the project's central government concerns. These were planned to be achieved through knowledge haring forums and policy discussions. Recommendations of improvement of HRH policies and guidelines were informed by various assessments conducted during the project period. They include the Review of Recruitment Challenges of Health Workers in Tanzania and Ways of Closing the Gaps: Case of Government Recruitment Practices and Underlying Principles and Multisectoral Criteria for Defining Underserved Areas (A basis for developing an incentive package) among others.

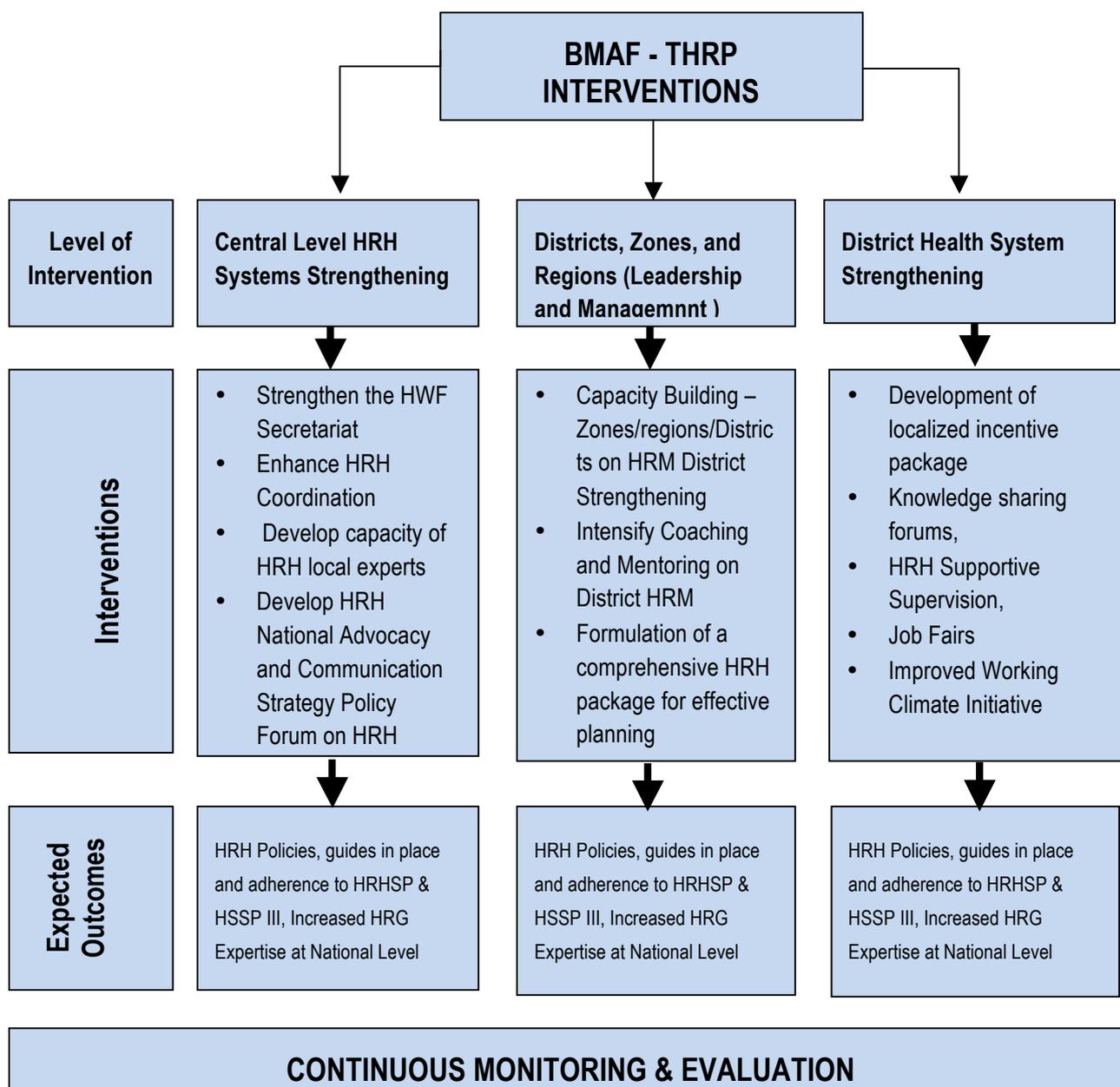
BMAF worked with LGAs to build the capacity of health managers on HRM through "HRM district strengthening initiatives"<sup>10</sup> which aimed at reducing vacancy rates, use of localized incentive packages to attract and retain new staff, implement OPRAS, orient all new recruited health staff in LGAs using developed National Orientation Guide, conduct HR Supportive supervision as part of routine Supportive Supervision at the districts level and improving working environment.

District Health System Strengthening involved developing localized incentive packages, knowledge sharing, HRH supportive supervision, job fairs and improving working climate. Figure 2.1, illustrates THRP implementation at all levels through BMAF interventions.

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<sup>10</sup> See Training, coaching and mentoring and knowledge sharing reports

Figure 2.1, Illustration of THRP implementation through BMAF.



### Sustainability

THRP was designed with due consideration of continuity of project outcomes after the end of the project. There are a number of principles that were designed to support sustainability of interventions. These include:

1. Training of central government ministries, district decision makers and local experts to deliver effectively the intended project outcomes and build on the HRH knowledge base,

2. Building awareness of media reporters on HRH situation in the country and THRP interventions; in order to enable them to effectively advocate for health systems improvement,
3. Enhancing knowledge and use of HRH evidence based information to improve policy related interventions and implementation at all levels,
4. Pilot testing of innovative approaches that address HRH bottlenecks with an ultimate goals of having best practices scaled up,
5. Partnership, networking and advocacy using potential local organizations example, professional bodies, media, all aiming at raising the awareness on HRH issues to the public and key beneficiaries,
6. Integration and effective use of existing Government structures and systems for systems strengthening and sustainability purposes, and
7. Coaching and mentoring of the CHMT post training.

## 2.8 Coverage of THRP under BMAF Interventions

THRP activities implemented under BMAF covered 54 Local Government Authorities (LGA's) located in five regions in Tanzania mainland. The regions are Lindi, Mtwara, Iringa, Mwanza, Kagera, Shinyanga, Mara and Ruvuma<sup>11</sup>.

## 2.9 Project Key Performance Indicators (KPIs), Monitoring and Evaluation

THRP implemented a Monitoring and Evaluation (M&E) system that involved continuous monitoring and regular evaluation of project processes and results to contribute to the project goals. Deployed M&E techniques and approaches include periodic reports (quarterly, Bi-annual and annual), site visits (supervision). The M&E framework supported decision making processes, and reflected concerns for accuracy, timeliness and rigor. The system enabled BMAF and other stakeholders to track the implementation of project activities and progress towards targets, review the quality of inputs, assess the effectiveness of project interventions, and identify areas in need of further strengthening or mid-course correction, and supporting the documentation of lessons learned.

The Performance Monitoring Plan (PMP) provides indicator information (definitions, data sources, benchmarks and end-of-project targets), and reporting schedules. As a dynamic document, the PMP served as the foundation of a detailed M&E operational plan with more precise indicator definitions and delineated processes of data collection, utilization, and assigned roles and responsibilities for M&E tasks. Section 3 outlines the strategies and highlights the level of performance achieved.

A range of activity, quarterly, semi-annual and annual reports summarized progress against expected benchmarks and mid-term and end-of-project targets. Routine monitoring activities involved documenting the implementation of planned project activities, documenting changes in national or sub-national systems or capacity related to the targeted indicators, and collecting data that examine the causal/contributory link between the project's activities and desired outcomes.

And End of Project report and final quarterly report were prepared to document the results of, and lessons learned from, interventions and piloting experiences in selected districts. These enabled the project to identify best practices which would be used in subsequent projects to scale up interventions based on evidence.

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<sup>11</sup> Liwale DC, Ruangwa DC, Nachingwea DC, Kilwa DC, Lindi DC, Lindi MC (**Lindi Region**) -: Newala DC, Tandahimba DC, Masasi DC, Mtwara MC, Mtwara DC, Nanyumbu DC (**Mtwara Region**): Makete DC, Kilolo DC, Njombe DC, Njombe TC, Ludewa DC, Mufindi DC, Iringa DC, Iringa MC (**Iringa Region**), Geita DC, Sengerema DC, Ukerewe DC, Magu DC, Misungwi DC, Kwimba DC, Mwanza CC (**Mwanza region**), Karagwe DC, Bukoba DC, Bukoba MC, Misenyi DC, Muleba DC, Ngara DC, Chato , Biharamulo DC (**Kagera region** ) and Musoma MC , Musoma DC , Tarime DC, Serengeti DC, Bunda DC, Rorya DC (**Mara region**) , Kahama DC, Maswa DC, Meatu DC, Bariadi DC, Shinyanga DC, Shinyanga MC, Bukombe DC, Kishapu DC (**Shinyanga region**) Songea DC, Songea MC, Mbinga DC, Tunduru DC, Namtumbo DC (**Ruvuma Regions**)

## Section 3 – THRP Strategies, Interventions and Achievements

### 3.1 Introduction

This section presents detailed review of THR strategies undertaken by BMAF since the commencement of the project. It takes a detailed account of interventions, approaches and processes/tactics adapted to achieved the project's intended objectives. In assessing the project's achievements, the focus is on efficiency and effectiveness of implemented activities. In this context, efficiency entailed ascertaining how well the project activities were achieved in terms of quantity and timeliness through planned processes. Effectiveness is mainly an indicator of adequacy of adopted approaches and methodologies. Efforts made in capacity building of future implementers and appropriateness of laid down strategies and assumptions are key factors for effectiveness.

### 3.2 Strategic Objective 1:

**(To Assist the MoHSW and PMORALG to orchestrate the implementation of the HRH Strategy and the HR components of the HSSP III)**

To achieve this objective, various strategies and interventions were employed. Some of these are described under respective sub-headings below:

#### **Strengthening Leadership and Stewardship**

Supporting the MoHSW to strengthen the leadership capacity of HRH secretariat is among the key implemented activities by BMAF at central ministries. In order to effectively implement various Strategic Objectives (SO) of the MoHSW's strategic plan, Training Needs Assessment was conducted by the ministry aiming at strengthening coordination capacity of the HRH secretariat where competence gaps were identified.

As part of THRP support, training sessions were conducted by Management Science for Health (MSH) consultants to enhance managerial capacity and strengthen coordination capacity of HRH secretariat members and leaders of respective Strategic Objectives (SO). In addition, the team was oriented on their roles and responsibilities, and were supported to develop key strategies and plans for the years 2011 – 2012.

Also, BMAF collaborated with MSH technical assistance to strengthen the managerial capacity and strengthen coordination capacity of Technical Working Group (TWG) HRH members and respective Strategic Objectives team leaders.

#### **Training of National HRH experts**

A team of HR professionals with HRM responsibilities drawn from the CMHT's, RHMT's, ZHRC's and private sector were trained to become HRH experts. The aim was to develop and support HRH champions with the skills, attitude and authority to articulate the issues build and advocate for appropriate strategies and HRM systems guide regions and districts in tackling HRM challenges that the districts, regions and central ministry face<sup>12</sup>.

BMAF subsequently used these "local experts" in various capacity building activities and assignments as facilitators or consultants, especially in district strengthening initiatives. Of the 37 local experts training 26 were actively engaged in coaching their HR colleagues in the 54 districts.

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<sup>12</sup> HRM Local Expert Training Report, 2010, p.4

## **Training of media reporters**

As part of THRP, the BMAF facilitated a four day media training which involved 20 participants from different media categories such as Televisions, Radios and print media. This strategy was aimed at engaging the media as change agents to further advocate for an improved HRH management system for the Tanzanian health workforce with a motive of increasing job attractiveness, motivation and staff retention.

Specific objectives were to update media professionals on the common bottlenecks (include attrition) faced by the Government and the entire Country in attracting and retaining skilled HRH professionals, share existing studies and recommended strategies to support HRH matters and to update on current strategies adopted by the Government and partners focusing at improving the status of health workforce and the underlying rural-urban disparity. Also, discussions were centered on how media professionals could effectively solicit information and package it to convey the right HRH messages to the public at large, key decision and policy makers.

## **Involvement in HRH Technical Working Group (TWG)**

Throughout THRP implementation, BMAF was actively involved in HRH Technical Working Group (TWG). Through this involvement, feedback on various documents and policies were brought to the attention of the TWG. These include improved guidelines (CCHP, National Supporting Supervision, Orientation Package for health workers and recruitment bottlenecks assessment in underserved areas and related interventions).

## **Review of the Comprehensive HR Components of CCHP**

The Comprehensive Council's Health Plan (CCHP), is a policy guideline for monitoring and evaluating performance of health sector in district councils. In 2010, the MoHSW was reviewing the CCHP. As part of THRP initiative, BMAF in collaboration with the MoHSW engaged a consultant to gather inputs for improving the HRH components of the guidelines, in order to address the gaps. Specific HRH targets and indicators were added into the CCHP.

## **Use of media**

News inserts were made to inform the general public on various HRH interventions. These were extracts of various HRH reports and activities. For example, the status of absorption of health professional graduates to the public sector employment for the year 2010/11 was captured in the media. According to the News Insert, the Government of United Republic of Tanzania for the FY 2010/11 released employment permit of 7,471 approved posts of different health cadres to the public sector. As of March 2011, a total of 6,230 (84.4%) out of the approve posts were posted to respective duty stations.<sup>13</sup> Also, TV and Radio were used for dissemination of HRH news to the public.

## **Involvement in the revision of staffing norms**

BMAF participated in providing input for the revision of staffing norms in the health sector. This include the input on the 'Staffing Level Guidelines for the Health Sector (2011/12 – 2015/16) which involved an assessment of the various approaches for determining staffing levels as well as recommending approaches for estimating HRH needs. Revision of staffing norms also involved defining the roles of National hospitals, Consultant Hospitals,

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<sup>13</sup> News Insert titled 'Absorption of Health Professional Graduates to the public sector employment, what is the Status?' issued by the Benjamin William Mkapa HIV/AIDS Foundation (2011).

Special Hospitals, Agencies, and MoHSW Departments, district hospitals, health centre and dispensaries. Criteria for staffing level for various facilities were set.<sup>14</sup>

### **Leadership on Planning of National HRH Day**

BMAF played the leading role in coordination of the HRH day for 2011, which was held during the month of September. The event was intended to allow the stakeholders make reflection on progress of HRH situation within the country. Specific objectives involved, review of progress on the implementation of HRH Strategic Plan, assessment of progress against HRH 2010/11 milestones. Also, the forum focused on sharing key HRH development in the context of policy development, good practices on HRH (production, recruitment, management, retention, productivity) as well as to agree on specific budget priorities on HRH for Medium Term Expenditure Framework (MTEF) for the fiscal year 2012/2013 and to agree upon the milestones for 2011/2012.

Every year a joint review is undertaken of health sector progress, constraints and future priorities within the Sector Wide Approach (SWAp). This process is led by the MOHSW and PMORALG, with close collaboration of other parts of government (MOFEA), development partners, civil society organisations, private sector, research institutions and other health sector stakeholders.

### **Assistance to MOHSW in its centralized recruitment processes**

BMAF supported the MOHSW to improve recruitment process in a centralized environment.

Results indicate that all targets were fully achieved (100%) against set indicators. Table 3.1 below illustrates.

### **The Policy Forum**

A policy forum was designed to discuss selected THRP tested interventions, challenges, policy implications and influence policy change. The forum, which was held in August, 2012 brought together senior policy makers from central government ministries namely POPSM, PMO-RALG and MoHSW. Others representatives at the forum were from the Public Service Recruitment Secretariat, Regional Administration Offices and the LGAs.

The policy forum achieved the following key milestones:

- a) Improvement of MoHSW posting letters to include contact information of the new staff to enable tracking of posted staff and hence reduce incidences of no show to new work stations.
- b) Inclusion of description of districts to which the new staff is posted to enhance interest.
- c) Inclusion of HRH checklist (Appendix IV) into the National Supportive Supervision Guideline and issuance of enforcement letter by the MoHSW.
- d) Dissemination of 40 HRH news against a target of 30 (133%), which improved public awareness on HRH.
- e) Endorsement of developed health workers Orientation Package.

### **Review of Guidelines**

BMAF supported the review and pilot testing of various national guidelines with the view to ensure they are aligned with HRH strategies and policy direction and reinforcing HRH activities in LGAs. These include the National Supportive Supervision Guidelines (NSSG) and the Comprehensive Council Health Plans (CCHP).

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<sup>14</sup> Ministry of Health and Social Welfare, Staffing Level Guidelines for the Health Sector(2011/12 -15/16),

Inclusion of HRH checklist in the NSSG and increased number of HRH activities in CCHP are among the key milestones achieved towards improving the deployment, utilization, management and retention of health workers.

### **HRH Supportive Supervision**

The Human Resources for Health supervision checklist is one of the components of the National Supportive Supervision guideline for quality health care services and **not a parallel tool**. This checklist is intended to be used by RHMT's, and CHMT's to strengthen their lower health management teams on human resource for health management issues. It will assist these organs and heads of lower health facilities in the implementation of their HRH plans and ultimately strengthen human resource management at the lower level. Management teams are urged to comprehend to the details of this document in order to acquire the necessary competencies before conducting supervision activity.

Supervision teams are expected to go through the information thoroughly and choose few areas of this checklist to be included in every supervision visit conducted. It is important to note that every supportive supervision visit is different in terms of objectives and expected outputs. The checklist has taken into consideration the different levels of service delivery (Regional/District Hospital, Health Centre and Dispensary Levels).

### **Tracking of posted health workers**

A tracking tool of reported health workers against those who are posted was developed under THRP. The Ministry of Health and Social Welfare in collaboration with BMAF tracked new staff hired from 2007/2008 to 2009/2010 and set a permanent tracking system using the Zonal Health Resource Centers (ZHRCs) in the country. The ZHRCs oversee 2 to 3 regions that have 5 to 6 districts each. Each ZHRC has a Health Secretary and each Regional has a Health Officer. Therefore each zone has on average of 4 officers.

The MOHSW Secretariat developed a tracking draft tool (Data collection form). ñ These teams (4 officers from each ZHRCs) convened for two Days at Morogoro to identify more information to be captured and come up with a final budget for the exercise Teams prepared tracking activity plan to be implemented at their respective Zones. Each regional Health Secretary will link with District health secretaries in respective districts to collect information.

### **Studies and Assessments**

Studies and assessments were conducted with the view of adding to existing knowledge on various HRH issues and challenges. Findings were used to inform and/or improve various interventions. These include:

- Tanzania Human Resources Capacity Project, *'Baseline Study on Human Resources for Health Management System Strengthening at the District Level'* (November, 2011).
- Benjamin William Mkapa HIV/AIDS Foundation, *'Assessment of the Effectiveness of Temporary and Permanent Health Workers with the Focus on Underserved Districts'* (2010).
- Assessment on Orientation Process and practices: BMAF undertook a study to understand the strengths and weaknesses in orientating new health workers. It was established that inadequacies in orientation were limiting the ability of LGAs to retain newly recruited health workers. Subsequently, a new orientation package for health staff in LGAs was developed and adopted by MoHSW.

- **Multi-sectoral definition of underserved districts and the use of localized incentives:** BMAF undertook an analysis to develop generic indicators for defining underserved area. A multi-sectoral definition was eventually developed as well as the recommended incentive packages. These were shared with responsible ministries for usage and informing pay policies. THRP has contributed to the ongoing discussion and through successful local incentive in rural districts demonstrated effectiveness of innovative local incentives.
- **HR Components of CCHP:** An assessment of adequacy of HRH activities included in CCHP was conducted. Findings were used to recommend, review and inclusion of HRH components into CCHP.
- **Recruitment bottlenecks:** Analysis of recruitment bottlenecks in LGAs, and especially underserved areas was conducted with the view of identifying factors undermining the ability of LGAs to attract, recruit and retain competent health workers. Findings were used to inform and improve various interventions, especially district strengthening initiatives.
- **Assessment and re-enforcement of OPRAS:** Assessment of OPRAS was undertaken with the view of understanding implementation challenges. Findings were used to develop simplified OPRAS training methodology which was used during coaching and mentoring sessions across LGAs.

**Table 3.2 Achievements on Studies and Assessments**

<b>PMP Indicator</b>	<b>Achievement</b>	<b>%</b>
<b>Multi-sectoral definition of underserved areas established and adopted</b>	Multi-sector definitions of underserved areas were developed and shared with stakeholders. Generic incentive packages were also designed and shared.	<b>100%</b>
<b>Baseline studies and assessments</b>	Study on Orientation package was commissioned, undertaken, completed and informed process improvement	<b>100%</b>
	Study on CCHP components was commissioned, completed and informed inclusion and review of HRH components into CCHP in all target districts	<b>100%</b>
	Recruitment bottleneck study undertaken and informed HRH interventions on recruitment and retention of health workers	<b>100%</b>
	OPRAS assessment undertaken and informed simplification of forms, training and adoption.	<b>100%</b>

### **3.3: Strategic Objective 2:**

**(Strengthen the capacity of the national and LGAs to predict, plan for, and recruit the health and social welfare workforce)**

#### **3.3.1: Strategies employed:**

##### **Training**

Most of the districts covered under THRP were lacking qualified HR professionals with the necessary knowledge, skills and expertise to effective HRM systems. Some of the critical HRM skills that were lacking include HR Policy, performance management, managing staff training, HR data system, HR strategy development and general leadership and management. <sup>15</sup>.

##### **Development of HRM Manual.**

BMAF in collaboration with IH, Training Resource Group (TRG) and MSH developed HRM District Strengthening Manual. The objective of the manual is to improve Practices on human resource for health in LGAs in order to

<sup>15</sup> HRM Training report that was conducted in Mwanza from 18<sup>th</sup> -27<sup>th</sup> July, 2011

reduce the vacancy rates, improved retention and productivity. Specifically the manual focuses on: components of HRM system, their functions, and their interrelated nature, Identify systems necessary to support good HRM practices, leadership and management practices that can support HR strengthening in the district, ways of integrating gender and diversity issues in the districts HRM plans and HRH plans for improvement of priority areas.

The manual consists of 13 modules namely; introduction to HRM in Tanzania, Health Action Framework, Workforce Planning and Recruitment and Deployment. Others are Staff Orientation, Performance Management, Professional Development and Work place Environment. The manual also covers retention, Leadership, Gender Mainstreaming as well as Planning for improvement. These modules were developed following HRM practices, policies and guideline pertaining to HRM in the LGA's.

### **HRM Training Roll-out to 54 districts**

Training to CHMTs was conducted across LGAs to reinforce the usage of the manual. Eight (8) officials in each district received HRM District Strengthening Training in all 54 LGA's. The Training modules were reviewed by MoHSW, adopted and rolled out through GFR9 HSS project support to the remaining districts countrywide. A total of four (4) trainings were carried out in Ruvuma, Iringa, Mwanza and Kagera regions attracting a total of 149 R/CHMT members. Participants were drawn from all the above regions as well as Lindi, Mtwara, Shinyanga and Mara. At least three local experts were used in each training location as facilitators and in total; twelve facilitators were involved in this roll out. According to training feedback obtained, training objectives were met. However, a number of limitations were experienced, including:

- a) Absence of representations from - non governmental health facilities including faith-based organizations ,
- b) Non involvement of district focal point for gender.

### **Coaching and Mentoring**

Coaching and mentoring district leadership, especially after the HRM training, was a key strategy implemented within the district strengthening initiative. The objective was to provide onsite on-the-job support to people entrusted with HRM in the districts. The key objective of coaching and mentoring was to enhance LGA performance on HRM practices and provide continuous support on HRM functions at LGA level. The approach involved the review of progress on implementation of work plans developed during HRM training, provide on-site training on the use of HRH supportive supervision guide, tracking district staffing trends and review the use of HRH national orientation package for newly recruited health workers and other emerging issues of recruitment, retention and performance management. Coaching and mentoring activities were mainly undertaken through on job training and review sessions conducted bi-annually, with each coaching and mentoring visit focusing on particular areas which needed follow up or improvement.

Checklists were developed for coaching visit depending on specific issues to be followed up. For example, some of the key specific aspects in the 2011/12 coaching checklist included:

- Integration of the developed HRM action plans into the CCHP
- Implementation of HRM activities budgeted in 2011/12 CCHP
- Recruitment, orientation and retention,
- Use of orientation package,
- OPRAS implementation,
- Supportive supervision,
- Work climate initiatives and improved performance.

### **Achievements on District Strengthening**

District strengthening strategy was instrumental in building capacity of CHMT's on various areas of HRM. Eight (8) officials in each district received HRM District Strengthening Training in all 54 LGA's. Other specific achievements include increased HRH components in the CCHP thus resulting to 72% of CHMTs increasing their budget in CCHP. Also, a total of 600 HRH National Strategic Plan III documents were printed and disseminated across LGAs.

## **Strategy 2: Job Fair**

Two job fairs were staged. These involved prospective graduates of Secondary school and College students respectively. The Job Fair for college students involve informing prospective graduates on available recruitment opportunities in the health sector and encouraging them to apply. Programs intended to reduce internal brain drain by attracting graduates to work in the public service within their LGAs. Other objectives also include establishing and maintaining database for students in health training institutes who wish to be employed in the health sector after they graduate and providing opportunities for LGAs to market themselves by explaining to the students about the employment opportunities, district profile, attractions, retention and motivations available in their districts so as to attract health care workers, especially the new ones.

On the other hand, Job fair to Secondary school students aimed at motivating students to study science subjects in order to be able to join medical colleges in future.

## **Achievements on Job Fairs**

The Job Fair for college students sensitized prospective candidates into the sector and LGAs in particular, with the intention of attracting new staff to districts where they are needed most. BMAF established the "Students in Health Training Institutions" database; (485 students). These are potential candidates from Health Training Institutions who filled the LGAs forms that make them eligible for recruitment in the LGA job positions once they complete their studies. 96% of Secondary School students who attended the Job Fair in Mtwara indicated their willingness to undertake medical career.

## **3.4: Strategic Objective 3**

**(Improve the deployment, utilization, management, and retention of the health and social welfare workforce)**

A number of strategies were employed in realizing the objective of improving the deployment, utilization and retention of health works. These include the roll out of Orientation Package, review of various operating guidelines and implementation of local incentive package in the THRP-supported districts. These initiatives were sustained through coaching and mentoring and related efforts. Further details of strategies and achievements are presented below:

### **3.4.1: Strategies employed**

#### **Roll out of Orientation Package.**

Roll out of health workers orientation package in LGAs aimed at providing specific guidelines on receiving and orienting new health recruits in LGAs. The strategy addressed gaps in previous orientation processes, which were inconsistent with the best practices and contributed to high turnover of new hires. The new orientation package is executed at different levels, each level with clear objectives, individuals responsible for orientation

and a checklist of activities to be performed. A new employee is undergoing orientation process at different levels through The Ministry of Health; Local Government Authority and at hospital or health facility level.

The package was disseminated to the districts for implementation and coaching reinforced the implementation processes. Currently, the package awaits final endorsement by the MoHSW.

### **Strategy 3: Implement Local Incentive package**

Assessments, such as Recruitment Bottleneck Study (2010), showed the lack of incentives, especially during first appointment of health workers as one of the factors undermining the ability of LGAs to attract potential recruits and contribute to low level of retention. Through knowledge sharing sessions conducted by BMAF, districts shared the best use of local incentives. These include salary advances, settling-in allowances and temporary accommodation during initial months after relocation of new staff. Others are incentives related to improving the work environment such as provision of bicycles and motorcycles to facilitate transport in remote areas.

#### **Achievements**

- a) A total of 49(91%) districts, out of those covered under THRP developed and are using local incentive packages to attract and retain staff which are being financed by districts or through external support.
- b) There has been a serious uptake of local incentive package initiative by the government. For example, some of the developed incentive packages are being funded through CCHP.
- c) Evidently, there has been a steady decrease in vacancy rates in all 54 Districts that has been contributed to partly by the THRP intervention year by year. Up to 52% districts have shown evidence of decreased vacancy rates.
- d) Up to 87% of 54 districts have indicated an increased retention rates.

### **3.5: Strategic Objective 4: Increase productivity of the health and social welfare workforce.**

#### **3.5.1: Strategies employed**

##### **Implementation of OPRAS.**

Individual accountability in the Public Service in Tanzania is managed through the Open Performance Review and Appraisal System (OPRAS), which was introduced in the Public Service in the financial year 2003/04. Thus it is the mandate of CHMTs to ensure that the system is fully operational in health department in the districts. Scale up the uptake of OPRAS through simplification of OPRAS training methodology, supporting setting up of annual performance targets and coaching mentoring are some of the activities undertaken by BMAF under THRP.

At the end of the project in April, 2013, Liwale district reported to have increased implementation of OPRAS from 25% for CHMTs and 9% for other staff in 2009/10 to 54% for CHMTs and 72.3% for other staff.<sup>16</sup> On job training, use of simplified methodology for filling of OPRAS forms through use of CCHP or job descriptions for lower cadre staff were some of the reported success factors.

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<sup>16</sup> THRP end of project feedback presentation from Liwale district, presented on 31<sup>st</sup> June, 2013 at Double Tree Hotel in Dar es Salaam.

## Training on National Supportive Supervision Guidelines (HRH Component).

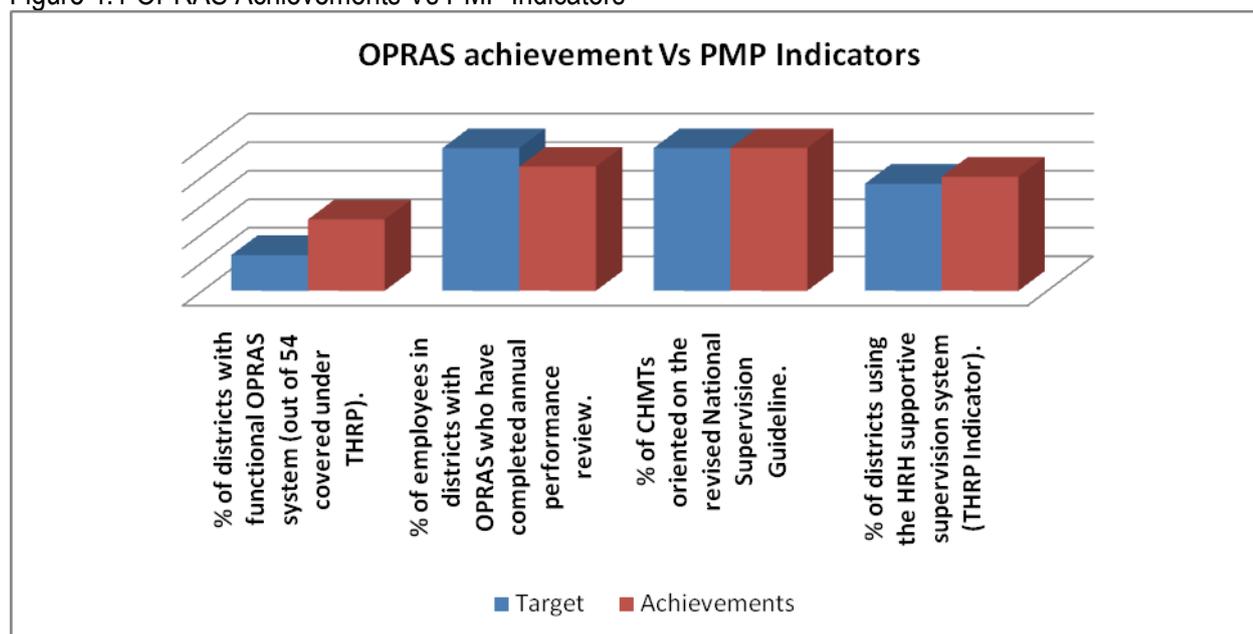
The training on the HRH component of the National Supervision Guideline was conducted to CHMT members and other district members to form a TOT group to support the districts. Up to 54% (29 districts) of CHMTs in the target districts were trained resulting to 80% of target district using the guideline.

### Achievements

Achievements of OPRAS interventions include the following:

- All the 54 project Districts received OPRAS training as part of HRM District Strengthening curriculum, which was also emphasized during the Coaching and Mentoring visits,
- 27 districts out of 54 (50%) covered under THRP had a functional OPRAS at the close of the project. PMP target was to have at-least 25% of the district having fully functional OPRAS,
- 100% of districts/Council Health Management Teams oriented on the revised national supervision guidelines (THRP Indicator),
- 75% of districts successfully filled OPRAS for 2011-2012 and 50% of districts filled OPRAS for 2012-2013. However lack some staff at lower level skills and knowledge to fill the forms were reported to be among the challenges observed.

Figure 4.1 OPRAS Achievements Vs PMP Indicators



## Section 4- The Impact of THRP Outcomes on Human Resources for Health Strategic Plans, Lessons Learnt and Sustainability

### 4.1. THRP Outcomes

THRP responses to Tanzania's HRH crisis have brought numerous changes to the central government and to the LGAs, particularly, improvement of health systems and enhanced ability of LGAs to attract, retain and manage human resources for health. Accomplished results under central government support include the following:

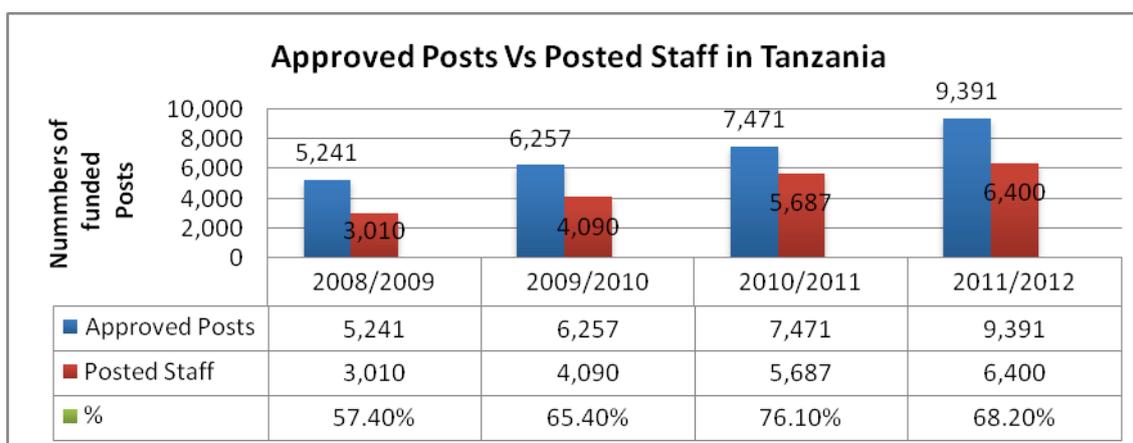
- Development and endorsement of the National Orientation Package for HRH has streamlined the manner in which new health workers are received and treated, especially on first appointment. This has contributed to increased staff retention and potentially minimized problems caused by shortage of health workers in the project districts.
- Endorsement of the improved HR component of the National Supportive Supervision Tool (Appendix IV of the National Guideline) in March, 2013, will make HRM a part of national routine supportive supervision. As a result of the strategic guideline districts will conduct HRM Supportive supervision alongside the routine supportive supervision visits
- Through improved CCHP guidelines, where additional priority area on HRH (number 7) has been added as well as two HRH indicators; allows for inclusion of HRH activities into CCHP budgets.
- The HRM Training Manual, endorsed and adopted by the MOHSW was used in all districts under GFR9 support.
- Tracking of posted workers through introduced tracking tool -2009/10, 2010/11. The usage of the tool has improved the ability of both the MoHSW and LGAs to trace posted employees. Tracking exercise of posted staff by MOHSW to the LGA's between the period of 2007/2008 and 2009/2010 indicated that, during this period 17,935 permits were approved and records indicates that a total 11,912 (66%) of staff were posted to the districts. 9,875(85% of the posted) were tracked. A total of 6,228 (63%) of the tracked staff reported to the new station, and during the visit 5,437 (87%) were still in their respective working station. 791 (13%) of those reported left immediately after reporting,
- Policy forums, which aim at sharing evidence based HRH findings and policy implications have been instrumental in not only sharing best practice across LGAs and central ministries, but also to develop a common understanding and resolve various HRH crosscutting issues. For example, at the policy forum held in September, 2012, key resolutions centered on improving recruitment, posting and tracking of posted health workers in LGAs, implementation of OPRAS and utilization of supportive supervision guidelines. Responsibilities of Ministries (POPSM, MoHSW and PMO-RALG) as well as LGAs in process improvement were defined and agreed.
- Multisectoral definition of underserved areas and proposed generic incentive packages, if properly used will resolve the problem of double standards in prioritizing the needs of underserved areas across the ministries
- 37 HRM Local experts was developed as TOT's for the HRM District Strengthening Training drawn from the CMHT's, RHMT's, ZHRC's and Private sector. Apart from facilitating the trainings, the Local experts also conducted Coaching and Mentoring on HRM to 54 LGA's. The team of experts is been used in rolling out of HRM district strengthening training in non THRP beneficiary districts under support of GFR9. The list of Local Experts had officially handed over to MOHSW, PMORALG for providing a sustainable pool of HRH/M experts.

- Knowledge Sharing Forums at the district, regions and central government ministries officials have been useful in sharing HRH best practices, challenges and in improving policies and guidelines. The forums are expected to continue to be catalysts for performance improvement.

District strengthening outcomes relate to improved recruitment, deployment, retention and management of health workers, which were achieved through implementation of various strategies, including use of motivational aspects like local incentive packages. Increased technical capacity of the districts to improve HR management capacity is yet another key achievement. This was attained through improvement of various policies and guidelines. Major outcomes are highlighted below:

- Increase of posted staff in LGAs from 57.40% in 2008/09 to 76.10% in 2010/11 recorded after BMAF intervention. Figure 4.1 illustrates:

**Figure 4.1: Trend of posted staff**

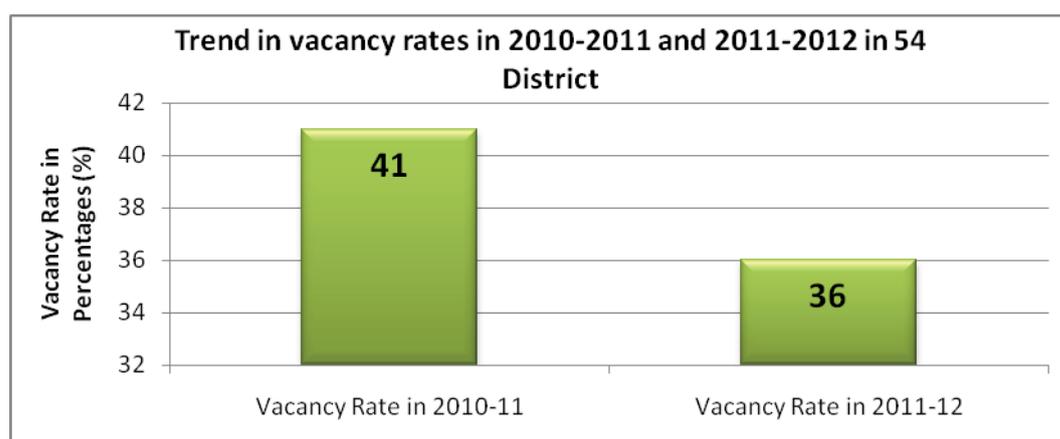


Source: Human Resources for Health Tracking Analysis for the Posted Health Workers in Financial Years 2007/2008 – 2009/2-10.

- Reduction of vacancy rates from 44% in 2009/10 to 36% in 2011/12

**Figure 4.2 Reduction of vacancy rates in 54 THRP districts**

Source: Summary of CCHP Analysis (2012)



- Improved retention of health workers in LGAs: Overall, in 54 districts an increase in retention of health workers from 76% in 2009 to 91% in 2012 was recorded. This refers to new staff posted within the first 12 months.<sup>17</sup>

<sup>17</sup> See BMAF Coaching and mentoring reports for Mach 2011, December 2012 (34 districts) and February 2013 (20 Districts).

The following table 4.1 summarises key accomplishments of THRP as well as the outcomes and interventions. As can be noted, some interventions have yielded multiple outcomes.

**Table 4.1 THRP Interventions and Major Accomplishments at LGA level**

ACCOMPLISHMENT	INTERVENTIONS	OUTCOME	DATA SOURCE
Attraction of health workers in District rural settings across the 54 districts	<ul style="list-style-type: none"> <li>▪ Job Fair – Career expo events</li> <li>▪ Review of adverts, inclusion of the district profile and tracking tool</li> <li>▪ Localized incentive package to the newly recruited staff</li> </ul>	<ol style="list-style-type: none"> <li>1. Reduction of vacancy rates from 45% in 2009/11 to 36% in 2011/12 (ref. CCHP analysis data for trend)</li> <li>2. Increase of posted staff in LGAs from 57% in 2008/09 to 76% in 2010/11 (see trend below) – after BMAF support on the advertisement and other recruitment process</li> </ol>	<ul style="list-style-type: none"> <li>▪ CCHP analysis report</li> <li>▪ Baseline report</li> <li>▪ MoHSW annual report for posted HWs (BMAF review)</li> </ul>
Improved retention of health workers in the districts	<ul style="list-style-type: none"> <li>▪ Localized incentive package</li> <li>▪ The use of the newly developed orientation package</li> <li>▪ Improved working conditions</li> </ul>	<ol style="list-style-type: none"> <li>1. Increased retention of health workers from 76% in 2009 to 91% in 2012</li> </ol>	<ul style="list-style-type: none"> <li>▪ Coaching and mentoring report for March 2011</li> <li>▪ Coaching and mentoring report for Dec 2012 for 34 districts and Feb 2013 for 20 districts</li> <li>▪ Baseline report</li> </ul>
Improved performance management systems in LGAs	<ul style="list-style-type: none"> <li>▪ Linking OPRAS with CCHP for CHMT and individual work plans for lower cadre staff</li> <li>▪ Use of simplified cross functional matrix for filling of the forms (especially for lower cadre staff)</li> <li>▪ Coaching and mentoring</li> </ul>	<ol style="list-style-type: none"> <li>1. Increase of employees completed annual performance reviews from 34% in 2009/10 to 87% in 2011/12 for CHMTs and from 4% to 35% for other staff.</li> <li>2. Increase of districts with functional OPRAS system (out of 54 covered under THRP) from 4% in 2009/10 to 50% in 2012/13 for the supported CHMTs and from 1% to 17% for other staff.</li> </ol>	<ul style="list-style-type: none"> <li>▪ Baseline report</li> <li>▪ Coaching and mentoring report conducted in Dec 2012 and Feb 2013</li> <li>▪ PMP</li> </ul>
Improved HRH planning in LGAs	<ul style="list-style-type: none"> <li>▪ Preparation and incorporation of HRM action plans into CCHP</li> </ul>	<p>Increase of HRM financing from 9% in 2009/10 to 17% in 2011/12 (including PE Budgets)</p> <p>Increase of HRM activities into CCHP from an average of 13% in 2009 to 17% in 2012</p>	<ul style="list-style-type: none"> <li>▪ CCHP analysis report</li> <li>▪ Coaching and mentoring report for Dec 2012 and Feb 2013</li> </ul>

## 4.4 Lessons Learned

Some of the lessons relate to efforts to secure sustainability, knowledge sharing and partnerships. They include concepts that were initially introduced during the project design that proved useful during implementation. Lessons were also drawn from developed concepts that did not work as initially designed and concepts that were modified during project implementation to suit specific situations.

### 4.4.1 General lessons

- Involvement of district authorities in recruitment processes significantly contributed to improved reporting and retention rates. For example, preparation of district profiles; follow up of posted health workers through telephones and involvement of district in local recruitment campaigns. The approaches increase creativity, ownership and accountability of LGAs in recruitment processes.
- Regular information sharing between the supply (Health Training Institutions -HTIs) and demand side (LGAs) of the health workers is effective to reduction of staff shortage in LGAs.
- OPRAS systems can be fully functional if the trainings and guidelines consider skills and knowledge differential (customized) between the professional and operational cadres.
- Some THRP methodologies such as Job Fair, Knowledge Sharing and Coaching and Mentoring proved to be very successful. For example, job fair approach was adopted under THRP, but was widely rolled out by the MoHSW through GFR9 HSS project. Together with other initiatives the approach contributed to increase of filling of the approved posts, whereby before the initiative the posts were filled at an average of 60% but after the initiative the posts are filled and at instances there have been more applications than the government capacity to deploy.

### 4.4.2 Generated concepts that proved useful throughout project implementation

- **District HRM Strengthening Initiative**

Underlying ideas in this concept include designing customized training, undertaking coaching and mentoring and knowledge sharing to inform policy improvement. The concept proved to be valid throughout project implementation. Specifically:

- ▶ Training was targeted to address the key skills and process gaps on HRM in LGAs. It involved identifying the gaps, developing training programs and guidelines, delivering training and developing action plans. Involvement of local resources and stakeholders to manage implementation as “change champions” was so effective in realizing the expected results.
- ▶ Coaching and mentoring enabled timely identification of operational gaps during implementation of the “plans for improvement” and provided timely and collectively owned solutions to address the gaps. This promoted more accountability, continuous capacity building, ownership and sustainability.
- ▶ Involvement of stakeholders proved to be effective in development and review of guidelines/policies and for timely completion and to secure ownership.

- **Job Fair ( Aligning demand and supply)**

As indicated in section two, the concept was designed in response to the mal-distribution of the health workers and brain drain, due to weak system of aligning and informing the initiatives and efforts done by the supply side and the demand side of the health workforce.

The underlying objective is bridging the critical information gap, between the source of health workforce supply (students and training institutions) and the employers (central and local government). Most of the information

regarding the efforts done by the government, both central and local (employers) on improving management and benefits of the health workers were focused to the in service health workers and least, if not none was focused on reaching the pre-service which is the key source of new entrants. The situation leads to wrong assumption to the students about the health sector, particularly for the LGAs in underserved areas and most was repelling factor that lead to intensive mal-distribution and internal and external brain drain.

- **Bottom – up approach in policy development and approval**

It was learnt that creating and approving policy documents could be greatly simplified when a bottom – up approach is adopted as it was done under THRP. Under this arrangement, initially, policy gap analysis is undertaken in form of assessments. Based on the findings, innovation solutions are developed and tested/piloted. Finally, a guideline which is informed by the results of the pilot is created. Experience in using this approach has shown that it takes less than two years to get an approved new policy while the usual top-down approach could take up to five years.

#### **4.5 Sustainability**

- **Project Design**

THRP interventions were planned with due consideration of sustainability. Thus, implemented activities were aligned with the Human Resource Strategic Plan and were built in the existing government systems and structures. Capacity building were designed for improving skills of staff involved in various levels of decision making pertaining to HRH. Planning for improvement developed during the trainings was integrated into the CCHP for continuity. These include sustainable HRM systems such as localized incentive packages and improved work climate. Others are:

- i) Designing of need - based training modules and alignment to the established TORs for the CHMTs with effective involvement of local resources to promote ownership and sustainability. The modules have been adapted by the Government and are being rolled out to other non-THRP districts under GFR9 support.
- ii) Development of a sustainable pool of local experts in HRM who were drawn from the Districts, Regions, Zones and Private sectors. Upon closure of the THRP these experts were handed over to the Government for future utilization.

- **Sustainability through developed guidelines**

The manner in which various guidelines were developed during the project ensures sustainability of their intended objectives and THRP results. For example, developed CCHP guideline became a mandatory document to be used by all LGA's in the development of the CCHP, which is the planning tool of the health sector in the LGA's. This will sustainably guarantee financing of HRH/M activities through government funds as well as improve HRM.

Approval of the revised staffing level guidelines by the government ensures that the districts will utilize an updated version of the guidelines; which takes into consideration the current context of ongoing reforms, changes in disease patterns and policies. This warrants realistic district plans in future.

Endorsement of the human resource checklist of the National Supportive Supervision tool, which is currently being rolled out to all LGA's in the country under GFR9, gives assurance of its existence in the next few years to come. Impliedly, HRM aspects will sustainably receive adequate attention.

The new Orientation Package, which was developed as part of districts strengthening training has been presented to the MoHSW for endorsement. When endorsed, the package will sustainably become a catalyst of best practice in recruitment, deployment and retention of health workers and minimize turnover rate.

The HRM district strengthening training manual, which was adopted by the MoHSW is being rolled out through GFR9 support to non- THRP districts. The use of the manual in HRM capacity building across the country will enhance capacity building at the district level and sustain THRP results.

Tracking tool for reported health workers has been adopted by the LGAs covered under THRP. Integration Negotiations are underway to integrate the tracking tool of reported health workers into HIMS. This integration ensures sustainable use of the tool.

#### **4.5 Ongoing Challenges**

Despite various achievements made under THRP, a number of challenges exist, which may undermine ongoing and ongoing district strengthening efforts, if not adequately addressed. These include:

- a) Lack of strong operational linkages across Ministries (MoHSW, PMORALG, and PO-PSM&MOFEA). This limitation significantly undermines coordination and addressing of HRH crosscutting issues. Policy forums could be one among the best ways of addressing this challenge.
- b) Limited Complementarities of Health systems and service delivery interventions which are critical for partners' involvement and collaboration during projects' designs.
- c) Limited district capacity and authority for institutionalizing and formalizing innovations/best practices.

## Section 5 - Conclusions and Recommendations:

### 5.1: Conclusion

THRP interventions implemented by BMAF in four years since 2009 have responded to the dynamics in the health sector in Tanzania, both at Central Government and LGAs. They have revolved around innovative strategies and tactics for enhancing the ability of LGAs to attract, engage and manage human resources for health. Various guidelines were developed, approved by the government and rolled out in the districts to ensure consistency, uniformity and spill-over effect of interventions across the covered districts and to foster central government control and oversight. Evidence from the project indicates that local personnel engagement is crucial to facilitate uptake of various interventions at the districts and to speed up review and approval of policies and guidelines.

Evidently, the Government of Tanzania is committed to scale up various THRP interventions, strategies and tactics across the country. For example, as indicated in previous sections of this report, the government has endorsed and adopted various guidelines developed during the project. Further, during THRP feedback workshop in May, 2013, which marked the official closure of the project, the government officially launched THRP documents and rewarded best performing districts. This is clearly a positive development.

#### Key lessons:

- Task related training & Coaching and Mentoring highly contributes to realization of training effectiveness,
- Regular information sharing between the supply (HTIs) and demand side (LGAs) of the HWs is effective to reduction of HW's shortage in LGAs,
- Involvement of the district authorities in recruitment processes significantly contributes to improved reporting and retention rate,
- OPRAS system can be more effective if the trainings and guidelines can consider skills and knowledge differential (customized) between the professional and operational cadres, and
- Effective involvement of the beneficiaries at all levels from the project design, pilot testing/implementation is effective for sustainability, process and policy improvement.

Despite recorded positive outcomes of the project, health sector challenges, especially in the districts have not been fully resolved. More needs to be done at Central Ministries and LGAs to further enhance and sustain achieved results under THRP, especially human resources management.

Some of the challenges that need to be resolved include:

- Lack of strong operational linkages across Ministries (MOHSW, PMORALG, PO-PSM&MOFEA) contributes to the HRH challenges
- Limited complementarities of Health systems and service delivery interventions which is critical for partners involvement and collaboration during projects' designs.
- Limited district capacity and authority for Institutionalizing and formalizing innovations/best practices.

The following actions are recommended for central ministries and LGAs.

## **Central Government**

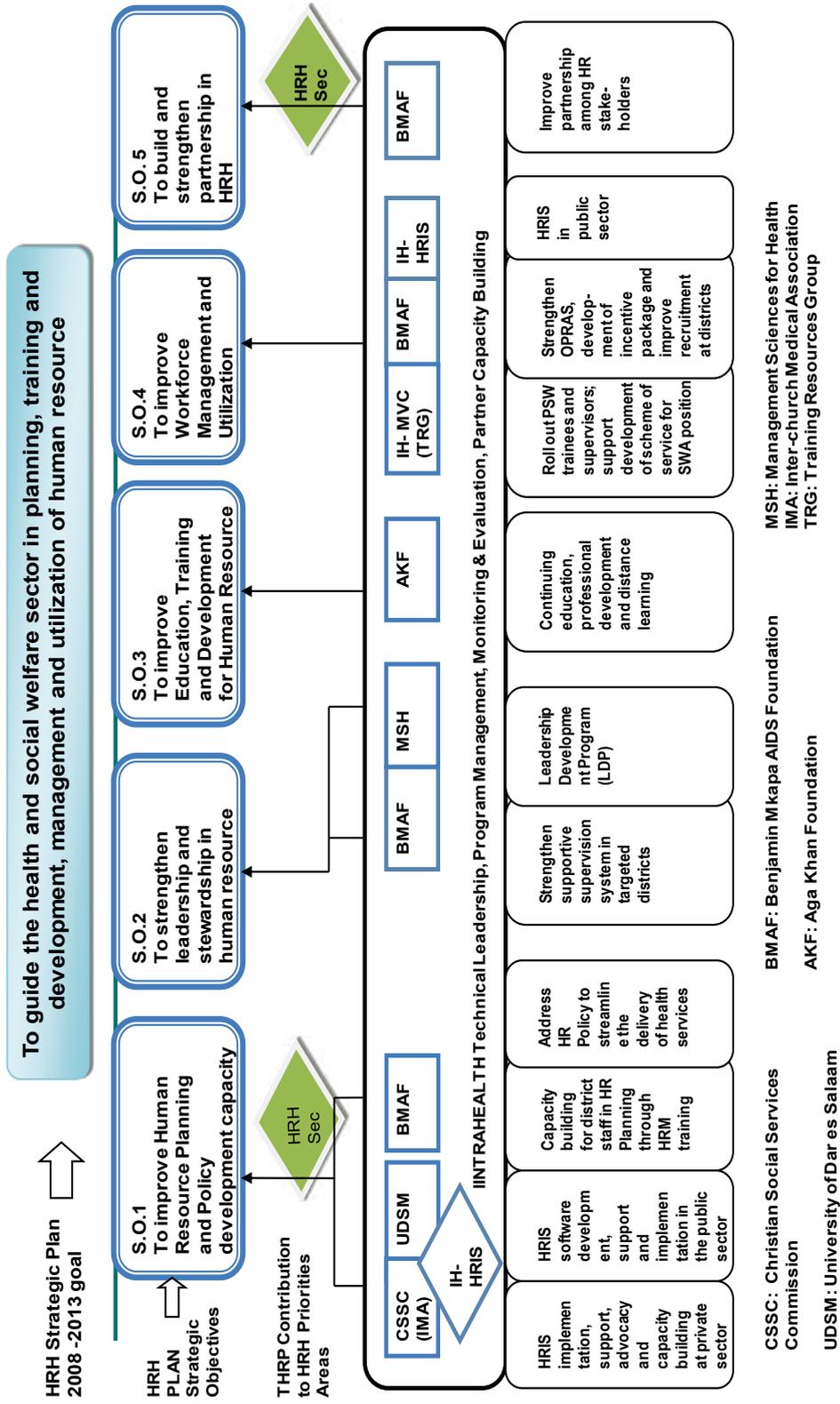
- Spearhead the roll out of the manuals, guidelines and HRH best practice to non THRP districts to enhance the spill over effect of achieved milestones during the project,
- Enhance the understanding and utilization of developed guidelines, manuals and HRH best practice to districts covered by THRP,
- Establish mechanisms for increased impetus for supporting the districts through developed pool of national experts,
- Improve coordination of supported programs and multi-sectoral approach to interventions,
- Utilize THRP approach and methodologies in similar subsequent interventions, and
- Enhance oversight supervision in districts to ensure compliance to approved guidelines.

## **Local Government Authorities**

- Continue utilization of approaches and methodologies adopted during THRP to optimize results in respective areas of HRH.
- Strengthen utilizing guidelines developed during the project.

Appendix A

TANZANIA HUMAN RESOURCE CAPACITY PROJECT CONTRIBUTIONS TO HRH STRATEGIC PLAN 2008-13



## **Appendix B**

### **The Human Resources for Health Toolkit**

#### **1.0 Introduction**

To complement government efforts to improve health services in Tanzania, BMAF through THRP initiated HRH interventions in 54 districts in Tanzania. The interventions strengthen the capacity of Council Health Management Teams (CHMTs) in the districts to improve Human Resource Management, health workers' attraction and retention. The project among other things led to the development of the user-friendly tools for carrying out required interventions in addressing the Human Resources for Health (HRH) challenges in Tanzania

This toolkit provides overview of Human Resource Management methodologies and strategies that have proven successful in addressing human resource policies, practices and systems under Tanzania Human Resource Capacity Project (THRP). It therefore brings together a set of existing tools that are in use in the 54 districts in regard to HRH planning, management, monitoring and evaluation. The toolkit includes HRM district strengthening manual, Orientation package for Health Workers and HRH Supportive supervision

The toolkit intends to provide quick reference on the various HRM components as in the district strengthening programs follows:

#### **2.0 Human Resource Management manual (District Strengthening)**

BMAF in collaboration with IH and Training Resource group, developed HRM District strengthening Manual consisting of 13 modules namely 1) Introduction to HRM in Tanzania 2) Health Action Framework, 3) Workforce Planning 4) Recruitment and Deployment 5) Orientation 6) Performance Management 9) Professional Development 10) Work place Environment 11) retention 12) Leadership 13) Gender Mainstreaming, 10) Planning for improvement. These modules were developed following HRM practices, policies and guideline pertaining to HRM in the LGA's

##### **B2.1. Objectives of the manual**

The objective of the manual is to improve Practices on human resource for health in LGAs in order to reduce the vacancy rates, improved retention and productivity. Specifically the manual focuses on: components of HRM system, their functions, and their interrelated nature, Identify systems necessary to support good HRM practices, leadership and management practices that can support HR strengthening in the district, ways of integrating gender and diversity issues in the districts HRM plans and HRH plans for improvement of priority areas.

##### **2.2. Uses of the manual**

CHMTs officials received HRM District Strengthening Training from 54 LGA's benefiting from THRP. The Training modules were reviewed by MOHSW, adopted are been rolled out through GFR9 HSS project support to the remaining districts countrywide. The components of the model are described hereunder:

## HRH DISTRICT STRENGTHENING MANUAL

Areas of Focus	Objectives of the module	Key references
Human Resources Management in the Tanzanian Context	<ul style="list-style-type: none"> <li>• Explain the HRH situation in Tanzanian Context</li> <li>• Interpret the context in improving HRH situation at the district level</li> <li>• Apply gender and Diversity awareness in Human Resource for Health</li> </ul>	<ul style="list-style-type: none"> <li>• Staffing norms 1999</li> <li>• National Health Policy June 2007</li> <li>• Primary Health Services Development Program 2007 – 2017</li> <li>• Human Resources for Health Strategic Plan 2008 - 2013</li> <li>• Health Sector Strategic Plan III July 2009 – June 2015</li> </ul>
Introduction to the Human Resources for Health Action Framework and Human Resources Management Systems	<ul style="list-style-type: none"> <li>• Describe the Human Resources for Health Action Framework (HAF) and ways in which it can serve as a comprehensive tool to analyze and address HRH challenges.</li> <li>• Explain how the HAF – and the action fields and areas of intervention – link to their work as district HRH leaders and health administrators in Tanzania</li> <li>• Explain what is meant by the HRM system and why it's important to think about HRM in these terms</li> <li>• Name three factors that make development of a systemic approach to HRM difficult</li> </ul>	<ul style="list-style-type: none"> <li>• WHO HAF Framework</li> <li>• MoHSW- TZ HAF Poster</li> </ul>
Workforce Planning	<ul style="list-style-type: none"> <li>• Describe basic workforce planning approaches</li> <li>• Describe the key types of data and planning assumptions needed for workforce planning at district level</li> <li>• Describe the labour market and how it influences workforce planning</li> <li>• Use available workforce planning tools at district level</li> </ul>	<ul style="list-style-type: none"> <li>• Seniority List -TANGE</li> <li>• Staffing level – 1999</li> <li>• PE Budget guideline, 2009</li> </ul>
Human Resources Information System (HRIS)	<ul style="list-style-type: none"> <li>• Describe HRIS and its importance in HRM</li> <li>• Identify the attributes of quality data and its use in HRM</li> <li>• Describe benefits of using electronic HRIS</li> <li>• Explain the role of participants in Effective HRIS</li> <li>• Understand the HRIS initiative supported by THRP</li> </ul>	<ul style="list-style-type: none"> <li>• THRIS user guide</li> <li>• HCMIS user guide</li> </ul>
Recruitment and Deployment	<ul style="list-style-type: none"> <li>• Describe the components of effective recruitment</li> <li>• Identify some of the key bottlenecks to effective recruitment in Tanzania</li> <li>• Name 3 things that can be done in their districts to improve recruitment and/or deployment</li> </ul>	<ul style="list-style-type: none"> <li>• Report on Bottleneck Study</li> <li>• Public Service Management and Employment Policy of 1999</li> <li>• Public Service Regulations, 2003</li> </ul>
Orientation	<ul style="list-style-type: none"> <li>• Link orientation with health workers recruitment, posting and tracking</li> <li>• Develop orientation plan and identification of necessary documents prior to reporting of new health workers</li> </ul>	<ul style="list-style-type: none"> <li>• National Orientation package for the Health workers, 2012</li> <li>• Posting letters from MOHSW, letters of employment from LGAs, Job Descriptions, , OPRAS forms, sample of</li> </ul>

	<ul style="list-style-type: none"> <li>To effectively implement orientation at the work places to promote attraction, retention and productivity of the health workers.</li> <li>Evaluate orientation and identify solutions for re-planning of alternative action.</li> </ul>	<p>district profiles, organizational structures, medical forms, personal data sheets/forms, district staff establishments, and Professional codes of ethics and Sops, District Human Resources Development Plans developed orientation packages e.t.c</p>
Performance Management	<ul style="list-style-type: none"> <li>Identify key performance management factors</li> <li>Analyze how each of these factors is 'at work' at the district level in Tanzania</li> <li>Explain their roles in promoting the use of performance management factors throughout the system</li> <li>Describe the OPRAS system and how they can use it to most effect in managing performance in their districts</li> <li>To align diversity issues (gender, disability, HIV/AIDS) with performance management practice.</li> </ul>	<ul style="list-style-type: none"> <li>OPRAS establishment circular , 2004</li> <li>OPRAS Guideline, 2004</li> <li>OPRAS forms, TFN 832</li> <li>OPRAS training manual, 2006</li> </ul>
Professional Development	<ul style="list-style-type: none"> <li>Describe the importance of professional development to both the health worker and to the health facility</li> <li>Identify key actors in continuing professional development</li> <li>Describe ways of implementing the MoHSW Continue Professional Development/ Continue Education Policy in their district</li> </ul>	<ul style="list-style-type: none"> <li>HRH strategic Plan, 2008-13</li> <li>Tanzania HR Training manual , 2009</li> </ul>
Work Environment (Work Climate)	<ul style="list-style-type: none"> <li>Define the concept of work place environment/work climate</li> <li>Describe the factors and practices that contribute to and promote positive work environment</li> <li>Explain the link between work climate and staff motivation, job satisfaction, productivity and retention.</li> <li>Identify practical ways of planning and implementing work climate improvement interventions and addressing work environment challenges at the district level in Tanzania</li> </ul>	<ul style="list-style-type: none"> <li>USAID 2009, Measuring the Impact of Health Systems Strengthening, A Review of the Literature</li> <li>WCI and productivity study- conducted by BMAF –Tanzania, 2011</li> </ul>
Health Worker Retention	<ul style="list-style-type: none"> <li>Define the concept of retention and related terms (attraction, attrition, and turnover)</li> <li>Describe factors that influence health worker retention</li> <li>Describe approaches for improving health worker retention</li> </ul>	<ul style="list-style-type: none"> <li>Public service pay and incentive policy, 2010</li> <li>Incentive package from Districts (local initiatives)</li> <li>Tracking report conducted by BMAF, 2010</li> </ul>
Introduction to Leadership in the HR Context	<ul style="list-style-type: none"> <li>Define Leading and Managing practices</li> <li>Describe the differences as well as complementarities between leadership and management</li> <li>Describe the link between leading and managing practices and organizational goals and results</li> </ul>	<ul style="list-style-type: none"> <li>Leadership Manual written by Jesse Mashimi, 2012</li> <li>The Public leadership code of Ethics (1995)</li> <li>Explanatory Manual for code of ethics; Doing the right Thing</li> <li>MSH leadership framework</li> </ul>

	<ul style="list-style-type: none"> <li>Identify practical ways of applying leading and managing practices in their HR work and roles</li> </ul>	
Gender in Human Resource Management	<ul style="list-style-type: none"> <li>Explain the difference between sex and gender</li> <li>Discuss rationale for integrating gender in HRH</li> <li>Describe different types of gender discrimination</li> <li>List expected outcomes of action for gender equality in health workforces</li> <li>Describe gender related policies and their implementation in Tanzania</li> <li>Identify areas for integrating gender in HRM components</li> </ul>	<ul style="list-style-type: none"> <li>Handouts <ul style="list-style-type: none"> <li>Women- Friendly, Family Friendly actions to improve the climate in the health work-place</li> <li>OSHA – Gender dimensions</li> <li>Tanzania National Gender Policy</li> <li>Employment and Labor relations Act, 2004</li> <li>Guidelines for managing Diversity in the Public service, 2010</li> </ul> </li> </ul>
<b>Planning for Improvement</b>		<ul style="list-style-type: none"> <li>PowerPoint Slides on basics on effective action plan ( Smart objectives, Identification of priority action plans and take them through the planning templates)</li> <li>Handouts: <ul style="list-style-type: none"> <li>Doc. 13.1: Planning for Improvement in the Districts: Priorities</li> <li>Doc. 13-2: Planning for Improvement in the Districts: Action Plans templates</li> </ul> </li> <li>Planning Template – CCHP</li> </ul>

### 3.0 Orientation Package

#### 3.1 Introduction

A recent review of orientation processes and practices for health workers in the districts, which was carried out by IntraHealth International and Benjamin Mkapa Foundation suggests inadequate staff orientation as one of the contributory factors to staffing problems. In response to this gap, an orientation package is designed to improve orientation practices for health workers.

#### 3.2 How was it developed?

A participatory approach was used in designing the package to suit the needs of the health sector in Tanzania, particularly those employed by the Local Government Authorities (LGA). Several stakeholders participated in the review of the orientation processes and underlying gaps. These included; the Prime Minister's Office – Regional Administration and Local Government (PMO - RALG) Ministry of Health and Social Welfare (MOHSW), The Tanzania Public Service College (PSC), the Local Government Training Institute (LGTI), the Local Government Authorities and District Hospitals of Njombe, Tandahimba and Newala. The review also gathered some inputs from independent Medical consultants.

### 3.3 Uses of the package

The orientation package is executed at different levels, each of them with clear objectives, individuals responsible for the orientation and a check list of activities to be performed. Major execution points will include: Ministry of Health and Social Welfare; Local Government Authority and Hospital/ Health Care Facility level as described hereunder:

<b>Level 1</b>		
<b>Ministry of Health and Social Welfare</b>		
Stages/ Time	Activities	Expected Output
Recruitment and posting process	<ul style="list-style-type: none"> <li>• Include address and the mobile phone of the posted health worker or his/her referee on the letter of appointment</li> <li>• Provide Detailed profiles of the respective LGA</li> <li>• Letter of posting to be addressed to respective employee.</li> <li>• Time frame of reporting date included on the posting letter</li> </ul>	Posted staff can easily tracked and with sufficient information on the work station

<b>Level ii</b>		
<b>Local Government Authority</b>		
Stages/ Time	Activities	Expected Output
Before joining	<p>Letter of employment as it exists now in addition:</p> <ul style="list-style-type: none"> <li>• Addendum letter with instruction on Documents one is supposed to receive/refer to .i.e. Public Service Act and its Regulations, Standing orders for the public service, Code of ethics &amp; Conduct for the public service, Professional ethics handbooks, hospitals structure, training programme (to include job related skills building and to consider gender aspect in planning of trainings), career progression plan preferably in a summarized format - a handbook.</li> <li>• Medical examination forms.</li> <li>• Personal particular forms.</li> <li>• Payroll registration forms.</li> <li>• List of generic Duties and Responsibilities.</li> <li>• Proposal for alternative accommodation.</li> <li>• Alternative sources of funds to support salary for the recruited health workers prior for the</li> </ul>	<p>Availability of all employment requirements Within a required time.</p> <p>Reduce the time of filling personnel records forms.</p> <p>Promote more accountability to the DHRO.</p>

	systems.	
1 <sup>st</sup> Week	<ul style="list-style-type: none"> <li>• Report and meet with DED.</li> <li>• Meet DHRO and other Heads of Departments at the LGA.</li> <li>• Facility &amp; environment tour of the LGA (respective offices - Procurements, social services sites- banks, hospitals, pharmacies, water authority, schools, court houses, recreational centers)</li> <li>• Open staff personal file</li> <li>• Fill personal particulars forms.</li> <li>• Fill payroll forms/personnel data sheet.</li> <li>• Medical examination.</li> <li>• Disbursement of the subsistence allowance as per governing laws.</li> </ul>	<p>Effective industrial relations,</p> <p>effective staff settlement,</p> <p>timely registration into the council payroll</p>
2 <sup>nd</sup> Week	<p>Brief session on :</p> <ul style="list-style-type: none"> <li>• Councils strategic plans, vision, mission, core values, public code of ethics, performance management systems, diversity (inclusion of women and men in social and physical needs in planning and implementation of HR functions at work place, PLWHA and Disability) as stipulated in the standing order, guideline for management of HIV/AIDS in the public service No. 2 of 2007 and the guideline for managing disability in public service 2008. This documents should be a accessible by all staff, perhaps be allocated at mini library, website and posted to notice boards.</li> <li>• Structures, reporting lines, operational and personnel policies, guidelines and procedures (Tanzania Occupation Health and Safety Act 2003, Labor Laws &amp; regulations, Human Resources Development Plans, planning supervision, codes of ethics, schemes of service etc).</li> </ul> <p>Follow up on the payroll and other forms to ensure completion.</p> <p>Invite a motivational/corporate speaker to talk with new employees (can be any in the health sector or social development circles like PCCB, Professional Councils, and credit facilities within and outside the locality, ICT, relevant academic institutions/schools</p>	<p>Effective accessibility of social development facilities to promote personal growth</p> <p>Effective accessibility of social development facilities to promote personal growth and enhance effective settlement retention within the locality</p>

	<p>for members of the family, insurance services, investment avenues within the locality).</p> <p>Communication to the head of the facility where the recruited/transferred health worker will be placed.</p> <p>Invite gender person to provide basic gender discrimination issues as provided by related governing Policies and Acts ie. employment and labor relation sub-part C, Section 7.1, (6), (10), Code of Conduct (description of mechanisms).</p>	
<b>1st 2nd -4th Months</b>	<ul style="list-style-type: none"> <li>Evaluate the implementation of the orientation for the new employees at the facility and obtain feedback from the new staff. Evaluation can be done through site visits, staff meetings and review of the departmental reports</li> <li>Analyze the findings and develop tentative plans to address the identified gaps. The gaps can be addressed through capacity building programs and integrate plans into the CCHP. Share the reports and plans with the DMO and facility in charges</li> </ul>	<p>Orientation gaps identified, action plan to address the gaps developed and integrated within the CCHP, HRDP and operational support Schedules.</p> <p>Set annual performance targets .</p>

<b>Level iii</b>	<b>Hospitals/ Health Centers/ Dispensaries</b>	
<b>Stages/ Time</b>	<b>Activities</b>	<b>Expected Output</b>
<b>Before Joining</b>	<ul style="list-style-type: none"> <li>Preparation of a space/Office, and work facilities. This refers to staff duty office/ area like maternity ward or surgical ward where specific duties and responsibilities should be driven</li> <li>Develop specific duties and responsibilities for the expected staff based on their specialization and section of placement</li> <li>Prepare OPRAS forms</li> <li>Preparation for proposed/alternative housing/accommodation</li> <li>Identification of mentor</li> </ul>	Ensures accountability and good employee relations
<b>1st Week stages/Time</b>	<ul style="list-style-type: none"> <li>Report to meet DMO,DHS and head of sections</li> <li>Confirm on staff accommodation/ housing</li> <li>Facility tour with briefings on the function of each section (Offices, departments, Units, rest rooms, social service centers around the facility, banks, schools, court offices)</li> <li>Inform the employee on the eligible rights, benefits and accountabilities. Explain the required process, procedure and systems to access their eligible rights and benefits (i.e all forms of leave, confirmation of employment, promotions, trainings, medical coverage, social security schemes and credit facilities)</li> </ul>	Successful familiarization with LGA environment and work

Level iii	Hospitals/ Health Centers/ Dispensaries	
Stages/ Time	Activities	Expected Output
	<ul style="list-style-type: none"> <li>• Explain on general administration procedures (eg. Attendance register, duty roaster, letter writing, reporting lines, leave schedules, leave forms and requests, schedule of meeting)</li> <li>• Identify employee immediate supervisor and mentor</li> <li>• Supplied with written specific duties and responsibilities</li> <li>• Shown a place to sit and working facilities</li> <li>• Provide staff with duty facilitative tools/facilities, uniforms (where requires) and protective gears</li> <li>• Given a formal identity cards</li> <li>• Follow up on the payroll and other forms and make sure all are completed</li> <li>• Provide medical insurances for self and family</li> </ul>	
<b>2nd Week</b>	<ul style="list-style-type: none"> <li>• Provide more guidance on his/her duties and responsibilities. Review duties and responsibilities.</li> <li>• Setting performance goals/complete OPRAS Forms.</li> <li>• Plan for reviews procedures and appraisals.</li> <li>• Assign duties (Resume responsibilities) &amp; attach to a mentor/colleague.</li> <li>• Invite a guest speaker for any work related topics in health or in public service at large, (e.g. professional ethics &amp; SOPs, Public Service regulations, Code of Ethics and conduct for the public service, gender equality at work places, P4P, CCHP etc specifically at District level).</li> <li>• Supervisors should print and disseminate the mentioned documents to staff of the section. Some to be posted to the notice boards and use sectional meeting to discuss them.</li> <li>• Conduct staff meeting which include new and existing staff, one of the agenda being the position of women and men having the right to work free from discrimination and violence (Including sexual harassment), The expectation of equal opportunity in recruitment, promotion and pay</li> </ul>	<p>To ensure that there are no problems facing the new employees.</p> <p>To raise staff commitment to the environment.</p> <p>Promote career advancement, performance improvement; prompt Human Resources Management challenges and timely mitigation or address of the challenges.</p>
<b>1st<sup>2nd</sup> -3rd Months</b>	<ul style="list-style-type: none"> <li>• Provide capacity building training performance goals, by identifying the proper/resource person for on job training and out of site training.</li> </ul>	<p>Career and skills growth, Identify and mitigate all challenges including leadership.</p>

Level iii	Hospitals/ Health Centers/ Dispensaries	
Stages/ Time	Activities	Expected Output
	<ul style="list-style-type: none"> <li>• Liaised with respective supervisor to address any challenges that need to be addressed.</li> <li>• Complete circle assess from different angles evaluate in relation to performance targets, obtain top down opinions (supervisors, peers and subordinates)</li> <li>• Feedback (checklist 3) should also include gender discrimination issues.</li> </ul>	Obtain feedback from the supervisor, newly recruited staff and their workmates on how the orientation excises have been conducted and how the exercise had attributed to their motivation, retention and productivity
<b>1st Quarter</b>	<ul style="list-style-type: none"> <li>• Conduct evaluations on the orientation.</li> <li>• Linked with supportive supervision visits.</li> </ul>	Reduction of attrition rate, performance improvement, motivated workforce

#### 4.0 HRH Supportive supervision

##### 4.1 Introductions

The Human Resources for Health supervision checklist is one of the components of the National Supportive Supervision guideline for quality health care services and **not a parallel tool**. This checklist is intended to be used by RHMT's, and CHMT's to strengthen their lower health management teams on human resource for health management issues. It will assist these organs and heads of lower health facilities in the implementation of their HRH plans and ultimately strengthen human resource management at the lower level. Management teams are urged to comprehend to the details of this document in order to acquire the necessary competencies before conducting supervision activity.

Supervision teams are expected to go through the information thoroughly and choose few areas of this checklist to be included in every supervision visit conducted. It is important to note that every supportive supervision visit is different in terms of objectives and expected outputs. The checklist has taken into consideration the different levels of service delivery (Regional/District Hospital, Health Centre and Dispensary Levels).

##### 4.2 Objectives of the tool

The objectives of the HRH SS tool include to facilitate supervisors in LGAs to identify and address HRM gaps in their areas and ensure uniformity in performance standards and reporting through use of generic checklist as a guide. Integration of HRH component into the National Supportive Supervision tool responds to the missing HR components in the National Supportive Supervision Guidelines. Therefore, Supportive supervision is meant to promote quality outcomes of health system by strengthening communication, identification and solving of day to day problems, facilitating team work, and providing leadership and support to district health facilities to monitor and improve their own performance based. It is carried out in order to guide, support and assist the health management teams and health providers in carrying out their assigned tasks. It involves on-job transfer of knowledge and skills between the supervisor and the one being supervised through opening of administrative and technical communication channel.

##### 4.3 Uses of the tool

Following consultative process of preparation of the tool, the Ministry of Health and Social Welfare have officially endorsed the tool for the use in the Health Facilities across Tanzania. Thus the tool can be used by RHMT to supervise health facilities within the region, CHMT to supervise health facilities within the District and for Self assessment by the Health Facilities themselves. The key components of the tool are described hereunder:

Standard	No	Indicator question	Verification criteria	Levels of service delivery				Y/P/ N/X	Re mar ks
				HOSP	HC	DISP	ALL		
<b>Organizational structure and functional relationship</b>									
Organisation structure and functional relationship are appropriate in line with MoHSW management processes	1.	Does the hospital have an organogram which clearly specify roles and functions at the hospital levels?	Verify the availability of an updated standard organizational structure with composition adhering to PMORALG /MOHSW or any LGA guideline.	X					
	2.	Does the facility have specified and assigned roles and functions for each health worker?	Verify if there are clearly up to date (through a regular process of review), written Job Descriptions, which are provided, to every employee as stipulated in the Government circular.  Specific duties and lines of supervision are clearly stated.				X		
Qualified human resource for health (HRH) are available and well placed as per guidelines and standards for health services	3.	Does the hospital have qualified human resource and well placed as per guidelines and standards of health services?	Verify if the hospital facility have adequate qualified human resource as per approved staffing levels of the Ministry of Health and Social Welfare 2009				X		
			Verify if HRH are placed according to qualifications and skills.				X		
<b>Human Resource for Health (HRH) Planning</b>									
HRH activities are planned, budgeted and implemented taking into consideration their compliance	4.	Are the facility committee's members involved and participated in planning, monitoring and evaluation of health activities according to schedule (Facility Management committees, and Facility Governing Committees?	Verify planning team members by names through plan document and interviewing sampled members to check their awareness.			X	X		

Standard	No	Indicator question	Verification criteria	Levels of service delivery				Y/P/ N/X	Re mar ks
				HOSP	HC	DISP	ALL		
with the National Health Policy, health facility vision and mission.	5.	Does the health facility have annual work plan?	Health facility annual plan available as per CCHP			X	X		
	6.	Is the work plan linked to the district strategic plan?	Verify if the Mission, Goals and Objectives are linked to annual HRH planning and are used for forecasting of staffing and recruitment needs in terms of numbers, skills, working facility.			X	X		
	7.	Does the annual HRH plan base on formal assessment of the HRH staffing needs, employees' data?	Verify whether the annual HRH plan is based on staffing needs and employee's data.			X	X		
	8.	Are the hospital management committees members involved and participated in long (Strategic) and short term planning, monitoring and evaluation of health activities according to schedule (Hospital Management committees, and Facility Governing Committees)?	Verify planning team members by names through strategic plan document and interviewing sampled members to check their awareness.	X					
HRH recruitment, retention and development are in accordance with the government establishment.	9.	Does the district /health facility has qualified staff according to approved staffing level of the MoHSW?	Verify whether the available qualified staff meets the approved staffing level of the MoHSW				X		
	10.	Is there a systematic way of HRH data collection, updating, maintaining and use in HRH planning?	Verify whether all HRH data and staff list available and updated				X		
			Verify whether the systems are in place for HRH data collection, updating and maintaining.				X		
			Verify whether the data is formally used for HRH planning and forecasting and decision-making.				X		

Standard	No	Indicator question	Verification criteria	Levels of service delivery				Y/P/N/X	Remarks
				HOSP	HC	DISP	ALL		
	11.	Is there HRH retention mechanisms available?	Verify whether the retention of HRH is adhered to (employees should stay and work in the health facility for at least 12 months).				X		
			Verify whether there is training program for all staff				X		
			Verify whether promotions are conducted timely				X		
	12.	Does a hospital/facility conduct <b>orientation</b> to new employees?	Verify whether the hospital/facility conduct orientation sessions to all new employees emphasizing the vision, mission, goals, and performance standards expected and general environment				X		
			Verify whether employees are made aware of HRH rights and retention schemes available in the hospital/facility level				X		
<b>Utilization of Human Resource for Health Information System (HRHIS)</b>									
Functional HRHIS in place according to HRHIS Strategic Plan 2008 to 2013	13.	Is the HRH Information generated by HRHIS utilized at local level?	Verify where the HRH Information generated by HRHIS utilized at local level for HRH planning and management				X		
	14.	Is the HRH Information generated by HRHIS and forwarded to higher level?	Verify the HRH Data in the HRHIS is updated regularly.				X		
			Verify whether health facility forward HRH Data to higher levels regularly				X		
	15.	Are there hospital Management team members who received HRHIS operational training available?	Verify whether hospital HMTs who received HRHIS operational are available	X					
	16.	Is IT environment for HRHIS feasible at the site?	Verify the IT environment for HRHIS operation at the site is feasible	X					
17.	Is the HRH data is collected regularly?	Verify HRHIS data collection progress.	X						

Standard	No	Indicator question	Verification criteria	Levels of service delivery				Y/P/N/X	Remarks
				HOSP	HC	DISP	ALL		
	18.	Is Hospital ICT Personnel supporting update of HRHIS in one's jurisdiction area?	Verify whether the Hospital ITC Personnel receives update of HRHIS and support from RHMTs and CHMTs for update of HRHIS regularly	X					
	19.	Is the HRH Information generated by HRHIS utilized at local level?	Verify where the HRH Information generated by HRHIS utilized at local level for HRH planning and management	X					
	20.	Is the HRH Information generated by HRHIS and forwarded to higher level?	Verify the HRH Data in the HRHIS is updated regularly.	X					
			Verify whether District hospital HMTs forward HRH Data to higher levels regularly	X					
	21.	Is the HRHIS maintained regularly?	Verify the HRHIS maintenance report is available.	X					
	22.	Is there a systematic way of HRH data collection, updating, maintaining and use in HRH planning?	Verify whether all HRH data and staff list available and updated				X		
			Verify whether the systems are in place for HRH data collection, updating and maintaining.				X		
<b>Staff Motivation and Job Satisfaction</b>									
Health staff are highly motivated with job satisfaction and meet performance standards	23.	Does the Hospital Management consider creating the good working environment for the staff?	Verify whether there is any plan/ activities to create good working environment to motivate staff				X		
	24.	Are HRH policy guidelines shared and communicated to all staff?	Verify the accessibility and awareness by interviewing at least five staff on the interpretation of HRH policy guidelines and circulars to all staff through notice boards, staff meetings, minutes, workers councils and others.				X		
	25.	Does the Hospital have and implement the policy guideline that promotes performance?	Verify whether the motivation or reward schemes or merit had been provided based on annual performance assessments for each staff	X					
	26.	Do compensation and benefits system	Verify if a formal compensation and benefit system available and is used to				X		

Standard	No	Indicator question	Verification criteria	Levels of service delivery				Y/P/ N/X	Re marks
				HOSP	HC	DISP	ALL		
		consistently applied and staff are aware on the system?	determine extra duty allowances and benefits that get recognition for a good work done by the employee.						
			Verify the operation of P4P and New recruit retention funds available and utilized.				X		
	27.	Are the public service, professional ethics and codes of conduct communicated and adhered to?	Verify the availability and accessibility of the public service code of ethics and conduct from the POPSM, professional ethics codes of conduct publication materials.				X		
			Verify whether the Communication and follow up on the adherence of ethics by way of meetings, workshops, public opinion box and others done.				X		
	28.	What innovations does the hospital have on monetary and non-monetary incentives for staff in your facilities?	Verify what kind of innovation approaches are taken for monetary and non monetary incentives for staff				X		
	29.	Do health workers receive salaries timely and monetary and non-monetary incentives?	Verify the leadership creativeness on mobilization of available resources to attract, motivate and retain staff within their working areas (monetary and non monetary).				X		
			Verify whether staff receives reasonable monthly salaries and paid on time (paid between 25th and 31st of the month).				X		
	30.	Are meetings conducted according to schedule in order to maintain industrial democracy	Verify whether there are at least two general staff meetings a year involving all health workers in the facility as per public Service regulations.				X		
			Verify availability of minutes of meetings showing participation of staff and recommendations.				X		
			Actions taken to implement recommendations from biannual staff meeting.				X		
			Minutes of the departmental meetings properly written up and filed.				X		

Standard	No	Indicator question	Verification criteria	Levels of service delivery				Y/P/ N/X	Re mar ks
				HOSP	HC	DISP	ALL		
<b>Productivity &amp; Performance management</b>									
The productivity and performance closely monitored, reported.	31.	Is the hospital managers has knowledge on productivities and performance management?	Verify whether the managers understand importance of productivity and performance management, and know how to measure them.	X					
	32.	Is the hospital management taking safety measure for health workforce?	Verify whether the hospital is taking safety measures to protect health workforce from occupation hazards.				X		
			Verify if staff are aware of HIV/AIDS intervention at work place policy 2008				X		
	33.	Is the hospital creating good working environment?	Verify whether the hospital understand the importance of creating good working environment for performance improvement and making effort to create good working environment.				X		
	34.	Is Supportive Supervision conducted according to the national supervision guidelines?	Verify whether the supportive supervision of different departments done by the management teams as planned evidenced through availability of supervision reports.				X		
			Verify whether the clear systems of supervision, review and appraisal in place.				X		
			Verify whether the supervisors understand their roles and lines of authority and meet regularly with their employees to develop work plan and evaluate performance.				X		
	35.	To what extent has the government performance appraisal system been implemented in the hospital?	Verify whether a fully implemented OPRA System with scheduled meetings between supervisors and subordinates taking place at the hospital level.				X		
	36.	Is Supportive Supervision conducted according to the national supervision guidelines?	Verify whether the supportive supervision of different departments done by the management teams as planned evidenced through availability of supervision reports.				X		
			Verify whether the clear systems of				X		

Standard	No	Indicator question	Verification criteria	Levels of service delivery				Y/P/ N/X	Re mar ks
				HOSP	HC	DISP	ALL		
			supervision, review and appraisal in place.						
			Verify whether the supervisors understand their roles and lines of authority and meet regularly with their employees to develop work plan and evaluate performance.				X		
	37.	Are Staff appraisals conducted at the right time?	Verify whether the semi and annual appraisals are taking place evidenced through availability OPRAS reports.				X		
	32.	Do staff feel comfortable discussing their concerns and issues with their supervisors (Please explain your response)	Verify whether the existence of an OPRA system.				X		
Verify whether the documented official minutes of meetings between supervisors and subordinates.						X			
	38.	Does the hospital have a duty roaster for staff (Daily/Weekly)	Verify whether the hospital have displayed a well-updated duty roster indicating who does what, where and when.				X		
<b>Clients/Patients Satisfaction</b>									
	39.	Are clients/patients satisfied with quality of services offered?	Verify from random clients/patients sample if are satisfied with reception, communication, organization and other health services including handling of complaints in line with Clients Services Charter of MoHSW				X		

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**Benjamin William Mkapa HIV/AIDS Foundation**

Chole Road, Plot No. 372 Masaki, Dar es Salaam

Tel: +255 (22) 2600531/ +255 (22) 2600540/2 | Fax: +255 (22) 26000543

Email: [info@mkpahivfoundation.org](mailto:info@mkpahivfoundation.org)

Website: [www.mkpahivfoundation.org](http://www.mkpahivfoundation.org)