



Assessment of Health Worker Recruitment in Tanzania

A report prepared by the Benjamin W. Mkapa HIV/AIDS Foundation

OCTOBER 2015

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Established in 2006, the Benjamin William W. Mkapa HIV/AIDS Foundation is dedicated to enhancing the delivery of quality HIV and AIDS care, treatment, and other related services, including Reproductive and Child Healthcare to Tanzanians.

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The contributions of the council health management teams (CHMTs) of 30 assessed districts are highly appreciated, particularly the District Medical Officer, District Health Secretary, and District Council in each district. We extend a special thanks to the district medical officers and district health secretaries of Iringa Municipal Council and Kilolo District Council for responding to the many questions we raised.

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EXECUTIVE SUMMARY

Inadequate human resources for health (HRH) and inappropriate deployment of health workers (HWs) pose significant challenges to developing sustainable health systems in sub-Saharan Africa. The continent has 3 percent of the world's health workforce and less than 1 percent of the world's health expenditures. In Tanzania, according to a new staffing levels guideline adopted by the MOHSW in 2014, the minimum number of HWs required to provide quality services in the health sector is 145,454. The actual number of HWs available is 70,244, leaving a shortage of 75,210, or 52 percent.

The Benjamin W. Mkapa HIV/AIDS Foundation (BMAF) and the USAID-funded Health Policy Project (HPP) commissioned this study to understand challenges and best practices in the HW recruitment process in Tanzania. The results of the study will be used to develop human resources (HR) advocacy strategies and create concise policy briefs to inform decisionmakers on the need to address the shortage of HWs.

In this report, we assess the recruitment and deployment process for the health workforce by cadre, service level, and geographical area. To that end, we examine HRH needs, requests for staffing permits, permits approved, HWs recruited, and HWs posted in 30 Big Results Now (BRN) and non-BRN districts¹ in the three most recent years for which data are available: 2011/12 to 2013/14.

In addition to quantitative analysis of the recruitment process, we undertook semi-structured interviews to gain a more holistic understanding of the bottlenecks in HRH recruitment as perceived by key stakeholders.

Overall, we found that the government of Tanzania has established a clear system for the recruitment of HWs, with policies, guidelines, and systems to support the recruitment process. However, despite these notable successes, districts are not getting all the staff they request, and the Ministry of Health and Social Welfare (MOHSW) has not been able to post all approved staff to district councils. The first priority should be to get most, if not all, current positions filled to build a case for increasing the number of HW recruitment permits granted by PMORALG.

¹ Big Results Now (BRN) is an initiative of the Tanzanian government, through which the government strives to improve HRH distribution, among other goals, in nine focus regions with critical HRH shortages: Geita, Kagera, Katavi, Kigoma, Rukwa, Shinyanga, Simiyu, Singida, and Tabora.

ABBREVIATIONS

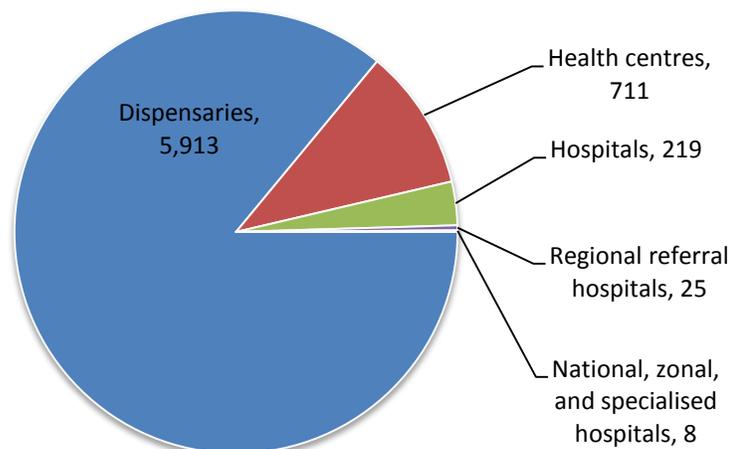
AIDS	acquired immunodeficiency syndrome
AMO	Assistant Medical Officer
BMAF	Benjamin W. Mkapa HIV/AIDS Foundation
BRN	Big Results Now
CHMT	council health management team
DC	district council
DHRO	District Health Resource Officer
HIV	human immunodeficiency virus
HRH	human resources for health
HPP	Health Policy Project
HRHIS	Human Resources for Health Information System
HRM	human resources management
HW	health worker
LGA	local government authority
MC	municipal council
MOF	Ministry of Finance
MOHSW	Ministry of Health and Social Welfare
PE	personnel emolument
POPSM	President's Office, Public Service Management
PMORALG	Prime Minister's Office, Regional Administration and Local Government
TC	town council
USAID	U.S. Agency for International Development
WHO	World Health Organization

INTRODUCTION

Background

Inadequate human resources for health (HRH) and inappropriate deployment of health workers (HWs) pose significant challenges to developing sustainable health systems in sub-Saharan Africa. The continent has only 3 percent of the world's health workforce and less than 1 percent of the world's health expenditures. As governments and donors have responded to the HIV/AIDS crisis by supporting prevention, care, and treatment initiatives, the fragility of health systems and the insufficiency of the health workforce have been illuminated. In Tanzania, a Ministry of Health and Social Welfare (MOHSW) report (MOHSW, 2014) shows that in 2013 there were a total of 6,876 health facilities in the country (see Figure 1).

Figure 1. Health Facilities in Tanzania



According to a new staffing levels guideline issued by the government of Tanzania in 2014, the minimum number of HWs required to provide quality services in the health sector is 145,454. However, as of 2014, the number of HWs available was 70,244. This equates to a shortage of 75,210 HWs, or 52 percent of the minimum staffing requirement.

This shortage is more pronounced in rural and hardship areas, and among mid-level HWs, such as nurses, clinicians, midwives, and pharmaceutical and laboratory technicians. The HRH available to provide skilled attendance at birth is 7.74 per 10,000 population, a third of the World Health Organization (WHO) recommended level of 22.8 per 10,000, compromising the ability of the health system to deliver quality health services to its people.

The government of Tanzania has taken steps to alleviate the HW shortage through various initiatives. In 2013, Tanzania committed to addressing three key HRH areas, which were also publicly declared at the Third Global Forum for HRH in Brazil. These commitments are as follows:

1. Increase the availability of skilled HWs at all levels of health service delivery from 46 percent to 64 percent by 2017, based on 2013 staffing levels. To realise this goal, the government of Tanzania has committed to increasing the HW-to-population ratios of districts in five regions (Kigoma, Rukwa, Shinyanga, Singida, and Tabora) from 0.73 HWs per 1,000 population to the national average of 1.47 HWs per 1,000 population.
2. Increase the financial base (other charges and private sector investment) to operationalise the pay incentive policy by 2017 to promote HW retention and productivity, and improve the quality of health services.
3. Develop an operational guideline based on the consolidated 2013 WHO guideline on task sharing to enhance existing production and quality assurance systems by 2015 (MOHSW).

In addition to these international commitments, the government of Tanzania has also incorporated the health sector into its signature Big Results Now (BRN) initiative, through which it strives to improve HRH distribution, among other goals. Nine regions with critical HRH shortages were selected as focus regions for BRN. These regions are Geita, Kagera, Katavi, Kigoma, Rukwa, Shinyanga, Simiyu, Singida, and Tabora.

However, for these efforts to be successful, programmatic decision making must be evidence based. Efforts to recruit and redistribute HWs to critical areas must address the key bottlenecks that have inhibited HW supply in these areas in the first place.

Purpose of the Assessment

Therefore, in support of these efforts, this study analyses recruitment trends in recent years and identifies challenges contributing to poor HW staffing in under-served areas. It also provides recommendations to improve the recruitment process in Tanzania. The information will be used for the following purposes:

- **Support HRH advocacy:** This assessment will help determine strengths and areas for improvement in staff recruitment and retention. This information will be used to develop HRH policy briefs for use in advocating for an effective recruitment process and resource allocation.
- **Source document for the Health Sector Strategic Plan (HSSP) IV strategy development:** The Benjamin W. Mkapa HIV/AIDS Foundation (BMAF) will share the preliminary findings of the recruitment assessment with key policymakers during development of the HSSP IV HRH component. The policymakers will be informed about the gaps in existing human resource management (HRM) systems and recommendations on priority areas that will result in significant improvements in staff recruitment management to increase productivity. We expect that the strategies developed will be geared to address the gaps in current HRH management systems.
- **Informing HRM and learning:** The information from the assessment will be used to inform the MOHSW and other key HRH stakeholders in Tanzania on the HRH process at district level. To ensure that lessons learned from the assessment are used to continue improving HRM systems and working environments in the districts, BMAF will use the HRH briefs developed to engage the Tanzanian HRH Technical Working Group during their bimonthly meetings.

METHODOLOGY

In this report, we assess the process of recruitment and deployment of the health workforce by cadre, service level, and geographical area. To that end, we characterised districts' needs for HRH, requests for staffing permits, permits approved, HWs recruited, and HWs posted in the three most recent years for which data are available: 2011/12 to 2013/14. In addition to quantitative analysis of the recruitment process, we also undertook semi-structured interviews to gain a more holistic understanding of the bottlenecks in HRH recruitment as perceived by key stakeholders.

Region and District Sampling

Regions

Assessment regions were purposively sampled to be representative of various levels of HRH performance while allowing for specific comparisons between BRN and non-BRN regions. Several factors were considered in choosing the regions, including the following:

- BRN focus districts
- Poor infrastructure and hard-to-reach areas
- HRH performance indicators, including staffing levels for professional cadres
- Regions that benefited from the previous HRM intervention by BMAF and IntraHealth

Seven regions were selected after a series of consultative meetings with the BMAF team; consultants; and facilitators from the MOHSW; the President's Office, Public Sector Management (POPSM); and the Ministry of Finance (MOF). These seven regions are Geita, Iringa, Kilimanjao, Mtwara, Pwani, Ruvuma, and Shinyanga. Four of these regions (Geita, Mtwara, Pwani, and Shinyanga) are BRN-targeted regions. Iringa, Kilimanjaro, and Ruvuma are non-BRN regions with relatively good performance in HRH staffing level indicators compared with BRN regions. All regions except Kilimanjaro and Pwani benefited from the Tanzania Human Resource Capacity project led by BMAF and IntraHealth International from 2010 to 2014.

District Councils (DCs)

From the seven regions, 30 districts were selected to provide a mix of urban and rural settings (Table 1). All urban districts from each region were included because there are very few of them.

Table 1. Regions and Districts Sampled for the Assessment

Region	# Districts	Names of Districts
Geita	2 (Urban 0, Rural 2)	Bukombe DC, Chato DC
Iringa	5 (Urban 1, Rural 4)	Kilolo DC, Mafinga DC, Iringa DC, Iringa MC, Mufindi Town council (TC)
Kilimanjaro	7 (Urban 1, Rural 6)	Same DC, Mwangi DC, Siha DC, Rombo DC, Hai DC, Moshi DC, Moshi TC
Mtwara	5 (Urban 2, Rural 3)	Tandahimba DC, Masasi DC, Masasi TC, Mtwara DC, Mtwara Municipal Council (MC)

Pwani	5 (Urban 1, Rural 4)	Kisarawe DC, Rufiji DC, Bagamoyo DC, Kibaha DC, Kibaha TC
Ruvuma	4 (Urban 1, Rural 3)	Mbinga DC, Namtumbo DC, Songea DC, Songea TC
Shinyanga	2 (Urban 1, Rural 1)	Shinyanga MC, Shinyanga DC

Data Collection Tools

Two primary tools were used in data collection. The spreadsheet-based Recruitment Data Matrix was the template for structured quantitative data collection on staffing needs and recruitment numbers. Key informant interview guides were used to collect qualitative data to explain the observed recruitment trends and challenges.

Tool 1: Recruitment Data Matrix

The matrix was used to collect data on staff requested, staff permits approved, new staff posted, staff reported, and staff attrition rate.

Tool 2: Key informant interview guides

Key informant interview guides were developed for MOHSW officials, POPSM officials, and Local Government Authority (LGA) officials. The interview guides included open-ended questions to assess the role of each key actor in the recruitment process, coordination, and challenges in the process.

Examples of guide questions include the following:

- Do you have staff recruitment plans for the short and long terms?
- Do you have adequate professional staff in the districts? If not, what is the vacancy rate? How does the shortage affect service delivery? Give concrete examples.
- Are staff posted based on staffing needs? If not, how does this affect staff productivity?
- Do you get the staff mix you request? If not, why?
- How do you negotiate and compromise in case the permits granted do not meet your staffing requirements?
- Assess the distribution of staff to health facilities in rural and urban settings. Are new staff distributed in the facilities in urban and rural settings based on needs and requested cadre mix?
- What advocacy tasks will generate more attention from policymakers to improve the recruitment process?

Data Collection

The assessment used both quantitative and qualitative data collection methods to collect HWs' recruitment data.

HRH data

Data on staff requested, approved, posted, hired, and distributed were obtained from district councils, the MOHSW Human Resources for Health Information System (HRHIS) database, and the POPSM LAWSON database.

Key informant interviews

Qualitative information was collected from semi-structured interviews with government officials at the national and district levels. This information was used to complement the quantitative data and provide insight into staffing needs, bottlenecks in the recruitment process, and priority areas for advocacy.

Table 2. Key Informant Interviews by Organisation and Position Title

Organisation	Informant title	Respondents
LGAs	<ul style="list-style-type: none">• District Medical Officer and District Health Secretary of Iringa MC• District Medical Officer and District Health Secretary of Kilolo DC	4
MOHSW	<ul style="list-style-type: none">• Director of Human Resource Planning• Human resource officer	2
POPSM	<ul style="list-style-type: none">• Assistant Director of Human Capital Management	1
MOF		1
Total		8

Limitations

Due to resource constraints, the assessment sampled only 30 out of 120 LGAs in the country. However, key indicators were compared with national averages to inform the interpretation of results.

To increase confidence in the data, some HRH indicators were triangulated from different data sources. For example, staffing requirements, staff available, and staff hired were collected in parallel from POPSM, the MOHSW, and LGAs. Indicators from different sources sometimes did not match. To address this situation, researchers and external consultants convened to determine which source was most reliable, and the consultants worked with relevant government staff to conduct data cleaning.

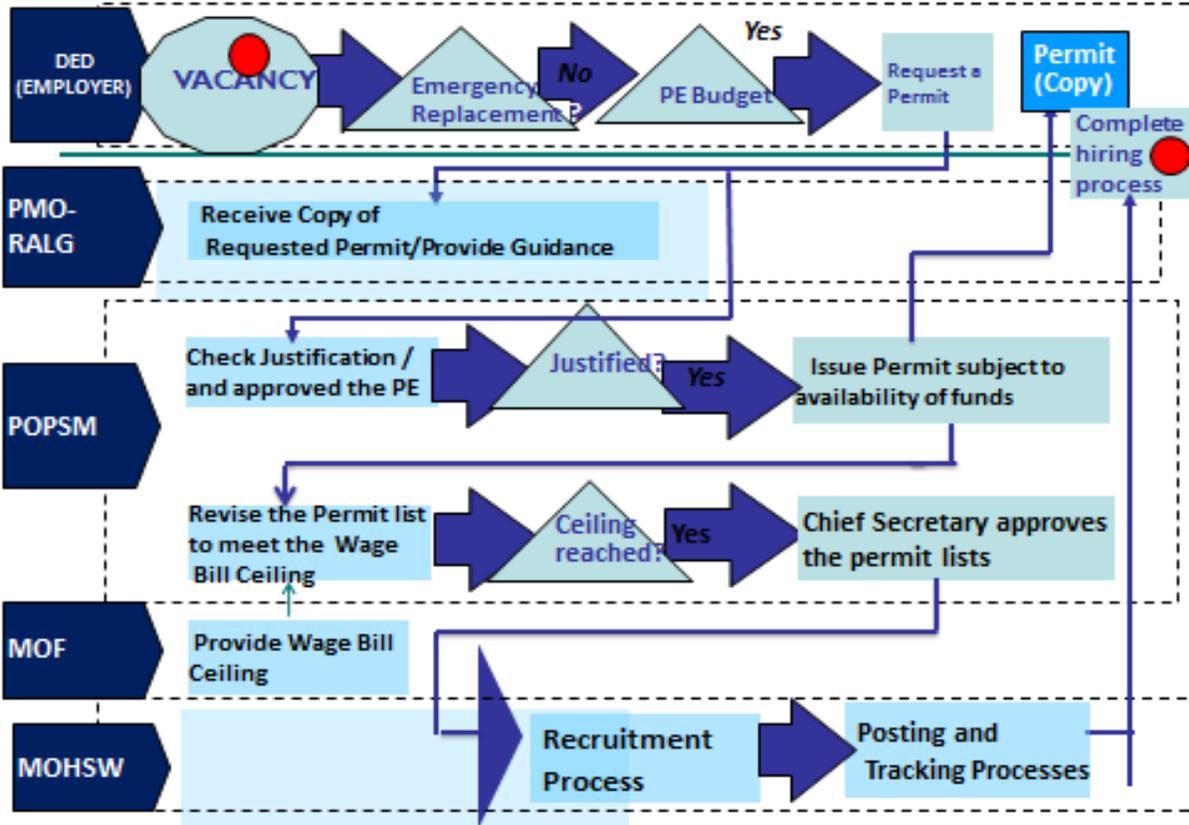
Due to the simultaneity of qualitative data collection with the annual district planning period, respondents were often unavailable, and researchers were not able to complete all of the intended interviews as planned. However, researchers did complete interviews with key council staff, MOHSW staff, and POPSM staff involved in the HW recruitment process.

RESULTS

Recruitment Process for New Health Workers

According to key respondent interviews, recruitment of HWs involves a complex interplay of four government entities: LGAs, POPSM, the MOF, and the MOHSW. Each body has a different role in facilitating the recruitment process. Figure 2 summarises these relationships.

Figure 2. Recruitment Process Flow



Staffing requests

Council health management teams (CHMTs) develop the Personnel Emolument (PE) budget using the staffing norms and PE budget ceiling from the previous year. The PE budget includes salaries for existing staff, promotions, and new staff. The districts said that hiring priority is given to the health, education, and agricultural and livestock sectors, and POPSM confirmed this information.

According to CHMT members interviewed, each department within the district uses its staffing norm to request new staff. Therefore, the CHMT members said there is no negotiation for staff hiring among the different departments, nor is there any political influence on the decision as to the number of new staff to request. The District Health Secretary and CHMT members use current staffing levels and the previous year’s PE budget to prepare a list of new staff requests by cadre. The District Human Resource Officer (DHRO) reviews the new staff requests for all departments, consulting them for clarification when needed. The DHRO then prepares the PE budget projection to be sent to POPSM.

In previous years, districts would send a team to POPSM to defend the PE budget requests before approval. In 2013/14, POPSM introduced the LAWSON system, a web-based human resource database. Therefore, councils are now submitting requests for new staff online. POPSM verifies that all information from each district is accurate and in line with staffing norms, that there are facilities to accommodate the new staff, and that their roles and responsibilities have been clearly stipulated. If these conditions are met, POPSM approves the PE budget for salaries for existing staff and new employees, subject to availability of funds.

Permits

The role of the MOF in this process is to collect government funds from different sources and distribute them to the districts according to budgets. Priority is given to existing staff salaries, other charges, and development grants. Any funds remaining can be allocated for new staff. The MOF sets a general ceiling for the wage bill at the national level, and POPSM allocates the budget for existing staff salaries and promoted staff as agreed with the district councils.

According to POPSM, this budget usually does not accommodate all requests for new staff. To bring the number of new staff permits approved into alignment with funding availability, POPSM reviews and reduces the number of permits which were approved. District councils are not involved in this second review of permit approvals, partly because the wage bill ceiling given by the MOF is set nationally. The number of permits requested by the LGAs is reduced by considering the availability of cadres in the market. Requests for skilled cadres, such as medical doctors, medical specialists, and assistant medical officers (AMOs), are usually reduced because these cadres are not readily available in the labour market. Following these amendments, POPSM compiles the final permit list and sends it to the Chief Secretary at the President's Office, who reviews and approves the permits. The POPSM Permanent Secretary then sends the list of approved permits for new health workers to the MOHSW for posting and to district councils for follow-up and hiring.

Recruitment

The role of the MOHSW is to facilitate and support districts in recruiting new staff. The MOHSW's Department of Administration and Human Resource Management receives the approved permits from POPSM and posts recent graduates to fill these positions based on their qualifications. In previous years, offers to new recruits were made via letter; currently, these placements can be accessed on the MOHSW website. This new system has helped reduce forgery because districts can quickly confirm the credentials of all arriving staff through the website. Districts can also receive up-to-date information about staff postings via the web.

When new staff report to the districts, they receive a subsistence allowance and an orientation. Their details are uploaded to the online system, and they are entered into the payroll. Typically, staff begin receiving their salaries one to two months after reporting; before the online system was introduced, it took a minimum of four to six months.

Staff Availability and Shortages

An effective human resources recruitment plan is highly dependent on the accuracy of forecasting methods for HWs and underlying assumptions. This study used the staffing norms of 1999 for forecasting HW requirements for the years 2011/12 and 2012/13, and new staffing norms for requirements in 2013/14.

In 2014/15, the number of HWs available in 30 assessed districts was 8,224, which was a shortage of 13,160, or 62 percent (Figure 3). Nationally, the HW staff shortage in Tanzania shortage stands at 52 percent, which is lower than in the study areas. The trend shows the staff shortage increasing from 22 percent in 2013/14 to 62 percent after the new staffing norm was introduced in 2014/15. This shortage compromises the ability of facilities to offer high-quality healthcare services to clients.

The slow growth of available staff has remained constant, showing that hiring of new staff has not yet increased significantly after the introduction of the new staffing levels in 2013 (Figure 3). Retention of HWs is very high once they have been hired. On average, around 98 percent of HWs are retained.

Figure 3. Availability of Staff in 30 Facilities (2011/12 through 2013/14)

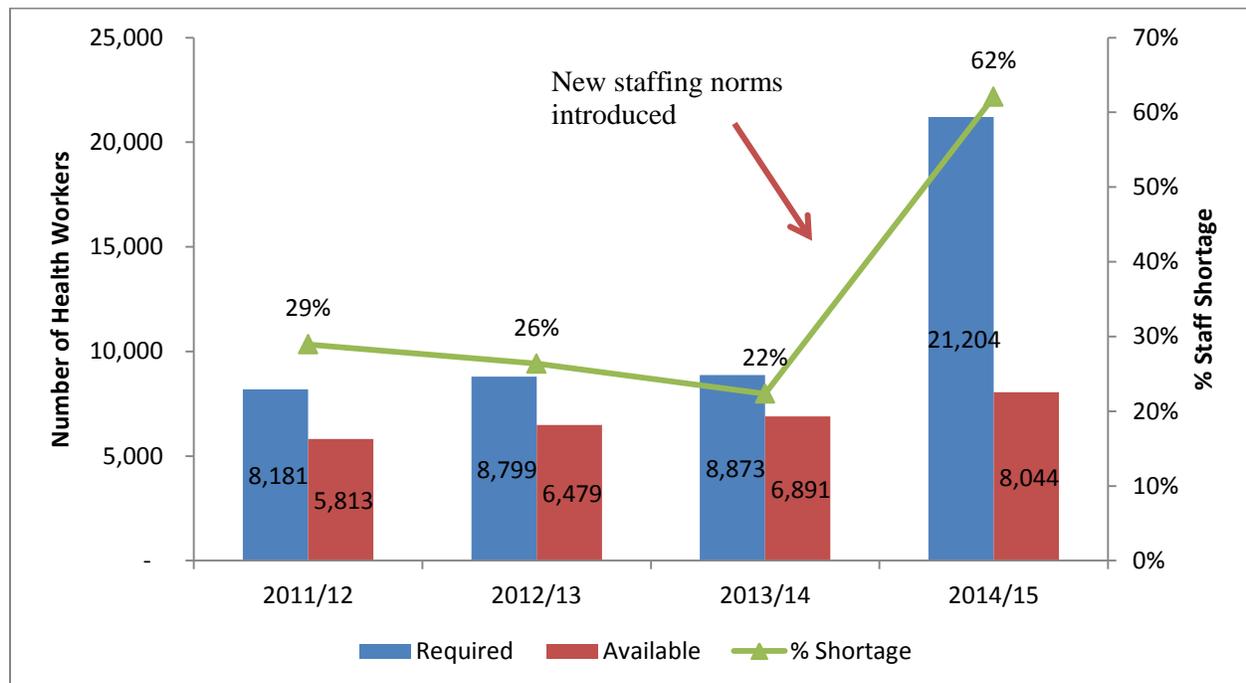
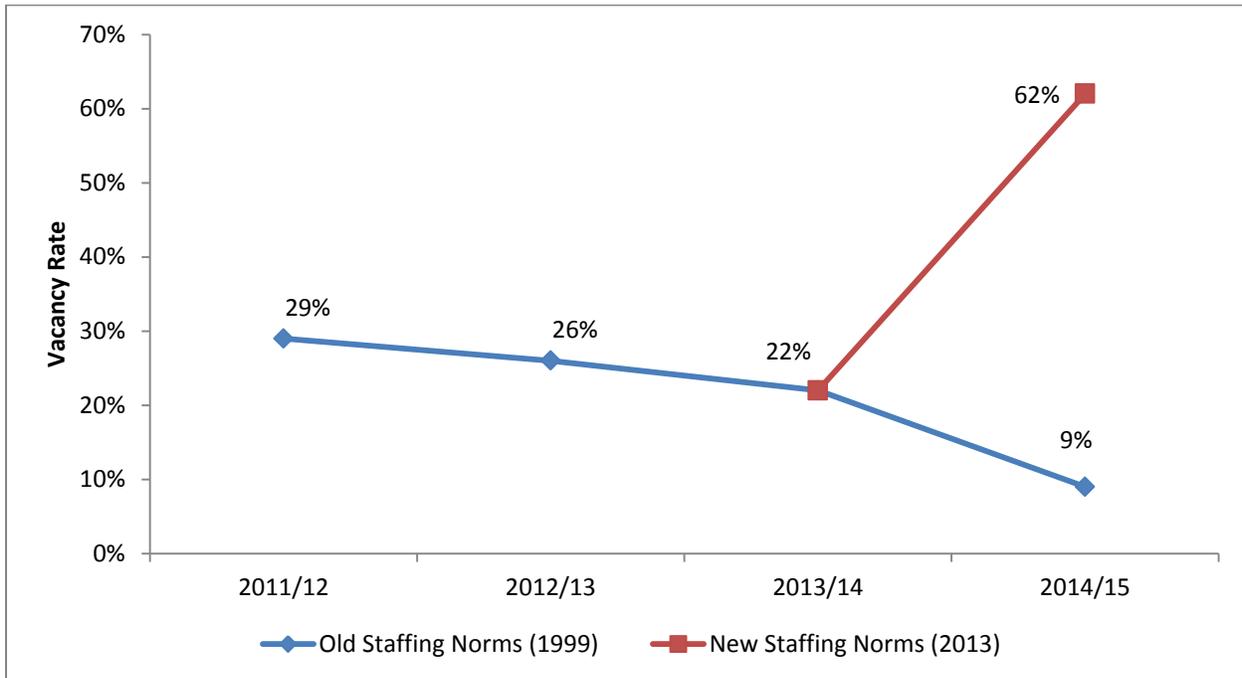


Figure 4 shows vacancy rate trends before and after the introduction of new staffing norms. The staffing shortage increased from 22 percent to 62 percent after the new staffing levels were introduced in 2014/15. However, if 1999 staffing norms had continued, the gap would have actually decreased from 21 percent to 9 percent, assuming staffing requirement remained at the same level (8,873) in 2014/15. These findings indicate that the recruitment of HWs did not increase to reflect change in the policy document. Moreover, interpretation of staff shortages is highly dependent on what staffing norms are used.

Figure 4. Staffing Status in 30 Districts Using New and Old Staffing Norms



Data from MOHSW using new staffing norms indicate that health facilities required 21,204 staff in 2014/15, whereas data from the districts show a staffing requirement of only 11,935 in 2014/15. This difference indicates that some districts are still using the old 1999 staffing norm. Similar concerns were raised in the MOHSW 2014 annual report. There is a need to disseminate the new staffing norms to district councils.

Staffing Levels by Cadre

Altogether, 11,783 (59 percent) HW positions are vacant. Critical staff shortages extend across all cadres of the health workforce. Vacancies are highest among nurses (5,207). Unfilled positions are also particularly high for AMOs (1,595), health laboratory technologist assistants (1,213), assistant clinical officers (1,025), and medical doctors (235). Other cadres, including medical attendants, assistant environmental health officers, and health secretaries have less severe shortages in comparison (see Table 3). All positions are filled for the cadre of environmental health officers.

Table 3. Staff Availability, by Cadre (2014/15)

#	Cadre	Required	Available	Shortage	Percentage shortage
1	Assistant Biomedical Tech	48	25	23	48
2	Assistant Dental Officer	166	7	159	96
3	Assistant Environmental Health Officer	207	281	-74	-36
4	Assistant Medical Officer	1,744	149	1595	91
5	Assistant Nursing Officer	971	655	316	33
7	Clinical Assistant	1,307	282	1025	78
8	Clinical Officer	1,642	1213	429	26

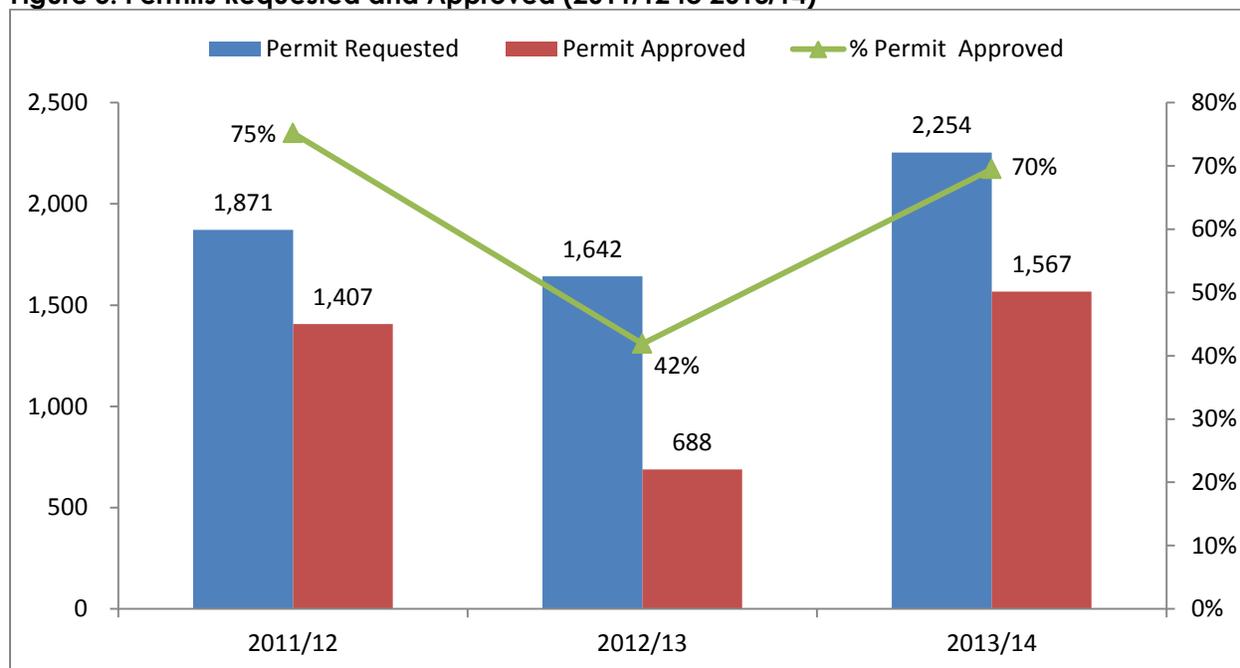
#	Cadre	Required	Available	Shortage	Percentage shortage
9	Dental Surgeon	25	14	11	44
10	Dental Therapist	181	44	137	76
11	Environmental Health Officer	24	79	-55	-229
12	Health Laboratory Scientist	24	14	10	42
13	Health Laboratory Technologist Assistant	1,398	185	1213	87
14	Health Laboratory Technologist	222	153	69	31
15	Health Secretary	49	52	-3	-6
16	Medical Attendant	3,311	2565	746	23
17	Medical Doctor	341	106	235	69
18	Nurse	7,220	2013	5207	72
19	Nursing Officer	288	134	154	53
20	Optometric Technologist	25	0	25	100
21	Optometrist	171	0	171	100
22	Pharmaceutical Technologist	220	37	183	83
23	Physiotherapist	24	11	13	54
24	Physiotherapist Assistant	1	0	1	100
25	Radiographer	172	4	168	98
26	Ophthalmologist	25	0	25	100
	Total	21,180	8,023	11,783	59

Requests for Recruitment Permit and Approval

The government of Tanzania's policy on local government reform in human resources states that "the LGAs will be fully responsible for planning, recruiting, rewarding, promoting, disciplining, development and firing of their personnel. LGAs will adopt staffing plans and budgets." According to key respondents, the implementation of this policy has not been as successful as expected because, in reality, the staff recruitment approval process and budget are still determined at the central level. This fact limits the ability of district councils to plan and recruit staff based on their needs.

Figure 5 shows the trend for new staff permits requested and approved by POPSM for the past three years. The trend shows a fluctuating pattern, in which 75 percent of permits were approved in 2011/12, 42 percent in 2012/13, and 70 percent in 2013/14. Respondents reported that the primary reasons for not approving all requests include a lack of funds to accommodate requests and the unavailability of more skilled cadres, such as medical specialists, AMOs, medical doctors, nursing officers, and biometric engineers. The total request for these cadres is usually greater than what is produced in the market, and POPSM is forced to distribute the few available staff between 120 councils. Therefore, the majority of councils will not have their full staffing request approved.

Figure 5: Permits Requested and Approved (2011/12 to 2013/14)



For some cadres, the discrepancy between the projected staff shortage and the number requested can be large, suggesting that not all councils are using the new staffing norms to determine their needs. The majority of requests for more skilled cadres, such as medical doctors, AMOs, and clinical officers, are approved by POPSM, perhaps because the number requested is relatively small. It is interesting to note that medical attendants and nurses have had the lowest percentage of permits granted in the past two years (See Table 4.)

Table 4. Staff Shortage, Permits Requested and Approved in 2013/14

Designations	Staff shortage	Permits requested	Permits approved	Percentage approved
Medical Doctor	259	70	50	71
AMO	1,597	49	70	143
Clinical Officer	561	302	274	91
Assistant Nursing Officer	553	179	98	55
Nurse	5,455	614	310	50
Nursing Officer	170	80	40	50
Medical Attendant	944	306	96	31

As mentioned previously, the districts are not consulted during the second review of permits done by POPSM, after the MOF provides a wage bill ceiling. Reportedly, districts often receive permits for a number of staff they did not request. These staff members are usually of a lower cadre than the staff requested and are not sufficiently skilled to offer quality services.

Only five out of 20 districts that requested medical doctors were given permits to match their full request (Chato DC, Moshi DC, Mwanga DC, Namtumbo DC, and Shinyanga MC). Only three districts received permits to recruit AMOs and nurses to match their full requests. No district got permits to recruit the

number of medical attendants they requested. Annex A reports staff requests and approvals for all sampled districts.

During key respondent interviews, representatives from POPSM explained that they look at the HRH production data to determine which cadre is available in the market and then approve requests for staffing permits. However, from the data in Annex A, it is still unclear how POPSM determines which permits to approve.

The decisionmakers at POPSM/MOF have not been exposed to routine work at health facilities. They are not aware of the workload of providers or the working environment in health facilities. They don't see patients suffering or losing their lives because of lack of treatment due to lack of qualified personnel to offer quality treatment. It is very important to arrange regular visits with them to the facilities see the situation in the health facilities so [they can make an] informed decision.

– MOHSW representative

The POPSM Assistant Director agreed that visits to health facilities to understand working conditions would be very useful for POPSM and MOHSW staff to understand the situation facing health facilities and inform their approval decisions.

Staff Posting and Reporting

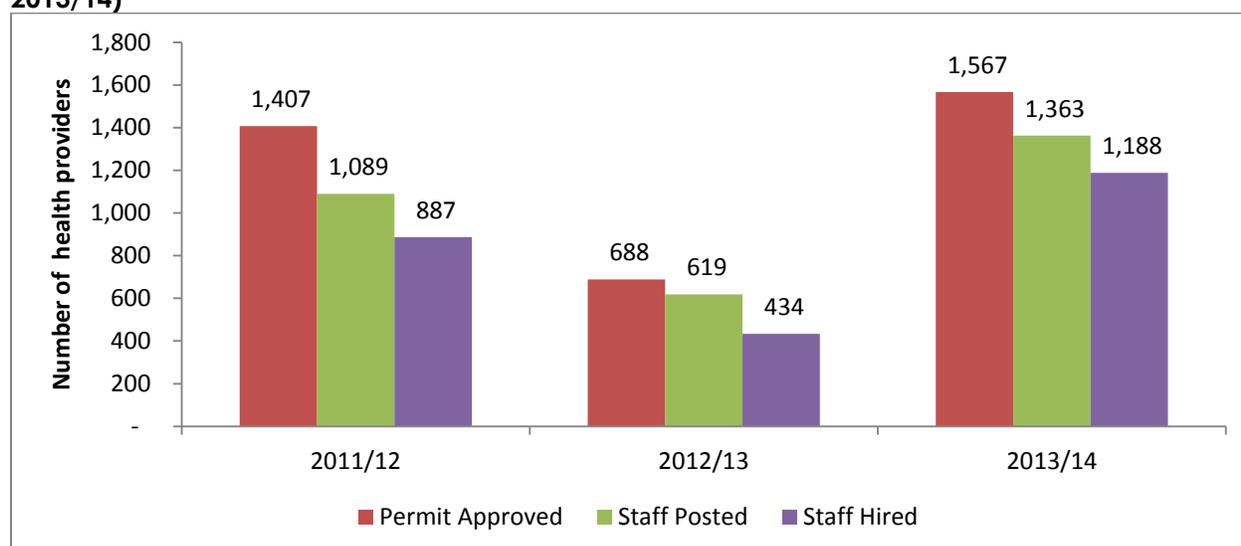
The role of the MOHSW is to support districts in recruiting new staff. The Department of Administration and Human Resource Management receives approved permits, by cadre, from POPSM and posts recent graduates who have applied for the posts, based on their qualifications and an approved permit. The recruitment trend for HWs in the whole country for the past four years shows that the number of HWs available is lower than the number of approved positions; around 74 percent of approved positions were posted in the past four years. The lowest availability was in 2013/14, when only 68 percent of approved positions were posted.

Table 5. Permits Approved and Staff Posted (2010/11 through 2013/14)

Year	Permits approved	Staff posted	Percentage
2010/11	7,471	5,687	76
2011/12	9,391	7,028	75
2012/13	6,959	5,762	83
2013/14	11,221	7,677	68
Total	35,042	26,154	74

Similar trends are apparent in the 30 districts included in the assessment.

Figure 6. Approved Permits, Staff Posted and Hired in 30 Sampled Districts (2011/12 through 2013/14)



Respondents cited several important contributing factors to explain this trend:

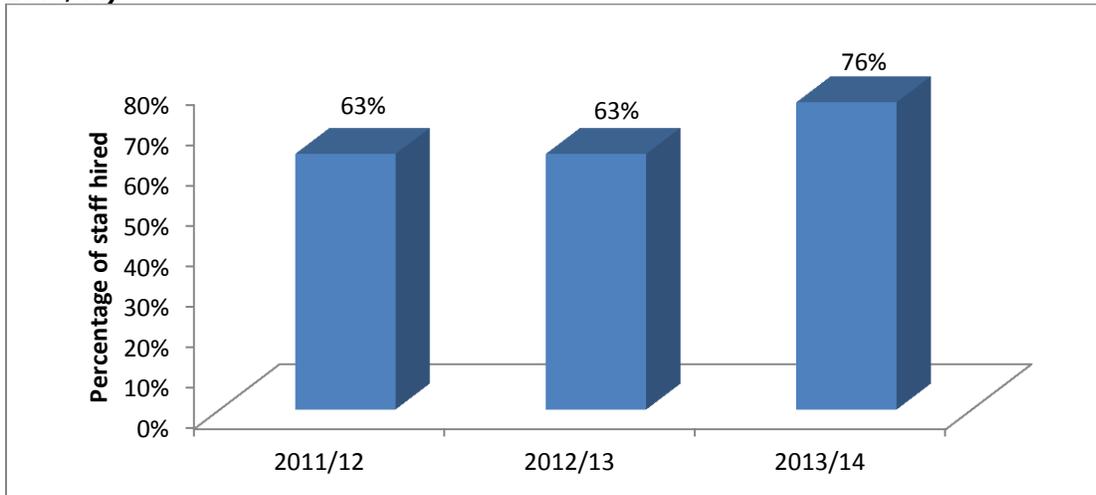
- 1) Some cadres (particularly medical specialists, medical doctors, AMOs, and pharmacists) are not readily available in the labour market.
- 2) Medical specialists and AMOs are upgrade courses for staffs that have already been employed in the health sector and are in short supply.
- 3) Cadres in high demand often prefer to work in urban areas.
- 4) The nursing officer degree has begun being offered only recently, despite high demand for this cadre.
- 5) Women health workers often relocate to where their husbands work.

According to POPSM, the wage bill budget for 2013/14 was about 6.5 trillion shillings for the entire public sector—52 percent of the national budget. It will be very difficult for the government to increase the budget for HWs because of other government priorities. In addition, the MOHSW has not been successful in posting all approved positions, and allocations for new staff are not fully utilised. POPSM's role is to ensure that funds are utilised properly, so unless the MOHSW is able to post most of the approved positions, it is unlikely that POPSM and the MOF will substantially increase permits to recruit new staff.

Interviews with district staff found that staff postings match the cadres according to permits approved, but not all staff who are posted actually report to the districts. The council receives a list of the staff posted on the MOHSW website. However, tracking of posted staff is difficult because the list on the website does not include adequate contact information (i.e., mobile number) for posted staff. A better tracking system is needed to reach out to posted staff and encourage those who have not yet made their decisions to accept the postings.

The data for 30 districts were examined further to determine the gap between approved permits and hired staff. Findings show that while the hiring trend has increased recently, nearly one quarter (23%) of approved staff members were not hired in 2013/14. In other words, 23 percent of approved funds that were set aside to pay salaries and benefits for new staff were not utilised (Figure 7).

Figure 7. Percentage of Requested Staff Who Were Hired in 30 Sampled Districts (2011/12 through 2013/14)



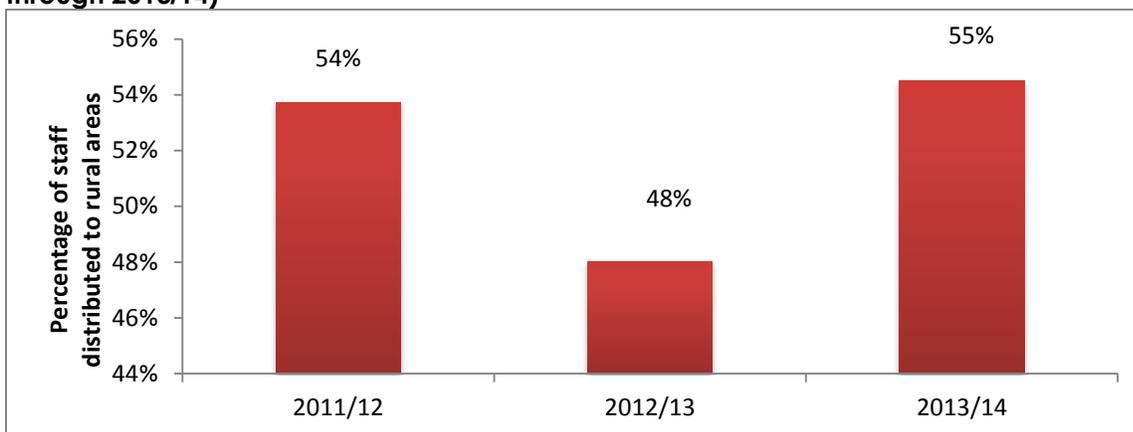
Urban and rural distribution of new staff hired

Respondents from the MOHSW report uneven distribution of staff in urban and rural areas. Seventy-four percent of medical doctors are found in urban settings, with a doctor-to-population ratio 17 times greater in urban settings than in rural areas. Nationally, Dar es Salaam, Kilimanjaro, and Mwanza have two-thirds of all skilled HRH (MOHSW, 2014).

The analysis shows that roughly half of HWs are distributed to urban locations, even though these locations comprise only 30 percent of sampled districts. Kibaha DC, Kibaha Town Council, Moshi DC, and Songea Municipal Council, located in urban settings, have exceeded their staffing levels. In this assessment, “urban” is defined as all facilities in the jurisdiction of municipal councils (MCs) or town councils (TCs) and hospitals in the jurisdiction of the district councils. Likewise, around half of hired staff members were distributed to rural facilities despite the fact that rural areas represent 70 percent of the assessed districts.

Respondents reported that staff members prefer to work in urban rather than rural areas for many reasons, including the availability of social services, co-location with a spouse, and better working environment.

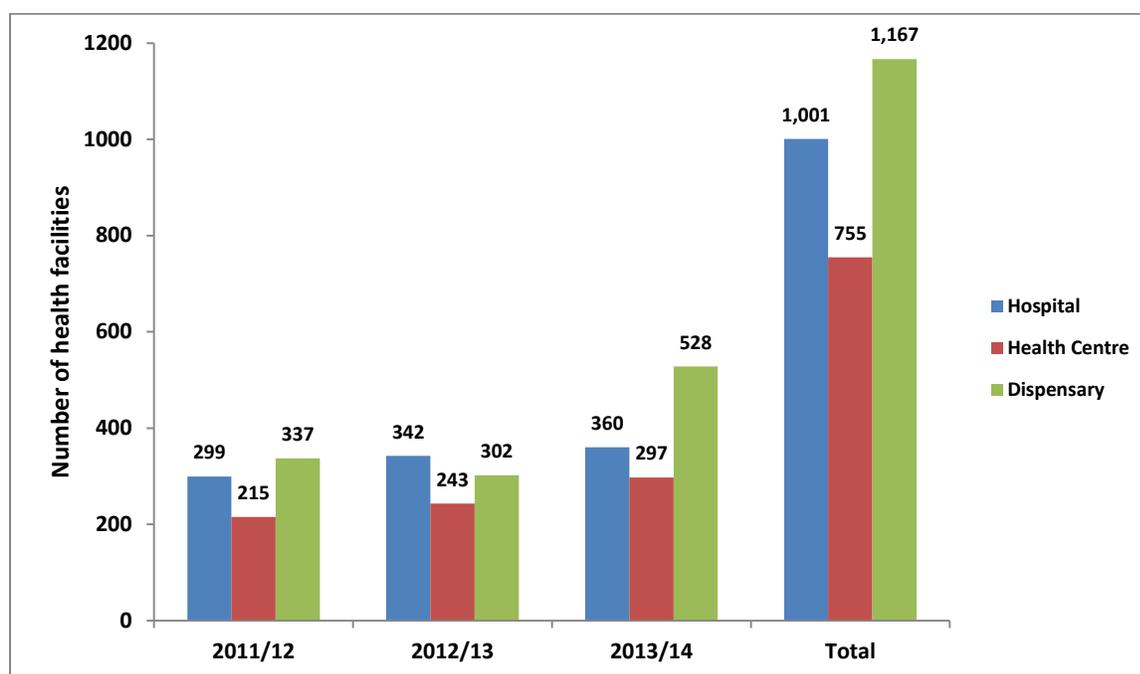
Figure 8. Percentage of Staff Distributed to Remote Facilities in 30 Sampled Districts (2011/12 through 2013/14)



Distribution of Hired Staff in Health Facilities

The data show that most staff are posted to dispensaries, followed by hospitals and health centres. Dispensaries account for more than 80 percent of facilities in the districts, but hospitals offer a wide range of services and have greater staffing requirements.

Figure 9. Distribution of Staff Hired by Facility Type (2011/12 through 2012/13)



Use of Multiple Systems to Collect HRH Data

POPSM has developed LAWSON, a human resource management system for the public sector, which combines many human resources functions, including benefits administration, payroll, recruiting, and training into one package. Through this web-based system, functions for the recruitment of new staff are now online. LAWSON can generate various reports, such as staff expecting to retire, number of new staff, staff attrition, and so on. The system has improved management of data and utilisation of resources despite the challenges of implementing and updating it.

[The] LAWSON system is very useful and generates a lot of HR reports. The database is also linked to [the] payroll system and staffs are entered in payroll on time after introducing the system. Before this system, it took four to six months to get the staff in the payroll and new staff were sent back home while waiting to be entered in the payroll. The system is very useful and encompasses information for around 500,000 government employees.

– Assistant Director, POPSM

In parallel, the MOHSW, with support from JICA, developed the HRHIS for recording HW information in the public and private sectors. The information that the MOHSW is collecting for the public sector is also collected in LAWSON by the same council staff. We compared the number of staff in the 30 study

districts using data generated from both the LAWSON and HRHIS systems. Table 6 compares the data on staff available from 24 councils. HRHIS reports indicate 20 percent more staff available than LAWSON (a difference of 1,478) in the same districts. The data are different across the two systems, and five districts (Mafinga DC, Masisi TC, Moshi MC, Same DC, and Mwanga DC) have a difference of more than 100 staff.

Table 6. Comparing Data from LAWSON and HRHIS for Staff Available in 24 facilities (2013/14)

Council Name	Staff available (LAWSON)	Staff available (HRHIS)	Difference
1 Bukombe DC	233	316	83
2 Chato DC	238	241	3
3 Hai DC	271	339	68
4 Iringa DC	266	289	23
5 Iringa MC	273	294	21
6 Kibaha MC	178	257	79
7 Kilolo DC	190	246	56
8 Kisarawe DC	309	399	90
9 Mafinga DC	371	491	120
10 Masasi DC	97	232	135
11 Mbinga DC	456	529	73
12 Moshi DC	358	383	25
13 Moshi MC	363	722	359
14 Mwanga DC	306	410	104
15 Namtumbo DC	232	242	10
16 Rombo DC	244	267	23
17 Rufiji DC	284	314	30
18 Same DC	303	418	115
19 Shinyanga DC	162	178	16
20 Shinyanga MC	157	156	-1
21 Siha DC	132	133	1
22 Songea DC	181	209	28
23 Songea MC	210	209	-1
24 Tandahimba DC	248	266	18
Total	6,062	7,540	1,478

CONCLUSIONS AND RECOMMENDATIONS

This analysis has identified a number of notable successes in the area of HRH. The government of Tanzania has established a clear system for HW recruitment through policies, guidelines, and systems that support the recruitment process. Key policy documents that inform HW recruitment include staffing norms and PE budget guidelines. POPSM has also established LAWSON, a web-based system that has sped up the recruitment of HWs. The LAWSON database manages data for all employees in the country, such as personal data, designation, and promotions. LAWSON has enabled councils to request permits for new staff online. Moreover, posted HWs are now entered on the payroll within one month of reporting.

Despite these accomplishments, districts are still not getting the health staff they request, and the MOHSW has not been able to post all of the approved staff to councils.

Key Findings and Recommendations

Our findings show that, over the past four years, the MOHSW has faced challenges in filling the approved permits for HWs. It is unlikely that PMORALG will approve greater numbers of staffing permits until the MOHSW has shown that it can fill existing permits. In 2013/14, 26 percent of approved permits for HWs were not filled. The availability of some cadres, such as AMOs and registered nurses, is very limited in the labour market. However, councils are requesting these cadres because they are not using HW production data to inform their staffing requests. The MOHSW receives lists of graduates from government health universities and colleges and allocates new staff to councils based on permits approved and location preference.

- The MOHSW should consider providing information about the availability of HW cadres to CHMTs for the staffing planning cycle and supporting councils to prepare their staffing requests based on the state of the labour market. The number of students graduating each year should be made accessible to districts for use in determining the number of staff permits to request.
- After updating the permit list to reflect the budget wage bill ceiling, POPSM should consider requesting feedback from district councils on the revised permit list before submitting it to the Chief Secretary for final approval. District councils should ensure that approved requests reflect the optimal mix of cadres, and if not, they should propose a more appropriate mix based on staff available in the market.
- The MOHSW should consider expanding the scope of recruitment to cover non-government health institutions. The MOHSW could strive to attract more graduates to work in rural settings by contacting all government and non-government health universities and colleges and talking to graduates about career opportunities in government and councils. The MOHSW could also organize job fairs annually to enable councils to meet graduates and encourage them to work in their districts.

Another key finding from this study is that not all posted staff are reporting to their assigned work stations. This trend has been fluctuating: 20 percent of posted staff did not report in 2011/12, 30 percent in 2012/13, and 13 percent in 2013/14. The MOHSW has strengthened the reporting system considerably in the last four years. The posting list is now posted on the MOHSW website and can be accessed by everyone, including graduates. The list includes personal details and placement locations for posted HWs. The website also includes a posting letter with general information about reporting time and documents

required for verification. The MOHSW is no longer sending letters for all posted HWs as in previous years.

- In the current posting system, there is no direct communication with posted HWs to attract them to report to their assigned working stations. It is likely that some graduates may decide not to report to their postings because the locations are remote, they don't have relatives or friends working in the area, or they don't know the living conditions and who to contact for assurance and guidance. The MOHSW should consider encouraging communication between posted HWs and councils to increase the proportion of HWs reporting to their assigned posts. This could be done in various ways, such as including contact information for all councils on the MOHSW website, or sending a list of posted HWs and their contact details to councils and encouraging councils to contact the HWs and welcome them. A similar recommendation was given in the previous recruitment study conducted by BMAF, but has not been addressed since the MOHSW moved to a web-based posting system. This recommendation remains valid and was requested by CHMT members interviewed.
- Councils should develop incentive packages and establish good working environments to attract staff. The government HRH strategy advocates for districts to use pay per performance schemes and develop localized incentive packages based on their ability to generate resources. There should be an incentive package for new HWs to get them settled in new locations. Posted HWs should be contacted before arriving at their postings and informed about these special incentives to increase their chances of reporting.
- To increase staff retention, councils should conduct proper orientation for new staff. Some councils, like Kilolo DC and others, have managed to increase retention of posted staff in hard-to-reach areas by assigning them to the district hospital for six or more months, allowing them to become familiar with the new environment before being posted to remote areas. These practices should be widely explored and applied throughout the country.

Our study also revealed that the POPSM LAWSON database and the MOHSW HRIS database contain conflicting information, with HRHIS reports indicating 20 percent more staff available than LAWSON in the same districts. These systems are not linked and data is entered into both systems from paper-based sources.

- Both systems are very important in planning and making HRH decisions. To use resources effectively and reduce the burden on council staff (who must enter the same information into both systems), the LAWSON and HRHIS systems should be linked. To avoid duplication, the MOHSW should consider extracting data elements for public sector employees into LAWSON, and HRHIS could cover only HWs working in the private sector.

The study shows that there are critical staff shortages for all HW cadres. To close this gap, collective efforts are needed to first ensure that all approved permits are filled and then to advocate for more recruitment permits for HWs. According to new staffing level norms (2014), the shortage of HWs in the 30 assessed districts in 2013/14 was 68 percent of the requirement. Nationally, the shortage of HWs is 75,210, which is 52 percent of the requirement. The following recommendations will become more applicable after the MOHSW manages to fill most of the approved staffing permits:

- Conduct regular policy table discussions with key policymakers at POPSM, the MOF, and the MOHSW to review progress made toward Tanzania's commitment—made at the Global Health

Workforce Alliance—to increase skilled HWs at all levels of health service delivery from 46 percent to 64 percent by 2017. Evidence should be used to advocate for the government to implement evidence-based strategies to address staffing gaps.

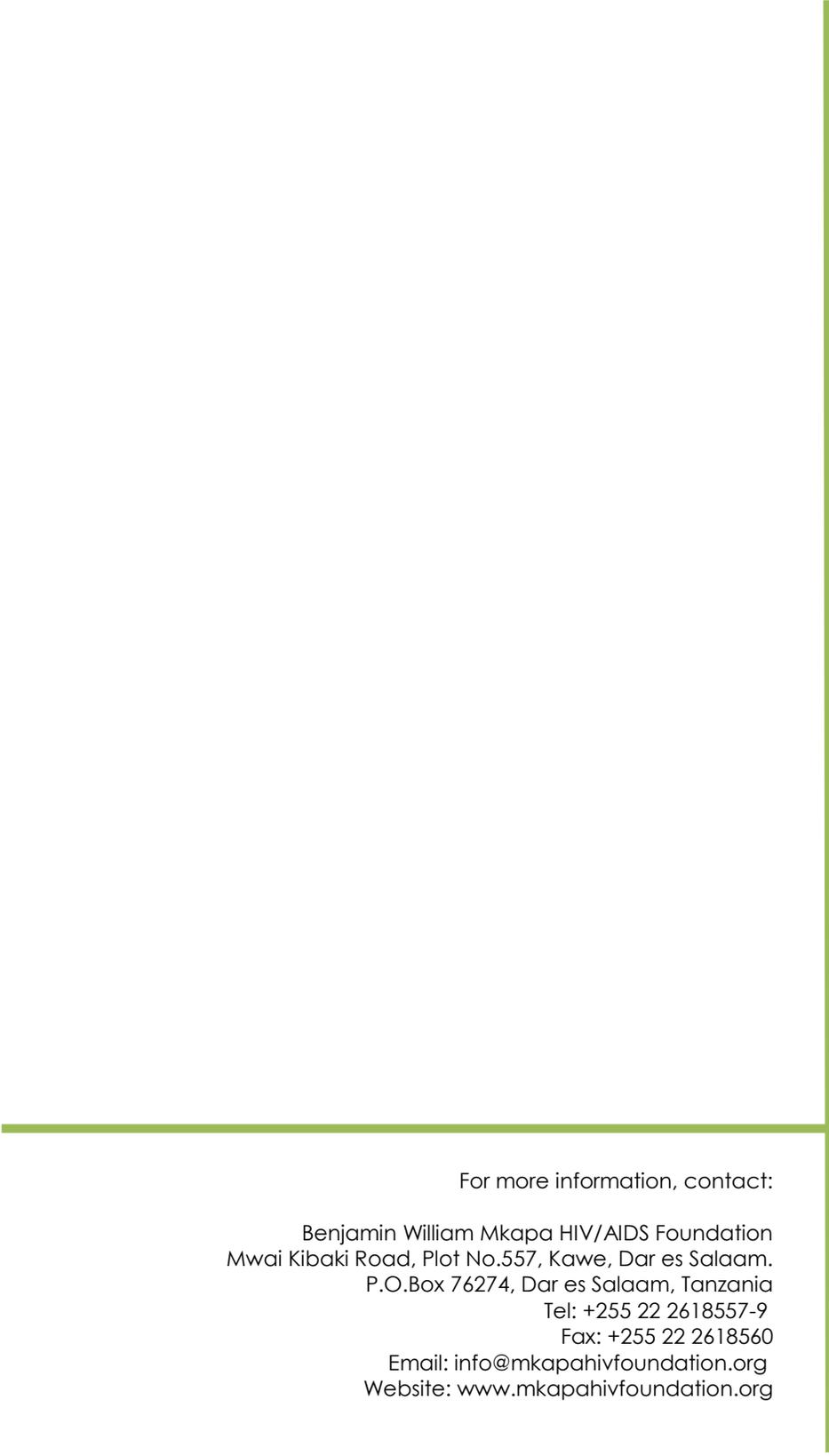
- Organize field visits for key policymakers from POPSM and the MOF to health facilities in rural areas to expose them to current working conditions and provider workloads, enabling them to examine how these affect service quality. Understanding the challenges that health facilities face in service delivery will help policymakers make more informed decisions and better prioritize resources to improve health outcomes. Currently, these decisions are made without a thorough understanding of the reality in the field.
- Complement the HRH BRN initiative, a positive government strategy, by advocating for policymakers at POPSM and the MOF to allocate more permits in councils with critical staff shortages. BMAF can track progress on addressing staff shortages in relation to improving health outcomes, sharing the findings with the policymakers to inform evidence-based decisions.

ANNEX A. STAFFING PERMITS REQUESTED AND APPROVED, BY DISTRICT, 2013/14

District	Medical Doctor		AMO		Nurse		Medical Attendants	
	Requested	Approved	Requested	Approved	Requested	Approved	Requested	Approved
Rombo DC	2	2	0	0	13	8	0	0
Bagamoyo DC	10	2	10	4	20	3	20	5
Bukombe DC	14	2	5	3	15	5	7	2
Chato DC	1	1	0	0	22	11	13	0
Hai DC	1	0	10	0	6	0	9	0
Iringa DC	3	2	0	0	13	13	7	10
Iringa MC	0	0	0	0	15	0	30	0
Kibaha DC	1	1	0	0	18	4	12	1
Kibaha TC	2	0	0	0	3	0	2	0
Kilolo DC	4	2	4	2	18	6	0	2
Kisarawe DC	2	0	1	2	9	8	8	7
Masasi DC	0	0	0	0	3	3	0	0
Masasi TC	6	1	0	2	10	3	6	0
Mbinga DC	5	0	0	0	20	4	10	0
Moshi DC	1	1	0	0	3	0	0	0
Moshi MC	0	0	3	2	7	3	10	0
Mtwara DC	0	0	0	0	20	5	7	0
Mtwara MC	0	0	0	0	0	0	0	0
Mufindi DC	4	0	4	3	66	20	0	0
Mwanga DC	2	2	2	2	10	4	12	0
Namtumbo DC	1	1	5	2	18	5	0	0
Rufiji DC	2	0	0	0	10	9	15	8
Same DC	2	1	2	0	6	3	0	0
Shinyanga DC	4	0	0	3	46	0	0	0
Shinyanga MC	2	2	5	5	4	4	0	0
Siha DC	2	1	2	0	13	4	12	0
Songea DC	0	0	0	0	0	0	0	0
Songea MC	0	1	1	1	5	4	0	2
Tandahimba DC	0	0		2	10	11	0	0
Total	68	22	54	33	390	140	182	37

REFERENCES

Ministry of Health and Social Welfare (MOHSW), Human Resources Development Directorate. 2014. *Human Resource for Health and Social Welfare Country Profile 2013/2014*. Dar es Salaam: MOHSW.



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